

The cover features a complex abstract design. On the left, there are overlapping organic shapes in red, green, yellow, and purple, some with a pixelated or mosaic-like border. A large, light green shape dominates the center. To the right, a dark, textured area contains a pattern of small, colorful triangles and squares. The overall composition is vibrant and layered.

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David Geffen School of Medicine at UCLA
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NOTE

from the editors

Welcome to this year's edition of the Beat. We are pleased to bring you the sixth edition of our one-and-only journal of art and literature. The Beat was established to showcase the many dimensions of talent on our campus, and this year was no exception. After collecting hundreds of photographs, paintings, and drawings, and dozens of poems, essays, narratives, and short stories from all corners of the campus, we assembled this year's edition.

Some gems were retrieved from research labs down long, dark hallways of CHS, while others came in from faculty, staff, and students from the Jules Stein Eye Institute, Transplantation Services, the Neuropsychiatric Institute, the School of Public Health, the Mail Room, Janitorial Services, and the departments of cardiology, neurosurgery, internal medicine, and pediatrics, just to name a few. It was a difficult selection process because of the volume of outstanding submissions we received. We want to thank everyone who sent us their work, and we encourage you all to submit again in the future.

Perhaps the greatest pleasure of compiling and arranging the work shown in the Beat was discovering the artistic connections between people, often times complete strangers, on campus. It was a pleasure to join the work of different artists, bringing together work with complementary themes and styles. We made an effort to highlight the connections between distinct pieces in our layout.

Equally gratifying for us was the opportunity to learn of the diverse inspirations and aspirations of each artist. Submissions often came with a description of what the piece meant to the author, or the story behind its creation. This provided insight into the emotional and intellectual growth that comes with creative expression.

Putting together the Beat was a creative endeavor that encouraged our own growth. In both the process and the final presentation of the journal, we exercised extensive creative license. Because the Beat is student-driven and still in its infancy, it is up to each year's editors to design the journal according to their own vision. This process can be both exciting and daunting. In the end, we were pleased to show off the talents of all the artists featured in these pages.

We sincerely hope you enjoy your trip through the Beat.

Sara Aree & Daria Crittenden

A View From Scripps
by Kevin Mouillesseaux



You Reading This: Stop

Don't just stay tangled up in your life.
Out there in some river or cave where you
could have been, some absolute, lonely
dawn may arrive and begin the story
that means what everything is about.

So don't just look, either:
let your whole self drift like a breath and learn
its way down through the trees. Let that fine
waterfall-smoke filter its gone, magnified presence
all through the forest. Stand here till all that
you were can wander away and come back slowly,
carrying a strange new flavor into your life.
Feel it? That's what we mean. So don't just
read this — rub your thought over it.

Now you can go on.

by William Stafford



Upper Yosemite Falls
by Nicole Rostoker



Prospect Park
by Ulrich Batzdorf, MD



Sky Between the Branches
by Daria B. Crittenden

Health Care Expedition to *La Puna, Argentina*

by Wendy Ruggeri, Cheryl Go, and Gabriel Aranovich

*Last spring, three UCLA medical students embarked on a journey to the northwest frontier of Argentina, the land of the *huaca*. They joined medical personnel and volunteers from around the United States and Argentina on the maiden medical mission to this underserved area. Inspired by Rosario Andrade de Quispe, a political activist from this remote area, and sponsored by an international healthcare group called Medical Wings in collaboration with UCLA and the University of Buenos Aires, they set out for the Jujuy Province of Argentina. Family and classmates donated money allowing them to purchase medicine to give away when they got there. They were stationed in the town of Abra Pampa for five days in the spring of 2003.*

The Jujuy Province is located in the northwest corner of Argentina. The zone known as La Puna occupies 60% of the province's territory and is located 3500 meters above sea level. It is a desolate, arid region whose inhabitants, who identify themselves as Kolla, are descendents of the great indigenous nations that populated South America before the arrival of Europeans. The region is so removed and isolated that in Argentine slang, "La Puna" has come to have a meaning similar to the American expression "the boonies." Thirty percent of homes are without water or gas. For many years the Kolla worked the great mines of the Andes Mountains. But when most of the mines shut down, the people of La Puna found themselves without jobs and, as a result, no way to house, clothe, and feed their families. To compound their difficulties, the Argentine economic and political systems have suffered one of the most infamous collapses in recent decades, resulting in unprecedented unemployment rates and a paucity of resources. In addition to these economic difficulties, the Kolla grapple with both geographical and cultural isolation from the rest of the country.

The Kolla suffer from desperately poor health. Access to healthcare is virtually nonexistent. The available health facilities suffer from lack of supplies, and people have a long way to travel for specialty or intensive care. Less than 20% of the population has any kind of insurance coverage that would allow them to seek treatment in the capital, San Salvador de Jujuy, even if they could travel the distance to get there. These disadvantages have devastating effects on the health of the Kolla. In particular, the region's women and children are suffering extremely high rates of fatal illness and mortality. Prominent causes of death among women in La Puna are cervical cancer,





complications from pregnancy and birth, septicemia, breast cancer, and leukemia. The incidence of cervical cancer in the region is estimated to be around 300 cases per 100,000 women. For comparison, the rates in the United States and Colombia are 9/100,000 and 50/100,000, respectively. Statistics also demonstrate a grave lack of infant health care: 7% of babies weigh less than 2500g (5.5 pounds) at birth, 18% are born underweight, and 58% are born prematurely. Infant mortality is greater than 40%. The local healthcare is simply unequipped to provide the necessary care. The few local hospitals are understaffed and lack resources and funds.

Rosario Andrade de Quispe has risen from this truly humble background to international recognition over the last decade. Growing up in the remote town of Abra Pampa, with no formal education, she has become a leader in the fight to preserve the lands and culture of her people. Most of all, she is fighting to get the Argentinean government to acknowledge and address the hardships suffered in this isolated part of the country. She is the reason this medical mission materialized. Rosario is the founder and leader of a women's organization known as Warmi Sayajsunqo, which is Quechua for "Resilient Women." She has campaigned relentlessly for national and international recognition of her community's plight. After learning of the Kolla's situation, three of us first-year UCLA medical students made a goal of alerting international medical aid groups to their cause



Our hope was to organize a trip to bring health care to La Puna. It took months of hard work and planning—much more than we ever thought. We had to find physicians and an organization that were willing to trust us and take on this endeavor. Preparing for the mission also involved getting to know the community of La Puna and its leaders from a

distance and, through email, contacting doctors, nurses, and potential financial donors and advisors. After endless meetings, our efforts culminated with the commitment of Medical Wings International to send a medical mission. One of their stipulations was that the UCLA students take part, so we packed our bags!

Our mission took place in the spring of 2003. The staff was composed of a dentist, an optometrist, a family physician, a pediatrician, several volunteer nurses, five medical students from the University of Buenos Aires, and the



pediatrician, and family doctor, with one room where medical students could do physical exams when there was an overflow of patients.

Individuals and families were bused in from the surrounding communities from morning until night for the five days we were in La Puna. Many of the patients waited all day and could not be seen on the first day, so they had to return on the following days from great distances. Many of the young adults were being seen for the first time in their lives. People arrived with complaints ranging from rotten teeth to pitting edema to respiratory infec-

three of us medical students from UCLA. We set up an impromptu clinic in the town of Abra Pampa, taking advantage of a small clinic that the town had recently built. Abandoned railroad tracks sliced through the center of the main street. Next to the tracks was a small building housing the clinic, with the inscription "Unidad Sanitaria" painted on the outside. The clinic did not have any medical equipment or personnel, but it did give us a place to set up our stations. We took over the five rooms in the building, setting up rudimentary examining tables in three of them, and using the outside area to take vital signs and histories. The rooms were occupied by the dentist, optometrist,





ultrasound—you name it. In these situations, education and prevention are the best tools to keep the community healthy, so there was an emphasis on equipping the patients with information they would need after we were gone. The group managed to see over 600 patients in those few days, sending many home with a supply of donated medications. A total of 350 pairs of donated glasses were given out, and a few patients with urgent



conditions were taken to the state capital for further care.

As first-year medical students at the time, this experience was one of tremendous learning, both about hands-on aspects of clinical medicine and about team work. We aided in Spanish translation, assisted the dentist in pulling out rotten teeth with little or no anesthesia, performed physical exams, and educated patients on how to manage their health best in spite of their living conditions. In addition, this trip sparked the interest of the medical students from Buenos Aires to organize new projects that will benefit this community. The trip was such a success that Medical Wings has also committed to returning. As for us, it was an exciting and deeply fulfilling experience to reach out to those in need and witness the positive effects on each person. Whether abroad or closer to home, we will never forget the immense rewards of providing medical care to those who need it most.

tion to ichthyosis. Because of their work, many miners were suffering the consequences of years of exposure to heavy metals, and many women who worked with llama wool were suffering from eye problems. The doctors on staff found themselves challenged by the lack of the diagnostic tools taken for granted back home. We did without x-rays, EKGs, blood tests,

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Banana Leaves

by Sung-Jae Lee, PhD and Truc Tang, MPH



Alaskan Sunset
by Mark Goodarzi, MD

Finding My Way by Joseph Gius

As I enter the trail it is dark. A rift in the clouds reveals a starry sky. Farther along, I see the silhouette of a coyote. High on the ridge, overlooking the sleeping city, lights defining avenues and boulevards, I compare my tiny place within the vastness of the heavens.

Is it not possible that I can find my way in this small speck of the universe?

I reach the summit. Savoring an apple, I observe the sky slowly evolve from black to a rumor of daybreak to a fiery red—engulfing the east and splashing its color on the clouds.

A jogger approaches. “Beautiful,” I say, pointing.

“Yeah, beautiful,” she replies.

On the way down the trail, I pass a proud and noble owl perched on a telephone pole.

