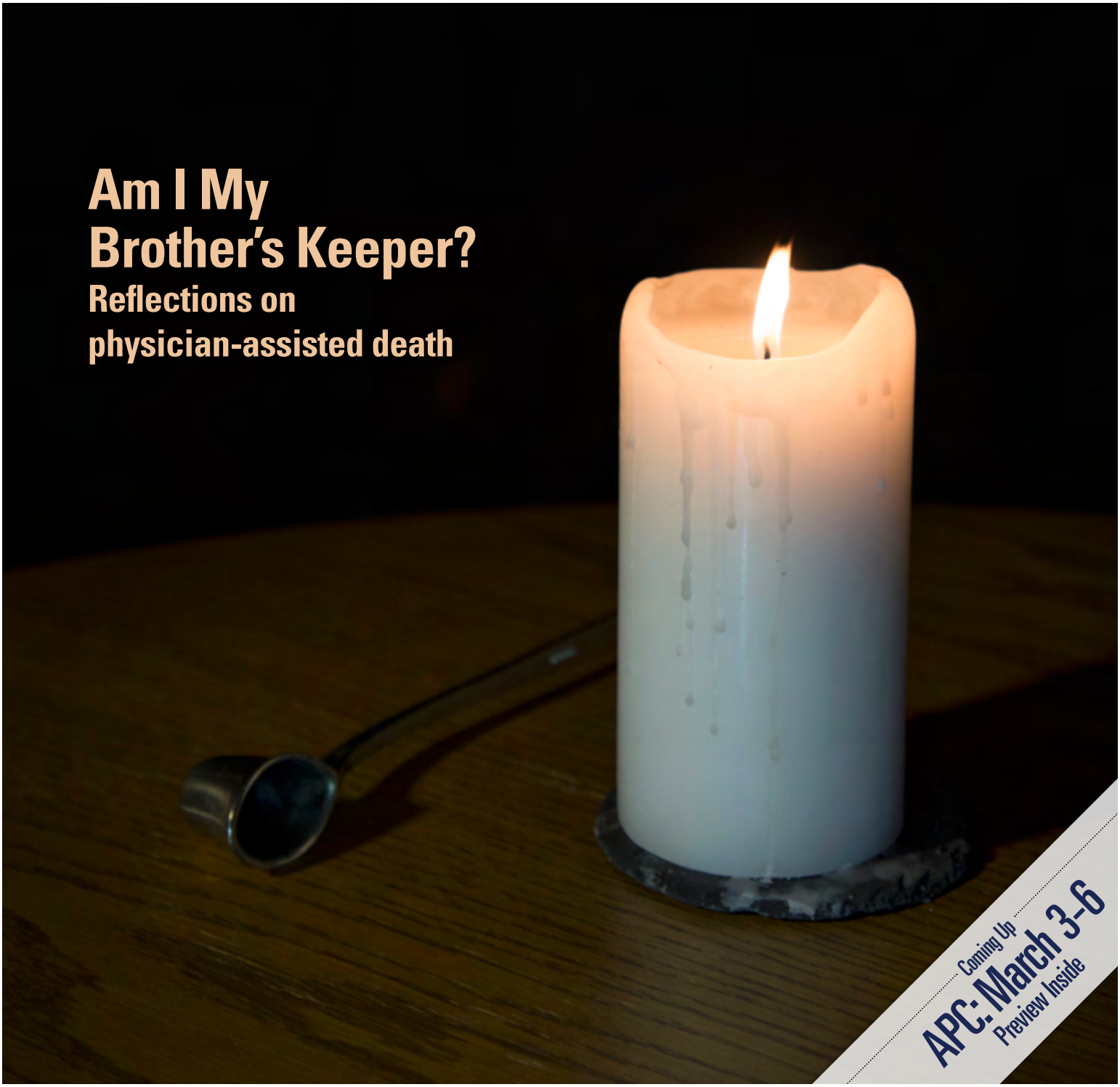
4-2017

# Alumni Journal - Volume 88, Number 1

Loma Linda University School of Medicine

Alumni
# JOURNAL
Alumni Association, School of Medicine of Loma Linda University
**January–April 2017**



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## Alumni JOURNAL

January–April 2017
Volume 88, Number 1

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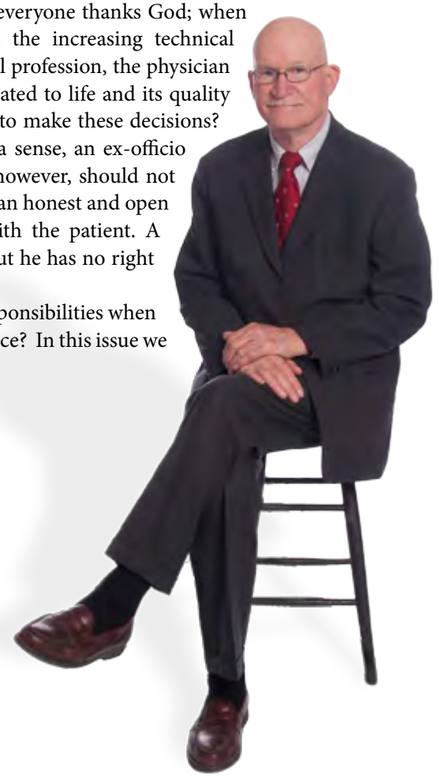
# To Prolong Life

In the beginning God created man. The intent was that man should live forever. But following the incident of Eve with the serpent and fruit, we find that man became subject to death. The when and where of death for each of us is unknown, but it is a fact of life that the "living know that they shall die" (Ecclesiastes 9:5). Throughout recorded history man has striven to understand death and to prevent its occurrence when possible.

"What would it be like to live disease free?" This is a question that may cross the mind when contemplating the health issues that afflict people. Dr. Oliver Wendel Holmes, in his poem "The Deacon's Masterpiece," describes the long life of a perfectly constructed carriage without a single part that breaks down. Instead, after 100 years, its driver finds himself sitting on a rock, the "poor old chaise" having fallen apart suddenly in a heap. "You see, of course, if you're not a dunce, / How it went to pieces all at once,— / All at once, and nothing first,— / Just as bubbles do when they burst."

Ideally, this is what happens when a healthy old creature dies. There is no central flaw. There is no gradual deterioration. The dying process is built into the system so it can occur all at once at the end of a pre-clocked, genetically determined allotment of living. A surgeon I once knew commented to me, "When it is my time to go, I want to be on my farm in Vermont taking a walk in the woods." One day, he went for his walk and did not return. He was found along the path of his usual stroll, dead from a heart attack.

One must recognize that this is the ideal process and circumstances which come to our minds at the phrase "death with dignity." Unfortunately, on earth there is usually disintegration of one or two, or perhaps three, bodily systems over a period of time.



Someone has said, "When the patient lives, everyone thanks God; when the patient dies, it's the doctor's fault." With the increasing technical advances being made by science and the medical profession, the physician is more frequently having to make decisions related to life and its quality and value. Do we, as physicians, have the right to make these decisions? My supposition is yes, because we become, in a sense, an ex-officio family member of our patient's. This decision, however, should not be made in isolation by ourselves, but only after an honest and open discussion with the family and, if possible, with the patient. A physician has every obligation to prolong life, but he has no right to prolong the act of dying.

If I am my "brother's keeper," what are my responsibilities when my patient wishes to die and requests my assistance? In this issue we reflect on physician-assisted death. ■

Burton A. Briggs

**Burton A. Briggs '66**
*Editor*





# New Staff Videographer/ Photographer

With Calvin Chuang's transition into his new role as executive director of the Alumni Association there was a hole left in the media production department. Jon Hwang joined the staff in September 2016 to help fill that void as videographer and photographer.

"I've appreciated getting to meet new people and hear different stories," Jon says so far of his time at the Alumni Association. He has jumped right into his work, creating a number of short videos about the Association to show at the Annual Postgraduate Convention (APC), as well as videos about graduating seniors for the APC Gala. He looks forward to further developing his ability in documentary storytelling and says he is grateful to work with Calvin, who is familiar with the ins and outs of the filmmaking process and can provide constructive feedback.

Jon was born at the Loma Linda University Medical Center and has lived in the Inland Empire his entire life. He graduated with a degree in entrepreneurial marketing from La Sierra University. Over the years he has explored a variety of interests including calligraphy, tailoring blazers, and baking French macarons. In high school he ran a small side business designing and making duct tape wallets that he sold to his classmates. He may still be taking orders if you're interested. ■

# New Perpetual Members

New or Upgraded Memberships
January 1–December 31, 2016

Life (perpetual) membership dues are paid once and fund not only member benefits, but the Alumni Association endowment, the income from which supports operations and special projects benefiting alumni and students.

A very special **thank you** to the alumni listed below who have invested in the Alumni Association through perpetual memberships or upgrades in 2016. Thanks also to our previously established perpetual members and those who have made donations to support the Alumni Association. To see a complete list of perpetual members online, visit www.llusmaa.org/page/perpetual-memberships.

For those considering perpetual membership or an upgrade to your current membership, now is the time. See the back cover for more information. ■

**Triple Diamond:**
Mark E. Reeves '92

**Diamond:**
Kelly D. Beams '87
David H. Creamer '04
Edwin H. Krick '61
Roland E. Lonser '67

**Platinum:**
Andrew C. Chang '90
J. Mark McKinney '87
Harold Del Schutte '84

**Gold:**
Donna L. Carlson '69
Donald R. Massee '86
Gina J. Mohr '96
Walter P. Ordelheide '54
Gordon R. Osborn '54
Michelle E. Reeves '86
Tamara L. Thomas '87
David C. Ward '08
Sabrina C. Ward '08
Kee P. Wong '74

**Silver:**
Hans-Peter Boksberger '79-A
Robert A. Christenson '80-B
Albert B. Crum '57-aff
Kenneth R. Jutzy '77-A
Laura Ann Foster '12
Jeanette M. Smith '81
Gregory R. Wise '73-B

# Letters to the Editor

**Fellow Bun Burner** Just picked up the latest *Alumni JOURNAL* and wanted to share my enthusiasm as a fellow biker. Pictured is a trip two summers back going north. I remember my Bun Burner ride as an exhausting loop into Idaho and Montana and back. Haven't had the courage to sign up for a full Iron Butt 11-day rally. Not sure I could deal with the fatigue safely. I enjoyed your editorial ("Of Worries, Doubts, and What ifs," September–December 2016, page 2).

–**Richard A. Flaiz '78-A**

# APC Future ...

For the 2017 Annual Postgraduate Convention (APC), the Alumni Association Board of Directors, together with the APC Governing Council, is working to ensure the same quality and distinctiveness as in the past, but integrated into the first Loma Linda University Health Homecoming weekend (see the 2017 APC Preview on page 14 for more information).

We anticipate that APC attendees will make up the significant majority over the weekend. However, this will allow alumni to participate in cross-disciplinary educational events if they so desire. In addition, it gives those who have friends and family who are graduates of other LLU schools the chance to socialize together while still preserving the excellence and uniqueness of APC for School of Medicine alumni.

Over the past 85 years, APC has maintained an approach of flexibility, but always with a relentless focus on educational excellence and innovation. This has allowed it to stay highly relevant for nearly a century. The Board of Directors and the APC Governing Council see this year's APC as part of that tradition. As in the past, the Board will closely monitor and make adjustments as necessary to maintain the educational quality for which APC is known.


*Two attendees of the 50th Annual Postgraduate Convention in 1982 exit Gentry Gym, where the technical exhibits were hosted from 1969 to 2005. This photo was first printed in the April–June 1982 issue of the* Alumni JOURNAL.

Over the years, APC has experienced a number of "twists and turns," as seen on the following page. In spite of this, the longstanding Alumni Association event has provided alumni with an opportunity for educational excellence and an invaluable time to renew relationships. We are planning for this tradition to continue long into the future.

See you at the 85th APC! ■

Mark Reeves

**Mark E. Reeves '92**
*Alumni Association President*

## Register today for the 85th APC!

See page 14 to learn more about this year's event.

**Note to annual and perpetual members:**
Turn to page 23 to find a voting ballot for electing new board members. Please complete the ballot and return it to the Alumni Association office, or vote online at the link provided on the ballot. Thank you for your participation.

# ... and Past

The Annual Postgraduate Convention, better known as APC, is turning 85 this year. It has taken place annually in one form or another without interruption since 1933. Most alumni have experienced APC, whether as a student or after graduation. However, even the most ardent fans of Alumni Association and School of Medicine history may not know some of the events that have occurred along the way in APC's long and distinguished history. Here is a compilation of a number of APC facts from across the years. How many do you know?

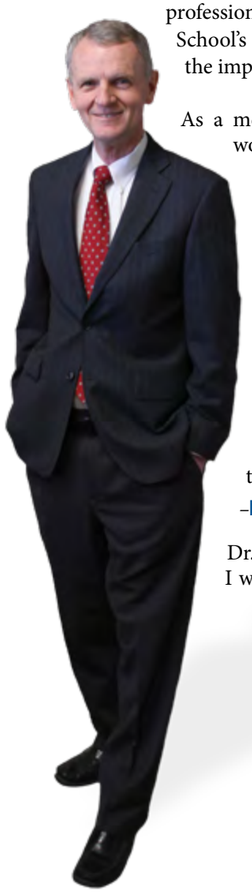
- In the fall of 1932, four College of Medical Evangelists alumni—**Roger W. Barnes '22**, **Malcolm R. Hill Sr. '24**, **Walter E. Macpherson '24**, and **G. Mosser Taylor '24**, along with **Benton N. Colver '04-AMMC**—met to discuss the need for a postgraduate education program.
- This meeting gave birth to what was known in those days as the Alumni Clinical Congress (ACC).
- The first ACC was held in 1933, after a year of planning. The clinics, demonstrations, etc., were held at the White Memorial Hospital. The registration fee was a staggering $1.00.
- The March 10, 1933, Long Beach earthquake occurred two days before the first congress on March 12. The attendees, "unshaken," were not deterred from attending.
- The 1934 Congress added a tour of the LA County Hospital.
- The 1935 meetings were expanded to a full day.
- Beginning in 1938, individual programs were mailed to every alumnus in California and Arizona.
- In 1940, the registration fee was increased to $2.00.
- The Congress in 1943 reflected the somber mood of World War II.
- Because of World War II, the congresses were canceled from 1944 to 1946. In 1947, the ACC re-emerged for one last time.
- In 1948, the ACC merged with the Postgraduate Assembly meetings, which had held didactic lectures, without interruption, since 1934. The merger resulted in meetings under a new name: the Alumni Postgraduate Assembly (APA).
- In 1948, the meetings was expanded to three days.
- In 1951, the APA moved to the Biltmore Hotel in downtown LA. The three-day package cost $15.00.
- In 1953, the name once again changed, this time to "APC": the Alumni Postgraduate Convention. The first APC was held at the Ambassador Hotel in LA.
- During the '50s and '60s, the scientific assemblies, exhibits, and banquets were held either at the Biltmore or Ambassador hotels.
- APC 1965 marked the first time the 25th and 50th anniversary classes were honored at the annual banquet.
- Beginning in 1968, all religious programs were held in Loma Linda, as well as the refresher courses.
- Gentry Gym first hosted the technical exhibits in 1969.
- The year 1972 marked the 40th year of APC and proved to be the last year it was held in Los Angeles.
- In 1973, APC was held for the first time entirely on the Loma Linda campus.
- In 1976, the annual banquet moved from the San Bernardino Convention Center to the Disneyland Hotel.
- In 1977, the name of the 45th APC was changed once again to what it is today: from "Alumni" to Annual Postgraduate Convention.
- In 1992, the annual banquet was held at the Disneyland Hotel for the last time, after which it moved to Ontario.
- In 2005, APC was held for the last time in the Gentry Gym. Between 2006 and 2009 it was hosted in various campus locations until moving to its current site at the Centennial Complex.
- In 2015, the APC annual banquet moved from Ontario to the Riverside Convention Center.
- Here are some 2016 APC numbers: 1,182 APC attendees, 458 annual banquet attendees, 160 scientific posters, and 31 technical exhibits.
- In 2017, APC will celebrate its 85th year.
- In 2017, the Alumni Association's APC will share the weekend with the university-wide LLUH Homecoming event with the understanding that the Alumni Association will maintain its stellar APC tradition. ■

# In Tribute: Wil Alexander

**Wilber Alexander, PhD, '93-hon** died last November. He was 95 years old. He was professor in both family medicine and the School of Religion and the founding director for the Center for Spiritual Life and Wholeness.

The last message I heard from him was the homily he gave September 24, 2016, at the memorial service for **Louis L. Smith '49**. As he spoke, I marveled that Dr. Alexander was as cogent and relevant as he was 43 years ago when he first made bedside rounds on unit 6100 at LLUMC. He was an indispensable component of medical student, resident, and faculty education and wellness for more than two-thirds of the School of Medicine's living alumni. Dr. Alexander's teachings and influence played a crucial role in redefining the spiritual mission of our School.

Receiving news of Dr. Alexander's death, many wrote eloquently about what he meant to their personal and professional lives. Sharing excerpts written by the School's alumni and students effectively conveys the impact of this gentle, spiritual giant:



As a medical student, I always loved when he would come on rounds. He was not a physician, but he understood physicians better than anyone I know. I have modeled my approach to patients more after him than after any physician. I am so thankful to have known Wil.

–**Richard E. Chinnock '82**, *Chair, Pediatrics*

He was a remarkable individual who made a great contribution to individual lives, like mine, and to institutions like Loma Linda. The worlds of religion, of education, and of ethics could use thousands like him.

–**Irvin N. Kuhn '55**, *Emeritus Professor, Medicine*

Dr. Alexander welcomed me years ago when I was a young and clueless medical student. He remembered my name, and he made me feel special. I learned much from him, most importantly how to draw out of patients things they are uncomfortable sharing.

–**Laura D. Nist '95**, *Associate Professor, Neurology*

Dr. Alexander taught us that when we understand the uniqueness of each patient we are enabled to practice medicine with compassion. Though we have had many legendary figures at LLU—with campus buildings and awards named in their honor—none has had more of an impact on the practice and art of medicine on this campus and beyond than Dr. Alexander.

–**Anthony A. Hilliard '02**, *Associate Professor, Medicine*

"I picked this flower for you," Dr. Alexander said, as he handed a lavender flower to a young patient. It seemed as if the corners of her mouth would touch her ears. What seemed a small gesture meant the world for this patient. Dr. Alexander then began to talk about her life, family, and kids. I left "Love Rounds" as a witness to the epitome of whole person care and the value of patient rapport. I kept telling myself, "I hope to be like him."

