When words fail, a unique and highly specialized center at UCLA is there to help patients find their voice.
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There’s something special about the beginning of a new academic year, a reminder of how critical education is to our ongoing success. The arrival of new house staff, medical students and graduate students inspires great confidence in our future. Today we have cause for supreme confidence. We continue to recruit stellar students, residents and fellows. Interest among medical-school applicants continues to grow, with a 20-percent increase in applications. The David Geffen Medical Scholarships and Leaders-of-Tomorrow Scholarship have ushered in a new era that enables many of our students to pursue their passions unencumbered by medical-school debt. Our Graduate Programs in Bioscience (GPB) consortium recruited 65 outstanding students to make up the first GPB class. Additionally, GPB piloted a summer program for undergraduate research to promote the transition of underrepresented students into UCLA bioscience graduate programs.

In the area of graduate medical and continuing medical education, UCLA Health launched this year the Healthcare Improvement Institute, a program to engage our house staff and faculty in the cultural transformation of healthcare delivery through quality-improvement education and project improvement. And our trainees continued to distinguish themselves as emerging leaders in health and science. MD and MD/PhD students mentored by our faculty received a number of prestigious awards, including predoctoral fellowships from the National Science Foundation, National Institutes of Health and Howard Hughes Medical Institute, and several medical students have been nationally recognized for their leadership and service.

Recent leadership of our educational enterprise catalyzed broad, campus-wide discussions of the future of medical and graduate education. New leadership recruitments, including Clarence Braddock, MD, as vice dean for education, reflect renewed energy and a spirit of new ideas as we steer into the future.

This new era is embodied in the Teaching and Learning Center for the Health Sciences, a 110,000-square-foot state-of-the-art education building for which we broke ground in September 2013. As the construction takes recognizable shape, exciting conversations have begun about the new programs and teaching methods that this building will foster. Even as we await the opening of this new facility, in Fall 2016, we continue to advance the infrastructure for medical education, including the opening of our new Simulation Center and the migration to a leading-edge residency-management IT system.

Finally, in June 2014, we received our eight-year re-accreditation by the Liaison Committee for Medical Education. This critical certification validates the strength of our medical-education programs and the dedicated work of our faculty, staff and education-leadership team.

As I reflect on the path forward for our academic enterprise, even as we acknowledge the many challenges ahead, I am confident and reassured by our fantastic students and dynamic programs that our future indeed is quite bright.

A. Eugene Washington, MD, MSc
Vice Chancellor, UCLA Health Sciences
Dean, David Geffen School of Medicine at UCLA
Gerald S. Levey, MD, Endowed Chair
As a practitioner and an educator, I was delighted to read about innovative patient-education mechanisms designed to prepare patients for informed decision making regarding their healthcare, as presented in Shari Roan’s article “Partners in Care” (Summer 2014, page 18). The programs described in the article offer accessible, interactive and personalized education aimed at yielding better patient comprehension, compared to traditional handouts or time-consuming face-to-face conversations. Follow-up by trained professionals such as health coaches provides patients with an opportunity to assess their learning and understanding and devise the best plan of action for their healthcare. I look forward to integrating some of these concepts into my practice. Nonetheless, it is important to point out that simply educating people does not ensure that they become equal partners in decision making. Partnership and shared decision making must be valued and desired by both sides of the partnership. As patients benefit from learning more about their options and clarifying their values and choices, physicians, too, must become proficient in facilitating partnerships that promote shared decision making. Learning how to collaborate with diverse patient populations requires commitment and specialized training for all healthcare professionals.

Liat Gafni
Assistant Professor of Occupational Therapy
Saginaw (Michigan) Valley State University

Dr. Robert Vinetz hit it on the head (“In Box,” Summer 2014) when he pointed out that a big reason why U.S. healthcare is so costly, compared to other countries, was the comparative overhead costs. He cites the example of Medicare’s overhead cost of less than 3 percent versus insurance-companies’ costs of 15 percent to 25 percent. That extra cost will never be overcome as long as the insurance companies can influence the legislators and in so doing preclude them from fixing the system. The Accountable Care Act is a small step forward, but there’s still a long way to go.

Dan Olincy
Los Angeles, California

In response to Dr. Robert Vinetz (“In Box,” Summer 2014), who favors a single-payer system for healthcare, I’m unconvinced. Granted, a “Medicare-for-all” system would eliminate the costly middleman — the private-insurance company, with its inherent conflict of interest (profit vs. claims payment) — but I doubt that it would lead in the long run to high-quality care with efficient utilization of resources. Remember, in a national system of single-payer health insurance, the payer will be the government. This is the same government whose ever-compounding missteps have gotten us doctors to where we are today; the same government that fostered health insurance in the first place, irrationally linking it to employment, and then monopolized elder care; foisted HMOs, PPOs and managed care on doctors and the public; fixed physicians’ fees; instituted an extravagant, unfunded prescription-drug scheme; and topped it all off with the non-affordable Affordable Care Act.

I’d sooner believe that pigs can fly. It’s more likely that regulations will proliferate, bureaucratic inefficiency will thrive, claims will increasingly be denied and therapeutic innovation will be stifled. Toward the end of his letter, Dr. Vinetz cites the need to “engage the patient from the get-go” in order to develop his/her understanding. The goal is laudable, but universal Medicare won’t achieve it for the reason that the patient will remain (as now) the only passive member on the healthcare team, disconnected from the costs of care, uninformed of alternatives in care and, at best, only dimly aware of how things work or why they are done. Instead of universal Medicare, I propose two complementary innovations: medical scrip and personalized medicine. Medical scrip (or vouchers for healthcare) would put the power of the purse into patients’ hands, creating a free market in care and maximizing choices. Scrip could be spent at a medical-doctor’s office, local hospital, HMO or with an insurer. It would be dispensed by the government on the basis of demographics, medical needs or both. Unused scrip could be saved for future health needs, in the manner of a health-savings account. By way of comparison, vouchers for food (food stamps) keep indigent families well-nourished, if used wisely. Vouchers for education promote educational quality by offering more choices to consumers and thereby fostering competition. Medical scrip should enjoy success similar to that of vouchers for other basic human needs. The other innovation, personalized medicine, has been gaining traction for several years. A quick Google search reveals a dozen prestigious institutions with established or nascent programs in genetically based, individualized medicine. Clinical application is sparse at present, but when widely available, personalized medicine will stand in stark contrast to our statistically based, one-size-fits-all medical model predicated on the fallacy of the “average human.” Human beings are, because of Mendelian genetics, by nature diverse and individual, not interchangeable. A system that recognizes that will maximize patients’ choices, lower costs and achieve the best outcomes.

Richard P. Huemer, MD ’58
Palmdale, California
Thank you for your article “Body Language” (Summer 2014, page 24) that details UCLA’s Surgical Science Laboratory and the work of Dr. Warwick J. Peacock. As a layperson, I found it fascinating to know that the David Geffen School of Medicine at UCLA is using innovative techniques to train surgical residents. It is clear Dr. Peacock has a mission and teaches anatomy from an enthusiastic, joyful mindset. The writer describes the “bubble of excitement” experienced by these residents, and as a reader, I could feel it. I also loved reading about Dr. Peacock’s personal journey as a physician, first as a pediatric neurosurgeon who developed new techniques for treating children with cerebral palsy and then his battles with authority to improve patient care along the way. What a force he was to stand up to apartheid policies embedded in hospital care in his native South Africa at the time and move black children from their overflowing ward to the nearly empty white-children’s ward. That same forceful personality is why UCLA has its Surgical Science Laboratory. Kudos to the writer, Lyndon Stambler, for providing so much rich detail about Dr. Peacock’s life and giving us a strong sense of his empathic character and his enthusiastic and humorous personality. His saying to residents, “Make sure you’re not cutting into the bowel. It spoils the day,” made me laugh out loud. As a teacher, I want to share this article with other teachers; Dr. Peacock models how important it is to transfer enthusiasm to students. That is what teaching needs to be about everywhere. Finally, I was impressed that UCLA treats the donated bodies with such dignity, even building rituals of respect and gratitude toward the deceased into the training for these residents.

Cheryl Miller
Los Angeles, California

“Picturing Pain” (Summer 2014, page 4) was a great article, one of the many I enjoyed in U Magazine. Artwork is a great way to connect with the suffering of patients. Compassionate care resulting from understanding the nonverbal world of our patients is something I have worked with for many years as a gastroenterologist caring for patients who have chronic disorders or cancers. I found the article validating and inspiring to continue the journey toward healing the body and spirits of people in need. And many of the artworks were deeply moving in ways beyond words.

Jesse Lachter, MD
Rambam Healthcare Campus
Technion-Israel Institute of Technology
Haifa, Israel
Imagine watching a procedure through the eyes of the surgeon. That’s exactly what surgical leaders in the United States were able to do while overseeing surgeons training in Paraguay and Brazil with the help of UCLA doctors and Google Glass. David Chen, MD (RES ’09), clinical director of UCLA’s Lichtenstein Amid Hernia Clinic, and Justin Wagner, MD, a surgical resident, have made it their mission to teach hernia surgery around the world, and they are harnessing the latest technologies to help.

Hernia repair is among the most-common surgical procedures performed worldwide, as well as one of the most teachable, lending itself to the advent of today’s technology, Dr. Chen says. The team used Google Glass, which, while worn like conventional glasses, houses a computer the size of a Scrabble tile and is outfitted with a touch-pad display and high-definition camera that can wirelessly stream live images.

With Drs. Chen and Wagner’s help, surgeons at a hospital in Paraguay wore Google Glass while performing a common type of hernia repair, transmitting the operations live to a select group of leading surgeons in the United States who could watch and oversee the procedures. The experts could also transmit their comments to the Paraguayan surgeons, who could read them on the Google Glass monitor.

“We are one of the first to use Google Glass in teaching and training surgeons from outside a country,” Dr. Chen says, adding that hernia surgery is just the beginning. “Our goal is to utilize the latest technologies like Google Glass, Facebook and Twitter in connecting everyone in medicine worldwide for educational purposes that can help improve medical care in resource-poor countries,” Dr. Chen says.

The UCLA team also visited Brazil, where they used Google Glass during three hernia surgeries and also streamed a live post-surgery debriefing session. The team also plans to train 15 surgeons from around Brazil who will then become trainers to teach other surgeons at several regional hospitals for underserved patients.

Similar programs are being implemented in Haiti, the Dominican Republic, Guatemala and Ecuador as part of an educational arm of Hernia Repair for the Underserved, a nonprofit organization that provides free hernia surgery to children and adults in the Western Hemisphere. Dr. Chen is spearheading these educational projects with the UCLA team to help “train the trainers” and increase the number of surgeons performing this procedure in underprivileged countries. “We are developing practical applications for these technologies, so that surgeons in any setting can have access to the global surgical community from within their own operating rooms,” says Dr. Wagner. “Even after the training is over, local surgeons can be teleproctored remotely, so they will remain connected to experts worldwide.”
Dr. Martin Chenu, a surgeon from Luque, Paraguay, wears Google Glass during surgery. 

Opposite Page, Top: The view was seen in the United States by a group of leading surgeons.

Photo Composition: Courtesy of Dr. David Chen
The U.S. Food and Drug Administration (FDA) approved a new immunotherapy drug to treat advanced melanoma, signaling a paradigm shift in the way the deadly skin cancer is treated. UCLA led the international team of researchers testing the drug, pembrolizumab, in the largest Phase 1 study ever conducted in the history of oncology. Pembrolizumab (Keytruda) was tested on more than 600 patients who had melanoma that had spread throughout their bodies. Because so many of the patients in the early testing showed significant long-lasting responses, the study was continued, and the FDA granted the drug “breakthrough therapy” status, allowing it to be fast-tracked for approval.

“This drug is a game-changer, a very-significant advance in the treatment of melanoma,” says principal investigator Antoni Ribas, MD (FEL ’98, ’01), PhD, assistant director for clinical programs in the UCLA Human Gene Medicine Program. “For patients who have not responded to prior therapies, this drug now provides a very real chance to shrink their tumors and the hope of a lasting response to treatment.”

Pembrolizumab, formerly known as MK-3475, is an antibody that targets a protein called PD-1 that is expressed by immune cells. The protein applies the brakes to the immune system, keeping its T cells from recognizing and attacking cancer cells and hindering therapeutic attempts to fight the disease. Pembrolizumab, in effect, cuts the brake lines, freeing up the immune system to attack the cancer.

“We have long believed that harnessing the power of our own immune systems would dramatically alter cancer treatment,” says Judith Gasson, PhD, senior associate dean for research at the David Geffen School of Medicine at UCLA and director of UCLA’s Jonsson Comprehensive Cancer Center. “Based upon work conducted over the past two decades, we are beginning to see the clinical benefits of this research in some of the most-challenging cancers.”

Generally, about one-in-10 patients responded to previous immunotherapy drugs. Some of those who responded, however, exhibited long-lived benefits, which sustained scientists’ interest in the method as an effective mechanism to fight cancer. The response and duration rates for pembrolizumab were much greater than for previous drugs, Dr. Ribas says. In the new study, 72 percent of patients responded to the drug — their tumors shrank to some degree. Overall, 34 percent of patients showed an objective response, meaning that their tumors shrank by more than 30 percent and did not re-grow.

Dr. Ribas said pembrolizumab has the potential to be used to treat other cancers that the immune system can recognize, including cancers of the lung, bladder, head and neck.

To hear melanoma survivors speak about their experiences with pembrolizumab, go to: uclahealth.org/tomstutz and uclahealth.org/kathythomas
Scientists at UCLA have discovered a new hormone, erythroferrone, which regulates the supply of iron needed for the production of red blood cells. Using a mouse model, researchers found that erythroferrone is made by red-blood-cell progenitors in the bone marrow in order to match iron supply with the demands of red-blood-cell production. Erythroferrone is greatly increased when red-blood-cell production is stimulated, such as after bleeding or in response to anemia. The erythroferrone hormone acts by regulating the main iron hormone, hepcidin, which controls the absorption of iron from food and the distribution of iron in the body. Increased erythroferrone suppresses hepcidin and allows more iron to be made available for red-blood-cell production.

“If there is too-little iron, it causes anemia. If there is too-much iron, the iron overload accumulates in the liver and organs, where it is toxic and causes damage,” says Tomas Ganz, MD ’78 (RES ’81, FEL ’83), PhD, professor of medicine and pathology. “Modulating the activity of erythroferrone could be a viable strategy for the treatment of iron disorders of both overabundance and scarcity.”

Researchers first focused on what happens in the bone marrow after hemorrhage. From there, they focused on a specific protein that was secreted into the blood. This protein attracted their attention because it belonged to a family of proteins involved in cell-to-cell communication. Using recombinant-DNA technology, they showed that the hormone suppressed the production of hepcidin and demonstrated the effect it had on iron metabolism.

The team foresees that the discovery could help people with a common congenital blood disorder called Cooley’s anemia, also known as thalassemia, which causes excessive destruction of red blood cells and of their progenitors in the bone marrow. Many of these patients require regular blood transfusions throughout their lives. Most iron overload is attributed to the iron content of transfused blood; however, even patients who are rarely, or never, transfused can also develop iron overload.

“Overproduction of erythroferrone may be a major cause of iron overload in untransfused patients and may contribute to iron overload in transfused patients,” says Elizabeta Nemeth, PhD, co-director of the UCLA Center for Iron Disorders. “The identification of erythroferrone can potentially allow researchers and drug developers to target the hormone for a specific treatment to prevent iron overload in Cooley’s anemia.”

