It is hard to believe the summer is gone, but we hope that the fun and sunshine will remain with us for the rest of the year. The summer left us with many lessons that will be incorporated into the new academic year, and of course, the rest of our lives. The summer served to provide our students with opportunities to perform research at local laboratories, working closely with renowned UCLA researchers, and in clinics throughout LA County. Other members participated in research activities not only at UCLA but in other continents. These experiences have left us better prepared to face the challenges ahead.

The fall will bring exciting opportunities. The new class of 2017 has joined us and it will be exciting to meet this new generation of medical students and future physicians. As usual, there are several mentoring and social events planned to give our students an opportunity to meet faculty and alumni, such as the LMSA Dodger game night planned for August 30th and of course the Lennox Health Fair on November 16th, which is one of our major events of the year.

It is then that with renewed spirits and a fully charged battery we begin our new 2013-2014 academic year. We are looking forward to a year full of new learning experiences that will allow us to grow not only as medical providers but also as individuals. We would like to congratulate the class of 2013 and welcome the new class of 2017. The LMSA will gain a group of mentors as the members of the class of 2013 make their way into their professional lives and we hope to hear from their experiences from time to time. At the same time, with the class of 2017, we gain a new generation of students that we are convinced will bring talent and passion to continue the mission of the LMSA. We are hopeful that these recent graduates and new students will join the current LMSA family to continue to serve and improve the health of our communities.
“Humbly Learning”
A Summer Global Health Experience in Peru
By Jasmin Reyes

Here, motor vehicles take “PARE” as a suggestion, not a command. So darting between oncoming cars while on my early morning jog was a skill I quickly learned. Car horns blared and clouds of exhaust filled my lungs with each breath. But despite these foreign country differences I continued my morning jogging routine. Because no, I wasn’t on vacation, I was living in Peru.

As one of four first year medical students in the Global Health – Short Term Training Program in Peru, I lived for four weeks in the capital city of Lima. From a previous experience on a medical mission to the Philippines, I had become disheartened with the lack of sustainability and the exoticism that came with the idea of serving the underserved internationally. My decision to apply to the global health program was therefore a thoughtful one. I came to Peru to learn Spanish. I came to learn how to make an impact abroad that would empower the local community. And I got what I came for.

I participated in a study that measured chronic disease risk factors in Pampas San Juan de Miraflores - a shanty-town on the outskirts of Lima. With steep rocky hills and only half the homes with water and sewage connections, Pampas is the home of primarily Andean immigrants who come to Lima for more opportunity. I was shocked to learn that even in areas like these, disease profiles are changing. Where we think we’d find rampant infectious diseases, we find that non-communicable diseases are instead on the rise. With 80% of chronic disease related deaths occurring in low and middle-income countries like Peru, diabetes, hyperlipidemia, and hypertension are no longer considered diseases that affect the rich. They disproportionately affect those who are poor. So through a partnership between researchers at Johns Hopkins University, Universidad Peruana Cayetano, and a non-governmental organization PRISMA, we measured BMI, blood pressure, lung function, and took blood samples with Pampas residents who otherwise could not afford this comprehensive evaluation. I was proud to participate in this study because I knew that this data could be used to create much needed interventions and at the same time was inspired by the trust that participants had with PRISMA’s técnicas de enfermeria. They exchanged besitos and called each other “mamita” – PRISMA has been serving their community for 27 years. Manifesting as low participant attrition rates, the trust that community members had with this NGO was an important aspect of successful epidemiological research.

Taking a daily one-hour bus ride to the outskirts of Lima meant that the people there spoke no English. And my courage often dwindled as I found myself tongue-tied with my project supervisor when I didn’t know how to say words in Spanish such as “age-stratified random sample.” But equipped with research protocols, Google-translate, and a hunger to learn, I found myself able to converse for hours about enfermedades crónicas, los factores de riesgo, y cómo la tasa de obesidad está aumentado en comunidades pobres. I’d return home feeling accomplished, exhausted, and most importantly humbled. I finally understood how immigrants to the U.S. might feel in their struggle to express themselves in a new language while still trying to make ends meet and live their daily lives.