–**Michael Nwosu ('17)**

Since I have been dean, Graham Maxwell, **Jack W. Provonsha '53-A**, and Wil Alexander have passed away. These men of the cloth have profoundly and positively defined what Loma Linda's value-added is to its students. These three taught and showed us a relevant God who we can unabashedly bring to the patient's bedside—my deepest and most profound gratitude to each one of them. As to Wil Alexander, the dedication in the School's devotional book "Evening Rounds" says it best:

> "Lovingly and gratefully dedicated to Wil Alexander, Whom Christ has used to bring wholeness to patient and healer alike." ■

*See page 48 for Dr. Alexander's obituary.*

**H. Roger Hadley '74**
*School of Medicine Dean*





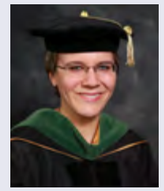
# Senior Interview Host Program Continues to Help

The Senior Interview Host Program connects alumni and senior medical students who are in the interviewing process. These alumni "hosts" provide assistance to the traveling seniors such as transportation to and from the airport, overnight housing, and advice.

Seniors can easily find a list of alumni who have opted to be part of the host program—as well as contact them—at the Alumni Association website: www.llusmaa.org. Interested alumni can opt in as a host through their profile pages at the website as well.

Thank you to those alumni who have been able to support a senior in some way through the program.

To the right are testimonials from a couple of seniors who have been hosted in the past. ■



*"I had a very positive experience staying with **Dr. Andrew Giem '04** and his wife in Sacramento. They hosted me at their home overnight, including breakfast the next morning, and it was amazing! It was practically like staying at a luxury hotel."*

–**Sarah Massatt '16**

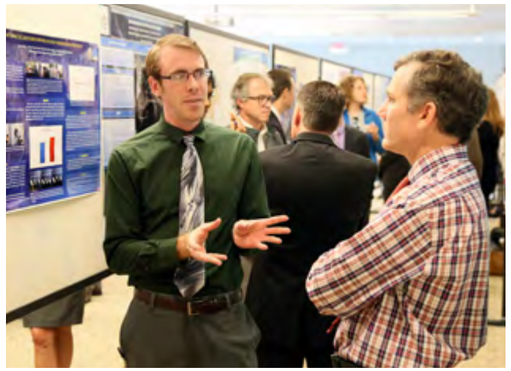
*"I stayed with **Dr. Max Taylor '55** and his wife in Phoenix, Arizona. They shared their life experiences with me and gave me a comfortable room to stay in. They are such a wonderful couple. Interview season can be expensive, but this was one trip I didn't have to spend any money on since I drove there and back. Please, continue to get more alumni to do this."*

–**Tobi Afolayan '16**

# New Scientific Poster Reimbursement Program

For medical students who conduct research during medical school and use a poster to present their research findings, printing costs can be an added expense and worry. The Student Affairs Council has recently launched a new program to reimburse medical students for the printing costs of such research posters.

If the cost for the poster is not covered by a school department, medical students may be reimbursed up to $100 for the cost of printing their posters. To be eligible for reimbursement, students must bring an original receipt to the Alumni Association office. ■



# Photo Op: Ice Cream at PSR

▲ *Students and faculty enjoy ice cream sponsored by The Student Fund during the annual School of Medicine retreat at Pine Springs Ranch September 24, 2016. The cool treat was served by LLUSM faculty, staff, and class officers while judges deliberated the winners of the Saturday night talent show. Faculty and staff seen in this photo include **Roger D. Woodruff '81** (left, light blue shirt), **Paul C. Herrmann '00** (left, white shirt), **Henry H. Lamberton, PsyD, '01-fac** (right, blue shirt), and Darrell Petersen, DrPH (right, red shirt).*

◀ ***Cayde Ritchie ('18)** presents his research to **Jason L. Lohr '01** during the 2016 Annual Postgraduate Convention. A new program made possible by The Student Fund allows printing costs for scientific posters to be reimbursed to medical students.*

**The Student Fund** is a branch of the Student Affairs Council and part of the Alumni Association, LLUSM. Its activities are financed by your contributions and greatly appreciated by LLU medical students. For more information or to make a donation, please contact the Alumni Association at 909-558-4633 or llusmaa@llu.edu.

# SM Family Medicine Ranked Nationally

Loma Linda University School of Medicine ranked sixth in the nation for producing the highest percentage of graduates who entered family medicine residency programs as first-year residents in 2015–2016, according to the American Academy of Family Physicians.

This status is significant considering that in the top 20 list LLUSM appears to be the only private school while all others are public universities. This demonstrates the forward-thinking model at Loma Linda University, which recognizes that the future of medicine is rooted in "population health," and is based on a primary care model of health care delivery. Family medicine is now the pivotal medical specialty in this futuristic health care model.

"In the midst of a changing health care system that calls for an expanding primary care force, we are honored to make a strong contribution to the family medicine field," said Wessam Labib, MD, director of Medical Student Education for the department of family medicine. "The credit goes to our mission-focused students, dedicated faculty and staff, and supportive university that made it possible for us to carry a rigorous clerkship. At the Loma Linda University Family Medicine Clerkship we pride ourselves on our interactive learning model, well-rounded clinical exposure, our multidisciplinary approach to chronic disease, integrated health care, and whole person care concepts that allow the students to experience the strength of the family medicine field." ■

**Table 3: Ranked Order of US MD-Granting Medical Schools Based on the Last Three Years' Average Percentage of Graduates Who Were Family Medicine Residents, 2015**

| US MD-Granting Medical School | Percent |
|---|---|
| Minnesota, University of | 19.0% |
| Kansas, University of | 17.8% |
| North Dakota, University of | 17.4% |
| East Carolina University | 16.7% |
| Washington, University of | 16.6% |
| Loma Linda University | 16.5% |
| Arkansas, University of | 16.3% |
| Nebraska, University of | 16.1% |
| Oklahoma, University of | 16.0% |
| Oregon Health & Sciences University | 15.8% |
| Wisconsin, University of | 15.6% |
| Uniformed Services University | 15.5% |
| Texas Tech University, Lubbock | 15.5% |
| New Mexico, University of | 15.5% |
| South Dakota, University of | 15.2% |
| Michigan State University | 13.2% |
| California, Irvine, University of | 13.1% |
| University of Nevada | 12.9% |
| Iowa, University of | 12.8% |
| Hawaii, University of | 12.5% |
| East Tennessee State University | 12.5% |

*Source: American Academy of Family Physicians*

# SACHS Receives NCQA Award

The Social Action Community Health System (SACHS)–Norton clinic was awarded Level Three Patient-Centered Medical Home (PCMH) by the National Committee for Quality Assurance (NCQA) on August 3, 2016. This is the highest attainable PCMH recognition by the NCQA (only some 10 percent of clinics are able to attain it nationally).

The year-long process culminating in this recognition involved two medical school faculty: a close collaboration of operations leaders, including **Jason L. Lohr '01**, assistant professor, family medicine and preventive medicine (now the chief medical officer at SACHS), and the quality department leaders, including Kevin Shannon, MD, MPH, associate professor, family medicine and preventive medicine (now the executive medical director of Quality and Safety at SACHS). **Richard G. Rajaratnam '85-res**, the chief operations advisor at SACHS, was also a key player in the process.

Congratulations on this significant accomplishment. ■

*Jason L. Lohr '01*

*Kevin Shannon, MD*

# Remembering Wil Alexander

"Wil, most of your lasting accomplishments have come through you since you turned 70."

**Wilber Alexander, PhD, MTh, '93-hon** reflected on those words from **B. Lyn Behrens, MBBS, '63-aff**, emeritus professor of pediatrics and former dean of the School of Medicine as well as former president of LLU, in the December 31 entry of the School of Medicine's devotional book "Evening Rounds." "I have been thinking about this as I now turn 92," he wrote in the 2013 book. "Not much is written about oldies like me, but recently I read somewhere about the last phase of life as that of 'finishing well.'"

He quoted an unknown author: "This phase reflects a sense of fulfilling what you were born to be and do while reaping the fruit of a lifetime of faithfulness. Your focus is now more on your ultimate contribution—a godly legacy that you are to leave behind in people, resources, and accomplishments for kingdom purposes. This season is best spent investing godly wisdom in younger leaders using the ways of God you've gleaned from your life's journey."

He then finished with a list of suggestions for "finishing well," which in his signature way was clear, concise, and blooming with wisdom. Yet those who knew him didn't need a list. As the countless number of students, colleagues, and friends will tell you, they learned the most from Dr. Alexander through the way he lived his life.

*Wilber Alexander, PhD, MTh, '93-hon smiles with his wife Mary. Dr. Alexander passed away November 11, 2016.*

"My life, like the lives of so many others, has been personally and deeply influenced by Wil," said **Roger D. Woodruff '81**, associate professor and chair of family medicine. "His caring heart was always there when I needed a listening ear. He demonstrated incredible compassion and wisdom. He was the 'real deal'—genuine, caring, quintessentially reaching my heart and the hearts of those around him to connect and encourage."

We will remember you, Dr. Alexander, for not only finishing well, but for living well.

Dr. Alexander, professor of family medicine in the School of Medicine, emeritus professor of relational studies in the School of Religion, and founding director of the Center for Spiritual Life and Wholeness, was 95. ■

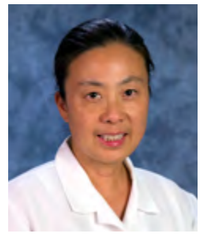
# NASA Selects SM Investigation for Space Mission

NASA is after Xiao Wen Mao's research. Again.

NASA notified Mao, MD, associate research professor in the department of basics sciences, division of radiation research, last November with exciting news: Her investigation, which explores how space flight environment induces remodeling of vascular network and glia-vascular communication in mouse retina, was selected to be part of a team for NASA's first Joint Rodent Research mission on the International Space Station.

NASA selected only three researchers—including Dr. Mao—for this mission currently targeted for SpaceX-12 in June 2017. It will be a live animal return mission with no injections or procedures to be performed in orbit.

Dr. Mao is no stranger to NASA. This mission is part of a long-term collaboration that included a $750,000 grant that NASA awarded Mao about a year ago. ■



*Xiao Wen Mao, MD*

## Upcoming Alumni Events

**March 2–6, 2017**
LLUH Homecoming

**March 3–6, 2017**
85th Annual Postgraduate Convention

**May 28, 2017**
School of Medicine Graduation

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*The School of Medicine News is developed by Tony Yang, marketing director at the School of Medicine.*

# 85 Years of the *Alumni JOURNAL*

By **Dennis E. Park, MA, hon-'07**, *consulting editor/historian*

Every publication has a beginning. Some don't last long. Others run a number of years before they go out of print. Then there are those enduring publications that keep the presses running. The *National Geographic*, *The Atlantic*, *Scientific American*, and *The Nation* are a few that come to mind. No matter the publication's genre: a connection to its audience is the common denominator of those that are successful. When an organization, institution, or company has a constituency with a common mission, it is easier for their publication to connect with its prospective audience. If that relationship is breached, or is never established, the magazine is destined to end on the trash heap of publishing history.

The College of Medical Evangelists (CME), founded in 1905 in Loma Linda, California, had a prospective audience—the members of the worldwide Seventh-day Adventist church who were eager to know more about the small college out west, where nurses, physicians, gospel workers, and dietitians were trained to spread the "Three Angels Message" to the world. The College needed its own publication to illustrate and disseminate information about its mission. In 1908, three years after the college was established, a little 16-page publication rolled off the press: *The Medical Evangelist*. The new journal bore a name similar to that of the school so that, in the words of the editors, it could "represent the [school's] principles … if possible" and "emphasize the importance of training for evangelistic work, rather than mere professional work or general philanthropy."[1]

*The Medical Evangelist*, an unattractive publication by today's standards, according to the editors lacked any "credentials except the truth."[2] Unbeknownst to these editors, their magazine would become the progenitor of a number of non-academic campus magazines. These include the *Loma Linda University Magazine* and the *University Observer*, which were succeeded by the publications still in print, *Scope* and *Today*, respectively. There was, of course, one other: the *Alumni JOURNAL*.



The JOURNAL
of the
ALUMNI ASSOCIATION
COLLEGE OF MEDICAL EVANGELISTS

VOLUME 1 JANUARY - FEBRUARY, 1931 NUMBER 1

ALUMNI HALL

THE present Alumnus remembers the old Assembly Hall as being located on the top of the Loma Linda hill and as a place where varied activities were centered. Converted in 1905, from a recreation hall and bowling alley into suitable accommodations for nurses' classes, it was used for those purposes for about four years. Then, in 1909, the College of Medical Evangelists opened its doors. The doors were those of the Assembly Hall.

Some will recall those beginning days when the Assembly Hall was THE place. In it were contained the lecture rooms, the laboratories, the

library, and associated offices. Some will remember when, in 1911, the Medical School moved to new quarters in the North Laboratory and the Assembly Hall took on some new functions. Who, of those who had the experience, will ever forget the small compartments, arranged on the south side of the building, which served as living quarters for medical students? Who will fail to recall the social evenings spent in the main assembly room and the Sabbath School which was conducted there for medical students, nurses and faculty members? Some will remember when, in 1925, the new hospital building was built on the hill and the old

Continued on page 7

*The cover of the first issue of the* Alumni JOURNAL*—in 1931 it was called* The JOURNAL*—exhibits a number of differences from covers of today.*

Celebrating 85 years of continuous publication with its January–April 2016 issue, the lineage of the *Alumni JOURNAL* can be traced back to *The Medical Evangelist*—and in fact, even before it. The first "publication" for alumni started with circular letters written to CME graduates—all six of them—from the Class of 1914. By the end of 1923, the medical school could boast 164 graduates, and the letter writing continued but was becoming more of a chore and expense.

During its 15 years in publication, *The Medical Evangelist* editors had successfully woven a promising "ministry of healing" thread throughout its pages, channeling the institution's mission statement of service, healing, and teaching to its audience around the world. This far-reaching achievement was noticed by a few CME alumni who approached the editors of *The Medical Evangelist* with the idea of using some of its space to

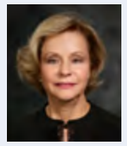
## Editors Emeriti of the *Alumni JOURNAL*

Years of service are included in parentheses.

- **Orlyn B. Pratt '24** (1931–1944)
- **Hubert Swartout '33** (1944–1946)
- **Molleurus Couperus '34** (1946–1951)
- **Theodore Bergman '30** (1951–1975)
- **Carrol S. Small '34** (1975–1982 and 1988–1990)
- **Raymond West '52** (1982–1988)
- **Henry K. Yeo '68** (1990–2011)
- **Donna L. Carlson '69** (2012)

From 2013 to 2014, there was no official editor. Instead, Alumni Association presidents **Gary R. Barker '80-B**, **Mickey N. Ask '79-A**, and **Roland C. Zimmermann '66** stood in as interim editors.

*Burton A. Briggs '66*



*Donna L. Carlson '69*

In 2015, **Burton A. Briggs '66** was selected *Alumni JOURNAL* editor and approved by the Board of Directors. Dr. Carlson continues to serve as associate editor and has been involved with the *JOURNAL* for 25 years.

chronicle the activities of the School of Medicine and its alumni. In 1924, these alumni and the magazine editors reached an agreement, as reported in the pages of *The Medical Evangelist* in a brief notice written by **Charles H. Lewis '20** under the heading: "Medical Evangelist Official Alumni Organ." Dr. Lewis wrote that at the annual Alumni Association meeting "it was unanimously voted that The Medical Evangelist should be the official publication for the graduates of our medical school."[3] Evidently, the justification for this action was the fact that "considerable space [had] been devoted to Alumni doings and happenings."[4] Alumni Association bylaws from sometime between 1927 and 1935 confirmed this relationship with the words: "The official organ of this Association shall be the Medical Evangelist."[5]

Though this publishing venture would last for approximately six years, the earlier letters continued to be mailed as revealed by Alumni Association Board of Directors minutes. For example, in the minutes for the July 20, 1930, Board of Directors meeting it was suggested that information regarding the school songs be "placed in the Medical Evangelist and the Alumni letter."[6]

All the while, behind the scenes discussions concerning an alumni publication continued. At the same July 20 meeting, the subject of an alumni magazine was on the agenda. After some discussion, it was recommended that a committee of three be appointed to study the matter.[7] Although there was no decision made at the meeting, the board continued discussing the issue at subsequent meetings. Over time board members considered such items as "cost projection, general planning, name suggestions, content, mailing costs, handling costs, and possible publishers."

At the November 25 meeting later that year the board voted to ask **Orlyn B. Pratt '24** "to act as Editor-in-chief of the first issue of the Alumni magazine to be published before the banquet to be held January 25."[8] By the January 20, 1931, meeting, the board minutes reflect that Dr. Pratt gave a report on the progress to date. The minutes state: "Printing of the magazine is to begin tomorrow. The secretary was asked to prepare an amendment to the constitution setting minimum dues of $3.00 to include a subscription to the Journal for one year."[9]

The inaugural issue of the alumni magazine, *The JOURNAL* of the Alumni Association College of Medical Evangelists, was presented to the banquet attendees a few days later. In that introductory issue, the *raison d'être* for *The JOURNAL* was revealed under the heading "Our Alumni Association." The author, **F.B. Moor '20**, wrote: "This magazine is not just a novelty. It is badly needed as an avenue of communication among our members. Our alumni have increased in numbers until the mailing of a letter to every member is a formidable task. Much of this communication can now be done through these columns."[10]

By 1930, the college had boasted 501 graduates stationed all over the world, and the number only grew each year. This continuous increase and global dispersion of alumni meant much work for those running the Alumni Association in Los Angeles, where already—as **Albert F. Brown '33** remembered it—the "trenches were narrow, the funds were tight." Even so, the editorial team faithfully published *The JOURNAL*, and the alumni benefited from their herculean efforts.

Of the fledgling alumni publication, **G. Mosser Taylor '24** wrote in the second issue:

> Although a good number [of graduates] settle locally, many are scattering to other states as well as to other countries. All of us want to keep in touch with the progress of the school and the activities of its graduates. Much time, money, and effort is consumed in the development of our students and then by the nature of the circumstances they are left with few contacts with the work and interests so thoroughly stressed during their course. This vacancy is to be supplied by the Journal, the first number of which was distributed among the assembled Alumni. We were all delighted and many were the favorable comments. Dr. Orlyn Pratt, originator, promoter and editor-in-chief, certainly deserves the appreciation and thanks of the Association for this contribution to our progress.[11]

*The JOURNAL* was well received by the alumni. Despite no general announcement made—which the editors acknowledged—regarding the voted $3.00 increase in dues to help defray the cost of *The JOURNAL*, there were those alumni who inquired about the financing of the magazine and sent in their dues anyway.[12] There was further interest from readership outside the Association, and the board voted a $2.00 annual fee for non-members. In addition, because "the material passing through the board should be of general interest," the board decided to begin including such items regularly in *The JOURNAL*.[13]

The Alumni Association leadership and the editors of *The JOURNAL* did not take time to rest on their laurels. While they continued their work on publication, they started a new venture in harmony with a September 15, 1931, Board of Directors action: "That a directory of the Alumni of the College of Medical Evangelists published by the Alumni Association be prepared and sent as a supplement to the journal." Thus, the 1931–1932 issue of *The DIRECTORY* became the first Special Edition of *The JOURNAL*. It was published, as the editors noted on the front cover, "to meet the demand which has existed for some time."[14]

**By 1930, the college had boasted 501 graduates stationed all over the world, and the number only grew each year.**

Since those first issues by forward-thinking alumni, what began as *The JOURNAL* has undergone a number of slight variations in name over the years. These are reflected in the changing nameplates and mastheads. The January 1952 issue marked the magazine's first official appearance as *The CME Journal*. Less than a year later, in the December directory issue, the name was changed to *CME Alumni Journal*. This was because, as stated with apparent tongue-in-cheek in the following issue, it could be confused "with three hundred [other] periodicals called *The Journal* and because the title, *The CME Journal*, is misleading." When the College of Medical Evangelists became Loma Linda University on July 1, 1961, the Alumni Association followed suit with its July–August 1961 issue, altering the magazine's name from *CME Alumni Journal* to *The Alumni Journal*. This change lasted just three issues until, beginning with the November 1961 directory issue, the name of the publication became what it is today: the *Alumni Journal*. No matter the nuances in acronym placement or capitalization of the magazine's official name, editors and readers have always referred to it fondly as "the journal."