The discovery could also lead to treatments for other common anemia-related conditions associated with chronic kidney disease, rheumatologic disorders and other inflammatory diseases. In these conditions, iron is “locked up” by the effect of the hormone hepcidin, whose levels are increased by inflammation. Erythroferrone, or drugs acting like it, could suppress hepcidin and make more iron available for red-blood-cell production. The next stage of research is to understand the role of the new hormone in various blood diseases and study the molecular mechanisms through which erythroferrone regulates hepcidin.

“Identification of erythroferrone as an erythroid regulator of iron metabolism,” Nature Genetics, July 2014
A Double Dose of Promising Lung-cancer Findings

UCLA scientists report that two new experimental drugs have shown great promise in the treatment of patients with non-small-cell lung cancer, which accounts for about 85 percent of all lung cancers. The drugs — ramucirumab and CO-1686 — were shown in separate clinical trials to increase survival times with fewer toxic side effects than standard treatments. The findings of both trials were presented at the annual meeting of the American Society of Clinical Oncology.

Edward Garon, MD (FEL ’06), assistant professor of hematology-oncology, conducted an extensive multi-year Phase 3 clinical trial testing ramucirumab in a population of 1,253 patients whose cancers had progressed during or after first-line chemotherapy treatment. Ramucirumab is an antibody that targets VEGFR-2, an extracellular protein that is important in the formation of the blood vessels that support cancer cells. Patients were given ramucirumab in combination with docetaxel, a clinically approved chemotherapy drug considered the cornerstone of second-line treatment in advanced non-small-cell lung cancer.

Tumors shrank significantly in 23 percent of patients receiving ramucirumab. The drug is the first new therapy for previously treated non-small-cell lung cancer patients to improve overall survival, when added to standard therapy with findings showing a disease-progression-free survival rate of 4.5 months and median overall survival of 10.5 months.

Another class of targeted drugs being investigated is EGFR (epidermal growth factor receptor) tyrosine kinase inhibitors. Recent studies, however, have shown that when a patient develops resistance to EGFR inhibitors, more than half the time it is due to the emergence of a new “gatekeeper” mutation, called T790M. CO-1686 is an investigational drug that has been discovered to selectively target both the initial EGFR mutations and the T790M-resistance mutation.

Jonathan Goldman, MD (FEL ’08), assistant professor of hematology-oncology, was among the leaders of a study of 88 patients with advanced non-small-cell lung cancer who had previously been treated with an EGFR inhibitor and had developed resistance. In a Phase 1 trial, CO-1686 was administered continuously to the patients in 21-day cycles. Response to the drug was seen in 58 percent of the patients. Treatment-related side effects were for the most part mild and manageable.

Scans show how therapy with CO-1686 has diminished tumors in lungs of patient with T790M mutation, as well as reduced tumors in metastases that have spread to the brain.

The Healing Heart

There has been debate over the question of whether or not heart muscle can regenerate itself. Now, UCLA scientists have provided an answer: yes. A study by Reza Ardehali, MD, PhD, assistant professor of cardiology, and colleagues has demonstrated the first direct measure of heart-muscle cells renewing themselves. The findings have important implications for future research that could lead to the regeneration of heart tissue to repair damage caused by disease or heart attack.

It was initially believed that heart-muscle cells, or cardiomyocytes, were unable to replicate themselves and that their total number was set at birth; however, research over the past two decades has indicated that these cardiac cells have limited proliferative activity, though there has been no clear agreement within the scientific community as to why and how much.

In part, the indirect methods used to measure this potential cell division have been difficult, and at times inaccurate, preventing a scientific consensus. Some groups of researchers used carbon dating to detect the age of human cardiomyocytes to
determine whether or not they divided after initial fetal development, but the accuracy of this technique was debated. Others published theories that the heart muscle had a very-high proliferative ability; recently, many of those papers were retracted because colleagues were unable to replicate the data. To address the problems of measurement, Dr. Ardehali and his colleagues pioneered a novel genetic approach called mosaic analysis with double markers, or MADAM, to directly measure for the first time heart-cell division in a mouse model. They found that limited, lifelong symmetric division of cardiomyocytes, while rare, is evident in mice, but it diminishes significantly after the first month of life. No stem cells are involved in this process, the researchers said, and division of cardiomyocytes is limited to less than 1 percent per year.

The daughter cardiomyocytes that are the products of this rare cell division also divide, the researchers said, though very seldomly, which had not been shown before. The scientists found that the rate of cell division did not increase as a reparative response when myocardial infarction was induced in the mice.

“We show that MUL1 dosage is key, and optimizing its function is crucial for brain health and to ward off Parkinson’s disease,” Dr. Guo says. “Our work proves that mitochondrial health is of central importance to keep us from suffering from neurodegeneration. Further, finding a drug that can enhance MUL1 function would be of great benefit to patients with Parkinson’s disease. This finding is a major advance in research into Parkinson’s disease.”

There are several implications to this work. MUL1 appears to be a promising drug target, “and it may constitute a new pathway regulating the quality of mitochondria,” Dr. Guo says. She and her team plan to test their results in more-complex organisms, hoping to understand more about how MUL1 works. The team also will work on identifying compounds that could specifically target MUL1 and examine whether or not mutations in MUL1 exist in some people with inherited forms of Parkinson’s.

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The accumulation of unhealthy or damaged mitochondria in neurons and muscles ultimately results in Parkinson’s disease.

In the new study, Dr. Guo and her colleagues found that a gene called MUL1 (also known as MULAN and MAPL) plays an important role in mediating the pathology of the PINK1 and parkin. The study, performed in fruit flies and mice, showed that providing an extra amount of MUL1 helps reduce the amount of damage that mutated PINK1/parkin create in mitochondria and that inhibiting MUL1 in mutant PINK1/parkin exacerbates the damage to the mitochondria. In addition, Dr. Guo and her collaborators found that removing MUL1 from mouse neurons of the parkin disease model results in unhealthy mitochondria and degeneration of the neurons.

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Gene May Offer Target to Combat Parkinson’s Disease

UCLA researchers have identified a new gene involved in Parkinson’s disease, perhaps providing a target for drugs that could one day prevent, or even cure, the debilitating illness.

Ming Guo, MD (RES ’01, FEL ’02), PhD, associate professor of neurology and pharmacology, and her team were one of two groups in 2006 that first reported that two genes, PTEN-induced putative kinase 1 (PINK1) and parkin, act together to maintain the health of mitochondria, which power the neurons that are important for maintaining brain health. Mutations in these genes lead to early-onset Parkinson’s disease.

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Data from: Dr. Ming Guo, UCLA

U MAGAZINE

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The True Healthcare Costs of Undocumented Immigrants

Undocumented immigrants in California see the doctor and visit emergency rooms significantly less often than U.S. citizens and documented immigrants, a UCLA study finds. Undocumented immigrants also seek fewer preventive-health services, according to the study. The findings contradict perceptions that undocumented immigrants overburden U.S. emergency departments and health providers.

The UCLA researchers found striking differences in ER visits by adults: One-in-five U.S.-born adults visits the ER annually, compared with roughly one-in-10 undocumented adults. “Most people who go to the emergency room have insurance and are not worried about providing documents,” says Nadereh Pourat, PhD, director of research at the UCLA Center for Health Policy Research and a member of UCLA’s Jonsson Comprehensive Cancer Center Division of Cancer Prevention and Research. On the other hand, “the undocumented who end up in the emergency room have often delayed getting any care until they are critically sick.”

The study also found that the average number of annual doctor visits by undocumented immigrants was lower: 2.3 for children and 1.7 for adults, compared with 2.8 doctor visits for U.S.-born children and 3.2 for adults.

Of all California residents who lack insurance, undocumented adults who are uninsured had the fewest mean doctor visits of all groups — 1.6 per year, compared with 1.8 visits for U.S.-born residents, legal permanent residents and naturalized residents. Nine percent of uninsured undocumented immigrants had visited the ER, significantly lower than the 12 percent of uninsured U.S.-born residents, who had the highest ER use of all groups.

To determine undocumented immigrants’ use of health services in the state, the researchers used 2009 California Health Interview Survey (CHIS) data to predict the likelihood of respondents being undocumented. In 2009, California was home to more than 2.2-million undocumented immigrants, the study found. And while these immigrants make up 6.8 percent of California’s residents, they represent nearly a quarter of the state’s uninsured population.

“The great majority of the undocumented in California are working-age adults who contribute greatly to California’s economy by working in physically demanding service, agriculture and construction jobs,” Dr. Pourat says. “It makes financial sense to make sure they have affordable health-coverage options so they can stay healthy.”

Lower utilization of care comes at a great cost, the study findings suggest. The undocumented don’t get preventive care, potentially leading to more-advanced disease and higher public expenditures. If undocumented immigrants had access to health insurance, the authors say, their doctor and ER visits would remain below or be the same as documented residents.

The 2010 Affordable Care Act extended access to health coverage to about 3.3-million people in the state but not to California’s undocumented immigrants, the study notes. The authors conclude that allowing undocumented immigrants to buy unsubsidized coverage could benefit the insurance-exchange market, as they are a large, young and relatively healthy population that could help keep premiums low. In addition, their health coverage could reduce the burden of uncompensated care on safety-net providers.

“The Assesing Health Care Services Used by California’s Undocumented Immigrant Population in 2010,” Health Affairs, May 2014
Lost in Translation

Millions of people in the West utilize traditional Chinese medicine, but only a few schools in the United States that teach Chinese medicine require Chinese-language training. And only a handful of Chinese medical texts have so far been translated into English. Given the complexity of the language and concepts in these texts, there is a need for accurate, high-quality translations, say researchers at UCLA’s Center for East-West Medicine.

Now the center has published a document that includes a detailed discussion of the issues involved in Chinese medical translation. The document is designed to help students, educators, practitioners, researchers, publishers and translators evaluate and digest Chinese medical texts with greater sensitivity and comprehension. “This publication aims to raise awareness among the many stakeholders involved with the translation of Chinese medicine,” says Ka-Kit Hui, MD ’75 (RES ’78, FEL ’79), founder and director of the UCLA center.

The 15-page document, Considerations in the Translation of Chinese Medicine, was developed and written by a UCLA team that included a doctor, an anthropologist, a China scholar and a translator. Authors Sonya Pritzker, a licensed Chinese-medicine practitioner and anthropologist, and Hanmo Zhang, a China scholar, hope the publication will promote communication in the field and play a role in the development of thorough, accurate translations.

The document highlights several important topics in the translation of Chinese medical texts, including the history of Chinese medical translations, which individuals make ideal translators, and other translation-specific issues, such as the delicate balance of focusing translations on the source-document language while considering the language into which it will be translated.

The document also addresses issues of technical terminology, period-specific language and style and historical and cultural perspectives. For example, depending on historical circumstances and language use, some translations may be geared toward a Western scientific audience, or, alternately, it may take a more-natural and spiritual tone. The authors note that it is sometimes helpful to include dual translations, such as “windfire eye/acute conjunctivitis,” in order to facilitate a link between traditional Chinese medical terms and biomedical diagnoses.

The final section of the document calls for further discussion and action, specifically in the development of international collaborative efforts geared toward the creation of more rigorous guidelines for the translation of Chinese-medicine texts.

To view a copy of Considerations in the Translation of Chinese Medicine, click on the link to this article at: magazine.uclahealth.org

Depression Increases Risk for Diabetic Seniors

A diabetic’s risk of premature death is about double that of someone of the same age without diabetes. In addition, diabetics are twice as likely to have depression, which further increases their mortality risk. A new UCLA-led study suggests that for diabetics age 65 and older, depression is linked with a far-greater chance for early death compared with people of the same age who do not have depression. This may perhaps be because those with depression are less-likely to adhere to a regimen of prescribed medications, diet, exercise and glucose self-monitoring.

While the link between depression and mortality among people with diabetes has been the subject of other studies, this one is the first to examine the phenomenon among those 65 and older versus younger people, says Lindsay B. Kimbro, MPP, project director in the Division of General Internal Medicine and Health Services Research. Each participant was given a baseline survey and was contacted for a follow-up survey six-to-seven years later. “Although depression is an important clinical problem for people of all ages, when you split the different age groups, depression in the younger group doesn’t lead to increased mortality six-to-seven years later,” Kimbro says.

Using data from the eight-state Translating Research Into Action for Diabetes study, the researchers analyzed information on 3,341 people with diabetes, including 1,402 who were 65 years of age and older and 1,939 between the ages of 18 and 64. They measured mortality risk as the number of days until death since the time of the interview. The researchers controlled for age, gender, race and ethnicity, income and co-morbidities such as heart and kidney disease associated with diabetes.

As in previous studies, the results revealed that the risk for early death among depressed people with diabetes was 49-percent higher than among those without depression; however, the correlation was even more pronounced among older adults: Researchers found a 78-percent higher mortality risk among those 65 and older than they did among non-depressed people with diabetes within that age group. For younger participants with diabetes, the effect of depression on their risk for early death was not statistically significant.

Redesigning the Well-child Checkup

Well-child visits are the foundation of pediatric primary care in the U.S., accounting for more than one-third of all outpatient visits for infants and toddlers. But several studies have shown that the current system needs improvement. For one thing, well-child-care guidelines issued by the American Academy of Pediatrics call for physicians to provide more services than can realistically be completed within a standard 15-minute office visit. As a result, many children do not get all of the preventive-care services that they need — and the problem is more acute for low-income families.

“The usual way of providing preventive care to young children is just not meeting the needs of the low-income families served by these clinics and practices,” says Tumaini Coker, MD ’01, assistant professor of pediatrics and a researcher with the Children’s Discovery and Innovation Institute at Mattel Children’s Hospital UCLA.

In a year-long study led by Dr. Coker, researchers developed a new design for preventive healthcare for children from birth through age 3 from low-income communities. The team partnered with two community pediatric practices and a multisite community-health center in Greater Los Angeles. “Our goal was to create an innovative and reproducible — but locally customizable — approach to deliver comprehensive preventive care that is more family-centered, effective and efficient,” Dr. Coker says.

To design the new care models, researchers gathered input from two sources. First, they solicited ideas from pediatricians, parents and health-plan representatives about topics such as having non-physicians provide routine preventive care and using alternative-visit formats — meeting with healthcare providers in alternative locations, meeting in groups as opposed to one-on-one or getting providers’ advice electronically instead of in person. Second, the teams surveyed existing literature on alternative providers, locations and formats for well-child care. From that information, four possible new models were developed for review by a panel of experts on preventive-care-practice redesign.

Two models were then selected to implement and test — one for private practices (one-on-one visits) and the other for a community-clinic setting (group-visit format). Both models shared several characteristics, including a “parent coach” to provide such services as preventive-health education, parenting education and preventive-health services related to development, behavior and family psychosocial concerns; longer preventive-care visits; a website that enables parents to customize their child’s specific needs prior to their visit; and scheduled text messages or phone calls enabling the healthcare team to communicate with parents.

The preventive-care models are now being tested in the clinical settings. “For clinics and practices that provide child preventive healthcare to families living in low-income communities, the process we used to develop the new models — or the new models themselves — could help them bring innovation to their own practices,” Dr. Coker says.

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The rankings take care of themselves

25 consecutive years Best in the West and Top 5 nationally
U.S. News & World Report

The doctors, nurses, staff and volunteers of UCLA are honored to be at the top of U.S. News & World Report’s Best Hospitals for 2014-15. We’re especially proud to be the only hospital in Southern California consistently ranked among the best in the country. Still, our greatest honor is serving you. From the routine to the most complex, bringing world-class medical care to you always comes first.

To find a UCLA doctor near you, just call us at 1-800-UCLA-MD1 or visit uclahealth.org
Change Agent

As the landscape of American healthcare continues to shift, UCLA will embrace new opportunities to lead the nation in improving patient safety and the quality of care delivery. Dr. Robert A. Cherry is steering that drive.