When I was not at Pampas or in Spanish class, I was touring different medical centers. I learned how good medicine and public health can be accessible to even low-resourced communities. Instituto Nacional Materno Perinatal – despite being a government hospital that saw patients covered by what is our equivalent of MediCaid – was a pioneer in culturally competent alternative labor and delivery practices. With vertical birthing chairs, stability balls, and a bathtub, an Andean immigrant woman could safely give birth in a manner she was most comfortable with – standing and squatting included.

By living in Peru, I learned that sustainable and empowering work was indeed being done abroad. Whether it was a team of U.S. physicians who partnered with an established NGO to understand a rising chronic disease epidemic, or a public hospital that made culturally sensitive labor practices accessible to low-income mothers, people were fostering relationships and investing resources that enabled marginalized communities to reach for higher qualities of life. Four weeks in Peru was essential to my learning, and yet still was not enough. I humbly accept that during a global health experience, I receive greatly more than I could ever give. It’s the nature of being the visitor and novice. But with that gift we can pay-it-forward. Let’s continue to practice Spanish despite our heavy med school workload. Let’s continue to find sustainable ways to serve our World’s most poor.
History of Lennox Health Fair:  A Partnership Between Lennox School District, Hughes Space and Communication Company, and DGSOM

By Rosibel Hernandez

In 1992 Hughes Space and Communication Company (HSCC) approached the UCLA School of Medicine, now known as the David Geffen School of Medicine (DGSOM) at UCLA, with a project in mind. Recognizing the importance of science and education, HSCC wanted to develop a partnership with the Lennox school district to promote preventative health care and education. In order to do so, they requested the help of DGSOM at UCLA, so that together they could offer health education opportunities to residents of the Lennox school district.

The Lennox school district was chosen due to its need of educational and health opportunities, but mostly for its growth potential. At the time, this area of Los Angeles was a point of entry for recent immigrants, primarily from Latin American countries. The area served as a transition area for immigrant families, where they lived for 5 to 6 years before moving to more established locations, once economic growth and stability were achieved. With a steady population growth, a need for a centralized health care center in the community became evident. Many families were afraid of seeking health care for fear of legal repercussions. As a result, emergency rooms were often used as the only source of primary care. In addition, teachers in the Lennox school district were worried about the students’ nutritional habits and vaccination statuses. In 1992 there were over 27,000 residents in the Lennox district that lacked a community clinic offering affordable health care to non-English monolingual-low income families. With this information in hand, the HSCC, the UCLA School of Medicine, and the Lennox school district sought to develop a self sustaining program of primary preventative health care. Now in its 20th year, the Lennox Community Clinic has a different name, but the same goal: creating a healthier Lennox.

The initiative for preventative health care had two aims: development of a need-based health care system and empowerment of the Lennox district through community education programs. As such, the Lennox Community Health Clinic and bilingual Lennox Public Health Coordinator positions were born. The coordinators worked throughout the year, organizing professional volunteers to educate parents, students, and teachers on preventative health measures, while highlighting the resources available to the community. Monthly workshops addressing wellness and preventative health care were developed for parents and residents of the Lennox district.

“...children wrote and drew about wanting to become doctors and scientists when they grew up after having spent time with the UCLA medical students and physicians.”

On June 12, 1993, more than 100 volunteers, teachers, parents, physicians, and medical students worked together to organize the

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first Lennox Community Health Clinic. More than 230 adults and children were seen for health related issues. Of those seen, 101 individuals were referred for management of newly diagnosed chronic illnesses. Besides being evaluated by physicians, the children of the Lennox school district were introduced to new possibilities. To children of recent immigrants, medical students in white coats became a symbol of hope for the future; a glimpse into a profession they might one day be apart of, so that they too could help their community. Dr. Earl Homsher, co-organizer of the first Lennox Community Health Clinic, remembers that teacher involvement made the health fair a much greater success. “They put a lot of soul and heart into the community” he says. He also recalls teachers sharing with him that after these activities children wrote and drew about wanting to become doctors and scientists when they grew up after having spent time with the UCLA medical students and physicians. The seed of science had been successfully planted in the children. With the aid of Buford Elementary School Principal, Tom Johnstone, teachers and parents rallied together and empowered their community. The project was truly developing into a successful partnership; a collaboration between different organizations with a common passion.

