DO THE RIGHT THING

Today’s technologies can extend and save lives, but they also open the door to thorny ethical issues.

Art featured at the Gallery at the LRC addresses a broad scope of diseases and conditions. In “Two Belts,” Susan Myrland offered a visual diary of the last few years in the life of her mother Ginny as she struggled with dementia. The photographs and narrative showed two women fighting to maintain a quality of life against the relentless downward pull of disease.

Art: “Nap” (left) and “Premium Chicken,” Susan Myrland, San Diego, California

U.S. News & World Report’s Best Hospital Survey ranks UCLA the No. 3 hospital in the country and Best in the West.

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

UCLA Health
David Geffen School of Medicine
WINTER 2016
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, state, and year 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.

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LEADERSHIP

The Essence of What We Are About

The tale of our excellence is told in patents, inventions and start-ups, but the truest measure of our value is in the newer and safer treatments our scientists develop to alleviate suffering and cure disease.

What is the essence of a great research university?

This can be summed up in a single word: discovery. It is knit into the fabric of our being as a top-tier research institution to conceive fresh ideas, generate new knowledge and bring forth cutting-edge products to benefit society.

The ties between UCLA Health and the David Geffen School of Medicine at UCLA create an environment that fosters collaboration and the cross-pollination of ideas. Our combined strength gives UCLA the extraordinary research power and resources to open and explore new worlds of inquiry and the clinical expertise and practice to take groundbreaking discoveries from the bench to the bedside to advance newer and safer treatments to alleviate suffering and cure disease.

The numbers tell a piece of the tale. One clear measure is the level of research support our faculty in the David Geffen School of Medicine at UCLA receives from the National Institutes of Health (NIH); our NIH funding continues to be very robust, and in 2015 our ranking moved up. Another measure is to examine the results that flow from that funding — a wealth of knowledge and output that directly benefits society. Look at recent data from the UCLA Office of Intellectual Property & Industry Sponsored Research. In 2014-15, 16 David Geffen School of Medicine at UCLA-originated start-ups were launched (bringing the lifetime total of start-ups to 82). In addition, there have been 49 U.S. patents issued (lifetime total: 721), 311 inventions disclosed (lifetime total: 3,010) and 288 licenses and options issued (lifetime total: 1,062).

These are wonderful metrics of our success, but NIH funding, inventions, patents and start-ups are not in themselves the full story. They are means to an end, which is to create newer and safer treatments for patients worldwide and to generate the revenue necessary to continue to build our medical school and healthcare enterprise to support research and train the next generations of healers and scientists. These funds are also used to support a wide range of non-medical campus programs that are important but underfunded.

Now we are moving to construct an even stronger foundation upon which to build toward those goals. It is one thing for our faculty to receive research grants, make great discoveries and publish in prestigious journals. But we fail in our mission as a center for discovery and innovation if we cannot help our talented faculty to overcome the barriers that exist to move their ideas beyond the printed page and get them, in a practical and physical sense, out into the world. That is why we have established a Technology Accelerator for the David Geffen School of Medicine at UCLA that has been operational on a limited scale and will fully launch in 2016. It will enable us to improve the process for getting these valuable ideas into the public sphere. Doing so will have tremendous benefits for all concerned — our faculty, our campus and society as a whole. By some estimates, this approach could generate an annual revenue stream of tens of millions of dollars or more. This is revenue that can then be returned to the school to further support the work of our faculty and help them to turn their discoveries into new products that can be brought to market to further improve the lives of people throughout the world.

And that is the essence of what we’re all about.

John C. Mazziotta, MD (RES ’81, FEL ’83), PhD
Vice Chancellor, UCLA Health Sciences
CEO, UCLA Health
The walk up Fifth Avenue in New York City on Veterans Day was only 1.3 miles, but it took hundreds of thousands of steps, both physical and emotional, for 10 patients from UCLA’s Operation Mend to get there.

Jimmy Gentile was among those who made the journey. “It was a complete honor, and I felt very blessed to represent Operation Mend and to walk with all the other wounded veterans,” says Gentile, who, with his family — wife Megan and children Tristan, 17, Alyssa, 14, Callie, 6, and Kimber, 2 — marched at the head of the Operation Mend contingent holding the group’s banner. “It is a very different environment to be around other wounded guys who understand what you have been through. For my children, I thought it was really good for them to see what sacrifices have been made for them.”

Gentile was a corporal in the U.S. Marine Corps in Iraq in 2004 when he was shot in the face and nearly killed. He has undergone more than 35 surgeries, but he was blinded in his right eye and lost much of the vision in his left. Through Operation Mend — the program established in 2007 as a partnership among UCLA Health, the U.S. military and the Department of Veterans Affairs to help service members injured in the post-9/11 wars — Gentile came to UCLA to undergo a procedure called refractive lens exchange to replace the natural lens of his remaining eye with an intraocular lens and restore his sight. “Now I have full, perfect vision in that eye,” he says. “Everything in my daily life is better because I have that vision, and I don’t have that fear of one day I am not going to be able to see.”

U.S. Marine Staff Sargent Johnathan Rose was another UCLA Operation Mend patient in the 2015 America’s Parade, which gathered together more than 20,000 participants. SSgt. Rose was wounded in Afghanistan in 2010, when his vehicle was hit by an improvised explosive
device. The blast blinded him in one eye and caused second-degree burns as well as fractured bones in his leg, jaw, hip and hands. He has undergone medical and dental care at UCLA to restore his teeth and mouth. Operation Mend and the staff at UCLA “have become my West Coast family,” he says.

SSgt. Rose still is on active duty in the Marine Corps. Though he was stationed in the New York City area for three years before he was deployed to Afghanistan, he never got to take in the sights. “I was working 24/7,” he says. So in addition to the honor of walking with Operation Mend, he welcomed the opportunity to come back to New York as a tourist. And he embraced the camaraderie of being with other veterans with whom he had shared experience.

Walking in the parade, he says, “was awesome.” The crowds lining the route were “five-, six-, seven-people deep. I don’t think there was an empty spot on either side of the street.” SSgt. Rose carried a GoPro camera on top of an Operation Mend flag — “I had the birds-eye view from 10 feet up” — and when he got home, he reviewed the video. “I was like, wow,” he says. “I didn’t realize there were that many people there.”

For more information about UCLA Operation Mend, go to: operationmend.ucla.edu
Genetic Testing All Women for Breast Cancer Might Not be Worth the Cost

Women who are carriers of mutated BRCA genes are known to have a significantly higher risk for developing breast and ovarian cancers than those who don’t. But a new UCLA study questions the value of screening for the genetic mutations in the general population — including those who do not have cancer or have no family history of the disease — because of the high cost. The UCLA researchers found that compared with universal screening, other diagnostic tools remain more efficient and might be more cost-effective.

The researchers concluded the BRCA genetic test that is most widely used today, which costs about $4,000, is too expensive to warrant universal screening, given how rare BRCA mutations are. “The cost of BRCA testing would need to drop by 90 percent for testing to be cost-effective for the whole population,” says Patricia Ganz, MD ’73 (RES ’76, FEL ’78), director of the Division of Cancer Prevention and Control Research at UCLA’s Jonsson Comprehensive Cancer Center.

Dr. Ganz and a colleague in the UCLA Anderson School of Management calculated that for every 10,000 women screened, BRCA screening could avert four cases of breast cancer and two cases of ovarian cancer more than would family-history-based testing. But the BRCA screening would only extend patients’ lives by an average of two days. For 99.75 percent of women screened, a negative genetic test offers no increase in life expectancy, nor would it eliminate the need for regular mammograms, and it could provide false reassurance that a woman is not at risk for breast cancer.

Harmful BRCA gene mutations are more likely to be found in families affected by breast and ovarian cancers, and carriers can pass the mutated genes to both daughters and sons. Those who carry a BRCA mutation are thought to have a 45-to-80-percent lifetime risk of developing breast cancer. Women carrying the BRCA-1 mutation have up to a 39-percent lifetime risk; women with BRCA-2 have a 10-to-17-percent lifetime risk for ovarian cancer.

The U.S. Preventive Services Task Force advises BRCA genetic testing only for women with a known family history of breast, ovarian, tubal or peritoneal cancer.

“It’s like looking for a needle in a haystack,” says Elisa Long, PhD, Dr. Ganz’s co-investigator. “If only one-in-400 women across the country has one or both of the BRCA-1 or BRCA-2 mutations, universal screening would cost $1 million to $2 million to detect a single BRCA mutation, or nearly $400 billion to screen all women in the U.S. Perhaps this money could be better spent on other diagnostic tools for young women, such as magnetic resonance imaging, to have the greatest impact.”

Cost-effectiveness of Universal BRCA1/2 Screening Evidence-based Decision Making,” JAMA Oncology, September 3, 2015

7 percent of women in the U.S. will get breast cancer by age 70

50 percent of women in the U.S. with BRCA1 or BRCA2 mutation will get breast cancer by age 70
People in the midst of alcohol or drug addiction tend to imagine life without those substances as one of deprivation, which can make kicking the habit seem like a joyless and dreary prospect. But recovery has at least as much to do with rewarding oneself as it does with depriving oneself, a UCLA expert in addiction treatment asserts.

“People with the most success in staying sober tend to get involved in a range of pleasurable activities and do them frequently,” says Suzette Glasner-Edwards, PhD, adjunct associate professor at the Jane and Terry Semel Institute for Neuroscience and Human Behavior at UCLA and author of The Addiction Recovery Skills Workbook (New Harbinger Publications, 2015). “These activities can replace the time and energy that they had been spending on addictive behaviors, enabling them to experience pleasure without the devastating consequences of alcohol or drug use.”

Among the newest approaches Dr. Glasner-Edwards describes in her book is behavioral activation therapy, which advocates rediscovering life’s healthy rewards. Dr. Glasner-Edwards says the strategy is effective because it combats the allure of drugs and alcohol at their source. Rather than taking pleasure from the high level of dopamine that is released in the brain by drugs and alcohol, patients using this approach instead find that fulfillment through activities that they once enjoyed but perhaps lost touch with as a consequence of their addiction, or they discover new ones: Cook something new, plan a party, exercise, visit a museum, engage in a sport. “Ideally, you should have one pleasant activity worked into each day,” Dr. Glasner-Edwards says.

Patients are encouraged to rate how good — or how miserable — they expect the new (or renewed) experience will be on a 10-point scale and then, after the activity, to rate how fun (or not) it actually proved to be. “More often than not, an activity is more fun than you thought it was going to be,” she says, adding that seeing the pattern play out repeatedly can break down people’s resistance to pursuing future fun activities. “Just like the rewarding feelings that follow the use of drugs or alcohol in the early stages lead to forming a damaging habit, rewarding healthy behaviors can establish positive habits,” Dr. Glasner-Edwards says.

One important consideration in choosing such pursuits is whether or not the activity is likely to trigger a relapse. Dr. Glasner-Edwards counsels against activities that a recovering addict would associate with his or her substance abuse. Someone trying to stop using marijuana, for instance, might avoid attending concerts by musicians they used to listen to while high. Another consideration is people with whom the recovering addict spends time during his or her new activities. One recovering alcoholic whom Dr. Glasner-Edwards treated began grilling dinners for his friends. Although he relished his guests’ compliments about his cooking, there was one problem: They often arrived with bottles of wine or six-packs of beer. “I finally had to say, ‘OK, you have this love of grilling, but you have to be careful with whom you grill,’” she says. “Because if they bring booze, all of a sudden you’re feeling like, ‘Why not have just one?’”
UCLA researchers have identified a molecule that signals brain tissue to form new connections to compensate for damage after a stroke and initiate repairs to the brain. The finding could lead to new treatments to promote brain repair and functional recovery in people who have suffered a stroke. The five-year study, performed in an animal model, was the first to identify growth differentiation factor 10, or GDF10, a molecule that previously had no known role in the adult brain.


The scientists found that GDF10 promotes the ability of brain cells to form new connections, and they identified the signaling systems that control the process. “We found that GDF10 induces new connections to form in the brain after stroke and that this mediates the recovery of the ability to control bodily movement,” Dr. Carmichael says.

Finally, the team identified all of the molecules that are turned on or off by GDF10 in brain cells after a stroke and compared the cells’ RNA to RNA in comparable cells during brain development and normal learning and to RNA in the brain cells of people with other diseases.

They found that GDF10 regulates a unique collection of molecules that improves recovery after stroke. The discovery indicates that brain-tissue regenerating after a stroke is a unique process rather than just a reactivation of the molecules that are active in brain development.

The team also administered GDF10 to the animals that had experienced strokes and then mapped the connections in the brain that are tied to body movement. They compared those to the connections in animals that had experienced a stroke but were not given GDF10, in animals with healthy brains and in animals that had experienced a stroke and had a reduced level of GDF10. “The results indicated that GDF10 normally is responsible for the very limited process of the formation of new connections after stroke,” Dr. Carmichael says. “Delivering more GDF10 markedly enhances the formation of new connections and does so mostly in a specific brain circuit. The formation of connections in this circuit with GDF10 administration significantly enhanced recovery of limb control after stroke.”

Neurons (in green) are producing growth differentiation factor 10 (red), a molecule discovered by UCLA scientists that previously had no known role in the adult brain.

Image: Courtesy of Dr. S. Thomas Carmichael

“The brain has a limited capacity for recovery after stroke,” Dr. Carmichael says. “Most stroke patients get better after their initial stroke, but few fully recover. If the signals that lead to this limited recovery after stroke can be identified and turned into a treatment, it might be possible to enhance brain repair after stroke.”