When the phone call came asking Robert A. Cherry, MD, if he might be interested in becoming UCLA Health’s chief medical and quality officer to lead system-wide quality-improvement efforts, his response was immediate. “I didn’t even have to think about it,” he says. “UCLA has such a great reputation, and I was instantly intrigued with the opportunity. I was very impressed with the degree of enthusiasm and passion about quality and safety. It was an easy decision.” Dr. Cherry, who trained as a critical-care and trauma surgeon, was appointed to the newly created position in January 2014. Before coming to UCLA, he served as director of clinical and operational excellence at Navigant Consulting, in Chicago, Illinois, where he was responsible for the strategic development and implementation of such key healthcare initiatives as the early adoption of accountable-care-organization models, physician-integration strategies and enhancement of quality and safety systems. He also served as chief medical officer and vice president for clinical effectiveness at Loyola University Medical Center, outside of Chicago. Becker’s Hospital Review named him among the “100 Hospital and Health System CMOs to Know.” Dr. Cherry spoke about his vision for UCLA’s role as a world leader to shape the future of healthcare delivery with U Magazine contributing writer Dan Gordon.

How do you define quality, and what’s the basis of your strategy for promoting quality within UCLA Health?

Dr. Robert A. Cherry: Quality can mean different things to different people. And there are so many metrics and initiatives that it can be difficult to communicate within large, complex organizations what we need to achieve in order to be successful. That is why I’ve been articulating a quality strategy, called MOVERSTM, as a way to provide a structured framework for positive change. It’s an acronym with six buckets that represents the overall quality strategy for UCLA Health. Within each bucket, we have initiatives to move the needle forward. The idea is that everyone here is a change agent for safety and quality; everyone contributes to the overall quality strategy and is part of the fabric that makes up our safety culture.

What does MOVERSTM stand for?

Dr. Cherry: The M is for reducing risk-adjusted mortality. Right now we’re especially centered on reducing mortality rates related to sepsis, as well as integrating early-warning systems and intervening rapidly before a patient gets into real trouble. O stands for outcomes. We’re focused on a variety of publicly reported metrics in areas ranging from inpatient surgical care to outpatient population-health measures. Where there are specialty-specific metrics, we encourage individual departments and clinical-service lines to pursue those outcome measures as well. V is for value — delivering optimal care while also being responsible stewards of our limited resources. Consumers, employers and health plans are increasingly looking at that. So that bucket is about redesigning the clinical care in a way that
provides value, reduces cost and increases the quality of care. E is for patient experience. We look at selected measures related to both inpatient and outpatient experience to make sure that it is optimized. R is for reducing readmissions. This is increasingly important because as people live longer, they are sometimes living with complex chronic diseases that need to be appropriately and safely managed within the home environment. And S is for safety. Our ultimate goal is to make sure that all patients are safe from harm during the course of their care and treatment. We look at the list of publicly reported patient-safety incidents and call them “never” events — we never want to see them. A high-performing safety culture requires open communication, transparency and trust to be successful.

You have said you envision UCLA as a global leader in this arena — not just one of the best, but a true change agent.

Dr. Cherry: We want to be the healthcare system in the United States that organizations and individuals turn to for leadership in quality and safety. To get there, we need to be consistent and high-ranking in terms of our publicly reported measures. Consumers, employers and health plans are increasingly looking at these measures to make judgments about our organization, and we have to make sure that the reputation of the organization matches the publicly reported outcomes. That’s one aspect of leadership. But the other is for UCLA Health to be a visionary leader and innovator within the broad realm of quality and safety.

What would be an example of an area in which UCLA can serve as a healthcare change agent?

Dr. Cherry: Leveraging technology is one area that we have been looking at for some time. For example, wouldn’t it be great to have an app on your smartphone that enables you to better manage your clinical condition — based on your doctor’s recommendations — by recording your response to treatment and making it possible to communicate more effectively with your physician? With these kinds of interactive apps, the physician can understand exactly what’s going on with you at home; when you come in for an appointment, the physician then has a much-more complete picture and is able to render much-more precise and individualized care. The UCLA Inflammatory Bowel Disease Center has already developed a patient-centered, interactive app, and there are other physicians who are exploring these concepts. The advent of social media and smart technology will provide a level of connectivity between the physician community and the patient that, in the future, will allow us to leverage knowledge and decision making in ways that we don’t yet fully understand. We’re also looking into how the electronic health record can be used in new ways for clinical-decision support. Technology is going to continue to be a major driver of change in healthcare, as it has been for a while.
“Employers are now thinking about how to manage resources within healthcare ... and they’re interested in innovative strategies and new partnerships with healthcare facilities.”

How does the Affordable Care Act (ACA) affect an academic institution such as UCLA?

Dr. Cherry: A lot of changes actually started before the ACA. We are looking more systematically at managing the health of populations, potentially in collaboration with other employers. Employers are now thinking about how to manage resources within healthcare, as well, and they’re interested in innovative strategies and new partnerships with healthcare facilities. An example of such a partnership is UCLA’s new collaboration with other leading healthcare centers in Los Angeles and Orange counties to offer an integrated, multicenter health-plan option through a new Anthem Blue Cross entity called Vivity. The California Public Employee’s Retirement system already has signed on as the plan’s first major customer. In another example, some very-large employers are developing centers of clinical excellence, not just within their local community, but also at places distant from their primary location. For certain types of tertiary and quaternary care, patients are traveling to facilities where the employer knows that the outcomes are consistent and strong. Employers want to know that their workers, who go to particular facilities for certain types of care, are not only getting high-quality care, but they’re also getting it at a cost that may be less than if they were to go to a local hospital or, in some cases, a local academic medical center. For us to be able to compete in that environment, we need to demonstrate that we can provide services to patients that employers will find attractive as well.

In addition, employers are looking very carefully at their network of physicians and hospitals, and they are starting to develop preferred-provider networks so that they can manage their employee population with a set of healthcare facilities that are favorable in terms of the types of healthcare outcomes they are seeking. They are also reading publicly reported measures and making judgments about organizations. With that degree of transparency, it becomes very important that we put our best foot forward so that we’re attractive to employers and health plans.

Finally, some large companies are starting to consider public and private healthcare exchanges, and that’s putting pressure on academic medical centers, which are structured for high-end complex tertiary and quaternary care, making the cost structure unfavorable for a lot of routine care. It means that we need to deliver value in the care that we’re providing — whether it’s primary and secondary care or tertiary and quaternary care.

What advantages does UCLA offer over some of these other options for employers?

Dr. Cherry: UCLA has extraordinary advantages because it has a cadre of faculty who are looking to innovate in this area. From a health-system-leadership point of view, we have a chief innovation officer, Dr. Molly Coye, who encourages faculty and other staff to look at creative ways of redesigning care within the institution through new technology and innovative treatment models. In addition, we have a chief operations officer, Shannon O’Kelley,
who is also looking at innovative ways to deliver care more efficiently and effectively. Dr. Sam Skootsky, our chief medical officer for the UCLA Medical Group, is consistently implementing novel strategies to improve the health of our patient population. We also look outside of our own organization; if there are others who are implementing unique strategies, we spend time learning about those organizations and try to replicate some of those initiatives here.

Is it more difficult to maintain high quality at a time when there is such a strong mandate to reduce costs?

Dr. Cherry: The key is to use evidence-based practice and make sure that physicians, as best they can, reduce the day-to-day clinical-practice variations in their approach to patients. The more that physicians and surgeons collaborate as a team, and come up with consensus opinion after reviewing the literature, the better off we’ll be in terms of managing our limited resources while improving the care that is delivered. You find that the cost of care becomes much-more expensive when we’re not all on the same page regarding optimal treatment. The outcomes may be the same, but one physician may be using more-expensive treatment options than another. Getting the same, or better, outcomes by using our resources more wisely is part of the task ahead.

Do you see any tension between quality and cost constraint? As we try to reduce costs, does that necessitate trade-offs in quality?

Dr. Cherry: Not at all. When we’re able to provide improved care with reduced cost, we can take that savings and reinvest it in ways that will allow for better care over time. As an academic research institution, we must continue to invest in cutting-edge technology to care for patients. To do that in this era, we have to make sure we manage our resources well. In the past, we didn’t have to think about that as much. Now, it’s imperative that we provide care that is as efficient and lean as possible and then use the savings to invest in new technology, supplies and pharmaceuticals for the betterment of our patient population.

How has your background as a trauma surgeon influenced your thinking in more executive-focused roles?

Dr. Cherry: I always received a great deal of satisfaction from taking care of the individual patient, but I’ve also found extraordinary satisfaction from managing clinical systems and contributing to the delivery of optimal care at a macro level. In trauma surgery, it is tremendously rewarding to rescue a patient from the brink after he or she has gone through a life-threatening or limb-threatening emergency. Now, there is a tremendous reward from watching mortality rates decrease, infection rates decrease, and fewer adverse events occurring within a facility because of creative teamwork, as well as the collaborative implementation of new and creative ways of delivering care.

“The more that physicians and surgeons collaborate as a team, and come up with consensus opinion after reviewing the literature, the better off we’ll be in terms of managing our limited resources while improving the care that is delivered.”
When Erik Laurence transferred to Shanghai, China, in 2009, as vice president of a software company, he thought his biggest challenge would be improving his Mandarin-language skills and learning the nuances of the Chinese business scene. But his vocal cords, not the foreign nation, turned out to be his undoing.

Laurence, who was in his mid-40s at the time, had struggled for about 20 years with a mild case of spasmodic dysphonia (SD), intermittently losing his voice at odd times. SD is a neurological disorder that involves spasms of the vocal cords, which causes the voice to break up or have a strained or strangled quality. “Building a career in marketing involved winning over new people, conference presentations and constant talking,” he says. “My job had evolved to where I spent entire days on conference calls — with a voice I couldn’t count on to work.” He says the feeling of SD is “like you are running along and suddenly you trip, and you didn’t see it coming. Your voice is fine, then suddenly it stops working in the middle of a sentence.”

Speaking was even more difficult when he played sports and his heart rate went up. “It was like my brain was over-firing, causing the signals to the nerves to be too strong and making my vocal cords slam together, not allowing them to vibrate,” Laurence remembers. “At social events, I wouldn’t speak much, even though I had lots to say. Sometimes I’d get a sense of what words would work out for me, so I would say only what I could say.”

When words fail, a unique and highly specialized center at UCLA is there to help patients find their voice.
Epiglottis
Larynx Vestibule
Vestibular Fold
Vocal Fold
Vocal Muscle
Cricoid Cartilage
Thyroid Cartilage
Infraglottic Space
Trachea

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His move to China made the problem markedly worse. “Work demands and trying to speak a new language aggravated all my vocal problems. It came to a head at a meeting where I was called on to speak to about 250 people,” he says. “My voice was horrible, cracking and missing words. I wanted to crawl away and hide.”

Clearly something had to be done. Laurence, who was trained as an engineer, methodically scoured the latest medical research on SD and took a week’s vacation in New York to confer with specialists. That’s when he learned about otolaryngologist Gerald Berke, MD (RES ’80, ’84), chair of the Department of Head and Neck Surgery, and UCLA’s Voice Center for Medicine and the Arts. At UCLA, Dr. Berke performs a specialized surgery that severs the nerve pathway between the brain and vocal cord and grafts a new nerve from the neck. It essentially rewires the larynx. The alternative for Laurence would have been Botox injections that usually correct the symptoms for about six months. But a Botox injection when he was younger left Laurence with only a whisper of a voice for two months, “which was miserable. So I was wary of the injections. I wanted a permanent solution.”

FOR PATIENTS WHO HAVE BAFFLING PROBLEMS with talking, breathing, singing or swallowing, the UCLA Voice Center for Medicine and the Arts can be an oasis in a desert of inconclusive tests, endless doctors’ appointments and despair. The 10-year-old center flows from the life’s work of its founder, Dr. Berke, who is an international authority on the physiology of the larynx. “Your voice is how you express yourself to others,” Dr. Berke says. “If it’s compromised, it impairs your personality and how you interact with the world, which can be overwhelmingly frustrating.”

In addition to patients like Laurence, world-class singers such as Celine Dion and John Mayer have made their way to Dr. Berke for help with their ailing vocal instruments and then been public in their support of his work. “Through his medical care, I learned that the voice is an instrument ... and nobody sees that as delicately and carefully as Dr. Berke and his colleagues at UCLA,” Mayer told an audience in January 2014 at a fundraising gala to benefit the Department of Head and Neck Surgery. Many other entertainers who have trekked to the center’s understated facilities in one of UCLA Health’s outpatient offices prefer to keep quiet about any problems with their voices.

The Voice Center for Medicine and the Arts is known for novel treatments for such disorders as vocal-cord paralysis, airway stenosis and the SD surgery that Laurence underwent. In-office laser therapy, digital-video endoscopes and minimally invasive approaches are used to treat myriad complex and common disorders of the larynx and trachea. Dr. Berke started the center in 2004 with Bruce Gerratt, PhD, a speech and language pathologist who consults on all Dr. Berke’s patients, and Dinesh Chhetri, MD ’97 (RES ’03, FEL ’05), an otolaryngologist who specializes in swallowing disorders. The younger generation of physicians at the center now includes otolaryngologists Jennifer Long, MD (RES ’10, FEL ’11), PhD, who joined the practice four years ago, and Abie Mendelsohn, MD ’06 (RES ’11, FEL ’11), who joined in 2012.

For Laurence, the surgery itself was swift and without significant pain, but his long-term recovery process proved to be more difficult. Three weeks after his surgical procedure in Los Angeles, he
was back on the job in China, but his voice, while no longer spasming, was weak, breathy and raspy. Because his vocal cords were farther apart than before due to the surgery, he also had to push out more air to make sounds. As a result, he got light-headed when he talked for an extended time and often felt exhausted. Sometimes he pretended to be Marlon Brando in *The Godfather* to lighten the mood, but after months, it became increasingly difficult to carry out his work duties. Finally he bowed to the inevitable, quitting his job and taking a year off to travel and fully recover. He channeled some of his creative energy into a blog, SpasmodicDysphoniaSurgery.com, about his up-and-down recuperation. "Dr. Berke and his team told me it would take up to eight months to get my voice back to normal, but I selectively heard 'two months,'" he says.

Now, three years post-surgery, Laurence is in charge of marketing at FeeX, a New York startup, and his voice, to his great joy, is no longer an issue. "I don’t have to measure my words anymore, and I’m back to the fun-loving person I was a long time ago," he brags. His only regret: going back to work too soon, without giving his body sufficient time to heal.

**WE LISTEN IN AWE TO THE SOUNDS**
emanating from the mouths of a Joan Sutherland or Luciano Pavarotti and marvel at how these vocal titans play their voices like fantastic musical instruments.
vocal titans play their voices like fantastic musical instruments, but the truth is that every healthy human voice is a complex and nuanced instrument. The flexible, versatile and emotional sounds produced by our bodies have been the envy of composers and musicians for generations.

Ironically, our vocal cords, also called vocal folds, have humble origins. Early in our development as human beings, they were simply a barrier to protect the airway against food passing into the lungs. Eventually they evolved to produce the array of sounds that form the basis of our voice. Located in the larynx, the cords consist of loose tissue that vibrates in a wave-like manner at 80-to-300 cycles a second when air from the lungs is pushed through them. "It’s amazing that when we are talking, our vocal cords are robust enough to bang together about 100 times a second, without stress or strain," says Dr. Berke.