The growth of this symbiotic relationship allows medical students a unique opportunity to work with underserved populations and learn about cultural competency while reinforcing the medical education gathered throughout the year

The Lennox Community Health Clinic, now known as the Lennox Health Fair, continues its efforts to bring health care access to everyone in need. In its 20 years, the Lennox crew has seen somewhere between 6,000 and 8,000 patients. Medical students, undergraduate volunteers, teachers, and physicians still work together to bring local health partners to the residents of the Lennox district. The growth of this symbiotic relationship allows medical students a unique opportunity to work with underserved populations and learn about cultural competency while reinforcing the medical education gathered throughout the year. Just as they did in 1993, the types of services offered include dental and vision check-ups, nutritional and health education, immunizations, and physical examinations. Equally important, the Lennox Health Fair acts as an initial connection between community health providers and residents. After the health fair, a referral system gives individuals the opportunity to continue to develop these relationships.

Currently students from the Latino Medical Student Association (LMSA) at the David Geffen School of Medicine at UCLA act as the primary organizers of the Lennox Health Fair. The biannual health fair works with the Lennox school district to serve the needs of the students, families, and area residents. With continual staff and faculty support, LMSA members work tirelessly alongside the Lennox school district to create a healthier Lennox. LMSA looks forward to the next Lennox Health Fair this coming November 16th, 2013 at Felton Elementary. Contact LMSA members Rosibel Hernandez or Elizabeth Canales for more information on how you can be apart of this legacy. We hope to see you there!
Immigration Health: Does the ACA Improve or Worsen the Situation?

By Caleb Wilson

During the past summer months the Center for Medicare and Medicaid services (CMS), along with the Health and Human Services (HHS), have been very busy getting ready for the full implementation of the Affordable Care Act (ACA), which starts to take effect with the opening of the exchanges on October 1st 2013. The ACA does many things but three of its most notable achievements are 1) to standardize care and requires insurers to offer a minimum number of benefits, known as Essential Health Benefits, 2) to provide generous government subsidies to those who otherwise would not be able to afford insurance, and 3) to expand Medicaid eligibility to those whose income is less than 138 percent of the federal poverty line. The ACA is truly making insurance and healthcare affordable to millions of Americans. The ACA does, however, explicitly state that undocumented immigrants are not eligible for the Medicaid expansion or the federal subsidies. So it seems that many people (an estimated 11 million) will still be in the same position they were before the ACA when it comes to healthcare. Although many consider this unjust as it stands, the situation may actually be worse than the previous statement leads us to believe.

Reasons why undocumented immigrants are worse off with the ACA than they were before:

Many economist and healthcare experts have predicted sharp increases in healthcare insurance premiums once the ACA takes full effect. This is to be expected due to the fact that the ACA also abolishes what is known as “medical underwriting.” Medical underwriting is the practice of charging different prices for the same health coverage to different people based on various health-related factors, such as the person’s past medical history and family history. This is similar to the underwriting that is done in the auto insurance industry, where males under 25 with a previous accident can pay more than double for insurance than it would cost for a female over 25 without a history of accidents. In the healthcare industry this was done because statistically these patients would use more healthcare resources and incur higher costs than otherwise healthy individuals. Since the ACA abolishes this, while also requiring insurance companies to insure anyone, the cost in premium for many Americans will substantially increase in order to compensate for these new high-risk individuals that will enter the insurance pool. This is why the Medicaid expansion and government subsidies are so important because they ensure that coverage is still affordable for many low-income Americans. However, since undocumented immigrants are ineligible for these provisions they will most likely face higher premiums that are unaffordable and therefore forgo medical insurance.

