

Dean's Newsletter

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Table of Contents

- Stanford and the AAMC Institute for Improvement in Medical Education
- Stanford is a Leader for Postdoctoral Scholars
- HEAL
- More on the NIH Roadmap from Dr. Zerhouni
- Thoughts on Service Lines from the Council of Deans
- Personal Reflections on a Hot Day with a Long Road Ahead
- Another Successful Beckman Symposium
- Ryan Adesnik Becomes Head of Federal Relations for Stanford University
- Women's Health @ Stanford Sponsors National Women's Health Week Activities
- Events
- Honors and Awards
- Appointments and Promotions

Stanford and the AAMC Institute for Improvement in Medical Education

To date we have not participated in the Institute for Improvement in Medical Education that was initiated by the Association of American Medical Colleges (AAMC) in the Fall of 2002. Nonetheless it is notable how many of the issues raised by the IIME work group have already been addressed – and in a number of cases implemented – at Stanford. That said, it is always helpful to assess our progress against the reflections of others in the field of medical education.

At the AAMC Council of Dean's Meeting that was held from April 24-27th, Dr. Joe Martin, Dean of the Faculty of Medicine at Harvard, reviewed some of the preliminary findings of the IIME Work Group he chaired. He noted that while there have been changes in medical education during the past decade, most of the attention in medical schools around the country has been directed to the first two years of the curriculum. Little change has occurred in re-engineering the clinical training. Moreover, resident education is seen as unlinked and as not necessarily adequate in preparing physicians for the practice of medicine. In tandem with this is the fact that the continuing education of physicians is not employing education methodologies likely to impact meaningfully on the quality or type of clinical care they provide.

The Committee identified as one of the major problems the fact that each of the phases of medical education (undergraduate, graduate, postdoctoral training and continuing medical education) is governed by different oversight bodies (e.g., LCME, NMBE, RRC) that neither communicate with each other nor even have overlapping goals and objectives. Based on this, the committee identified the need to better coordinate

medical education across the continuum of learning. As many of you know, this is one of our major goals in the new Stanford Curriculum.

The IIME will be calling for reforms in medical education, in which we will also participate in. At this stage they have identified some of the key initiatives that should be pursued. Among the programmatic reforms the IIME has identified are the following. The state of our Stanford progress is noted in red.

- “The need to present early in the curriculum a patient-centered clinical experience that will imprint on entering students the importance of viewing a patient as a person, a member of a family, and a member of a community”. **As we look to the future at Stanford, we have already initiated this by introducing issues and topics in clinical medicine into the first year curriculum – both by integrating clinical problems into basic science and by the breadth of the new courses :Health and Human Disease” and “Practice of Medicine”.**
- The IIME notes “medical schools and residency programs should provide clinical learning experiences in an interdisciplinary nature for the purpose of preparing future physicians to function effectively as team members”. **This is an important focus at Stanford both in the interdisciplinary “Mechanisms of Human Disease” as well as in the exposure to various interdisciplinary themes that emerge from our Scholarly Concentrations (see <http://med.stanford.edu/md/curriculum/>).**
- The IIME recommended that “medical schools and residency programs should establish rigorous formative and summative assessment programs to ensure that students and residents are acquiring the knowledge, skills, attitudes and values deemed necessary at their stage of learning, and that they are able to perform in a developmentally appropriate manner the complex, integrative tasks required to provide patient care”. **This is clearly an important area and is not one we have achieved. Indeed our evaluation process for students is still far from the level of excellence I would like to see in place. Moreover, while a number of our residency programs do quite an excellent job in resident evaluation, there is inconsistency across programs. This is surely an area where we need greater and more consistent focus, both in undergraduate and residency education and across the entire continuum of medical education.**
- IIME recommends that “medical schools should provide students meaningful experiences with physicians engaged in a variety of career activities...and should offer a variety of joint degree and research training programs, and should be flexible in tailoring programs that allow students, residents and practitioners to acquire the education needed to pursue specific career goals”. **Although we certainly have more work to do, I think we already excel in these areas. Stanford’s curriculum for medical student education has been long defined as highly flexible. The additional changes now being brought into relief, especially with the Scholarly Concentrations and the opportunities for joint degree programs they bring, should put us in the forefront of this important**

area. Further, discussions are beginning with the other graduate and professional schools at Stanford about further reforming graduate education writ large to create an environment of true cross-school joint degree education.