The study also showed that GDF10 is released after a stroke in humans and in many different animals. During a previous study, Dr. Carmichael and his team determined which molecules become more prevalent in the brain during the recovery period after a stroke and listed all of the genes that are up- or down-regulated. Heading into the new study, researchers believed that one of the molecules on the list could be a signal telling the brain to repair itself after a stroke, and they screened for the molecules that saw the biggest increase in the brain after stroke.

Discovery of Molecular Signals Could Lead to Improved Stroke Recovery
New Method to Measure Artery Stiffness in the Brain

UCLA researchers have discovered a noninvasive method to measure vascular compliance, or how stiff an artery is, in the human brain, a finding that may have ramifications for preventing stroke and making the early diagnoses of Alzheimer’s disease. Using a new magnetic resonance imaging (MRI) technique, the UCLA team measured the volume of cerebral arteries twice, using a technique called arterial spin labeling, which can magnetically “label” the blood in arteries without the use of an external agent. The team measured once at the systolic phase of the cardiac cycle, when the heart was pumping the blood into the brain, and again at the diastolic phase, when the heart was relaxing.

The team found that the stiffer the arteries were, the smaller the change in the arterial blood volume between the two cardiac phases, because stiff arteries are not as able as elastic arteries to change shape or comply with the blood-pressure changes. “Vascular compliance is a useful marker for a number of cardiovascular diseases, such as hypertension and diabetes,” says Danny J.J. Wang, PhD, associate professor of neurology and researcher in the Ahmanson-Lovelace Brain Mapping Center at UCLA. “Growing evidence suggests intracranial vascular pathology also may be associated with the origin and progression of cerebrovascular disorders and neurodegenerative diseases, such as Alzheimer’s disease. However, to date, few methods are available to assess that role.”

The UCLA team compared stiffness measurements in young and elderly patients and found that arterial stiffness is significantly increased in elderly patients. This finding is consistent with the theory that aging is associated with stiffening of the arteries. The team also found that increased arterial stiffness is associated with reduced cerebral blood flow, suggesting stiff arteries impair the blood supply to the brain. Additionally, the researchers found artery stiffness is correlated with the stiffness of the largest artery of the human body, the aorta.

“We hope our technique can provide an early marker for a number of socioeconomically important diseases like Alzheimer’s,” says Lirong Yan, PhD, assistant researcher in the UCLA Department of Neurology. “A number of studies suggest that vascular dysfunctions, including arterial stiffening, are associated with the development of Alzheimer’s. The development of early bio- or imaging markers for Alzheimer’s is of great importance for slowing disease progression. Hardened arteries due to the accumulation of plaques on the vessel walls also is linked to cerebrovascular disorders such as stroke.”


Representative maps of cerebral blood flow (CBV) at systole and diastole, as well as the corresponding CBV change (ΔCBV) between systole and diastole from a young (21 years, male) (a, b and c) and an older (59 years, male) (d, e and f) subject, respectively.

Graphic: Courtesy of Dr. Danny J.J. Wang.
A UCLA-led study suggests that wrist fractures among postmenopausal women who are younger than 65 may predict more serious fractures in other parts of their bodies later in life.

The researchers found that one-in-five women who had experienced a broken wrist went on to suffer a non-wrist fracture during the next 10 years. They also suggested that women who broke a wrist stood a 40-percent higher chance of breaking other bones during the subsequent 11 years compared with women who did not break a wrist.

“Our results emphasize that wrist fractures do identify a group of women at particular risk for future fracture,” says Carolyn Crandall, MD '91 (RES '94), professor of medicine. “The information highlights the great importance of working to develop strategies to prevent future fractures after an initial wrist fracture occurs.”

The researchers used information from the Women’s Health Initiative (WHI), whose participants were aged 50 to 79 at the start of the study in 1993. More than 160,000 women answered annual questionnaires detailing the fractures they experienced during more than a decade of follow-ups.

They found that having a wrist fracture was associated with:

- a 50-percent higher risk of subsequent spine fractures;
- an 80-percent higher risk for upper-arm fractures;
- a 90-percent higher risk of a lower-arm non-wrist fracture;
- a 40-percent higher risk of leg fractures; and
- a 50-percent higher risk of hip fractures.

These associations persisted even after adjusting for factors such as bone-mineral density, physical activity, smoking and alcohol use, calcium and vitamin D intake, falls and all other known fracture-risk factors.

The study has some limitations. Self-reporting of fractures may not be as accurate as medically verified breaks, but misclassifications of fractures in the WHI have been low; WHI participants may be healthier than other women, so these findings may not be representative of postmenopausal women as a whole, and the number of women who had normal bone-mineral density but nonetheless suffered wrist fractures was low.

But the findings do indicate a “substantial missed opportunity” to devise interventions to prevent subsequent fractures in women who experienced a wrist fracture, the researchers write. Among postmenopausal women who have experienced wrist fractures, those who have a bone-mineral-density T-score less than or equal to -1.0 should be diagnosed as having osteoporosis, they write.


Scientists at the UCLA Eli and Edythe Broad Center of Regenerative Medicine and Stem Cell Research have shown that the cells responsible for generating deadly prostate cancer share some genetic qualities with the tissue-specific stem cells that naturally reside in the healthy prostate.
Scientists Use Nanoparticles to Shut Down Cancer Growth

In an advance toward developing a novel therapy for cancer, scientists from UCLA and the City of Hope used nanoparticles to deliver a nucleic acid known as small interfering RNA, or siRNA, into tumor cells to inhibit the expression of a specific protein and cause inhibition of tumor growth in an animal model.

The protein, TWIST, is a master regulator of a cancer program called epithelial-to-mesenchymal transition (EMT) that is implicated in tumor metastasis. Delivering siRNA into tumor-bearing mice inhibited the expression of TWIST, which in turn shut down the EMT program and dramatically reduced the size of tumors. “This demonstrates the effectiveness of targeting EMT for cancer therapy,” says Fuyu Tamanoi, PhD, professor of microbiology, immunology & molecular genetics and director of the signal transduction and therapeutics program at UCLA’s Jonsson Comprehensive Cancer Center.

In previous studies, siRNA has been shown to effectively shut down gene expression in tumor cells grown in the laboratory. But the technique had not been effective in living organisms because enzymes in the blood called nucleases degrade siRNA before it can reach tumor cells. To circumvent that problem, the UCLA and City of Hope researchers attached siRNA to the outside of a particular type of nanoparticle developed by Jeffrey Zink, PhD, professor of chemistry and biochemistry and a member of UCLA’s Jonsson Comprehensive Cancer Center. The nanoparticles are comprised of mesoporous silica coated with a substance called polyethyleneimine, which acts to bind and protect the siRNA when the particles are injected into the blood. As a result, the research team, led by Carlotta Glackin, PhD, at the City of Hope, found that the nanoparticles could accumulate in the tumor cells, and the siRNA could go to work inhibiting the cells’ expression of TWIST.

The study found that giving mice siRNA-loaded nanoparticles once a week for six weeks inhibited tumor growth and that it shut down not only TWIST, but also other genes under the control of the EMT process. The result confirms the critical importance of TWIST and the EMT process in cancer progression, the scientists say. TWIST is re-activated in a number of metastatic cancers, including triple-negative breast cancer, melanoma and ovarian cancer. By shutting down the EMT process, Drs. Zink, Tamanoi and Glackin may develop new therapy options for these cancers.

Another important finding was that shutting down TWIST expression enabled cancer cells to overcome their resistance to cancer drugs, suggesting that the therapy can be an effective way to sensitize cancer cells to anti-cancer drugs.

“Mesoporous Silica Nanoparticle Delivery of Chemically Modified siRNA against TWIST1 Leads to Reduced Tumor Burden,” Nanomedicine: Nanotechnology, Biology and Medicine, May 2015

Illustration: Courtesy of Dr. Fuyu Tamanoi

“Pinpointing the cellular traits of cancer — what makes those cells grow and spread — is crucial because then we can possibly target those traits to reverse or stop cancer’s progression,” says Owen Witte, MD, founding director of the UCLA Broad Stem Cell Research Center. “Our findings will inform our work as we strive to find treatments for aggressive prostate cancer.”

Dr. Witte and postdoctoral researcher Bryan Smith, PhD, worked with collaborators from UC Santa Cruz to investigate the genetic characteristics of aggressive prostate cancer, which spreads, or metastasizes, to other organs in the body. The research team analyzed biopsies from living patients with metastasized prostate cancer who are participating in clinical trials for the Stand Up To Cancer initiative. Biopsy analysis provided the team with a 91-gene “signature” for the stem cells that naturally reside in prostate tissue. Comparing this signature to genetic data from patients with aggressive prostate cancer, the researchers found that normal prostate-tissue stem cells and aggressive prostate-cancer cells possess similar characteristics.

“Evidence from cancer research suggests that aggressive cancers have stem-cell-like traits,” Dr. Smith says. “We now know this to be true for the most aggressive form of prostate cancer.”

“Treatments for early-stage prostate cancer often are successful, but therapies that target the more aggressive and late-stage forms of the disease are urgently needed,” Dr. Witte says. “I believe this research gives us important insight into the cellular nature of aggressive prostate cancer.”

UCLA researchers have reported the first evidence that obstructive sleep apnea contributes to a breakdown of the blood-brain barrier that plays an important role in protecting brain tissue by limiting harmful bacteria, infections and chemicals from reaching the brain. The discovery could lead to new approaches to treat obstructive sleep apnea, which causes frequent interruptions in breathing during sleep because the airways narrow or become blocked.

From research conducted at UCLA over the past 12 years, experts have learned that the gasping during the night that characterizes obstructive sleep apnea can damage the brain in ways that lead to high blood pressure, depression, memory loss and anxiety. It also can cause extreme daytime sleepiness and can lead to stroke, diabetes, loss of testosterone and endocrine-related problems.

The damage to the brain likely stems, in part, from the reduction of oxygen to the body as a result of the repeated breathing interruptions. But doctors do not yet fully understand exactly what causes the brain injury and how it progresses. While previous studies have found that reduced exposure to oxygen and high blood pressure can affect the blood-brain barrier, which in turn can introduce or enhance brain-tissue injury, Dr. Kumar and his colleagues are the first to show that this breakdown occurs in obstructive sleep apnea.

The study was conducted with a magnetic resonance imaging procedure that uses the brain’s own blood and fluids to measure the breakdown of the blood-brain barrier. In the new study, the researchers found that in patients who recently had been diagnosed with obstructive sleep apnea and not yet treated, the permeability of the blood-brain barrier was significantly higher than it was in healthy people. “This suggests that besides improving breathing in obstructive sleep apnea patients, we need to repair or improve blood-brain barrier function, perhaps by using treatments already available for other conditions,” Dr. Kumar says.

He noted that the study was small — nine people with obstructive sleep apnea were compared to nine healthy controls. Now, in addition to confirming these findings in a larger population of patients with obstructive sleep apnea, the researchers are planning to study whether or not strategies known to be effective in overcoming blood-brain barrier breakdown in people who have had a stroke and other neurological conditions also can help minimize brain injury in people with obstructive sleep apnea or other long-standing respiratory problems.

Studies have found that a compromised function of the blood-brain barrier is associated with significant brain damage in stroke, epilepsy, meningitis, multiple sclerosis, Alzheimer’s disease and other conditions. “We found that the blood-brain barrier becomes more permeable in obstructive sleep apnea, a breakdown that could contribute to brain injury, as well as potentially enhancing or accelerating the damage,” says Rajesh Kumar, PhD, associate professor of anesthesiology and a member of the UCLA Brain Research Institute. “This type of brain injury in obstructive sleep apnea has significant consequences to memory, mood and cardiovascular risk, but physicians and researchers have developed pharmacologic and non-pharmacologic therapeutic strategies to repair blood-brain barrier function in other conditions.”

How Obstructive Sleep Apnea Damages the Brain

Brain maps showing compromised blood-brain barrier function in one person with obstructive sleep apnea (left) and one person with a healthy brain. Regions with yellow-to-red areas represent an intact blood-brain barrier; regions with blue-scale colors indicate an altered blood-brain barrier.

Image: Courtesy of Dr. Rajesh Kumar

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Keeping Gut Bacteria in Balance Could Help Delay Age-related Diseases

Why do some people remain healthy into their 80s and beyond, while others age faster and suffer serious diseases decades earlier? UCLA researchers may have found a possible key to unlock the answer. Analyzing intestinal bacteria (microbiota) could be a promising way to predict health outcomes as we age, they say.

The researchers discovered changes within intestinal microbes that precede and predict the death of fruit flies. “Age-onset decline is very tightly linked to changes within the community of gut microbes,” says David Walker, PhD, professor of integrative biology and physiology. “With age, the number of bacterial cells increases substantially, and the composition of bacterial groups changes.”

The study used fruit flies in part because some live to an age that would be the equivalent of humans in their 80s and 90s, while others age and die much younger. In addition, scientists have identified the fruit-fly genome and know how to switch individual genes on and off.

In a previous study, the UCLA researchers discovered that five or six days before flies died, their intestinal tracts became more permeable and started leaking. In the latest research, the scientists found they were able to detect bacterial changes in the intestine before the leaking began. As part of the study, some fruit flies were given antibiotics that significantly reduce bacterial levels in the intestine; the study found that the antibiotics prevented the age-related increase in bacteria levels and improved intestinal function during aging. The biologists also showed that reducing bacterial levels in old flies can significantly prolong their life spans.

The intestine acts as a barrier to protect organs and tissues from environmental damage, “The health of the intestine — in particular, the maintenance of the barrier protecting the rest of the body from the contents of the gut — is very important and might break down with aging,” says Rebecca Clark, PhD, a postdoctoral scholar when the research was conducted.