The main source of care for many low-income immigrants, especially those who are undocumented, is derived from Disproportionate Share Hospitals (DSHs). DSHs usually deal with a large uninsured population and provide a substantial amount of uncompensated and undercompensated care to low-income patients. These hospitals are provided annual Medicaid and Medicare DSH payment allotments in order to continue to serve their communities and make up for this loss of revenue. Since the ACA’s Medicaid expansion is predicted to expand coverage significantly to many Americans, HHS/CMS have determined that these hospitals will no longer need all the money they were originally receiving. This will lead to a substantial reduction in DSH payments beginning in the fiscal year of 2014. Even more concerning is that these DSH reductions will take place on a national basis regardless of whether an individual state decides to expand.

Medicaid coverage, which the Supreme Court decided was their right to decide. In states that elect not to expand Medicaid these hospitals will be receiving less funds but still have to deal with the same population. Therefore, it is likely that many of these hospitals will be forced to start charging higher co-payments, turning away new patients, and even closing their doors permanently. As mentioned previously, these hospitals play a vital role in providing care for low-income individuals and any financial stress on them will undoubtedly be inadvertently transferred to the patients they serve.

Immigrants and their contribution to public health programs:

Another contemporary, albeit misguided, view in the United States when it comes to immigration is that immigrants tend to drain essential resources from native, U.S. born, citizens and thus the U.S. needs
Immigration Health: Does the ACA Improve or Worsen the Situation?

(CONTINUED FROM PAGE 2)

harsher laws to control immigration. This has been especially true in regards to immigration reform and healthcare. When politicians begin to discuss how to control the escalating cost of our health care system, a simultaneous discussion about immigration reform is almost certainly going to ensue as well. The current view is that immigrants, many who are impoverished, low-income, undocumented, and uninsured, rely heavily on uncompensated care and government subsidized programs such as Medicaid, Medicare, and their respective Disproportionate Share Hospital (DSH) programs. Basically, as supporters of this view argue, immigrants take from but contribute little, if any, to the healthcare system and drain medical resources from native born, tax-paying and contributing, U.S. citizens. A recent article published in Health Affairs by Leah Zallman, Steffie Woolhandler, David Himmelstein, David Bor, and Danny McCormick presents new evidence contradicting this argument.

At first glance, this argument would seem to make intuitive sense; however, it is clear that it relies on two important premises: immigrants do not significantly help finance our health care system and immigrants utilize and spend more. The aforementioned study sought out to test these hypotheses and looked at these variables as they relate to the Medicare program. Specifically, the authors looked at the total dollars contributed to and received from the Medicare Hospital Insurance Trust Fund, which pays mainly for inpatient care, for both immigrants and U.S. born citizens older than 65. They found that between 2002 and 2009 immigrants contributed 115.2 billion IN EXCESS of what they utilized while U.S. born individuals withdrew 28.1 billion more than they contributed. So instead of the contemporary argument that U.S. born citizens are financing the healthcare of immigrants, the data show that in fact immigrants are partially subsidizing U.S. born citizens, at least when it comes to Medicare inpatient care. The authors go on to explain possible reasons for this, citing the fact that many immigrants are working-aged adults that likely contribute to payroll taxes under valid social security numbers. Even those that are undocumented frequently use social security numbers linked to fictitious names or belonging to someone else and in essence still contribute to payroll taxes because employers need only report, not verify, Social Security numbers for their employees. The authors go on further to discuss the policy implications of their findings stating that laws that reduce immigration will most certainly hurt Medicare financing. Instead it may be more prudent to provide a less obstructed path to citizenship to the estimated 11 million undocumented immigrants in order to drastically decrease the “off the book” payments and increase total payroll contribution by the immigrant population.

The astute reader, while perhaps impressed by these findings and their possible implications, may be wondering why the authors did not compare Medicaid’s (also known as MediCal in California) contributions and expenditures for the aforementioned groups. Indeed it seems plausible that the Medicaid data might paint a different story since “most immigrants are working aged adults” and therefore may not qualify for Medicare causing them to utilize Medicaid more. This crossed my mind as well, but an answer to this question might be that it is harder to obtain the said data for the Medicaid program as compared to the Medicare program. Furthermore, it should be noted that in addition to all undocumented immigrants, many legally residing immigrants are also ineligible (although they still have to pay taxes) for the Medicaid program if they have not been legally residing in the U.S. for at least five years. It is improbable that the story would be much different within the Medicaid program.