- Following this theme, the IIME recommends that “medical schools should explore the possibility of integrating into undergraduate, pre-medicine programs some of the course work required in the biological sciences, bioethics, the medical humanities, informatics, communication skills and health systems”. **One of our future goals is to improve the alignment between the undergraduate college curriculum at Stanford and the undergraduate medical curriculum. Some of this exists informally through the program in Human Biology as well as in the Sophomore Seminars available to undergrads. Moreover, an ever-increasing number of our medical school faculty are engaged in teaching undergraduates. The number of undergrads who are either involved in research at the medical school or who are pursuing community services relevant to medicine and healthcare is also increasing. That said, there is certainly much more we can do in this important area and I hope we will make progress in this important area in the years ahead. One way of integrating these programs will emerge when SMILE (the Stanford Medicine Information and Learning Environment) becomes a reality.**
- Further, the IIME noted, “medical schools, residency programs, and accrediting bodies should explore the possibility of providing opportunities for residency requirements to be integrated into the medical school curriculum”. **One of the major concerns is reducing the length of training – especially in some of the surgical programs that require five or more years of residency training. Clearly this is important, especially given the debt burden of students and, equally important, the need to preserve some semblance of work-family balance. At the same time, I believe one of our greatest opportunities and needs is to better integrate clinical medicine and basic science through the lifetime of the trainee as well as the practitioner. In addition, we need to anchor medical residency with opportunities to pursue “scholarly concentrations” analogous to those now being developed for our medical students. Rather than requiring our students to take in new knowledge in discrete bits, often at a rapid-fire pace and in staccato rhythm, it seems much more sensible to provide them with in depth and integrated experiences that would result in more of a learning continuum. We are now exploring how to make this happen and I hope that this will be another area where Stanford can take the lead.**
- To improve education, the IIME notes that “medical schools should develop and support a cadre of teaching faculty whose main responsibility is the education of students as they progress through the educational program...(and further) that medical schools should require faculty members and residents who have regular contact with students to complete periodically a program orienting them to the

goals and objectives of the educational program as a whole... (and that) medical schools and teaching hospitals should share learning resources (e.g., simulation laboratories, standardized patient programs, information technology applications, etc) to ensure that learners at each stage of their education receive the highest quality education experience”. **We are fortunate to have at Stanford faculty members like Professor Kelly Skeff who have developed programs for training faculty and residents to become more effective teachers. At the same time, we are not using these programs broadly or effectively enough, and I believe we must do more to inculcate a tradition of teaching excellence that permeates throughout our community. While a number of medical schools (e.g., Harvard, UCSF) have developed “Academies” to foster a cadre of excellent teachers, I think it is important for our entire faculty to take responsibility for teaching excellence. That said, one of the major challenges that virtually every medical school is facing, especially for clinical faculty, is how to pay for the time spent teaching, given the expectation that clinical faculty earn their salary through funds emanating from clinical care or research grants. While we have restructured the School’s Operating Budget to focus more specifically on education – and especially on small group teaching – our available resources fall short of what is necessary to adequately fund teaching. Accordingly, one of our important development objectives must be to raise endowment dollars to help support education – in the form of professorships as well as teaching supplements that permit clinical faculty to free up time for teaching. We also need to garner a better understanding of all of the resources available across the medical center to support teaching – including the Graduate Medical Education dollars that come to both the Stanford Hospital and Clinics and the Lucile Packard Children’s Hospital through Medicare or the Children’s Hospital GME Bill. Finally, we are committed – and we are already making progress to addressing ways to share teaching resources, we expect that SMILE will play an important role in this matter. Equally importantly, we want to be sure that we optimally utilize the distributed resources that emerge from SMILE as well as the centers for simulation that now exist at the VA Hospital as well as in the Departments of Surgery and Pediatrics – and that are housed (or will be) at SHC and LPCH.**

I was very pleased to learn more about the work of the AAMC Institute for Improvement in Medical Education. Clearly this work group has highlighted some important issues and has drafted some very reasoned recommendations. We will no doubt participate in this initiative as it matures. But, at the same time, it is comforting to know that we have already identified a number of these issues during our efforts to reform our educational curriculum at Stanford and that we have, in fact, made considerable progress to date. Since one of our overarching goals has been to serve as a role model among research-intensive medical schools, I would say that in the area of medical education, we are clearly fulfilling that goal.