He turns toward me, threatened by my presence. A rival bird takes up station on a post near him, and they fill the morning air with their cries.

I never get to see the majestic owl expand his wings and fly away. When I look again, he is gone.

Farther on, I reach a water tower and rest on an old, rusty pipe. The sky continues to change. Light comes. The clouds are filled with color. Slowly, a glowing orange-red globe appears.

It is a new day. The promise of a new beginning. Another chance.



Sip

by Melissa Gee

Say Goodbye

She said she'd sit on the rock,
didn't feel like sleeping,
and the tent too small for three.
Eyes, winking into the sun.
Come morning we thought,
she wandered off for awhile.
Forever it turned out.
Gone. Without a word or motion.

My dad did the same.
Commercial break, I went for drinks.
"Coke," he said. "The real thing."
Coming back I found him,
head down like quiet sleep.
Soundlessly into the future,
he left me alone in the present.

Sometimes when you're late,
clock ticking nervously,
I get the same dread sickness.
Thinking you've walked off,
with them into tomorrow.
If you ever do decide,
please, at least say goodbye.

SB2: EMPLOYER MANDATED HEALTH COVERAGE

California leads the way, but in which direction?

by Aaron Nayfack

In the weeks leading up to California's historic recall election, a flurry of bills were passed by the democratic-controlled state legislature and signed into law by Governor Gray Davis. SB2, a bill requiring employers to provide health insurance to employees, was passed and signed into law and has potentially enormous implications not just in California but for the nation as well. Unfortunately, with all the attention that was paid to the recall election, this bill became law without the attention it deserved. While the bill may in fact be groundbreaking relative to the rest of the nation, it may not go far enough in solving California's health care woes.

In brief, by January 2006, employers with over 200 employees will be required to offer health benefits to employees and their dependents. By January 2007, employers with between 20-199 employees will be required to offer benefits, but only to the employee. There is an exemption for employers with between 20-49 employees: they are only required to offer benefits if and when the state provides them with a 20% tax credit toward the purchase of coverage. For all businesses, employers will have the choice to either provide the coverage themselves, or to pay into a state fund that will then purchase the coverage for their employees. Those electing to provide benefits must cover a minimum of 80% of the premium on the policy; the employee pays for the rest. The cost of this coverage is tax-deductible for employers.

What does this mean for the ranks of the uninsured in California? As it turns out, not much. Current estimates vary but suggest that there are six to seven million uninsured individuals in the state. Even the most optimistic projections from the SB2 supporters estimate that the new benefits will cover no greater than 17% of those lacking coverage. One reason is the relatively small number of businesses to be affected. It is estimated that roughly 88% of employers in the state have less than 20 employees and will not be impacted, and 95% have less than 50 employees and will not have to pay unless a tax credit is provided. Of the 5% of companies with over 50 employees, it is estimated that 90% already provide

health coverage for their employees. When all is said and done, less than 2% of California businesses fall under the purview of the new law, and these businesses account only for about 6% of the labor force. In addition, this law does nothing for undocumented workers or for the ranks of the unemployed in the state (the latest numbers put this at slightly greater than 1 million people).

To be fair, this bill does expand coverage for some who desperately need it, and certainly there was plenty of reason to support it. After all, some increase in coverage is better than nothing (or a reduction). However, as Don McCamie, President of Physicians for a National Health Program (PNHP) wrote:

"SB2 is the most expensive model of reform, and will increase California's global health-care costs significantly. It leaves in place the highly flawed and fragmented system of funding health care with its egregious administrative waste, catering to the private health insurance industry. It perpetuates many of the inequalities in both the funding of health care and in the allocation of our health care resources. It clearly is not a measure that we can pass and then walk away from, as if the job were done."

Indeed, the bill does nothing to address any of the major flaws in our current healthcare system. There is no mechanism of cost control, even though the cost to employers of insurance premiums has been increasing by an average of 15% a year, with some plans raising their premiums as much as 25% this year. In addition, many critics have cried out that in these economic times, or for companies with a low-profit margin, this law places an undue burden on business owners; and there is no guarantee that employees will like it either. For proof, we need look no further than the recent supermarket strike, where employees were resistant to paying 18% of their premiums, a number that falls well within the guidelines of the new law.

So, if SB2 is not the answer, or at least not the best answer, what can or should be done? One intriguing alternative is a bill (SB921) proposed by state Senator Sheila Kuehl in 2003 and passed by the state Senate. It is due for hearings in the Assembly later this year. Entitled "The Healthcare For All Californians Act," this bill proposes a universal healthcare system for all Californians. This plan envisions the elimination of insurance coverage linked to employment. Instead of premiums, co-pays, and worker's compensation fees, the plan would be financed by a 4% payroll tax on employers and a 2% tax on workers. This money would be combined with state and federal monies from Medi-cal and Medi-care to create a global budget to cover all Californians. The consolidation decreases administrative costs (this reduces the number of plans in California from its current level of 30,000 to one), and allows for a bulk-purchasing discount. These changes are estimated to save 14 and four billion dollars a year, respectively. In addition, with every Californian having access to a primary care provider for preventive and early care, there would be an estimated three billion dollars in savings from unnecessary visits to emergency rooms (the most expensive place to receive primary care).

Critics, including the California Medical Association, claim that this bill sets up a system whereby the government, making a political rather than a scientific decision, will decide who is covered, and for what. They

also state that with everybody having access, the demand for services would outstrip the supply.

Speaking at an event at St. John's Medical Center in Santa Monica last fall, Senator Kuehl addressed these concerns, noting that her plan sets up an elected health commissioner and a board composed of healthcare providers and consumers to make coverage decisions. This would be independent of the political process. In regards to the point that demand would be too great, Kuehl alluded to the fact that we have a lot of people with insurance at the moment who avoid seeing the doctor because it is not a pleasant experience, and simply providing the opportunity for 6 million more people would in no way overwhelm the system.

SB921 is just one of several ideas now circulating with regards to the future of healthcare in California. While the effect of SB2 remains to be seen, with its passage California has taken the first step on the long road of healthcare reform. The whole nation will now be watching to see how the California experiment comes out (only one other state, Hawaii, has taken the employer mandate route, and it has been met with mixed reviews). If we succeed, others will follow, and we may one day be able to look back and say the healthcare revolution started here and started now.

References available upon request. E-mail anayjack@ucla.edu.



Mármol de Gondor, Tierra Media
by Fernando Antelo

Crossing

Tint of blue crests the moon
Four shadow years in tune

Spinning breath is still
We walk north until

One step to the edge
Approaching the blazing red ledge

Poised for some great turning
Upside down and back yearning

Forever changed on this crossing
Lost with the oceans tossing

Misting blue shudder and shake
With nothing & everything at stake

Rolled back round we begin again
I am hoping this time for a different end

by Kimberly Saxon

Crossing
Tint of blue crests the moon
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Native
by Monissa Villanueva



Verona Colosseo
by Jeremy Hogan, MD

Night Float

by Jessica Nord, MD

I.

Waiting for the phone to ring, a heart jolt in a quiet room, as the clock creeps toward early morning. On the other side of the door, nurses dose upright in the light of the front desk, the unwatched TV droning on the wall. I lie still on my back trying not to rustle the plastic sheets, trying to slow the blood pulsing in my ears. Anticipation of the sudden sound, of what might be on the other end of the line, keeps me wide eyed in the dark. Just as I drift from vigilance, I am sitting bolt upright on my cot, contacts dry as saucers, listening to Leon from 2 West. *Doctor, sorry to wake you, but Mr. Jones wants morphine and his dose isn't due for two hours. He's slamming doors! We need you to come up here right away.* Reluctantly, I drag on my white coat and shuffle past our commander-in-chief down the deserted VA hallway, up the empty elevator to the locked door of the psychiatric ICU. The sound of Mr. Jones' rage reaches through the door where the bright inside world greets the sleeping hallway. *Oh doctor, I'm so glad you are here . . .*

II.

Pulling into the garage at 8:12 a.m., I open the door on a still house. My perplexed cats run to the kitchen wondering if it's dinner time again. I meet my husband coming down the stairs, clutching his coffee and smelling like aftershave. He kisses me as he flies by, late for a morning meeting, scanning my crumpled scrubs and giving a quick sniff for hospital smells. *Were you really at the hospital last night or are you having an affair,* he grins, the twilight suspicions now silly in the bright light of morning. When the garage door closes, I am alone in the sunlight of my house craving a cup of coffee and Morning Edition. Outside, the movement of day is beginning. But I have to sleep after a night of walking deserted hallways. Writing notes about twilight events, irrelevant to the outside world. Keeping everyone alive until morning. It is time to lower the shades on the day and try to sleep in sheets still warm from the night.

III.

Smelling like shower in clean scrubs, I descend the stairs at 5 p.m. with my "morning" coffee. My cats follow me down wondering if it's time for breakfast again. Driving up Wilshire Boulevard, I listen to "Ryan Seacrest for the Ride Home" and watch commuter traffic, with people fighting to get to happy hour, or home for family dinner. If I call I will find my husband at work, finishing up the day. He'll be thinking about how to spend another evening alone, while I am off having my nightly affair with the VA.



Franny
by Haley Steele



Still life I and II
by Dawn Ogawa





Waterfront Property
by Neil Parker, MD



Spiny Orb Weaver
by Lynwood Lord

A TRICK OF THE LIGHT

by Aostara Kaye

Ted stared at the woman across the table, torn between anger and uncertainty. He wanted desperately to believe that the bitter, haughty expression on his mother's face was just a trick of the light, that she was still the gentle nurturer of his childhood memories, someone who honestly valued his happiness and would never intentionally hurt him. Then again, maybe she'd always been this way and it was only now, after everything he'd been through, that he was able to see it.

"Mother, you can't seriously be considering suing me for custody of my own children," he said, struggling to keep his tone light, amused, as if all this—the stilted politeness of the country club lunch, the threats, the unfamiliar hardness in eyes the same pale blue as his own—was some sort of misguided practical joke.