Conclusion:

Despite the many great things the ACA does for many low-income Americans, it leaves one of the most vulnerable populations defenseless to the inevitable premium price increases. In addition, in many states (around 20) that elect not to expand Medicaid, immigrants that frequently use DSHs as their primary source of care will most likely face new financial problems with the commencement of the ACA provisions. The situation is getting worse for undocumented immigrants despite data showing that they do indeed significantly contribute to the same government programs that they are being denied access to. This calls for a significant policy discussion in relation to immigrant healthcare and reform laws to help better serve this population.
Student Profiles: The Next Generation of Latino Physicians

We asked two DGSOM Latino students to share a bit about themselves to get to know who they are, how they got to DGSOM, and what their plans for the future are. In this edition, Viviana Huang Chen, an MS3, and Emilio Ramos, an MS2, give us a glimpse of themselves.

I was born in San Diego and grew up crossing the San Ysidro border on a regular basis. My family has a multi-generational history of living on both sides of the border and being part of the border community with all of its grandeur, fascinating history and shortcomings.

In high school- to no one’s surprise- I had no idea what I was doing. About anything. I was in one of the least known garage bands in history, playing sold out shows in front of hundreds of my dad’s tools and several washing machines and driers. In all seriousness, I was interested in music or joining my dad as a garbage man. As life tends to ignore plans and decide otherwise, I had an inspirational biology teacher at Castle Park High School named Mr. Manroe who encouraged me to apply to college. I hesitantly applied to UC San Diego and majored in General Biology thinking, “Why not?”

The most challenging thing about medical school has been to follow the rules and be on time to things. I tend to like to do things my own way, on my own time and have found myself running- literally sprinting- late to PBL and afternoon sessions every week. At least my mile time is much improved. Staying on task is also challenging since I can easily entertain myself with extracurriculars like guitar, cooking or running with my wife, Julia. I don’t take myself too seriously, but medical school can be a serious matter and I need to respect it accordingly.

Aside from the obvious - a dad and family who worked the strawberry and tomato fields of Southern California - my biggest inspiration comes from curiosity and trying to emulate parts of the people who inspire me, current UCLA faculty and classmates included. I like learning all that I can about the universe and life itself and have been lucky to find people that are willing to love, teach and help me. It has been only in the last few years that I realized I can do

Lucky me, I have two hometowns: The first one is Mexicali, B.C., México where I was born, and the second one is Brawley, California, where I lived since middle school. UC Berkeley is my alma mater (Go Bears!). While at Cal, I double majored in Molecular & Cell Biology with an emphasis in Immunology-Infectious Diseases, and Hispanic Languages & Bilingual Issues. I remember that once I decided to go to Berkeley I looked through its course catalogue and the Immuno major seemed very exciting and appealing, so without knowing much more than that I somehow ended up not changing my mind. Once there, I felt the need to balance my days with something different and enjoyable. Unexpectedly, I ended up walking out of my Spanish advisor’s office having declared Spanish as a major rather than a minor. Go figure! I loved the linguistics and issues of bilingualism so much that I ended up writing an honors thesis!

My interest in medicine started when I saw too many family members hitting roadblocks unable to obtain the medical care they needed and deserved, whether it’d be problems with access, quality, or plain linguistic barriers. I figured that by doing something about it and becoming a provider of care I would be in a position to change this.