Stanford is a Leader for Postdoctoral Scholars

Postdoctoral scholars and trainees – both in research and clinical medicine – comprise the largest single community in our Medical School – exceeding the number of medical and graduate students as well as faculty. We have long known that postdoctoral scholars are among our most important assets, contributing enormously to our research, clinical care and education missions. Around the nation, however, postdoctoral scholars are a more silent majority and are frequently less well supported or recognized than should be the case. Thankfully, at Stanford, there has been a long tradition in supporting postdoctoral scholars. In fact, the first postdoc office began at Stanford in 1989 and led *Nature* (2004;428:690-691) to refer to us as a “trailblazer” in this important area. Over the years a number of improvements have occurred in securing better compensation and benefits for our postdocs as well as in improved mentoring and career guidance. These important issues have become topics for a national debate emanating in part from the review and update by the National Academy Committee on Science, Engineering, and Public Policy (COSEUP) that can be viewed at www.nationalacademies.org/postdoc.

On Wednesday, April 21st, the Stanford Postdoc Association held a Town Hall meeting to review a number of the issues and challenges they face. Thankfully, the group and its leadership are working quite cooperatively with the Dean’s Office and our Postdoc office and have been successful in addressing a number of important issues, even though many remain to be solved. Again, these are also part of a broader national agenda and can be viewed on the National Postdoc Association website at www.nationalpostdoc.org. We remain committed to working as closely and cooperatively as possible with our postdoc colleagues to make their personal and professional opportunities as successful as possible.

Health Education Asset Library (HEAL)

At the recent Council of Deans’ meeting I became aware of a digital library that offers multimedia-teaching materials. Referred to as HEAL it began as a California consortium in 1999 (that included Stanford) and now provides images, video and audio clips, animations and presentations, in what is a continuing work in progress. It is accessible at <http://www.healcentral.org/index.jsp>. I have reviewed it and suggest you take a look at it for materials that might be helpful for either teaching or learning.

More on the NIH Roadmap from Dr. Zerhouni

In previous editions of the Dean’s Newsletter I have provided background material and updates on the NIH Roadmap (<http://nihroadmap.nih.gov/>). As many of you know, this is a work in progress. On Saturday April 24th, Elias Zerhouni, Director of the NIH, gave his own version of the status of the NIH Roadmap to the Council of Deans. Because this has been discussed in other settings, I will only provide a few highlights of Dr. Zerhouni’s comments and observations.

Not surprisingly, Dr. Zerhouni began by defining the rationale for the Roadmap, which includes the need to address evolving public health challenges such as the shift

from acute to chronic illness, the aging of the population, the increasing disparity in health access and outcomes, globally emerging diseases and the unfortunate need to address biodefense. Coupled with this are the extraordinary expenditures on health in the USA – now nearly 15% of the GDP and rising. Of course while this has been happening, there have also been some extraordinary scientific advances, including the human genome project, the emerging findings in proteomics, the insights from integrative biology, and information technology. Fundamental to the future is to use these and related insights and discoveries to develop interventions before the symptoms of disease emerge. This will have positive consequences on both disease morbidity and the cost for care. It is Dr. Zerhouni's hope that the Roadmap can help catalyze some of these efforts, even though it will itself be only a small portion (1% or less) of the overall NIH budget. Importantly, Dr. Zerhouni stressed the importance of making sure that the nation's investment in basic research was sustained and that there is sufficient funding in the RO1 pool so that young investigators do not become discouraged. He went on to say that the success rate should not fall below 20%. Obviously we will have to see how that pans out.

As you know, one of the themes of the Roadmap is to foster the creation of resources that would be difficult for any one medical center or institute to develop on its own. This will require the need to build public access data bases that will contain molecular libraries and imaging probes. This will necessitate new organizational models that will require multidisciplinary and interdisciplinary themes as well as resource sharing.

Another important goal of the Roadmap is to migrate clinical research (especially patient-oriented investigation) from a cottage industry to a more successful enterprise. This task is difficult given the current financial landscape in academic medicine, where margins are continuing to decrease, making opportunities for investment more challenged. This will require new partnerships, which Dr. Zerhouni believes need to include the patient community and a much better linkage to community based health providers. This will also require regional and national research networks. It is of interest that the NIH has already announced its plans to help support some regional translational research networks. This is something Stanford is already exploring with its colleagues in PharmaStart (<http://www.pharmastart.org/>). Further details about those efforts will be provided in the months ahead. Importantly, Dr. Zerhouni recognizes that the number of patients currently enrolled in clinical trials is quite low in the USA – something that needs to improve. Not surprisingly, from my perspective, the now decades long experience in pediatric oncology provides a model for increasing participation in clinical trials as well as evidence of the impact they can have. Today more than 70% of children diagnosed with cancer in the USA are enrolled in a clinical trial. Clearly this type of model needs to be extended to other areas of medicine.