"If you're seriously considering having that horrible Samuel Evans move in with you, then yes, I am," the elegantly coiffed and attired woman responded without a hint of humor in her voice.

"That's crazy."

"Theodore—he's a convict, a drug addict, and a murderer."

"So am I."

Her tastefully lipsticked mouth tightening into a

thin line, Evelyn shook her head. "I don't think of you that way."

"That's painfully obvious." Leaning forward, he pinned the stranger in his mother's body with an intense stare, eyes glittering like the ice melting in her third Tanqueray Dry and tonic of the afternoon. "You still see the law degree, the house in the suburbs, the wife and 2.5 children, but that's not what I am anymore. What I am is a disbarred alcoholic who committed felony vehicular manslaughter and killed a seven-year-old girl. Oh, and who picked up a nasty little cocaine addiction after his run-ins with the head of the local survivalist sect led to his wife's murder. Remember?"

Ted paused, waiting until his mother's eyes narrowed in reluctant acknowledgement of facts she'd rather forget before continuing.

"Okay, so eventually I got cleaned up and turned things around, took responsibility for myself and my mistakes. So has Sam. Six years, Mother, and other—than sobriety—he's the only good thing that happened to me in that hellhole; you can't expect me to just abandon him."

"What I expect is for you to not let him anywhere near Sharon and Peter ever again. Do you realize that they've actually started thinking of him as family? Telling their little friends about him?"

Judging by her pursed lips and sour expression, that was just about the worst thing she could imagine, and it suddenly occurred to Ted that this had a lot more to do with Sam being male than with him being a convict. More disappointed than truly angry, he sighed, then stood. "Well, Mother, that's not going to happen, so I guess I'll see you in court."

The next three weeks were a living hell for Ted, easily rivaling all but the worst days in prison. Having decided to present his own case, he spent most of the week before the hearing at his old law firm, soliciting legal advice and tapping their extensive research library. Once the case began, he settled into a pattern: spending mornings looking for an apartment, afternoons either preparing for or in court, and increasingly awkward evenings at the house he'd grown up in. Those hours were always the worst, as he struggled to remain the open and loving father his children so desperately needed while carefully avoiding all but the most banal of conversations with his mother.

Ted realized that the man he'd been before his conviction, before prison had stripped him down to his basest elements and forced him to discover an inner core of strength he'd never even suspected, would've fallen off the wagon and into despair within days. Granted, he did find himself dropping in at one Twelve Step meeting or another nearly every day—two on the day the family court judge sat in on Sam's parole hearing—but overall he was fairly confident. He had to be; the very idea of losing terrified him beyond belief.

On the fourteenth day of proceedings, Judge Hawkins asked to speak to the children alone in her chambers, solemnly promising to render a decision the following morning.

A few days later, Ted turned from loading the last of his boxes into the moving van and gave Sam a sad smile. "I'm sorry it had to come to this."

"Me too," Sam replied. "Your mom, I guess she must've meant well, but—"

"Don't," Ted interrupted, raising a hand and gesturing angrily before resting his palm on Sam's broad chest, grounding himself in the reassuring rhythm. "She knows damn well that the only things that kept me sane in that place were you and the hope of getting back to my kids. For her to ask me to choose one over the other . . ." He stopped, his throat too tight to continue.

Sam pulled him into a comforting embrace, not letting go until the door to the house slammed open behind them. Evelyn stood alone in the doorway for a moment, giving both men an icy glare, then Peter and Sharon rushed out, eager to trade the tension of the past month for the excitement of moving day. They took a moment to hug and kiss their grandmother goodbye before racing across the lawn and throwing themselves into Sam and Ted's arms. While Sam took care of locking the back of the van and getting the children buckled in, Ted hesitantly approached his mother.

"I'll bring them back in two weeks for their first weekend visit," he said softly.

Evelyn nodded brusquely, her eyes focused on a point somewhere beyond his left shoulder. Ted waited for a moment, hoping for something more, then walked back to the van and settled wearily into the passenger seat. As Sam pulled out of the driveway, Ted looked back and thought he saw trails of moisture glistening on her cheeks. Then again, it might have just been a trick of the light.

THE H ELEVATORS

by Doris Fink

Elevator Angst

The NPI's "H-elevators"
have lately gone awry.
Their psycho-pathology
all do mystify.
Previous diagnoses
seem no longer to apply.

Specialists were called in,
H's symptoms to clarify.
Psych tests were ordered,
and an fMRI.

It was in the interview
that H began to cry,
"I feel so up and down,
can you tell me why?"
Fret not, dear "H,"
your angst we can identify.
You have elevated moods,
the tests all verify.
Your feeling up and down
is not spurious alibi.
Bipolar disorder
is the reason why.
The DSM-IV
your symptoms certify.



Research Group/Warren Hall, UCLA 1974
by Armand Fulco, PhD



Intaglio

by Celina Nadelman, MD

Love's a Wet Ride

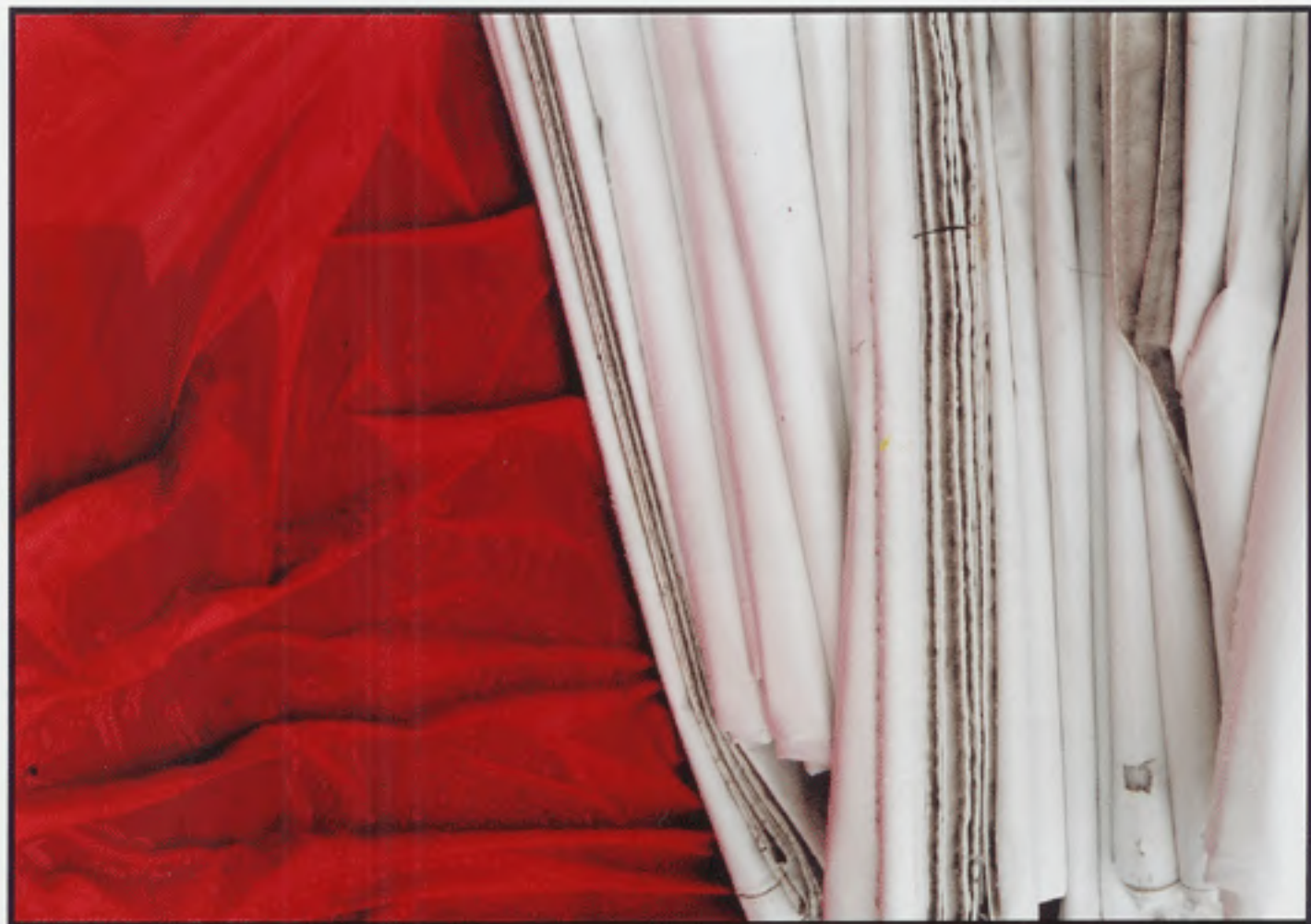
Love's a wet ride on a stormy day
And no matter what, it will have its way,
And it's "Whoa, that chick is outta sight,"
And it's "Rock me, mamma, on your lap tonight."

Love's a rock in this world of woe,
And it's "Kiss me under the mistletoe!"
Love's the one, and love's the many,
Love's "Don't knock here — I don't have any!"

You might get lucky, but you might lose,
So why risk a run-in with Old Man Blues?
It's not really such a riddle —
If love's the tune, then we're the fiddle.

Love's the ocean and we're the sand,
When the tide rolls in, this sand feels grand.
Love's a wet ride on a stormy day,
And no matter what, it will have its way.

by Alice Claggett



After the Rain
by Natasha Haykinson



So Long, Frank Lloyd Wright
by Benjamin Graves



Suomenlinna I and II
by Cheryl Go



Under the Tracks
by Matthew Zimmerman



After the Storm
by Lawrence Hy Doyle

Awakening

Into the light of day our dreams recede
As rays diffuse the dark, destroy our sleep
And steal, like alien beams, the thoughts that breed
The answers and memories we fight to keep!

by Jed Santa Maria

Willow

willow trees bending
low branches kiss the water
ripples on a pond

by Mary Trahey



Baby Chicks
by Joann H. Lin, MD

with Judith Gasson, PhD

by Daniel Zaghi

Photography by Monissa Villanueva

Dr. Judith Gasson, PhD, has been at UCLA since 1983. Currently she serves as director of the world famous Jonsson Comprehensive Cancer Center at UCLA. She also teaches molecular biology to the medical students, who appreciate her vibrant style and sense of humor.