The everyday challenge for me has always been balancing 1) the need to study, learn and be a student, with 2) the urge to help and positively impact the community I now live in, and 3) the responsibilities of family and friends. In addition to school I do volunteer work. LMSA, SNMA, SRHC and the PRIME Council all have their own ways of positively impacting the community at large through mentorship, health fairs, provision of health care, and teaching English classes, amongst the many other amazing service projects that I don’t have room to list out. I am very honored to have been a part of all these wonderful organizations that have allowed me to “give back” while

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something special with my life, despite my flaws. At some point, it dawned on me that my family members never had the privilege to choose their occupations and that I would have to use my imagination to go beyond what I was able to see around me. I also happen to have a healthy fear of wasting opportunities and not making the most of my time with my loved ones.

I would lean toward any specialty that would best allow me to incorporate basic science research and community service. I’m not married to any idea at the moment, but my favorite lecturer of first year was Gasser Hathout. I was fascinated by his intelligence, strong speaking style and was on the edge of my seat for both of his two-hour lectures. At the end of the first one, I was so happy that I felt like jumping in my corner of the lecture hall and giving him a standing ovation. Needless to say, I saved myself the embarrassment. Something in the Radiological Sciences might be possible, but that depends on where life leads me.

What I want from life is to keep learning all that I can about everything. It’s part of my problem since I seem to lack focus at times. I am looking forward to starting a family soon and sharing a career in biomedical science with my Julia. I like the idea of developing new medicines and had a great time working as a scientist at Amgen this summer of 2013. I want to continue getting better at science, the guitar, astronomy and brewing beer. This year I had several explosions in my apartment from over-fermented beer that I made up for with lots of foot rubs and home-made Mexican dishes. I am excited to see what becomes of me.

Everyone has a different path to medicine and there is no reason why you can’t do it either. All you need is one acceptance (I am sure I am not the only one). The medical school application process is prohibitively expensive and difficult, but there is no way around it. I was surprised to find that some of the best scientists and doctors that I have worked with were not accepted to medical school the first time around.

My favorite moment of medical school so far has been going into the anatomy lab during Block 2 was when I first felt like a medical student. Until then we’d only had basic science lectures and it felt like I was 10 years back and in college. I cannot accurately describe the feeling of placing my hands on the bodies those first few times - a mix of hesitation, sadness, curiosity, disbelief and respect - all while showing nothing on the exterior.

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My current interests in terms of specialties are family and community medicine. I really feel strongly about empowering families and communities to achieve and maintain good health via disease prevention and health education.

My most important influence was my Mother. She was my first teacher, role model, and my lifelong inspiration. Simply put, my parents and family are the primary reason why I chose the field of medicine, so I am living my dream of becoming a physician to care for those in medically underserved areas and to help eliminate obstacles in accessing culturally sensitive and responsive care. Somewhere down the line, I would love to establish and run a free clinic system in areas of most need while continuing to see patients, and impact the community through education and mentorship.

My most important advice to those interested in medical school is to learn everything you can, and when you have the opportunity share with others what you’ve learned along the way, do it. And when you are fortunate enough and have the chance, do what you can to help others and give back – I can’t stress how important it was for me to volunteer at clinics and mentor others as a reminder of where I am and where I want to be.

We all have things we wish we had done differently, but the key is not wish for the past to change, but learn to change the future.

In terms of doing something new at UCLA, let’s see; Does the rowing machine at the Kinross gym count? Well, in all honesty, working with the homeless community has been a new underserved population that I had not necessarily worked with prior to medical school, and I have definitely found myself looking for many ways through my involvement in Student Run Homeless Clinics (SRHC) to positively impact this community.

My favorite moment at the David Geffen School of Medicine so far has been finishing the very last lecture of our preclinical years and walking out to the cheering tunnel of first year medical students high-fiving us!

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 Didn’t get enough of Emilio and Viviana? Don’t worry it happen to everyone! We have the extended version of the student profiles and more on our website. http://www.medstudent.ucla.edu/lmsa
Do what you want to do. Don't compromise on your passions.

With a cheerful smile on his face, Dr. Warwick J. Peacock shares the story of his life adventures as he followed his passion for medicine. Born and raised in South Africa, Dr. Peacock always had a calling to help others. As a teenager following his innate desire to work with others and serve as a symbol of hope and relief, he was convinced he would become a priest. As he fell in love with medicine, he knew that he had to follow his passion no matter where it took him. After making a promise to himself that he would approach medicine with the same dedication he would have approached being a priest, Dr. Peacock went on to study medicine at the University of Cape Town, South Africa.

