UCLA Reaches Out to Haiti
Injured, maimed and crippled, but not alone

The Real World
Doctors and nurses learn together

A Matter of the Heart
Dr. Abbas Ardehali offers hope to older patients

Letting Go
What is the true price tag at the end of life?

Conversation
UCLA’s role in healthcare reform
01 • Leadership
The new dean and vice chancellor’s vision.
By Dr. A. Eugene Washington

02 • The Cutting Edge
News and research: Quit smoking to save your eyesight.

08 • Conversation
Dr. A. Eugene Washington talks about UCLA’s role in healthcare reform.

FEATURES

12 • Injured, Maimed and Crippled, but Not Alone
UCLA’s healthcare community reaches out to help a battered Haiti.

18 • Letting Go
What is the true price tag at the end of life?
By Kathy A. Svitil

22 • A Matter of the Heart
Dr. Abbas Ardehali reshapes how other physicians think about organ transplantation. By Mona Gable

26 • The Real World
Medical and nursing students learn to learn from each other. By Dan Gordon

NEWS + NOTES

30 • Faculty Notes
Notables, honors and achievements: UCLA’s surfing surgeons.

32 • Alumni Notes
What’s happening from the MAA: Humanitarians abroad.

34 • Friends
Donor roundup: A young patient turns inventor and philanthropist.

37 • Epilogue
The road less traveled.
By Thomas S. Laughrey, M.D. ’10

Cover: Kayla Vandegrift, R.N.
NEW BEGINNING. Dr. A. Eugene Washington takes the helm as vice chancellor for UCLA Health Sciences and dean of the David Geffen School of Medicine at UCLA.

IN COMING TO UCLA, I believed the institution was uniquely positioned to build the future of science, medicine and health. I sensed that I was joining a community of extraordinarily talented and dedicated people with an unflinching commitment to excellence. I anticipated a pervasive esprit de corps across the campus that nurtured collaboration and innovation. And I expected that UCLA’s location in Los Angeles, with its size and scope, provided an opportunity to make a substantial impact locally, nationally and globally.

Four months into my tenure as Vice Chancellor and Dean, I am not disappointed. Far from it. Today, I am even more confident about the leadership role we in the David Geffen School of Medicine at UCLA and UCLA Health System will play in shaping the future and improving human health.

My confidence emanates principally from the great people I have met here – renowned faculty who are provocative educators, brilliant scientists and masterful healers; gifted staff who are exceedingly passionate about their work and phenomenally effective at it; creative students, residents and postdoctoral scholars who are full of anticipation and promise; devoted alumni who are deeply committed to sustaining the vitality of their alma mater; and visionary friends, donors and volunteers who are ineffably supportive and astonishingly generous.

Great people are the lifeblood of great institutions. And we are inarguably one of the world’s preeminent health-sciences campuses today precisely because of our exceptional people. By almost any measure one might apply, we have the best and the brightest.

Complementing this wealth of human capital is the spirit of collegiality and cooperation I have witnessed among colleagues across multiple disciplines. This ease of collaboration is energizing and reassuring. And it is pivotal. Why? Because innovation and impact in health are increasingly rooted in collaborative ventures, whether in education, healthcare or research.

Our rich intellectual substrate and collaborative nature are the reason we are leading the way in pioneering new models of team-based interdisciplinary care, creating novel inter-professional courses and learning experiences, and accelerating the translation of discoveries into treatments and disease prevention.

But we must do more. Our location in Los Angeles represents both an opportunity and an obligation. Emerging breakthroughs in medicine offer unprecedented possibilities for improving the health status of the community in which we live. Taking advantage of these opportunities is critical since the need is great and urgent.

To succeed – let’s say in improving the health status of Los Angeles in a measurable way by 2020 – will require us to take the lead in bringing diverse constituencies (other academic institutions, businesses, community groups, philanthropic supporters and governments) together to resolve the challenges affecting the health of fellow citizens. Fortunately, the foundation for such an ambitious undertaking has already been firmly established under the steady guidance of my predecessor, Dr. Gerald S. Levey.

Now we must, and will, build on this legacy in a meaningful way befitting our school’s inspiring history, worldly stature and tremendous promise.

In the years ahead, I look forward to working with all of you in our remarkable UCLA community. Together, we will advance a bold agenda in pursuit of excellence and impact. Together, we will shape the future of medicine – for the benefit of all.

Vice Chancellor, UCLA Health Sciences
Dean, David Geffen School of Medicine at UCLA
Gerald S. Levey, M.D., Endowed Chair
“The take-home message is that it’s never too late to quit smoking. Even older people’s eyes will benefit from kicking the habit.”

Quit Smoking, Save Your Vision

IF YOU NEED A LITTLE EXTRA INCENTIVE to chuck those cigarettes, consider this: A UCLA study finds that even after age 80, smoking continues to increase one’s risk for age-related macular degeneration (AMD), the leading cause of blindness in Americans over 65 years of age.

“The take-home message is that it’s never too late to quit smoking,” says lead author Anne Coleman, M.D., professor of ophthalmology. “We found that even older people’s eyes will benefit from kicking the habit.” The findings were published in The American Journal of Ophthalmology.

AMD causes progressive damage to the macula, the center of the retina, which enables us to see fine details. When the macula degenerates, people experience darkness or blurring in their central vision, preventing them from being able to read, drive and recognize faces. After age, smoking is the second most common risk factor for AMD.

Dr. Coleman and her colleagues followed 1,958 women who underwent retinal photographs at five-year intervals, starting with a baseline exam at age 78. Four percent, or 75 of the women, smoked. The researchers compared the retinal images at ages 78 and 83 to check for the appearance of AMD and evaluate if smoking affected the women’s likelihood of developing the disease.

“Age is the strongest predictor for AMD, yet most research in this field has been conducted in people younger than 75,” Dr. Coleman says. “Our population was considerably older than those previously studied. This research provides the first accurate snapshot of how smoking affects AMD risk later in life.”

Overall, women who smoked had an 11 percent higher rate of AMD than other women their age. In women older than 80, however, those who smoked were five-and-a-half times more likely to develop AMD than women their age who did not smoke.

“The bottom line is that AMD risk increases with age,” Dr. Coleman says. “And if you smoke, your risk of developing the disease rises even more.”
A Week of Hope and Healthcare

WHEN THOUSANDS OF PATIENTS descended upon the Sports Arena near downtown Los Angeles in April for the week-long Remote Area Medical (RAM) clinic, UCLA was there.

“I don’t believe it is cancer,” family medicine specialist Michael Rodriguez, M.D., reassured one young woman who came to have a lump on her wrist examined. “I know it can be scary when you don’t know what’s going on, but I want to reassure you that this is not worrying to me. You don’t need to be scared. It’s probably just a cyst.”

The growth had been troubling the young woman for more than a year, and Dr. Rodriguez’s reassurance was just what she needed. “I don’t have any insurance right now because I lost my job, so I really wanted to come here,” she said. “I feel taken care of, and my questions have been answered. This was such a relief.”

About 100 members from the UCLA Health System community participated in the clinic, which, in addition to physicians and medical students, included volunteers from dentistry and nursing. The university also sent the UCLA Mobile Eye Clinic, as well as donations of lab test equipment and $5,000 worth of urological supplies.

That kind of participation “is highly consistent with our vision of leveraging all the remarkable intellectual resources in the David Geffen School of Medicine at UCLA and UCLA Health System to improve the health of our communities,” said A. Eugene Washington, M.D., M.Sc., vice chancellor for UCLA Health Sciences and dean of the medical school.

Using an all-volunteer workforce, the RAM free clinics travel the country providing care to underserved communities. Throughout the Sports Arena, recession stories abounded: people working two low-paying jobs to make ends meet; jobs-and-insurance—lost in the economic downturn; years of having to wait before seeing a dentist or doctor for lack of health coverage.

Despite long lines and waits of several hours, patients seemed appreciative to finally receive care. “It’s terribly sad, but they are relieved that someone can tell them what’s going on,” Dr. Rodriguez said. “They all have this sense of uncertainty about their health.”

And while he acknowledged that participation in an outreach such as RAM was part of UCLA’s service mission, he looked forward to the day when it was a thing of the past. “We have to work to make this sort of thing unnecessary,” he said. “People shouldn’t have to do this to receive healthcare. It’s unacceptable.”

To watch a video about UCLA’s participation in the RAM clinic, go to: http://streaming.uclahealth.org/ram-la

There’s No Place Like Home

FOR PARENTS OF CHILDREN with multiple medical problems, keeping up with doctors’ appointments, ongoing tests and a variety of medications can be overwhelming, especially for those in challenging socioeconomic situations. As a result, families often wind up using the emergency room, the country’s most expensive form of care delivery, to get help for their kids.

But a growing concept in healthcare reform called the “medical home” offers parents a way to simplify, organize and coordinate the complexities of their medically fragile child’s healthcare needs. In the first quantitative study to look at the benefits of utilizing the medical home concept in a resident-education outpatient clinic at a specialized children’s hospital, UCLA researchers found that participation in the program reduced families’ use of the emergency room by 55 percent. The findings were published online in Journal of Pediatrics.

The medical home program at UCLA includes four basic components: a formal 60-minute intake appointment, follow-up appointments of 40 minutes (twice the length of standard appointments), access to a bilingual family liaison to help families navigate the medical system, and a family binder that keeps all of a child’s medical information in one place.

In addition to examining the program’s effect on emergency room visits, the UCLA study focused on the need to train future pediatricians in the principles of the medical home. “While the medical home concept has been shown to be effective in community pediatric practices, it has not been a standard part of the educational curriculum for our country’s future pediatricians,” notes lead author Thomas Klitzner, M.D., chief of the UCLA Division of Pediatric Cardiology and executive director of the medical home program at Mattel Children’s Hospital UCLA. “We set up a pilot program within our outpatient pediatric resident teaching clinic to develop a working model while building the required curriculum. We were pleasantly surprised to learn that we could run an effective program in a teaching clinic and create medical efficiencies that decreased the overall cost of medical care by reducing emergency department visits.

“The parents told us that they felt empowered by the pediatric residents, supervising faculty and medical home staff to use scheduled outpatient primary care and specialty visits rather than using the emergency department to get care,” Dr. Klitzner says.
Another Step Toward Understanding Schizophrenia

FOLLOWING UP ON EARLIER WORK that identified three gene locations that may be implicated in schizophrenia, researchers at UCLA and colleagues from around the world now have identified additional genes that confirm what scientists have long suspected — that the immune system may play a role in the development of the disorder. Further, they have also identified genetic anomalies that disrupt the cellular pathways involved in brain development, memory and cognition, all markers of schizophrenia. The research was published online in *Nature*.

Roel Ophoff, Ph.D., associate professor at the Center for Neurobehavioral Genetics at the Jane and Terry Semel Institute for Neuroscience and Human Behavior at UCLA, and collaborators from nearly 50 institutions worldwide performed a genome-wide scan of 2,663 people diagnosed with schizophrenia and 13,498 controls from eight European locations. They were looking for single nucleotide polymorphisms, genetic variations that are commonly present in the general population but more often present in those suffering from the disorder. They found significant associations with genetic markers on the Major Histocompatibility Complex, a group of genes that controls several aspects of the immune response. Further, they discovered additional variations in two other genes, called NRGN and TCF4, which points to perturbation of pathways involved in brain development, memory and cognition.

And that’s important, he noted, in developing new techniques to thwart the disease. “Knowing these specific genes are involved in the pathway leading to schizophrenia provides unique clues as to which molecular mechanisms are involved,” Dr. Ophoff says.

Don’t Assume HIV Vaccine Would Be Accepted

HIV VACCINES are considered the holy grail of AIDS research, yet the availability of one would not ensure that it would actually be taken by people at risk for HIV. “We know from vaccines for other diseases that mere availability is not sufficient,” says William Cunningham, M.D., professor of internal medicine and health-services research at UCLA. “The vaccine must be acceptable and accessible to people, particularly those at highest risk, in order to facilitate uptake.”