Recently, scientists have begun to connect a wide variety of diseases, including diabetes and Parkinson’s, among many others, to changes in the microbiota, but they do not yet know exactly what healthy microbiota look like. “One of the big questions in the biology of aging relates to the large variation in how we age and how long we live,” Dr. Walker says.

When a fruit fly’s intestine begins to leak, its immune response increases substantially and chronically throughout its body. Chronic immune activation is linked with age-related diseases in people as well. Dr. Walker said that the study could lead to realistic ways for scientists to intervene in the aging process and delay the onset of such aging-related diseases as Parkinson’s, Alzheimer’s, cancer and diabetes.

“Distinct Shifts in Microbiota Composition during Drosophila Aging Impair Intestinal Function and Drive Mortality,” Cell Reports, September 8, 2015

Intestinal cells on the left appear to be young and healthy. As the cells age (moving to the right), they degenerate, the intestinal barrier declines, gaps between cells appear and the level of bacteria increases (colorful objects).

Illustration: Dr. Rebecca Clark
Building Sound Bodies and Sound Minds

Inadequate physical activity is a behavioral pattern established during youth. Many schools are forced to cut back or eliminate resources for physical education, contributing to an increased number of overweight, physically inactive students. The goal of UCLA Health Sound Body Sound Mind is to help schools and educators prepare students for a lifetime of healthy activity by installing state-of-the-art fitness programs in middle and high schools. In 2015, the Sound Body Sound Mind Foundation committed $3 million to establish a partnership with UCLA Health. Now known as UCLA Health Sound Body Sound Mind, the joint organization replicates the original program model of the Sound Body Sound Mind Foundation, while taking advantage of UCLA Health’s network of experts and individuals working in the Los Angeles community.

For more information, go to: uclahealth.org/soundbodysoundmind
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Death Becomes a Matter of Choice

California’s new physician-assisted suicide law gives terminally ill patients and their doctors a legally sanctioned process to have responsible and compassionate conversations about choices at the end of life. UCLA’s Neil Wenger, MD ’84 (RES ’87, FEL ’89), MPH, and David Wallenstein, MD, are at the forefront of discussions about how to implement this new law.

Both of you, in your roles at UCLA, are intimately involved in end-of-life issues. What are your views about the legislation signed into law by Gov. Brown?

**Dr. David Wallenstein:** I am an advocate of patient autonomy. Looking at it from that perspective, I’m relieved that patients are being listened to in this way.

**Dr. Neil Wenger:** It may very well be that this kind of permission is what’s necessary to open up this debate over physician-assisted suicide has been controversial and often contentious. Now that it is law in California, hospitals and physicians must develop their own policies for how it may be implemented. U Magazine contributor Dan Gordon spoke with two physicians at the forefront of these discussions at UCLA: Neil Wenger, MD ’84 (RES ’87, FEL ’89), MPH, director of the UCLA Health Ethics Center, and David Wallenstein, MD, a specialist in pain management and palliative medicine.

In terms of my own personal experience, I became interested in medicine 30 years ago because I was an AIDS volunteer back before there were any treatments available for AIDS and HIV. And there was a great deal of suffering, and many people chose to end their own lives, and they really had no professional guidance in doing this. So, from that perspective, I’m glad that there now is, in California, a legally sanctioned process for patients to begin to have these conversations with their physicians. It’s very important for physicians to be able to speak about this issue responsibly and compassionately to patients. It also is a really important point to make, in the context of this discussion, that data show that in the four states where physician-assisted suicide has been legal (Oregon, Washington, Vermont and Montana), the number of people who actually go through with physician-assisted suicide is really quite small. When patients can talk openly and honestly about these issues with their physicians, it often becomes possible to find other ways to address their fears and concerns, and being able to have these conversations is a great comfort to them. I am hoping this new legislation will facilitate better dialogue between patients and physicians on this difficult issue.
When a patient makes a request for physician-assisted suicide, it is incumbent upon the physician to take his or her own beliefs out of the equation while talking with the patient.

But there also are some concerns inherent in this issue. One is whether or not a physician should be participating in an activity, the goal of which is to end life. And a second concern is whether or not this might erode trust between some groups of patients and their physicians. Certain groups, especially disenfranchised groups that have had difficulty getting adequate medical care all the way along, at the end of life have difficulty believing that the right thing to do may be to receive less medical care. And if the physician has, as part of his armamentarium, the consent of the state to actually help provoke death, that is an additional potentially difficult point that may need to be addressed in these rather sticky end-of-life discussions. Thus, it is particularly important to be aware of the protections within the law. The law contains many carefully crafted checks and balances. There even is a provision in the California law that isn’t in the Oregon law that requires patients to be taken aside in a closed space, with no one else there, to make sure that they’re not being coerced.

You raise the role of the physician in this. But facilitating the kinds of discussions you encourage perhaps is not a skill that has been taught to physicians in the past, and having to do this may be outside the comfort zone for many. What should they know to have the best possible conversations about these issues?

Dr. Wenger: It’s going to take an enormous amount of education for physicians to lead these discussions, and having these conversations is a lengthy process. There are questions that need to be asked not only of the patients, but also of the consultant physician, questions to consider about when a patient should be referred to a mental-health provider for evaluation, how to interact with that mental-health provider to know whether or not a patient’s emotional state is encumbering his or her ability to make rational choices. This fits into the broader question of how to teach doctors to do advance care planning. Doctors are just now learning how to do this well. This new law will add greater complexity.

Dr. Wallenstein: When a patient makes a request for physician-assisted suicide, it is incumbent upon the physician to take his or her own beliefs out of the equation while talking with the patient. The physician needs to hear, without judgment, what the patient has to say. That doesn’t mean a physician has to do something that he or she feels is inappropriate.
“It is written into the law that this does not allow an infusion of medication to kill the patient, it does not allow mercy killing, and the patient has to self-administer the lethal medication.”

or immoral, but the physician does have to have the conversation in such a way that the patient’s feelings and beliefs and needs are heard, genuinely respected and honored as part of the patient’s right to both self-determination and autonomy.

Some opponents of the law expressed concern that there will be people — maybe those going through depression or temporary pain — who might be vulnerable to being pressured into making a choice not necessarily in their best interest, and that there are opportunities for abuse.

Dr. Wenger: This law has been tested in Oregon (where the state’s Death with Dignity Act went into effect in 1997), and that has not been shown to be a problem. There were a few celebrated news reports of individuals saying that they were feeling coerced, but the fact is that in the nearly 20 years Oregon has had this law, it doesn’t appear that there have been problems among the approximately 850 people who have exercised the option. That said, California is not Oregon; Los Angeles County alone is three times bigger than the entire state. And Oregon doesn’t have nearly the ethnic diversity that we have here. We could potentially have some difficulties that Oregon hasn’t experienced.

Dr. Wallenstein: California is a much more complex and diverse environment, and it will be incumbent upon the physicians here to speak to these issues in a way that’s sensitive to the individual patient’s background.

Are there misconceptions that patients and their families might have about what this law means for them?

Dr. Wenger: It is written into the law that this does not allow an infusion of medication to kill the patient, it does not allow mercy killing, and the patient has to self-administer the lethal medication. That is a really, really important component, but there could be misunderstandings.

Dr. Wallenstein: There’s another confusion that I have heard and that I think is very important to clear up. The issue of physician-assisted suicide is not, strictly speaking, part of palliative care; it’s a far bigger and more general issue. I am a palliative-care physician, and I do end-of-life care, and I think it is critically important to consider the issue of physician-assisted suicide separate from that of good symptom and pain control. One of the misconceptions that I have had to deal with, just as this legislation was being discussed, is an assumption by many patients, and also by some physicians, that physician-assisted suicide is going to be the exclusive domain of the palliative-care doctor. I think that’s a serious misconception that really needs to be put to rest, not only because it is inaccurate, but also because it conflates the specialty of palliative medicine with the fictional “death panels” that were discussed while the Affordable Care Act was being constructed. Another thing that I think people need to understand is that this is not an instantaneous process. A patient can’t come in
“A patient can’t come in and say, ‘Hey, I want to die,’ and 15 minutes later, it’s done. People need to understand that it’s a very measured and carefully thought-out process.”

Dr. Wenger: And it also is important to note that — based on what we have seen in the other states that have legalized physician-assisted suicide — a third or more of the patients who receive the medication ultimately choose not to use it.

What systems currently are in place at UCLA to effectively implement the new law, and what will need to be developed that’s maybe not in place right now?

Dr. Wenger: We have a lot of very smart doctors at UCLA, and we have really, really good palliative-care physicians, but we haven’t yet figured out the system to implement the law. It is an ongoing discussion that needs to take place. We still don’t know exactly when the law will take effect — probably late in 2016, and recently there’s been talk that it might not happen until 2017. In Oregon, the voters initially approved physician-assisted suicide in 1994, but it wasn’t reaffirmed and implemented until 1997.

What, then, does UCLA need to do to move this forward?

Dr. Wenger: We need to bring together all the parties who will be engaged — doctors, nurses, pharmacists, social workers.

Dr. Wallenstein: Clergy.

Dr. Wenger: Yes, clergy. And patients. That’s how we will attempt to develop policy around this.

The question of physician-assisted suicide was rejected by California’s voters in 1992, and follow-up bills failed in the Legislature in 2005, 2006 and 2007. Why do you think the time was right now for it to pass in the legislature?

Dr. Wallenstein: It’s multifactorial, but I think that a large piece of it is demographics. There is a very large segment of the population, the Baby Boomers, who are moving into the final phases of their lives, and historically we have been a generation that has been very assertive about what it wants. There has been a great deal of patient empowerment around diseases like HIV and breast cancer, and I think that has led to a shift in opinion within the general public about how much control patients should have over their own lives. And, finally, I think the role of the physician has changed drastically over the last 40 years. The physician no longer is broadly seen as an all-powerful medical deity — which is a change that many of us are very happy about. Now, patients really are seeing themselves as having dominion over their own bodies. And that includes dominion over the choices they will make as they approach the end of their lives.

To read the language of the End of Life Option Act, click on the link to this article at: magazine.uclahealth.org

“Patients really are seeing themselves as having dominion over their own bodies. And that includes dominion over the choices they will make as they approach the end of their lives.”
Do the Right Thing

By Veronica Meade-Kelly
Illustrations by Felix Sockwell
As advances in life-extending and lifesaving technologies open new possibilities for patient care, they also make the practice of medicine more complicated and raise difficult ethical issues. UCLA is at the forefront of efforts to ensure that healthcare professionals are properly trained to address these ethical quandaries in the clinical setting.

A modern hospital is a technological marvel. In the developed world, patients have access to vaccines that have vanquished diseases and tempered epidemics, surgical techniques and devices capable of giving new life to the dying and machines and drug therapies that can extend the lives of the ailing for years longer than was imaginable even 50 years ago. In the U.S., these technological advances have helped stretch the average lifespan by more than 10 percent since 1970.

But with every advance, it seems, comes an ethical shadow — a cost or effect that reminds us that where technology is concerned, its use is rarely an unequivocal good. The use of lifesaving drugs and vaccines, for example, may run afoul of a patient’s beliefs or be too costly to be given to all who need them. The limited availability of organs for transplant may raise questions about which patients are most appropriate to receive them. And end-of-life treatments risk extending biological existence at the expense of quality-of-life, prolonging the dying process while offering little hope of recovery.

Such issues occupy thorny ethical territory and have complicated the practice of medicine for all involved in the healthcare system. When difficult decisions need to be made about patient care, clinicians, patients and families can struggle to reach a consensus when the “right” thing to do is not clear-cut and is colored by personal belief. Within this uncharted terrain, a field that has been attracting increasing attention has arisen: clinical ethics. While clinical ethics itself is not a new discipline, a new professional practice has arisen, that of the clinical ethicist or ethics consultant. Its practitioners help healthcare workers, patients and families frame ethical issues and reflect on the implications of decisions made at the bedside and mediate when ethical dilemmas create seemingly intractable disagreements. At UCLA, ethics consultation is provided by the UCLA Health Ethics Center, which was founded in 2002.
We are called into a situation when one of the stakeholders in the doctor-patient relationship is unsure what the right thing to do is from a moral perspective in a particular situation," explains James Hynds, PhD, senior clinical ethicist and director of the center's Arny and Anne Porath Clinical Ethics Fellowship. "In cases where there are value-laden clinical decisions to be made, our job is to facilitate respectful dialogue — to help individuals find their moral voice and to help people listen respectfully to the moral voice of others."

In a sense, clinical ethicists are stewards to the human side of medical practice. Amid the mechanical and the automated, they attend to the metaphysical and personal. But finding the most humane course of action, where technology is concerned, can be more complicated than would first appear. While seemingly cold, unnatural or artificial in nature, technology, in the medical setting, also carries with it hope and possibility, appealing to our humanistic instincts.

It is this duality that often is the source of conflict, as physicians and their patients must constantly consider how, if and when the use of these burgeoning technologies actually enhances medicine or undermines it. "There exists the possibility that technology, used for less than truly human ends, may actually threaten the fundamental goal of medicine, which always has been to heal or cure the sick, so that they can go on living the rich, fulfilling, flourishing life that we all want," Dr. Hynds asserts.

In medicine — perhaps most often in situations involving end-of-life care — there comes a point when attempts to cure may inflict more suffering than withholding treatment. It is a dilemma that, Dr. Hynds says, can trap the clinician between his most basic commitment — to "do no harm" — and the desires of the patient or the patient’s family to do everything possible to save that patient’s life.

Such times call for tough decisions on the part of doctors, patients and their families, and all parties may not agree on the “right” course of action. While doctors have the best perspective on prognosis, patients and their families know best the patient’s wishes, needs and limitations. Where clinicians may see the decision to deny treatment as humane, patients and family members might see it as a betrayal. Add to the mix the social implications that may factor into a medical decision — the potential cost of long-term care or the allotment of limited resources — and the ethical complexity and moral weight of each decision can be profound for both sides.