The Beat: You have been described by Dr. Gerald Levey, provost of Medical Sciences and Dean of the David Geffen School of Medicine at UCLA, as a "brilliantly imaginative scientist." In your opinion, what has been the highlight of your research career?

Judith Gasson: As an individual scientist, the highlight was my work on GM-CSF expression and mechanism of action. For the past eight years, I've been director of UCLA's Jonsson Comprehensive Cancer Center. In that capacity I've "participated" in multi-disciplinary research projects by raising philanthropic funds to support groups of scientists with novel approaches to prevention, detection and treatment of cancer. UCLA has a world class cancer research faculty and it has been very rewarding to watch the development of new programs in molecular imaging, prostate cancer, and Phase I clinical trials, to name a few. The cancer center is currently engaged in collaborations ranging from nanoscience to outreach into underserved communities in L.A. County.



TB: Your work was instrumental in purifying granulocyte-macrophage colony stimulating factor (GM-CSF) for the first time. GM-CSF has been shown to increase the speed of bone marrow cell reproduction. How has this discovery improved cancer treatment?

JG: At the time, GM-CSF was the first of several human hematopoietic growth factors to be purified. Once the genes were cloned it was possible to produce large amounts of recombinant growth factors for use in patients. Currently, recombinant hematopoietic growth factors are used to treat many side effects of cancer and its treatment, such as neutropenia and fatigue. They can improve the patient's quality of life as well as allow for a more rapid recovery after chemotherapy. A novel use for GM-CSF these days (shown by other labs) is to help generate human dendritic cells in culture to produce cancer vaccines targeting tumor antigens.

TB: Is there a feature that you think particularly distinguishes the Jonsson Comprehensive Cancer Center as one of the nation's leading institutions in cancer research and treatment?

JG: That's very easy. I would say that it has been our translation research, meaning our scientists have been more effective in taking research discoveries from the laboratory to the clinic than any other cancer center in the country. This includes the FDA approval of Herceptin. That entire project was lead by Dr.

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Dennis Slamon, who is the clinical translational director for the cancer center. The next one that came along was Gleevec. Gleevec was approved a couple of years ago and that followed 20 years of basic research in myeloid leukemia by Owen Witte, followed by the translation work by Charles Sawyers who was one of three investigators in the United States that did the Phase I trial on Gleevec. And this year, Erbs has been approved by the FDA for use in a subset of lung cancer patients. So, I think we have shown that we can actually merge laboratory science with clinical trials more effectively than other cancer centers in the United States. Having said that, that's not the only thing we do. We have lots of other fine programs, including a very good division in cancer prevention and control research. But I think that is the most distinguishing feature.

TB: You became director of the Jonsson Comprehensive Cancer Center in September of 1995. Did you experience any unique difficulties or challenges as the first female cancer center director in the nation?

JG: I was too blissfully naive to be worried! I didn't know how hard it was going to be, and I just thought that the faculty here were terrific and if I could play a role in helping them be successful, that would be really neat. I was at a point in my career where I was very successful in my own research, but I also realized that it was going to have a limited impact. As a scientist working in your laboratory, you can accomplish certain things. You can publish in *Science* and you can publish in *Nature* and that's all great, but it's nice to toy with the idea of moving to a level where you can help multiple scientists not only be successful as individuals, but also be successful as a group. The local press was very positive and enthusiastic when I got the job. My colleagues and friends were very receptive. Now, when I go to cancer center director meetings, everyone knows me because there are only two women who are directors. It can be an advantage to be different from

other people because you stand out and people remember you.

TB: What convinced you to pursue cancer research?

JG: When I was in fifth grade, my parents asked me what I wanted for Christmas. I've told this story so many times that it's almost like I'm giving a lecture! I had decided that I wanted a microscope. That was a very unusual gift for a girl to request in those days! This was when I was 11, in the early 60s. I told them that I wanted a microscope and they got me one. People have asked me in the past to

*"You can publish in *Science* and you can publish in *Nature* and that's all great, but it's nice to toy with the idea of moving to a level where you can help multiple scientists not only be successful as individuals, but also be successful as a group."*

what I attribute whatever success I've had in my career and I always give them the same answer: Nobody ever told me "no." Nobody ever said, "You can't do that because you're a girl." My parents bought me this microscope and I had it in the basement. It was a piece of junk! I couldn't see anything! Just couldn't see anything! But it was very precious to me. When I was in high school, I took honors science courses and I really felt that I wanted to major in science in college. I went to the University of Colorado and majored in physiology, which I had always been interested in. Then I stopped and worked for two years in a research lab to see if I liked it and I just became totally hooked at that point. A lot of people said I should go to medical school or think about going to

medical school, but I really didn't think that was the way I could make my contribution. I was afraid then, and it's probably true, that I would become much too emotionally involved or emotionally attached to the patients and that it would be better for me to do research in the laboratory setting. I've never really regretted that decision. Now, of course, as cancer center director, I do have to deal with patients and families, in the context of people seeking information and with clinical trials. But, I don't think that direct patient care would have really been my calling.

TB: After earning your doctorate in physiology from the University of Colorado, you came to California. Was there something in particular about UCLA that brought you here?

JG: I finished my postdoc at the Salk Institute in 1979. I had always worked on hormones and receptors and that sort of thing. I worked on a peptide hormone as a grad student and a steroid receptor as a postdoc and I wanted to get into a new area of hormone-like molecules. This is all very old news to you, now, of course because this has all been figured out and now part of the curriculum! Then, the two choices I felt I had were to go into neuroscience or to try to start studying blood cell production or hematopoiesis. Since I knew virtually nothing about the brain, that option was kind of excluded.

There was a group of people here at UCLA, in Hematology/Oncology, who were working on purifying the growth factors that stimulate bone marrow cells to proliferate and divide. I decided that was sort of a new frontier and that I could apply my clinical training in hormones, receptors and signal transduction to that area. So, I came here thinking that I would sort of check it out and see if I liked it. That was in 1983, and as you can see, I'm still here, so I guess I liked it!

TB: Tell us a little about your family background and upbringing.

JG: I was born in Kansas and grew up in the suburbs of Denver, Colorado. My father was a bank president and my mother a teacher-turned-homemaker. My mother is a fabulous cook, and both parents were avid golfers. I have a younger sister and brother. One of the things my father instilled in us was his love of nature. We had a cabin in the mountains where we hiked, fished and skied. Don't get me wrong, I have no

athletic ability of any kind. I just like to be outside! I attended an all-girls high school, which helped to foster my interest in science. My parents emphasized education and they were thrilled to discover that the University would actually pay me a stipend while in graduate school. My dad had a wonderful sense of humor and loved to play jokes on friends and neighbors. Before he died last year, of cancer, he told the three of us kids that he was very proud of us.

TB: Can you tell us more about your family today?

JG: Sure. I've been married for more than 20 years and my husband, David, is an attorney, who has worked in the entertainment industry for many years. He is currently a senior fellow at the Rand Corporation and we have two kids. My son, Andrew, is a freshman at Berkeley and he is majoring in molecular biology. He would like to join Doctors Without Borders eventually, which I think would be an incredibly neat thing. My daughter, Lauren, is a freshman at Miramonte High school and she is very much enjoying it. They're very different. She's much more artistic and just finished a play. She does fencing and she is in French club and different things like

that. My son is artistic in his own way but he's much more focused on academics and on science.

TB: I distinctly remember your first lecture to the now second year medical class. You introduced yourself by relating your perilous trip down the Grand Canyon on the back of a donkey with your family. Could you tell us more about that?

JG: The trip that I was talking about is a very special memory. My father revealed to me that his lifelong dream was to go to the bottom of the Grand Canyon on a donkey. I was horrified because I'm really terrified of heights! But we couldn't let him go by himself, and my mother has two artificial knees so there was no way she was getting on a donkey. So, I persuaded my son, who was 13 at that time, to accompany us and it was a very moving experience on a lot of levels. It was something I was so afraid of, but once you've done it, it's liberating in a sense. It was also very special to me, now, because my father died a year ago of cancer, and I will always have that memory of doing something really incredibly extraordinary with him.

TB: What advice do you have for students trying to balance personal and professional demands?

JG: I would encourage them to learn a very important word and that word is, "No!" Sometimes the faculty that are coming on are just asked to do really too much and they need to remember that it's ok to say, "No, thank you. I can do this, but I can't do that." Young people who are entering academics need to be cognizant of the fact that as they become successful, the organization will

ask them to do more and more and they should just pick and choose. They should pick a couple things that they care about and participate in those. They can't do everything else! The other piece of advice is not to listen to people who are negative. Pick anything and you can find lots of people who will tell you why it won't work, why you can't do it. My advice is to walk away and find someone who is supportive.

"If eight years ago when I became center director, you had come into my office and asked, 'When do you think there will be a pill that people can take to target cancer?' I would have said, 'A pill? Are you crazy? Let's be realistic. That's a long way off.'"

This is more of a marathon than a sprint and you're in this for the long haul. When I was in graduate school, I used to say that the three most important things are cash flow, perspective and a sense of humor. Now that I'm a cancer center director, it's still the same thing. We still need to raise enough money and we need perspective. When you look back over the past 10 to 20 years, a sense of humor is key to making sure the important things are always the important things and that you don't get caught up in the day-to-day hassles. If you can't laugh at yourself or find the humor in the situation, if you take yourself too seriously, it is not going to work.