In a study of 1,100 high-risk adults published in *Health Services Research*, Dr. Cunningham and colleagues at the University of Toronto gave participants cards representing vaccines with various characteristics, such as 50-percent or 99-percent effectiveness; few or no side effects; costs of $10 or $250; and one-year or 10-year protection, and asked the participants to rate the acceptability of each. Participants also were asked to make trade-offs designed to determine those characteristics most important to them. For example, one card described a vaccine with 99-percent effectiveness but with minor side effects and a cost of $250, whereas another described a vaccine that was only 50-percent effective but has no side effects and cost only $10.

Participants were moderately accepting of an HIV vaccine overall, giving it a mean score of 55 on a 100-point scale, a finding that, while still positive, indicates that acceptability should not be taken for granted. Vaccine efficacy was the most important factor in boosting acceptability, followed by possible side effects and out-of-pocket costs. Also, 10 percent of at-risk adults indicated they would engage in more risky behavior if they were vaccinated. However, they were less likely to do so if the vaccine was only 50-percent effective versus 99-percent effective, suggesting they would adjust their behavior and expectations accordingly.
Sticky Solution

**JUST AS FLY PAPER CAPTURES INSECTS**, an innovative new device with nano-scale features developed by researchers at UCLA is able to grab cancer cells in the blood that have broken off from a tumor. These cells, known as circulating tumor cells, or CTCs, can provide critical information for examining and diagnosing cancer metastasis, determining patient prognosis and monitoring the effectiveness of therapies.

The current gold standard for examining the disease status of tumors is an analysis of metastatic solid biopsy samples, but it is often difficult in the early stages of metastasis to identify a biopsy site. By capturing CTCs, doctors can essentially perform a “liquid” biopsy, allowing for early detection and diagnosis, as well as improved treatment monitoring.

To date, several methods have been developed to track these cells, but the UCLA team’s novel “fly paper” approach may be faster and cheaper than others – and it appears to capture far more CTCs. In a study published in *Angewandte Chemie*, the UCLA team developed a 1-by-2-centimeter silicon chip that is covered with densely packed nanopillars and looks like a shag carpet. To test cell-capture performance, researchers incubated the nanopillar chip in a culture medium with breast cancer cells. As a control, they performed a parallel experiment with a cell-capture method that uses a chip with a flat surface. Both structures were coated with an antibody protein that can help recognize and capture tumor cells.

The researchers found that the cell-capture yields for the nanopillar chip were significantly higher: The device captured 45-to-65 percent of the cancer cells in the medium, compared with only 4-to-14 percent for the flat device.

“We hope that this platform can provide a convenient and cost-efficient alternative to CTC sorting by using mostly standard lab equipment,” says senior study author Hsian-Rong Tseng, Ph.D., associate professor of molecular and medical pharmacology.

The Frailer Generation

**IN A DEVELOPMENT** that could have significant ramifications for the nation’s healthcare system, Baby Boomers may be entering their 60s suffering more disabilities than their counterparts of previous generations.

Researchers from the Division of Geriatrics at the David Geffen School of Medicine at UCLA found that the cohort of individuals between the ages of 60 and 69 exhibited increases in several types of disabilities over time. By contrast, those between the ages of 70 and 79 and those aged 80 and over saw no significant increases.

While the study, which was published in the *American Journal of Public Health*, focused on groups born prior to the Baby Boom, the findings hold “significant and sobering implications” for healthcare because they suggest that people now entering their 60s could have more disabilities, putting an added burden on an already fragile system, researchers say.

“If this is true, it is something we need to address,” says Teresa Seeman, M.D., professor of medicine and epidemiology and the study’s principal investigator. “It will put increasing pressure on our society to take care of these disabled individuals.”

The researchers used two sets of data — the National Health and Nutrition Examination Surveys (NHANES) for 1988-94 and 1999-2004 — to examine how disabilities for the three groups of adults aged 60-69, 70-79, and 80 and older had changed over time. They assessed disability trends in four areas: basic activities associated with daily living, such as walking from room to room; instrumental activities, such as performing household chores; mobility, including climbing 10 steps without stopping for rest; and functional limitations, which include stooping, crouching or kneeling.

“We’re not sure why these disabilities are going up,” Dr. Seeman says. “But if this trend continues, it could have a major impact on us, due to the resources that will have to be devoted to those people.”
Antiviral Assault Gains Ground

A national group of researchers led by a team from UCLA may have found a broad-spectrum antiviral that will fight a host of viruses by attacking them through some feature that is common to an entire class of viruses, without producing unwanted side effects.

In a proof-of-principle study published online in *Proceedings of the National Academy of Sciences*, the researchers have identified an antiviral small molecule that is effective against numerous viruses, including HIV-1, influenza A, filoviruses, poxviruses, arenaviruses, bunyaviruses, paramyxoviruses and flaviviruses. These viruses cause some of the world’s deadliest...
Antiviral Assault gains ground
diseases, such as AIDS, Nipah virus encephalitis, Ebola, hemorrhagic
fever and Rift Valley fever. Even better, the compound – a rhodanine
derivative that the researchers have dubbed LJ001 – could be effective
against new, yet-to-be discovered enveloped viruses.

U.S. Food and Drug Administration-approved broad-spectrum
antivirals do exist but are rare, for various reasons. They are effective
against only a limited number of viruses, for example, or they have
unwanted side effects or are too expensive for widespread use. But the
putative mechanism for LJ001 is surprising, says Benhur Lee, M.D.,
associate professor of microbiology, immunology and molecular genet-
ics. “We provide evidence that the small molecule binds to both cel-
lular and viral membranes, but its preferential ability to inactivate viral
membranes comes from its ability to exploit the biogenic reparative
ability of metabolically active cells versus static viral membranes,”
he says. “That is, at antiviral concentrations, any damage it does to
the cell’s membrane can be repaired, while damage done to static
viral membranes, which have no inherent regenerative capacity, is
permanent and irreversible.”

While the exact mechanism of viral membrane inactivation is
unknown, the researchers – including scientists from the University
of Texas at Galveston, Harvard University, Cornell University and
the United States Army Medical Research Institute of Infectious
Diseases – are pursuing some promising leads that could answer
that question.

Why the Mirror Lies

EVERYONE CHECKS THEMSELVES IN THE MIRROR now and
then, but that experience can be horrifying for individuals
suffering from body dysmorphic disorder, or BDD, a
psychiatric condition that causes them to believe, wrongly,
that they appear disfigured and ugly. Now researchers at
UCLA have determined that the brains of people with BDD
have abnormalities in processing visual input, particularly
when examining their own face. The research was published in
Archives of General Psychiatry.

“People with BDD are ashamed, anxious and depressed,” says
Jamie Feusner, M.D., assistant professor of psychiatry and lead
author of the study. “They obsess over tiny flaws on their face or
body that other people would never even notice. Some refuse to
leave the house, others feel the need to cover parts of their face
or body, and some undergo multiple plastic surgeries.”

To better understand the neurobiology of BDD, Dr. Feusner
and colleagues examined 17 patients with the disorder and
matched them by sex, age and education level with 16 healthy
people. Participants underwent functional magnetic resonance
imaging while viewing photographs of two faces – their own
and that of a familiar actor – first unaltered and then altered
in two ways to parse out different elements of visual process-
ing. Compared to the control participants, individuals with
BDD demonstrated abnormal brain activity in visual processing
systems when viewing the unaltered and low-spatial frequency
versions of their own faces. They also had unusual activation patterns
in their frontostriatal systems, which help control and
guide behavior and maintain emotional flexibility in responding
to situations. Brain activity in both systems correlated with the
severity of symptoms. In addition, differences in activity in the
frontostriatal systems varied based on participant reports of how
disgusting or repulsive they found each image. Basically, how ugly
the individuals viewed themselves appeared to explain abnormal
brain activity in these systems.

The abnormal activation patterns, especially in response to
low-frequency images, suggest that individuals with BDD have
difficulties perceiving or processing general information about faces.
“This may account for their inability to see the big picture – their face
as a whole,” Dr. Feusner says. “They become obsessed with detail
and think everybody will notice any slight imperfection on their face.
They just don’t see their face holistically.”
DR. A. EUGENE WASHINGTON. The new vice chancellor for UCLA Health Sciences and dean of the David Geffen School of Medicine at UCLA addresses the role of UCLA and academic medicine in helping to advance healthcare reform.

Legislation to reform healthcare has finally been passed in this country, but it is still an evolving issue. What is UCLA’s role in contributing to the direction of the movement toward healthcare reform?

Dr. Washington: When you look at it very closely, the healthcare reform bill that was passed in Congress and signed by President Obama creates a framework within which many different groups and academic health-science institutions can come together to help orchestrate this movement that will dramatically change the healthcare-delivery landscape in this country. And I believe that we at UCLA will, in fact, be an active participant in that small group that will be helping to shape the future of healthcare in the U.S.

How do you envision UCLA’s participation?

Dr. Washington: It will be the academic health-science institutions like UCLA that will develop the demonstration projects and pilot test various models to determine which are the highest-quality programs that add the best value at the most-reasonable cost.

What are some examples that we may look to from our own experience at UCLA?

Dr. Washington: When I think about the remarkable excellence we have already achieved in delivering the highest-quality care, as well as the opportunities for improvement still before us, I think of them in three dimensions. First is what goes on inside our hospitals,
particularly related to innovations needed to continue improving quality of care. In this area, UCLA is at the forefront of a very elite group of institutions that are contributing important advances.

The UCLA operating system represents our organizational approach to performance management and improvement. By linking our mission and vision with goals, dashboard metrics and lean performance-improvement efforts, we strive to continuously improve. One highlight of this approach is our C-I-CARE project to improve the patient experience. As a result of engaging our staff and physicians in developing the C-I-CARE program, UCLA now ranks in the 96th percentile in customer satisfaction compared to all hospitals in the nation. This effort also underscores our unwavering commitment to patient safety and patient-centered care. Moreover, the success we currently enjoy reflects our steadfast culture of putting the patient first and honoring this concept in all we do. C-I-CARE is an example of where we at UCLA are solving a problem internally; however, the challenge of patient-centered care is also one that other institutions are facing. Other institutions are likewise facing the general challenge of consistent execution of best practices and ensuring that, at an operational level, people are on the same page, following all of the same protocols, and are very clear about their roles and responsibilities.

So an element of our contribution to shaping the future of healthcare is establishing mechanisms to effectively disseminate these innovations beyond UCLA in a timely manner. Such diffusion can involve simply telling our colleagues at other institutions about our experiences or sharing them with the world through presentations and publications. In other instances, this approach might involve more technological innovation and the creation of intellectual capital, and perhaps even the establishment of a company created to advance and disseminate some of these innovations that we identify.

What is another dimension of your view of the changes that need to come?
Dr. Washington: The outpatient setting. Our UCLA Faculty Practice Group has about 76 office practices concentrated near our hospitals in West-wood and Santa Monica. While we are also providing highest-quality care in our practices, the opportunity before us is to continue to elevate this quality, in the same manner that we’ve done in our hospitals. We are currently pursuing this goal by promoting quality and service metrics and standards of excellence that are uniform across all practices, and performance improvement where we fall short. In doing so, we are positioning ourselves to be a leader in identifying best practices for the outpatient setting and to play a role in continuing to shape future best practices for us and for others.

And the third dimension involves what I see as one of the ultimate objectives of health reform – more
focus on population health. At UCLA, we have a health system that incorporates both our inpatient hospitals and all of our outpatient practices to provide direct care of exceedingly high quality. In fact, we deservedly rank among the world’s best. With a successful model of integrated outpatient and inpatient care, we are also well positioned to become a health system in the years ahead whose reach extends well beyond the care we are providing in our hospitals or clinics. The aim here is to augment our high-quality, patient-centered care, which will remain indispensable, with additional programs and interventions that we know promote health and prevent disease. In pursuing this aim, we will be working to keep more people out of our hospitals and clinics by educating and counseling them about best practices to stay healthy.