The cords are operated by specialized muscles that have exceptionally fine control. As we talk louder, the folds are closed longer and are pressed together more firmly. To manipulate the pitch of our voice, we automatically tighten the cords to make our voice higher or loosen them to make our voice lower. "It works in the same fashion as letting the air out of a blown-up balloon," Dr. Berke says. If you pull the neck of the balloon, it changes the sound coming out.

What makes each of our voices unique is the size of the cords we are born with — superstar-tenor Pavarotti, for instance, had massive vocal cords that could push large amounts of air through at high pressure — combined with the way we modulate sound through our throat, mouth, tongue and lips. "We learn how to control our voices as infants," Dr. Berke says. "A baby making seemingly meaningless baby talk is probably the child first experiencing how its voice works."

But to this day, the actual mechanism that causes vocal cords to vibrate is not very-well understood. "Because the cords are down low in the throat, and they vibrate so fast, it has been hard to study and measure the process until recently," says Dr. Berke. Only in the last 20-to-25 years have researchers had instruments that can examine vocal cords.
the cords in detail and study the wave as it occurs over the cords, he says. The good news is that recent information about how the voice works has transformed what doctors at the voice center can diagnose and treat today.

While disease can contribute significantly to voice issues, that is not always the cause. Sometimes we do it to ourselves. Because the voice operates more-or-less on automatic pilot, without our having to think about it, we sometimes unknowingly put extra strain on our already hard-working vocal folds. We overburden our voices by talking a lot when we have a cold, or by smoking, or by yelling. Like an overworked muscle, the vocal cords can get tired and stiff and prone to injury. The result can be calluses, nodules, ulcers and other painful damage to our cords.

That damage can show up years later. In fact, the center is seeing an “epidemic” of voice issues in people who survived the 1960s era of sex, drugs and rock ‘n’ roll, Dr. Berke says. Members of that cohort, now in their 60s, 70s and 80s, are being seen with throat cancers and other problems tied to the common sexually transmitted human papilloma virus (HPV), apparently contracted from risky behaviors in their free-wheeling youth. The Centers for Disease Control and Prevention reported in 2013 that each year about 8,400 people in the U.S. are diagnosed with cancers of the back of the throat that may be caused by earlier HPV infections.

**SINGER HARLEY JAY WAS CONVINCED HE OVERTAXED HIS VOICE** while performing the lead role in the play *Rent* for two years, both on Broadway and on tour. It made sense; he was performing eight shows over six days each week. “It got to where we had to hide containers of water all over the stage because I’d have to keep sipping water to be able to get any notes out,” he recalls.

Later, Jay cut back to singing his signature city-country style with a band for four or five nights a week. But by then his voice had become “impossible,” he says. “Sometimes my voice would crackle and crack and make horrendous sounds, or I’d open my mouth to sing and no sound would come out.”

After a few years of putting up with it, he found his way to UCLA and Dr. Berke, who he vaguely remembered meeting years earlier. The news was not good. Dr. Berke’s examination showed that Jay had cysts and a hemorrhage, which meant that Jay had to stop talking entirely for four weeks until the hemorrhage cleared up. Only then could the cysts be surgically removed.

In the fall of 2013, after a month of jotting messages on his cell phone and the nearest napkin or turning to his wife to be his voice, Jay underwent a three-hour operation. Six more weeks of silence — not even a whisper — followed. “Being unable to speak was depressing. I felt like a hermit,” Jay says. His old way of relieving stress was to drive around in his car and sing his heart out, but during recovery he had to learn other ways to cope. “I made videos on Instagram, and I wrote poetry — things you can do without a voice,” he says. After six weeks, he could talk again, but Dr. Berke forbade him to sing for another four weeks. For Jay, all the waiting was more painful than his healing vocal cords, which he says felt like a bad sore throat.

Then the time finally arrived for him to sing. “I immediately scheduled a voice lesson and the results were so good that I hopped in my car and sang really hard,” he recalls.

Jay says he now, at age 31, sounds better than he did when he was 20. “Since the surgery, my voice is not quite as gravelly, which [is a sound that] many rock singers may like. But, hey, I can sing like this for six hours a day. That sure beats being a gravelly singer who can sing only two hours a week,” he says. To show off his new, improved vocals, he plans to release an EP with his band in October 2014.

**INSIDE THE VOICE CENTER, NOSTALGIC PHOTOS** of John Lennon and other rock ‘n’ roll artwork decorate the walls of the Westwood Boulevard offices. The atmosphere is homey and warm, in contrast to the gleaming state-of-the-art technology. All new patients receive a comprehensive evaluation that includes an analysis of speech and voice quality and a videoendoscopic examination of the larynx, designed to assess the motion and pliability of the vocal folds. Laryngeal electromyography is performed as needed. Then a comprehensive management plan is developed, which may include voice therapy, surgery or in-office or operative procedures.
A fully equipped sound studio in the middle of the center allows patients like Jay to record their voices to test quality and effectiveness. “Our work is all about balance,” says Dr. Long. “The larynx is there to protect the airway, so sometimes procedures to improve breathing or swallowing interfere with a patient’s voice. We often need to strike a delicate balance.”

Lucila Toche was one of those patients whose voice was out of balance. For more than four decades, she would run out of breath whenever she talked a lot, walked briskly or went dancing. When she slept, she woke up breathless every couple of hours. Asthma treatments didn’t seem to help so she just learned to put up with it. That was until September 2013 and what she calls her “nightmare at Disneyland.”

That day, Toche spent about eight hours showing her nieces from Peru around the Magic Kingdom, translating for them “and chatting, laughing and screaming. We were having lots of fun,” she remembers. Then, suddenly, she collapsed and could hardly breathe, nearly blacking out. “When paramedics arrived, I was terrified of having to go to the hospital, so I insisted that as soon as I stabilized they would let me go home to see my own doctor,” she says. The next day, her doctor took one look at her throat and sent her to UCLA’s Department of Head and Neck Surgery. There, she met Dr. Long and was introduced to the voice center.

A quick exam solved the mystery. When Toche underwent thyroid surgery in her native Peru 40 years before, doctors inadvertently injured the nerves in both of her vocal cords, essentially paralyzing the cords so they could not regulate her breathing properly. Dr. Long conducted endoscopic laser surgery to open up the frozen cords in December 2013, and Toche was out of the hospital the following day. “I had not been in a hospital since 1981, and I was really afraid and nervous about staying there overnight,” she says. “But the UCLA hospital and staff made me feel really safe and well-taken-care-of.”

Recovery meant almost no talking for three days, and she had to speak softly for a few weeks afterward. The upside: Her breathing was immediately better, and it stayed strong for three months. When it became strained again, in March 2014, Dr. Long performed a follow-up, inpatient surgery. In the months since, Toche reveals in how much her life has improved. She says she hasn’t had an asthma episode since the first surgery, she sleeps through the night without interruption, can keep up through an entire Zumba fitness class and doesn’t wheeze when she goes salsa dancing. Her voice sounds a little different than it did before, but “that’s nothing. My breathing used to be so bad, people were always asking me, ‘Are you okay?’” she says. “But nobody asks that anymore.”

GEORGE HICKER ALWAYS QUIETLY SUSPECTED that the source of his nagging sore throat was cancer. The discomfort started in 2011, and over the next year his doctors treated him with antibiotics and steroids. But he still had two serious bouts of bronchitis, “and the coughing, pain and hoarseness just wouldn’t go away,” he says. Almost every night, the constant hacking disrupted his sleep. But Hicker, who was 64 at the time, kept working at his industrial-real-estate company in Sherman Oaks, California.

Near the end of 2012, just before he was slated to take a vacation in Kenya, the answer finally came, loud and clear. His throat specialist found a growth on his left tonsil, ordered a biopsy, and confirmed that, yes, it was cancer. Surgery, radiation and chemotherapy were recommended. But because of the upcoming trip, Hicker couldn’t wait the weeks it was going to take to schedule an appointment with a surgeon from the health system where he was a member. Instead, he reached out to friends in the medical field and was referred to Dr. Berke. Within a week, Dr. Berke examined Hicker and gave him the go-ahead for his trip. When Hicker returned, Dr. Berke and Dr. Mendelsohn used the da Vinci robotic system to remove the cancerous growth. They also performed a lymph-node biopsy, with only a small incision on Hicker’s neck.

A week later, he went back to the hospital for another night’s stay to get an additional procedure to improve his swallowing. Returning home afterward, “I stopped for an In-N-Out burger and milkshake, which I had no problem swallowing,” he recalls. The robotic surgery “saved him six-to-seven weeks of chemo and radiation therapy and damage to his jawbone,” Dr. Mendelsohn says. Hicker took

While disease can contribute significantly to voice issues, that is not always the cause. Sometimes we do it to ourselves. Because the voice operates more-or-less on automatic pilot ... we sometimes unknowingly put extra strain on our already hard-working vocal folds.

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about a month to fully recover. “That’s more than a year-and-a-half ago, and my check-ups show I’ve had no recurrence,” he says. A college basketball player and sports-radio announcer in his younger days, Hicker boasts that his voice is stronger now than it was before the treatment.

THE VOICE CENTER IS ABOUT MORE THAN JUST CLINICAL TREATMENT. There also is a large research component to the work done there. The center’s physicians attract numerous grants from the National Institutes of Health, as well as gifts from private philanthropy. In one research project, Dr. Long has spent five years researching how to use adipose-derived stem cells to grow tissue for vocal-cord replacement. And Dr. Mendelsohn, a fellowship-trained specialist in transoral robotic surgery and laser microsurgery, notes that the center incorporates national clinical trials for his throat-cancer patients, the first such trials in many decades. The center’s research programs help develop treatments that are less invasive and more effective for patients, Dr. Chhetri says. “This center is unmatched in its combination of clinical care and research to advance the knowledge of these disorders, making a huge difference in patients’ quality of life,” he states.

“Our work is more than just medical care to help people make sound; it also is about the way we form sounds to make words,” Dr. Berke says. But “words mean more than what is set down on paper,” he continues, quoting from the poet and author Maya Angelou’s *I Know Why the Caged Bird Sings.* “It takes the human voice to infuse them with the shades of deeper meaning.” Thus, the voice is at the very core of our gift to communicate. It is in essence what makes us human, and Dr. Berke’s mission and that of the center he founded is to preserve that humanity by returning a lost gift to its rightful owners.

Bay Area freelance journalist Joan Voight’s articles, blog posts and columns have been published in Wired, Adweek and on CNBC and CBS Interactive websites.

Dr. Abie Mendelsohn examines patient George Hicker, who underwent robotic surgery to remove a cancerous growth from his throat. It’s been more than 18 months since the surgery, “and my check-ups show I’ve had no recurrence,” Hicker says.
Patients may love the idea of care that is tailored to their personal needs, but is that always in their best interest? Standardized approaches enhance the quality of care and cut down on waste.
Given the strong current of rugged individualism that always has run through American culture, it’s not surprising that we, as healthcare consumers, want, and expect, treatment plans that are tailored to our unique biology and circumstances. But is purely personalized care always the best medicine?

Despite strong evidence on the benefits of cholesterol-lowering statin medications for patients with certain cardiovascular-disease risk factors, there is considerable variation in which patients are prescribed the drugs — with physician preferences and geography often carrying more weight than data from large randomized controlled trials, which are considered the gold standard for clinical research. Similarly, the research is unequivocal on the benefits of administering certain antibiotics at key points before specific operations, yet it isn’t always done. And if the evidence points to the value of colonoscopy screening in normal-risk patients beginning at age 50, we don’t expect our doctor to decide on a case-by-case basis whether or not to recommend it.

In other words, even as many people like to romanticize medicine as something of an art, in which decisions about treatment are made creatively and individually, that is not really what we want in cases where the science clearly points to a single approach as most effective. Then, we’d prefer to go by the book.

"Intuitively, we want care that is patient-specific. But in reality, patients are much-more similar than they are different," says Tom Rosenthal, MD, chief administrative officer for UCLA Health. "When care is purely individualized, we find a lot of variation that isn’t explainable by the evidence and isn’t in the patient’s best interest." In addition, there is "variation that is not based on necessity and therefore arguably wasteful. By standardizing the appropriate aspects of care and setting up processes to ensure that they are delivered reliably, we reduce that random variation. In so doing, we improve quality while reducing cost."

Standardization makes for a more-consistent product, adds Samuel A. Skootsky, MD (RES ’82, FEL ’83), chief medical officer of the UCLA Faculty Practice and Medical Group, which oversees the outpatient practices of UCLA Health. That, “almost by definition, means higher quality. Particularly when patients are engaged to help define the standardized-care pathways, it’s more likely to result in the outcomes that they want,” he says.

Although evidence points to the need for more standardization as a way to improve the safety and efficiency of care, no one is advocating a checklist approach to all aspects of medicine: Some individual physician discretion will always have its place. Moreover, Dr. Skootsky is quick to point out that within most standardized pathways, there will be exceptions. “A particular patient may come along for whom the standardized approach is not in his or her best interest,” he says. “In such cases, you can’t be dogmatic. Instead, it’s an opportunity to learn, then see if this is a situation that should be built into the approach for the future.”
“The goal is to make sure we are reliably providing the best-possible care at the right time for every disease process.”

STANDARDIZATION ALSO DOESN’T NECESSARILY MEAN one set of rules for all patients. “A patient with a brain tumor can be a 16-year-old girl who is otherwise perfectly healthy, or it could be a 78-year-old man with cardiac and pulmonary disease and diabetes. Obviously, those two very different patients, with the same diagnosis, will require different patterns of treatment,” says Neil Martin, MD, chair of neurosurgery at the David Geffen School of Medicine at UCLA. “The goal is to make sure we are reliably providing the best-possible care at the right time for every disease process. We don’t want to rigidly standardize, but we want to eliminate variation that is non-scientific and based on individual physician preference.”

Dr. Martin’s department is in the process of systematically evaluating every step of treatment for patients with particular conditions to define the best approaches and ensure that they are applied in all cases. The effort involves weighing the existing scientific evidence and collecting input from all personnel involved in the care of patients before, during and after the surgery, along with surveying the patients themselves. Standardized protocols have been developed to enhance recovery after surgery in a way that emphasizes safety and value to the patient. For example, benchmarks have been set for when and how to begin mobilizing postoperative patients, including specific criteria they need to pass to advance to the next level. This has led to a substantial increase in the percentage of patients who are able to ambulate under their own power — an important achievement that stimulates the patient’s motivation to recover — the first morning after elective surgery, from 20 percent to 60 percent. Promptly getting a patient up and moving dramatically reduces the risk of dangerous postsurgical complications, such as pneumonia and deep-vein thrombosis, and increases the likelihood of a shorter hospital stay.

“Standardization allows us to be sure we are meeting specific goals for the care items most important to our patient population,” says Nancy McLaughlin, MD (FEL ’12), assistant clinical professor of neurosurgery and leader of the department’s care-redesign effort, which also has focused on pain management, patient education and communication and transition of care among care providers. “Standardization drives care delivery so that we are not reinventing the process every time a care provider comes into contact with a patient.”

She notes that the standardization of processes shouldn’t be undertaken blindly; rather, it should be done in conjunction with a value-redesign initiative that will ensure improved outcomes and reduced costs, with room for customization of elements, where appropriate.

“Ninety percent of the patient problems we see can be managed with some type of algorithm,” says Michael Yeh, MD, section chief of the UCLA Endocrine Surgery Program. “And I would argue that you could bring it to 99 percent by making a thinking algorithm that adapts.”

Dr. Yeh’s group has developed and studied two clinical pathways for endocrine-surgery patients. One assigns patients to the most-appropriate surgical setting based on the clinical complexity of their case. It has resulted in substantially lower costs by shifting appropriate patients to community inpatient or ambulatory-care facilities. A second standardizes the initial management of patients with thyroid cancer by assigning them to care pathways based on their parathyroid-hormone levels. The new protocol resulted in a 70-percent reduction of laboratory tests, while decreasing the likelihood of patients presenting with critically low calcium levels by 30 percent.