TB: Do you envision a day when the indiscriminate killing of cancerous and normal cells (i.e. cancer chemotherapy) will be a thing of the past? A time when we can selectively target cancerous cells and thereby avoid the serious complications currently associated with cancer treatment? If so, when will this day come?

JG: Yes. For some patients, it's coming now. For CML patients who can be effectively treated with Gleevec, they have very few side effects. I think the treatment five years from now will be radically different than what we have

now. It eight years ago when I became center director, you had come into my office and asked, "When do you think there will be a pill that people can take to target cancer?" I would have said, "A pill? Are you crazy? Let's be realistic. That's a long way off." Having said that, with such incredible progress, in part brought about by the completion of the human genome project, things are moving so much faster every year now. When Nixon declared war on cancer over three decades ago, he said, "We will find a cure." Now we know that there won't be a cure for cancer. There will be many cures for many types of cancer. What we talk about now, rather than a cure for cancer, is making cancer become a chronic disease like heart disease and diabetes, getting to the point where the targeted therapies will control cancer so that the patient will not succumb to cancer and can go on to live normally and have a good quality of life. I think that we are already seeing glimpses of that with the targeted therapies that are available now. People's lives have already been saved by those therapies, and I believe the future is very promising.

TB: Is a cancer vaccine on the horizon—a vaccine that will do to cancer what the polio vaccine did to polio?

JG: I would say that's a ways off. But we have a number of clinical trials going on right now looking at vaccines for brain cancers, melanoma, and kidney cancer that involve ways to harness the patient's own immune system to locate and destroy the tumor cells. We've had some stunning early successes here under the leadership of James Economou, who is the director of the gene medicine program. In these cases, the patient's own immune cells are exposed either to artificial tumor antigens or tumor cells or some combination of the two, and this goes back into the patient. He's had some very

striking results in a subset of melanoma patients. If we can get those strategies to work, I think it would be possible to vaccinate those who don't have cancer, but that's quite a ways off in the future.

TB: You worked for five years to establish the Drew/UCLA Cancer Partnership Program, which was proudly announced last fall. This partnership has been cited as an important step in "closing the gap in racial disparities" related to cancer incidence. Tell us about your involvement and what you envision for the program.

JG: As you know, Los Angeles is the most ethnically diverse county in the United States. In my 14 or so years of



teaching medical students, I got to know a number of students from the Drew program and became interested in the mission of Drew. Over one million Angelinos, primarily Hispanic and African-Americans, are served by King/Drew Medical Center. After I became cancer center director, I was made aware of a program funded by the National Cancer Institute that partners comprehensive cancer centers with minority-serving institutions. This MI/CC Partnership is dedicated to enhancing the training, education, and research programs between the two partner institutions, with the ultimate goal of reducing the unequal burden that cancer places on underserved minority communities. After several years of trying to put

together a partnership, I teamed up with Dr. Jay Vадgama at Drew, and we were successful in securing funding from the NCI. Together with funding from the cancer center, we've recruited three new faculty members, including both clinical and population-based researchers. We've funded three innovative community-based projects submitted by students. We've opened the first clinical trials for cancer patients treated at King/Drew. We're currently reviewing pilot projects that represent collaborations in basic science cancer research between the two institutions on projects that are relevant to health disparities.

TB: Tell us about your current research projects. From your perspective, what interesting applications are on the horizon?

JG: My current research is focused on a better understanding of the transcription factors that regulate the earliest events in hematopoietic lineage commitment and maturation. In all areas of cancer research, the future will bring better molecular classification of tumors, which will lead to more effective and

better targeted therapies. Combinations of these therapies will allow us to think of most cancers as chronic diseases, not life-threatening ones.

TB: So can I get your autograph? You are a celebrity in cancer research circles, you know.

JG: You think so? That's funny.

TB: How much do you think I could fetch for this on eBay? Med school's not cheap.

JG: My autograph? Absolutely nothing. Absolutely nothing! —

Dr. Janet Pregler

has been at UCLA for 12 years and has been the Director of the Iris Cantor-UCLA Women's Health Center for the past seven years. She went to medical school at Northwestern and did her residency training at George Washington University.

by David Stempel

Photography by Monissa Villanueva

INTERVIEW...



The Beat: Can you tell us about the creation of the Iris Cantor-UCLA Women's Health Center?

Janet Pregler: When I came to UCLA there was a critical mass of people here that were interested in women's health, including researchers, physicians, and educators. Then, in the mid 1990s, a philanthropist named Iris Cantor came to UCLA and said that she was interested in establishing a comprehensive women's health center. In response, they pulled in people from all across the medical school, myself included. Mrs. Cantor was offering UCLA significant resources for something that had not been done before. We committed to putting together a comprehensive women's health center, working with the other entities on campus that deal with breast cancer, reproductive health, and so forth. She approved of our plans and funded the center. The US Public Health Service has a program to designate

Centers of Excellence, and we applied for that and were selected. That took a lot of our work to the national level and put us in a network of likeminded researchers and educators across the country. It was a great program for us to get involved in.

TB: To what extent did the curriculum address women's health when you were in medical school?

JP: When I was a medical student I was very interested in women's health but at that time, particularly at Northwestern, which was a very traditional medical school, women's health was basically equal to obstetrics and gynecology. As I have said to the first year class every year, my medical school curriculum taught about the 70 kg man—that was our model. So, when we learned about the kidney we learned about it in the 70kg man. And nobody ever really talked about women, unless you were going into OB/GYN. There are a million examples of that, like doing a rotation in gastroenterology where you are supposed to evaluate people with abdominal pain, but there is no way to do a pelvic exam, and you know, that is really a male model. When I did GI, boy you'd certainly be in trouble if you did not do a rectal exam on a man! But if you even suggested, hey maybe we need to figure out if this woman has pelvic pain on the basis of some reproductive tract problem, they would be say, "oh...errr... that is not our thing, you had better send them to gynecology."

TB: Why did you choose internal medicine over OB/GYN?

JP: When I did my clerkships, I realized that what OB/GYNs did was not my main area of interest. I would say that I am the classic kind of person that goes into internal medicine. I really enjoy the thought process and pattern recognition, and things like that, applied to a wide range of medical problems. I realized that I really wanted to be an internist with a focus on women's issues. The politics of it were interesting, too. In the United States, a lot of the health care that underserved women can obtain is funded on the basis of their reproductive status. You can get state funding to prescribe a woman birth control pills, but you

can't get state funding to screen her for diabetes, because that does not have to do with her maternal/fetal role. I wanted to find a way to improve this system.

TB: In the primary care fields it is important to know both ends of your spectrum. I mean, to have knowledge of men and women's issues—

JP: It is also particularly relevant to research. As I think most people now know, for decades, in many areas of research, such as cardiovascular health, studies were basically done only on men. Part of the issue may have been that

type of broad subject matter that I enjoy. Sometimes they ask me to comment on specific topics, but a lot of time they ask me to bring in issues I think people would be interested in.

TB: You had a very interesting NPR segment on obesity, and dieting. It seems that once people are overweight, it's very difficult for them to lose weight. Most of the data says no diet will help people return to a normal weight. What can be done?

When I did GI, boy you'd certainly be in trouble if you did not do a rectal exam on a man!

researchers were not comfortable using women as subjects in their studies because they were ignorant about hormonal differences and the like. They just decided that they would not deal with that. Of course, this was problematic. As you may have heard me say before, lupus is nine times more likely to affect women than men. This has to have some biological relevance. Until you are examining these gender differences, you are missing out on understanding some mechanisms that may be applicable to both men and women.

TB: I see that you are the author of a textbook, "Women's Health: Principles and Clinical Practice" (2002). Are there any other works in progress?

JP: Ha, ha! I think a lot of people that have written a textbook say they never want to do it again! Actually, it was a really neat experience. I worked with over 100 different authors from around the country and met a lot of incredibly bright people who had either been thinking about gender differences already or who I was able to recruit. More recently, in addition to the new first-year curriculum, I have been working on public health education and outreach programs. Our work includes a domestic violence training program for teens. Cindy Moskovik, a social worker, has been an integral part of this project. I have also been doing a series on National Public Radio, on a show called Day to Day. That has been really fun and exciting.

TB: I have listened to your clips on NPR and noted that you have talked about subjects ranging from andropause to flu vaccines to obesity. Could you tell us a little about how you got involved with that?

JP: Well, for a long time I made myself available if there were questions on general medicine in female patients, because that is what women's health really is. Then, they were putting together this new show based here in LA, and the producer went to the media relations people at UCLA and asked if there was somebody that could come out and do a segment. They suggested calling me. So, I began working with them. It has been very satisfying for me because it is the

JP: I think this is one of the biggest areas of frustration for primary care doctors. There continues to be this mantra, including even from the NIH, saying "you primary care physicians need to counsel patients better." On the other hand, there are reams of data suggesting that even if you could convince your patients to diet, it may not help them. Once people are obese, they are obese. Finally we are getting to the point where there is more research being done in children, who have been largely ignored. I think it took this tremendous epidemic of Type II diabetes in children to get people to stand up and pay attention.

But we have had similar problems with studying and treating children as we have had with adults. For instance, in the 80s and 90s you had people coming out and off the top of their heads advocating a high carbohydrate diet without any data. It was a disaster. Now, as we try to counsel parents about young children, we are up against popular wisdom that is not always based on data. Sometimes parents are told to let the kids eat whatever they want, other times that they should be very strict with what the kids eat. We need more research.

TB: Did you coin the term "andropause"?

JP: Ha! No, I did not, but it's funny because there is this whole argument among physicians and researchers about whether something similar to menopause really exists in men. Sometimes I get asked about it when I am lecturing and what I tell people basically is that I don't know, and that is seems a whole lot more research is needed, which is what the ICM report said. But I don't think andropause is what causes our 50-year-old male patients to go out and buy red sport cars. It's not a sudden thing that happens to you at a certain age.