As vice chancellor overseeing one of the preeminent health-science systems in the country, and dean of one of top medical schools, what personal role do you see for yourself in the ongoing reform effort?

Dr. Washington: In my role as dean of the David Geffen School of Medicine at UCLA, I am focused on educating and training the next generation of health-science leaders – physicians and researchers and educators. And it is these future generations who will be carrying these reforms forward. In addition, I work with colleagues to create new knowledge and new approaches to patient care and disease treatment through rigorous investigation. In the research arena, we have decided that one of our priorities will continue to be translational medicine – taking advantage of what’s become available through unprecedented scientific discovery to accelerate its translation into public benefit. And as vice chancellor for UCLA Health Sciences, I work with the leadership of our hospital system and our UCLA Faculty Practice Group to advance healthcare innovation, which we already have discussed.

How is the push toward reform going to affect the way we educate and train our future generations of healthcare leaders?

Dr. Washington: It’s not going to be dramatic, and it’s not going to happen overnight, and we’re not going to see big shifts in the next five years. But there are aspects of the reform legislation that are going to prompt changes in how we approach our educational mission. Most of our training now is about cure – diagnosis and treatment – which is obtained on specific rotations in the hospital or clinic. But increasingly, we are going to pay much more attention to health promotion, disease prevention – to addressing behaviors that can lead to or exacerbate illness.

We are also going to have to pay more attention to systematic care coordination for the chronically ill. In all of these areas, encounters in the examination
room may, in many cases, become much more focused on decision making assisted by state-of-the-art technologies, which will require a different approach for the physicians that we train. To some extent, it will require emphasizing the physician’s role within the healthcare system. In addition, some of the counseling that physicians offer currently is not performed very well because we have not traditionally been trained sufficiently, and we don’t have the time. It might be better, then, to have allied health professionals take on more of this role. While I believe we will see an expansion in this pool of professionals, I suspect that there are going to be roles within some healthcare systems and organizations in regard to counseling, education and shared decision making that we don’t think of today as central to the physician/patient encounter, that will fall to physicians. So physicians will require commensurate training.

There will also be a greater emphasis on training primary-care providers. The need in this area is already acute, but it is going to be even greater under healthcare reform, as the expansion of health insurance to another 32-million Americans will increase demand. The good news is that the legislation calls for an increase in reimbursements for primary-care physicians, which is specifically designed to expand the population of primary-care doctors. Most experts who look at healthcare agree that, going forward, for our national healthcare system to work well, it will require that we have a greater primary-care delivery base. The allied health professionals will be an integral part of that base, but we still are going to need an expansion of primary-care physicians. There will also be money for primary-care physicians to improve their working conditions, which have not always been as attractive as they are for specialists, by underwriting improvements to information technology.

Finally, I think that there will be more respect for primary-care practitioners. Given a health-oriented system with a greater emphasis on the primary-care provider as a leader on the team, there is likely to be broader recognition that he or she will greatly influence the degree to which the system is successful.

**“Most of our training now is about cure — diagnosis and treatment ... But increasingly, we are going to pay more attention to health promotion, disease prevention — to addressing behaviors that can lead to or exacerbate illness.”**

**Do you see a focus at UCLA, then, in growing that area?**

**Dr. Washington:** It depends on what we decide regarding the role we want to play, and I think we will have answers to this question in the coming months. Right now, we play a pivotal role as the best of the best in providing primary, secondary, tertiary and quaternary care. And we will definitely continue to play a leadership role in regard to training primary-care physicians, especially given society’s needs. But the degree to which we will expand in this area is undetermined.

**There is so much emotion, as well as confusion and misinformation, surrounding the healthcare discussion. What can we, as a school and as a healthcare system, be doing to not just look at the best delivery methods for healthcare, but also to help inform the debate about reform?**

**Dr. Washington:** It is an area where I think we can do much more. At UCLA we should be thinking about the messages and the information and knowledge that we want to help convey in this region about healthcare reform. And we should definitely continue to play a leadership role in regard to training primary-care physicians, especially given society’s needs. But the degree to which we will expand in this area is undetermined.

...
When a magnitude 7.0 earthquake devastated Haiti in January, members of the UCLA healthcare community responded by volunteering to go help. Some went as part of an organized UCLA effort – Operation Haiti – while others traveled on their own or with other non-governmental organizations. Whether they worked on board the U.S. Navy hospital ship the USNS Comfort or from a tent on the ground in Port-au-Prince, each volunteer went with an open heart and outstretched hand to the beleaguered Haitian people. Many filed blogs and took photographs. Here, in their own words and pictures, is a journal of their experiences.

**INJURED, MAIMED AND CRIPPLED, BUT NOT ALONE**

**UCLA REACHES OUT TO HAITI**

*Once we started driving through Port-au-Prince, you just felt the emptiness and the devastation that had happened there. Just tent city … tents everywhere.*

— BITA ZADEH, M.D

ABOVE: The magnitude 7.0 earthquake turned buildings in and around Port-au-Prince into mounds of rubble.

LEFT: Hastily erected tent cities sprang up to provide some shelter.

PHOTOS BY KAYLA VANDEGRIFT
It was very, very hot, and when we arrived, we saw different areas where the smoke was coming up really thick. And so, we asked, “What is burning over there?” and they said, “They’re funeral fires.”

— PATTI TAYLOR, R.N

I went to the ped floor [on board the USNS Comfort] … and just held the kids because a lot of them didn’t have family. They had nothing. Their parents were dead. Their siblings were dead. They didn’t know where their parents were. They didn’t know where their siblings were. They didn’t have people taking care of them. They didn’t have somebody tucking them in at night. And it broke my heart to see that. It broke my heart.

— JESSICA KUBISCH, R.N

The baby being held by this doctor from an NGO team was the only surviving child of a mother who lost her husband and five other children in the earthquake.

PHOTO BY JESSICA KUBISCH

A baby [brought on board the USNS Comfort] had been buried for three days, and her mom wouldn’t give up looking for her. And they had brought her to the Comfort to have surgery, but she’d been in the field hospital for several days. And the mom told us that when they had found her she … was moving air but breathing very lightly. And so, the neighbors had told her to throw her in the garbage because [they thought] she was gone.

— SHANNON MCCARVILLE, R.N

One child tries to cheer another as he recovers from his injuries.

PHOTO BY JESSICA KUBISCH
Up at the top of the mountain, they had this great need. They have had no medical care. They can’t get to them. So we drove up there on the first day and there was already a line of people waiting for us ’cause they heard we were coming. We set up our pharmacy in one area, our treatment in the other area. My triage area was a rickety pair of stairs, and we just started seeing patients. I think we saw probably 140 patients that day in maybe five hours, and then we had to promise we’d come back the next day ’cause there were lines of people waiting for us, which was really hard to turn them away.

— KERRY GOLD-TSAKONAS, R.N.

We went to the orphanage. And the little kids came up with their arms up in the air, and we thought maybe they wanted candy or something. They kept putting their hands up, and then we realized they just wanted to be picked up and held. And they just clinging to you. And all they wanted was to be held.

— KERRY GOLD-TSAKONAS, R.N.

Suffering unites humanity.

— JESSICA KUBISCH, R.N.
We went all over Port-au-Prince. We took a few duffel bags, a card table, a few chairs and just set up shop wherever we felt needed it, whether it was in a cinderblock building in the slums or on the streets.

— KAYLA VANDEGRIFT, R.N.

The first thing that struck me was the odor from the tent. … The weather was about 95 degrees with huge humidity, and so the air inside the tents didn’t move much. … The next thing that struck me was just how beautiful the Haitian people are. They’re an extremely beautiful and graceful people as a whole. And the third thing was the wounds that were going on when I walked into the wound-procedure room … [a] huge number of orthopaedic injuries and huge number of amputations.

— BARBARA BATES-JENSEN, R.N.

I was walking through the compound. It was the end of the day. It was about four or five o’clock in the afternoon, and there were people flying a kite … a little group of people, and here’s a kite up in the sky. I just couldn’t believe it. It just seemed so hopeful.

— BARBARA BATES-JENSEN, R.N.
The wound care that we provided to the patients, while necessary, was intensely painful. In the afternoons, usually around four or five o’clock, you’d be doing your bedside rounds to try to change the dressings on patients, and your patients would all be there, with their arms raised in the air, singing. After that singing, the entire attitude within the tent would change, and it would be really difficult to do things as invasive as some of the wound care that we provided.

— BARBARA BATES-JENSEN, R.N.

The Haitian culture is warm, welcoming and resilient. Almost every patient welcomed us with a smile. It is amazing how the people are able to tell us their story of the earthquake in such a calm voice and then continue on with their day.

— KAYLA VANDEGRIFT, R.N.

These two young men assisted as translators in the remote mountain area.

PHOTO COURTESY OF KENWAY HEYDEN

Here is how it works: Just don’t even think of showering in the morning. The humidity is so intense, you’re sweating before you even get on the bus. The heat in the tents becomes nearly unbearable by midday, and the only thing keeping you going is the knowledge you’re really making a difference in these people’s lives. They need us, so we’re here for them. You just drink some water and keep going.

— KENWAY HEYDEN, R.N.

Late at night in the orthopaedics tent, UCLA R.N. Kenway Heyden places an IV for a patient.

PHOTO COURTESY OF KENWAY HEYDEN

This handicapped man took up residence on an old hospital bed outside the partially collapsed University Hospital in Port-au-Prince.

PHOTO BY KENWAY HEYDEN

THE HAITIAN CULTURE IS WARM, WELCOMING AND RESILIENT. ALMOST EVERY PATIENT WELCOMED US WITH A SMILE.
The strength of the Haitian people is incredible. The wards are filled with hymns. Family members are quick to assist the nurses, and to provide any aid they can for the other patients. After being on board the USNS Comfort, where they have plenty of medicine, food, shelter and water, they bravely return to the uncertainty of the land without complaint. They give back to us all that they have — a smile and a thank you.

— BETHANY FONTENOT, R.N.

The tragedy of Haiti’s poverty has been magnified by the devastation of the earthquake, which destroyed what little these people had, leaving them injured, maimed and crippled, but not alone. The world has responded to beautiful, marred Haiti’s plight. Struggling desperately against all odds, Haitians will need support and aid for years to come as they rebuild their country, their country that, as one Haitian woman described it, fell on them.

— JESSICA KUBISCH, R.N.

I have incredible drawings by a teenager who was trapped in the rubble for several days. He drew what he saw when he finally regained consciousness. It’s all very overwhelming.

— JESSICA KUBISCH, R.N.
The ongoing national discussion over healthcare reform, the high cost of end-of-life care often is at the center of the debate. And, for better or worse, UCLA often finds itself framed within the spotlight of that discussion.

For example, a study conducted by researchers at Dartmouth University about Medicare spending during the last two years of life, which was published in 2008, found that UCLA’s expenditures were among the highest in the country – an average of $93,842.

While that number might strike many as shocking, it does not tell the whole story. The Dartmouth analysis only examined costs in patients who ultimately died and “ignores the possibility that resource-intensive care may improve survival rates,” as countered in a separate study by a group of physicians at UCLA and five other California teaching hospitals.

Indeed, this second study, published in the journal *Circulation: Cardiovascular Quality and Outcomes*, found that hospitals, including UCLA, that spend the most money on heart-failure patients do indeed have lower mortality rates. Clearly, despite the cost, extraordinary medical care – involving months in the intensive care unit and scores of high-tech diagnostic tests, transplants and more – can save lives.