To this day, more than 85 years later, Dr. Orlyn Pratt and his associates' prodigious efforts, along with the labors of the *Alumni JOURNAL* editors emeriti, continue to resonate through the bound volumes of the *JOURNAL*. Those men and women would be heartened to know that these volumes do not gather dust on the Alumni Association bookshelves. They are often removed from the shelves and the pages turned, not only by staff, but by alumni and friends. When used for reference purposes in our editorial meetings, a plethora of memories comes flooding back to those of us who remember personalities of the past and times when the University was a College.

***The JOURNAL* was well received by the alumni ... [and] there was further interest from readership outside the Association.**

Chris Clouzet, our young assistant editor, must be applauded, for he good-naturedly tolerates the musings of **Burton A. Briggs '66**, **Donna L. Carlson '69**, and myself, as he tries to keep us on track to meet our deadlines.

The *Alumni JOURNAL*, School of Medicine of Loma Linda University, began and will forever be a publication "by Alumni, about alumni, and for alumni."[15] It is the only known journal of its kind that is not financially supported nor published by a medical school or its university. During the *JOURNAL*'s long and storied history, each editor has shepherded every issue under their purview with journalistic acumen. Through its pages, the *JOURNAL* has told the stories of CME, the University, and the School of Medicine; the alumni and students, including those who served in mission fields around the globe; the history and work of the Alumni Association; alumni who went to war; the merger of the campuses; Baby Fae; the various building projects on both the Los Angeles and Loma Linda campuses; the passing of alumni, notable pioneers, academicians, administrators, and clinicians who made an indelible mark on the campus and in their communities. The list could go on, but space does not allow.

Over the decades, *JOURNAL* editors have been constrained by a budgetary guard rail, which has placed a limit on the number of pages per issue. Now, with the internet and digital capabilities, a flicker of light can be seen at the end of the publishing tunnel. The editors and the Alumni Association are expanding their journalistic creativity through the web, and making inroads into digital

*(Continued on page 41)*


*From left: **Delmar R. Aitken '73-B**, **Kenneth L. Kelln '64**, **Takkin Lo '86**, and another APC attendee enjoy some conversation between lectures at the Damazo Amphitheater at APC 2016.*

# APC 2017: A Preview

## March 3–6, 2016

We can't wait to see many of you at the 85th Annual Postgraduate Convention in March. As you may have heard already or seen in this publication, this year's APC will be just a little different than before. The University is hosting the first campus-wide Loma Linda University Health Homecoming weekend, an event bringing together alumni from all the schools at one time. The University is collaborating with APC organizers to make the weekend as seamless and enjoyable as possible for APC attendees.

The events being organized by the University that have typically been "APC events" include the main vespers and church services, as well as the campus tours on Friday. A haystack lunch will be provided following Sabbath's church service at the Drayson Center. There will also be a Homecoming Kickoff Celebration on Thursday, March 2, with food and family-friendly activities from each of the schools, as well as music by the Wedgwood Trio.

Traditional APC offerings such as the plenary sessions and specialty symposiums, scientific poster exhibits, technical exhibit hall, class reunions, and gala are being planned by the APC Governing Board and will take place as usual. There is a stellar cast of guest speakers and School of Medicine faculty lined up for the continuing medical education lectures. A hands-on musculoskeletal ultrasound workshop is available on Sunday and the Lawrence Longo Lectureship series taking place Monday morning will feature presentations celebrating the research of the late **Lawrence D. Longo '54**.

More information can be found on the following pages, in the APC preregistration brochure, and at the APC website: apc.llusmaa.org. We hope you will consider joining your classmates and fellow alumni this year at APC. See you there! ■

# Scientific Program

## Plenary Session Featured Speakers

**Walter D. Johnson, MBA, MPH, '83**
*Program Lead, Emergency and Essential Surgical Care, WHO*
"Surgery Within the Context of Global Health: WHO's Critical Role"

**Jeffrey C. Kuhlman, MPH, '87**
*Former physician to the president of the United States*
"Health Lessons from the President"

**Kent L. Thornburg, PhD**
*M. Lowell Edwards Chair for Research (cardiovascular medicine); Professor of Medicine, OHSU*
"Adult Disease Risk Is a Remnant of Early Life"

**Ted Hamilton, MD, MBA, '73-A**
*VP of Medical Mission, Adventist Health System*
"Medicus Integra©: Toward Physician Wholeness"

Dr. Hamilton is also giving the devotional on Sunday and Monday mornings at 7:45 a.m.

## Plenary Session Presenters

Marti Baum '79-B
Ingrid K. Blomquist '81
Barbara Couden Hernandez, PhD
Ihab R. Dorotta, MBChB
Ramiz A. Fargo '96
Ciprian Paul Gheorghe, PhD, '08
Paresh C. Giri, MBBS
Ravi Goyal, MD, PhD
H. Roger Hadley '74
Walter D. Johnson, MBA, MPH, '83
Jeffrey C. Kuhlman, MPH, '87
Benjamin H. Lau, PhD, '80-A
Hobart H. Lee, MD, FAAFP
Gina J. Mohr '96
Carolina Osorio, MD
Kent L. Thornburg, PhD

## Ultrasound Workshop

Alexander Chien, MD
Christopher M. Jobe '75
Karina D. Torralba, MD

## Specialty Symposium Featured Speakers

**Ryan P. Hawks, Lt. Col., USAF, '02**
*Special Operations Surgical Team Surgeon, 720th STG/STM*
"Tyranny of Distance: The Role of Damage-Control Surgery in the Special Operations Environment"

**Jeffrey Kenkel, MD, FACS**
*Director, Department of Plastic Surgery, University of Texas, Southwestern Medical Center*
"Advances in Body Contouring" & "Nonsurgical Rejuvenation of the Face & Body for the Plastic Surgeon"

**J. Patrick Johnson, MD**
*Neurosurgeon and Director of Neurosurgery Spine education,Cedars Sinai Medical Center, Los Angeles*
"Cervical Spondylotic Myolopathy"

## Specialty Symposium Presenters

### Otolaryngology
Scott A. Asher, MD
Thomas Bravo '10
Christopher A. Church '96
Brianna Crawley, MD
Priya Krishna, MD
David J. Puder '10
Kristin Seiberling, MD
Alfred A. Simental '95
Paul Walker, MD

### Surgery
Ryan P. Hawks, Lt. Col., USAF, '02
Aarthy Kannappan, MD
Donald C. Moores '87
Naveenraj L. Solomon '03
David Turay, PhD, '10-res
Philip Y. Wai, MD

### Orthopedics
Jens R. Chapman, MD
H. Francis Farhadi, MD
Christopher Furey, MD
Munish Gupta, MD
J. Patrick Johnson, MD
Larry Khoo, MD
Steve Ludwig, MD
William J. Richardson, MD
Christopher I. Shaffrey, MD
Francis Shen, MD
Jeffrey C. Wang, MD

### Plastic Surgery
Alexander Chien, MD
Subhas Gupta, MD, PhD, FACS
Jeffrey Kenkel, MD, FACS

**New Registration Location: 1st Floor, Centennial Complex**
The convenient location will allow attendees to register and visit the technical exhibit booths (first and second floors) without walking far from where many of the CME lectures take place.

# More APC Events

### Sunday Alumni Luncheon

Sunday, 11:45 a.m. | Wong Kerlee Conference Center

Hosted by the Holding Fund, the Walter E. Macpherson Society (WEMS), and the Alumni Association, this luncheon provides an opportunity for APC attendees to learn more about the current activities and future plans for WEMS, the Association, and the School of Medicine.

### Scientific Poster Session

Sunday, 8:00 a.m.–5:00 p.m. | Level 4, Centennial Complex

Medical research will be displayed exclusively on Sunday, with special medical presentations taking place 11:00 a.m.–1:30 p.m. Other research will be displayed Thursday–Monday.

### Technical Exhibits

Sunday, 8:00 a.m.–5:00 p.m. | Level 1 & 2, Centennial Complex
Monday, 8:00 a.m.–4:00 p.m. | Level 1 & 2, Centennial Complex

This year the technical exhibits will be located on the first and second levels of the Centennial Complex near the Damazo Amphitheater. Exclusive exhibit hours and a complimentary lunch for students and attendees will take place Monday 11:00 a.m.–1:15 p.m.

# Spiritual Weekend

Steeped in Loma Linda University Health's rich history is the mission *to continue the teaching and healing ministry of Jesus Christ.* As part of LLUH Homecoming, the spiritual programming for the weekend will focus on this mission.

### Morning Devotionals: Ted Hamilton

Sunday and Monday, 7:45 a.m. | Damazo Amphitheater

### Mission & Prayer Breakfast

Friday, 7:00–8:00 a.m. | Location TBD

### Friday Night Vespers

Friday, 7:00 p.m. | LLU Church

Join alumni from all the schools to hear inspirational music and guest speakers during an evening of worship and inspiration.

### Prayer Walk

Sabbath, 7:00–8:00 a.m. | The Quad

Spend time with fellow worshipers in quiet reflection and prayer as the day begins.

### Sabbath School & Church Service

Sabbath, 9:00–11:45 a.m. | Drayson Center Fields


*Attendees make their way through the exhibit hall and scientific poster session during APC 2016.*

### Stay Tuned!

Find the latest details and information online:

- APC: apc.llusmaa.org
- Alumni Association: www.llusmaa.org
- LLUH Homecoming: www.llu.edu/homecoming

### Send us your favorite reunion and APC photos.

We may use them on our website or in the *Alumni JOURNAL*.
Email them to llusmaa@llu.edu.

# Sabbath Afternoon

### Haystack Lunch

Sabbath, 12:00 p.m. | Drayson Center Fields

The University will be serving haystacks following the church service for alumni who don't have a class reunion at this time.

### AIMS Meeting & Mission Symposium

Sabbath, 12:30 p.m. | Drayson Center

Bring your haystacks inside to meet the Global Service Award recipients and hear reports from global service missionaries in training. There will also be special presentations by elder G.T. Ng, secretary of the General Conference of SDAs, and **Walter D. Johnson '83** of WHO.

### Medical Auxiliary Mission Vespers

Sabbath, 4:00 p.m. | LLU Church

### LLUSM Class Reunions

Various Times and Locations, see page 17

*Medical students hold flags of various countries at the world missions–themed Friday Night Vespers during APC 2015.*

# Class Reunions

If you are organizing your class reunion and do not see your information listed here, please contact our office at 909-558-4633.

**Pioneer** Saturday, March 4, 6:00 p.m.
Slate Room, Wong Kerlee, LLU
Andrea Schröer (alumni office)
909-558-4633

**1947** Saturday, March 4, 6:00 p.m.
Rock Room, Wong Kerlee, LLU
Robert Mitchell
bgmitc@verizon.net

**1952** Saturday, March 4, 6:00 p.m.
Hispanic Room, Wong Kerlee, LLU
Roy Jutzy
rvaljut@yahoo.com

**1953-A** Saturday, March 4, 5:30 p.m.
Joan Coggin residence
Robert Horner
rlhhands@gmail.com

**1953-B** Saturday, March 4, 1:30 p.m.
Harding Residence
George Harding
gtharding@llu.edu

**1955** Friday, March 3, 12:00 p.m.
Hilton Garden Inn
1755 S. Waterman Ave., San Bernardino
Ralph Longway and Irwin Kuhn
ralphlongway@gmail.com

**1956** Saturday, March 4, 6:00 p.m.
Peterson Room, Wong Kerlee, LLU
Carlton Wallace
treka@ca.rr.com
bonewall@ca.rr.com

**1958** Saturday, March 4, 6:00 p.m.
Jesse Room, Wong Kerlee, LLU
Stewart Shankel
stewart.shankel@ucr.edu

**1959** Saturday, March 4, 6:00 p.m.
Slate Room, Wong Kerlee, LLU
Richard Jensen
dickjdoc@aol.com

**1960** Saturday, March 4, 6:00 p.m.
Chonkich Residence
George Chonkich
gchonkich@gmail.com

**1961** Saturday, March 4, 6:00 p.m.
Faculty Lounge, Wong Kerlee, LLU
Ed & Bev Krick
ebhk@verizon.net

**1962** Saturday, March 4, 6:30 p.m.
Redlands Country Club
1749 Garden St., Redlands
Hugh Watkins and George Petti
hcwatkins@verizon.net
dixiegram@verizon.net

**1963** Saturday, March 4, 6:00 p.m.
Lotus Garden
111 E. Hospitality Ln., San Bernardino
Lamont Murdoch
lmurdoch@llu.edu
beckymurdoch@aol.com

**1965** Saturday, March 4, 6:00 p.m.
Contact Gary Frykman for information
gkfryk@gmail.com

**1967** **Gold Anniversary – 50 Years**
Saturday, March 4, 6:00 p.m.
Redlands Country Club
Main Ballroom ($60/person)
1749 Garden St., Redlands
RSVP: Anton Hasso
anhasso@uci.edu

**1968** Saturday, March 4, 6:00 p.m.
Lotus Garden
111 E. Hospitality Ln., San Bernardino
Lavon Nolan
lavonnolan@roadrunner.com

**1969** Saturday, March 4, 1:00 p.m.
Najwa's Mediterranean Cuisine
24711 Redlands Blvd., Loma Linda
Doug Ziprick
knziprick@gmail.com

**1970** Saturday, March 4, 2:00 p.m.
Magan Hall, LLU
Robert Rentschler
rerentschler@roadrunner.com

**1973-B** Saturday, March 4, 1:00 p.m.
Delhi Palace Fine Indian Cuisine
2001 Diners Ct., San Bernardino
Elmar Sakala and William Hayton
esakala@llu.edu
bchayton@sbcglobal.net

**1974** Saturday, March 4, 6:30 p.m.
Bergdorff Residence
Monica Neumann
mneumann@llu.edu

**1980-B & 1981** Saturday, March 4, 6:00 p.m.
Thiel Residence
Gary Barker
garyrbarker@gmail.com
Roger Woodruff
rdwoodruff@gmail.com

**1982** Saturday, March 4, 1:45 p.m.
Wat-Jacobson Residence
Randy Tan
randall.l.tan@kp.org

**1986** Saturday, March 4, 1:00 p.m.
Reeves Residence
Marilene Wang
mbwang@ucla.edu

**1991** Saturday, March 4, 6:00 p.m.
Benjarong Thai Cuisine
1001 W. Park Ave., Redlands
Jennifer & Duane Baldwin
jdunbar@llu.edu

**1992** **Silver Anniversary – 25 Years**
Saturday, March 4, 6:00 p.m.
Redlands Country Club
Main Ballroom ($60/person)
1749 Garden St., Redlands
RSVP: Julio Narvaez
narvaezjd@gmail.com

# APC Gala

**Sunday, March 5, at 7:00 p.m.**
(Social Hour begins at 6:00 p.m.)

**Venue:** Riverside Convention Center

**Featured Entertainment:** Musical numbers and short videos featuring students of the LLUSM Class of 2017

***S. Wesley Kime '53-A** receives his Honored Alumnus award from Alumni Association president **Mark E. Reeves '92** (left) and School of Medicine dean **H. Roger Hadley '74** at the 2016 APC Gala.*

# Brain Surgery to Global Surgery

## An interview with Dr. Walter Johnson

Interviewed by Chris Clouzet, *staff writer*

About six years ago, **Walter D. Johnson '83** was professor and vice chair of neurosurgery at Loma Linda University and working on an MBA degree at Claremont Graduate University. Then he developed numbness in his dominant hand. The hand improved after multiple surgeries and lots of occupational therapy, but performing neurosurgery was no longer an option. When he finished the MBA degree, he was suddenly left wondering what to do with himself. His longtime interest in international work propelled him to pursue an MPH degree, also at Claremont. When he finished, he thought he'd find some work that would "keep [him] off the streets."

The topic of the Percy T. Magan lecture at the 2011 Annual Postgraduate Convention, "Surgical Practice in the Developing World," changed the course of Dr. Johnson's life. "It was absolutely an epiphany," he says. His years of experience in academic surgery and his newfound pursuit of public health meshed perfectly in global surgery. He pursued the subject with a passion, reading everything he could find and calling experts whose journal articles he'd read.

In 2012, Dr. Johnson attended a meeting on global surgery where he met Meena N. Cherian, MD, program lead of Emergency and Essential Surgical Care (EESC) at the World Health Organization (WHO). She invited him to spend the summer working with her at her WHO office in Switzerland, so his family rented a small apartment in Geneva and Dr. Johnson got his first taste of global surgery at the WHO level. He continued to work with Dr. Cherian over the next few years and when she retired in 2015 he was asked to cover until a permanent director was found. But in September 2016, WHO asked Dr. Johnson to become full-time EESC program lead. For him, the work is "a perfect fit."

Dr. Johnson kindly spent some time speaking to the *JOURNAL* about global surgery and his responsibilities at WHO. He will also be lecturing on this topic at APC in March (more information on page 15).

### Can you summarize what you do as lead of the Emergency and Essential Surgical Care program?

The term "essential surgery" covers basic surgical procedures that the World Bank, WHO, and several global institutions have accepted. There are about 30 to 40 basic procedures, like hernia repairs, C-sections, setting of open fractures, open laparotomy, and surgeries for injuries. In parts of sub-Saharan Africa there are no surgeons, and young men in the prime of life who are bread-winners can die of a simple hernia. Women die during childbirth. The availability of basic essential surgery in the district hospitals of those countries would save millions of lives every year.

We're not pushing the agenda of doing heart surgery, transplants, or neurosurgery in every hospital in sub-Saharan Africa, although these are also badly needed. Our aim is to develop the capacity for basic surgical care at the district hospital level. That includes anesthesia, without which most surgery is difficult.

**The availability of basic essential surgery in the district hospitals of [countries in sub-Saharan Africa] would save millions of lives every year.**

Our program encompasses surgery, anesthesia, and obstetrics. Although maternal and child health is another section of WHO, we still include emergency C-sections and some fistula surgery.

### In the March 2016 WHO *Bulletin* you were quoted in a report referring to the training of clinical officers in Africa to do more surgeries and the lack of surgical and anesthesia supplies.