“We have reduced costs and improved quality by eliminating wasteful services,” Dr. Yeh says. He argues that improved quality will often go hand-in-hand with reduced cost because “the most-expensive thing you can have in surgery is a complication that requires additional care.”

In cardiac surgery, the complexity of the cases and the multidisciplinary-team approach to care demand that it be highly protocol-driven — from the preoperative evaluation of patients to the surgery itself and through the postoperative treatment and post-discharge care. But there are inevitably variations in the care that is provided, and those become an opportunity to formally discuss and improve on the standards, says Richard Shemin, MD, chief of cardiothoracic surgery at UCLA.

Dr. Shemin heads a consortium of the five University of California chiefs of cardiac surgery that is examining aspects of the operations that lead to costly complications. The group is seeking to develop best-practices by sharing clinical and
By querying our robust database to look for trends and assess what happens when patients are treated outside the established norms, we can find ways to improve on practice guidelines.

THE BENEFITS OF EARLY MOBILIZATION

This information sheet presents significant benefits of early mobilization. Additionally, it is important to remember that early mobilization is both safe and feasible.

- Promotes independence
- Improves outcomes
- Decreases length of stay in hospital
- Facilitates returning to work

THE CONCEPT OF STANDARDIZING CARE-PATHWAY protocols to reduce unsupported variations and improve quality isn’t new. Nor is UCLA’s leadership in the effort. A similar movement took hold in the 1990s, with the UCLA kidney-transplant program serving as a national benchmark for its ability to produce the best results with the greatest efficiency through standardized practices. UCLA’s place at the forefront of the movement has remained constant. This was illustrated most recently when UCLA Health was selected by the Centers for Medicare and Medicaid Services (CMS) as the only academic medical center in California to sponsor and participate in the federal government’s Medicare Shared Savings Program as an accountable care organization — working with the CMS to enhance care coordination as a way to provide high-quality service and care to Medicare fee-for-service beneficiaries while reining in costs.

What’s changed in the last decade, both nationally and at UCLA, has been the enhanced focus on efficiency in the face of growing concerns about healthcare spending. “We have not been on a sustainable path,” says Dr. Skootsky. “Society is telling the healthcare industry that we have to figure out ways of doing this better and less expensively. With a standardized, evidence-based approach to care, we can have a higher level of confidence that we aren’t utilizing unnecessary resources.”

Wide variations in cost for the same procedures across institutions, and even within the same institution, provide strong evidence that new efficiencies can be achieved. “You can study 20 different surgeons and find that the costs of delivering financial data across the UC sites. One of the projects has focused on reducing atrial fibrillation, a postoperative arrhythmia that can cause stroke, keep patients in the hospital longer and require expensive and invasive care. The group has found that assigning patients to low-, intermediate- and high-risk categories based on risk factors and then treating high-risk patients more aggressively with prophylactic therapy reduces the incidence of atrial fibrillation more efficiently. Other areas being addressed by the consortium include blood conservation, swallowing difficulties after heart-surgery intubations and protocols for discharge and follow-up to prevent hospital readmissions.

“The established norms for treatment represent the status quo,” Dr. Shemin notes. “By querying our robust database to look for trends and assess what happens when patients are treated outside the established norms, we can find ways to improve on practice guidelines.”

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a joint-replacement operation vary dramatically, even when the unit prices and patient-acuity levels are the same,” Dr. Rosenthal notes. “That tells us that if we were able to reduce that variance, we would have a more-efficient health system, with more resources available for other things.”

At the individual patient level, Dr. Yeh argues, the issue is value, not cost. “People aren’t looking for the cheapest care possible, because that would be no care at all,” he says. “We need to be able to provide the highest-quality care for the lowest-possible cost.”

Dr. Yeh found in his study that moving simple operations out of the hospital to the outpatient-surgery center cut costs in half. “Those patients are getting the same quality, if not higher quality, because we can streamline the operation so that many of them go home the same day,” he says. “By holding the quality constant and dropping the cost by half, we double the value.”

Standardization also makes it easier for health systems to measure their performance. “If 100 people have a gall-bladder operation, and each time you improvise — using slightly different medications, different lab tests, different vital signs — you don’t have a controlled experiment that you can look back at in a year,” he says. “That makes systematic improvement impossible.”

Beyond affording accountability, standardization promotes advances in care through testing the effects of incremental changes against a backdrop in which all other aspects of care remain constant.

The potential for standardization to improve the quality and efficiency of care at UCLA is bolstered by the health system’s electronic health-record (EHR) program. Instituted in 2013, the EHR enables the records of UCLA Health patients to be immediately accessible, regardless of where the patients are seen, and facilitates standardization across the enterprise in the way medical information is stored and accessed. Beyond that, UCLA’s EHR provides clinical-decision support to make it easier for providers to follow evidence-based approaches. More than 1,000 standardized order sets, designed by UCLA clinicians, are used in both the hospital and ambulatory settings.

“As you see patients with specific medical problems, you can call up one of these evidence-based order sets, and it will guide you through the care of the patient,” explains Michael Pfeffer, MD (RES ’07), assistant clinical professor of medicine and chief medical informatics officer, who was the lead physician in implementing UCLA Health’s EHR. Active clinical-decision support is also provided in the form of alerts. Providers are notified of everything from potentially dangerous drug-drug and drug-allergy interactions to notifications specific to the patient’s disease state or health-maintenance needs, such as reminders of when an influenza vaccine or cancer screening is due.

The EHR also makes it possible to conduct the types of systematic analyses that can inform quality-related efforts. “We’re able to look at gaps in processes based on evidence,” Dr. Pfeffer explains. “It helps us identify opportunities for improvement across our enterprise in a much-faster, more data-driven way.”

IDEALLY, STANDARDIZATION OF CARE PROMOTES ADHERENCE to evidence-based medicine, making decisions about patient care supported by the best-available research findings. But there are many aspects of patient care that have been studied inadequately, if they’ve been studied at all. “It’s easy to say that we’re going to only practice evidence-based medicine,” Dr. Skootsky says. “The problem is that there isn’t strong evidence for every situation.”

In such cases, clinical teams will often get together in an effort to agree on what is the best practice so that decisions don’t come down to individual preferences. Another approach, increasingly applied at UCLA and other major institutions, involves bringing clinicians together, agreeing on a protocol, applying it systematically, tracking the data and then learning from the results. Where applicable, input is collected from...
patients about what’s important to them before deciding on the new protocol. “Standardization is very consistent with an agenda that pushes for more shared decision making and getting patients involved in the design of care delivery,” Dr. Skootsky notes.

To enhance the value of the care it provides for common conditions, the UCLA Department of Urology has conducted research on patients’ preferences and their experiences with treatment at UCLA. The initiative began with a focus on benign prostatic hyperplasia (BPH), a noncancerous enlargement of the prostate that is common as men get older and can lead to bothersome urinary symptoms. “We were offering at least five surgical therapies for that indication, and patients were often confused about what to do, which was a source of dissatisfaction for many of them,” says Christopher Saigal, MD ’94 (RES ’00, FEL ’01), MPH, vice chair of the department, who has headed the effort.

The survey of patients revealed some surprising findings that led to changes, Dr. Saigal says. For one, patients were more concerned than the UCLA urologists realized about having to use catheters at home after surgery. To address that concern, the department created a video on catheter management that became the most-widely visited page on its website, drawing thousands of views each month. The department also instituted shared-decision-making processes to assist patients in coming to treatment choices consistent with their preferences and the evidence, and it produced a video for referring physicians on how to optimally manage patients with BPH prior to referral for potential surgery.

Finally, drawing from the EHR database, dashboards have been created for individual physicians comparing their outcomes across BPH therapies. Measures include infection rates, emergency-room visits, hospital-readmission rates and the rate of patients returning to medical therapy, as well as each physician’s costs for delivering each service. This enables the physicians to make value-based recommendations to their patients, Dr. Saigal notes. Similar efforts are underway for prostate- and bladder-cancer treatments.

“Standardized protocols, enabled by the immense amount of observational data we’re getting through electronic health records, can make a big impact on improving care,” Dr. Saigal says. “But they have to be informed by patient input and designed with patients’ goals in mind. Patients have different preferences, and the pathways must incorporate those.”

Daniel Hommes, MD, PhD, director of the UCLA Center for Inflammatory Bowel Diseases and quality director of UCLA’s Division of Digestive Diseases, says that the value-based care pathways his group has instituted are “creating structure out of organized chaos.”

For a variety of chronic diseases — starting with inflammatory bowel disease and then moving on to conditions that include other gastrointestinal disorders, as well as diabetes, chronic back pain and rheumatoid arthritis — Dr. Hommes’ team has employed national and international practice guidelines as frameworks for standardized-care pathways. Using these as starting points, providers learn on a patient-by-patient basis which elements are most effective and where more emphasis needs to be placed. Then they adjust their patient’s care plan each year through a feedback loop informed by a “value quotient” — a measure that incorporates the annual burden of the patient’s disease, patient-defined quality of life and work productivity, divided by the cost of the care.

“When patients are running around from doctor to doctor getting all kinds of tests, that’s organized chaos,” Dr. Hommes says. “We start from the literature. Then we fine-tune the patient’s care each year based on the value quotient. We need those standardized-care pathways to capture meaningful data that will enable us to move toward personalized-care pathways.”

The idea that standardization can be used to enhance care based on patient preferences and experiences isn’t surprising to Dr. Yeh. “This isn’t one-size-fits all. The goal of standardization is to make sure the right patient is getting the right care in the right place at the right time for the right cost,” he says. “People complain that standardization promotes ‘cookbook medicine.’ What’s wrong with having a cookbook? Try to find one household that doesn’t have one.”

Dan Gordon is a regular contributor to U Magazine.
“That extra support and compassion is amazing. I’m so grateful that they were there for Ashlee and for us,” Jeannie Malabanan says of UCLA’s Children’s Pain and Comfort Care program.
At the End of Too-few Days

By Marina Dundjerski  •  Photography by Ann Johansson

No family should be alone when facing the death of a child. UCLA’s Children’s Pain and Comfort Care program helps them to endure the ordeal.

The news Jeannie Malabanan received in January 2014 was devastating. Following a year of difficult and aggressive chemotherapy for a rare bone tumor, the cancer at the base of her daughter Ashlee’s spine had metastasized to her brain. After a recurrence of her symptoms, Ashlee began to have seizures and was re-hospitalized at UCLA. The Children’s Pain and Comfort Care (CPCC) team was called in to assist. “They talked to us and supported us and provided Ashlee with as much quality care as was possible during this end-stage of her life,” Malabanan says. “Basically, they helped our family to process and survive this ordeal.”

Ashlee decided to forego further treatment and to stay in the hospital. “It was a hard choice for us to accept — as a parent, you want to keep your child alive for as long as you can,” Malabanan says. “But I know keeping Ashlee alive was not what she wanted. She didn’t want to just be breathing and not have any quality of life.”

In the two weeks that Ashlee was hospitalized, the CPCC team worked with her primary medical team and others to provide whatever assistance was possible. “They came by regularly to make sure her last days were as comfortable as possible, as she fell deeper into her terminal illness,” Malabanan says. “They let us know that we were not alone and that if we wanted them, they would be with us every step of the way.” The Chase Child Life Program of Mattel Children’s Hospital UCLA created a plaque with Ashlee’s palm print, and the CPCC team had her fingerprint replicated on more than a dozen pendants for family members to wear. When Ashlee lost consciousness, her wishes were known. Arrangements were made so that family members could stay with her, and until the end they never left Ashlee’s side. She was 21 years old when she died.

Since it was established in 2008, UCLA’s CPCC program, which is within Mattel Children’s Hospital UCLA, has worked to succor pediatric, adolescent and young-adult patients, like Ashlee, in their days of need and to help their families grapple with the unfathomable: the death of a child. While the broad-based CPCC team includes a psychologist, three physicians, nurse practitioner, social worker bereavement coordinator, chaplain, child-life specialist and administrative assistant, the front-line clinical-service team, including the physicians and nurse practitioner, sees some 200 patients a year in the hospital setting and another 325 patients through its outpatient clinic. Taking an interdisciplinary approach to address the core goals of care decisions, pain and symptom management and bereavement support, the team has a mission to enhance the comfort and quality of life for children with complex medical conditions and for their families. They work to relieve symptoms of disease or its treatment and to address psychological, social and spiritual needs.
At such difficult moments, “parents have many questions but sometimes are afraid to ask them,” says pediatric critical-care specialist Julianne Harrison, DO (FEL ’10), one of CPCC’s attending physicians. “One of the most-common questions they have is: ‘Will I be able to hold my child?’ Another is: ‘Can I take him outside?’” The CPCC team not only answers the questions and assists with such requests, when possible, but moreover, they also help provide comfort and understanding. Says Malabanan: “That extra support and compassion is amazing. I’m so grateful that they were there for Ashlee and for us.”

MORE THAN 10-MILLION CHILDREN in the United States live with chronic disease. Of these, 1.5 million have life-threatening illnesses. According to 2007 U.S. child-mortality data, approximately 53,000 children die each year from their illness — 25 percent before they reach 1-month old and another 25 percent between 1 month and 12 months of age.

While many hospitals have adult palliative-care and pain-management units, few have pediatric-palliative and pain-management teams to care for these young patients and the members of their families. Although the number of centers with such programs has been growing, many medical professionals believe it is not happening fast enough.

Among the increasingly loud voices calling for change is Stefan J. Friedrichsdorf, MD, medical director for one of the largest pediatric palliative-care programs in the country, at Children’s Hospitals and Clinics of Minnesota, and a pioneer in the field. “In the year 2014, pain management for children in the United States remains abysmal,” he says. “And the younger the child is, the less likely it is that the child gets appropriate pain medication.”

A significant issue, experts agree, is that society-at-large does not want to dwell on the thought of dying children, and support for pediatric palliative-care programs nationwide is lacking. Rather, the focus is on finding cures and saving children. Accepting a terminal diagnosis also is a challenge for parents and physicians, who are dedicated to the singular goal of helping and protecting the child. Even just the word palliative has difficult-to-overcome connotations when it is linked to a child. People perceive that requesting palliative care is akin to giving up, but that is not the case, UCLA and national authorities assert; it means that everyone involved — the patient, the family and the medical team — is hoping for the best outcome but preparing for the worst. “We can’t predict the future,” Dr. Friedrichsdorf says. “Some children do live for years in the end-stages of life. Palliative care means that we provide them with the best pain and symptom management that we can for whatever length of time remains for them.”

Palliative care for children indeed is highly specialized, and it varies a great deal from that of adults. Although characterized as “natural” for statistical purposes, a child’s death is, after all, never truly “natural.” “Children are expected to reach adulthood,” says Lonnie Zeltzer, MD, director of the CPCC. This can stir up a brew of emotional and psychological needs and special considerations. Unlike an adult’s, the needs of a child will vary greatly depending on his or her developmental stage. And the trajectory of illness to death is often longer and less predictable for a child than for an adult.

Which children should receive palliative care? Palliative care should be incorporated into the care of any child with a potentially life-limiting or medically complex condition, including children who are born with conditions they are not expected to survive or to live through to adulthood, notes Michaela Nalamliang, NP, CPCC clinical coordinator. But palliative care should not be limited to those with an expected limited life expectancy, she emphasizes. Palliative care should also be considered for those born with complex conditions with unknown or long-life expectancies, those who suffer trauma and those who acquire complex illnesses. “It is important to think about palliative care at all stages of illness — planning and re-planning goals of care with a focus on communication, quality of life and good symptom control. Advance care planning is a process, not an event.”
palliative care at all stages of illness — planning and re-planning goals of care with a focus on communication, quality of life and good symptom control,” notes Elana Evan, PhD, director of CPCC’s comfort-care research and program planning.