And yet, as an article on the Dartmouth study published in *The New York Times* last year pointed out, while aggressive care can save lives, it doesn’t always, and in these situations, the toll is more than monetary. When a patient, in spite of the best intentions of caregivers and loved ones, is kept alive beyond any capacity for an existence without machines, past the point of futility, and dignity, the “cost” is steep and impossible to quantify. It’s an issue of continued concern to the UCLA hospital administration and medical staff.

“The ‘we’re not going to let you die’ credo has been part of the culture here,” says Tom Rosenthal, M.D., chief medical officer of UCLA Health System. “And it remains true that if there’s a chance we can save your life, that’s what we’re going to try to do. The question is, when does it become clear that we’re not going to succeed? And when we can’t succeed, what are we going to do to still provide the best care?”

“Sometimes, providing the best possible care means the newest and latest aggressive therapy and technology,” says Anne Walling, M.D., a clinical instructor and Specialty Training and Advanced Research fellow at Ronald Reagan UCLA Medical Center. “But sometimes it means sitting down to have an honest conversation about end-of-life issues and developing a care plan that focuses on comfort.”

Questions like how to determine that striving for a cure is not actually in the best interest of the patient and when to stop aggressive care and let go are especially complex at a place like UCLA, which, as a tertiary and quaternary care facility, tends to the sickest of the sick. Patients often don’t come to UCLA until they’ve run out of options, and, because of the extraordinary level of care and the excellence of the hospital and its staff, “they come hoping for us to save them,” Dr. Rosenthal says.

“It does happen, but for many patients, that’s not the outcome,” says Patrick Dowling, M.D., chair of the UCLA Department of Family Medicine. That statement is particularly true for the very elderly. “People are living much longer than before, so we take care of many more people in their late 80s and 90s, and they’re very fragile. At that age, many systems – heart, kidneys, etc. – start breaking down. This is one of those times when more care may not be better care.”

“I think that we, as doctors really have to be humble and recognize there are cases where we can’t save a life,” says Tamara Horwich, M.D., a heart-transplant specialist at Ronald Reagan UCLA Medical Center.
letting go

as the end of life nears, when is it time to say enough?

by kathy A. svitil • illustration by juliette borda
But such acceptance can be a challenge, especially for doctors who treat patients with the most complicated medical cases.

Complex care requires an ability “to look at zebras and find alternatives,” Dr. Rosenthal says. “Doctors who thrive on complexity are really good at doing everything they can to save your life, but in the midst of that effort they might be reluctant to step back and ask if the plan of care is still consistent with the patient’s interests, if there really is a chance for survival.”

It is a troubling situation for people who devote their lives “to defeating disease at every stage,” says Dr. Dowling. “They see giving up as a failure.”

What needs to be understood is that “there’s no bad guy here,” says Neil S. Wenger, M.D., director of the UCLA Health System Ethics Center. “It’s a struggle to pull back.”

The struggle to pull back is as real for the families of terminal patients as it is for the physicians who treat their loved ones. And sometimes that can lead to unfortunate outcomes for patients who are no longer able to make decisions for themselves and wind up receiving aggressive care they would not have chosen. “It’s a real roadblock,” Dr. Dowling says. “People want everything done for their loved one, and they don’t understand what that means, what it does. These very aggressive responses can cause pain and injury to a patient, especially to a frail, elderly person.” And once life-sustaining measures are initiated, “it is a very difficult problem to unhook someone.”

There are those cases “where families make decisions the patient wouldn’t have wanted, and the patient’s dignity is compromised because families are pushing for heroic measures that are bound to fail,” Dr. Wenger says. “If there is evidence of the patient’s wishes, we don’t allow that. But when there is no advance directive, the family usually makes the call. It’s important to have a discussion with patients in a timely manner, when they are able to make their wishes known.”

The best course, says Dr. Horwich, “is from the get-go to keep the patient and family educated and informed about every single issue in the process of care. If we say ‘your heart is weak and you have lung disease because you’re a smoker, so we don’t know how well you’ll do,’ then, when you let them know that transplant is not an option due to advanced lung disease, and there are no other options, the family is not surprised or angry.”

**Facilitating and Standardizing**

Such conversations and giving doctors, patients and families the tools and support to make the difficult decision to suspend aggressive treatment in favor of comfort care are ongoing goals of UCLA Health System. For example, over the past two years, the hospital has expanded significantly its palliative-care program (see “Comfort Measures,” *UCLA Medicine*, Fall 2009) and begun emphasizing the program’s services to its physicians. “More physicians are asking for consultations with the palliative-care team,” says Dr. Dowling, and not just in terminal cases.

Drs. Dowling and Rosenthal and others at UCLA would like to see palliative-care services utilized early in treatment, as a standard part of care. “The expansion of the program has been a major change at UCLA,” Dr. Dowling says. “I’m pleased with that because it’s really about patient rights – about them understanding their rights.”

When a disease course presents no options, the service gives patients and their families help in making informed end-of-life decisions – about, for example, pain and symptom control and whether or not to transfer to hospice care.

“Our goal is to determine what the patients would want,” says Bruce Ferrell, M.D., director of adult palliative-care services at UCLA. “Do they want dialysis? A ventilator? Do you do a procedure on a patient when it is unlikely they will recover? There are a lot of decisions to be made. We need to be realistic with patients about the natural course of diseases, and we really get to know patients and their families so we can help them come to peace with their decisions.”

Sometimes patients come hoping for a miracle, “but that likelihood is so remote, and maintaining the patient is uncomfortable and difficult for them, while the resources that are necessary are enormous,” Dr. Ferrell says. “We don’t pull the plug on people – if a person has a legitimate belief system, stated in an advance directive, we respect those wishes.” When there is no such directive but the family is
pushing for extreme yet ultimately futile care, “we get the ethics committee involved,” he says.

The ethics committee can step in—at the request of the medical staff, patients or families—for a variety of reasons. Sometimes, patients don’t trust the advice of their doctors, or they get conflicting information. “That can become an issue when different doctors are involved who are seeing different things,” says Dr. Wenger. “It’s like the story about the blind men feeling an elephant; each one feels a different part of the body and has a different interpretation of what kind of animal they’re touching.”

More commonly, patients or their families may have unrealistic expectations, or may have religious or cultural objections, to a plan of care. Or, they simply may not want to stop even when treatments become futile. “Optimally,” says Dr. Wenger, “we on the ethics committee should play no role, because these decisions should be made in an iterative fashion by patients, families and doctors. In most cases, it does move in that direction, and doctors are getting increasingly skilled at handling these issues.”

Recently, to help doctors with such issues—and, ultimately, to improve care—a project led by Dr. Walling has begun an assessment of the quality of care in hospitalized end-of-life patients. Dr. Walling and her collaborators are evaluating factors like communication among doctors and patients and the family, the adequacy of symptom management, and if patients’ stated preferences match the care they receive.

“We’re looking at things like whether a patient’s pain and other symptoms are being addressed in a timely fashion and whether patients’ preferences for care are being considered,” Dr. Walling explains. “The ultimate goal is to measure these processes like we measure processes in other fields, look at the results, and then review them with clinical leaders.”

In this way, improvements can be identified and recommended. “For example, we might enhance physician and nurse education to remind them that this is something they should be paying more attention to or develop intervention measures to improve care,” Dr. Walling says. “If, for example, there needs to be a more timely assessment and follow-up on symptom control, we might be able to do something like improve the electronic medical-record system to prompt physicians to make a more timely assessment. Focusing not just on prolonging survival but looking at quality measures of the patient experience,” she adds, “might be one way of changing the culture.”

The public conversation over the past year that has focused on these thorny issues began with a contention that much of the costly medical care that is delivered toward the end of life is wasted and that Medicare expenditures could be reduced if that care were somehow made more efficient. It is an assertion to which Dr. Rosenthal replies, “For us at UCLA, it is never an issue of resource utilization. Without a doubt, there are complexities involved when caring for people at the end of their lives that must be taken into consideration. But ultimately, whatever decision is made, it must be made for the benefit of the individual patient.”

Kathy A. Svitil is the lead science writer at the California Institute of Technology and a former writer and editor for Discover magazine.

ADVANCING THE ETHICS DEBATE

HOSPITALS LIKE UCLA’S that develop and provide cutting-edge medicine need a mechanism to balance complicated medical and ethical issues.

“Academic medical centers often confront complex life-and-death questions. We must help patients and their families through the process of negotiating difficult ethical decisions,” says Neil Wenger, M.D., director of the UCLA Health System Ethics Center.

The Ethics Center was created to address these increasingly complex issues that arise out of the confluence of medical advancements, the explosion of information availability and economic pressures.

“In a context of medical advancement, economic constraints and patient need, this center provides resources to explore and develop potential solutions to some of the problems facing our society today,” says Katherine Brown-Saltzman, R.N., co-director of the center.

“We aim to have a positive impact on patients here at UCLA and elsewhere.”

The center, which is supported by UCLA Health System and members of the UCLA community, is committed to:

• Promoting the care of patients in an environment that is humanistic and compassionate.

• Drawing on the perspectives of health professionals, patients and families.

• Addressing the challenges of rapid socioeconomic, cultural and technological changes in healthcare.

• Utilizing UCLA’s academic resources to reach out to the community and combine the strengths and perspectives of various disciplines and professions.

• Carrying out innovative research to advance ethical aspects of healthcare and health policy.

• Engaging the community in debating clinical-ethics topics of public importance.

For more information about the UCLA Health System Ethics Center, go to: www.uclahealth.org/ethics
A Matter of the Heart

Dr. Abbas Ardehali has been a leader in reshaping the medical community’s approach to transplantation in older adults.

On a Wednesday morning at Ronald Reagan UCLA Medical Center, Abbas Ardehali, M.D., leans over a patient in the O.R., delicately removing the scarring inside her damaged heart. The director of the UCLA Heart and Lung Transplant Program is not only mending two of the woman’s heart valves, he also is redoing a coronary bypass she had a few years before. Except for the steady beeping of monitors and the rustle of nurses fetching instruments, the brightly lit room is quiet, the atmosphere calm. When Dr. Ardehali addresses his team, he is polite and direct.

Dr. Ardehali has done this surgery countless times. It is tricky, to be sure, but it’s hardly his most complex procedure. That would be the double-lung transplant he performed two nights before on a 46-year-old man. The surgery, which began at 4 a.m., after the donor organs arrived from Saddleback Hospital in Orange County in a limo – it was too foggy to fly them – lasted until 1 p.m. the next day.

Yet there is one aspect of this morning’s surgery that is unusual: the woman on the table is 80 years old. When she arrived at UCLA, she was in heart failure. Because of her age and chronic medical problems, her own surgeon considered her too high-risk for surgery. Not Dr. Ardehali.

“We don’t get too many healthy 80-year-olds,” he says with a warm smile on the morning of the woman’s surgery, sitting in his tidy office on the sixth floor of the Center for the Health Sciences building. Dressed in a lab coat, scrubs and New Balance shoes, the surgeon is fielding calls from colleagues as he waits to hear if the woman is ready for the operation to begin.

Given her condition, it’s hard not to wonder why he accepted her case. For Dr. Ardehali, that decision reflects his deeply felt philosophy of medicine. “I’m willing to take the risks,” he says. “At UCLA, I feel we have a commitment to expand the horizons of the field.”

And then he adds: “The alternative would be consigning her to death.”
“I am willing to take the risks. At UCLA, I feel we have a commitment to expand the horizons of the field.”

OVER THE LAST DECADE, a dramatic change has swept the field of heart and lung transplantation: The number of older people receiving the lifesaving gift of a transplant has increased. As one of the few physicians in the United States with specialties in both medicine and surgery, Dr. Ardehali has been a leading innovator of this development. Since 1999, when he became head of UCLA’s program, the Iranian-born surgeon has performed dozens of transplants on older patients, with significant results. In a 2008 study of 50 patients who received lung transplants at UCLA between 2000 and 2006, Dr. Ardehali and his colleagues found that patients 65 years and older had nearly identical three-year outcomes as those who were younger than 65 years of age.