Clinical ethicists are called upon to mediate in such situations — to help both sides recognize the concerns of the other and understand the potential consequences of a difficult choice. It is also the job of the clinical ethicist, Dr. Hynds contends, to help both sides see that the person with whom they disagree is equally invested in doing what is in the patient’s best interest, reminding all involved that reasonable people can disagree and helping the opposing sides reach an understanding and personal peace, if not an agreement.

"Because the stakes for patients are so high — often life and death — it seems to me a matter of justice that the people who are advising clinicians and advising patients have a high level of professional competence," Dr. Hynds says. "Patients and their families have a legitimate expectation that a clinical ethicist will be professionally trained, just as they expect their nurse or medical clinician is professionally trained."

WHEN PHYSICIANS AND NURSES ARE PUT THROUGH THEIR PACES during their professional training, there is a defined set of standards they must meet before they are deemed ready to handle cases in the clinic — completing an accredited academic program, passing licensure exams and spending years gaining practical experience by shadowing experts in their fields before taking on cases themselves.

But compared to the ancient practice of medicine, the field of clinical ethics consultation is still relatively recent, and it has yet to establish robust requirements regarding the expertise and
training of those entering its ranks. Moreover, in this still-nascent field, it remains unclear what, exactly, that training should be.

“When employers are looking to hire someone with a clinical-ethics skill set, they don’t really have a full understanding of the scope and the nature of the work,” says Bruce White, DO, JD, director of the Alden March Bioethics Institute at Albany Medical College in Albany, New York. “It would be easier to hire qualified individuals if it were clear what skill set they should have and if there were ways to validate whether or not candidates truly possessed that skill set.”

This vocational ambiguity has prompted many in the field to call for formalized standards for the education and training of clinical ethicists. “Many of us would like to see the accreditation of programs that train clinical-ethics consultants. It is important for the discipline to recognize that having a degree in a related field, along with an interest in helping people, is not enough. There needs to be a clearer delineation or definition of what a clinical ethicist should be,” Dr. White says.

In 1998, the American Society for Bioethics and the Humanities outlined a set of “core competencies” for clinical ethicists, but there are no mechanisms currently in place to evaluate whether or not someone who claims to have those core competencies truly possesses them. Those charged with overseeing clinical ethics in U.S. hospitals come from a variety of disciplines — medicine, law, theology — often with degrees in bioethics, a field that has grown contemporaneously with clinical ethics to address many of the same complex ethical issues. Few, however, come to the field with any practical experience dealing with ethical issues at the bedside.

Perhaps nowhere are the standards more rigorous than at UCLA’s Ethics Center, where the Arny and Anne Porath Clinical Ethics Fellowship sets high demands for both entrance and completion of its two-year program. Now entering its fifth year, the fellowship has a high bar for admission — only applicants possessing a doctoral degree in ethics are considered — and fellows, once chosen, must complete two intensive years of academic and practical training and pass multiple assessments in order to fulfill their requirements.

While the demands of the fellowship include coursework and the publication of academic papers, practical experience in clinical ethics lies at the heart of the program. Following an apprenticeship model, fellows are mentored by clinical ethics consultants from the UCLA Health Ethics Center, including Dr. Hynds; center director Neil Wenger, MD ’84 (RES ’87, FEL ’89), MPH; and co-director Katherine Brown-Saltzman, RN, MA. The fellows first shadow their mentors as they consult on ethics issues in the hospitals they serve. Then, gradually, fellows are encouraged to take the lead during consultations — under the watchful eye and guidance of the experts.

The goal is to graduate fellows who have gained extensive, real-life experience in a variety of clinical and ethical contexts. Immersed over a two-year stretch in such diverse settings as Ronald Reagan UCLA Medical Center, the Stewart and Lynda Resnick Neuropsychiatric Hospital at UCLA and UCLA Medical Center, Santa Monica, fellows are exposed to a wide range of consults in several disciplines, including neonatology, pediatrics, transplant medicine, neurology and psychiatry. Past fellows have come out of the program having engaged in well over 200 consults — a substantial amount of experience that prepares them for a career as a solo ethicist.

“In cases where there are value-laden clinical decisions to be made, our job is to facilitate respectful dialogue — to help individuals find their moral voice and to help people listen respectfully to the moral voice of others.”

UCLA’S ETHICS CENTER IS AMONG THE VANGUARD OF INSTITUTIONS that have established fellowship programs to provide those trained in bioethics with experience in the clinical setting. The directors of these programs — Drs. Hynds and White among them — constitute an informal network dedicated to the professionalization of their field. Their fellowships are training a new professional generation of expert clinical ethicists, and, in the process, the hope is to define a high set of standards for those entering the discipline for years to come.
This practical training, Dr. Hynds says, is in high demand; UCLA’s program has more than 50 applicants for each fellowship slot that it offers. “We are inundated by people who want to be clinical ethicists, who realize that one can only truly claim expertise — and feel comfortable as an ethicist — if one has practical training from clinical experience,” he says. Though the demand is high, the number of fellowship programs nationwide is relatively small. This is due, in part, to limited available funding. For its part, UCLA’s ethics fellowship receives much of its support from donors, some of whom provide matches to the funding that UCLA Health provides.

Recent fellow Tyler Gibb, PhD, JD, agrees. “I attended a high-quality graduate program in bioethics, but it was an academic program that did not offer effective clinical experience. I was lucky to secure a fellowship that could bridge the gap,” he says. “Both in terms of the complexity and acuity of the cases and in terms of the intimate mentorship, the training I received at UCLA’s Ethics Center was unparalleled.”

Since completing the fellowship, Dr. Gibb has been appointed assistant professor of medical ethics, humanities & law at Western Michigan University’s Homer Stryker MD School of Medicine in Kalamazoo, Michigan. There, he will serve as an ethics consultant at two local medical centers and will help develop the ethics curriculum for the brand new medical school. Dr. Gibb is evidence that clinical ethics is maturing. He is part of a new generation seeding the field at medical centers across the country. He and other fellows bring with them a cultured view of the discipline that is a product of the mentorship and practical training they received. “Those of us who go through these fellowships come out the other end not only with sound academic credentials, but also with a commitment to improving the craft of clinical ethics,” he says. “We really are trying to set the bar very high for our profession.”

While having trained clinical ethicists in U.S. health systems is becoming more commonplace, their success still depends, at least in part, on the awareness of healthcare professionals to recognize ethical issues and to call on ethicists for support. To that end, the center has partnered at UCLA with Clarence H. Braddock III, MD, vice dean for education in the David Geffen School of Medicine at UCLA and Maxine and Eugene Rosenfeld Chair in Medical Education, and Neveen El-Farra, MD, interim associate dean for curricular affairs, to design a new clinical-ethics curriculum that will expand the training and exposure medical students have to ethical issues that arise in the clinic.

The curriculum, which Drs. Hynds and Braddock plan to roll out over the next few years, will prepare the next generation of clinicians for the ethical challenges that await them in clinical practice. The intent is to provide students with both theoretical and experience-based coursework from the time they enter medical school through graduation that will prepare them for their post-medical school residency, when they will have primary responsibility for patient care and the ethical quandaries that come with it.

The proposed curriculum will begin with an in-depth and sustained study of the nature and goals of medicine as a moral endeavor. Thereafter, a mainly case-based model will be employed to expose first- and second-year students who are not yet in the clinic to the foundational principles that guide ethical decision-making in medicine. Derived from elective seminars Drs. Hynds and Braddock have led in recent years, the courses will be taught through the lens of fictionalized cases based on real situations encountered by the consultants at the
UCLA Health Ethics Center. The approach allows for lively discussion of ethical issues and introduces an analytical framework students can use to work through the moral morass.

When students move on to their final years of training, during which they work as part of a healthcare team conducting clinical rounds, real-life situations they encounter will be integrated into the curriculum. Sessions will allow the students to debrief and make sense of ethical dilemmas they encountered on their rounds and the role they played in their resolution.

Dr. Braddock, who specializes in medical ethics and doctor-patient communication, says the experience will be a unique opportunity for students to resolve the sometimes dissonant realities of theory and practice. “You can have a conversation about a particularly gnarly ethical dilemma and talk about how you might handle a situation, but turning that into practice — having difficult or emotional conversations with patients or families or resolving conflict among parties — takes a separate set of skills that is not necessarily addressed yet by medical education,” he says.

But helping students recognize and analyze ethical issues is not enough. Dr. Braddock says that the curriculum also must address the unique position of the medical student in the ethical context of the clinic. “Because our students get exposure to ethical issues during their education, one of the interesting things that happens when they first land on the hospital ward or in the clinic is that they recognize these issues, while others don’t seem to or don’t share the same level of concern,” Dr. Braddock says.

In 1993, Dr. Dimitri Christakis and Dr. Chris Feudtner — then students at the University of Pennsylvania School of Medicine in Philadelphia, Pennsylvania — reported on the phenomenon in the Academic Medicine article “Ethics in a Short White Coat.” They found that when students first entered the clinical setting, they frequently encountered what they considered ethical dilemmas but that almost no one talked about them. These students came to believe that either they were wrong about the issue or that the ethical issue was, in fact, not really there.

There’s inherent danger for students in this disconnect, Dr. Braddock says. Students risk losing whatever insight or sensitivity they may have gained in their ethical training by virtue of enculturation into a medical system that seems to dismiss their ethical concerns. He and Dr. Hynds hope that the new curriculum will help empower students to feel confident raising questions about ethics in the clinical setting and to understand that their voice and perspective serve an important role that is of value to their medical team.

The pair intends to introduce the new curriculum first as a set of electives that will be the prototype for a series of courses and activities that they hope will be integrated into the required curriculum in the coming years. Such a curriculum would be at the forefront of medical education in terms of preparing students for the ethical aspects of the next phase of their clinical training.

The goal, Dr. Hynds says, is far-reaching: “We would like for all students to emerge from medical school with a solid theoretical and practical foundation in clinical ethics, having learned from in-depth critical reflection on real-life cases and real-world practice dealing with these issues in the clinic. Ultimately, the goal is better doctors and better healthcare.”

Veronica Meade-Kelly is a science writer at the Broad Institute of MIT and Harvard.

WHY I GIVE

Recognizing a need for service and an opportunity to clinically train future ethicists, Arny Porath established the UCLA Arny and Anne Porath Clinical Ethics Fellowship Program in 2011. Since its inception, the program has provided nearly 1,000 consultations to patients, families and clinicians at UCLA, and UCLA-trained ethicists have gone on to provide services across the country.

“Clinical ethics is the part of healthcare that no one sees, but it is crucial to the continuum of care. My service on the ethics committee opened my eyes to the high volume of complex medical situations that would benefit from ethical consultation. Early and skilled interventions benefit patients and their families. This is what inspired us to establish the fellowship program.”

– Arny Porath
The family of a patient being treated for a stroke at Ronald Reagan UCLA Medical Center this past year wrote a note to the hospital, thanking the team of doctors and nurses for providing outstanding care to their convalescing father. Such notes are not uncommon, and this one, like many, praised the standard battery of tropes — kindness, compassion, attentiveness — that contributed to a speedy recovery and eventual discharge. One line, however, stood out. The family recalled, “One of you even asked, ‘What was he like before the stroke?’” Embedded in this simple question is a crucial and historically overlooked attribute in the practice of medicine: clinical empathy.

At first blush, empathy seems to arise innately in some people and not in others, like musical ability or aptitude for foreign languages. But speaking French and playing the violin don’t simply happen without cultivation and practice. Empathy, too, can be learned and taught, irrespective of natural predisposition. And yet, empathy does not conform to scales or grammatical rules — its mechanics and expression are hard to pin down. How, then, does one go about teaching it? Flush with talk of humanistic and patient-centered care, medical schools across the country are seeking ways to fold instruction on clinical empathy into the curriculum. At the David Geffen School of Medicine at UCLA, the faculty and administration have engaged an unlikely ally: art.

The Learning Resource Center, or LRC, is a hub for medical students who come there to study and attend classes at least three times a week. It sits nestled like a concrete bunker behind a row of pine trees on the UCLA campus, at the intersection of Westwood Plaza and Charles E. Young Drive South. For the past five years, the LRC also has housed an art gallery, sponsored by the medical school’s Center for Educational Development and Research. On a recent visit, a series of large portraits lined the walls of the foyer — bright, colorful, messy mixed-media collages depicting a nude female form missing her right arm from the elbow down. The artist, Damienne Merlina, who lost her arm in an accident 11 years ago, funneled into her art practice the shock of suddenly possessing a radically altered body. One piece replaces her skin with a layer of bricks. On another, hateful insults are scribbled atop her flesh.

Art captures a multitude of meanings and guides us to see the world in different ways, as it offers visual expression to help medical students better understand those with illness.
“Of Course It’s Real Blood,”
Damienne Merlina, Los Angeles, California
Photo: Courtesy of Ted Meyer
New work goes up in the LRC four times a year, coordinated thematically with the medical school’s curriculum. Each show aims to expose students to artwork that has been used as an emotional outlet for patients with conditions that range from cancer to multiple sclerosis to a debilitating phobia of germs. “We’re trying to get medical students to look at their patients and say, ‘This person needs a new heart valve, and maybe that’s the source of her poetry or her painting,’” says Ted Meyer, the LRC’s artist-in-residence and creator of the gallery program. “It’s about seeing the patient as more than an illness.”

Not only do students pass by the artworks on their way to and from class, but each artist also gives a talk about the realities of living with illness and using art as a tool to convey that experience. “We had one artist with cystic fibrosis who came in with his oxygen tank and talked about what it’s like to be waiting for new lungs,” Meyer says. “You could have heard a pin drop.”