While the financial investment in the Roadmap is intended to be kept small, its impact can be quite large. Among the most important outcomes will be assuring that the public trust in medicine – and clinical research – is sustained, and that the public continues to value the nation's investment in biomedical research. It is of course equally important for the Congress and government to share this value. But, hopefully, the

Roadmap will also foster new dialogues and opportunities that will create an amplification effect to enable us to improve our work in translational medicine and education as well as to continue our investment in the pursuit of knowledge through basic biomedical research.

Thoughts on Service Lines and Clinical Cooperation from the Council of Deans – and this Dean

Just as the rapid changes in research are yielding new interdisciplinary models that break down traditional departmental or discipline-specific barriers and thus open up new opportunities and vistas, the same is also happening in clinical medicine. While some approach the new clinical venues with zest and excitement, in a number of quarters there are protests and anxieties, largely because new technologies and innovations breach the traditional academic departmental boundaries and create avenues for competition over increasingly scant resources – especially money. Despite that, it is imperative that we find ways to rise above these financial boundaries and do what is best for our patients, trainees and institutions.

It is notable that in the past weeks the issue of “service lines” or service centers has been a topic of opportunity and concern at Stanford although this is certainly not new. As you know from the joint planning activities between the School of Medicine, Stanford Hospital & Clinics (SHC) and the Lucile Packard Children’s Hospital (LPCH), we have identified four major areas that integrate our efforts under the overarching umbrella of the Stanford Institutes of Medicine – Cancer/Stem Cell, Cardiovascular Medicine, Immunity/Transplantation/Infection and Neurosciences. These efforts will bring together leaders across departments and embrace basic research and clinical faculty, as well as faculty in other schools at Stanford. These four areas in many ways will serve as our flagships, although they should not be taken to connote areas that are either academically more important or that are more valued either by our patients or by our faculty and staff. For example, in addition to these areas, SHC will be making strategic investments in orthopedics and its related disciplines.

At the same time, several other interdisciplinary initiatives will unfold – some of which have had some difficulty getting off the ground, in part because of the aforementioned struggles over resources, authority, etc. Perhaps the most current example of this within our midst is the “Vascular Center”, which despite dozens of meetings and decisions has yet to be fully embraced. Because I believe these new alignments better serve our patients and offer improved venues for interdisciplinary training for our residents and fellows, I am committed to doing everything I can to bring these new alignments to fruition, as long as they truly improve patient care and education and offer opportunities for research collaborations. Needless to say, they must also make financial success for the faculty, departments and the hospital.

Interestingly, the issue of service lines and new clinical alignments was a topic of discussion at the Council of Deans meeting on April 26th. Based on evaluations done at multiple medical centers it now seems that nearly all have some form of a service line

structure, this represents a major migration over the past 10-15 years. While the perceived wisdom a decade ago called for vertical integration in academic medical centers, the negative consequences in many have underscored that a more sensible route is through horizontal integration. In that arrangement, alignment between like clinical services (e.g., neurology, neurosurgery and psychiatry, or cardiology and CV surgery) appear to make more sense. In a number of ways, that is consistent with our plans to align around the Stanford Institutes of Medicine along with their matched clinical centers at SHC and LPCH. At the Council of Dean's meeting, a considerable part of the discussion focused on the characteristics of the individuals who might best lead such service lines – and equally on the resources and authority they would need to be successful. It was recognized that the types of leaders for service lines not infrequently varies over time according to the stage of evolution of the program - for example, for the initial phase and start up, an individual with more entrepreneurial skills might be best, whereas during the growth and transition phase, individuals with more of a visionary leadership style can be more effective. The ability of these leaders to affect change comes from their real or symbolic power and the resources they control. Accordingly, in the process of defining the service-line or center, it is important to assess strategically the phase of development, the resources that can be extended and the skills of the individuals being asked to assume leadership roles. It is important to note that there was recognition about continuing to support the departmental structure, especially for training of students and residents.