“Advance care planning is a process, not an event.”

From the moment the team is first consulted, it will review a patient’s entire medical history to know precisely what the patient has gone through and make recommendations to the child’s primary physician group on medication adjustments that can greatly ease a child’s symptoms and his or her pain. Earlier this year, the team was asked to consult on an infant who had been in the PICU for six months after a heart transplant. The young boy was constantly crying and agitated, and the nurses had a hard time approaching him. Nothing seemed to soothe him. When the team was called in, the physicians reviewed the baby’s medical history. A medication that was being administered at bedtime to help him sleep but which wasn’t doing much good was switched to the morning to help calm him. In addition, he was prescribed an anti-epileptic that is also administered to provide neuropathic relief. Gradually, the child calmed, and he has since been removed from breathing support and now is a playful child, although still medically precarious, the team says.

Team members stress that a CPCC referral is not a hospice referral, although transitioning to hospice care is an option with which the team will assist, if needed. In some instances, consultation with the CPCC is automatic. Such automatic consultation recently was implemented by UCLA’s pediatric bone-marrow-transplant unit for all of its patients. Children who need a bone-marrow transplant are at significant risk and often have distressing symptoms. The CPCC team is able to assess the best medication approaches and also recommend strategies such as massage or other non-medical soothing therapies.

Being brought in early for consultation on any case can make a significant difference, CPCC team members say. “It’s better when the family knows you for weeks or months,” Nalamliang says. The earlier the team can become involved, the better. Ideally, Nalamliang says, that connection is made at the time of diagnosis. “That allows our team the time to get to know the children and their families,” she says.

“Conversations about goals of care, particularly the provision of life-sustaining treatments, evolve more naturally when we have that relationship.”

Neil Wenger, MD ’84 (RES ’87, ’90, FEL ’89), director of the UCLA Health Ethics Center and chair of Ronald Reagan UCLA Medical Center’s ethics committee, agrees. “It really is critical because it creates a relationship early on with those who will be able to provide advice regarding symptom control,” Dr. Wenger says. “While they may not ultimately be needed for difficult end-of-life decisions, if they are, they are already well-known and integrated.” The situation is made more complicated when the patient is a child and not a decision maker, he adds. “By getting to know the patient and her family members, the members of the team are often able to integrate what the child would want and what the parents think is best for their child’s care.”

To accomplish this, UCLA’s team works closely with all facets of the healthcare community, including child life, social workers, spiritual care, as well as all medical departments from anesthesiology to transplant services. In addition, the team has close relationships with outside hospice providers and rehabilitation centers and also works to ensure appropriate arrangements for any transitions needed, whether for short-term or long-term care.

Sometimes the issues of care can become a tangle of conflicting wishes and desires. Not every member of a family may agree on what approach to take, or a child who is old enough to state his need may have different ideas than those of the parents. In some cases, it can be difficult for loved ones to perceive the child’s suffering, Dr. Wenger notes. In such situations, the team’s experience can be indispensable. The team also tries to help families to be at peace with their decisions and avoid regrets. Questions that are carefully addressed include such issues as intubation — the placement of a tube in the airway for a breathing machine — for example. One parent told Dr. Harrison that if she had known that her son, who was dying of cancer, would never be free from the tube and therefore never be able to talk again, she would not have agreed to intubate him. These are the difficult questions that the team tries to address beforehand. And whenever possible, when the child is a minor but has a sense of what he or she wants, the team tries to respect the child’s wishes by communicating with the parents.

“Their support has given us the ongoing tools to both grow and develop our innovative model as well as sustain the program as it exists today. They believe in us and the services we provide to pediatric patients, families and healthcare providers and want to see us thrive.”

– Elana Evan, PhD CPCC program director
“This team is invaluable,” Dr. Wenger says. “They are able to pull everyone together to focus on reaching the best clinical outcome that can be achieved and also to ensure that the family remains intact while reducing the suffering and preserving the dignity of their child.”

WHEN DR. ZELTZER ARRIVED AT UCLA, in 1988, she was dismayed to find there was no dedicated pediatric-pain service. She initiated such a service and began with postoperative pain management. She also established a pain-research program. In 1991, she started an outpatient clinic for children with chronic pain. “It soon became clear that in those arenas — outpatient and inpatient — we were seeing kids with very-complex medical conditions,” Dr. Zeltzer says.

Pediatric pain management is a relatively new field of the 20th century, Dr. Zeltzer says. “Our understanding of pain perception in newborns was quite stunted in the past. It was assumed that they did not feel pain. Obviously, we’ve learned a great deal, and we have come a long way since those dark days. A lot of children also are living longer now, surviving the NICU but needing multiple surgeries and other treatments. The concept of pediatric palliative care is even more recent than pain care for children. Pain and palliative care for children is not necessarily just end-of-life care. It’s much-more involved.”

Dr. Zeltzer’s innovations made UCLA one of only a handful of medical institutions in the United States focusing on pediatric pain and palliative care. In 2005, Dr. Zeltzer recruited Dr. Evan, then a postdoctoral fellow. Dr. Evan obtained a grant for $300,000 for three years to do a needs assessment, create a palliative-care interdisciplinary task force in the hospital and set up a program. The palliative-care program, under Dr. Evan’s leadership, began as a clinical service in 2008, and the pain and palliative-care research programs and the inpatient and outpatient pain and palliative-care clinical services were combined to become what is known today as the CPCC program.

Word of what UCLA was doing soon spread to other medical enterprises. “Everyone was calling me asking, ‘What did you do at UCLA? How can we do that?’” Dr. Evan recalls. Soon, she was organizing a network of Southern California caregivers who wanted to create pediatric palliative-care programs for their health organizations. Since then, CPCC has expanded, primarily due to additional grants and support from UCLA Health. The program continues to grow, and in 2014, the UniHealth Foundation awarded Dr. Evan and the CPCC a grant to create the Telemedicine Educational Program for Pediatric Palliative Care, which enables the team to provide outreach education and consultation through a pilot program at the Mattel Children’s UCLA unit at UCLA Medical Center, Santa Monica.

Today, policy changes implemented under the Affordable Care Act greatly aid palliative care. California was already at the forefront, having been one of the first states to recognize the need for comprehensive pediatric palliative care, according to the UCLA Center for Health Policy Research. The Nick Snow Children’s Hospice and Palliative Care Act of 2006, which was implemented in 2010 (and has been renewed until 2017), provides home-based palliative-care services in a rollout to 11 pilot areas, which currently include Los Angeles, Orange, San Diego and Fresno counties. The CPCC members continue to provide their expertise to push forward further reform.

In addition to helping on the statewide level, the team’s work was integral during the development of UCLA Health’s Advance Care Planning and Services Initiative, which aims to establish programs to ensure the excellence of end-of-life care throughout the spectrum of the health system’s services. In pediatric care, advance care planning provides the child and parents with control by giving them the information needed to make decisions. “Advance care planning does not take away hope,” Dr. Zeltzer says. “Rather, it increases the quality of the child’s life in whatever time remains for the child. It prevents complicated grief and gives the parents and child permission to say ‘enough.’” Advance care planning includes the identification of proxy decision makers as well as the clarification of communication preferences, the goals of care and which interventions — such as resuscitation and artificial nutrition — to utilize to meet those goals.

“CPCC is a mini version of our overall vision to integrate advance care planning at the earliest stages, when it focuses on values and goals,” Dr. Wenger says. “This provides a foundation on which to make treatment decisions and facilitate end-of-life care, if, in fact, it is needed.”
Every case is a lesson for the team. “Everyone is different,” says the Rev. Irene Johnson, pediatric chaplain at Mattel Children’s Hospital UCLA. “This team doesn’t dismiss anything. The members process everything they experience and try to make things better for the next time.”

THE RELATIONSHIP BETWEEN CPCC AND A PATIENT’S FAMILY extends beyond the child’s death. The team members remain on-call to families and help connect them with local services to aid in bereavement. In addition, any parent or sibling of a UCLA pediatric patient who has died can attend the Comforting Hearts Family Bereavement Group. The free group, which is supported by a grant from The Ralph M. Parsons Foundation and other sources and which meets twice a month at a church in Westwood that donates its space, is guided by Gina Kornfeind, MSW, MS, CPCC’s support and bereavement coordinator. Kornfeind, along with volunteer social workers and community volunteers, leads two sessions — one geared for parents and one for siblings.

For parents, themes tend to address issues such as how to deal with work again, how to interact with friends, how to handle holidays, relatives or traveling. Everything that is the “new normal,” Kornfeind says. That includes navigating difficult questions such as: How many kids do I say I have now? What about the possibility of having another child in the future?

For siblings, the support group includes sharing, as well as arts and crafts and a musical component. “The idea is for them to build trust and a sense of support with the staff and with one another, to feel connected with other kids who are also grieving, to learn how to cope with this loss and also to have some normal fun and camaraderie again,” Kornfeind says.

Ashlee Malabanan’s mother attends the meetings regularly. “It gives us a place where we talk about the way we feel and understand that each of us has been there,” Jeannie Malabanan says. “We can talk to other people in our lives about our feelings and experiences, but they really don’t get it because they haven’t been there. So this makes a huge difference. It’s a safe place for us to talk about how much it hurts and how we deal with it every day.”

Two months before she died, Ashlee, unbeknownst to her family, created a Website to raise money for her care, thinking she would need additional funds. In a short time, she had raised $8,000; her mother has donated the funds to help expand the bereavement program. Says Malabanan: “No family should be alone while processing the end of life of their child.”


To view a photo slideshow about the Comforting Hearts Family Bereavement Group, click on the link to this article at: magazine.uclahealth.org
Dr. Joshua Tobin, MD, knows what it’s like to serve on the front lines of medicine — and battle. The assistant professor of anesthesiology at the David Geffen School of Medicine at UCLA and commander in the U.S. Navy Reserve has been on his third overseas deployment, this time serving as head of anesthesia/critical care at the NATO Role 3 Multi-National Medical Unit (MMU) hospital at Kandahar Airfield in Afghanistan.

The Role 3 MMU operates like an intensive care unit, accommodating up to 15 patients with injuries ranging from severe bone fractures to severe wounds and who typically stay no more than 24 hours — long enough to undergo surgery and become stabilized before an air-transport team takes them to hospitals in Bagram, Northern Afghanistan, or Germany to recover. “We’re in a forward area, and we want to get the wounded out of here as quickly as possible,” Dr. Tobin says.

Speaking via FaceTime over the Internet from his office in Kandahar, Dr. Tobin appears comfortable and relaxed in his military fatigues, despite the 12-hour time difference and his disappointment over missing his daughter’s first communion earlier in the day. Deployed in November 2013 and not due to return home until the following September, Dr. Tobin uses FaceTime to stay connected with his wife, Nicole Tobin, MD, a pediatric infectious-disease specialist at Children’s Hospital Los Angeles, and their three children, ages 10, 8 and 6.

“I send them postcards and little presents, and they send me pictures that I put up in my room,” Dr. Tobin says. “FaceTime makes the separation a little easier, but honestly, it’s very hard — though probably hardest on my wife because she has to work and take care of three kids and a dog while I’m over here.”

A hardened structure with a roof, a floor, walls, plumbing and electricity, the MMU where Dr. Tobin works is “very different from Ronald Reagan UCLA Medical Center, but it’s actually a nice facility,” he says. “I’ve worked out of tents on forward deployments, but here we have X-ray machines and CT scanners. It’s not fully electronic like you’d see back home, but it is pretty darn close.”

The MMU’s adaptable physicians make up for whatever the hospital may lack in equipment. Earlier this year, Dr. Tobin was among six medical-team members who received a Romanian Medal of Honor for the lifesaving treatment they provided a group of Romanian soldiers severely wounded by an improvised explosive device in March 2014.

Before coming to UCLA, in 2012, Dr. Tobin was an assistant professor at the University of Maryland School of Medicine’s R Adams Cowley Shock Trauma Center. Previously, he was an attending anesthesiologist at Santa Clara Valley Medical Center in San Jose, California, and an affiliated clinical instructor in anesthesiology at the Stanford University School of Medicine.

The first member of his family to join the military, Dr. Tobin was in his residency in neurosurgery at the Medical College of Virginia during 9/11, and in 2003 he joined the U.S. Air Force Reserve. “When the war kicked off, I felt very strong that we needed to have good people taking care of our guys over there,” Dr. Tobin says. “Not wanting to argue with my own logic, I said, ‘well, if you feel that strong, you probably ought to join.’”

During the next seven years, Dr. Tobin served as a flight surgeon for the 24th Special Tactics Squadron, completing deployments in the Philippines as team leader of a special-operations critical-care evacuation team and in Afghanistan as team leader of a critical-care air-transport team that performed...
28 combat sorties. “In the Philippines, I worked with the medical civil-action program, and it was great because you really got to interact with the local people, giving clinical aid to those who really needed it,” he says. “When I was in Afghanistan, in 2010, I worked with the critical-care air-transport team, dealing with the aeromedical evacuation of casualties. So I have been able to see firsthand how far we have come since then in relation to trauma and patient care, and it is quite phenomenal.”

In 2010, Dr. Tobin switched to the U.S. Navy Reserve and became a diving medical officer for SEAL Team Seventeen, based at Coronado, California. “Basically, my job with them is taking care of diver fitness and making sure no one gets the bends,” Dr. Tobin says. “I love doing it and consider it an honor to work with the SEALs.”

At UCLA, Dr. Tobin’s research interests are closely aligned with his military experience. He co-authored a checklist for trauma anesthesia and published a paper on a novel critical-care transport approach for evacuating wounded combatants from the battlefield; his methodology, involving the use of trauma bays in evacuation helicopters, has been adapted from Great Britain. “The British have demonstrated better outcomes with sicker patients with the Medical Emergency Response Teams (MERT) method,” Dr. Tobin says. “Some colleagues and I are pushing to have the U.S. military adopt the MERT method of critical-care transport.”

Dr. Tobin says he feels lucky to serve his country and is glad he can apply the knowledge he’s gained from his military service to improve civilian trauma care. “I am very fortunate to be able to see both sides, civilian and military, of the treatment of patients and critical care,” he says. “Advances in medicine have always been at the end of war. The lessons we are learning from war-time medicine will definitely help the overall improvement of trauma care on the civilian side.”

Kim Kowsky is a freelance writer in Los Angeles.
Michael Rodriguez, MD '88, MPH, is professor and vice chair for global health in the Department of Family Medicine at the David Geffen School of Medicine at UCLA, co-director of the University of California Global Health Institute Center of Expertise on Migration and Health and founding director of the UCLA Blum Center on Poverty and Health in Latin America. His research activities focus on health inequities, including violence prevention, chronic diseases, such as diabetes and obesity, and efforts to strengthen the health system and develop partnerships with other institutions and stakeholders. He has authored articles and lectured internationally on a wide range of health issues. He also collaborates with the World Health Organization, UNICEF, the Pan American Health Organization and the Inter-American Development Bank. Dr. Rodriguez mentors and teaches UCLA faculty and trainees from numerous schools while volunteering at a community health center serving uninsured patients in Los Angeles.

Today, UCLA is improving global health by nurturing a new generation of leaders and by providing clinical, research and humanitarian training for medical students, residents, fellows and faculty. When I attended medical school at UCLA, in the
mid-late 1980s, global health was a concept not yet woven into medical training. As someone who identifies with Don Quixote’s sense of undertaking adventures for noble causes, I had the desire to make a difference beyond the boundaries of Westwood.