For medical students, direct, unhurried interaction with patients is hard to come by so early in their training. Neveen El-Farra, MD (RES ’05), interim associate dean for curricular affairs in the David Geffen School of Medicine at UCLA, sees this type of exposure as crucial to shaping truly humanistic physicians. “Students come in and are very fixated on their studies and exams,” Dr. El-Farra says. “Those are important, but one thing we’re working on is an early authentic clinical experience that our students have with patients to better develop a sense of connection and understanding.”

Until clinical rotations begin in the third year, patients often remain an abstraction, a hypothetical battleground of symptoms and interventions scrutinized in the classroom and lab. Third-year medical student Eric Ottey appreciates how the gallery focuses on aspects of the patient experience that easily slip out of the academic conversation. “It’s very different from what we get just being in the science books all the time,” Ottey says. “We are given opportunities to practice our humanity in the first two years — there’s a separate curriculum created to practice that — but art provides a good opportunity to see and think about it in a different way.” In a sense, the gallery deepens and complements these parts of the curriculum, in which students discuss cases as mock practitioners, by giving those stories a real, human face. “We spend a lot of time talking about patient-centered care,” says Margaret Stuber, MD (RES ’82, FEL ’84), assistant dean of student affairs for well-being and career advising. “But having artwork that dramatically illustrates the fear, anxiety, number of pills involved, distortions of the skeleton — it hits them in a different, more emotional way.”


IN AN ESSAY ENTITLED “THE EMPATHY EXAMS”, the writer Leslie Jamison reflects on her stint as a medical actor performing illnesses for medical students. She observes: “Empathy isn’t just listening; it’s asking the questions whose answers need to be listened to. … It suggests you enter another person’s pain as you’d enter another country, through immigration and customs, border crossing by way of query.”

Empathy comes from the Greek empatheia — the joining of em (into) and pathos (feeling) — the
richer, more penetrating sibling of *sumpatheia*, sympathy, whose prefix derives from *sun* (with). The latter implies commiseration — I’m with you — but not necessarily understanding — *I’m putting myself into your shoes*. It’s a subtle but important distinction. An empathetic doctor understands, for example, that she’s not simply treating a kidney with a disease, but a person with a diseased kidney, a person whose life began long before checking into the hospital and will (ideally) continue long after checking out of the hospital.

Until the latter quarter of the 20th century, this sensitivity to the patient experience was called “good bedside manner.” It rarely was more than a garnish atop the meaty entrée of technical expertise. If a doctor had it, great, but it wasn’t something to be fussed over. That changed in the late 1970s, when Arthur Kleinman, MD, a prominent psychiatrist at Harvard University, proposed his “explanatory model,” a series of eight questions designed for healthcare providers to better understand their patients’ lived experience of illness. At the time, against a backdrop of rapid economic inflation and unexpectedly high Medicare expenditures, the United States was going through a healthcare crisis. Many Americans felt the cost of care was rising and the quality was worsening, even though advances in medical technology should have meant the opposite. Dr. Kleinman’s model aimed to bridge the gap between the medical establishment and its patients, bringing the conversation back to a concrete, mutual understanding of what got people sick, how it made them feel and what they could do to fix it.

LuAnn Wilkerson, EdD, senior associate dean for medical education, sees the current emphasis on humanistic and patient-centered care as a natural extension of Dr. Kleinman’s work. “There’s always been a tension in medicine between technical expertise and your capacity to treat the whole person,” she says. “We had probably tipped the balance.”

In a healthcare environment increasingly enhanced by technological interfaces, from the implementation of electronic medical-record keeping throughout UCLA Health to the fleet of Tug robots that deliver drugs, linens and meals to patients in the UC San Francisco Medical Center at Mission Bay, patients and doctors alike reap the benefit of better, more efficient health outcomes, with one big side effect: They may directly interact much less with each other.

Since the 1980s, studies consistently have measured diminishing face time between doctors and patients, recently finding the average encounter to last a mere seven-to-eight minutes. Technology has, of course, enabled this reduction; perpetual tickertape of electronic data unspools from patients’ bedside monitors across closely watched tablets and screens in nearby nursing stations. Automated alerts raise red flags and remind caregivers when to feed and medicate.

Dr. El-Farra recently attended a presentation given by Abraham Verghese, MD, of Stanford University, in which he quipped that the patient has become the *iPatient*. “He had this image, from probably the 19th century, of a woman sprawled out on a couch and doctors kneeling by her, doctors looking at her, everyone surrounding her,” Dr. El-Farra recalls. “And then he flips to modern times and shows a picture of five residents all surrounding a computer, and the patient is on the other side of the room!”

To be clear, neither Dr. El-Farra nor Dr. Verghese is a Luddite railing against modern innovation. The evolution of technology in medicine has transformed impossible into routine. The challenge now for healthcare providers is to harness this technological power without sacrificing the opportunity for empathetic connection. The art program at UCLA fortifies its students for the challenge, long before they are beset by the exhausting and time-consuming demands of real-world medical practice.

“Art teaches us how to see the world from another perspective,” Dr. Wilkerson says. “We can wait for that to happen on its own, or we can build in opportunities that will help students understand how it feels to be trapped with an illness.”

THOUGH THERE APPEARS TO BE A CONSENSUS that art should play a role in the medical-school experience, there’s little empirical research on the topic. That might explain why Meyer had such a difficult time pitching his idea for UCLA to host a regular exhibition of patient art. It took about six months of repeated calls to the school before Meyer was able to connect with Dr. Wilkerson. She was not immediately receptive. “My initial thought was, ‘Oh, I’m way too busy,’” she
says. "It was actually my assistant’s insight as an artist that made me realize this was an idea worth pursuing — a kind of 'aha' moment."

Meyer’s own experience makes him especially suited to develop such a program; he has been creating art about illness for almost his entire life. As a child, he was diagnosed with Gaucher’s disease, an enzyme deficiency that leads to deterioration of the joints and organs, which had him boomeranging in and out of hospitals, on crutches and in constant pain. Then, in his late 30s, after several successful surgeries and the advent of improved treatments, he felt relatively healthy for the first time. "I started doing work about other people’s illnesses, because I still felt like I had a narrative to tell about illness but nothing left to say about my own," he says.

His Scarred for Life project documents the experiences of people who have been marked by illness or accident. Meyer applies paint directly to the skin of his subjects — a woman with a scar down the length of her spine, the result of multiple surgeries following a fall from a tree; a man whose stomach is marked where a shunt drained water from his brain as an infant; breast-cancer survivors with mastectomies — and makes a print of the scarred area, to which further details are added in collaboration with the model. "They tend to find me when they’re ready," Meyer says. "I’m like the Studs Terkel of scarred people. I feel a real responsibility to tell these stories and be very respectful of them."

The Scarred for Life project has been exhibited nationally. It works on two levels. For the scarred person, it provides an opportunity to bring a part of his or her body out of hiding, to proudly flout the rule that scars are embarrassing or shameful or best left unmentioned. At the same time, the viewer sees that art can emerge from unlikely places and that a person’s relationship to trauma is more complicated than it often seems. The art program at the LRC...
The gallery offers us a perspective into medicine, according to Aaron Reyes, a first-year medical student. “I would like to increase the medical students’ understanding of what it’s like to be a patient, but it also provides a platform for patients to share their experience with the students. Until they find the right doctor, or the right treatment, many people living with chronic illness feel like a hot potato lobbed between specialists and clinics. Meyer’s program allows them to share the frustrations and realities of that journey, which is cathartic on an individual level, while simultaneously sensitizing a new batch of future doctors to the value of slowing things down and really listening to the people they are treating.

**Other Universities Do Integrate Humanities and Art** into their medical-school programming, though few use it like UCLA to enhance the patient-doctor connection specifically. In most other cases, elective classes in art aim to enrich observational skills, which are commonly thought to be declining as more diagnostic work is taken over by machines. A growing number of institutions — including Yale, Harvard and Weill Cornell — take groups of students on trips to museums to hone their aptitude in pattern recognition, description and looking closely, all crucial tools in the exam room. But, as Dr. Wilkerson points out, this approach could "totally miss the message about feeling."

The closest analogue to the gallery at UCLA’s LRC is Columbia University’s Program in Narrative Medicine, in which seminars and workshops sift through a broad range of artistic practices — from literature and philosophy to film and dance — to develop the cognitive tools related to understanding, processing and absorbing stories of illness. Though the program at Columbia shares with UCLA the common goal of helping doctors find a way into the patient experience, it widens its lens far beyond the visual arts and offers a diverse roster of open lectures and classes, in addition to a full MS degree in narrative medicine.

With increases in funding and support, the gallery at the LRC could pursue similar growth. “The gallery offers us a perspective into medicine that the medical curriculum cannot — a vision into the minds of the people we will one day serve,” says Dr. Stuber, and it helps them to be better doctors. “If I’m going to have a chat with you about the experience of a below-the-knee amputation, it could be technically oriented, or I could bring in a piece of art from a patient to think about how this person will have to change his daily habits,” Dr. Wilkerson says. “You could talk about how it was a successful amputation, how there was no infection, and other technical measures, but the art might be the cause to discuss how we can help the patient move back into life.”

And that, after all, is what the best doctors do.

**In 2013, The Artist Susan Trachman Exhibited** at the LRC work that dealt with her multiple sclerosis. She collects and arranges empty bottles of medication and saline solution, creating intricately patterned, highly ordered collages that emerge from her inability to create order and balance, often physically, in life. After giving her talk, she recalls a student approaching her: “She said, ‘I could spend hours and hours studying, but I would never get this kind of an education from a textbook.’” Ottery echoed this sentiment. “It’s so different from the everyday education we get,” he says. “It’s done sort of as an extra thing now, but if there were more artists, and it was given more of a space, that would be even better.”

Beginning in 2015, the Medical College Admission Test for the first time included questions from the social sciences and humanities, a barometer of the increasing importance placed discipline-wide on holistic capabilities. “People are starting to realize that we can’t extinguish the humanities side of our students,” Dr. Stuber says. “We’re trying to tap into a different part of the way that you think.”

It’s a classic win-win: Medical students get to explore dormant interests apart from their vocational training, and these interests in turn push them to be better doctors. “If I’m going to have a chat with you about the experience of a below-the-knee amputation, it could be technically oriented, or I could bring in a piece of art from a patient to think about how this person will have to change his daily habits,” Dr. Wilkerson says. “You could talk about how it was a successful amputation, how there was no infection, and other technical measures, but the art might be the cause to discuss how we can help the patient move back into life.”

And that, after all, is what the best doctors do.

**Micah Hauser** writes about art and culture. His articles have been published in the Los Angeles Review of Books, The Bluegrass Situation and The Huffington Post.

To learn more about the LRC Gallery and to see photographs of exhibitions, go to: medsch.ucla.edu/lrcgallery

**WHY THEY GAVE**

In a January 2015 *Los Angeles Times* article, philanthropist and author Judi Kaufman talked about what having brain cancer meant in her life. Surprisingly, it was not all bad. “I lost all my inhibitions as a result of the cancer,” she said. Kaufman began to write poetry again, and she believed that her disease had given her a purpose. She and her husband Roy established Art of the Brain to encourage other patients to explore their creativity, to raise money for brain-cancer research and to support the work of Timothy Cloughesy, MD (RES ’91, FEL ’92), in the UCLA Neuro-Oncology Program. Since its inception, Art of the Brain has raised more than $7 million. Judi Kaufman died in September 2015.

[Image credit: ©2015, Wally Skalij/Los Angeles Times. Reprinted with permission]
The crack of wooden swords striking each other is crisply percussive and spare, a sound with echoes back to a feudal age. As the swords ritualistically knock together in sharp, angled blows, the sensei standing before his students on a second-floor racquetball court of UCLA’s John Wooden Center quietly calls out commands in Japanese.

“Ippon dachi” — first sword technique. “Nihon me” — second one. “Sanbon me” — third one.

Dressed in a traditional uniform of quilted and padded cloth, the half-dozen students obey as they practice their fluid movements, approaching, striking, blocking, retreating.

Shinkendo — the modern martial art of Japanese Samurai swordsmanship — “is the embodiment of philosophical exercise, bringing together mind, body and spirit,” says the sensei, Joseph M. Pierre, MD ’96 (RES ’00), clinical professor of psychiatry and biobehavioral sciences and co-chief of the Schizophrenia Treatment Unit at the VA Greater Los Angeles Healthcare System. It has “a meditative component. For me, as a psychiatrist, that is part of its appeal.”

The appeal also may have something to do with an interest in things with blades. For when he’s not instructing students in UCLA’s Shinkendo Club on the art of the sword, Dr. Pierre might be found in the garage of his home in Calabasas, California, working with hammers and an anvil next to a blazing furnace — a set-up he has christened Tengu Forge in honor of a mythical Japanese creature with the head and wings of a bird and the body of a human — to fashion traditional Japanese knives. The metallurgy of the craft fascinates him; the beauty that reveals itself as the blades take shape inspires him; and the physicality of the work utterly absorbs him.

Or maybe a part of the appeal for Dr. Pierre has to do with his heritage. “I am half Asian, half Caucasian,” he says. “When I was in college, I, like a lot of people at that age, wanted to learn about different religions, different spiritual practices. It was more from an intellectual standpoint than a religious one.” As an undergraduate at MIT, he began to explore East Asian philosophy and Zen Buddhism, with its strong connections to martial arts.