It was, of course, interesting to learn from deans from other medical schools that they are struggling with how to get these models correctly placed. Some seem to be doing better than others – but all have some challenges. We certainly fall into that mix. Certainly our major service line areas are just getting started (or more correctly, in some cases, restarted) but in other areas, like our vascular center, we still have some important issues to address. However, I am adamant about addressing the challenges because I believe that a number of these new alignments are better for patient care, provide more stable and even futuristic educational opportunities, and offer new opportunities for research.

Personal Reflections on a Hot Day with a Long Road Ahead

Each of us, in our own unique and sometimes private ways, makes choices about the paths we will follow in life, the adaptations we might make and the ultimate goals (and dreams) that motivate or inspire us. While it is sometimes possible to compartmentalize these according to our personal or professional lives, they not infrequently fuse and often one facet illuminates something about who we are in a different and sometimes unconnected way.

We all make choices - to be a scientist or physician, to pursue academics or business, to be outspoken or silent, to lead or to follow. Some of our choices are planned, others coincidental. Some fit us well and others seem asynchronous with who we otherwise seem to be.

For as long as I can remember, I have resonated to taking on challenges - more often than not ones that are difficult to achieve. Certainly that has guided much of my professional life, especially my research career, and even my decision to take on the challenge of helping to lead and guide an academic medical center like Stanford at this point in history. But we all have other facets of our personalities that further shape who we are – or not. Among my avocations are learning more about history and literature (of course in addition to science and medicine) and improving my physical endurance. The latter emerged from a childhood that was punctuated by significant asthma that negated most forms of exercise or athletics.

Some 25 years ago I decided to take up running – initially just enough to get “in shape” – but perhaps not surprisingly, over time, to achieve longer distances. That was fueled by the ironic observation that increased physical activity seemed to improve my asthma. Over the subsequent years, running has complemented my work schedule – and facilitated my history/literature learning by simultaneously listening to unabridged books on tape. During that time, I have also participated in a number of marathons – not competitively – but just sort of “in the pack”. While I do think that preparing for these marathons has many redeeming physical benefits in its own right, I have long found that they improve my mental and emotional endurance so that I am less daunted by big or difficult challenges – or perhaps that is what I simply try to convince myself.

Last year I had the opportunity to participate in two marathons, both in California, and in both I was able to achieve finishing times that “qualified” me for the Boston Marathon (of course in my age group – as an ever aging athlete). Having always lived on the east coast, I have marveled at the wonderful training conditions in the Bay Area and have revelled in my early morning runs around the Stanford campus. The cool morning temperatures have certainly convinced me about the correlation between ambient temperature and performance.

So participating in this year’s Boston Marathon posed some new challenges and offered the opportunity to learn something about myself. Although the day before and after the April 19th race day were cool, it was blazing hot at the noon-time start of the Boston Marathon – with a temperature over 85 degrees. I generally wilt in the heat – and the hours of waiting for the 26.2 mile run to begin from the Hopkinton start en route to Boston was no exception.

I generally like these races because they also afford an opportunity to be anonymous and to share a human experience with a group of people who are each competing as individuals but who are also sharing a common challenge. On that day, even though everyone has run prior marathons fast enough to qualify for Boston, nearly all felt the oppression of the heat.

I made the decision at the outset to move forward – and to keep moving forward – and to not stop running until the end of the race, regardless of how long that took. I also made the decision to slow down enough to avoid getting overheated or dehydrated - and to avoid being one of the more than 1000 individuals who needed medical assistance

during the day's race. I found I had to dig deep and to be focused. I also found that I kept thinking about patients that I had cared for over the years – mostly children and teenagers with cancer or AIDS – and reflected on the much more important challenges they faced and how that might inform my own. These are of course different facets of human endurance.

I was pleased to finish even though it took more than a minute more per mile than I would usually run to complete the course. But I was more pleased because it was an affirmation about who I thought I was – or at least want to be: someone who can take on unexpected challenges and endure. The marathon is simply symbolic because the much more important issue for me is the work that I do every day – during my “day job”. Of course here the challenges are even more daunting and the stakes much larger. But here too, I am determined to give it everything I have – to make the Medical School, Medical Center and University a better place. This may be a long road – but I am prepared to keep moving down it and hope to get help from each of you so we can finish together – successfully.