There is a lack of everything. In some district hospitals they don't have sheets on the beds; they don't have enough beds so there are two patients in each bed or people lying on the floor; they don't have IVs; they don't have sterile supplies. It's truly not what you expect when you think of hospitals.

There are three important things that happened in the spring of 2015. First, the third edition of "Disease Control Priorities" was published by the World Bank . Historically it's been a single volume. This edition, however, is a nine-volume set. The first volume is "Essential Surgery" and it sets the framework for the health economics of surgical

*Walter D. Johnson '83*

care. It gives evidence that a modest investment would yield a great return even to low-income countries. Just giving basic surgical care would generate an expected minimum of a 2 percent increase in gross domestic product. That's a big deal.

The second important event was the release of the *Lancet* Commission on Global Surgery report. The report made five key points: the first one was that 5 billion people on the planet, including residents of the United States, don't have access to safe, timely, and affordable surgical care. The second point is that 143 million additional procedures should be done globally every year.

The report also made a *big* point about the economic devastation that surgery and anesthesia can have on people. Thirty-three million have catastrophic expenditures; in this country, they file for bankruptcy. If your income is $300 a year and your surgery costs $900, you can't do it—it's either feed your family or have surgery. If you include indirect costs, like lost wages, travel expenses, food expenses, not tending to your crops, or caring for a loved one who's recovering from surgery, the number of affected people in the world probably goes up to 81 million persons a year.

The report's last two points were that surgical care is affordable based on the "Disease Control Priorities" report, and that there is a huge need for a greatly expanded workforce in surgery, anesthesia, and obstetrics, including mid-level providers, operating room nurses, etc.

The third big thing that happened in 2015 was that the World Health Assembly, which is WHO's governing body and sets the agenda for what's important in global health, for the first time passed a resolution to strengthen emergency and essential surgical care and anesthesia as a component of universal health coverage. The awareness of surgical care suddenly was on the map in ways that it hadn't been in the past.

**You're quoted about that: "Those three developments [in 2015] produced a groundswell of support."**

Right. Another driving factor for support in the last several years has been the push for overseas rotations in surgery, anesthesia, and obstetrics by residents in upper-income countries like the U.S., the U.K., and Australia. Interest has gone up tremendously, to the point where the American Board of Surgery, the American Board of Neurosurgery, and others, say, "If you go with approved supervisors you can do it as part of your rotation. It will count toward your residency requirements." Loma Linda has a strong rotation for fourth-year general surgery residents who go to Malamulo, Malawi, for two months each.

That whole effort to do surgical rotations overseas is mostly driven by residents. They see it as a great opportunity to do some humanitarian work. Unfortunately, while their enthusiasm remains after their training, it's eclipsed by the debt that they're in. Many of them cannot go back to do the humanitarian work they would like to do because of that debt.

**My impression is that WHO and the world have been focused on diseases like AIDS, HIV, tuberculosis, and malaria, but now essential surgery is coming to the forefront.**

In the entire world, including the lowest-income countries, disease patterns are changing. The prevalence of communicable diseases—like HIV/AIDS, TB, and malaria—is decreasing, while heart disease, stroke, and cancer are becoming more common. It's not simply a matter of lifestyle; it's more complex than that. The trend is projected to continue well into the future.

All of these non-communicable diseases require more surgical care than the communicable diseases did. So the importance of surgery and anesthesia will just keep rising.

These non-communicable diseases require more surgical care than the communicable diseases did. So the importance of surgery and anesthesia will just keep rising.

**What's it like to be part of that change?**

Thrilling. I have fun every day. I have so many projects that I'm involved with at some level. There are literally 25–30 things on my list, from working with health economists to finishing up WHO Ebola guidelines for surgical teams. We're working on safe anesthesia guidelines under a variety of different situations, from district hospitals to disaster situations. We've just finished a big project standardizing surgical kits—big modules of various surgical instruments and autoclaves and drugs and everything—that Doctors Without Borders, the Red Cross, and WHO drop in, often by helicopter, in every disaster situation. We standardized them so it doesn't matter whose logo is on the outside of the module, every tray has exactly the same instruments and equipment.

There are also a number of different organizations that have official working relations with my department, such as the International College of Surgeons, the World Federation of Societies of Anesthesiologists, the World Federation of Neurosurgical Societies. I help them with their programs (and vice versa), sometimes simply adding my name and logo to their efforts, which provides some leverage with the countries they're working in.

Another thing I do that is important has to do with the hundreds of WHO collaborative centers around the world. These are generally academic centers with a level of expertise in one particular area that help WHO to boost its skills or technical ability. In surgery we have two official ones now. We've had one in Mongolia for a number of years, focusing on education. We just started another one at Western University in Ontario, Canada, on perioperative medicine.

We're developing a third one at Lund University in Sweden. People there helped establish and are continuing to build the first global database on licensed surgeons, anesthetists, and obstetricians. We're working on developing one in Bogota, Columbia, on neurotrauma, and another one in Mumbai, India, on rural surgery. My plan is to have a collaborative center for surgery in each of the six global regions into which WHO divides the world.

**You are involved with a lot of different projects.**

I am. I'm inundated with requests for people who want to do internships with me, so I generally have three interns from all over the world with me all the time. This is good for me. Instead of teaching residents neurosurgery, I'm helping these young people develop an appreciation for the need for global surgery and anesthesia. I'm introducing them to the United Nations system and WHO and what we do. They generally have specific projects—writing papers and working on assignments for specific countries. One intern is involved with a project about access to electricity at hospitals in sub-Saharan Africa. In some countries 80 percent of the district hospitals don't have reliable running water and electricity. It's hard to run a good operating room under those conditions, but we're looking at innovative techniques to make that happen.

I'm at a point where there are fellows in global surgery and anesthesia who will be doing rotations around the calendar, but there are more applicants for intern spots than I have space for.

**What kind of background do these interns have?**

All of my interns are physicians or almost physicians. Last summer I had medical students from King's College London and Al-Quds University in Jericho in the occupied Palestinian territory, as well as a neurosurgery resident from Australia. We were a great team.

**I imagine despite politics your office is a very global place where people around the world work together.**

Oh, absolutely. The people in my department are from many different countries. I hear Japanese, Spanish, French, all sorts of different languages every day. Occasionally English. It's a remarkable place to work.

Most of the people in my department are physicians. Next door to my office is a transplant surgeon. Others are

## Informative Books on Global Health

As recommended by Dr. Johnson (in no particular order).

- "Awakening Hippocrates: A Primer on Health, Poverty, and Global Service" by Edward O'Neil
- "Global Surgery and Public Health: A New Paradigm" by Catherine R. deVries and Raymond R. Price
- "Walking Together, Walking Far: How a U.S. and African Medical School Partnership Is Winning the Fight Against HIV/AIDS" by Fran Quigley
- "Mountains Beyond Mountains: The Quest of Dr. Paul Farmer, A Man Who Would Cure the World" by Tracy Kidder
- "AIDS and Accusation: Haiti and the Geography of Blame" by Paul Farmer
- "Infections and Inequalities: The Modern Plagues" by Paul Farmer
- "Generous Justice: How God's Grace Makes Us Just" by Timothy J. Keller
- "Welcoming Justice: God's Movement Toward Beloved Community" by Charles Marsh and John M. Perkins
- "The Hole in Our Gospel: What does God expect of Us? The Answer that Changed my Life and Might Just Change the World" by Richard Stearns
- "Rich Christians in an Age of Hunger: Moving from Affluence to Generosity" by Ronald J. Sider
- "The End of Poverty" by Jeffrey D. Sachs
- "Global Politics of Health" by Sara E. Davies
- "Development as Freedom" by Amartya Sen
- "How to Change the World: Social Entrepreneurs and the Power of New Ideas" by David Bornstein
- "Enough: Why the World's Poorest Starve in an Age of Plenty" by Roger Thurow and Scott Kilman

### Interested in global health? Here's a bit of advice from Dr. Johnson:

"WHO is only one small piece of the global puzzle. For those interested in global outreach there are so many venues, particularly in the Seventh-day Adventist church. There are more than 130 Adventist hospitals and clinics around the world. Get involved with global efforts, either at the local level or regional level, or within your specialty. Interested alumni can write to me at johnsonw@who.int." ■

family medicine and public health specialists. Together we deal with primary health care, safe surgery—including preoperative checklists, infection control, human organ and blood supply safety—and palliative care.

### How many people are in your department?

It's a big department, 30 to 40 people. Our department is divided into several units, and my program is just one program in one unit.

### How many work in your program?

The Emergency and Essential Surgical Care program is just me and my interns. WHO is underbudgeted and for the most part understaffed, unless you have huge grants. But working with partners we can accomplish a lot. For example, although I am the only permanent person in my program I have strong ties with entities like the Harvard Center on Global Surgery and Social Change, the American College of Surgeons, Lund University, King's College London, and the World Federation of Societies of Anesthesiologists, sister-type organizations in Africa, and many others. WHO has quite a bit of influence, and working with partners and collaborative centers we can accomplish a great deal more than each of us could do by ourselves.

**I have fun every day. I have so many projects that I'm involved with, ... from working with health economists to finishing up WHO Ebola guidelines for surgical teams.**

WHO's mandate is to work at country level with ministries of health to help develop national surgical care plans. We start with gap analysis, see where needs and strengths are greatest, structure the plans, and help write them into the national health policy. The plans include follow-up data collection, monitoring and evaluation. If we can convince countries that the health of their population *is* getting better and that their GDP *is* going up as a result of good surgical care, then we're an asset.

### So you have to convince finance ministers that good surgical care can be a financial boost to their countries.

Right. One of the things the *Lancet* Commission on Global Surgery report pointed out was that an investment of $350 billion over 15 years in developing countries would solve much of the problem of global surgery. That amount—one third of 1 percent of the total annual world GDP of about $70 trillion (not a huge amount of money on a global scale)—would cover essential surgery, anesthesia, and obstetrics, and would address the lack of access. Failure to make this investment has been estimated to cost $12 trillion in lost productivity from death and disability. Disability alone is a huge burden, especially on poor families. So the issue is not just a matter of something that would be nice to have; essential surgery really is essential.

### I saw that you're speaking in Bogota, Columbia, in December. How often do you travel?

I get many more invitations than I can accept. Lack of time is my biggest problem. Energy is another one; and I have to be careful with the budget. I can't travel all the time because I have so much to do in Geneva. However, there are certain meetings that are key, like the World Congress of Anesthesiologists, where I meet with anesthesiologists from all over the world. Another is the Continental African Association of Neurosurgery meeting in Cape Town. Neurosurgeons attend from across Africa, from countries where different languages, including Arabic, French, English, and Portuguese, are spoken. I feel it is really important to support that meeting.

**I didn't have people saying, "Oh, thank you, doctor, for saving my life," but I know that I impacted the lives of millions of people who will never even hear of me.**

For a couple of months I was traveling once or twice a week and was in Geneva less than half the time. It was extremely worthwhile, but also extremely tiring because I was in a different time zone every day.

### You were a practicing and teaching neurosurgeon for about 20 years. How has your influence in medicine changed with this new position at WHO?

With surgery, it is a huge privilege to operate on people and—in neurosurgery—have them entrust their brains to you. It's humbling. But it's a slow process; you only operate on one person at a time.

Working in public health is different. For example, I recently testified before an expert committee about the use of a particular drug they wanted to make unavailable in the developing world where it is used as an anesthetic agent. I don't know if we'll win the war, but we won that particular battle. That one event kept anesthesia available for millions of people who wouldn't have had it otherwise, and thus, no anesthesia for many emergencies and C-sections. I didn't have people saying, "Oh, thank you, doctor, for saving my life," but I know that I impacted the lives of millions of people who will never even hear of me.

*(Continued on page 48)*



# Alumni Association
School of Medicine of Loma Linda University

## 2017 Board of Directors Elections

Please complete the form using a blue/black pen, or you may vote online by visiting:

**www.llusmaa.org/page/ballot-2017**

Your vote is greatly appreciated.

Full Name: _____ Class: _____ Email: _____

Address: _____ State: _____ Zip Code: _____

Alumni Association Annual and Perpetual Members: Do you approve of the appointment of the following persons to the Alumni Association Board of Directors?

| Yes | No | Abstain | | Yes | No | Abstain | |
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| ☐ | ☐ | ☐ | Steven C. Herber '86 | ☐ | ☐ | ☐ | Rebekah M. Wang-Cheng '78 |
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Do you know any LLUSM alumni that you believe would be interested in serving on either the Alumni Association Board of Directors or the Holding Fund Board of Directors in the future?

Name 1:_____ Please circle one: Board of Directors Holding Fund Board

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Thank you for your participation!

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# Though the campus may change,

*you will always be family.*


LOMA LINDA UNIVERSITY

Faculty Medical Group

We would not be where we are today without the hard work and dedication of each one of you, evident by the impact you have made in the world. As we prepare for the next phase of fulfilling our Mission to Continue the Healing Ministry of Jesus Christ, we are reaching out to partner with you as a member of our family. In preparation for the completion of our new hospital in 2020, our commitment is to grow our clinical faculty; meeting the needs of the Inland Empire, Southern California and the world. If you have an interest in returning home, or know anyone who would like to join the team, we would love to hear from you. You can visit our website at www.socaldocs.com or contact me anytime.

Mike Unterseher, CMSR
Director of Physician Recruitment
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# Am I My Brother's Keeper?

Introduction by **Burton A. Briggs '66**, *editor*

Ambroise Paré, a 16th-century French barber surgeon considered one of the fathers of surgery, served as battlefield surgeon through the reign of four French kings. During the French wars of the time, he treated many battle wounds and was innovative in their care.

*"Je le pansai, Dieu le guérit"* (I bandaged him; God healed him) is a phrase attributed to Paré. In his time, little could be done for horrific battlefield wounds. Mortally wounded men were often put out of their misery by their comrades. On one occasion, the story goes, Paré encountered two men terribly burned by gunpowder. A soldier asked Paré if they could be helped. When Paré shook his head, the soldier calmly took his dagger and cut their throats. Horrified, Paré shouted that the man was "a villain." To which the soldier responded, "Were I in such a situation, I would only pray to God for someone to do the same for me."

Fast forward to the 1920s, prior to the Nazi takeover of Germany in 1933. There was a tremendous barrage of propaganda against the traditional attitude of compassionate care for the chronically ill. Euthanasia became an openly discussed subject, and the extermination of the physically and socially unfit was mentioned in the official German medical journal. Though the support of this practice by the German Medical Association was deviously obtained, it was nevertheless supported.

Similar ideas began to appear in lay publications and educational materials. A widely used high school text, "Mathematics in the Service of National Political Education," used the following problem: "How many housing units could be built and how many marriage allowances could be given to newly wedded couples for the amount of money it costs the state to care for the 'crippled, the criminal, and the insane?'"

As a physician, scenarios like these raise questions for me. What do I do when patients cannot be cured? Do I abandon them? *(I can do no more.)* Do I refer them to hospice? *(Let someone with more skill than I treat them.)* Do I start them on pain medications, knowing the risk of addiction? Do I try a new therapy, hoping for a miracle? *(This is how progress is made.)* What do I do when the family comes to me saying, "Grandma didn't want to go through all of this, can we stop?"

These are not theoretical questions; they are real questions, though they vary with each patient and disease. Questions for the ICU patient are different from questions for the patient with a 12-year history of progressing Alzheimer's disease, or Amyotrophic Lateral Sclerosis, or chronic depression. They are different for the young child who has been hit by an automobile, or drowned in a swimming pool, different for the woman whose breast cancer has metastasized to skull, spine, and pelvis, despite surgery, chemotherapy, radiation, and more chemotherapy.

Physicians, have you every stood at a bedside and said to yourself, "I don't want to die that way." (Now be honest.) How would *you* want to die? Let's face it, we are all going to die someday and in some way.

These are not theoretical questions; they are real questions, though they vary with each patient and disease.

Fast forward again, to the 21st century and the surge of interest in legislative activity allowing or requiring physicians to consider or implement physician-assisted death (PAD). If physicians withdraw patient care or participate in PAD because society dictates that it is too expensive and not because of individual patient circumstances, then we take the first step on a potentially dangerous course.

In the countries of Western Europe and the states in this country that have legitimized PAD, the number of individuals receiving PAD is increasing year by year. Is this increase the result of more people being aware of the option to end their own lives or is it because of expanding the criteria ("criteria creep") for those who desire this option? In the law enforcement culture there is a phenomenon known as "suicide by cop." Is PAD a variation of this phenomenon?

California has recently been added to the list of those states which have passed legislation approving PAD. Hospitals have been given the option to opt out and not to allow physicians to participate in PAD in their facility. What would be your choice?

We have included four articles about PAD by physicians. Read them, and in your own mind try to answer the question: "Am I My Brother's Keeper?" Regardless of your answer, what are your responsibilities? ■

Dr. Briggs, emeritus professor of anesthesiology at LLUSM, is editor of the *Alumni JOURNAL*. He stays busy farming, shooting astrophotography, and guiding the *JOURNAL* from his home in Emmett, Idaho.

Ed. note: The two articles by **Gina J. Mohr '96** and **Philip Gold '01-fac** were first published online by LLU's Institute for Health Policy and Leadership at ihpl.llu.edu/california's-new-law-terminally-ill-patients. They are reprinted here by permission.

# Fundamental Ethical Difference: 'Allowing to Die' vs. 'Killing'

By **Gina J. Mohr '96**

There is no question that Americans fear suffering at the end of life. And they have good reason to. The advanced technology of our modern health care system enables us to keep people alive, often without getting them better. In our intensive care units, patients can be kept on ventilators and dialysis machines almost indefinitely, without the hope of ever getting them well enough to leave the facility.

Arguments commonly presented in favor of physician-assisted death (PAD) are relief from suffering and respect of one's autonomy to determine his or her own fate. These are good and noble goals, which palliative care seeks to address every single day. So while I agree with these goals, I disagree that the solution to achieving them lies in the form of killing our patients.

Brittany Maynard was a young woman in her 20s living in California who was diagnosed with a terminal brain tumor in 2014 and decided to move to Oregon to avail herself of the Death with Dignity Act in that state. She was a vocal proponent of California's End of Life Option Act. Her husband offered Brittany's uncontrolled pain in the ICU as one of his reasons for being in favor of PAD.

**Americans fear suffering at the end of life. And they have good reason to.**

This is not at all surprising. We, the health care system collectively, have not done an adequate job in managing pain, especially in the environment of opiate misuse, abuse, and diversion. For example, opiates may be limited by insurance companies to 60 hydrocodone tablets a month. While this may be appropriate for someone with chronic back pain, this is not appropriate for patients with rapidly advancing cancers whose pain levels change daily. These patients may sit at home in agony waiting days for prior authorizations to get approved or end up in hospitals where keeping people alive takes precedence over keeping people comfortable. This is unfortunate because trained experts are able to adequately control most pain once comfort becomes the goal, and the entire care team is educated and committed to this goal.