While his intellectual journey was leading him along a variety of spiritual paths, his academic journey was taking him in a distinctly scientific direction — hardly unusual for a child of two physicists (a brother also went into that field). “I wanted to be an oceanographer or something like that,” he says. Medicine was not originally on his radar, but he had, since adolescence, found himself attracted to the idea of psychiatry. “There’s something about psychiatry that’s sort of interesting and weird and a little dark,” he says. So after graduating with a degree in biology, Dr. Pierre shifted gears and enrolled in medical school at UCLA. His parents had reservations about his desire
to pursue psychiatry. “Are you sure you don’t want to be a surgeon?” he recalls his mother asking.

But it proved to be a successful choice. In 2005, Dr. Pierre received Young Investigator awards from both the International Congress of Schizophrenia Research and the American College of Neuropsychopharmacology. In addition, his excellence as a teacher (he is associate director of residency education in the Jane and Terry Semel Institute for Neuroscience and Human Behavior at UCLA) has been recognized with several awards, including the 2012 UCLA NPI Housestaff Teaching Award.

His interest in martial arts began when he took lessons in kung fu at age 13. And he always found himself enticed by swords. “I wanted to own a Japanese sword, which is kind of a fantasy for a lot of young boys. But I wasn’t going to buy one until I learned how to use one,” he says. Dr. Pierre was introduced to Shinkendo in 2005 (this past August marked the 10th anniversary of his training).

It offered what he calls a “blend” — philosophy, heightened mental acuity, mastery of a difficult skill and unity with the sword — that he could embrace. The knife-making started a few years later, when he found himself with time to fill while his future wife was on the East Coast finishing her training as a veterinary cardiologist. He had considered taking up Thai boxing but concluded he was too old to fight in a ring. “I decided to make knives instead,” he says.

For Dr. Pierre, Shinkendo and knife-making are less about stress relief — “psychiatrists don’t get that stressed,” he says — than they are about centering his life. “The swords and the knife-making are so physical. There literally is no hands-on component in my work as a psychiatrist, so this provides a balance to what I’m doing,” he says. “It’s like a third arm, in a sense, one that’s involved in something other than writing or doctoring or philosophy.”

Like the carefully choreographed movements of Shinkendo, the forging and pounding of steel as he works it into the shape of a blade lock Dr. Pierre into a moment, one that simultaneously clears and focuses his mind. “Hammering hot steel all day ... blisters on my hands,” he rhapsodizes, with a smile of deep fulfillment. “It’s just so cool.”

Robin Keats is the author of three nonfiction books, has written for numerous magazines and creates nonfiction TV programming.

Awards & Honors

Dr. Anne Coleman, Fran and Ray Stark Foundation Professor of Ophthalmology, presented the Jackson Memorial Lecture, the highest honor of the American Academy of Ophthalmology.

Dr. Rajan Kulkarni (MD ’09), clinical instructor in the Division of Dermatology and a member of the UCLA Jonsson Comprehensive Cancer Center, received a Young Investigator Award of $75,000 from the Melanoma Research Alliance.

Dr. Gary W. Mathern (RES ’85, ’91), director of epilepsy neurosurgery, was named inaugural holder of the Dr. Aftonina Q. Davies Endowed Chair in Honor of Paul Crandall, MD, for Epilepsy Research.

Dr. James McCracken (FEL ’87), Campbell Professor of Child Psychiatry and director of the Division of Child and Adolescent Psychiatry, received the 2015 Blanche F. Ittelson Award, the American Psychiatric Association’s highest honor for research in child and adolescent psychiatry.

Dr. Lee Todd Miller, professor of clinical pediatrics and vice chair for education in the Department of Pediatrics, was named associate dean for student affairs in the David Geffen School of Medicine at UCLA.

Dr. Jeffrey Saver, director of the UCLA Comprehensive Stroke Center, received the American Neurological Association’s 2015 Soriano Leadership Award and lectured at the association’s annual meeting on recent breakthroughs in the treatment of acute stroke.

Dr. George Slavich, associate professor of psychiatry and biobehavioral sciences, received three awards for early-career contributions in clinical psychology; the Early Career Research Award from the Society for Research in Psychopathology, the 2015 Early Career Investigator Award from the Society of Behavioral Medicine and the Susan Nolen-Hoeksema Early Career Research Award from the Society for a Science of Clinical Psychology.

Dr. Stephen Smale, Sherie L. and Donald G. Morrison Chair in Molecular Immunology, was named inaugural vice dean for research for the David Geffen School of Medicine at UCLA, providing oversight of and support for all aspects of the school’s research enterprise.

Dr. Lawrence Zipursky, Distinguished Professor of Biological Chemistry in the David Geffen School of Medicine at UCLA and a Howard Hughes Medical Institute Investigator, received Columbia University’s 2015 Louisa Gross Horwitz Prize, the university’s highest honor for achievement in biological and biochemical research.

In Memoriam

Dr. Edward M. Ornitz, professor emeritus of psychiatry and biobehavioral sciences, died September 14, 2015. He was 86 years old. Dr. Ornitz joined the UCLA faculty in 1963, and he remained for 43 years, until his retirement in 2006. Dr. Ornitz was in the vanguard of biologically based child psychiatrists in the 1960s and ’70s. Going against the prevailing dogmas of psychoanalysis, he and his UCLA colleagues were among the first to demonstrate neurophysiologic differences in children with autism compared to healthy children, findings that helped establish its brain-based nature.

Dr. Ornitz also performed seminal studies on the development of sleep and brain-stem responses in children and applied psychophysiological measures to study children with post-traumatic stress disorder and children at risk for anxiety.
Reflections: Expanding the Definition of Beauty

Eva Ritvo, MD ’79, is a dual-UCLA-degree holder. She graduated in 1983 with a BA in psychobiology and earned her MD four years later. She did an internship in psychiatry at UCLA and completed her residency training at Cornell University in 1991. Dr. Ritvo then joined the faculty at the University of Miami Leonard M. Miller School of Medicine, where she rose to vice chair of the Department of Psychiatry and Behavioral Sciences. For the past five years, Dr. Ritvo has been in private practice in Miami Beach, Florida. She is an internationally known speaker, executive coach, psychiatrist and author. She is a longtime member of the United Cerebral Palsy Foundation (UCP) Board of Directors. In 2015, she was selected as the UCP Ethel Hausman Volunteer of the Year. Dr. Ritvo is co-director of the Bold Beauty Project, a nationwide project that is working to expand the definition of beauty.

The mainstream definition of beauty excludes those who do not fit the stereotype. In my career, I have had two opportunities to challenge the status quo and empower others to look at themselves through a lens of acceptance. In 2008, I co-authored The Beauty Prescription with another UCLA alumna (and staff dermatologist at the UCLA Arthur Ashe Student Health & Wellness Center) Debra Luftman, MD (RES ’90, ’96). In our book, we talk about the difference between innate and evolving beauty receptors. Innate receptors are the ones we are born with. Yes, we are born knowing what is beautiful. Babies just a few hours old stare longer at attractive faces, and by the age of 1, they cooperate better with attractive sitters. As we move through life, we evolve new beauty receptors based on what we are exposed to.

Currently, I’m involved in the Bold Beauty Project (BBP), an innovative visual-arts project that showcases 20 women living with disabilities. Through the photographers’ creative lens, the audience gets a glimpse into the lives of these incredible women, such as Marilee Adamski-Smith, and recognizes their beauty, strength and sensuality — their boldness. Marilee is 39 and lives in Virginia. She was born with a disability called tetra-amelia and has no arms or legs. She attributes her great success in life to her parents, who always pushed her to be strong and provided the love and support she needed to thrive. She completed college and now runs her own business, Adamski-Smith Multimedia Solutions. In 2002, Marilee found her soulmate, Joseph, and married him in 2008. Marilee wears her wedding ring on a necklace around her neck. She has a wonderful, outgoing and upbeat personality.

The first Bold Beauty Project event was held in Washington, DC, on October 10, 2015, and was an enormous success. The leadership of BBP would like the event to expand to sites across the country to more broadly affect the definition of beauty on a national scale.

I am inspired by the courage and vulnerability of the BBP models, as was my sister Anne Bielamowicz, MD ’90, who participated in the project as a photographer and found the experience very moving and enriching. I stand with these women as they stand up for a new definition of beauty. It is my great privilege to know and work with them. Through overcoming seemingly insurmountable barriers and obstacles, they have achieved so much personally and professionally.

Often, passions grow out of personal experiences. This is certainly true for me and my enthusiasm for BBP. My daughter, who was born during my psychiatry residency, has a form of cerebral palsy called hemiparesis. I am delighted that she will be a model in a future event.

For more information about the Bold Beauty Project, visit: boldbeautyproject.com
Stitching for Advocacy

Helen E. Blumen, MD ’75 (RES ’78), practiced internal medicine in Santa Monica, California, for more than 10 years. Since 1991, she has lived in Chevy Chase, Maryland, where she has worked in a variety of nonclinical roles, focusing on evidence-based appropriate medical care. She currently is a principal in the health practice of Milliman, Inc., a consulting firm that provides actuarial and related services.

I always have considered myself first and foremost a doctor, even though I haven’t been a full-time clinician in a long time. So I have always made time for face-to-face clinical work, volunteering in various local clinics, serving low-income patients, on a part-time basis. When I recently moved on from one of them, I decided to see if there was a way to use my hobby of quilting to help other people.

The Advocacy Project (AP) is a nonprofit organization that works to help marginalized communities around the world to tell their stories as a way of producing social change. My quilt guild was fortunate to be able to partner with AP in creating two quilts related to the 2012 conflict in northern Mali. AP worked with an organization in Mali, Sini Sanuman, to teach women who were recovering from the physical and emotional traumas of sexual violence to create embroideries that communicate what happened to them.

The idea was then to produce a quilt that can be used to advocate for this community of women. My quilt guild embraced the challenge of working with the Malian embroideries, interspersing Malian cotton brocades and mud-cloth panels among the embroidered panels. We divided the panels into two groups. One of the quilts explicitly depicts acts of war and sexual violence, while the other conveys gentler images of village life.

Now that the quilts are finished, their photos and stories have been posted to the AP website. There are plans to exhibit them in the Washington, DC, area, in New Jersey and, later this year, in Germany. I am hopeful that we can find other exhibition venues, and I am looking for another volunteer opportunity to quilt for a cause.

To learn more about the Advocacy Project, go to: advocacynet.org
To see photographs of the quilts, go to: advocacynet.org/quilts/women/sini-sanuman
Originally from Ethiopia, Ruth T. Getachew, MD ’15, and her family moved to San Jose, California, when she was 10 years old. She now is starting her intern year at Harbor-UCLA Medical Center as part of the Family Medicine Residency Program. Her upbringing in Ethiopia inspired her to pursue a medical career focused on low-income and underserved communities. In 2015, Dr. Getachew returned to her birthplace and discovered the need for primary-care and specialized physicians to not only treat patients, but also to teach aspiring doctors.

During the 1990s in Ethiopia, there was a sense of unease as our country recovered from the famine of the 1980s, transitioned from a communist to a democratic government and grappled with the growth of HIV/AIDS. As a result, once I came to live in California, I was not eager to return. Yet, every time I land in Ethiopia, I struggle to hold back tears. I love and miss Ethiopia’s ancient traditions and its earnest thirst for progress.

In my most recent trip to Addis Ababa, I was shocked to find that the practice of preventive care is in its infancy in Ethiopia. The country has made great progress in reducing fetal mortality, and it has increased medical access in rural regions. Nonetheless, preventive care is restricted to those who can afford an annual exam, and the nation’s medical resources are overwhelmed by the management of communicable and tropical diseases.

As excited as I am about my future career goals, including contributing to Ethiopia’s primary care, I learned that there is a great demand for specialized doctors. Chi Y. Chung, MD (RES ’04), former assistant program director for the Pan-African Academy of Christian Surgeons, arranged for me to visit Myungsung Christian Medical Center and Myungsung Medical College (MMC), as well as meet with Rahel Getachew, MD (no relation), an MMC dean. She repeatedly stressed that the hospital and medical school need assistance from specialized doctors in all fields of medicine to volunteer their services and/or teach. The MMC faculty and medical students I met echoed the same concern. Currently, MMC students have access to an international faculty of permanent and visiting professors from several countries, including Ethiopia, the United States, Korea, Canada and Egypt. Perhaps some of my Class of 2015 colleagues will be part of Ethiopia’s solution — once we have attained the invaluable skills we are learning during our residencies.
In His Own Words:
Herb Rheingruber, MD ’65 (RES ’69)

After completing a residency in obstetrics and gynecology, Herb Rheingruber, MD ’65 (RES ’69), practiced with the Northern California Kaiser Foundation Medical Care system until his retirement in 1998. Dr. Rheingruber has been a longtime volunteer with Helping Hands Health Education (HHHE), and he has been on nine excursions with the organization. This organization helped expand his existing interest in the study and execution of policies relating to women’s health issues in underdeveloped countries. Currently, Dr. Rheingruber serves on the board of directors of HHHE as the international medical coordinator.

Practicing medicine in a Third World country comes with overwhelming challenges, such as diseases due to unsanitary conditions and a lack of public-health education. Political strife and religious conflicts also impede significant development. HHHE has utilized a new paradigm in volunteer work, the basis of which is educating women and children. Educated mothers lay the groundwork for a new generation by lending their care and influence. The children mature to follow their mothers’ teachings of sustaining health and population change.

The process began when I encountered a man in Nepal with a parallel vision. Starting as an immigrant, he made his fortune as an entrepreneur. His birthright, however, was to return his largesse to Nepal and other similar areas to make a difference in health and education without religious or political associations. With HHHE, we meet with local leaders to discern the possibility of implementing and staffing a children’s/women’s clinic conjoined with a classroom for education. First, though, the leaders want to have their health problems evaluated — we fit them in to gain their cooperation. We start with a conjoined classroom and a clinic — one to teach and one to treat. We recognize that it is the women who hold up “half the sky” and so accomplish our goal by improving maternal health, autonomy and education.