I am a child of immigrants from Mexico and El Salvador and the first in my family to graduate from high school. I grew up learning the value of advocating for the rights of disenfranchised communities to promote equity. During my second year of medical school, I acted on my strong commitment to support population-responsive medical pipelines by organizing a campaign to obtain donations for a new medical school in Managua, Nicaragua. The school, Universidad Nacional Autónoma de Nicaragua (UNAN), was being built to address the need for more health professionals to serve the country. I became aware that the new medical school needed equipment for the students, so I solicited and received donations of microscopes and teaching slides, as well as a microtone and materials to make new slides, from UCLA, as well as from the UCLA departments of pathology and laboratory medicine and anatomy. The summer between my second and third years, I hand-delivered the equipment to UNAN and met the dean of the medical school. It is difficult to put into words the emotions I felt or the impact that this undertaking, and the support I received from the UCLA School of Medicine (now the David Geffen School of Medicine at UCLA), had on me. Certainly, this project set me on the path I have taken in my professional life.

Fast forward almost three decades, and I’m still promoting exchange to create positive change. In March 2014, in my role as founding director of the UCLA Blum Center on Poverty and Health in Latin America, I returned to Managua to meet with the current UNAN dean to establish a collaborative relationship between UNAN and the UCLA Blum Center to build health and training programs that will benefit the people of Nicaragua, as well as UCLA trainees. The dean took me by the same mango tree and the same office I visited 29 years prior. It was a déjà-vu experience. I feel I have come full circle and I am inspired to collaborate with colleagues at UCLA and other locations in the United States, Latin America and beyond. My goal is to identify and advocate for effective responses in health policy and practice in order to improve the health and healthcare in Latin America and in the areas to which those from Latin America immigrate.

To learn more about the UCLA Blum Center, go to: blumcenter.ucla.edu
Kevin Teehee, MD ’97, is one of 250 Native Americans actively practicing medicine in the United States. After completing an internship in general surgery at UC Davis and a residency in family medicine at USC, he was selected as the first full-time medical director at American Indian Health & Services Clinic in Santa Barbara, California. Dr. Teehee also has served as California representative for the Executive Council on the National Council of Clinical Directors for the Indian Health Service. He was awarded the Outstanding Model Program Award from the Association of American Indian Physicians and honored by the organization as its Outstanding Member Affiliate. Recently, he returned to the American Indian Health & Services Clinic to serve on its board of directors.

My roots are from the Cherokee Nation of rural Oklahoma. Although my parents both attended government Indian boarding schools from the age of 8 and never returned home, they passed on the Cherokee heritage and values to my brother and me. I grew up in rural Northern California, attended UC Berkeley and was motivated to be a physician by the traditional Cherokee values of generosity and emotional, physical, spiritual and social well-being. I can assure you that no one who knew me in my youth would have guessed that I would have ended up an accomplished doctor in a big city.

When applying to medical school, I was immediately attracted to the Charles Drew/UCLA Medical Education Program because of its mission to transform the lives of underserved communities through health education, biomedical research and compassionate patient care. I did not want to attend any other school. I identified with this patient population because it was similar to my family and hometown community. My entire medical career has been spent providing quality healthcare to the underserved. I truly enjoy practicing clinical medicine in this setting.

The part of medicine I am still most passionate about is the first challenging seconds of meeting an apprehensive patient who may be distrustful of doctors, receiving information through a translator or frightened by the uncertainty of their medical condition. I intentionally use words that will make the patient and family members comfortable and will give them confidence in the care they will receive. Often, I use humor. If I can get the patient to crack a smile, then the rest is easy.

For more information about the American Indian Health & Services Clinic, go to: aihscorp.org
Postcard from Mozambique

Daniel DeUgarte, MD ’97 (RES ’05), is associate clinical professor of surgery at the David Geffen School of Medicine at UCLA. He trained in general surgery at UCLA and in pediatric surgery at the University of Michigan, Ann Arbor. In 2013, he earned a Master of Science in clinical research and a Global Health Certificate from UCLA. Dr. DeUgarte now serves as co-director of the Global Health Education Programs, one of the major initiatives of the UCLA Center for World Health. In 2010, he was invited by Lee Todd Miller, MD, vice chair for education in the Department of Pediatrics and director of the Global Health Education Programs, to join a Partners for Pediatric Progress trip to Mozambique to help provide training in pediatric surgery. Dr. DeUgarte has returned to Mozambique seven times since his first trip.

When I first traveled to Mozambique, in 2010, there were only 10 local pediatricians and one general surgeon dedicated to the care of the country’s 10-million children. Inspired by the work that Dr. Miller was doing in pediatrics, I decided to devote a portion of my career to making a sustainable impact on pediatric surgical care in Mozambique by helping to build local capacity. The rewards of my training and proctoring trips over the years have been immense. As an example, I helped a young local surgeon, Vanda Amado, MD, perform her first repair of a complex cloacal birth defect. Dr. Amado and I were so grateful for the opportunity to help this beautiful infant girl and her family. However, without reliable anesthesia support and postoperative care, our operations have not always been successful. Operating in Mozambique has also required that we creatively find solutions to address limited supplies. For example, we have utilized a 50-cent thermostat wire and a $200 nerve stimulator in place of a commercial $10,000 muscle stimulator to evaluate the anal sphincter complex in our repairs of anorectal malformations. These experiences also have given me perspective on excessive healthcare costs and wastefulness in the United States. I now have a much-better appreciation for how the Mozambican physicians have adapted to the local environment, and I am invigorated to contribute to developing the health system as a whole. Now, there are two trained Mozambican pediatric general surgeons and three additional ones in training. The partnership I established has expanded to include multiple exchange programs, as well as quality-improvement and research activities. Our support has come from Mending Kids International, the Centers for Disease Control and Prevention, the President’s Emergency Plan for AIDS Relief, Sun West Mortgage Co., Inc., and from the generosity of other philanthropic sources.

I have no doubt that our students return home with more humanism, a richer cultural sensitivity and an even-greater commitment to working with underserved populations here in our own backyards — and I’m proud to contribute in this arena as well.

With the establishment of the UCLA Center for World Health by A. Eugene Washington, MD, MSc, vice chancellor of UCLA Health Sciences and dean of the David Geffen School of Medicine at UCLA, it is an incredible time to be involved in global health at UCLA. When I was a medical student, global-health opportunities were not readily available. Now, students can competitively apply for supplemental funding to participate in research and clinical experiences abroad.

For more information about the UCLA Center for World Health, go to: worldhealth.med.ucla.edu
UCLA Chancellor Gene Block recently awarded two friends of the university and UCLA Health Sciences — James L. (Jim) Easton and David Geffen — with the UCLA Medal in recognition of their long-standing support and advocacy on behalf of UCLA. The medal is the highest honor the university gives to an individual for extraordinary achievement. It is conferred on those with exceptionally distinguished academic and professional achievement whose bodies of work or contributions to society illustrate the highest ideals of UCLA.

In honor of Easton’s (UCLA ’59) tireless devotion to his alma mater, Chancellor Block presented Easton, a top manufacturer of athletic equipment, with the UCLA Medal on May 8, 2014. Easton received his BS degree in engineering from UCLA in 1959, and for the last five decades he has made extraordinary contributions to the university and the global community. In 2008, he made a $10-million donation in honor of his mother, naming the Mary S. Easton Center for Alzheimer’s Disease Research at UCLA. The UCLA Easton Center also includes the Jim Easton Consortium for Alzheimer’s Drug Discovery and Biomarker Development, a separate research program funded by Easton. In addition, he has supported programs in athletics, management and technology. The UCLA Medal citation presented to Easton states: “In addition to philanthropic gifts, you have lent immeasurable hours of service and strategic guidance, elevating UCLA’s ability to provide competitive learning opportunities and hasten critical research in medicine.”

During the David Geffen School of Medicine at UCLA Hippocratic Oath Ceremony on May 30, 2014, Chancellor Block presented the UCLA Medal to Geffen, entertainment executive and philanthropist. “David Geffen exemplifies the spirit of optimism and innovation that is the hallmark of UCLA,” Chancellor Block said. “By advocating for the arts, healthcare and human rights, he has served as a powerful force for enhancing human welfare and as an exemplary role model in the UCLA community.” In 2012, Geffen — a former regent of the University of California — established the $100-million David Geffen Medical Scholarships, which cover the entire cost of medical education for nearly 20 percent of entering students, enabling them to pursue their dreams and graduate debt-free. In 2002, he made a landmark $200-million unrestricted gift to UCLA’s medical school — at the time the largest gift ever given to UCLA and to the University of California and the largest single donation ever made to a United States medical school. The funding helped propel the David Geffen School of Medicine at UCLA to its current status as a world-class institution for education and research. In 1995, he donated $10 million toward UCLA’s Westwood Playhouse, which was renamed the Geffen Playhouse, and he serves on its board of directors.
In a special, private ceremony, Dr. David T. Feinberg (RES '92, FEL '94), president of UCLA Health System, presented longtime UCLA benefactor Robert Draine with a Dean’s Letter of Proclamation for his ongoing support of the David Geffen School of Medicine at UCLA — particularly the UCLA Division of Geriatrics and the UCLA Longevity Center. Draine has contributed more than $550,000 to the university and was the creative force behind the development of several successful programs. In addition, numerous friends he has introduced to these important UCLA programs have contributed additional resources.

When Draine wanted to honor his late wife, Patricia, who suffered from Alzheimer’s disease, he provided the impetus to establish the UCLA Alzheimer’s and Dementia Care Program. He has been involved in numerous efforts to promote and expand the program, as well as raise additional funds. In addition to his personal contributions, he engaged James Collins to provide a lead gift for the program. Draine was instrumental in developing a method for patients to communicate electronically with physicians through a secure website, which promoted doctor-patient relations and gave physicians the ability to electronically prescribe, thus bringing in additional clinical revenue. In addition, his funding named a patient room in the north wing of UCLA Medical Center, Santa Monica in memory of Patricia Draine.

UCLA Health Sciences Honors Robert Draine

UCLA surgeons Drs. F. Charles Brunicardi (left) and Ronald W. Busuttil. Photo: Reed Hutchinson

Dr. F. Charles Brunicardi, Moss Foundation Chair in Gastrointestinal and Personalized Surgery and chief of general surgery at UCLA Medical Center, Santa Monica, showcased the UCLA Personalized Surgery Program at a combined lecture/music event hosted by the UCLA Division of General Surgery at UCLA’s Fowler Museum on June 25, 2014.

“The Intersection of Medicine and Music” featured a presentation by Dr. Brunicardi on innovative trends in personalized surgery. The evening also included music from Dr. Brunicardi’s CD, Where Sunset Meets the Beach.

Attendees included Dr. Ronald W. Busuttil (RES ’77), William P. Longmire, Jr. Chair in Surgery, chief of the Division of Liver and Pancreas Transplantation and director of the UCLA Pfleger Liver Institute; Dr. Joe Hines (RES ’97), Robert and Kelly Day Chair in General Surgery and chief of the UCLA Division of General Surgery; Dr. Mark S. Litwin (FEL ’93), Fran and Ray Stark Foundation Chair of the Department of Urology; and potential donors.

The division is at the forefront of personalized surgery, which has enormous potential to transform surgical care. The pioneering technique utilizes the latest genomics and targeted therapies, based on each individual’s molecular profile.

Dr. F. Charles Brunicardi enhanced his lecture on personalized medicine with selections from his CD of original music. Photo: Reed Hutchinson
Art and Science Take Flight at the Space Shuttle Pavilion

On July 12, 2014, against the backdrop of the Samuel Oschin Space Shuttle Endeavour Pavilion in the California Science Center, co-chairs Loic Bailly and Ted Gagliano, president of feature post production at 20th Century Fox, brought together hundreds of members of the entertainment industry, as well as UCLA physicians, research staff, patients and their family members, for the 2014 Golden Portal Awards. Gagliano and Bailly launched the annual event, which recognizes and honors the art and science of film and medicine, three years ago. They have raised nearly $450,000, in addition to their personal commitment of $1 million, to support the innovative clinical trials led by Dr. Linda Liau (RES ’97, FEL ’98, PhD ’99), director of the UCLA Brain Tumor Program. The trials develop new, personalized therapies to train the body’s immune system to recognize and eradicate brain cancer.

The 2014 awards included:
• Best Film Science: Gravity
• Tom Sherak Best Film Innovation: Adobe Premiere Pro
• Tenacious Discovery: Dr. Susan Bookheimer, professor-in-residence in the UCLA Department of Psychiatry and Biobehavioral Sciences
• Tenacious Bravery: Brian O’Connor
Tenacious Discovery award-recipient Dr. Susan Bookheimer demonstrates advances in brain mapping made at UCLA.

Actress June Lockhart (left), star of 1950s and ’60s hit TV shows *Lassie* and *Lost in Space*, presents the Best Film Science award for the movie *Gravity* to Warner Bros. representative Darlene Gorzela.

Representatives from Adobe Premiere Pro, recipients of the Tom Sherak Film Innovation honor, pose with their award in front of Endeavour.

(From left) Co-chairs Ted Gagliano and Loic Bailly, Tenacious Discovery award-recipient Dr. Susan Bookheimer, Tenacious Bravery award-recipient Brian O’Connor and Dr. Linda Liau, director of the UCLA Brain Tumor Program.
More than 600 people attended the 7th annual Dealing for Duchenne Texas Hold ‘Em poker tournament and silent auction on May 10, 2014, at Sony Pictures Studios. The star-studded event raised $650,000 for the Center for Duchenne Muscular Dystrophy at UCLA, one of a handful of facilities in the nation offering comprehensive care, clinical trials and translational research for Duchenne muscular dystrophy. American Idol finalist Jessica Sanchez, the Canadian quartet The Tenors and Grammy Award-winning musician/producer David Foster provided live music and entertainment at the gala, hosted by Mad Men actor Joel Murray.

Hard Rock Café co-founder Peter Morton presented Dr. David T. Feinberg (RES ’92, FEL ’94), president of UCLA Health System, with the Meyer-Whalley Instrument of Change Award for his support of the center. The award is named for Tom Whalley, former CEO and chairman of Warner Bros., and his wife Melanie Meyer, who were instrumental in raising money to launch the Center for Duchenne Muscular Dystrophy at UCLA.

Duchenne muscular dystrophy strikes one-in-3,500 boys, weakening their muscles until they lose the ability to move and breathe on their own. UCLA researchers and physicians combine their efforts to extend the lives of children with the deadly genetic disorder. Dealing for Duchenne was launched seven years ago by local parents Amy and Chris Martin, who have a son affected by the disease. Proceeds from the event have led to promising experimental therapies.
It takes a visionary philanthropist with a strong conviction about what is possible to recognize the potential of pioneering research. Agi Hirshberg is one such person. Her nearly $5-million investment in UCLA over an 18-year period has yielded a return of more than 11 times that amount in support of novel investigations that have had a profound impact on pancreatic-cancer research and care. Following the loss of her husband Ronald S. Hirshberg to pancreatic cancer in 1997, Hirshberg was determined to respond in a meaningful way. She founded the Hirshberg Foundation for Pancreatic Cancer Research, which focuses on advancing pancreatic-cancer investigations and on supporting pancreatic-cancer patients and their families with information and resources.