Peers in the field have taken notice. “He is widely regarded as an excellent surgeon and an innovator in the field,” says Kenneth R. McCurry, M.D., surgical director of heart and heart/lung transplantation at the Cleveland Clinic.

Historically, those who were 60 years or older found it nearly impossible to get a transplant. The reasons were many. Older patients didn’t tolerate immunosuppressive drugs well. They had problems with organ rejection. Add to those reasons various medical problems like high blood pressure or stroke, and their chances of survival were considered poor.

But there also was a generalized attitude within the transplantation community that younger patients, with many years of life potentially still ahead of them, should get preference. Didn’t they, after all, have the most to gain?

It was a philosophy Dr. Ardehali didn’t share. “It’s the only area in medicine where we ration care,” he says. “The rationale is there is a limited organ supply – organs should be transplanted to younger patients who are more likely to have a better outcome. However, at UCLA we continued to ask how can we improve access to transplantation for older patients without affecting organ availability for younger recipients?”

As transplant surgery got safer and patients were surviving longer and leading healthier post-transplant lives, the attitude began to change, and it was Dr. Ardehali who helped pave the way. He also took the lead in another breakthrough for older patients. He began to offer them organs that were older or slightly damaged or that might have been rejected as unusable because of the donor’s uncertain health, significantly increasing the supply of donor organs.

In a recent case, a 20-year-old donor was suspected of having died from IV-drug use. After numerous tests, Dr. Ardehali and his team believed the young man’s lungs were healthy. When he offered them to two older recipients, explaining the donor’s history, “one patient agreed, and now is home and off oxygen. The other patient decided not to accept the organ.”

In such a grave situation, how does he know the right thing to do? “I cannot make that decision for them,” says Dr. Ardehali, a slight, handsome man with thinning black hair. “You have to rely on the patients and their families. I need their help so we can make the best decision together.”

In addition to his work in the O.R., Dr. Ardehali is also an active researcher. He’s the principal investigator for the U.S. clinical trial of the “heart in a box” — a machine that can preserve a still-beating heart in isolation for hours until it can be transplanted.

Besides UCLA, the trial is being held at four other transplant centers: Columbia University, Cleveland Clinic, Washington University and the University of Maryland. If successful, the new technology could break down the geographic barriers to transplantation, making it possible for donor organs to be transported anywhere in the country where a patient is in need.

With today’s technology, a heart must be delivered to the recipient within six hours for it to remain viable for transplantation. And many organs are, for a variety of reasons, thought to be too fragile for transplantation. In 2006, for example, 64 percent of donated hearts were not used because they were considered too weak or otherwise imperfect. The “heart in a box,” however, could sustain an organ for up to 24 hours, and further opens the door to salvaging some hearts that were previously deemed unusable, giving more desperate patients much-needed hope.

AS A BOY GROWING UP IN TEHRAN before the Islamic revolution, Dr. Ardehali was fascinated by medicine. He vividly remembers hearing the stunning news in December 1967, when South African surgeon Dr. Christian Barnard performed the world’s first heart transplant. “That was one of the moments in my background as a child that affected my career goals,” he says.

Dr. Ardehali’s family placed a tremendous value on education. His father, who received his Ph.D. from Clark University in Massachusetts, was an economist for one of the leading banks in Iran. But Dr. Ardehali particularly credits his mother for his drive and that of his five siblings to do something meaningful with their lives. Long before the 1979 revolution overthrew the Shah and sent tens of thousands of Iranians fleeing abroad to escape the repressive theocracy that followed, Dr. Ardehali knew he would finish his education in America, just as his father had done.

In 1976, when he was 16 years old, he left Iran and moved to Fall Rivers, Mass., to live with a family who were friends of his father. Although his English was good, the Iranian teenager definitely stood out among his all-white Catholic schoolmates. But in his characteristic upbeat way, he downplays any difficulties of the transition: “It was a different culture, but after going to the prom, I felt pretty acclimated to the system.”

But as his new life unfolded in America, tragedy struck his family in Iran. His grand-
father died of a heart attack. And his grandmother, to whom he was especially close, died suddenly in her early 50s when her pacemaker malfunctioned. Their deaths were a terrible blow. Yet in one sense, their deaths also were a catalyst to eventually motivate the disciplined and intellectually gifted student to focus on afflictions of the heart.

He almost took a different path. Engineering had also intrigued Dr. Ardehali. After earning a master's degree in chemical engineering from Rutgers University, he decided to apply to the Ph.D. program at Stanford University and to several medical schools. When he was accepted to every one, it produced a crisis of sorts. “My thought was, where could I see myself happiest?” Dr. Ardehali recalls. In the end, the heart won out.

He earned his medical degree at Emory University in 1986 and went on to specialize in internal medicine and cardiology at UC San Francisco. In 1990, he came to UCLA, where he completed residencies in surgery and cardiothoracic surgery. It was at UCLA that he first saw desperately sick patients and cardiothoracic surgery. It was at UCLA that he first saw desperately sick patients and to see the new heart you have placed there beating.”

After years of training, the young doctor found his calling. “It’s an awe-inspiring moment to look into a human being’s chest ... and to see the new heart you have placed there beating,” he says.

Asked what drives him, Dr. Ardehali’s wife, Mitra, says it’s not only his high expectations of himself. “He is constantly thinking of the patient,” she says. “He is just really dedicated to what he does.”

That devotion and Dr. Ardehali’s stellar reputation have drawn people from across the country to the program at UCLA. Patients like Ed Griganavicius, who came to Dr. Ardehali after more than two years of grappling with a potentially fatal heart condition.

Griganavicius owns an IT company in Orange, Calif., with an emphasis on healthcare. In the summer of 2006, the avid backpacker and climber was just 42 when his heart rate began soaring to 220 beats a minute. Like his mother, who died of the disease, Griganavicius was diagnosed with cardiomyopathy, a condition where the heart muscle is inflamed and doesn’t work as well as it should. In January 2007, after several harrowing trips to the emergency room, Griganavicius had a pacemaker defibrillator put in. “Unfortunately, it was shocking me,” he says. It was only later, after he’d been stabilized, that he learned he was in heart failure. He was also told he should get a heart transplant.

Shortly thereafter, Griganavicius’s wife, Lisa, gave birth to their daughter. It was bittersweet for Griganavicius; by the time his child was a few months old, he was so weak that it was hard for him to carry her.

In the meantime, Griganavicius was methodically comparing transplant programs. He was particularly impressed by Dr. Ardehali’s depth of experience and success with patients. “UCLA pretty quickly became the place to go,” he says.

In September 2008, Griganavicius met with the heart-transplant team, which included a cardiologist, a psychologist, a social worker and the transplant coordinator. Dr. Ardehali participated in the evaluation, too. In spite of his difficulties, Griganavicius was still too healthy to qualify for the transplant list, but he entered UCLA’s cardiomyopathy program. In November 2009, his condition worsened, and he was admitted to the hospital and placed near the top of the transplant list.

When word came, in January, that a donor heart was available, Griganavicius contemplated the upcoming surgery, and the thought of his own heart being lifted out of his chest. He wasn’t afraid. “I had done everything I could,” he says. “I had found the right place. I had the support of my family.” He was confident he was in good hands. “The fact you have a team of professionals that you truly believe in — that helped to alleviate any fear or uncertainty,” he says.

The surgery to replace Griganavicius’s dying heart went perfectly. Five hours later, he was off the respirator, and a few days later, he was up and walking.

As Griganavicius recovered in the hospital, his new heart beating away in his chest, Dr. Ardehali came by to check on him. How was he feeling, Dr. Ardehali asked. Was he eating? Getting any sleep? How was his state of mind?

“It was about my overall well-being, not just the disease itself, but my entire quality of life,” Griganavicius recalls.

On January 21, eight days after his transplant, Griganavicius returned home. That first day, he walked up the stairs of his two-story house. For the first 24 hours, his daughter, now 2½ years old, wouldn’t let him out of her sight. Six weeks out, he’s working again. Under his doctor’s supervision, he’s also planning some trips. His heart is doing beautifully.

“Everything is firing on all cylinders,” he says. “I’m just grateful that I got a second chance,” he says. “And that second chance is because of two reasons: the fact we have a donor program and somebody donated their heart to me, and the fact I had the best medical team I felt I could have gotten.”

It’s no wonder Dr. Ardehali feels so passionate about his work.

“I couldn’t have chosen a better profession,” he says. “The concept of having a direct impact on someone’s life and being able to see it within hours or days, it’s even highlighted more. These are patients who otherwise had no chance.”

Mona Gable is a freelance writer and journalist in Los Angeles.
In Doctoring 3, future physicians and advanced-practice nurses learn about each other while confronting the provocative issues they will have to face together.

The Real World

By Dan Gordon  Photography by Patricia Williams

Sitting in on a Doctoring 3 class one Thursday morning at the David Geffen School of Medicine at UCLA, one quickly realizes that little of the conversation can be found in any textbook.

On this day, in a small room that barely contains the rectangular table around which sit eight students, the topic is germs. Guided by two faculty facilitators, the young men and women engage in a free-wheeling discussion in which they share the experiences they’ve had on hospital wards – and, in moments of digression, in fast-food restaurants (you don’t want to know). Like Las Vegas, the understanding is that what’s said in this room stays in this room, and the conversation is remarkably frank. Students who have learned in previous courses and on their clinical rotations how things should be are now talking about how they really are. Each has some war story to tell of providers they’ve observed who remove their masks around sick patients or don’t wash their hands before leaving a patient’s room. At a time when the H1N1 flu virus is spreading rapidly, the students are resigned to the reality that putting themselves at risk of infectious diseases is a hazard of the job, and that when they do get sick, the culture demands that they will have to muddle through.

No topic is out of bounds in Doctoring 3: Abortion, medical marijuana, end-of-life care and racial/ethnic and gender stereotyping are just a few of the issues that will be discussed during the academic year. But something else is different about this and the eight other Doctoring 3 groups that meet each week: Half of the students in the class are from the UCLA School of Nursing.

The Interprofessional Seminar/Doctoring 3 course groups third-year medical students with second-year master’s students who are preparing to become advanced-practice nurses (APNs) in the School of Nursing’s acute-care and oncology nurse practitioner/clinical nurse specialist programs. While a growing number of institutions have moved toward interprofessional education and team-building exercises, there is little precedent for what Doctoring 3 did in 2009-10 – for the first time bringing graduate nursing and medical students together as equals, in a required course for a full academic year.

The course is designed to provide an opportunity for students to discuss issues that are difficult to address in other parts of the curriculum. But with the introduction of advanced-practice nursing students, it is serving another important purpose: breaking down traditional barriers among individuals who are increasingly working together in multidisciplinary teams.

“If we want people from different health professions to understand each other and not view one another as potentially antagonistic, we need to have them grow up together as students,” says Margaret Stuber, M.D., the Jane and Marc Nathanson Professor of Psychiatry and director of the 20-year-old Doctoring Program at UCLA, which focuses on psychosocial, ethical and interpersonal issues and competencies.
WITH THAT TEAM APPROACH as the premise, an Interprofessional Education Task Force with representatives from the medical and nursing schools had been discussing potential ways to bring the two disciplines together. Integrating APN students into Doctoring 3 seemed an ideal fit. “Medical students and APN students have a lot in common,” notes Dr. Stuber, who developed and oversees the Doctoring 3 course. “Both groups are going to be writing orders and making clinical decisions, and this is a time in their education when they are learning how to do that.”

Courtney H. Lyder, dean of the School of Nursing, believes such collaborative efforts represent the future of medical and nursing education. “No two groups of health professionals are more interrelated in practice,” he says. “This innovative program starts the process where it belongs – in the classroom.”