Sometimes, pain at the end of life can remain unrelieved despite high doses of opiates and other interventional procedures. In these rare cases, we have the procedure of palliative sedation available to us. This is where, at the patient or their surrogate's request, we intentionally decrease their level of awareness so they do not continue in unrelenting misery. This is usually done with the means of a continuous infusion of a medication such as a benzodiazepine or barbiturate while continuing other medications for symptom management. The goal of this procedure is to relieve suffering as the patient is dying and not to intentionally hasten death. While some would argue this is equivalent to PAD or even euthanasia, I would unequivocally deny this.

Many argue that we already do PAD in the form of disconnecting ventilators, stopping hemodialysis, or discontinuing artificially provided hydration or nutrition. However, there is a fundamental difference between "allowing to die" and "killing."

Allowing to die: Stopping an intrusive intervention that is not meeting a patient's goal and is simply preventing them from dying.

Killing: Actually writing a prescription for the explicit goal of making them dead.

I believe intention matters and means matter, and that there is a fundamental ethical difference between "allowing to die" and "killing."

One of the supreme tenets in medicine is the Hippocratic Oath of "do no harm." I would define harm as both too much aggressive care when patients are dying, as well as giving them a lethal prescription to cause their death. I fear that assisting in suicide carries the danger of compromising the patient–physician relationship and the trust necessary to sustain it. It also undermines the integrity of the profession and diverts attention from the real issues in the care of the dying.

Another failure in our health care system is in medical education. If you go to any medical school in the country, including our own, you will find that 100 percent of medical students are required to rotate through OB-GYN though only about 10 to 15 percent of medical students actually go into this field. Yet, how many students or residents are required to take a palliative medicine rotation in this country? Zero percent—it's simply not a requirement.

Consider how many students will eventually care for seriously ill patients needing symptom management, goals of care discussions, and attention to social, emotional, and spiritual distress. They all will, unless they go into pathology or radiology. Because medical education does not prioritize training students how to relieve the pain of our patients whether or not they can be cured, our patients and families continue to suffer.

**Because medical education does not prioritize training students how to relieve the pain of our patients whether or not they can be cured, our patients and families continue to suffer.**

I believe that what's at the center of this debate revolves around meaning. If you look at the Oregon data, loss of autonomy—rather than fear of pain—is the number one reason patients choose PAD. Although I believe in giving patients as much control as possible, autonomy is really based in a negative right. That is, if you are a patient with decision-making capacity, you are allowed to refuse anything and everything even if that may save your life. In the same way, autonomy is not a positive right—you cannot demand things that are inappropriate.

Americans believe they can eliminate death and often request inappropriate or ineffective treatments. Just as this is not the answer to dealing with death, neither is the demand for death to come at the time and place of our choosing. While patients should be allowed to refuse things, I don't believe there is an underlying right to demand PAD and the Supreme Court has upheld this. I would also disagree that having control is the ultimate achievement of being human. Viktor Frankl, psychiatrist and holocaust survivor, said, "Life is never made unbearable by circumstances, but only by lack of meaning and purpose." He went on to say that, "Those who have a why to live, can bear with almost any how."

The Oregon data also shows us that the majority of those who chose PAD—95 percent—were white and that almost two-thirds had at least some college education. In effect, we have essentially created another "right" for our more socioeconomically well-off patients who are choice-enabled, while leaving those who are disadvantaged in our society with an option that they are not interested in and that does not meet their needs. This should give us pause when we reflect on health care disparities in this country.

The biggest irony of all in this debate is that we have now created, by legislation, this new "right" to PAD—but Americans still don't have a right to health care. The United States is the only developed country that allows its citizens to go bankrupt over health care costs. Families are left with the overwhelming burden to care for their loved ones and one of the greatest fears Americans have is going to a nursing home. Without good family support, this is often inevitable for a large majority of us. Another irony of our health care system is that almost every American is within 5 to 10 minutes of having a hospital on wheels show up with lights and sirens at their doorstep to provide things such as defibrillator paddles, intubation, and epinephrine. However, if I want to provide a bath and a warm, nutritious meal to my frail, elderly patient at home, it's almost impossible or takes considerable effort.

It saddens me to think of the enormous time, emotional energy, and monetary resources that have gone into promoting the End of Life Option Act. We likely could have provided palliative care to thousands of Californians who need it with those funds. When we resort to PAD, we are relying on a technological and medical answer to an existential problem. Just as this does not work to fend off death, it is not the solution to make death come at our choosing. John Donne, the 17th-century metaphysical poet wrote: "Any man's death diminishes me, because I am involved in mankind." Both society at large and medicine in particular have a duty to safeguard the value of human life. This duty applies especially to the most vulnerable members of our society: the sick, the elderly, the poor, the disabled, ethnic minorities, and other vulnerable persons. We should concentrate our efforts in educating future doctors to truly know how to provide comfort care when it's needed and fix a broken system that makes Americans feel PAD is their best option. ■

Dr. Mohr is the founding director of the Palliative Care Program at Loma Linda University Health. She is an assistant professor in the department of family medicine and serves as chair of the Ethics Committee for Loma Linda University Medical Center and the Children's Hospital.

# Basic Overview of California's End of Life Option Act

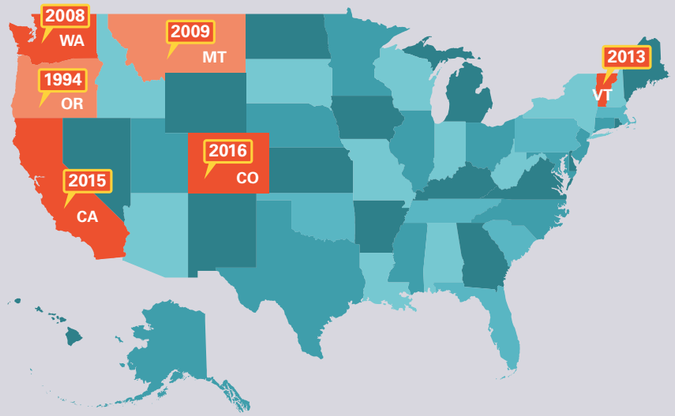
The Act allows terminally ill, mentally competent, adult (over 18) residents of California to request, obtain, and self-administer "aid-in-dying medication."

**To obtain this lethal dose of barbiturates:**

- The patient must voluntarily express his or her wish to the attending physician by providing:
  1. Two oral requests submitted at least 15 days apart
  2. One written request signed by at least two adult witnesses
- Two physicians must agree that the patient has a terminal illness with less than six months to live
- Interpretation must be available for non-English speakers

## 6 states have legalized PAD

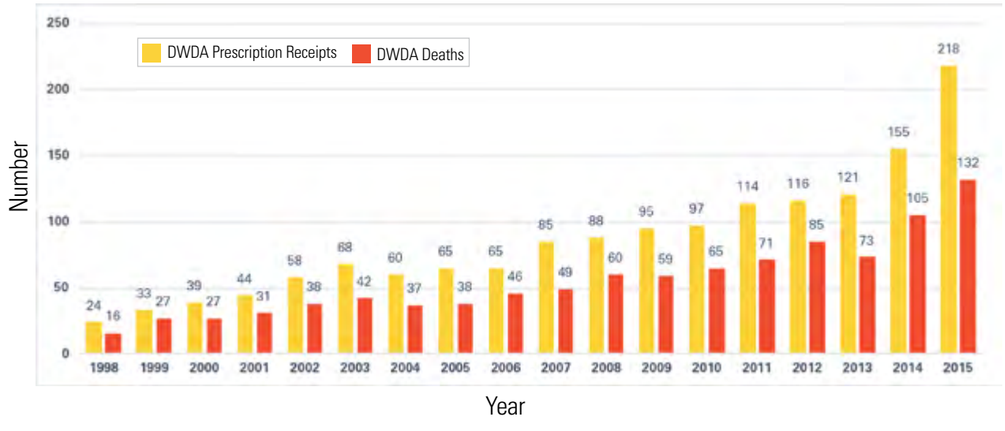
- Oregon (1994)
- Washington (2008)
- Montana (2009)
- Vermont (2013)
- California (2015)
- Colorado (2016)




## 7 countries have legalized PAD

- Belgium
- Canada
- Finland
- Germany
- Luxembourg
- The Netherlands
- Switzerland

## The Statistics: Oregon's Death With Dignity Act




*Sources: Loma Linda University Institute for Health Policy and Leadership's "Policy At A Glance: California Senate Bill 128 ('The End of Life Option Act')"; euthanasia.procon.org; public.health.oregon.gov*

*If physicians "only think in terms of curing, then [their] uncured patients become a mark in [their] 'loss column,'" writes Karl D. Sandberg '84.*

# A Natural Death

By **Karl P. Sandberg '74**

There are a few of us old dinosaur physicians who believe that health care in the United States is devolving in many areas, rather than evolving. I believe that one evidence of this is the push to legislate the involvement of doctors in hastening death. In some people's minds, death is now being thought of as a form of treatment, referred to euphemistically as "end-of-life care."

More than half of physicians in a poll taken in 2015 favored medical assistance in dying. Almost half of the states in this country have introduced bills for physician-assisted death. California, Colorado, Oregon, Vermont, Washington, and Montana have made legal provision for it. Alabama, Idaho, Massachusetts, Nevada, North Carolina, Ohio, Utah, Virginia, West Virginia, and Wyoming do not have existing laws that criminalize the abetting of suicide. Public opinion is increasingly in favor of death.

Consider our neighbors to the north. In Canada, physicians, if requested by their patients, are required to perform assisted suicide or at least make an "effective referral." Apparently, legislators there consider this mandate to be "an appropriate balancing of the rights of patients and the conscience rights of physicians." So the doctor is required to either kill the patient himself or make sure somebody else does. Neither option is acceptable to me.

Belgium legalized euthanasia in 2002. Now the country is pushing to require all physicians to accede to a euthanasia request within seven days, or to refer the patient to a physician who will. Expedience. Let's get this over with. Don't wait for tincture of time to work its wonders on the depressed patient.

According to a report from the Oregon Health Authority called "Suicides in Oregon: Trends and Associated Factors 2003–2012," Oregon's suicide rate had risen to 42 percent higher than the national average by 2012. It had been declining before voters in Oregon made assisted suicide legal. This skyrocketing of suicide could have been foreseen as an impact of turning suicide into a socially acceptable choice.

In some people's minds, death is now being thought of as a form of treatment, referred to euphemistically as "end-of-life care."

The argument is made that terminally ill patients become incapacitated and thus cannot commit suicide, but the vast majority of these patients do not become incapacitated until the very end. They usually have plenty

PHOTO: ENVATO MARKET

of time to kill themselves without help. If they ask friends and doctors to help them commit suicide, they are often looking for approval of their act. It should be no one's job to kill another person, and it is really unfair to ask doctors and family members to do so. Being responsible for another person's death is emotionally traumatic, as is evidenced by the psychological scars of those who have worked as executioners.

United States citizens already have the right to refuse any medical treatment at any time. We can choose pain relief only. We can tell our hospice nurses and caretakers to keep everyone out of our room. We can refuse nourishment and hydration. We already have control, and we don't need assisted suicide.

Kaiser Health News had an article in March of 2016 advocating that doctors be trained in how to present (or is that how to sell?) the option of ending life.

Managed death (assisted suicide) doesn't have to be hastened with a massive dose of Seconal, it can be achieved by withdrawing treatment, including nourishment and hydration. The idea that doctors are advocating such "treatment" is troubling to many of us.

Does a do-not-resuscitate order result in poorer care? This is an important question to answer. Every good doctor knows that medicine is an art as well as a science. No one can predict with 100 percent certainty who will live and who will die. Although it is rare, some terminally ill patients can and do get better. Sometimes family members disagree with physicians about whether treatment of a condition is useful (versus futile), and sometimes they are right.

Brain death is often assumed to be final and irreversible. Is it really? When are you dead? When your brain dies? When your heart stops beating? When you stop breathing? When you are in an irreversible coma? How can you know for sure? The father of George Pickering III resorted to brandishing a gun to prevent the pulling of "the plug" on his son. Dad went to jail. His son fully recovered from his supposedly "irreversible" condition. Other anecdotes should cause us to question the "irreversible" prognosis. Jahi McMath was actually issued a death certificate, yet responds to her mother today and has brain waves on EEG.

The Mississippi Supreme Court upheld a $4 million award to the family of a woman misdiagnosed with cancer and then given a lethal dose of painkillers. The 66-year-old woman was being treated at a hospice for cancer, which an autopsy showed she did not have. Medical errors are made every day. This is a fact. Do we want to compound such errors with physician-assisted suicide?

A young man was diagnosed with HIV in the Netherlands. Even though his doctors told him he might live many years free of symptoms, he asked for doctor-assisted suicide. No one talked to this young man and helped him work through his feelings of depression and of being overwhelmed by his own diagnosis. His culture was accepting of suicide and he ended his life in despair.

We all recognize that despair is not one of our good motivators. It can lead to very poor decisions. Why do we want to make it easier for despair to lead to death? I think doctors should be educated in at least recommending hospice care rather than assisted suicide. Consider prescribing low dose lithium. It has been documented as a treatment for suicidal ideation.

In his autobiography "Still Me," Christopher Reeve describes the despair he went through after becoming paralyzed in a riding accident. In the blink of an eye, he went from being a physically fit person to one who could not even twitch from the neck down. He could speak; he could drink through straws; and that was about the extent of it. He asked his wife to help him commit suicide, and she said, "I understand how you feel, but you're still you and I love you." So Reeve turned his wife's loving refusal into a book title: "Still Me."

It should be no one's job to kill another person, and it is really unfair to ask doctors and family members to do so.

Notice what Mrs. Reeve implied to her husband: "I love you and therefore I will *not* assist you in suicide."

Caring is not always curing, but it is every bit as important. If we only think in terms of curing, then our uncured patients become a mark in our "loss column." We can develop better ways of dealing with the incurable than to just sweep them under the rug, but we are less likely to do so if we pass assisted suicide laws.

In the Netherlands, it seems they have gradually morphed physician-assisted death over the years from assisted suicide, to euthanasia for the terminally ill, to euthanasia for the chronically ill, to euthanasia for psychological distress, to involuntary euthanasia (called "termination of the patient without explicit request"). There doesn't seem to be much difference between involuntary euthanasia and voluntary manslaughter.

A natural death should be part of life as we know it, The Oath of Hippocrates implies that physicians should be advocates of a natural, rather than an unnatural, death. ■

Dr. Sandberg is in general practice in Ola, Arkansas, and works as an ER/hospitalist on the side. He is in a Christian country music band that plays regularly for church.

# Physician-Assisted Death: A Utopian Mistake?

By **Donna L. Carlson '69**, *associate editor*

*"I have already related to you with what care [Utopians] look after their sick, so that nothing is left undone which may contribute either to their health or ease. And as for those who are afflicted with incurable disorders, they use all possible means of cherishing them, and of making their lives as comfortable as possible; they visit them often, and take great pains to make their time pass easily. But if any have torturing, lingering pain, without hope of recovery or ease, the priests and magistrates repair to them and exhort them, since they are unable to proceed with the business of life, are become a burden to themselves and all about them, and have in reality outlived themselves, they should . . . choose to die since they cannot live but in great misery; being persuaded, if they thus deliver themselves from torture, or allow others to do it, they shall be happy after death. Since they forfeit none of the pleasures, but only the troubles of life by this, they think they not only act reasonably, but consistently with religion; for they follow the advice of their priests, the expounders of God's will.*

*"Those who are wrought upon by these persuasions either starve themselves or take laudanum. But no one is compelled to end his life thus; and if they cannot be persuaded to it, the former care and attendance on them is continued. And though they esteem a voluntary death, when chosen on such authority, to be very honourable, on the contrary, if any one commit suicide without the concurrence of the priests and senate, they honour not the body with a decent funeral, but throw it into a ditch."*

*–Thomas More,"Utopia," Book 2 (1516)*

Published almost exactly 500 years ago, prescient lawyer–churchman Sir Thomas More's most famous book describes what we now call assisted suicide, euthanasia, and palliative care. In the ideal island world More imagined, government and church officials, the academia of the time, worked together to "persuade" the incurably sick and burdensome to end their lives "voluntarily."[1] Recently, the work has become eerily apt.

In 2015 the California legislature passed the End of Life Option Act (EOLOA), becoming the fifth state to formally legalize the practice of "physician-assisted death." The law went into effect June 9, 2016; there is as yet no report of how many people have invoked its provisions. This past November Colorado voters passed a similar measure through a ballot initiative. With the addition of these two, there are now six states where attending physicians may, without fear of criminal prosecution, prescribe lethal medications for people who "to a reasonable medical certainty" have fewer than six months to live.[2]

There are many alleged patient protections built into the new law although, like the related Natural Death Act, some of these provisions seem designed more to protect physicians from lawyers than patients from physicians.[3,4] Under the EOLOA, a competent adult (over 18) requesting lethal medication must have his or her terminal diagnosis made and confirmed by an attending physician and a qualified consultant physician. The patient must also make two personal oral requests for the medication 15 days apart and once in writing; surrogates and relatives can't make the requests. Both physicians must determine and attest in writing that the patient is competent and making an informed decision and has considered alternatives like more treatment, hospice, and palliative care. If either physician suspects a mental disorder, the patient must be referred for a mental status examination by a psychiatrist or psychologist. The physicians involved and the patient must complete and file a variety of forms. If the patient uses the medication and dies, the physician signing the death certificate must list the underlying disease—not the lethal medication—as the cause of death. Neither life nor health insurance policies may be voided if a policyholder chooses to die this way.

Some of these provisions seem designed more to protect physicians from lawyers than patients from physicians.

In my view, the EOLOA was unnecessary and I remain concerned that, despite the protective provisions,

it may well constitute the first step down an ethically slippery path. Firstly, we do not live in More's world; the passage of 500 years has brought advances in the control of disease and pain that our 16th-century forbearers could not have imagined. More's hearers lived and died in a world of truly untreatable diseases; they had (on average) a life expectancy of 35 years. We, by contrast, are the beneficiaries of a multitude of disease-fighting, pain-blocking substances. Antibiotics scotch most pneumonias, "the old man's friend" of earlier times. Emergencies like appendicitis now rarely result in death. Our oncologists and surgeons really can cure many cancers and often extend patients' lives for significant periods even when they cannot entirely eliminate a malignancy. And the pharmacologic descendants of laudanum remain readily available—and cheap.

Secondly, a review of statistics in states and countries with assisted death laws demonstrates that, despite the beneficent reasons alleged by advocates, the primary reason for the passage of these laws has little to do with "torturing, lingering pain, without hope of recovery or ease" or even fear of such pain.[5] Instead, the laws are based largely on the elevation of one ethical value above all others: an *Invictus*-like right to individual autonomy, sometimes defined as "freedom from external control or influence."[6,7] And there is little doubt that economic factors play a major role. No longer restrained by inconvenient religious beliefs (like a creator God, the bestower of the gift of life) civil and academic entities, with theologians and ethicists who supply moral justifications, serve the goal of efficient dispatch of the dying.