TB: Statistics show that the leading cause of death of women in America is heart disease, yet you don't see a whole lot of information out there on that. What can be done to educate people on the subject of heart disease?

JP: I think this particularly highlights one of our quandaries

in women's health concerning any type of comprehensive preventative approach. People tend to be interested in things that happen to them. Medical 'hot-topics' tend to be driven by the interests of upper middle-class, educated people, who are generally middle-aged or older. This has skewed a lot of legislation, research, and philanthropy toward certain issues. In women's health, we've had a big focus on things that happen in mid-life, like menopause and breast cancer. But are we looking at STDs? HIV? Things that happen to younger, underserved women? All of those are extremely important issues.

Right now, the heart disease issue has been put under the spotlight. In fact I have a conference call this afternoon with the NIH. We are putting together an

JP: The oldest one does. I think the little one is either going to be a CEO or Madonna.

TB: Well Madonna is like a CEO.

JP: Exactly, she has that whole thing going, but then she has the diva thing as well.

TB: What are some of your interests outside of medicine?

JP: I like yoga and reading history, of all kinds, and science fiction.

TB: What percentage of your time is spent between your various jobs as a clinician, radio correspondent, and educator?

"I don't think andropause is what causes our 50-year-old male patients to go out and buy red sport cars. It's not a sudden thing that happens to you at a certain age."

educational program for physicians about women's heart disease, because a poll was done about five years ago that showed that about a third of primary care physicians still didn't know that heart disease was the number one killer of women. And there was a study done that showed that physicians were particularly likely to under-diagnose and under-treat heart disease in African American women—they are in fact the segment of the population most likely to die of heart disease. So I think the challenge is how can we be comprehensive and how can we help educate people so that these different issues are really looked at.

TB: Can you tell us a little about your upbringing?

JP: I was born in Topeka, Kansas. I was eldest of four children. I attended public schools. I was a "science nerd," although I was also very interested in history and spent time studying history and doing historical research in Peru in college.

TB: When did you come out to California?

JP: I moved out with my husband, Johnathan Pregler, after residency and fellowship, in 1992. He joined the department of anesthesiology, and I joined the department of medicine. He's currently the Director of the Outpatient Surgery Center here at UCLA.

TB: Tell us more about your family.

JP: I have two daughters, ages seven and four. I am currently pregnant with our third child. As a family we like bicycling, role-playing computer games, and science fiction shows. My four year old daughter recently talked a lot about Stargate SG-1 at her kindergarten interview — luckily, she got in anyway!

TB: Do your daughters want to be doctors?

JP: I am 50% clinical and 50% administrative and educational, which includes my work on the first year medical school curriculum and other things like the contracts for the educational program I have with the NIH. This is kind of an unusual split. I think you find most faculty are 90/10 one way or the other. But I really like the balance of things that I have. I am not interested in becoming a 10% clinical time person, because seeing patients is very important to me.

TB: How do you feel that being associated with a large academic medical center keeps you on the forefront of clinical information?

JP: I think it is critical, and it is one of the reasons that I love being here. Teaching residents is tremendously challenging and rewarding because you always want to provide the most current and relevant information, so it keeps you on your toes, and I really enjoy that. But being up to date on everything is a huge challenge in itself, as we learn to use the technology available to us. It is amazing to me that when I was a resident, if we admitted a patient and didn't know what to do, we went to the library and tried to look something up in a book. So, the best residents were the people that knew how to break into the library at 3 a.m. Now of course, you have the internet 24/7. I am pleased to see that, working with medical students, we are moving towards creating doctors who realize when they don't know things and look things up, utilizing the available technology.

TB: I don't want to make you late for your conference call with the NIH. I think they might be more important than me.

JP: Ha, ha! Yeah, later I could say you ruined my career. That would make a good anecdote—I lost my contract with the NIH because we were sitting here yakking! —



Jennifer Flirting
by Tomas Ganz, PhD, MD



Compassionate Mother
by Nalini Saba

The Two Marías

*for María Teresa and María de Jesús Quijé Alvarez,
formerly conjoined twins from Guatemala*

Who would have thought of you
Who would have imagined a world
Separating you
To keep you together

Who could have broken a heart
And mended one
But you María and you María
As if I were your father

And who but you on your return
To a poor and happy country
Could wave little hands
Be more loved than a Pope

by Nels Christianson



UFOs over Sacré-Coeur
by George Helfand

It Must Have Been a Different Life

It must have been a different life
I can count the days between now and then
Quantify them. Still it seems impossible

Ice cold air, wearing a heavy coat
Where my scarf doesn't cover, the cold burns
But I carried a book bag of my own thoughts

Or further back, before any gesture to the new era
Dark black curls and a salt breeze
Meteor showers and gold in the sound

Some changes needed to happen
I don't propose going back in time
But my mind and body remember things they miss

I know I am the same person as before
Sometimes it all seems like one fluid story
Other times, I think it must have been a different life

by Daria Crittenden



Hope

by Sonia Dhaliwal, MD

What Filled a Land of Drought

I come from a land of drought,
where evening primrose was a weed
making its home in cement cracks.
We watched it wait till nightfall
to open its fragrant pink.

You've got to be stingy in a place like this,
where we pray for measured water,
and pray for rain.
We couldn't afford to spill a glass,
or sell a five cent lemonade on our corner,
with more than one cube of ice.

Others live by wide rivers,
write of trees, green summer grasses,
sleep with the echoes of Atlantic spring.
We watched the August trickle of Bear Creek
twist and evaporate before our eyes.
We dashed for the irrigation ditches.
Hoping for frogs
we dove, risking our lives.

That water came from the mountain.
Everything in our valley was imported:
Black and white TV,
the toy cars from England,
plastic soldiers from Japan.
What did we have but a sun
that filled the whole sky
from June to October?
And the acrid smell of tomatoes
left in fields for the cows.

by Nels Christianson

The Ceremony

by Betty Tomson

Sometime in May
of nineteen-fifty-three,
my husband and I decided
that we wanted to be
American citizens.

We had been denizens
of the British Isles.
And for the authorities
we proffered historical profiles.
Not detailed,
but the essential gist,
letting it be known
that neither of us were,
or ever had been,
a communist.

It was the McCarthy years.
Particularly in show business,
there were many fears.
My husband was a producer,
and had been contracted.
But as jobs fell through,
business wasn't always transacted.
Because of this:
Whoa! A financial abyss!
Things looked forlorn.
And by now,
our two children had been born!

During the war,
my husband volunteered
for the Red Cross.
He thought asking them for a job
could not be a total loss.
But, was told that only American citizens
could work for that organization.
So, after much deliberation,
we decided that being citizens
would improve our situation.

And thus we prepared.
In this we fared well.
Our interrogator was stage struck,

when he recognized my husband.
He said he had written a song
hoping to have it published,
wanting to belong
to the Hollywood crowd.

All naturalization questions,
my husband answered with ease.
For me, it was not such a breeze.
But, soon we were ready
to take the oath.
Standing up, we both
raised our right hand.

Just then the baby awoke,
and cried loudly
to make me understand
she was hungry.
Embarrassed, from the room I fled.
For she always refused a bottle
and would only be breast-fed!
I found a restroom,
where she drank 'till satisfied,
and gurgling with happiness,
she no longer cried.
So I re-entered the hall,
but found the room empty.
Except for my husband,
no one was left at all!

So by myself,
with baby over my shoulder,
I raised my right hand
and made the pledge.
By now, I felt much bolder
and was no longer on the edge
of panic.

In fact, I was ecstatic.
The ceremony was over,
and I'd made the grade.
I was no longer a British subject,
but American made!



Poppy Field
by Rodney Bianco

What I Learned While Dying

by Cole Gilker, MD, PhD

I am sitting in a small plastic chair pushed against the wall in a doctor's examining room, and I am being told that I am going to die. Not dramatically, but with quiet, calm words that fall just short of friendliness, that leave the room breathless. My right hand is grasped too firmly by the trembling hands of my wife, motionless beside me in her own plastic chair, and the senior consultant has seated himself in front of us, legs crossed and relaxed, ready to reveal my fate. Behind him is the now empty examining table and around the room various members of his team lean against the wall, listening politely but clinically to our conversation. As my mind tunes out and my own questions seem to come from afar, it strikes me that I am at least ten years older than this man, and that his white coat hangs just a little too big around his shoulders.

My voyage to this moment began 23 years ago, when I developed testicular cancer and was treated with a unilateral orchiectomy and radiotherapy to my abdomen. Luckily, I recovered easily, although I will never forget the long hours of crippling nausea during the weeks of radiation treatments. But the cancer never spread, my life gradually returned to normal, and the whole experience became a bad dream that I could summon as needed to keep myself appreciative of life and of living.

But then I began having mild abdominal pains at night, prompting me to see my internist when antacids failed. I underwent an ultrasound examination that showed nothing, and then a CT scan to look for gallstones. A minor annoyance, since a cholecystectomy would mean missing a few weeks of work.

Ironically, the CT machine was one that I use in my practice, manned by technologists with whom I have worked and joked for years, and supervised by a familiar radiologist. I endured some good-natured kidding as I lay within the machine, my arms above my head and relaxed for the ten minutes it took to do the exam. No big deal.

Afterwards I walked around to the console, curious to see the results. Without looking up from the screen, the radiologist said blandly, "I don't see any stones, but you've got that." She pointed to a two-inch mass nestled right up against my spine. What the radiologist did not know is that it was smack dab in the middle of where I had received radiation those 23 years before. The technologists, jovial only a few minutes before, now ignored me as they worked to display and record the tell-tale images.

My stomach fell out from under me and I lost my focus, for in medical school we learn that radiation can induce tumors that appear decades later, tumors that usually are malignant and almost always fatal. Quietly, I turned to the radiologist and said, "Ah, I was treated there with radiation a long time ago." The pause that followed seemed longer than it really was, as we both digested the news and its awful significance.