In the latest HHHE venture, by invitation from the Kingdom of Bhutan, our team assessed Bhutan’s modern and traditional medicine. We found nothing wrong with herbs, hope and prayer, but hemorrhage and obstructed labor require education. It is the women and their children who can make that difference.

Our first obligation on arrival is to solve emergency conditions. After triage, the team goes to work evaluating, treating and educating. We bring new fundamental equipment to measure how sick a patient is: thermometer, blood-pressure cuff, stethoscope, otoscope, a copy of CURRENT Medical Diagnosis &

Treatment, assorted medications and other equipment. We do the best we can with limited resources. We leave the equipment and medications behind when we return home.

To take on the rewarding drill of volunteerism is the type of activity that allows for self-inspired mental peace. The limited space available here prevents a discussion of the interesting diseases seen and the volume of illnesses treated. However, I have found that there is a solution to the obstacles found in these depressed situations. It lies with the children and the mothers who will guide them to become a new generation focused on healthcare reform.

Epilogue
I wish to recognize the importance of the UCLA Legacy Society, from which I received a scholarship given by someone I never had the opportunity to meet. The scholarship validated my existence and improved my financial state. When I leave this world, I will pass this gift on to students whom I will never meet through a charitable remainder trust. I know that if it were not for UCLA, I would not be writing this.

To learn more about Helping Hands Health Education, go to: helpinghandsusa.org

For learn more about creating a legacy through a trust at UCLA, go to: legacy.ucla.edu
UCLA Health Sciences has received a pledge of $10 million from Wendy and Leonard Goldberg, in large part to support migraine research, which will be led by Dr. Andrew Charles (MD ’86, RES ’90, FEL ’92), Meyer and Renee Luskin Chair in Migraine and Headache Studies. “The Goldbergs’ visionary gift, which names and endows the UCLA Goldberg Migraine Program, is one of the largest in history from individuals to support migraine research and treatment,” says Dr. John C. Mazziotta (RES ’81, FEL ’83), vice chancellor of UCLA Health Sciences and CEO of UCLA Health.

“Migraine, a disabling disorder of the nervous system that affects one-out-of-four Americans, is the third most common of all medical disorders worldwide. Every 10 seconds, someone in the United States goes to an emergency room with a migraine-related complaint. Despite the fact that it is clearly a major public-health issue, migraine has remained largely in the shadows, commonly minimized as ‘just a headache.’ “Migraine is generally under-recognized as a major medical problem, in part because it is not fatal,” says Dr. Charles. “But it is not hyperbole to say that it can ruin lives.”

The Goldbergs want to help advance the understanding of migraine and the care of patients with this disorder, which has a major genetic component. “Leonard and I have seen firsthand in friends and family members how debilitating migraines can be,” says Wendy Goldberg. “We are eager to help find better treatments and, ultimately, a cure.”

A portion of the Goldbergs’ gift also will establish the Goldberg Head and Neck Fund, led by Dr. Gerald Berke (RES ’80, ’84), Victor Goodhill, MD, Chair in Head and Neck Surgery, and the Goldberg Health System Fund.

Leonard Goldberg is an award-winning film and television executive and producer, who has served as head of programming for ABC and president of 20th Century Fox. He currently is executive producer of the CBS series Blue Bloods. Wendy Howard Goldberg is co-author of the national bestseller Blue Bloods Cookbook and Marry Me, and she collaborated on the bestseller Hollywood Moms. She currently serves as president emeritus of the California State Summer School Arts Foundation.

For more information, contact Karen Colimore at: (310) 267-0496

Wendy and Leonard Goldberg.
Photo: Courtesy of the Goldberg family
Good Friends Join Forces to Fight Cancer

For UCLA Jonsson Cancer Center Foundation Board members Manizheh Yomtoubian and Ali Jassim, a strong commitment to give back and a profound desire to stop cancer in its tracks created a powerful partnership. A friend of the Jassim family, Yomtoubian has known Ali Jassim for decades and was frequently a guest in the Jassim home. Jassim’s mother, Heshmat, had lost her brother to brain cancer and raised her brother’s children alongside Jassim and his siblings. These charitable lessons of family and commitment were not lost on young Jassim.

In the ensuing years, Jassim became a successful international businessman. Yomtoubian, a nurse at Ronald Reagan UCLA Medical Center for 18 years, established a foundation in memory of her husband Neria to encourage medical awareness in the Persian community. At a recent Jassim family wedding, Yomtoubian and Jassim’s conversation turned to philanthropy, and Jassim stepped forward to join Yomtoubian in the fight against cancer by making a $10-million commitment in honor of his family to UCLA’s Jonsson Comprehensive Cancer Center (JCCC).

Jassim is the first donor to name a suite of research laboratories in the newly reconfigured UCLA Center for the Health Sciences (CHS). The Ali Jassim Family Cancer Research Suite is located on the fifth floor of CHS — the very place where Yomtoubian finished her UCLA nursing career. In addition, Jassim’s generosity will establish the UCLA Ali Jassim Family Cancer Research Program to fund high-priority cancer research, as determined by the JCCC director.

This gift was the result of a conversation between friends that revealed a shared dedication to find new ways to treat cancer. “Don’t be afraid to talk about a cause that you think is important,” says Yomtoubian. “Most of the time, you can find people who sympathize with your cause. Friends can follow in the steps of the person who they believe is doing something important.”

For more information, contact Margaret Steele at: (310) 794-5244
UCLA Urology Celebrates Spielberg Family Gifts

On October 22, 2015, the UCLA Department of Urology celebrated the installation of Dr. Stuart Holden, associate director of the UCLA Institute of Urologic Oncology (IUO), as the inaugural holder of the Spielberg Family Chair in Urologic Oncology. The department also thanked the Spielberg family for its commitment to establish the Spielberg Family Program and Research Fund by dedicating the newly named conference suite in the IUO as The Arnold M. Spielberg Conference Suite. The naming pays tribute to Steven Spielberg’s father Arnold, who was an early pioneer in computer science. Steven Spielberg talked about how philanthropy is learned, not inherent, and how he learned about generosity from his father.

Event speakers included Dr. Clarence H. Braddock III, vice dean for education, chief medical education officer and Maxine and Eugene Rosenfeld Chair in Medical Education, who spoke about the school’s mission to educate the next generation of leading physician-scientists. Dr. Eric Miller (MD ’12), a UCLA urology resident, shared that the Spielberg gift supported his educational endeavors.

“The fine doctors and researchers at UCLA have given my dad a remarkable quality of life,” Spielberg said. “Their commitment to care is compelling, and I’m proud to do my part to support pioneering breakthroughs that might eradicate cancer in our lifetimes.”

The Spielbergs’ transformative gift enables the IUO to address its most critical needs, maintain its mission to provide the most advanced integrated patient care and to develop revolutionary treatments for the range of urologic cancers, including bladder, kidney, prostate and testicular.

For more information, contact Keri Eisenberg at:
(310) 794-2529
UCLA Health System Board Meeting Explores Immunology

On November 3, 2015, the UCLA Health System Board meeting convened at Ronald Reagan UCLA Medical Center. Hosted by Dr. John C. Mazziotta (RES ’81, FEL ’83), vice chancellor of UCLA Health Sciences and CEO of UCLA Health, and Henry Gluck, chairman of the UCLA Health System Board, the program featured a presentation by Dr. Antoni Ribas (FEL ’98, ’01), professor of medicine and director of the Tumor Immunology Program at UCLA’s Jonsson Comprehensive Cancer Center. Dr. Ribas, a leader in the field of immunology, shared the progress UCLA investigators have made in treating cancer by igniting the patients’ own immune system. Dr. Ribas recently led the largest Phase 1 clinical trial in the history of oncology, which resulted in the U.S. Food and Drug Administration approving the “breakthrough” drug Keytruda to treat advanced melanoma. While his research is focused on understanding and treating melanoma, Dr. Ribas stated that cancer is only the beginning of the immunology story. Immunotherapies have the potential to affect all facets of human health, from infectious diseases and allergies to arthritis, autism and more.

Dr. Benjamin J. Ansell (MD ’92, RES ’95), director of the UCLA Comprehensive Health Program and co-director of UCLA’s Cholesterol, Hypertension and Atherosclerosis Management Program, talked about how a person can take control of his or her health. Listed among U.S. News & World Report’s “America’s Top Doctors,” Dr. Ansell champions early disease detection and prevention and focuses his research on cholesterol-treatment strategies in preventing and managing cardiovascular diseases.

Volunteers from UCLA’s People-Animal Connection greeted guests at the reception.

For more information, contact Nora Bok at: (310) 267-0050
On October 23, 2015, approximately 100 guests attended a preview of Geffen Hall, the David Geffen School of Medicine at UCLA’s new medical-education building that will transform the future of medicine and is slated to open in the fall of 2016. Guests gathered at Irma and Norman Switzer Plaza for a reception that featured hard-hat tours of the building and interactive, simulation-based experiences used in student training.

UCLA alum Steve Gordon, co-chair of the Campaign Cabinet for The Centennial Campaign for UCLA, welcomed guests and expressed his enthusiasm for this groundbreaking project, saying, “What gets me most excited about Geffen Hall are the talented, brilliant young minds and hearts that will be shaped in this fabulous new facility.”

Dr. John C. Mazziotta (RES ’81, FEL ’83), vice chancellor for UCLA Health Sciences and CEO of UCLA Health, followed Gordon’s welcome and shared that the David Geffen School of Medicine at UCLA receives two-thirds of the $1 billion in research funds awarded to UCLA, and its ranking in National Institutes of Health funding increased in 2015. He called these facts evidence of excellence — evidence that UCLA is successfully training those who are making the new discoveries and becoming the leaders of today and tomorrow. “Geffen Hall is essential to fulfill and advance these societal responsibilities, these educational goals and this overall vision of excellence in healthcare,” Dr. Mazziotta said.

Designed to foster the most effective methods of teaching and learning currently available, with the flexibility to incorporate new methods in the future, Geffen Hall will enable a continuous and dynamic learning experience and allow for a variety of classes and gatherings for large and small groups. Spaces such as the teaching lab and clinical-skills lab will engage students with team-based clinical exercises, virtual patients, task trainers and other digital-learning activities, while spaces such as the auditorium suite seamlessly connect UCLA with institutions around the world.

“Geffen Hall symbolizes the launch of a new era — with high-tech, high-touch, highly interconnected, interactive education,” said Dr. Clarence H. Braddock III, vice dean for education, chief medical education officer of UCLA Health and the Maxine and Eugene Rosenfeld Chair in Medical Education. “Geffen Hall symbolizes the belief that we must be adaptable, never static, always dynamic and open to constantly improving the training of a UCLA graduate who is both a great doctor and a great leader.”

One such trainee, first-year medical student Marina Sprague, inspired the audience by sharing her passion for her studies and how Geffen Hall will enhance them, saying, “In Geffen Hall, I will be actively encouraged to be a leader and engage the world. I am confident, with the support and guidance of the David Geffen School of Medicine at UCLA and the amazing learning possibilities of the new Geffen Hall, that I will be able to practice medicine courageously, conscientiously and compassionately.”

Dr. Mazziotta then thanked everyone for coming and described how guests can leave a legacy through naming opportunities for the new facility. He closed the event by saying, “Your partnership will inspire generations of physicians, scientists and healthcare leaders and will profoundly affect medical education for decades to come. Join us on this journey as we imagine the future of medicine.”

For more information, contact Laura Pescatore at: (310) 825-1288
Left: Attendees had the opportunity to use the latest technologies in physician training through a hands-on experience with the types of simulation activities featured at Geffen Hall and the UCLA Simulation Center. Middle: (From left) Ron Simms, Steve Gordon and Dr. Clarence H. Braddock III. Right: (From left) Robert Beitcher, CEO and president of the Motion Picture and Television Fund, and Dr. Eric Esrailian (FEL '06), co-chief of the UCLA Division of Digestive Diseases.

Photos: Todd Cheney/UCLA Photography

Top Left: Following her hard-hat tour, Marianne Sprague, medical-education supporter and mother of medical student Marina Sprague, signed a column for posterity. Top Right: (From left) Dr. John C. Mazziotta, longtime UCLA benefactor Meyer Luskin, Dr. Benjamin Ansell and Sharon Shelton. Bottom Left: A hard-hat tour of the first floor of the Geffen Hall construction site at the intersection of Le Conte and Tiverton Avenues. Bottom Right: UCLA medical students (from left) Yulia Zektser, John Barber and Marina Sprague attended the event and expressed their enthusiasm and gratitude for the new facility that will focus on problem-based learning and provide a highly interactive experience to more fully prepare them to be leaders in medicine.

Photos: William Short Photography
A Vision for Healing

Photography by Vince Bucci

The 2015 Visionary Ball, benefiting the UCLA Department of Neurosurgery, was held October 29, 2015, at the Beverly Wilshire hotel. Hosted by television personality Jeff Probst, the annual event raised more than $3 million, which will help to increase the pace of discovery of new therapies for rare and complex neurological disorders.

Actress and producer Roma Downey and Emmy-winning producer Mark Burnett received the Visionary Award at the event. Variety recognized the married couple as "trailblazers" and listed Downey as among the 100 Most Powerful Women in Hollywood. The Hollywood Reporter listed Burnett as No. 1 on their Reality TV Power List, and TIME magazine named him one of the world's most influential people.