Moreover, while the right to personal autonomy is often cited as the moral base for the law, the reality is that within the health care system autonomy is a right recognized and respected almost exclusively in the negative. When a terminally ill patient refuses treatment, we defer to her "autonomy." Let the same patient request a therapeutic measure that may extend life for a few (to her) precious hours, days, weeks, or perhaps more, and respect for autonomy vanishes in a vapor of vague labels: inappropriate, unnecessary, futile. The words cloak a fundamentally financial determination *not* to honor the autonomy of patients who, providers and payers seem to believe, have "outlived themselves."[8] Sometimes these are patients whose lives appear to have been judged of lesser value.

Three years ago Mayo Clinic nurse-ethicist Joan Hellyer spoke at Loma Linda University Medical Center on "Decision Making for the Unbefriended Patient." Hellyer told the story of a mildly mentally handicapped man who had no close family or friends but who did have a strong will to live. He had spent weeks in intensive care (ICU) with a cascade of serious problems and had twice been successfully resuscitated after a cardiac arrest. He had exhausted his insurance benefits (Hellyer admitted but did not emphasize this fact) and members of the ethics team were sent to persuade him to sign a do-not-resuscitate (DNR) order. The visitors described in detail all the things that would be done to him if he had another episode: people would pound on his chest, shock him with electric paddles, put a tube down his throat, stick him with needles. "You don't want to go through all that again, do you?" Smiling from the chair beside his bed, the man responded to the effect that, "It wasn't so bad. I'd rather have you do that than let me die." Exasperated, the physician in charge of the unit opined that the patient only took that position because he was enjoying life in the ICU and was not intelligent enough to rationally evaluate his own interest. Despite the lack of a DNR order and a history of success with the procedure, the next time his heart failed, there was no effort to save him. I wonder if the Mayo Clinic team would have treated Stephen Hawking that way.

**"Those who think that we are far too enlightened a culture to head down a similar slippery slope are blind to the reality of what happens to medicine when it is ruled by political systems that have lost their soul." —Leo Alexander, MD**

Thirdly, as **Gina J. Mohr '96** points out in her article (page 28), we have not put time and resources into kinder, gentler alternatives. Individually and collectively many of us remain reluctant to care for those among us who inconveniently linger at the far edge of life. We do not "visit them often," or spend time "cherishing" them, "making their time pass as comfortably as possible," as More suggested. By these sins of omission we all participate in decisions encouraging others to die, turning instead to the easier, cheaper device of laws sanctioning physician-assisted suicide, laws that turn our healers into handmaidens of death.

Finally, although **Phillip Gold '01-fac** makes a good case in his article (page 36) for a small cohort of patients, the law is largely unnecessary for the purpose he describes. We have all had our "Nathaniels," but long before Oregon passed its Death with Dignity Act and other states followed suit, we dealt compassionately, and legally, with them. Mine was a 22-year-old mother of two who developed an aggressive osteosarcoma in her left humerus. When the orthopedic surgeon explained that her only chance for a cure was immediate amputation, "Jane" left for Tijuana and a six-week course of laetrile, a substance then touted as a "natural" cure for cancer. By the time she returned, the tumor had grown into her chest wall and amputation was impossible. For about a month, her pain was fairly well controlled at home with Dilaudid and Demerol injections; though weak, she was able to enjoy time with her husband and children. But eventually she was admitted to the hospital for a morphine infusion; she was on our service because the only oncologist on staff was a pediatric specialist.

One night I received an urgent page from her nurse. Jane was having breakthrough pain. I called the oncologist; we conferred and agreed. Though it might depress respiration, Jane needed more morphine to make her completely comfortable. I sat at her bedside, opened the line, and titrated the drip until she fell softly into a deep sleep, then telephoned her husband. He came in and held her hand as she slipped quietly away a short time later. What I did was not "illegal" at the time and it is no more "legal" now than it was then. Today we call it "palliative sedation"; then we called it taking care of a suffering patient by relieving her pain. We did not have an ethics committee consult, an advance directive signed in the business office to limit costs and protect the hospital from liability, and we did not have a stack of forms for her and her doctors to complete. We needed none of those. As Justice Sandra Day O'Connor said 20 years ago in *Vacco v. Quill*: "a patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death."

The belief that there is an "unassailable right to choose the time and manner of one's death" has not been supported by the United States Supreme Court in its seminal decisions dealing with the issue.[9] There is no such thing as a "right to die." Cautious voices remind us that freedom has limits; that personal autonomy is not absolute nor necessarily the highest of all moral values; that even the dying (i.e., all of us) have a duty to leave behind a world where the value of human life is confirmed and reflected in professional standards. Physicians, as Justice David Souter observed in his concurrence in *Washington v. Glucksburg*, are subject to "temptation—noble or not" to over-prescribe death because it is legal to do so—as happened in the Netherlands.[10] Citing one amicus brief with apparent approval, he noted:

> Physicians, and their hospitals, have their own financial incentives … in this new age of managed care. Whether acting from compassion or under some other influence, a physician who would provide a drug for a patient to administer might well go the further step of administering the drug himself; so, the barrier between assisted suicide and euthanasia could become porous, and the line between voluntary and involuntary euthanasia as well.

American psychiatrist Leo Alexander, consultant to attorneys for the Allies at Nuremberg, warned in a 1949 article in the *New England Journal of Medicine* against what some have since called a hardening of medical hearts:

> Whatever proportions these crimes [by physicians during the holocaust] finally assumed, it became evident to all who investigated them that they had started from small beginnings … [that] in its early stages concerned itself merely with the severely and chronically sick. … Those who think that we are far too enlightened a culture to head down a similar slippery slope [to euthanasia] are blind to the reality of what happens to medicine when it is ruled by political systems that have lost their soul. We are heading there slowly but surely. ■

Endnotes

1. Some experts think More's book was satirical in part, designed to mock both church and state officials.
2. Oregon, Washington, Vermont, Montana, California, Colorado
3. Passed in California and signed by Governor Pat Brown in 1976, the Natural Death Act went into effect January 1, 1977. The Act was the first in the nation to formalize the right of patients to refuse medical treatment and became the basis for Advanced Directive forms and procedures now used in every state.
4. See the Medical Board of California website for a legislative summary of the law in this state.
5. See, e.g., public.health.oregon.gov for the state's annual reports on the Death with Dignity Act.
6. "I am the master of my fate, I am the captain of my soul." William Ernest Henley (1888)
7. www.merriam-webster.com/dictionary/autonomy
8. In single letters in 2008 two patients—63-year-old Barbara Wagner and 53-year-old Randy Stroup of Oregon—were denied treatment for their cancers but offered coverage and referrals for PAD. This kind of communication is forbidden under EOLOA. In October 2016, 33-year-old Stephanie Packer of California was denied coverage for a new (less toxic) immunosuppressive drug for her terminal scleroderma but, upon inquiry, learned that her insurance company would pay for a PAD drug.
9. See *Washington v. Glucksberg* (521 U.S. 702 (1997)) and *Vacco v. Quill* (521 U.S. 793 (1997)).
10. See "Dying Dutch: The Spread of Euthanasia Across Europe" in the February 12, 2015, issue of *Newsweek*.

Dr. Carlson, associate editor of the *Alumni JOURNAL*, is a retired pediatrician and an attorney. She writes from Redlands, California.

# End of Life Options Act: Good Law, Good Ethics, Good Medicine

By **Philip Gold '01-fac**

Nathaniel became my patient when Lou Gehrig's disease impaired his breathing and swallowing. He was formerly a successful accountant and an active man who enjoyed gardening and outdoor activities. His wife of over 30 years was his love, soul mate, and constant companion. Together, they raised two loving and accomplished daughters.

Gradually over the years, his illness caused his world to shrink, his physical universe now confined to the bed of his living room. While I was able to control his pain well with opiates, he experienced the unending discomfort associated with profound physical immobility. And like many patients with chronic, terminal illness, his suffering was much more than the experience of pain, it was a suffering not just of his body but also of his heart and soul. I knew this because I asked him.

Nathaniel used to love food but was now nourished through a feeding tube, as he could no longer swallow safely. When he accepted a tracheostomy and feeding tube, I promised him he could die at home. I promised him I would be with him and see him in his home rather than in my office. I promised him that, if and when he chose to stop treatment and end his life, I would do all in my power to assure a quiet, peaceful death without discomfort.

So when Nathaniel decided it was time, I visited his sunlit living room with syringes of morphine and sedatives to fulfill the promises I made. He lay in his bed as a tube connecting him to his ventilator projected from his windpipe. His speech was painfully slow but intelligible. I was joined by his family in the living room where, for almost an hour, we shared family jokes and stories, memories of a life of purpose, and a life well lived. When the stories, laughs, and tears were exhausted, I injected the medicines, which ensured Nathaniel's comfort. He fell into a deep sleep and I turned off his ventilator. His family surrounded his bed in silent prayer.

I often think of Nathaniel and the many patients like him for whom I have cared over the years. When Nathaniel could envision no other future and no end to his dependence and misery, he died as he wished and was finally at peace. Assisting Nathaniel in his death was not only legal, most of the medical profession now supports what I did for Nathaniel as a morally correct professional obligation.

I have reflected deeply on the reasons why I believe that California's End of Life Option Act is good law, good ethics, and good medicine. My arguments are based on the ethical principles of autonomy and beneficence, and on what I hold to be the social and constitutional rights of all persons to exercise self-determination and maintain privacy in matters of their health. I firmly believe that terminally ill and suffering persons with capacity to make decisions have an unassailable right to choose the time and manner of their death.

My arguments also rest upon professional considerations. As physicians, we value life and must work compassionately and vigorously to preserve it. But as physicians, we are also called to relieve suffering and, at times, this is the greater good. In some situations, the relief of suffering is our foremost professional duty.

**I firmly believe that terminally ill and suffering persons with capacity to make decisions have an unassailable right to choose the time and manner of their death.**

I graduated from medical school 53 years ago and what I have learned over the past half century are the following:

- Uncertainty is certain and we all must learn to live with it. Medicine's diagnoses, prognoses, and recommendations are, at times, fallible.
- You can't win them all. Despite our knowledge, diligence, empathy, and prayers, some of our patients won't get well and all will eventually die (as will we).
- Every patient and every illness is special and unique. Medicine may be scientific but it is not a science. It is an art, at once a very human and personal enterprise.

Modern science and technology have made miraculous strides in extending life. At the same time, we have changed the way people die. People now die of chronic disease, usually more than one, and too often of complications related to their treatment. People die in hospitals. People die slowly and incrementally and their dying is regularly accompanied by great suffering.

My own attitude toward physician-assisted death has changed over time. Initially, I was swayed by the biblical injunction to choose life and by the professional mores I incorporated as a student and resident. My current position evolved over years of caring for dying patients and has been influenced by my interest in medical ethics.

**Every patient and every illness is special and unique. Medicine may be scientific but it is not a science. It is an art, at once a very human and personal enterprise.**

In large measure, my attitudes have been shaped and informed by the reasoning of Eric Cassell's "The Nature of Suffering and the Goals of Medicine." Cassell, a physician, argues that personhood is defined by one's family, pasts, roles, relationships, bodies, behaviors, secret lives, futures, and transcendence and explains suffering as the loss of this personhood. As chronic illness brings about suffering through the loss of personhood, it is particularly apt that this concept of personhood, its subsequent loss, and the suffering that goes with it should be a pivotal argument for physician-assisted death, especially in this community where our mission, one that is at my very core, is the provision of whole person care.

As patients confront terminal illness, most, but not all, lose components of their personhood. For many, the response to this loss is the experience of existential suffering. For such souls, death becomes preferable to life. The end of suffering becomes their last and only hope.

I have an interest in the power of narrative to teach us about the human condition and to make us better and more empathic caregivers. Our patients and we can view their illnesses as part of their life stories. Seen through such a lens, dying becomes a part of one's life story. I have learned that many terminally ill patients desperately want to write their own narratives, to choose how and when their stories end. As physicians, I believe assisting patients in writing the stories of their deaths as well as their lives, and relieving their suffering, are ethical, moral, and humane acts, and sacred responsibilities as well. ■

Dr. Gold, MACP, received his MD from UCLA in 1962. He is professor of medicine, program director of the pulmonary/critical medicine fellowship at LLU School of Medicine, and medical director of respiratory care at the LLU Medical Center.

# It Takes a Village

By **Tiffany C. Priester '04**

*Tiffany C. Priester '04 (blue scrubs) teaches echocardiography to Dr. Gooden, a visiting internal medicine resident, at Blantyre Adventist Hospital in 2013. Dr. Priester served as the only cardiologist in the country of Malawi for five years.*

It takes a village to support a missionary. In 2016, my husband and I returned to the U.S. after five years living in Blantyre, Malawi, where I was stationed as a medical missionary cardiologist at Blantyre Adventist Hospital. During that time, I was the only cardiologist in the country (with an estimated population of 16 million). The previous cardiologist had left 10 years before I arrived, and now that I have gone there is again no cardiologist. Malawi is one of the poorest countries in the world, ranking below Haiti, South Sudan, and Bangladesh. It also vies with Liberia and Niger for the worst access to health care with only two physicians for every 100,000 people.

It is impossible to summarize five years in Malawi. There was no way to even capture each year's stories when we came home on annual leave. Each month I saw the full spectrum of medical care: from chaos to routine, triple-overbooked to boredom, critically ill and dying to worried-well, those who put every waking minute into the work to those for whom the work was just a job, the very rich to the very poor—and everything in between.

The stories of lives lost and lives saved, of prayers miraculously answered and prayers seemingly unanswered, of sleepless nights and sleeping under the mosquito net with dreams of better things to come are too numerous to recount here. Mission work can be incredibly rewarding and infuriatingly frustrating. It is often performed with undertrained staff and few resources, relying on God to find a way to help and to guide, usually through others. After all, we are all God's hands and feet.

My husband and I are incredibly thankful for all those who rallied behind the mission work. With support from Adventist Health International (AHI), an Australian carpenter, a handful of nurses, a supportive administrative committee, and God's guiding hand the hospital opened a cardiology clinic and an intensive care unit. This was a tremendous accomplishment for such a poor country.

We also received Christmas care packages from Loma Linda University (LLU) Medical Auxiliary and from the Global Health Institute (GHI). Twice, important medical equipment arrived in containers from AHI and GHI. There was a six-week training course in Loma Linda for two of our new ICU nurses supported by AHI and the LLU Medical Center. Twice, LLU Medical Auxiliary gave us $10,000 for the hospital's projects. We had residents rotating on electives from the internal medicine residency program, and three times LLU School of Medicine alumni cardiologists covered the hospital and clinic during my annual leave. There truly was a village of people supporting our work in Blantyre.

**There truly was a village of people supporting our work in Blantyre.**

It is a tremendous blessing to have these organizations supporting the Church's medical mission work. And yet, there were days when it still felt like all the support wasn't enough—like we needed a bigger village to help! The needs are simply that great. And the potential is tremendous. There are many alumni serving dedicatedly in the mission field who need the same support I had from their "village."

Now that I have returned, I am joining the village. My family is supporting the ongoing medical mission work because it truly does take a village to raise a mission hospital. And we want to help create a bigger village. Each of you can also be part of this village in some way.

Join us in prayer. Join us in spirit. Join us in the mission field. Join us in financial support of AIMS, GHI, AHI, and the Medical Auxiliary. Join us as we take God's message of love to the ends of the earth. ■

Dr Priester is a staff cardiologist at the VA Loma Linda Healthcare System and an AIMS board member. She continues to take short-term mission trips to Malawi.

## Association of International Medical Services

A Refresher

### Our Vision

Global Health: A world whose people enjoy spiritual, physical, and emotional health

### Our Mission

- To inspire and support medical mission endeavors and humanitarian service
- To facilitate connection between mission-aligned LLU alumni and Christian health professionals worldwide
- To advance global and spiritual health through education, scientific exchange, philanthropy, and volunteerism

### Our Goals

The Loma Linda University campus, where AIMS was born, houses several mission-based organizations, including the Global Health Institute, Students for International Mission Service, Adventist Health International, the General Conference Representative's office, and the School of Medicine Medical Auxiliary.

Other on-campus mission organizations provide infrastructure, management, and equipment for many mission hospitals. In an attempt to avoid duplication, AIMS has decided to be about training the "boots on the ground." We are motivated to bring healing, sustained health, and the good news of salvation to all mankind. This is true global health. We wish to be His hands and feet.

### Our Current Projects

Current AIMS projects and financial needs:

- AIMS for KIDS: $500/project
- Tropical Medicine and Global Health Elective: $2,800/student/year
- Residents DMA Education for Global Service: $12,000/resident
- Summer Elective Projects: $500/student
- Hospital Adoption Program: $10,000/hospital

There are also opportunities to relieve overseas missionaries during their furlough through the Give Us a Break project.

More information about each project can be found on the AIMS website.

The total needed to fund this year's projects is $100,000. Make your tax-deductible donations online today at: www.aims.llusmaa.org/donate. You may also write a check to Alumni Association, SMLLU, 11245 Anderson St., Loma Linda, CA 92354. On the check, write "AIMS" and the name of the project you're donating toward.

You can also support the groundwork by becoming an AIMS member! We need 60 new memberships this year to balance the budget for our part-time staff. ■

# The Blessings of Giving

By **Edwin H. Krick '61**, AIMS past president

I grew up in a pastor's home during the Great Depression. Dad was being paid $10 a week to do "Harvest Ingathering" year round. I'll never forget my folks' dedication to meeting the needs of their church and God's work—be it educational, medical, publishing, radio, and later TV. They had a special method of donating funds: after paying 10 percent tithe on their income, they set aside a "second tithe" for other projects. I learned early on from my parents the blessing of giving, and my wife, Bev, and I have found it a great blessing to continue giving toward various projects in a similar manner.

Though 2016 has passed, I want to share of an annually recurring opportunity for giving. If you are 70½ or older and no longer working, the IRS requires that you start taking from your individual retirement accounts (IRA) an annual amount calculated on your remaining probable life span. This is called a Required Minimum Distribution (RMD), on which you must pay tax. However, congress has passed a law allowing you to have the RMD sent directly to a charity of your choice without paying any tax. Just send the name and address of your charity to the company holding/managing your IRA. If you have any questions, your certified public accountant can help with the process.

You might be interested in sending your RMD directly to one of several projects sponsored by the "mission arm" of the Alumni Association: the Association of International Medical Services, better known as AIMS. (And perhaps known to many of you by its former name, the Adventist International Medical Society.) A number of these projects and their financial needs are listed on the previous page.

Another option is perpetual membership in AIMS or the Alumni Association. Please consider joining me this year in upgrading your membership—it truly is a perpetual donation that never stops giving!

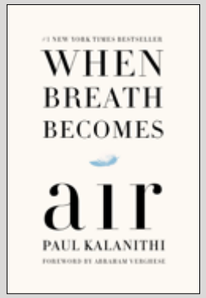
May God bless all you do in His service. ■

The AIMS Report is developed by the Association of International Medical Services. A part of the Alumni Association, it is an organization dedicated to the promotion of international health.
www.aims.llusmaa.org

# Forging a New Identity

By **Paige Stevens '16**

I have had the opportunity to interview prospective medical students for admission to Loma Linda University. The question "Why do you want to be a doctor?" inevitably evokes a response about how the applicant cares deeply for people who are hurting and wishes to pursue a career that ameliorates suffering. If Paul Kalanithi was asked this question, I suspect his answer would have had similar undertones about a moral obligation to walk with his patients through the most difficult times of their lives. However, his answer would also have included a desire to understand the meaning of life through the examination of death and the process of dying. A relentless determination to understand death—and life—through the direct experience of caring for the dying and being diagnosed with a terminal illness himself, is what Dr. Kalanithi examines in "When Breath Becomes Air."