Fear. Tangible, spreading, dry-mouthed, numbing, pit-of-your-stomach, overwhelming fear. Without formed thoughts, without plans, without relief, rooting your feet to the ground and sending your mind spinning. Waves of unreality, waves of disbelief, and more waves of fear.

✦ And this is my first lesson to share: *Patients are afraid. Really afraid.*

People who are crossing over to the land of the ill are terrified. This is not an abstract terror, not an anxiety-in-the-book-that-you-treat-with-counseling-and-medication, but an all-encompassing fear coloring every moment, like a bad dream but in lurid detail, and from which one cannot awaken. The swirling storm in my brain paradoxically froze my body and muted my voice, betraying my terror to those in that CT room as I mechanically thanked them and left to pull myself together.

I don't think many physicians realize just how frightened their patients really are. Sitting in an exam room equipped with bright windows and cheery magazines, calmly discussing test findings and treatment options, it is difficult to appreciate the terror that always lies just beneath the surface. Nor can friends or family appreciate this basic core of fear. But it is there nonetheless, magnified outside of the office and always present at night. It is something that cannot be appreciated unless experienced firsthand, and even then the protective mechanisms of our minds tenderly prevent our memories from becoming too vivid.

Impossible to imagine, difficult to remember, unthinkable for ourselves, we must never forget that this is the state of terror engulfing our patients and our loved ones who are ill. It is an inevitable and immutable part of their mental landscape.

The next two days only intensified the storm of fear growing within me. The next test was an MRI scan. The radiologist's promise to do his best to prove that the tumor was benign was soothing, but afterwards, when he couldn't quite eliminate malignancy from those radiologic shadows, the trap around me seemed to close even tighter. And it didn't help when he and I admitted to each other that the only tumors we had ever seen caused by radiation were malignant.

My interview with the cancer surgeon was even worse. He pleasantly assured me that my tumor was probably malignant, that my life depended upon complete removal, but that this particular tumor would be difficult to remove. He suggested that I would be served better at a nearby major hospital that was devoted to cancer diagnosis and therapy. He was kind, calm, competent, and appropriate, but the contrast between his friendly personality and the devastation behind his words only furthered the destruction of my already fragile peace of mind.

✦ Thus, a corollary to the first lesson: *There is no comfort. The fear won't go away.*



Perspective
by Nirav Patel

The next week I traveled to that cancer hospital where I was told I would die. What I was actually told was that the chance of my tumor being malignant was about 80 percent, and that in the best of circumstances my chances of being alive in five years were 50 percent. I remember thinking that those odds were the same as a coin toss.

The next step was a CT-guided biopsy. I checked in to the cancer hospital as a cancer patient, wearing a cancer arm band embossed with my cancer number, waiting with the other cancer patients – all stages of their cancer for their cancer blood work, cancer interviews, and other cancer administrative tasks needed prior to my cancer biopsy. I will never forget the desperate quiet kinship I felt with the five other cancer patients as we sat in the same room waiting for our blood to be drawn. Little needed to be said as each of us examined the faces of the others.

I waited most of the day in this fashion in preparation for the biopsy the next day. More fear, more panic and more despair.

✂— And here is the second lesson: *It's worth the wait.*

The inconveniences do not matter. I had been waiting in one or another doctor's office for several days, enduring uncomfortable tests and no end of questions, forms, and paperwork. But the only thing that mattered to me was the possibility of help. I would gladly have waited for hours and years in hundreds of waiting rooms if only that possibility turned into reality. Any wait, any inconvenience, would be worth it if I could only return to the land of the well.

Surprisingly enough, I do not believe that many patients share my attitude about medical inconveniences. As a physician, I commonly hear complaints about long waiting times and demands to have surgery before the weekend. To these patients I would say: Be happy that you have something to wait for, that the wisdom accumulated from hundreds of years of medical experience is available to you, that you are being given a chance. It's worth the wait. (On the other hand, it would be unfair of me to be too harsh, since my own partners were wonderfully supportive, granting me all the time I needed without grudge. But I am speaking more about a state of mind).

And to physicians I would say: Don't try to eliminate all the inconveniences of medicine, because you will not succeed. They are inevitable consequences of complex care and unforeseen events. Rather, try to recognize your patient's frustration as the symbol it is for the overwhelming fear that is always present, so that you can be of help and so that you do not casually dismiss your patient as merely being obtuse.

My surgical practice includes a lot of high technology, everything from image-guided MRI navigation systems to experimental infrared probes. CT scans, ultrasound exams, and MRI studies are a dime a dozen and I am inured to them. But as a recipient of these exams, as an observer from deep within the MRI machine rather than at its display screen, I was suddenly and primitively aware that this humming, banging device was performing an unbelievable feat: looking deep within my body in a matter of seconds to reveal exquisite anatomic details that I could only otherwise experience as pain.

✂— And so the third lesson: *The technology is incredible.*

After being told that I would die, I was sent for my biopsy. This was done by sticking a needle in my back while I lay naked on my stomach within a CT machine, a needle precisely guided to the center of that dreadful tumor. I had some rather pleasant sedation, the procedure was not terribly painful, and it was over in about half an hour. The anti-climactic nature of that afternoon did not do justice to the life-and-death nature of the task, for if the result was benign I would live, if malignant, I would die.

The next two days were spent at home waiting for the biopsy results. I would wake suddenly at night unable to fall back to sleep. Conversations were not fully heard, and even a steady diet of movies and good scotch could not dull the jagged thoughts jabbing into my world.

But what exactly did I fear? What was so frightening about dying? It was not that I would leave my work undone, or be unable to travel and experience the world. No, the waves of sadness came from thinking of my family. I would not see my youngest daughters graduate from high school, nor see my grandchildren; I would not be there to help my children as a

father with advice or with support. Most crushing of all, I would be abandoning my wife, who I love more than anything, to a life of loneliness and misery. The thought of her reaching for me alone at night, the thought of her having to sell our property and dreams, the thought of her alone without me as the children went off to college, the realization of how much I would hurt her if I died, were more than I could bear. And a final agony: the thought of sitting down with my children to break the news, the thought of planning my final goodbyes to them.

✦ So: *The family is the most important thing.*

On Friday morning, the surgeon called me to tell me the news. I could not sit, I was trembling and pacing in my bedroom, hyperventilating, while my wife did her best to keep her arms around me as she followed me back and forth.

But the news was good! The tumor was benign!

After the word "benign" was spoken, I scarcely heard the rest of the conversation, although I remember embarrassing my doctor with my newfound and enthusiastic affection for him. I called everyone, parents, friends, coworkers, sometimes in tears, to tell the news. It was a joyous moment, but it was not to be for long.

Later that weekend, after a celebration dinner, I began to wonder if the biopsy was really the final word. Perhaps a small bit of malignancy could hide, just out of reach of the biopsy needle. I was horrified to find that in fact, this had happened to others (leading me to vow to stay away from the Internet for awhile). Furthermore, I realized that even if my tumor was completely benign, I was still at risk for development of a malignancy from the radiation therapy delivered so many years ago. So, no matter what was to happen, the sword would always dangle over my head, and my viewpoint of life would forever be changed.

✦ And this is the final lesson: *Life is uncertain.*

But all of us know that. Or think we do. But not really, because while it is one thing to know that one must die in some abstract future, it is quite another to fully realize that this will happen next week. Despite lip service paid to our inevitable mortality, most of us secretly embrace the myth that we will never die.

With the passage of time and the resumption of a normal life, I can almost believe this myth again. My memory of those weeks is becoming more abstract, since the human mind is mercifully not built to sustain this visceral state of terror for very long. And since good can arise even from the most miserable of events, I am bothered less by small problems, and more motivated to do something worthwhile each day. I try to remember my experience, because life is truly uncertain, our voyages with our loved ones must inevitably come to an end, and we fool ourselves if we do not believe that, indeed, each day is a gift.

I underwent surgery that next week. My surgeons were able to skillfully remove the entire tumor, costing me only a bit of leg numbness and a small bulge in my already bulbous torso. It is tempting to include another lesson (Lesson 6: Surgery Hurts). But anyone who's had an operation can tell you about that.

A few more days of anxious waiting brought the final pathology report, which was read to me over the phone: Completely benign and completely removed. As the mixture of emotions swept through me, relief, gratitude, awe and fear all rolled into one delicious but painful sensation, the nurse said to me, "And it doesn't get much better than that."

Indeed not.

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Contributors

Fernando Antelo, MSII, graduated from UC Berkeley and hopes to one day complete his Jech training. He appreciates the hugs and newspapers that have been left for him in the SAD and promises to safeguard the secrets of the BBC in the future.

Aostara "Star" Kaye has worked for the UCLA Medical Center for nearly fourteen years and is currently the lead programmer/project manager for Transplantation Services. In her spare time, she indulges her right brain with meditation and hand drumming.

Gabe Aranovich is a second-year medical student.

Ulrich Batzdorf, MD, is a professor of neurosurgery and has been on the UCLA faculty since 1966. He is a summer vacation sketcher and pasteler and began painting five years ago, mostly abstracts and abstract landscapes.

Rothney Bianco has worked for the medical center for 26 years and is currently working in the department of nursing in the 7WICU. Photography is his artistic release and has been since high school.

Nels Christianson, employed at UCLA Medical Center for 28 years, is a native of Merced, California, who frequently writes about the Central Valley. Currently, he works in International Relations where he handled the financial arrangements for the formerly conjoined twins from Guatemala.

Alice Clagett has been working at CHS since January as an administrative assistant for Dr. Ronald Terrapins, who is Editor-in-Chief of the "World Journal of Surgery." For fun, she loves meditation, and on weekends she likes hiking in the Santa Monica Mountains.