When Cameron, Burnett’s son by his previous wife, became ill, he and Downey were out of the country with their children while filming. Cameron was admitted to a local hospital but did not improve and was flown back to Los Angeles, where he was diagnosed with a neurocytoma, a type of neuroendocrine tumor. Committed to getting Cameron the best possible treatment, Downey and Burnett had Cameron admitted to Ronald Reagan UCLA Medical Center, the only hospital on the West Coast dedicated to research in this area. Cameron, now thriving and enjoying life with his family, received this year’s Courage Award.

Dr. Melvin Cheatham, a member of the UCLA Neurosurgery Advisory Board, was honored with the Medical Visionary Award. In addition to serving as past president of the California State Neurosurgical Society and past president of the Western Neurosurgical Society, two organizations of the top neurosurgeons in the United States and Canada, Dr. Cheatham, along with his wife Sylvia, a surgical nurse, has devoted himself to full-time medical-relief work in developing and war-torn countries, including Kenya, Uganda, Somalia, Rwanda, The Congo, Sudan, South Korea, Bosnia, Kosovo, the former Soviet Union and North Korea, a country Dr. Cheatham has visited 26 times.

A star in the FX series Fargo, actor and stand-up comedian Brad Garrett accepted the Rodney Respect Award. He has won three Emmys and a Screen Actors Guild Award for his role as Robert Barone on the television series Everybody Loves Raymond. Following in the footsteps of Rodney Dangerfield, who founded the comedy nightclub Dangerfield’s in New York, Garrett recently opened his own comedy club at the MGM Grand in Las Vegas.

Performances by singer-songwriters Pharell Williams and Chris Martin of Coldplay were highlights of the event, along with patient testimonials.

For more information about the Visionary Ball, go to: visionaryball.org

For more information, contact Karen Colimore at: (310) 267-0496
Nancy Smith shared her brave and inspiring story during the Point of Light testimonials.

Special guest performer Pharrell Williams (left) and Dr. Neil Martin, chair of UCLA Neurosurgery.

Comedian Brad Garrett accepted the Rodney Respect Award.

Event co-chairs Edie Baskin Bronson (left) and Susan Dolgen.

Alan Finkelstein, (left) who shared his personal story during the Point of Light testimonials, and actress Marg Helgenberger.

Dr. Melvin Cheatham received the Medical Visionary Award for his medical-relief work.

Dr. Melvin Cheatham.

Nancy Smith shared her brave and inspiring story during the Point of Light testimonials.

Special guest performer Pharrell Williams (left) and Dr. Neil Martin, chair of UCLA Neurosurgery.
Mattel Party on the Pier a Wave of Success

The 16th annual Mattel Party on the Pier, held September 27, 2015, was a record-breaking event that raised more than $1 million in unrestricted funding to benefit high-priority research and programs at Mattel Children’s Hospital UCLA. The event was led by long-standing chair and Mattel Children’s Hospital UCLA Board member Liz Greenspan and 13 dedicated committee members, including silent-auction chair Loris Lunsford.

The event at Pacific Park on the Santa Monica Pier welcomed nearly 2,000 guests, including 50 patient families, who enjoyed games filled with Mattel toys, unlimited rides, teen celebrity appearances and a silent auction. Four-time Emmy Award-winning director David Silverman, best known for his work on The Simpsons, was honored as the Mattel Children’s Hospital UCLA “Doctor of Joy.” Actress and celebrity mom Sarah Michelle Gellar lent her support as a celebrity ambassador.

Funds raised will benefit children’s-cancer clinical trials, junior-faculty development and the Pediatric Bone and Soft Tissue Sarcoma Program at UCLA.

For more information about Mattel Children’s Hospital UCLA, go to: uclahealth.org/mattel

For more information, contact Kat Lauer at: (310) 267-1831
Art of the Brain Honors Founder, Celebrates 16 Years

Art of the Brain, a nonprofit organization that raises public awareness of brain cancer and spotlights the talent, strength and courage of brain-cancer patients, celebrated its 16th anniversary gala on September 26, 2015, at UCLA Schoenberg Hall. The event raised more than $370,000 to support brain-cancer research in the UCLA Neuro-Oncology Program under the direction of Dr. Timothy Cloughesy (RES ’91, FEL ’92).

Art of the Brain was founded by the late Judi Kaufman, who died September 21, 2015, at the age of 71, just days before the event. An international community activist, artist, author, philanthropist and a brain-cancer survivor of 18 years, she was named one of the winners of the 10th annual Los Angeles Business Journal’s Women Making a Difference Award. Since 2000, the organization has raised more than $7 million for the UCLA program.

“Art of the Brain is the lifeblood of the UCLA Neuro-Oncology Program, providing necessary funding to perform our critical research,” Dr. Cloughesy says. “We will all deeply miss Judi Kaufman as a friend, colleague and role model. We will honor her wishes by continuing the important work she started.”

“The Art of Friendship” was the theme for the evening, which featured gourmet food, desserts and fine wines. Attendees were treated to a performance by the Gay Men’s Chorus of Los Angeles. Dr. David Nathanson, assistant professor of molecular and medical pharmacology, was presented with the Johnny Mercer Foundation Research Award for his contributions to brain-cancer research.

Art of the Brain’s “Brain Buddies” volunteers were honored with the Judi Kaufman Founder’s Responsibility Award for their efforts and commitment to activities benefiting brain-cancer research and treatments. In the wake of the founder’s passing, attendance was among the highest since the organization’s inception. Sentiments about Kaufman’s generosity of spirit and devotion to changing the future of people with brain cancer were shared by all who took the stage, including Francesca Eastwood, Clint Eastwood’s daughter, who read Kaufman’s poetry. It was both a solemn and joyful occasion, acknowledging Judi Kaufman and others who have passed, as well as the many survivors in attendance.

Kaufman’s courage inspired countless people and will live on through her philanthropy. She is survived by her husband Roy, their daughters Jennifer and Suzy and grandsons Garrett and Sebastian.

For more information, contact Pamela Thompson at: (310) 267-1837

UCLA Cardiologists Serve Up Tips for a Healthy Heart

On October 22, 2015, the UCLA Women’s Cardiovascular Center presented an intimate evening called “A Taste of Health and the Science Behind It.” Co-hosted by Serge and Florence Azria and Mike and Irena Medavoy, the evening featured discussions with UCLA cardiologists and a heart-healthy interactive cooking class focused on the science behind a heart-healthy diet. Local chef and Meal and a Spiel founder Elana Horwich led the cooking demonstration, which included salmon radicchio wraps, a cornucopia of roasted vegetables with rosemary, quinoa and flourless black lava cake.

Experts from the UCLA Women’s Cardiovascular Center, cardiologists Drs. Tamara Horwich (RES ’02, FEL ’06) and Marcella Calfon Press, co-director of the center; Dr. Karol Watson (RES ’92, FEL ’97), director of the Barbra Streisand Women’s Heart Health Program; and Dr. Jamil Aboulhosn (MD ’99, RES ’02, FEL ’05, ’06), Streisand Chair in Cardiology, led the discussion on heart health and nutrition and were on hand to answer questions. Guests received a Taste of Health recipe book that included tips for a healthy heart.

For more information, contact Michelle Jacobson at: (310) 267-1213
Operation Mend Honored at Pentagon’s Hall of Heroes

On September 2, 2015, UCLA’s Operation Mend received the grand prize at the 16th annual Newman’s Own Award Ceremony at the Pentagon’s Hall of Heroes. Sponsored by the Newman’s Own Foundation, started by the late actor Paul Newman, as well as the Fisher House Foundation and Military Times, the annual competition seeks to reward ingenuity for programs that benefit service members and their families. More than 300 entries were submitted for the 2015 program. Six judges evaluated the entries based on each organization’s impact on their respective communities, creativity and innovation. U.S. Army Gen. Martin E. Dempsey, chairman of the Joint Chiefs of Staff, provided remarks, and Dana Katz, daughter-in-law of Operation Mend founders Maddie and Ronald Katz, accepted the $50,000 award on behalf of UCLA Operation Mend.

For more information, contact Karen Colimore at: (310) 267-0496

Basketball Enthusiasts Dribble Toward a Cancer Cure

On October 11, 2015, more than 650 participants and their basketballs gathered on the UCLA campus to dribble for a cure. The ninth annual event raised a record $186,700 for pediatric-cancer research and treatment. This year’s contributions took Dribble for the Cure past the $1-million mark in funds raised since the event’s inception eight years ago. Proceeds support treatment for pediatric-cancer patients at Mattel Children’s Hospital UCLA and the Pediatric Cancer Research Foundation in Irvine, California.

Starting at Drake Stadium, participants dribbled basketballs on a 1.2-mile course across the campus, finishing at Collins Court in the John Wooden Center. Dribblers included patients, honorary kid-captains, student athletes from UCLA’s men’s and women’s basketball teams and UCLA Athletics, as well as Bruin basketball great John Vallely.

For more information, contact Kat Lauer at: (310) 267-1831
Dr. Stanley G. Korenman, UCLA distinguished professor of medicine and associate dean for ethics, and Ann M. Pollack, UCLA assistant vice chancellor for research, have made a new five-year pledge to the UCLA-Caltech Medical Scientist Training Program (MSTP) in support of the Stanley Korenman Lecture. Headlining the annual MSTP Research Retreat, the lecture brings to the campus world-renowned scientists who, in addition to making outstanding presentations, engage with students and faculty. In 1983, Dr. Korenman founded the UCLA-Caltech MSTP — a premier program for combined MD-PhD training that prepares leaders in the biomedical and sociomedical sciences. More than 250 students have participated in this outstanding program.

The Shaffer Family Foundation has made two gifts totaling $485,000 directed to the UCLA Division of Nephrology and the Department of Urology. One gift will support Dr. Anjay Rastogi (RES ’03, PhD ’04, FEL ’05) and his team’s clinical research on recurrent urinary-tract infections in the Division of Nephrology. This gift will also provide for the development of educational tools to better train physicians on how to correctly diagnose and treat this condition.

The second gift will enable Dr. Chad Baxter (FEL ’10), a member of the UCLA Division of Pelvic Medicine and Reconstructive Surgery, to acquire and receive training on a state-of-the-art CO2 laser-delivery system that will expand treatment options and improve the quality of life for women with urologic and pelvic conditions. The Shaffer Family Foundation also generously supports the UCLA Broad Stem Cell Research Center.

The UCLA Division of Geriatrics received a $950,000 donation from Joann Stichman to support the work of the UCLA Alzheimer’s and Dementia Care Program. The gift is a tribute to her late husband Forrest Stichman, who graduated from the UCLA Anderson School of Management in 1947. The program is a free service that aims to help patients and their caregivers navigate the complex medical, behavioral and social needs associated with Alzheimer’s disease and other types of dementia and educates caregivers and family members on the resources available to them.

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

Carol and James Collins Endowed Chair in Geriatric Medicine has been awarded to Dr. Brandon Koretz (RES ’99, FEL ’00), co-chief of the UCLA Division of Geriatrics and interim CEO of the UCLA Faculty Practice Group. Dr. Koretz’s focus is on quality-improvement projects and on further developing the UCLA home health program.

The Collinses have a rich history with UCLA. James Collins received his civil engineering degree from UCLA and has held key positions on numerous UCLA boards and campaign committees. Carol Collins attended UCLA and is a member of UCLA Women & Philanthropy.

Carol and James Collins

For more information, contact Karen Colimore at:
(310) 267-0496
Back from the Streets
By James Maciel, MD ’15

“I hope you come back and learn from your mistakes. Come back a man, tell your story to these black and brown kids ... Let ‘em know you was just like them, but you still rose from that dark place of violence, becoming a positive person. But when you do make it, give back with your words of encouragement, and that’s the best way to give back to your city.”
– From Real, by Kendrick Lamar

These words of hip-hop artist Kendrick Lamar resonate so strongly for me. I, too, came back and learned from my mistakes. And I want to tell my story to those black and brown kids, many of whom I now, all-too-often, must treat for stab wounds, gunshots and other trauma in my surgical residency at Harbor-UCLA Medical Center.

Growing up, I never imagined I would arrive at this place, and, as I prepared this past June to take the Hippocratic Oath, I reflected on the journey that has brought me here. The week before graduation, I had some extra time, and I decided to drive through the neighborhoods where I was raised. As I drove along the streets from Garden Grove through Orange and then into Santa Ana, I was bombarded with old memories that I had long ago — at least so I thought — forgotten. Many were stirred by positive cues: the bus stop on The City Drive where I would meet up with Priscilla, my future wife; the house on Flower Street where my brothers and I grew up; the park where my father taught me the basics of being a goalkeeper for my soccer team; and the carniceria that my mother would send me to whenever she needed something to prepare for dinner.

But many of these cues also resurrected memories that were incredibly painful: the towering, salmon-colored Orange County
INTERIM DEAN, DAVID GEFFEN SCHOOL OF MEDICINE AT UCLA
John C. Mazziotta, MD (RES ’81, FEL ’83), PhD
David Geffen School of Medicine at UCLA
CHIEF COMMUNICATIONS & MARKETING OFFICER
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BY DR. JAMES MACIEL
Epilogue
California’s new right-to-die law.

BY MICAH HAUSER
Whole person.
and how it relates to the
experience of illness
be a powerful tool to help
physicians better understand the experience of illness and how it relates to the whole person.

BY VERONICA MEADE-KELLY
Healing Art
A patient’s visual expression of his or her disease can be a powerful tool to help physicians better understand the experience of illness and how it relates to the whole person.

BY JAMES MACIEL
Like us or not, we want to hear from you. Your input is important, so please give us your comments
medical alum (MD, PhD, Resident and/or Fellow), your degree(s) and graduation year(s). Letters
your comments on our social-media pages.

Submit letters to:
editor@medicine.ucla.edu

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

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Today’s technologies can extend and save lives, but they also open the door to thorny ethical issues.