When Breath Becomes Air
By Paul Kalanithi
Random House (2016)
256 pages

The narrative, filled with deep insight into the meaning of life and death, has become a *New York Times* bestselling title, a powerful story that has rippled through the medical community generating innumerable questions and discussions. The book has captivated hearts and minds and left a legacy of life-altering ways of thought for readers.

"When Breath Becomes Air" begins with the jarring reality that Dr. Kalanithi has been diagnosed with metastatic pulmonary cancer in his final year of neurosurgery residency. He describes the road he traveled to reach such a point in his career: four years of college at Stanford University as an English literature and human biology major, a year at Cambridge University completing a master's in philosophy of history and philosophy of science, four years at Yale School of Medicine where he met his wife Lucy, and six out of seven years of neurosurgery residency and research at Stanford University. In describing his pathway to medicine and neurosurgery, it is clear that his goal was threefold: to philosophically study human meaning, to become entwined with the neuron-filled organ that is responsible for creating life's meaning, and to participate in the tangible human relationships that allow people to experience the meaning of life.

Dr. Kalanithi unabashedly details the rigorous toll that neurosurgery took on his young life: the years of delayed gratification, the grueling hours away from his wife and the resulting strain on his marriage, the physical stress that surgery demanded of his body, and his initial attribution of his cancer's symptoms to the demands of his profession. He writes as well of the lofty responsibility of caring for the brain—the organ not only responsible for life and death, but also for the meaning that a person derives from life. Physicians in training will find it easy to resonate with the emotions and experiences he describes as he fought the callousing that naturally results from repeatedly facing disease, suffering, and death, all while constantly exhausted from an endless workload.

**Dr. Kalanithi describes with poignant prose the reality of being confronted with his own death just as he was finally ready to begin living life.**

Finally at the completion of his training, Dr. Kalanithi describes with poignant prose the reality of being confronted with his own death just as he was finally ready to begin living life. The highs and lows of cancer therapy—small victories followed by devastating setbacks—and the toll of the disease are brought to life by Dr. Kalanithi in a way that only a physician-turned-patient can elucidate. In the process of reinventing himself by realigning his priorities and finding meaning through it all, he learns from his oncologist that the true role of a physician in guiding patients through disease is not giving them back their old identity, but protecting their ability to forge a new one.

The book remains an unfinished work, not unlike the life of its young author. It ends with a paragraph written to his 8-month-old daughter—an invitation for her to one day explore the meaning behind the joy she provided him in his final months of life. His wife provides an epilogue that gracefully depicts the dignity, courage, integrity, and abundant love with which Dr. Kalanithi lived his life and approached death. I would encourage anyone, especially physicians, to settle in, inhale deeply, and contemplate the meaning of "When Breath Becomes Air." ■

Dr. Stevens always wanted to follow in her mother's footsteps and pursue pediatric medicine. She is now a pediatric resident at Children's Hospital Los Angeles and hopes to one day teach medical students herself.





## 85 Years of the *Alumni JOURNAL*

*(Continued from page 13)*

archiving, film, blogs, visual graphics, social media, and a host of other technological wonders yet to be imagined.

During my tenure at the Alumni Association, I have had the privilege of being part of the *Alumni JOURNAL* editorial team under the watchful eyes of editors **Henry K. Yeo '68**, Donna Carlson, and Burton Briggs. I can attest to the fact that the appearance of their names on the *JOURNAL* masthead is well earned. In conclusion, it is only fitting that I dedicate this article to the *Alumni JOURNAL* editors past and present. Their tireless and unseen efforts are found on the pages of each and every issue. *Bene factum! Bene factum!* ■

End Notes

1. "What is a Name?" *The Medical Evangelist.* (June 1908) Vol. 1; No. 1, p. 17.
2. Ibid, p. 1.
3. C.H. Lewis, M.D. "Medical Evangelist Official Alumni Organ." *The Medical Evangelist.* (October 2, 1924) Vol. XI; No. 14, p. 4.
4. Ibid.
5. Alumni Association Undated Bylaws circa 1927. Article I; Section 5, p. 1.
6. Alumni Association, "Action of the Board of Directors," July 20, 1930.
7. Ibid.
8. Alumni Association, "Action of the Board of Directors," November 25, 1930.
9. Alumni Association, "Action of the Board of Directors," January 20, 1931.
10. F.B. Moor, M.D. "Our Alumni Association." *The JOURNAL.* (January–February 1931) Vol. 1; No. 1, pp. 4, 5.
11. G. Mosser Taylor, M.D. "The Midwinter Alumni Banquet, Pacific Coast Club, Long Beach." *The JOURNAL.* (March–April 1931) Vol. 1; No. 2, pp. 9–12.
12. "Alumni Dues and JOURNAL Subscription Rates." *The JOURNAL.* (March–April 1931) Vol. 1; No. 2, p. 12.
13. G. Mosser Taylor, M.D. "Notes From the Alumni Board." *The JOURNAL.* (March–April 1931) Vol. 1; No. 2, pp. 7, 8.
14. Alumni Association, "Action of the Board of Directors," September 15, 1931.
15. Bo Ying Wat '49, former associate editor of the *Alumni JOURNAL.*

Dennis E. Park is former executive director of the Alumni Association. He enjoys writing about the history of the Association and the Loma Linda community and is the author of "The Mound City Chronicles: A Pictorial History of Loma Linda University, a Health Sciences Institution."

# Alumni News

## 1940s

Photography featuring the late **Vincent E. Gardner '44-B** when he worked as a medical missionary with the Navajo Nation in the 1950s was displayed at a one-day exhibit at the LLU School of Medicine on November 22, 2016. The event was in honor of Native American Heritage Month. The photographs were taken by a *Look* magazine photojournalist, many of which appeared in the September 4, 1956, issue of the magazine. Dr. Gardner began his work at Monument Valley Adventist Mission Hospital in 1950, later moving to a government hospital on the reservation.

## 1950s

"A Life of Art," a retrospective exhibition featuring the work of artist–physician **S. Wesley Kime '53-A**—most notably his LLU Faculty Gallery oil paintings—was on display at the Brandstater Gallery on the La Sierra University campus from November 28 to December 15, 2016. Dr. Kime was an artist long before becoming a physician and has produced art in a variety of forms his entire life. Readers of the *JOURNAL* will have seen his work—whether his flash sketches, formal portraits, or landscapes—in one form or another over the years.

**Elmer E. Hart '53-B** was in the midst of his studies at what is now Walla Walla University in Washington when he was drafted as a medic into the U.S. military during World War II. He served admirably in four island campaigns as a conscientious objector, never needing a weapon, he says. Dr. Hart was a contemporary of the late Desmond Doss, a courageous Christian who saved the lives of 75 of his fellow soldiers and whose story is featured in the film "Hacksaw Ridge." During the events portrayed in the film, Dr. Hart was mere miles away on the beaches of Okinawa. His story was published in November 2016 on the website of *The News Tribune*, of Tacoma, Washington. *(Photo: Dr. Hart displays Army memorabilia from World War II; from thenewstribune.com.)*

## 1970s

**Richard H. Hart '70** was recognized by *Becker's Hospital Review* in the 2016 edition of the Physician Leaders of Hospitals and Health Systems list as one of the 110 physician leaders to know in 2016. Recipients were chosen because they demonstrated "outstanding leadership and clinical expertise throughout their careers" and for leading initiatives that positively impacted their organizations and communities. Dr. Hart has a doctor of public health degree and is president of Loma Linda University Health.

▲ **Wesley E. Rippey '76-A**, surgeon and chief medical officer at Adventist Medical Center–Portland, was recognized by Adventist Health–Portland as one of four community heroes at its annual Heroes of the Heart Gala on October 19, 2016. He is a fourth-generation surgeon for Adventist Medical Center and has dedicated his career to serving his fellow Oregonians. Last year he received the hospital's Physician of the Year Mission Award "for his outstanding leadership and commitment to patient care and wellness." *(Photo: Dr. Rippey flanked by Dan Tonkovich (left), chair, Adventist Health Foundation; and David Russell, president and CEO of Adventist Medical Center; from facebook.com/adventisthealthnw.)*

## 1980s

**Takkin Lo '86** and **Steven W. Hildebrand '80-A** experienced a "small world" moment when they bumped into each other at the Kailua SDA Church in Hawaii in early November 2016. Dr. Lo, a pulmonologist and formerly of Loma Linda, now practices in Kailua. Dr. Hildebrand, an AIMS board member and cardiologist in Banning, California, was picking up his daughter after she had finished her studies at the University of Hawaii. *(Photo: Dr. Lo (left) and Dr. Hildebrand (right) pose with the church pastor; contributed by Dr. Lo.)*

## 2000s

**Joseph D. Foley '04** was one of the young professionals recently recognized by *The Business Journal* of Tri-Cities Tennessee/Virginia as a winner of its 40 Under Forty competition. The talented community leaders were recognized for the impact they are making in their region. Foley is an interventional cardiologist with the Wellmont CVA Heart Institute and was instrumental in developing a multidisciplinary vascular team at the Bristol Regional Medical Center. He also established a specialized service to treat patients with chronic, total coronary occlusions.

**Kamal R. Woods '05** was recognized by Continental Who's Who among Pinnacle Professionals in the field of health care. Dr. Woods is physician leader of neuroscience at Kettering Health Network and was formerly director of the spinal center at LLU Medical Center–Murrieta. He is board certified in neurosurgery and a leader in cutting-edge spine care. ■

**What's new?** Have you relocated? Changed careers? Started a fellowship? Served overseas? Has a classmate received an award? Email us about it: llusmaa@llu.edu.



# Placement Ads



# Classified Ads

# Alumni Remembered

## 1940s

**Elmer J. Martinson '42** was born November 16, 1917, and died June 27, 2015. He was 97.

Dr. Martinson grew up in Wayzata, Minnesota, with his parents Alma and **Carl J. Martinson '25**, his grandfather Martin Martinson, and his brother **Arthur J. Martinson '42** (all deceased). He attended Widsten School, Maplewood Academy, and Union College. Following medical school he joined the U.S. Air Force to command the hospital at the 8th Air Force base at High Wycombe, England.

After the war, Dr. Martinson completed a master's degree in surgery at the University of Minnesota and joined his father's medical practice in Wayzata. He was active as a surgeon at Abbott Northwestern Hospital and Metropolitan Medical Center, both in Minneapolis. Dr. Martinson was also a founder, leader, and volunteer with the Minnetonka and Westview Seventh-day Adventist churches and an accomplished golfer and alpine, Nordic, and water skier. He was active in the founding of Minnetonka Christian Academy and Wayzata Country Club.

Dr. Martinson is survived by his sons Thomas (Joan), Carl "Jack" (Yunhae), Bruce (Nancy), and William (Pamela); grandchildren Carrie (Ben Jones), Justin, Michele, Sarah, Marisa, Thomas Jr. "Fritz," Lindy, Lisa Ankeny, and Kristin Ankeny; and great-grandchildren James, Sam, Eli, and Jack Jones.

**Ernest Leroy "Lee" Williams '44-B** was born October 5, 1917, in Lark, North Dakota, and died August 31, 2016, at the age of 98 in the comfort of his home.

Dr. Williams graduated with honors from Inglewood Union High School and graduated from UCLA in 1939 with a degree in bacteriology. He taught a pre-nursing class at Pacific Union College in 1940 before completing medical school in Loma Linda. After completing his internship and an internal medicine residency at the LA County Hospital he entered the U.S. Army Medical Corps in 1946 with specialized training in neurology-psychiatry, serving as captain. He received an anesthesiology fellowship at UCLA Hospital in 1952.

His experience was varied: general practice, medicine, surgery, anesthesia, obstetrics, gynecology, pediatrics, geriatrics. He opened offices in West Hollywood, Canoga Park, and Delano, California, from 1947 to 1977. In 1977, he moved to Oxnard, California, where he worked at the Naval Hospital in Port Hueneme, California, and the Camarillo State Hospital until 1996. He then worked at the Wasco State Prison and the Central California Women's Facility in Chowchilla through 2001.

Dr. Williams joined a medical missionary group on a trip to the Dominican Republic and spent many hours volunteering at St. John's Regional Medical Center in Oxnard and the Port Hueneme Naval Base. His family is deeply saddened by his passing, but is comforted by years of memories of a life fully lived.

Dr. Williams was preceded in death by his parents Myron Levy and Lenora Bonus Levy; his brothers Myron Levy, Paul Levy, and Edmond Williams; his wife Carolyn Mitts Williams; his son Roger Williams; and his daughter Minette Williams. He is survived by his daughters Lynne Williams Fausset SN'66 and Tammy Pruitt, five grandchildren, and five great-grandchildren.

**Barney Estes McLarty '45** was born May 24, 1918, in Oxford, Mississippi, and died August 4, 2016, in Columbia, Maryland.

Dr. McLarty's lifelong dream of becoming a physician seemed shattered when he was unable to attend UT Memphis because he would not attend a freshman class on Sabbath. However, he eventually earned his medical degree from Loma Linda and married Marcella Whitney SN'46. After completing his internship at LA County–USC Medical Center and practicing for two years with **Roscoe M. Hippach '23**, he returned to Memphis and took two years of OB-GYN training at Methodist Hospital. He established a general practice and was joined in 1949 by **George T. Mills '49,** with whom he practiced for 38 years. They were later joined by Dr. McLarty's brother, **Alexander M. McLarty '53-B**. After retirement he lived in Calhoun, Georgia, and Columbia, Maryland.

Dr. McLarty was a leader in his local Seventh-day Adventist church, participated in overseas mission trips, and volunteered with Bibleinfo.com. He was co-founder of the Adventist Amateur Radio Network. A strong believer in Christian education, he sponsored many students. He also supported various Adventist causes around the world, but his deep, abiding gratitude for what LLUSM had done for him made it his most beloved cause, and he was a faithful and generous contributor.

Dr. McLarty was preceded in death by Marcella after 65 years of marriage. He is survived by his children Marilynn Peeke SPH'82, Arthur, John, Jean Cuttrell, **Gary L. McLarty '83**, and **Ruth McLarty '89**; 13 grandchildren, including **Jeffrey W. Peeke '01**, Jennifer Peeke Chalker SD'04, Brent Peeke SD'10, and **Justin D. McLarty '08**; and nine great-grandchildren.

Notify us of an alumnus who has passed at www.llusmaa.org/inmemoriam or by using our contact information on page one.

**Benjamin Russell "Ben" Boice '46** was born in Phoenix, Arizona, on November 5, 1921, and died February 24, 2014, at home in Idaho Falls, Idaho. He was 93.

Dr. Boice graduated from Phoenix Union High School and completed his premedical requirements in California. He earned his medical degree while serving in the U.S. Navy and continued on as a medical officer at Naval hospitals and aboard ship, surviving a harrowing experience on a submarine as a volunteer Navy medical observer. In 1951, he opened a general medicine and surgery practice in Sonora, California. Two years later he was joined by **Paul L. '47** and **Helen B. Anspach '47**. Together, they built the first modern hospital in Tuolumne County: Sonora Community Hospital, which they donated to the Seventh-day Adventist church in 1961, free of debt.

Drs. Boice and Paul Anspach responded to emergencies during construction of the Cherry Valley Dam. More than once, Dr. Boice rode horseback into the high country to help with a rescue. He sometimes took his son, Chuck (**Charles R. Boice '73-A**), with him on house calls. He retired from medicine in 1979, also retiring as president of the Sonora Community Hospital the following year. Dr. Boice and his wife Pat lived in the British West Indies where they were married for five years before moving to Idaho Falls in 1990 to be near family.

Dr. Boice lived a full, accomplished life and will be missed by countless people. He is survived by his wife, Patricia; three children from a previous marriage, Jeanette Boice Emery (Rick), Deanne Boice Hanscom, and Dr. Charles Boice (Susan); and two stepchildren, Dr. Randy Harrison (Gail) and Sheri Harrison Weber (**Don B. Weber '80-B**). He is also survived by three grandsons; five step-grandchildren; and numerous nieces, nephews, and grandnieces and grandnephews.

**Louis L. Smith '49** was born May 19, 1925, in College Place, Washington, and died September 9, 2016, in Loma Linda.

Dr. Smith was the third of three sons to parents who were both educators. His mother taught English and his father, Walter I. Smith, EdD, served as president of three Seventh-day Adventist colleges and continued to oversee their success in his role with the General Conference Department of Education. Because of the mentorship of his surgeon uncle, **Wilburn H. Smith 1905-AMMC**, Dr. Smith had decided to become a surgeon by the age of 12. He completed his premedical studies at Pacific Union College and Walla Walla College before beginning his medical training at Loma Linda. While there, he painted illustrations for Dr. Samuel Crooks' new anatomy syllabus. He also met Marguerite Gardner, whose father, **Floyd W. Gardner '21**, was on the medical faculty. Dr. Smith married Marguerite in 1947.

His parents' involvement in education made teaching the "thing to do," and in preparation to join the Loma Linda medical school faculty, Dr. Smith took a five-year vascular surgery residency at LA County General Hospital. Partway through, he took a leave of absence and served as chief of surgery for two years at the U.S. Air Force Base Hospital in Itazuki, Japan. Awarded a National Institutes of Health research fellowship in 1957, he completed additional postgraduate work in transplant surgery at Harvard University, training under surgeons Joseph Murray, MD, who performed the first successful human organ transplant, and Francis D. Moore, MD. Dr. Smith joined the Loma Linda faculty in 1959. In 1962, he became the first faculty member to move from Los Angeles during the School's consolidation in Loma Linda.

Always interested in research, Dr. Smith was director of the surgical research laboratory for 25 years and cofounder of the Walter E. Macpherson Society, serving as president from 1964 to 1967. In 1967, he performed the first organ transplant at Loma Linda. He was also a mentor to **Leonard L. Bailey '69**, LLU's infant heart transplant pioneer. He established the vascular surgical residency program and held numerous leadership and administrative roles, including president of the Pacific Coast Vascular Society, president of the Southern California College of Surgeons, and president of the Alumni Association 1986–1987. He was recognized by the Association as an honored alumnus in 1990 and Alumnus of the Year in 2000, and by the School of Medicine as recipient of the Distinguished Service Award in 2003. He also was author of more than 100 articles and 15 book chapters, and was known as one of the Loma Linda physicians who prayed with his patients.

Admired and respected by many, Dr. Smith will be remembered by colleagues as one of the best technical surgeons with whom they worked. He prioritized family activities, including water skiing and snow skiing trips and outdoor projects, and was an inspiration to others for his love of the Creator God.