Doctoring 3 cohorts have eight students who remain together throughout the year. The Thursday groups are evenly split between medical and nursing students; each group also has two faculty "tutors" – a physician and a nurse – who facilitate the meetings. Bringing the APN students into the mix adds an important perspective to the discussions, says Christopher Harris, M.D., associate professor of pediatrics and one of the tutors. “Many of them have been bedside nurses before they entered the graduate program at UCLA, so they have a lot more clinical experience than the medical students,” Dr. Harris says. “Because they’ve been in the trenches, they tend to be able to speak with more authority about what goes on in hospitals than the medical students can.”

After the concept was pilot-tested with a dozen nursing students who participated in Doctoring 3 for a single quarter in 2008-’09, it was apparent that the integration was valuable – and much-needed. “One of the things the nursing students told us after the experience was that they had learned that the medical students are actually pretty nice – which, unfortunately, was a surprise to them,” Dr. Stuber says, laughing. Likewise, she adds, few medical school faculty – much less medical students – are versed in the increasing scope of a nurse practitioner’s or clinical nurse specialist’s practice. But as they engage on the topics of the day, the students are also gaining an appreciation for the training of their counterparts and the approaches they bring to clinical settings.

“I feel the medical students understand us much better now – what our role is and how we contribute to healthcare,” says Liz Lizaso, a student in the School of Nursing’s dual clinical nurse specialist/acute-care nurse practitioner program. Lizaso, who had 13 years of experience as a registered nurse prior to starting her graduate training, says Doctoring 3 has also helped her overcome barriers she once felt when communicating with physicians.

“Nursing and medicine are often viewed as, if anything, in opposition,” says Richard Fogel, another acute-care nurse practitioner student who was part of the Doctoring 3 course. “It was strange at first to be in the same room with medical students talking about controversial subjects, and we didn’t know what to expect. But the most surprising part was how much common ground we had on most of the topics.”

To Fogel, it was just as revealing to get to know the medical students on a human level as it was to learn that they shared many of the same views on patient care as the nursing students. “My impression of them totally changed when I realized they had the same struggles and anxieties about what they’re going through as we do, along with the same feelings of triumph when things go well,” he says.

GIVEN THE PROVOCATIVE SUBJECTS that are broached, it’s not surprising that when the eight students and two tutors get together behind closed doors, the conversation is always lively. While there are plenty of important facts to be learned by would-be physicians and advanced-practice nurses – evidence-based knowledge about when to treat and what the best medications are for given conditions, for example – one reason Doctoring 3 is an ideal setting to mix medical and nursing students is that it covers clinical aspects that aren’t so black-and-white. “It’s about the context – both internal and external – in which we make decisions,” says Dr. Stuber. “What role do our biases and emotional responses play, and what are the legal, social and economic contexts in which these decisions are made? All of these can have an effect, and are thus important to learn.”

To prepare for a session’s directed topic, reading materials are divvied up, with each student responsible for reporting to the others on his or her tutorial. At the height of the debate on healthcare reform in the United States, for example, each student was charged with learning about a different country’s system to prepare for a discussion of the pros and cons of other models vs. the U.S. system. Students also share paragraphs they write about their own experiences and views vis-à-vis the week’s topic. For the session covering hospice and palliative care, tutorials covered subjects that included grief and bereavement, pain,
hospice care, complementary and alternative medicine, and final hours of living. Students reflected on their own experiences with end-of-life care: Was there a timely discussion about transitioning from curative to palliative care? Was there adequate attention to pain, fatigue, appetite and nausea? What ethical or spiritual issues were raised?

Students also examine their personal biases: Do they have preconceived notions about patients based on gender, ethnicity or appearance? How do those stereotypes affect their approach to care? A session on conflict of interest touches on everything from the impact of direct-to-consumer advertising to whether something as seemingly innocuous as using a pen with the name of a drug company might influence prescription orders. When abortion is the topic, students delve into difficult questions such as what they would do if they personally opposed the procedure but believed in a woman’s right to choose. Would they learn how to perform abortions or avoid any abortion-related interactions? “We’re stretching the concept of what it means to be a clinical decision-maker,” says Dr. Stuber.

The discussions also turn to personal interactions and conflicts within the healthcare team. Students share times when they felt uncomfortable after observing an attending physician not doing a good job of listening to a patient. They open up about experiences when they felt misunderstood or disrespected, and how they responded. When Lizaso described an incident involving a resident, the medical students helped her to better understand the resident’s perspective. “We’re always going to encounter conflict, but it’s helpful to hear what other people are going through and how other students overcame their conflicts,” Lizaso says. “It allows us to use that information in practice.”

**THE STUDENTS LEARN** from the start that Doctoring 3 provides an environment for no-holds-barred interactions, a place where they can feel safe in expressing concerns and vulnerabilities. “Some of the discussion is sensitive and doesn’t necessarily follow the party line, so it’s understood that what’s said will not leave the room,” says Maggie Dewan-Smith, a lecturer in the School of Nursing and one of the Doctoring 3 tutors. Like the students in Doctoring 3, Dewan-Smith keeps a busy schedule: In addition to lecturing at the School of Nursing, she works half-time as a nurse practitioner in UCLA’s Adult Non-Invasive Cardiology Lab and is in the U.S. Air Force Reserve. Nonetheless, she volunteered to serve as a tutor in the pilot year and was happy to play the same role when the program was expanded this year. “It’s just so interesting,” Dewan-Smith says. “We have wonderful, lively discussions. We laugh – it can be a great stress reliever. And a lot of trust builds up among the members of these groups.”

Doctoring 3 comes at a key moment for all of the students – a time of both transition and stress. The APN students are in the process of making the shift from following orders to writing orders, a significant change in how they conceptualize their role. They are giving grand rounds for the first time and completing their academic and clinical studies while preparing to take their comprehensive exams. Similarly, the medical students, after two years focused heavily on classroom- and laboratory-based education, are for the first time part of hospital teams where clinical decisions are being made that can have life-or-death implications. It’s the type of intense emotional experience for which no lecture can adequately prepare students.

But the course provides a welcomed respite. “We’re in a year in which we don’t get much of a break away from our work, and this gives us a chance to step back and reflect on what’s going on and how it’s affecting us,” says Vatche Tchekmedyian, a medical student in the Doctoring 3 course. “It’s great to go through that with the nursing students, and it felt very natural from the start.”

Dan Gordon is a regular contributor to UCLA Medicine.
ON A COLD AND WINDY MONDAY AFTERNOON IN MARCH, while other doctors lunch cozily in the hospital cafeteria, Eric Savitsky, M.D., heads to a remote stretch of windy beach near Ventura County to satisfy a different hunger. “I’ve been surf-starved,” says the UCLA emergency physician. “I haven’t been in the water in four days!” Despite winter-like conditions that make the erratic waves collide crazily onto themselves, Dr. Savitsky stays in the chill water for nearly two hours, finally emerging after everyone else has left.

It isn’t likely that surfing will replace golf or tennis as the physicians recreation of choice, but Dr. Savitsky is one among a small yet passionate group of UCLA doctors who head to the breakers to get a break. “People surf for different reasons — some to relax, some for the adrenalin rush,” he says. “For me, surfing is the ultimate relaxation. It keeps me in the moment.”

James N. Weiss, M.D., chief of cardiology, is another avid wave rider. He’s been surfing since 1978 and tries to get in the water three times a week. “Surfing clears the mind, restores the ability to think. When I haven’t been surfing for a week, my wife says ‘Go surfing — you’re cranky!’”

For some of UCLA’s surf-loving physicians, the beach has become an informal clubhouse away from work. Head-and-neck surgeon Keith E. Blackwell, M.D., learned to surf 10

“Awards/Honors

Dr. Leonard Apt, professor emeritus of ophthalmology and founder of the Division of Pediatric Ophthalmology and Strabismus, received the Castle Connolly Medical Ltd. Fifth Annual National Physician of the Year Award.

Dr. Jesus Araujo, director of environmental cardiology, received an Outstanding New Environmental Scientist grant award from the National Institute of Environmental Health Sciences to establish a UCLA program to study the effect of air pollution on the heart.

Dr. Heather Christofk, assistant professor in the Institute for Molecular Medicine, has received a 2010 Damon Runyon-Rachleff Innovation Award from the Damon Runyon Cancer Research Foundation to study how glucose metabolism is altered in cancer.

Dr. Daniel Cruz, clinical instructor of medicine, has been selected as a 2010-2014 Harold Amos Medical Faculty Development Scholar.

Dr. Jack Feldman, professor of neurobiology, was named a fellow by the American Association for the Advancement of Science for his research on the neural control of breathing.

Dr. Jorge Lazareff, professor and director of pediatric neurosurgery, was honored by Mending Kids International for his work to separate Guatemalan conjoined twins Maria Teresa and Maria de Jesus Quiej Alvarez in 2001 and for his continued partnership with the organization.

Dr. Mark S. Litwin, professor of urology, has been selected to receive the Distinguished Mentor Award by the American Urological Association for his contributions to mentoring research scholars and fellows.

Dr. Shlomo Raz, professor of urology, has received the Rodney Appell Continence Care Champion Award from the Society for Urodynamics & Female Urology.

Dr. Richard J. Shemin, the Robert and Kelly Day Professor, chief of cardiothoracic surgery, and executive vice-chairman of surgery and co-director of the Cardiovascular Center at Ronald Reagan UCLA Medical Center, was elected director-at-large of the Society of Thoracic Surgeons Board of Directors.

Dr. Stephen G. Young, professor of medicine in the Division of Cardiology, was selected to receive the 2010 Ernst Jung Medical Award from the Jung Foundation for Science and Research for his advances into lipid metabolism.
years ago with fellow head-and-neck surgeon Joel Sercarz, M.D. Four years later, colleague Vishad Nabilii, M.D., picked up a board. They are now sufficiently confident in their abilities to take an annual surf trip together to Fiji.

On a Saturday morning in March, the three surgeons gather on the sand at Manhattan Beach with their office assistants — novice surfers Hope Lattin and Anna Prus — Lattin’s husband, Daniel, and a sales rep, Don Kawachi. Surrounded by sea spray and seagulls, informality is the order of the day, and Dr. Blackwell doesn’t object when assistant Hope Lattin refers to him as “Blackie.” Still, he can’t completely escape the pull of the hospital, and, while floating in the lineup between waves, asks Dr. Sercarz his opinion on a thyroid case with a controversial pathology report.

“Surfing with each other is great,” Dr. Nabilii says, back on the sand. “We’re not the best surfers. We don’t catch the most waves. But we like the camaraderie — even when we’re talking about work!” — Kim Kowsky

OPPOSITE PAGE (from left): Drs. Vishad Nabilii, Keith E. Blackwell and Joel Sercarz regularly hit the waves to relax from the stresses of their practice in head-and-neck surgery.

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Grants

**Funding agency: American Association for Cancer Research**
Grant amount: $16.5 million
Grant duration: 3 years
Principal investigator: Dr. Dennis Slamon, professor of hematology/oncology
Summary: To develop a fully integrated translational research approach to developing more effective, less toxic therapies for the three major breast cancer subtypes.

**Funding agency: National Multiple Sclerosis Society**
Grant amount: $2.9 million
Grant duration: 5 years
Principal investigator: Dr. Barbara Giesser, professor of neurology
Summary: To provide comprehensive, integrated health and wellness interventions for people with multiple sclerosis so that they can maximize independence and quality of life.

**Funding agency: National Institute of Diabetes, Digestive and Kidney Disease**
Grant amount: $9.25 million
Grant duration: 5 years
Principal investigator: Dr. Mark S. Litwin, professor of urology
Summary: To better understand the burden of urologic disease on the American public in both human and financial terms.

**In Memoriam**

**Dr. Charles Lewis**, professor emeritus of health sciences, nursing and family medicine, died on January 7, 2010, in Los Angeles. He was 81 years old. Dr. Lewis’s chief area of interest was in physicians’ continuing education, particularly in the fields of AIDS, health education and health-services research.