Training Years

Dr. Peacock's eyes widen with pleasure as he recounts the six years of medical school as the best years of his life. Fascinated with people and the complexities of the body and mind, Dr. Peacock was “learning [the] most exciting things to learn in life”. With a large patient volume and little physician availability, Dr. Peacock was able to get hands on experience right from the start. Describing medical school as the “ideal environment”, he devoted himself to learning everything there was to learn. His dedication to understand every aspect of medicine, from psychology to dentistry was rooted in his desire to work as a “real doctor” in rural family medicine for three years following medical school.

“Real Doctor”

Working in Touwsriver and Durban, South Africa as a family medicine physician was the most “terrifying but wonderful experience” of his life. Armed with only a few books as his reference, and as the only physician in the small rural towns Dr. Peacock could not afford the luxury of self-doubt. There were always patients to see, house calls to make, and occasionally puppies to deliver. With a sparkle in his eyes and his ever-lasting smile, Dr. Peacock spiritedly describes his first day on the job.

Working in Touwsriver and Durban, South Africa as a family medicine physician was the most “terrifying but wonderful experience” of his life.

Having arrived minutes before the departure of the previous physician with only a small suitcase in hand, Dr. Peacock still remembers the first four patients he encountered. Just as he arrived, even before he could unpack his suitcase, he received a call of his first patient: a very ill little boy. This little boy had helped his father harvest grapes from their small farm, and had become very sick from pesticide poisoning. As the child was being brought to the clinic, Dr. Peacock reviewed the medical supplies available to him. He realized he had more supplies in his doctor’s bag than the clinic had, and was thankful that he remembered to bring atropine- a small vial that saved the little boy’s life. After stabilizing the boy at the clinic, he was then taken to the hospital an hour and a half away via the only ambulance the clinic had. As soon as Dr. Peacock could no longer see the ambulance driving along the dark and curvy dirt road, he received a call from his second patient of the night: a woman in labor bleeding to death. Unable to help her in the clinic, he put her in his own mini car and drove her to...
the hospital. After a two hours car ride, in which he could barely see where he was going in the dark, abandoned street, he delivered a healthy baby outside of the hospital at 10pm. He then got back to the clinic, ate his first meal in Touwsriver, and met his third patient at midnight. It was a young girl, 17 years old with seizures. He would later find out the seizures were not really seizures but a manifestation of sexual abuse. He was able to stabilizer her, went back to his house, and sleep for two hours before his next patient. At 4 am he heard the loudest most obnoxious alarm he had ever heard: the railroad alarm informing him of his fourth patient. Another ill little boy was riding on the train hoping to reach Dr. Peacock in time.

As Dr. Peacock stood waiting on the train platform, he saw the sun rising over the valley, a beautiful image of peace and tranquility etched in his mind for the rest of his life. Waiting, he knew there was only one reason the train was late: his fourth patient had died trying to reach him. Tired he drove back to his new home. As he passed the clinic, which was only a few yards from his house, he saw lines of patients already waiting to see the new doctor. “I just had to get on with it,” he remembers. He was the only physician there and the patients needed him.

Those three years made him into the resourceful physician he is today. Seeing infants die from dehydration and malnutrition, he created his own nutrition solution and used his living room as a treatment center for the children and their mothers. There were always patients to see, and so there “was not time to feel overwhelmed”. He felt fear of not being able to help his patients, but overtime it he felt prepared. There were moments of happiness and pride in what he was accomplishing. Serving as the only medical provider for miles, he became a man with many titles. On any particular day he could be saving a donkey from a gunshot wound in the fields, or he could be helping a dog deliver her breached puppies underneath a kitchen table with a pair of forceps. He was also a dentist and coroner, but most of the time he was a just a “real doctor”.