Another Successful Beckman Symposium

On April 30th another in the outstanding annual Beckman Symposia took place in the Fairchild Auditorium, this one focused on cancer. It featured an array of topics ranging from basic cancer biology to innovative translational medicine to public policy and politics. The speakers were, as expected, outstanding and the information they provided was both wide-ranging and highly informative. Such events require enormous planning and I want to thank the Beckman Center Director, Dr. Lucy Shapiro, for her outstanding leadership. Thanks also to the 2004 Beckman Symposium Co-Chairs, Drs. Gilbert Chu and Roel Nusse and to Dr. Ron Levy for making the program so outstanding. However, none of this would have happened with the level of excellence that was displayed without the dedicated and diligent efforts of Ms. Belinda Byrne. This was a special event and I am appreciative to those who made it happen – and to all who attended.

Women's Health @ Stanford Sponsors National Women's Health Week Activities

Dr. Linda Giudice, Stanley McCormick Memorial Professor in the School of Medicine and Director of Women's Health @ Stanford, has informed me of the many important activities being planned for the 5th Annual National Women's Health Week, May 9-15, 2004. These include sessions on women and cancer, weight management for women, cancer-related topics, and pregnancy. Admission to these events is free, although reservations are encouraged. Details may be found on the new web site for Women's Health @ Stanford at: http://womenshealth.stanford.edu/nat_whealth_week.html. Through attendance at these events, women from throughout the Bay Area will have the opportunity to experience how Stanford's interdisciplinary approach to Women's Health can generate increased knowledge, improved clinical care and the type of compassion so

important to achieving enhanced health and well being. Thanks to Dr. Giudice and her colleagues at Women's Health @ Stanford for their fine work in this area.

Ryan Adesnik Becomes Head of Federal Relations for Stanford University

Ryan Adesnik, who joined the Dean's Office a little more than one year ago as Director of Government Relations for the School of Medicine, has been appointed Director of Federal Relations for Stanford University. In this new, expanded role, Ryan will represent the entire University as well as the School of Medicine on issues related to the Federal government. He will continue to work with the School's faculty and leadership on the many critically important School-specific government affairs issues. Ryan will maintain an office in the Dean's Office and will continue to be available to the School's faculty for consultation and advocacy activities. He can be reached at 725-3322 or at radesnik@stanford.edu. Congratulations to Ryan, and we look forward to continuing to work with him on behalf of both the School of Medicine and the University.

Events

Community Lecture Series. In our continuing lecture series to educate the community about important research findings or issues impacting patient care, **Dr. Paul S. Buckmaster**, Assistant Professor of Comparative Medicine and of Neurology and Neurological Sciences, will lecture on *Epilepsy: Insights From a Comparative Approach* on Wednesday, May 5, 2004 at 7:00 p.m. in the Clark Center Auditorium. If you have any questions, please call 650-361-0995.

Honors and Awards

- **Dr. Stanley N. Cohen**, Kwoh-Ting Li Professor in the Department of Genetics was named this year's recipient of the Albany Medical Center Prize in Medicine and Biomedical Research for the seminal work he performed in the 1960's and 1970's that formed the basis of genetic engineering. Although relatively new, the Albany Medical Center Prize has quickly become one of the most prestigious awards in academic medicine. Dr. Cohen shares the prize with his long time collaborator Dr. Herb Boyer from UCSF. Congratulations to Dr. Cohen for another outstanding achievement that recognizes his important work.
- **Dr. Sheila E. Cohen**, will be awarded the Distinguished Service Award of the Society for Obstetric Anesthesia and Perinatology at the society's Annual Meeting to be held in Florida in May. Dr. Cohen has been a member of the Stanford faculty since 1975 and until recently was Director of Obstetric Anesthesia at LPCH. She is also a past President of the Society for Obstetric Anesthesia and Perinatology and has served on multiple committees in that society and in the American Society of Anesthesiologists.
- At the Annual American Academy of Neurology meeting being held in San Francisco, a number of the members of Neurology received awards or otherwise

played a significant role. They are as follows:

- **Gregory Albers**, Professor in Neurology and Neurological Sciences, spoke at the Contemporary Clinical Issues Plenary session.
- **Joyce Liao**, Instructor in Neurology and Neurological Sciences, received the S. Weir Mitchell Award for the outstanding young neurologist-neuroscientist.
- **Larry Steinman**, Professor in Neurology and Neurological Sciences, received the John Distel Prize for multiple sclerosis research.
- **William Mobley**, Professor in Neurology and Neurological Sciences, delivered the George C. Cotzias Award Lecture at the Presidential Plenary session.