**Dr. Amos Norman**, professor emeritus in the Departments of Radiation Oncology and Radiological Sciences, died August 8, 2009, in Woodland Hills, Calif. He was 87 years old. Dr. Norman was co-founder of the Medical Physics (now Biomedical Physics) Graduate Program in 1960.

**Dr. Leena Peltonen-Palotie**, founding chair of the Department of Human Genetics, died March 10, 2010. She was 57 years old. One of the world’s leading molecular geneticists, Dr. Peltonen-Palotie left her positions at the University of Helsinki and the Naitonal Public Health Institute to come to UCLA in 1998.

**Dr. Eli Sercarz**, professor emeritus of microbiology and molecular genetics, died November 3, 2009, in Topanga, Calif. He was 75 years old. Dr. Sercarz’s research helped reshape the field of immunology.

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Snapshot

Gerald A.M. Finerman, M.D.

Chair Emeritus and Professor, UCLA Department of Orthopaedic Surgery

**Education:**
The Johns Hopkins University School of Medicine, M.D., 1962
The Johns Hopkins Hospital, orthopaedic surgery, 1966-1969

DR. GERALD A.M. FINERMAN’S CAREER has spanned nearly 50 years. During his surgical training, he worked with injured players from the Baltimore Colts and was exposed to the new orthopaedic subspecialty of joint replacement. He went on to study in England with Sir John Charnley, a pioneer of modern total hip arthroplasty.

He came to UCLA as an assistant professor in 1971 after receiving his board certification in orthopaedic surgery, and he served from 1997-2009 as chair of the Department of Orthopaedic Surgery. In addition to his academic career, he has been the head team physician for the UCLA Department of Intercollegiate Athletics, and during the 1984 Olympic Games in Los Angeles, he was chief medical officer for the Olympic Village at UCLA.

— Ginny King Supple
As soon as the Haiti earthquake happened, I was compelled to go. A friend referred me to International Medical Corps (IMC). I submitted my application, and within a week I was working at various sites in Haiti, including the E.R. in Port-au-Prince and a mobile clinic in Carrefour.

The three weeks I spent in Haiti was the most intense and rewarding experience I have had as a physician and as a person. The situation embodied the original reason why I pursued a career in medicine. It was humbling to be among so many diversely talented and trained providers from all over the world who felt a similar calling to serve our global family and represent our peers who wanted to be there but were unable to for various reasons. The emotional, physical and technical challenges of practicing medicine in an unforgiving environment with sparse resources necessitated a reservoir of patience and practicality.

It was frustrating watching people suffer and die, knowing that under different circumstances, their outcomes would be more favorable. However, I have deep satisfaction in the connections I made with the Haitians, who were extremely appreciative and grateful for even the simplest of interventions. Their heartfelt smiles and the grace they displayed during unspeakable adversity are forever etched in my mind as a new standard of the strength of the human character.

In His Own Words: Keyvan Hariri, M.D.

CALL TO ACTION

International Medical Corps (IMC) was founded in 1984 by UCLA emergency physician Robert Simon, M.D., after he read about the plight of the Afghan people as a result of the 1979 Soviet invasion and occupation. It now provides volunteer medical services in more than 50 countries around the world.

For information about IMC and volunteer opportunities in Haiti and elsewhere, go to: www.imcworldwide.org.

MaA Reaches Out to Residents

The Medical Spouses and Partners Association (MSPA) will enable physician spouses and partners to receive the resources and support they need to help them through the stress of residency and post-training years. It will also provide medical families opportunities to participate in interest groups, social functions and philanthropy that relates to the UCLA medical community.

“UCLA trains the finest residents in the world of graduate medical education, and they bring with them spouses and families that deserve a way to quickly feel a part of the UCLA family. The MAA feels that this program has the potential to make that happen. Our residents can come to work knowing that their families will get extra care from all of us,” says Mark Morocco, M.D., UCLA Emergency Medicine Center Associate Residency Director.

For more information, contact Jemie Sae Koo, at jemie@jemiesaekoo.com, or call Valerie Walker, MAA director, at (310) 794-4025

Mobile Clinic Needs Volunteers

The UCLA Mobile Clinic Project (MCP) serves the homeless and transient communities of greater Los Angeles. Although MCP is student-run, attending physicians are needed to review client medical histories and help students with diagnosis and treatment; provide instruction about various diseases and disorders; and, at times, treat acute conditions. “The best part is watching students from multiple disciplines learn not only about the hardships of living on the streets and about serving medical needs, but also learning about the individual in front of them as a person,” says Walter G. Coppenrath III, M.D. ‘04.

For more information and to volunteer, visit: www.mcp.ucla.edu, or call (310) 825-4600
**Update: Books Without Borders**

The Winter 2007 issue of UCLA Medicine featured an article about Laura Pacha, M.D. ’98, and the Books Without Borders project, which was created after the Medical Alumni Association received an email from the U.S. Army major, who was deployed as a public-health officer with the 25th Infantry Division, asking for medical textbooks to distribute to schools and doctors in Iraq. Today, Dr. Pacha is a disease-surveillance specialist for the U.S. Army Public Health Command in Maryland, and Books Without Borders has become Operation Medical Libraries (OML). To date, OML has donated more than 30 tons of formal references and continuing-education materials for health-sciences students and professionals in developing countries. Most of these supplies have been medical textbooks sent to Afghanistan.

“I am extremely proud to be a graduate of the David Geffen School of Medicine at UCLA, where the MAA exemplifies the school’s commitment to compassion, education and addressing complex social issues,” Dr. Pacha says. “I am truly overwhelmed to find myself part of an organization that can harness such incredible support, not only from within its ranks, but also among other universities, hospitals and professionals to ensure the ongoing education of health-sciences students and providers in less-privileged and under-resourced countries.”

To learn more about Operation Medical Libraries, go to: http://opmedlibs.medalumni.ucla.edu

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**Patent Pending**

**Licensing Income** generated by the David Geffen School of Medicine at UCLA brings in millions of dollars each year. In the last fiscal year, for example, revenues from some 260 inventions exceeded $20 million, according to the UCLA Office of Intellectual Property & Industry Sponsored Research (OIP-ISR).

In March, the UCLA Medical Alumni Association (MAA) hosted “Driving Innovation to Market: How to Implement a Successful Patent” to offer health professionals within the UCLA community the opportunity to address the procedures and pitfalls involved in obtaining a patent. Speakers included Kathryn A. Atchison, vice provost for Intellectual Property and Industry Relations; patent attorney Jonathan Jaech; Neil A. Martin, M.D., chair of the UCLA Department of Neurosurgery; and Rajiv Yadav, senior intellectual property counsel for Edwards Lifesciences, LLC. Raphael Darvish, M.D. ’04, founder and medical director of Concierge Medicine/LA, and member of the UCLA MAA Board of Directors, was the facilitator.

The four presenters shared their perspectives on the issues surrounding the protection of a person’s innovations and also answered questions. There was a networking reception immediately following the symposium.

To learn more about the event, visit: [www.UCLAlumni.net/MAApats](http://www.UCLAlumni.net/MAApats)

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**What’s Your Story?**

The MAA is interested in hearing the stories of its alumni. To share yours, contact Valerie Walker at (310) 794-4025 or vwalker@support.ucla.edu.

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**Humanitarian Medicine 101**

July 29, 2003

Dear Mom,

I won’t be sending you this letter. Some things are too difficult to share.

I watch them die every day and feel helpless to stop it. I’m in over my head — it’s as simple as that. I thought I was prepared, but not for this. How could I have been?

What am I doing here? I can only ask myself. There is so much suffering, and I make so little difference. What should we do amidst so much pain? Give up? Give in? Go home?

This journal entry was written by Ross L. Donaldson, M.D. ’04, the summer before his fourth year of medical school at UCLA. He was in Sierra Leone, in West Africa, where he had gone to care for patients with hemorrhagic Lassa fever. “I knew my trip was risky, but the mix of danger and adventure surrounding the mysterious virus compelled me toward it,” Dr. Donaldson recounts.

“The Lassa ward had meager supplies and a never-ending onslaught of the sick inundating the hospital. I had studied in medical school to swear an oath to care for the sick. Ultimately, I found myself not only fighting for their lives, but also my own.”

When the young doctor-in-training returned to UCLA, he experienced a sudden change in health; he was diagnosed with myocarditis from some unknown infection. It took him about seven months to recuperate.

Dr. Donaldson’s experience in Sierra Leon, and his own close call with a life-threatening illness after he returned, did not dampen his passion for humanitarian medicine, and he now is an assistant clinical professor of medicine in the David Geffen School of Medicine at UCLA and director of the Global Health Program and Fellowship in the Department of Emergency Medicine at Harbor-UCLA Medical Center. He also is director of emergency medical care for International Medical Corps (IMC), and travels frequently to Iraq.

In 2009, he published The Lassa Ward: One Man’s Fight Against One of the World’s Deadliest Diseases (St. Martin’s Press).

Dr. Ross L. Donaldson (right center) recently traveled to Iraq, where he taught ultrasound techniques.

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To learn more about the event, visit: [www.UCLAlumni.net/MAApats](http://www.UCLAlumni.net/MAApats)
Boy Wonder

CAMERON COHEN NEEDED SOMETHING TO DO while he was stuck at home in a hip-to-toe leg brace for six months recovering from surgery. So he taught himself a new computer-programming language, developed an iPhone/iPod application he called iSketch and sold it to Apple Inc. This achievement wouldn’t be particularly noteworthy were it not for the fact that Cameron was just 11 years old at the time.

On top of his ingenuity, the sixth-grader went a step beyond to also become a philanthropist; his family is donating a portion of Cameron’s iSketch profits to Santa Monica-UCLA Medical Center and Orthopaedic Hospital, where he underwent surgery in March 2009 to remove what turned out to be a benign bone tumor, and to Mattel Children’s Hospital UCLA. Their contribution — $20,000 thus far — will go toward purchasing electronic and entertainment items for hospitalized teens.

“I had great care in the hospital,” says Cameron, who was able to enjoy his own iPod while there. “But other kids in the hospital need things to make them feel better, too, and I am really excited that I can make a difference by providing them with iPods, computers and other fun things to use during their stay.”

In Memoriam

Ted Chanock, Jr. died on February 13, 2010. His wife Beth Miriam Chanock passed away in 2003. He made a generous donation to name a main elevator lobby in Ronald Reagan UCLA Medical Center as the Ted Chanock and Family Lobby, in loving tribute to his wife. After graduating from Claremont McKenna College with a B.A. degree, Mr. Chanock initially worked at Hughes Aircraft Co. in the R&D Division, Aerospace Group. He helped found Thermalelectric Engineering, manufacturer of fire-detection and heat-sensing devices, and then acquired ownership and was operator of Clear View Cable TV Systems and Sausalito Cable TV, later sold to CBS/Viacom. He became western regional manager for Teletypewriter Corp. and a vice president of Century Cable TV. In the late 1970s, he was a partner and co-owner-operator of automobile dealerships in Valencia and Santa Monica.

Edward Dominik died on his 100th birthday, on February 15, 2010. Born in Lemberg, Austria, he became a pharmacologist developing drugs for a major company when World War II erupted. Losing nearly all of his family and friends, he moved to the United States, where he began selling household items and jewelry. Settling in California, Mr. Dominik started a wholesale jewelry business and played jazz piano to support his education at UCLA and the Gemological Institute. His creative collection of “portable sculptures” — 1,000-year-old carved jade accessories — led to the opening of the Edward Dominik Gallery in Beverly Hills and to exhibitions at the Los Angeles Natural History Museum. He loved gardening, playing chess and practicing at his Steinway piano every day. Sharing his interests and passion for adventure for 35 years before her death was his wife Amelia. Mr. Dominik also had a 35-year relationship with the Aspen Institute. At 99 years of age and a long-time donor to the Jules Stein Eye Institute, he did not need glasses to drive.