Neurosurgeon

After completing his three years in rural family medicine, Dr. Peacock went on to become a pediatric neurosurgeon, studying in both Cape Town, South Africa and Toronto, Canada. After completing his fellowship in pediatric neurosurgery in Canada, he returned to Cape Town and became the only pediatric neurosurgeon in the entire African continent. Following his love of movement, he became interested in cerebral palsy and epilepsy, conditions that severely affect body movement. He developed safer surgical techniques to treat such conditions and improve body function for the children. His techniques, still used today, allowed him to travel all over the world. As he fondly remembers, “there are not many places I haven’t been to”.

Dr. Peacock always had the patient’s best interest at heart. Instead of having patients come to him, many times at the risk of selling everything they ever owned to save their child, he would travel to them. He would schedule follow up appointments in different countries, teaching local doctors his own skills so that other patients could be taken care of. He sought to spread his own knowledge, giving other physicians the tools necessary to save more lives than he could ever do alone. Every where he went, he left a legacy behind, never with the intention of being know as great but rather just simply trying to do the best for his patients.

In 1986 he came to UCLA and developed a world-renowned pediatric epilepsy center. Saving children from permanent debilitating brain damage, Dr. Peacock only had one motto in his OR: “Let’s get it done”. As with everything else he did, he was always 100% committed to his patients. Dr. Peacock has performed more than 80 hemispherectomies, and has one of the largest operation records for epileptic disorders in the world, yet if asked what he enjoyed the most his response is quite simple. In all his years of practice what he will always cherish is the long lasting connections with the families. Once you save a child and improve the quality of life, you become a part of the family. Even after decades of practicing in South Africa, Dr. Peacock still keeps in touch with his patients and their families. “family reunions” he calls them, when he visits them from time to time.

Dr. Peacock has some advise for physicians in training: follow your passion and never forget the patient. Your passion will make you great. If you truly love something make it happen. Never compromise your goals for materialistic needs or fears. As you move on in your career and you decide what you want to accomplish, never forget the patient. “[The] satisfaction of medicine is the connection you make to the patient.” Talk to the patient and don’t rely on new technology to replace the power of listening. Show your patient that you care and put yourself in their situations. “How would [you] feel if it was you?” Dr. Peacock asks. Keep an open-trusting relationship with your patient and “get it done”.

Neurosurgeon
LMSA IN THE COMMUNITY

LMSA member, Henry Lew (MS2), performs a blood pressure exam to a day laborer during a health fair in Hawthorne California. LMSA members meet with these day laborers once a month to promote healthy activities as part of their PRIME program.

UCLA & DREW LMSA members Bert Pineda, Cynthia Mendez and Sergio Alvarez pose for a picture along with LMSA members of other West coast medical schools during a recent Latino Medical Student Association West Coast Meeting in Portland Oregon.

LMSA members talk to undergraduate students from CSU Northridge during an event organized by Dr. Efrain Talamantes. From left to right: David Torres Barba, Bert Pineda, Karen Martinez and Jennifer Menjivar.

LMSA members Cynthia Mendez, Jasmin Reyes and Karla Gonzales pose for a picture along with undergraduate UCLA students during “MLK Day of Community Service” at Belmont High School.

LMSA members and their physician mentors pose for a picture during a recent Latino Medical Student Association Executive Board Conference held at the David Geffen School of Medicine at UCLA.

Current LMSA board members pose for a picture with a couple of students from the class of 2017 during the Student Organization Fair held in the CHS plaza.
**LMSA FALL 2013 EVENTS**

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**UCLA & DREW LMSA**

**FRIENDS – COMMUNITY – MEDICINE – EDUCATION**

The UCLA / DREW LMSA group is always willing to collaborate and contribute to the improvement of health and education in our community. If you would like to know more about us or collaborate please check out our website and do not hesitate to contact us. Thank you for reading our newsletter, we hope you have enjoyed it and we will be waiting to hear from you soon...

For more about UCLA/DREW LMSA visit our website or find us on Facebook:

www.medstudent.ucla.edu/lmsa
www.facebook.com/groups/UCLA.CDU.LMSA/

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