Dr. Smith is survived by his daughter Patti Catalano (**Richard D. Catalano '76-B**), two grandchildren, and three great-grandchildren.

## 1950s

**Delmont S. Emery '51** was born April 28, 1926, in Sacramento, California, and died August 25, 2016, surrounded by his family.

Dr. Emery, known as "Bear" to his family, grew up the second of four children. Inspired by the life of explorer and medical missionary to Africa, Dr. David Livingstone, he pursued medicine at Loma Linda and became a missionary doctor for four years in Bolivia. He practiced urology in Los Angeles and Yuba City for 25 years, but found his true calling practicing medicine for 16 years in Penn Valley, California. He had a reputation as a caring and insightful physician, practicing the art of family medicine until 2001.

Dr. Emery deeply loved his soul mate of 43 years, Barbara, and their seven children. He encouraged and supported all of them through their educations and in the pursuit of their goals. They remember him as the calm in the storm of a full and rambunctious household. Dr. Emery was an avid gardener, a dog lover, water and snow skier, fisherman, hiker, Christian, and Republican. When he had trouble sleeping at night he would recite Psalm 23.

Dr. Emery was preceded in death by one son. He is survived by his wife, three siblings, six children, and 12 grandchildren.

**Grace M. Fairchild '52** was born in Stoneham, Massachusetts, April 16, 1922, and died in Paradise, California, December 16, 2015.

Dr. Fairchild was born to Peter Meister, a baker, and his wife Mildred, and was the fourth of six girls. She helped with the baking and delivery of bread in the mornings. The family joined the Seventh-day Adventist church and sacrificed so that the girls could attend the one-room Adventist school on the grounds of New England Sanitarium. She graduated as valedictorian from Stoneham High and attended Mount Ida Junior College, Atlantic Union College, and Pacific Union College. She worked as a medical technician before beginning medical school. Her sister, **Barbara Meister Jones '53-B,** later joined her.

Dr. Fairchild interned in Providence, Rhode Island, and worked in the emergency room of the New England Sanitarium. She married Arthur Warren Fairchild of Saugus, Massachusetts, where the couple made their home. They had four daughters and worked hard to provide them an Adventist education. Dr. Fairchild is remembered by her daughters as a loving, caring, sacrificing mother, devoted to her beliefs and to her family. She especially enjoyed reading history, long walks, and singing hymns.

She is survived by her daughters, Melinda Fairchild, **Karen S. Fairchild '82** (**Randall Tan '82**), **Sylvia (Fairchild Saad) Baron '84** (Gregory), Lisa Fairchild; and nine grandchildren.

**Royce Marion Brown '53-A** died peacefully October 11, 2016, at the John F. Keever Jr. Hospice Solace Center in Asheville, North Carolina.

A native of Middletown, Indiana, Dr. Brown was a son of Gerrell Fay and May Zirkle Brown. He married Gladys Bowen in 1948 and graduated from Emmanuel Missionary College (later Andrews University) the same year. Following graduation from medical school he completed an internship in South Bend, Indiana, an anesthesia residency in Indianapolis, and served for two years in the U.S. Air Force. He went on to practice anesthesiology for 35 years at Hinsdale Sanitarium in Hinsdale, Illinois. He and his wife retired to North Carolina in 1993.

Dr. Brown was preceded in death by one son, Gary Brown. He is survived by his loving wife Gladys; three children, Marileen Marcus, Sheralyn Brown, and Kevin Brown; and seven grandchildren, Capt. Joshua Marcus, Dr. Kyle Brown, Brittany Brown, Alexandra Pickens, Joseph Pickens, III, Samuel Brown, and Simon Brown.

**Arthur Adam Moores '53-B** was born January 20, 1923, in North Sydney, Nova Scotia, Canada, and died September 17, 2016.

As a young man, Dr. Moores joined the Royal Canadian Air Force during World War II. After leaving the Air Force, he attended Canadian Union College in Lacombe, Alberta, and La Sierra University in Riverside, California, before completing medical school in Loma Linda. There, he fell in love with Verna Litke. They were married in 1952, the beginning of a wonderful 64 years of harmonious married life.

After two additional years of medical training, Dr. Moores moved to Newfoundland, Canada, where he worked as a family practitioner, made house calls, and, along with his classmate, **Eugene W. Hildebrand '53-B**, traveled around the perimeter of the island by boat, providing health care to isolated fishing villages.

Wishing to serve as an overseas missionary for the Seventh-day Adventist church and feeling he would be more useful as a surgeon, Dr. Moores took five years of general surgery training in Halifax, Nova Scotia. In 1967, the family, including three sons, moved to Hong Kong where they happily spent the next 11 years. Dr. Moores served as medical director and chief of staff at the Hong Kong Adventist Hospital–Tsuen Wan. In 1978, the family settled in Fresno, California, before eventually retiring in Paradise.

Dr. Moores was devoted to his wife, his family, and his faith. He was commonly referred to as kind, gracious, caring, and godly. He continued to work as a surgeon until he was almost 90. He was so beloved by staff members that on his last official day of work they lined the halls to give him a standing ovation.

He is survived by his wife Verna; two sons, Bob and **Donald C. Moores '87**; five grandchildren, Alex, Jesica, **Tamara D. Moores '12**, Heather and Michael; two great-grandsons, Austin and Aaron; and a great-granddaughter, Madeline.

**Milo William Loye '55** was born October 22, 1923, and died quietly July 10, 2016, in his home in Auburn, California, with his family at his side.

Dr. Loye was born to Axel and Catherine Christiansen of Denmark and raised in Minneapolis, Minnesota. As a young man, he was drafted into the U.S. Army to serve in World War II. He was proud to be a veteran and received several awards including the Distinguished Unit Badge, Good Conduct Medal, and the WWII Victory Medal. He graduated with a degree in biology from La Sierra College in 1949. During medical school, he spent some time in treatment at the VA hospital for tuberculosis contracted during the war. He had a successful career in anesthesiology at Auburn Faith Hospital until retirement in 1993.

Dr. Loye loved his schools and was named Alumnus of the Year at La Sierra College in 2002. He was active in the Auburn Seventh-day Adventist Church, designing, installing, and maintaining the landscaping and grounds of the church from its construction in the '70s. A plaque of his service is placed in the church's courtyard.

Dr. Loye is survived by his devoted wife of 61 years, Patricia; three children; and four grandchildren.

## 1960s

**John S. Wang '60** was born October 26, 1934, in Nanjing, China. He died October 6, 2016, in Loma Linda.

Dr. Wang's grandparents were among the first in China to join the Seventh-day Adventist church. His father, James D. Wang, spent six years in the U.S. completing a PhD before returning to China. After WWII, the family moved to Hong Kong and Dr. Wang attended Sam Yuk High School. He came to the U.S. in 1949 on one of the last ships to leave China before the communists took over. He graduated from Klondike High School in 1952 and from Andrews University in 1956. During medical school in Loma Linda he met the love of his life, Betty, a student nurse. They both graduated on June 3, 1960, and were married in November later that year.

After internship at White Memorial Hospital, Dr. Wang joined the Public Health Service and was stationed in Staten Island, New York. He subsequently took a radiology residency in Chicago. The family later moved to Kettering, Ohio. Dr. Wang and his wife moved to Loma Linda after retirement, where he enjoyed singing in the William Chunestudy Men's Chorus, volunteering at the Loma Linda Broadcasting Network, and spending time with his grandchildren.

Dr. Wang is survived by his wife Betty; his children Waylene (Ron), Marilene (James), Samuel (Andrea), and Steven (Helena); and nine grandchildren.

**Peter Donovan Dudar '61** was born July 7, 1923, in Two Hills, Alberta, Canada, and died January 22, 2016.

Dr. Dudar was the son of immigrants from the Ukraine and the seventh of 10 children. When he was 10, his father died and he had to drop out of school to work the farm. As a young man he worked in a tin toy factory and as a taxi driver before returning to school at Canadian Union College where he finished elementary and high school. He continued his education at Walla Walla College and graduated from La Sierra College in 1957, then earned his medical degree at Loma Linda University.

Dr. Dudar lived a long, interesting life. He now awaits that trumpet call home. He is survived by his wife, **Rosamond L. Dudar '56**; his three children, Peter Donovan, Jr., Gary Alan SD'86, and Brian Wesley SD'03; and his grandchildren Brandon and Erika.

**Roland Clarence Emil Zimmermann, Jr., '66** was born May 25, 1938, in Marshalltown, Iowa, and died November 1, 2016, in Loma Linda.

Dr. Zimmermann was born to Roland and Geraldine Zimmermann. During his junior year at Campion Academy in Colorado, he met his future wife, Melba. He graduated from Washington Adventist University in 1959 with a degree in physics and minors in math and chemistry. He was a physicist in the radar division at the Naval Research Lab in Washington, D.C. before deciding to pursue medicine at Loma Linda. He once again crossed paths with Melba during medical school and they were married in 1963.

Dr. Zimmermann served two years as a physician in the U.S. Navy before becoming one of the first residents in the radiation oncology program at Loma Linda. For many years he was in private practice in San Bernardino and Redlands, California, later directing a large hospice covering the San Bernardino and Riverside counties. He served on the Mental Health Advisory Board, was president of the San Bernardino American Cancer Society, and served for 10 years on the City of Redlands Parks Commission. He was active on the Alumni Association Board of Directors for many years, serving as president in 2014–2015, and named an honored alumnus in 2016.

As an elder at the Loma Linda University Church, Dr. Zimmermann helped begin the TV ministry there in 1980 and was a founder of the Loma Linda Broadcasting Network. In retirement he taught a Sabbath School class at the Redlands Church. Outside of medicine, he enjoyed physical biochemistry, astronomy, botany, and books—his family still has his first library card from age 5. He also enjoyed traveling, camping, and backpacking with his family.

He is survived by his wife of 53 years, Melba; his children, **Rolanda R. Everett '92** (Kendall), **Gregory S. Zimmermann '94** (Laura SD'95), and Rob SBH'98 (Katie); nine grandchildren: Forrest, Madeleine, Kirk, Liesel, Claire, Will, Patrick, Mikayla, and Ethan; his two sisters; and two nieces and a nephew.

**Gerald B. Myers '67** was born June 4, 1935, in Berrien Springs, Michigan, and died January 31, 2016, in Puyallup, Washington.

Dr. Myers was an obstetrician gynecologist who practiced in Renton, Washington, until retiring in June 2000 after having delivered several thousand new lives. As a recreational pilot he flew over 87 missions for Angel Flight

Northwest. He also volunteered his medical skills on mission trips all over the world. His zeal for action and the outdoors is reflected in and carried on by his family, who today remain active in myriad outdoor pursuits.

He was a fine craftsman, lending his skill and refined eye to scores of projects, both for his own pleasure (reupholstering his plane's interior), and that of members of his tribe (remodeling a split-timber farmhouse into a showpiece residence for a friend). In all facets of his life he personified what it means to be a man of service.

Dr. Myers is survived by his wife, Deborah; children and step-children, Jeff Myers, Jenny Myers, Bruce Myka, Teresa Leach, Tara Dewar, Stephen Henkes, Kimberly Aeschlimann, C. Nicholas Aeschlimann, Kathleen Aeschlimann; grandchildren, Justin, Brodie, Josiah, Ashley, Jasmine, Quinn; brother, Leroi Myers; sister Darlene McMillan; and many other friends and family who will miss him.

## Honorary

**Wilber Alexander, PhD, '93-hon** was born in Boulder, Colorado, October 12, 1921, and died November 16, 2016. He was 95.

Dr. Alexander was raised by his grandmother and was the sports editor for his high school. In 1941, he became a psychiatric nurse in Colorado. He served as a chief pharmacist's mate in the U.S. Navy from 1942 to 1945 before earning his bachelor of arts degree in theology and biblical languages from La Sierra College (now University) in 1950.

After his ordination in Lynwood, California, in 1954, Dr. Alexander joined the faculty of La Sierra College as an associate professor of practical theology. Until 1963 he taught courses in counseling, guidance, evangelism, homiletics, preaching, and speech. Over the next decade he earned two master's degrees, a doctor of philosophy degree, and wore many academic and professional hats: chair, department of church and ministry, Andrews University Theological Seminary; chair, department of religion, Andrews University; senior pastor, White Memorial Church, Los Angeles; and public relations secretary, Southern California Conference of Seventh-day Adventists.

In 1973, Dr. Alexander rejoined the LLU faculty, serving in various capacities for more than 40 years until his death. He was professor of theology and clinical ministry and professor of family medicine. He served as the first dean of the faculty of religion at LLU after the separation from La Sierra College in 1990. Though there were those who would have liked the religion faculty to have been hired separately by the various LLU schools, he successfully preserved a unified School of Religion. During his leadership, from 1990 to 1993, LLU offered an MA program in biomedical ethics for the first time.

In December 1993, the University appointed Dr. Alexander Special Assistant to the President for Spiritual Life and Wholeness. In 1996, he founded the Center for Spiritual Life and Wholeness (CSLW), serving as director until 2002 and again from 2004 to 2005. In 2005, Carla Gober-Park, MPH, PhD, became director and continues to expand the legacy of Dr. Alexander. In 2015, Dr. Gober-Park and the CSLW produced a documentary called "A Certain Kind of Light" that followed Dr. Alexander on patient rounds sharing whole person care with patients and modeling it for medical students and residents. The film has won multiple awards at national and international film festivals.

Dr. Alexander was the author of numerous articles and three books. His distinguished career earned him a number of awards, including LLUSM's Senior Educator of the Year, La Sierra University Alumnus of the Year, and the LLU Distinguished Service Award. In 1993 he was awarded honorary membership by the Alumni Association, LLUSM. Greatly respected and beloved by many, Dr. Alexander's presence will be missed and his godly example treasured. ■

## Interview with Dr. Johnson

*(Continued from page 22)*

### What part of this job brings you the most satisfaction?

It's helping people in remote places who otherwise wouldn't have a chance at better health. There are literally entire populations of people in sub-Saharan Africa who don't expect in their entire life to even *see* a doctor. Not as a patient, and not at a distance. Yet, they all have the same medical needs that we do.

The satisfaction comes from making people's health, and thus their lives, better. If their health is good, then they're much happier people; they're much more productive; they're much more satisfied with their lives. So I'm enjoying it. I mean, incredibly.

### Is there anything else that you'd like to say to the *JOURNAL* or alumni?

Something I found surprising working at WHO is that most people are humanitarians who are interested in that kind of work. While it's certainly not 100 percent, I was surprised by the number of spiritual people there. Whether Christian believers or devout Muslims, for example, there is a higher level of religious devotion in the humanitarian world than there is just in the general world. ■

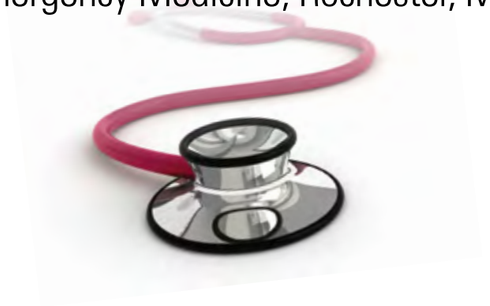
Chris Clouzet is assistant editor of the *Alumni JOURNAL* and staff writer for the Alumni Association. He lives in Forest Falls and enjoys trail running and reading.





# Torrey A. Laack '99

## Emergency Medicine, Rochester, MN



### What are you famous for among friends and family?

Energy. I am getting a little better at sitting still, but I still love to be active. Now I have three boys (Xavier, 12; Soren, 10; and Axel, 5) who keep me busy.

### What is your best memory from medical school?

The wonderful friendships I made during my years there. Memories include: breaks between classes; Irish dancing; Sabbath trips to the beach; volleyball; mountain biking; camping; hiking; intramural sports (football and soccer); long discussions about politics and theology. Also, an "urban plunge" where I spent two days and nights sleeping on the streets of LA to experience firsthand what it is like to be homeless.

But most importantly, I have memories with my best friend, Nadia (**Nadia Issa Laack '01**). We spent many hours watching pathology videos together, but I must admit, I spent more time watching her (sorry, Dr. Cao*). It worked, though, as we were married the day after I graduated.

### What has been the most meaningful experience in your medical career?

There have been many, but two come to mind. First, the countless hours I have been fortunate to spend training medical students and residents through simulation at the Mayo Clinic Multidisciplinary Simulation Center where I am now medical co-director.

The second is the opportunities I have had on three separate trips to work with an amazing group of people in an emergency department in Port-au-Prince, Haiti, after earthquakes, hurricanes, and cholera all have ravaged their country.

### If you were to have worked in a field outside of medicine, what would it have been? Why?

Growing up, I was always fascinated by the legal profession and my siblings even called me "lawyer boy," largely because I liked to debate and argue my case. I think I would have attended law school with a consideration for seeking elected office.

### If you could learn to do something new or better, what would it be?

I would love to be better at ice hockey. I am from Arizona and played hockey for the first time when we moved to Minnesota after residency. I am not very good, especially compared to people here, but I still play regularly.

### What is the best advice you've ever been given?

I had a little league baseball coach that taught me that I should always want the ball to be hit to me. That changed my experience in baseball and has stuck with me throughout my life. With that mental framework, one is prepared for anything and can embrace it as a challenge rather than a threat.

I have also found this invaluable in my career in emergency medicine. When I am working, if I mentally prepare and hope for the most challenging patients I can imagine (the difficult airway or sick neonate, for example), I am in a much better place when they do arrive. In other words, prepare for what you fear rather than run away from it. ■

* **Jeffrey D. Cao '71**

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# IMPORTANT ANNOUNCEMENT

## PERPETUAL MEMBERSHIP PRICES WILL INCREASE ON MARCH 6, 2017

The Alumni Association is working to permanently endow the organization by raising $3 million in new perpetual memberships or upgrades. In an effort to reach this goal, the Board of Directors voted to increase the price of both annual and perpetual memberships, effective March 6, 2017. A new Bronze level will become the entry level for perpetual membership. Below are the current and new prices:

| | Bronze | Silver | Gold | Platinum | Diamond | Double Diamond | Triple Diamond | Four-Star Diamond | Five-Star Diamond |
|---|---|---|---|---|---|---|---|---|---|
| **Current** | N/A | $5,000 | $10,000 | $15,000 | $25,000 | $50,000 | $75,000 | $100,000 | $125,000 |
| **New (March 6)** | $5,000 | $10,000 | $15,000 | $25,000 | $50,000 | $75,000 | $100,000 | $125,000 | $150,000 |

Available in the new pricing structure will be a 20% discount for groups of 10 alumni who upgrade together at the same time.

**Existing perpetual members will keep their current status level** and will only have to pay the difference to upgrade to the next level. Members who have committed to upgrading on a payment plan before March 6, 2017, will have that upgrade honored under the current pricing structure.

# SIGN UP OR UPGRADE TODAY

**Now is the perfect time to become a new perpetual member or upgrade your current membership**. To do so, please contact our Alumni Association office at 909-558-4633 or visit us at 11245 Anderson St., Loma Linda, CA.

We thank you for your understanding and your continued support as we strive to permanently endow the Alumni Association, School of Medicine of Loma Linda University.

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