Kenneth A. Jonsson, who, along with his late wife Diana, helped to found UCLA’s Jonsson Comprehensive Cancer Center, died March 15, 2010, at his home in Pacific Palisades. He was 79. He made his first donation to support cancer research more than four decades ago, and the cancer center was named for him and his family after a substantial cornerstone gift was made in 1975. The Jonssons contributed millions more over the years. Mr. Jonsson served on the Jonsson Cancer Center Foundation’s board of directors for 43 years, was president in the early 1970s, and was a long-time member of the board’s executive committee. He also served on the David Geffen School of Medicine at UCLA’s Board of Visitors for many years. He studied mechanical engineering at the Massachusetts Institute of Technology and, after graduation, worked for Texas Instruments, Inc., a company founded by his father. He spent 11 years at the company before moving to a small electronics firm. He later founded his own company. Mr. Jonsson is survived by four children, Mark, Mike, Erik and Anne, and eight grandchildren.
Events

On December 4, 2009, the Brain Research Institute hosted a luncheon, in celebration of its 50th Anniversary, at the Gonda (Gold-schmied) Neuroscience and Genetics Research Center. Dr. Chris Evans, director, thanked donors and friends for their support and highlighted BRI’s history and accomplishments. Dr. Michael Phelps, co-inventor of positron emission tomography (PET), gave a presentation entitled “Molecular Imaging Diagnostics with PET: From Research to the Care of Patients.”

The UCLA/Orthopaedic Hospital Center for Cerebral Palsy (CCP) hosted a reception for friends and supporters on March 16, 2010, at the Renee and Meyer Luskin Children’s Clinic of Los Angeles Orthopaedic Hospital in Santa Monica. The CCP is the only cerebral palsy clinic in the U.S. that treats both pediatric and adult patients, providing an extraordinarily high quality of interdisciplinary care regardless of ability to pay. Guests were welcomed by Drs. William Oppenheim, Anthony Scaduto, Robert Pedowitz and James V. Luck, Jr. Dr. Eileen Fowler presented details of the CCP’s research and educational endeavors, while staff demonstrated some of the latest equipment and modalities benefiting patients.

For more information about the CCP or to make a gift, visit: www.uclaccp.org, or call Adrienne Walt at (310) 267-1835

On Saturday, April 3, 2010, Mattel Children’s Hospital UCLA Board Members J.R. DeLang and Mark Sear hosted the Fifth Annual No Limit Texas Hold ’em Poker Tournament at Niente Winery, Jay Sures, partner and board member of United Talent Agency; and Dana Walden, co-chairman of 20th Century Fox Television. Ryan Seacrest, television/radio host and producer, served as honorary co-chair.

The 17th Annual Entertainment Industry Foundation Revlon Run/Walk for Women Los Angeles took place on May 8, 2010. The Revlon/UCLA Women’s Cancer Research Program is the leading beneficiary of this annual 5K event, which is the city’s largest fundraiser for women’s cancers. The UCLA Fights Women’s Cancer team (#105) was open to all supporters. Participants received a UCLA Fights Women’s Cancer team T-shirt and tote bag.

The 11th Annual Mattel Party on the Pier is scheduled for October 17, 2010, from 11 a.m. to 3 p.m. at Pacific Park on the Santa Monica Pier. The signature event underwrites the vital work of Mattel Children’s Hospital UCLA, supporting physicians, programs and research within the UCLA Department of Pediatrics.

For more information, visit: www.partyonthepier.ucla.edu

Supporting Scholarships

THE ANTHONY AND JEANNE PRITZKER FOUNDATION made a contribution establishing the Anthony and Jeanne Pritzker Family Scholarship to support medical students at the David Geffen School of Medicine at UCLA. By strengthening access to excellence for these aspiring physicians and scientists, the Pritzkers’ gift moves the medical school closer to its goal of ensuring that every student can attend, regardless of financial need. Mrs. Pritzker, a member of the school of medicine’s Board of Visitors, and Mr. Pritzker, a 2009 honoree at the Department of Neurosurgery’s Visionary Ball, are generous donors to several major areas on the UCLA campus, as well.
Gifts

An anonymous donor made a $250,000 gift to support the research of new treatments for progressive supranuclear palsy (PSP) syndrome and related tauopathies, using PET scanning technology. Tauopathies are a class of neurodegenerative diseases resulting from the pathological aggregation of tau protein in neurofibrillary tangles in the human brain. This project is under the direction of Dr. Gary Small in the Jane and Terry Semel Institute for Neuroscience and Human Behavior at UCLA. The donor also pledged $808,643 to the Department of Neurology to underwrite Dr. Daniel Geschwind’s collaborative efforts into the causes, treatment and prevention of tauopathies. His laboratory focuses on autism and neurodegenerative diseases and their relationship to the range of normal human higher-cognitive function. These two investments are vital to the Tau Consortium, whose participants from UCLA and other high-profile institutions investigate tau dysfunction that causes neurons to lose their connections to other neurons, thus resulting in profound effects on cognition – the ability to think and reason.

The Jonsson Cancer Center Foundation has received a gift of $850,000 from the Avon Foundation to support the UCLA-Avon Cares for Life program at Olive View-UCLA Medical Center, under the direction of Dr. Judith Gasson and breast-imaging fellowships under the direction of Dr. Lawrence Bassett. To date, the Avon Foundation has contributed more than $4 million to support breast cancer screening and research at UCLA.

Earl E. Gales, M.A. ’74, has contributed $50,000 to date to support the Earl Gales Family Fellowship in Endocrine Surgery, funding the work of Dr. Michael Yeh in the Division of General Surgery. Dr. Yeh is working to educate future surgeons on the intricacies of the endocrine system and to develop specialized techniques to address disorders of the endocrine glands. The Earl Gales Family Fellowship, established in 2009, was the first such program in the history of endocrine surgery at UCLA. It was named to honor the Gales family, including Earl’s wife Starla Gales, B.A. ’73, and their children Starla Cherie Gales, Earl E. Gales III and Ryan E. Gales.

Thanks to a three-year, $300,000 grant from the OneWest Foundation — matched by funds from UCLA Health System – Venice Family Clinic patients who need hospitalization or specialized medical care but do not have private insurance or qualify for Medi-Cal or Medicare coverage may be helped by a pilot project. “Currently, there is a fragmented system in place to ensure access to specialty and inpatient care for low-income patients seen at the Venice Family Clinic,” says Dr. David T. Feinberg, CEO of UCLA Hospital System and associate vice chancellor. Now such patients will be seen at Venice Family Clinic’s new Colen Family Health Center in Mar Vista. “It gives me great satisfaction to know that OneWest is playing a vital role in advancing UCLA’s mission of research, education, patient care and public service, as well as the Venice Family Clinic’s commitment to patient care ... We are proud to help make a difference in the lives of those in our community.”

- Steven T. Mnuchin

Denise and Peter Wittich made a gift of $400,000 to the Jonsson Cancer Center Foundation to support the Wittich Family Project for Emerging Therapies in Breast Cancer under the direction of Dr. Dennis Slamon. Through their consistent philanthropy, Mr. and Mrs. Wittich are committed to advancing the efforts of Dr. Slamon and his team as they strive to develop more effective, less toxic treatments for breast cancer.

Update

The Maggie G. Gilbert Endowed Chair in Bipolar Disorders, established by Mrs. Rose Gilbert to honor her daughter’s memory, was highlighted in the Fall 2009 issue of UCLA Medicine. As a result, Stephen White, M.D. ’71, who was a high school student in Mrs. Gilbert’s advanced-placement English class in the ’60s, was inspired to make a contribution to the endowment. In his letter, he stated, “…she managed to transfer to us some of her ferocious, unstoppable love of learning. That has stayed with me throughout my life, and I hope I passed some of it on to my children, as well.”

Doug’s Daily Dollar

Started by the principal of Lemoore High School, in the San Joaquin Valley, Doug’s Daily Dollar is a fundraising program to support student Douglas “DJ” Lucken, who has Lafora disease. It is a rare form of inherited epilepsy, with the patients’ life expectancy not exceeding 25. At UCLA, Dr. Antonio V. Delgado-Escueta and his colleagues are studying gene therapy as treatment, and the gifts, ranging from $1 to $100, are being used to underwrite this work on behalf of Doug. After just five days, the school and community had brought in $2,000.
AS A CHILD, I NEVER DREAMED of the possibility of growing up to become a doctor. But here I am. In June, I will graduate from the David Geffen School of Medicine at UCLA with the title M.D. after my name. Soon after, I will begin my residency in emergency medicine at the University of Virginia. I will be 33 years old.

How did I arrive here?

Though I have known the value and satisfaction of hard work and dedication to community since an early age, my path to a career in medicine has not been traditionally straightforward. My family has a long-standing history of military service. After graduation from high school in Rialto, California, I enlisted in the U.S. Air Force, where I trained as a firefighter and graduated from the National Fire Academy. I was assigned as an airport/structure firefighter, and was awarded the National Defense Service Medal for serving during a time of war. After completing my military service, I continued to serve as a firefighter and EMT in Clearwater County, Idaho, and also volunteered with AmeriCorps to teach adult basic education to incarcerated individuals at a maximum-security prison, assisting more than 100 of those prisoners to earn their high school diplomas.

There were many lives that I was able to touch as an EMT and volunteer, and it was tremendously rewarding, but the phrase I kept repeating to myself was, “I can do more.” With the encouragement of my mentor, Dr. Curtis L.V. Adams, a local physician whom I came to know during an EMT certification course, my experiences as a firefighter and EMT and my commitment to public service and bettering society in whatever way I can were coalescing into a new career direction.

I was no longer content to be the emergency medical provider who transported and delivered the patient to the emergency staff at the hospital; I wanted to be that doctor to whom the patient was being delivered.

So after two years, I made the difficult decision to return to school to pursue a degree in medicine. I enrolled at San Bernardino Valley College and then UC Riverside to complete my bachelor’s degree in biochemistry. At first, the long process of going back to school was an arduous task, and my goal of a degree in medicine seemed almost unattainable. However, when moments of doubt arose, the values I learned from my previous life experiences strengthened my resolve to accomplish my dream. Much like being in a structure fire, giving up was not an option. I put my head down and diligently completed my premed requirements at UCR.

While there, I continued my volunteer activities, facilitating organic chemistry workshops for the MESA program at San Bernardino Valley College. During my four years of medical school, I have volunteered with the UCR/UCLA Student Run Homeless Clinic to help homeless and indigent patients on the streets in the Inland Empire and with the Flying Samaritans at a small clinic in the Baja California community of El Hongo. And I work hard to balance these activities with recreation outside of the hospital such as martial arts and Scuba diving.

I did not start out with the goal of one day practicing medicine. It was instilled in me slowly over the years, the sum of my many varied experiences and with the strong support of my family and role models. The journey to arrive here has not been easy, but the life experiences I have collected along the way are precious, and they will be invaluable to me as I embark on this new journey as a physician. So when I opened my envelope on Match Day in March to learn where I would be going for my residency, the flood of excitement and satisfaction that I felt reaffirmed my choice to take the chance and pursue a dream that I didn’t even know I had until I was already well along the path of my life.

Thomas S. Laughrey, M.D. ’10, is the first member of his family to earn a professional degree, but the others are following close behind. Both his parents are pursuing graduate education—his mother toward a Ph.D. in psychology and his father toward a master’s in education—and one of his sisters is a senior completing a premed program, and another sister is a college freshman.
Mattel Party on the Pier

Mattel Children’s Hospital UCLA will celebrate 11 years of its signature fundraiser Mattel Party on the Pier on October 17, 2010, with fun for all ages, from unlimited rides to face-painting and the chance to meet therapy dogs from UCLA’s People-Animal Connection. The event helps the hospital raise funds to launch innovative projects and meet its most urgent needs.

For more information, go to: www.partyontheplier.ucla.edu