Matthew E. Conolly, MD, is a professor of medicine and anesthesiology. He is a graduate of London University and has been on the UCLA faculty since 1977.

Daria B. Crittenden (Dariae cryttondennis), MSII, can be found ranging

from the southwestern to northeastern quadrants of the United States. Diet includes mainly coffee, scones, salads, veggie burgers, and chocolate chip cookies. Known to participate in cardio kickboxing 3x per week, so may be dangerous when threatened or confronted.

Sonia Dhaliwal, MD, is a second-year radiology resident (PGY3) at UCLA. She graduated from UCLA School of Medicine in 2001. She loves photography, and says she is very glad that the school of medicine is maintaining this forum for sharing art.

Hy Doyle, Learning Skills Specialist for UCLA/Drew Center of Excellence, has worked for Schools of Medicine at UC Davis, U of Washington, U of Nevada, and UC Irvine. His favorite travel photo spots include Kona, Hawaii; Jeju, Korea; Kyoto, Japan; Nordkapp, Norway; Moorea, Tahiti; Big Sur; and So Cal.

Doris Fink has worked (enthusiastically) at the Neuropsychiatric Institute for about 20 years as an administrative assistant. Currently, she works for the "be-as-nice-as-he-is-brilliant" psychiatrist, Bruce L. Kagan, MD, PhD. She edits a twice-monthly, emailed NPIH Newsletter, which she started as a way of helping the many people who work at the NPIH get to know each other better.

Armand Fulco, PhD, currently a professor in the Department of Biological Chemistry, UCLA SOM, entered UCLA as a freshman in 1950, served in the U.S. Army 1952-54, earned a BS in Chemistry, UCLA 1957, a PhD in Physiological Chemistry, UCLA SOM, 1960, was an Post Doctoral Fellow at the UCLA Lipid Laboratories, 1960-1, a NIH Research Fellow in Biochemistry, Elsevier U., 1961-63 and a faculty member at the UCLA SOM, 1963-to date. His favorite hobby is B & W photography.

Tomas Ganz, PhD, MD is a physician-scientist with a lot of traveling to do. In between work, he likes to walk around, find interesting places, and take photographs. The idea of freezing time has always fascinated him. He even takes mental photographs

when he does not have a camera with him.

Melissa Gee, MSII, is a Whittier native and attended CSUF. She anticipates the day she no longer has to deal with the traffic in LA, even though the shopping and restaurants are the best.

Cole Giller, MD, PhD, (UCLA 1984) is a neurosurgeon at the University of Texas Southwestern Medical Center at Dallas, where he specializes in radiosurgery and surgery for Parkinson's disease and epilepsy. He is the author of the book *Port to the Sun: How to Make a Medical Decision and Live to Tell About It*, a guidebook for patients being apartant medical decisions.

Joseph Gins is a clerk at the Neuropsychiatric Hospital. He lives in West LA and enjoys hiking in Griffith Park.

Cheryl Go, MSII aspires to one day learn how to not fall asleep in movies that start past 9 p.m., bake cold berry pie, and run a marathon. She enjoys walking her dog Rigby, Sundays, and mangoes.

Mark Goodarzi, MD, is a senior fellow in endocrinology. He is also completing graduate work towards a PhD in Human Genetics. In spite of being a professional student, he manages to get away once in a while, camera in hand.

Benjamin Graves, MSIII, is a veteran Beat supporter. If he ever quits medicine, he'll go back to being a full-time rock'n'roller.

Marylou Hands was born in Ontario, Canada and moved to LA several years ago to avoid the wet summers. She enjoys literature and music as well as outdoor activities. She occasionally writes poetry and prose.

Natasha Haykinson works in the Department of Biological Chemistry. She started taking pictures in 2002, and since then photography has become her hobby. Most of her images are from UCLA, because there is always something on campus that would make a good photo.

George Helfand, manager of UCLA Photographic Services, has been a professional photographer for over 25 years but has yet to sell a single picture. He has recently gone digital and hopes that will make a difference.

Jeremy Hogan, MD, thinks we have a lot to learn from dogs. Seriously.

Sung-Jae Lee, PhD, and True Tang, MPH, are both graduates of the UCLA School of Public Health. Dr. Lee is currently an HIV researcher with the UCLA NPI/Center for Community Health. Engaged to be married in June 2004, both artists find time on the weekends to devote to their other interests, such as painting and drawing. Their submission to the Beat was their first joint project.

Joann Linn, MD, is a displaced Texan who recently finished her residency in pediatrics at UCLA and found a reason to stay in Southern California through a fellowship in allergy and immunology. Chinese brush painting has been a way for her to explore her cultural roots and express herself.

Lynwood R. Lord moved to Los Angeles one year ago after many years as a scientific and medical editor in Philadelphia. Currently, she works as a senior editor in the Center for Community Health. She loves just about all forms of nature photography.

Kevin Moutillesseau is a Research Assistant II in the Department of Medicine/Cardiology at UCLA. As appealing as the linoleum floors, fluorescent lights, and concrete walls of CHS may be, his true idea of beauty is the high country of the Sierra Nevada.

Celina M. Nadelman, MD, has always integrated art and science in her life. Art provides a nice respite in her busy life as a pathology resident, mother, and wife.

Aaron Nayfack is a second year medical student and a fledgling communist. *Hasta La Victoria Siempre!*

Jessica Nord, MD, is an intern in psychiatry at UCLA-NPI. She completed medical school at UCLA and just couldn't tear herself away. Her current

interests include interracial health, emergency psychiatry, eating non-cadaveric food, and getting as much sleep as possible.

Dawn Ogawa, MSIV, loves to paint, draw, and travel. Born in Anchorage, Alaska, raised in Honolulu, Hawaii, educated as an undergraduate in New Haven, Connecticut and fellow in Nishinomiya, Japan—who knows where the winds will take her next!

Neil Parker, MD, has previously published his underwater photos. When not with his head underwater, he likes to take photographs of the country and puffer fish. He believes looking through a lens at the world can give you different perspectives and help you see things you otherwise miss when looking at the big picture.

Nirav Patel, MSIV, is interested in critical care and infectious disease. He loves classical East Indian music, has a fanatical attachment to his computer, and though he claims reform, he is always up for quick spin around the block in his SS, which he hopes to extensively "mod" in the coming years.

Nicole Rostoker works as an occupational therapist in acute NICU and pediatrics at the Westwood Medical Center.

Wendy Ruggeri, MSU, was born in LA and grew up in Argentina. She says, "Travel, travel, and travel while you can—much better than med school!"

Nalini Suba enjoys painting portraits and seascapes. She felt inspired to paint *Compassionate Mother* when she was going through emotional healing to recover from abandonment she experienced in childhood. Art has been her healing companion throughout her life.

Jed Santa Maria, MSU, has just realized that the reason he loves geography so much is that he yearns to travel to all those places. In fact, according to Filipino superstition (which he finds interesting but doesn't really subscribe to), the mole on the sole of his left foot means he is destined to travel the world far and wide. He is

worried, however, that the mole has faded since he first noticed it.

Kimberly Saxon believes poetry is the current through which mysteries push to reveal themselves.

Halcy Steele, MSU, enjoys brightly colored socks, flat soda and crushing ice with her bare hands. She has only recently become aware that the term "She-Hulk" is not generally considered a compliment.


David Stempel, MSU, is a professional waterman who enjoys diving, spear fishing, swimming, surfing, and is a two-time national underwater competitive hopscotch champion. When he is not in the ocean he spends his spare time as a medical student and national health care advocate.

Betty Tomson has been a UCLA volunteer for the last 13 years. Her passion for the arts dates back to her childhood in native England, where she began her career as a dancer and vocalist. During WWII, she entertained the Allied troops. Later, in America she worked as a researcher and writer, a job that encouraged her love of travel and took her all over the globe. She has two grown children who are both artists.

Mary Trahey has been an AAI at the NPI for just over three years. The rest of the time she is involved in local theatre and enjoys reading, writing, and a good coloring book!

Monissa Villanueva, MSU, was born and raised in Connecticut.

Daniel Zoghi, MSU, lives for racquetball, chess, and all manners of procrastination. He also aspires to become a good husband, father, member of the community, and to travel the world as a traitor to an authentic Victorian style flea circus. Those who share his interests can reach him at DanZoghi@ucla.edu.

Matthew Zimmermann, MSU, enjoys photography with his disposable camera and hopes that digital cameras will go the way of the 8-track. 

congratulations

to the winners of

The Vital Signs Prize for Literature and Arts:

Art

Dawn Ogawa,
"Still Life I and II"

Photography

first:

Monissa Villanueva,
"Native"

second:

Cheryl Go,
"Suomenlinna I and II"

Writing

Jed Santa Maria,
"Awakening"

with a special thank you to our judges for
their ongoing support and participation:

Neil Paige, MD
Thomas Alloggiamento, MD
and Robert Collins, MD



Beat staff. From left: Eleanor Curry, Monissa Villanueva, Daria Crittenden, Sara Acree, Karen Dean, Aaron Nayfack, Fernando Antelo

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and to all of the staff, faculty, and students who contributed their work.

We welcome submissions from all faculty, staff, and students of the UCLA Health Sciences community. Written submissions should be submitted on PC disk to Charlotte Myers/Office of Student Affairs/12-59 CHS/Box 951720/Los Angeles, CA 90095-1720. Art and photography should be scanned at 150 and 700 dpi, respectively, saved as tiff files, and submitted via disk or CD to Charlotte Myers. Unscanned artwork and photos and may also be submitted to Charlotte Myers. Please include a brief bio about the author/artist with all submissions. All medical student submissions to the UCLA Beat are eligible for the Vital Signs Prize for Art & Literature. Submissions are solicited via campus-wide email each fall. Entries must be received by November 1, 2004. Our website is currently under construction but may be viewed at: www.medstudent.ucla.edu/uclabeat.