UCLA was the beneficiary of the foundation’s first gift, which established the Ronald S. Hirshberg Translational Pancreatic Cancer Research Laboratory and the Ronald S. Hirshberg Chair in Translational Pancreatic Cancer Research. “Agi’s vision, dedication and key support have made UCLA pancreatic research one of the premier programs in the nation,” says Vay Liang W. Go, MD, distinguished professor of medicine, director, UCLA Center for Excellence in Pancreatic Diseases in the David Geffen School of Medicine at UCLA and editor-in-chief of the journal Pancreas.

The Hirshberg Foundation Seed Grant Program, established in 2000, is an extremely successful program that provides start-up funds for scientists with innovative ideas, enabling them to pursue new research that will lead to improved diagnosis, new treatments and a greater understanding of pancreatic-cancer cell biology. The seed funding allows researchers to take investigative risks and compile the necessary data needed to apply for funding from the government and other agencies. The foundation estimates this has resulted in $45 million in additional support for its national awardees.

Hirshberg received the 2013 American Pancreatic Association Distinguished Service Award for her commitment to pancreatic-cancer research, which includes the annual Hirshberg Award supporting young investigators in the field. Since 2010, she has hosted the Hirshberg Foundation Keynote Symposium, which assembles top researchers in the field of pancreatic cancer to discuss vital topics. The foundation sponsors the LA Cancer Challenge, an annual (October) 5K/10K walk/run launched in 1998, and the Tour de Pier, which started in 2013, both of which were created by Lisa Manheim and Jon Hirshberg in memory of his father.

A dynamic UCLA supporter, Hirshberg is the president of Women & Philanthropy at UCLA and serves on the UCLA Foundation Philanthropy Committee and the David Geffen School of Medicine at UCLA Board of Visitors. “Agi Hirshberg has had a major role in the growth and development of one of the busiest and most-successful clinical programs for the multidisciplinary treatment of pancreatic cancer in the country,” says Howard A. Reber, MD, distinguished professor of surgery, chief of gastrointestinal surgery and director of the Center for Pancreatic Diseases at UCLA. “She has turned her personal loss into a powerful positive force to help patients afflicted with this dreaded disease and their families.”
A thousand mourners gathered on July 5, 2014, at Forest Lawn Memorial Park in Glendale, California, to pay their respects to Paula Kent Meehan, who passed away on June 23, 2014. A dedicated philanthropist, Meehan was a generous contributor to numerous UCLA programs. Most recently, she donated $500,000 to establish Paula’s PetPal Place within the UCLA People-Animal Connection Program. The new service will allow patients who are hospitalized for extended periods of time to reunite with their own family pets in a specially designated exterior space at Mattel Children’s Hospital UCLA. Meehan, founder of Redken Laboratories, used her success to the benefit of people and animals.

Elizabeth Smagala Tate passed away on June 8, 2014, at the age of 38, after a 13-month battle with breast cancer. She attended the UCLA School of Law and met her husband Phil Tate during her time at UCLA. After graduating, she worked for two members of Congress and California Gov. Gray Davis. Most recently, she was in-house counsel at Kilroy Realty Corporation. Smagala Tate grew close to her care team at UCLA Breast Center, Santa Monica, during her treatment, and the family generously requested gifts in her memory to support the center.

On April 8, 2014, Robyn Faye Weinstein passed away at Ronald Reagan UCLA Medical Center. The daughter of Susan Pondfield (William Mentlik) and the late Dr. Mark Weinstein, she also is survived by siblings Dr. Stacey Weinstein, in residency at the David Geffen School of Medicine at UCLA, Carly Mentlik and Jacob Mentlik. Robyn Weinstein’s family created the Robyn Faye Weinstein Memorial Fund for Liver Transplantation as a lasting tribute to her life and to her unending desire to help others. Contributions of family and friends will help other liver-transplantation patients have a bright and productive future.

Chairs of Distinction

The Steven C. Gordon Family Foundation has pledged a gift to the Department of Neurology in the David Geffen School of Medicine at UCLA to establish the Steven C. Gordon Family Chair in Parkinson’s Disease Research. The Gordon family graciously made the donation in memory of Steven Gordon’s father, Benjamin Gordon, who was afflicted with Parkinson’s disease. Dr. Carlos Portera-Cailliau, professor in the Movement Disorders Program in the Department of Neurology, has been selected as the inaugural chair holder. The department celebrated the Gordon family’s gift and Dr. Portera-Cailliau’s appointment on May 19, 2014, with both Mr. Gordon and Dr. Portera-Cailliau in attendance, along with their family and friends. This important philanthropic contribution will provide long-term teaching and research support for distinguished faculty in the Department of Neurology.

In Memoriam

Paula Kent Meehan

A thousand mourners gathered on July 5, 2014, at Forest Lawn Memorial Park in Glendale, California, to pay their respects to Paula Kent Meehan, who passed away on June 23, 2014. A dedicated philanthropist, Meehan was a generous contributor to numerous UCLA programs. Most recently, she donated $500,000 to establish Paula’s PetPal Place within the UCLA People-Animal Connection Program. The new service will allow patients who are hospitalized for extended periods of time to reunite with their own family pets in a specially designated exterior space at Mattel Children’s Hospital UCLA. Meehan, founder of Redken Laboratories, used her success to the benefit of people and animals.

Elizabeth Smagala Tate passed away on June 8, 2014, at the age of 38, after a 13-month battle with breast cancer. She attended the UCLA School of Law and met her husband Phil Tate during her time at UCLA. After graduating, she worked for two members of Congress and California Gov. Gray Davis. Most recently, she was in-house counsel at Kilroy Realty Corporation. Smagala Tate grew close to her care team at UCLA Breast Center, Santa Monica, during her treatment, and the family generously requested gifts in her memory to support the center.

On April 8, 2014, Robyn Faye Weinstein passed away at Ronald Reagan UCLA Medical Center. The daughter of Susan Pondfield (William Mentlik) and the late Dr. Mark Weinstein, she also is survived by siblings Dr. Stacey Weinstein, in residency at the David Geffen School of Medicine at UCLA, Carly Mentlik and Jacob Mentlik. Robyn Weinstein’s family created the Robyn Faye Weinstein Memorial Fund for Liver Transplantation as a lasting tribute to her life and to her unending desire to help others. Contributions of family and friends will help other liver-transplantation patients have a bright and productive future.
The Division of Cardiology, the Division of Cardiac Surgery and UCLA’s Jonsson Comprehensive Cancer Center will share the philanthropy of The Baiz Trust. The $175,000 bequest honors the late Karl and Ruth Baiz, who had a particular interest in furthering research efforts in cancer and heart disease.

The John W. Carson Foundation has renewed its commitment to the Division of Pulmonary and Critical Care Medicine in the David Geffen School of Medicine at UCLA with a $300,000 gift to the Innovation Fellows Chronic Obstructive Pulmonary Disease (COPD) training program — one of the most prestigious training programs in the division. The funding will support one John W. Carson Foundation COPD Research Fellow per year for three years and is a key resource to the fellow’s research into discovering new ways to prevent and overcome emphysema and related diseases.

Casa Colina Centers for Rehabilitation has expanded its partnership with UCLA’s Department of Neurosurgery. Casa Colina has made a commitment of $210,000 per year for two years, which will support the research of two Casa Colina–Neil Martin Fellows. This gift will help accelerate the investigations of exceptional junior neurosurgery faculty members in the areas of stroke, neurobionics and brain injury, and will create an opportunity for joint research between UCLA and Casa Colina. The fellowships are named for Dr. Neil Martin, professor and W. Eugene Stern Chair of the Department of Neurosurgery. Over the past three years, the fellowship has had a significant impact on UCLA’s efforts to enhance and streamline surgical care and the recovery of its patients.

The Robert R. McCormick Foundation awarded a $1 million grant to support the UCLA Welcome Back Veterans Family Resilience Center under the direction of Drs. Patricia Lester and Shirley Glynn in the Jane and Terry Semel Institute for Neuroscience and Human Behavior at UCLA. The UCLA Welcome Back Veterans Family Resilience Center, a joint initiative of the McCormick Foundation and Major League Baseball, has at its core two interdependent components — research and services/education. Programs help enhance the psychological health and resilience of military and veteran families as they cope with the impact of wartime military service and with combat-related physical and psychological health injuries.

Ann and Jerry Moss have made a contribution to support the UCLA Voice Center for Medicine and the Arts in the Department of Head and Neck Surgery. Their gift will bolster the research and clinical-care efforts of department chair Dr. Gerald Berke (RES ’80, ’84), Victor Goodhill, MD, Chair in Head and Neck Surgery, and his colleagues.

Beverly and John W. Carson Foundation COPD Research Fellow, Victor Goodhill, and his colleagues.

Michael and Becky Neidorf with their daughter Isabel (center).

Becky and Michael Neidorff have made a very special commitment of $500,000 to honor their daughter by establishing the Isabel Neidorff Fund for Oligo Tumor Cures in the UCLA Department of Neurosurgery. Isabel, now 16, was diagnosed with an inoperable, slow-growing oligodendroglioma brain tumor when she was just 4 years old. Since then, the Neidorff family has built a relationship with their neurosurgeon, Dr. Linda Liu (RES ’97, FEL ’98, PhD ’99), director of the UCLA Brain Tumor Program. After many years of partnership with Dr. Liu, both in their daughter’s care and in advancing brain-tumor research, the Neidorfs have partnered with their friends and family to make this generous gift. The William R. Payden Fund for Glaucoma Research was established in honor of long-standing UCLA Stein Eye Institute benefactor, the late William R. Payden, after a gift of $575,000 from the William R. Payden Restricted Philanthropic Fund was made to UCLA through the California Community Foundation. This exceptional gift will have a great impact on the research of Joseph Caprioli, MD, chief of the Glaucoma Division of the Stein Eye Institute. In addition, the UCLA Division of Digestive Diseases received a William Payden estate gift of $150,000 to advance the division’s priorities under the leadership of co-chairs Eric Ersaiiian, MD, MPH, and Gary Gitnick, MD, FACC. This contribution will enhance the division’s critical research efforts, as well as its clinical and training initiatives.

The UCLA Longevity Center and the Department of Neurology’s Stroke Program received a $1.37 million bequest from Robert “Bob” M. Shirilla. The late Mr. Shirilla graduated magna cum laude in 1971 with a degree in economics from UCLA and earned his MBA with high honors from Harvard Business School. He was a strong supporter of the UCLA Longevity Center and served as an Advisory Board member. This generous gift will support cutting-edge research in the prevention and treatment of Alzheimer’s disease and stroke.

Longtime UCLA donor Allan E. Smidt has given $100,000 to support the research of Dr. Kevin Miller (RES ’91), chief of the Comprehensive Ophthalmology Division at UCLA’s Stein Eye Institute. This contribution will help further advancements in cataract research.

Harry Winston, Inc., has become the first corporate sponsor of innovative pediatric fellowships within Mattel Children’s Hospital UCLA. The company’s $1 million pledge to the UCLA Children’s Discovery and Innovation Institute will establish the Harry Winston Fellowship Fund to support the work of young pediatric physician-scientists who are conducting research to prevent, treat and cure disease and illness in children. The UCLA Children’s Discovery and Innovation Institute, founded to save lives and advance children’s healthcare around the globe, pioneers advances in pediatric medicine in four core areas of research: brain, behavior and development; nutrition, metabolism and growth; cancer and regeneration; and infection, inflammation and immunity.
There sometimes comes a moment when you realize that what you’ve always believed to be your greatest weakness is in fact the source of your greatest strength. For me, that awakening began to flicker when I first considered entering medicine as my college years were coming to a close. I had been studying literature and economics, and I figured I would probably end up going to law school or into academia. I was working summers as a lifeguard, and to boost my pay, I decided to become an emergency medical technician (EMT). On the first day of class, the woman sitting next to me noticed the scar peeking out from the top of my shirt, and she began to cry. “You had open-heart surgery,” she said, as she leaned into me. She was right on target; when I was 5 years old, a surgeon cut into my chest to enlarge the narrow pulmonary valve that controlled the flow of blood from my heart to my lungs.

“You don’t know what it means to me to see someone who is in their 20s going to college and doing well,” she said, telling me that her young daughter had a severe form of congenital heart disease and was about to undergo her third heart surgery in a few months. The woman was in the EMT class to learn what to do if her daughter had a medical emergency at home. After a couple more classes, she asked if I’d be willing to
meet her daughter and the rest of her family. Over a few meals together that spring, something changed for each of us. Her daughter opened up and seemed more playful. My new friend and her husband became more relaxed and more comfortable expressing tenderness toward their daughter. As I observed these changes unfold, I wondered if law or academia was really the right step for me.

I don’t look back on my heart surgery as a particularly traumatic or pivotal time. But I do remember the office visits, walking into the hospital on the day of my surgery, the smell of the hallways, the nurses, the doctors and the stuffed animals. After the operation, I was able to engage in the same activities as other kids; I swam competitively in the summer and put on ice skates in the winter and played hockey. In the summer months, my scar was much-more visible and some of the coaches on the teams I was on called it my “worm.” The coaches were being playful, but kids can be cruel when one has a difference, so I learned to protect myself and compensate the best I could. As a teen and college student, I was encouraged by my doctors to consider medicine, but that never felt like an option for me. I was a patient, not a physician.

Then came this chance meeting with this woman in an EMT class. Maybe my personal experience would help me to be a good physician. It felt like such a risk — this was not the path I had set out upon — and I was scared of organic chemistry and all the competitive pre-meds. My college mentors, however, believed that medicine would be a good fit and worth exploring. So I did what comes natural to all human beings: I avoided making a decision. I told myself that I would take a year off and then enter a pre-med program.

One year turned into two, and two turned into three. I found myself working in corporate America, writing speeches and news releases for executives. I enjoyed the work, but I wasn’t very good at it. One night, I stayed late to work on a frustrating project, and the next day defeat must have been written all over my face, because a woman in the office sat down at my desk and said to me, “Don’t let a car payment prevent you from going to medical school.” That was an odd statement, I thought, until she explained, “A decade ago, my car broke down and I bought a new car. Having that loan made it too hard to go back to school.”

The next week, I signed up for general chemistry, and while I struggled to adjust to a science curriculum, slowly it all started to come into focus. In the end, I trained as a hybrid of an adult and pediatric cardiologist, and today I care for patients with congenital heart disease from birth into adulthood, as well as children and young adults with heart transplants.

For the most part, I went through my medical training without revealing my personal history; I didn’t want my heart condition to be perceived as the reason I got into medicine. But as I later began to share my story with colleagues, I found that personal history plays an important role for many of us who choose to pursue medicine. Whether it is from an experience of childhood illness or cancer in the family or friends or loved ones with other grave medical conditions, there is a common thread that reveals human tenderness and offers a touchstone for us to connect and care for our patients.

And while early in my career, I didn’t want to tell patients about my history for fear they might feel it somehow deflected from their own experience, I couldn’t have been more wrong. Instead, I found that my patients open up more. They ask more-insightful questions and have a greater willingness to talk about issues that make them feel vulnerable. They are more willing to share their hopes and fears and to admit to behaviors that affect their care, such as non-compliance and drug use. And my patients hug me more. My school-age patients think it’s pretty cool that their doctor has a scar like theirs; my teen patients feel like I “get it;” and my adult patients lean on me to make good decisions and help them through life events like pregnancy.

When I look back on that chance meeting in my EMT class, I’m thankful for the woman who sat next to me and grateful that she allowed me to look beyond my own scar to discover my strength and find my life’s work and passion.
The Comforting Hearts Family Bereavement Group of UCLA’s Children’s Pain and Comfort Care program helps families to adjust to the “new normal” following a child’s death, says social worker Gina Kornfeind (right). For siblings, the goal is “for them to build trust ... [and] to feel connected with other kids who are also grieving, to learn how to cope with this loss and also to have some normal fun and camaraderie again.”