

# Dean's Newsletter

## February 7, 2005

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### **Charting the Future and Pondering Some Important Questions**

Our annual Strategic Planning Retreats have permitted us to bring our leadership community together to address key initiatives and challenges and to chart the future course of the School of Medicine for the 21<sup>st</sup> Century. From January 27-29<sup>th</sup> a group of 80 leaders from the School, Medical Center and University met to reflect on the current status of the School and to assess the status of our efforts to fulfill our Strategic Plan “*Translating Discoveries*” (see <http://medstrategicplan.stanford.edu/>). This year’s retreat also had a special focus on how we will address the important challenge of enhancing the diversity and leadership development of our community. (see below).

I was enormously pleased with the outcome of our discussions and debates at the retreat. I believe we forged a closer alignment among our leaders that will allow us to further Stanford’s position as a role model among the nation’s leading research-intensive schools of medicine. For that I want to thank and acknowledge the participation and commitment of our basic and clinical science chairs, medical and graduate student as well as resident and fellow leaders, staff representatives and the Dean’s leadership group, for their diligence, creativity and vision. Of course it is important to acknowledge that a vision for the future is only one component of the complex equation for change. Equally if not more important is the resolve to implement and carryout proposed change – even when it is associated with a need for individual and institutional evolution – if not revolution.

In my “State of the School” address at the beginning of the retreat and in my reflections on “Charting the Future” that closed the event, I summarized the very significant progress we have made during the last several years. I included in my remarks our missions of medical and graduate education, fellowship and postdoctoral training, basic and translational research, patient care, workforce and professorial development, the deployment of novel information technology, and administrative alignments and financial performance, as well as communication strategy, advocacy and medical development. I think all would agree that the School of Medicine has evolved considerably during the past several years. While we can be proud (and I grateful) for the progress that has been made, we still have much to do in what I am confident will always be an organic, iterative and dynamic process of personal and institutional development. (See also Dean’s Newsletter Jan 10<sup>th</sup>.)

Accordingly, I invited the attendees to reflect on a question that is of fundamental importance to the future of Academic Medical Centers (AMCs). Specifically, I asked, if one were starting from a clean slate in 2005, how would an academic medical center and medical school be organized to serve as a vital resource for education, research and patient care in the decades ahead? In that context, I further asked whether the departmentally based structure that exists at nearly every AMC, including Stanford, which in many ways dates back nearly a century to the origin of AMCs in the post-Flexnerian era, would still be ideal or even appropriate.

While history and tradition shape the present, they can also sometimes constrain and even limit progress and evolution. Professions, disciplines and institutions can become captive to past traditions and may be reluctant to address new challenges and opportunities. Because medical science has changed so dramatically during the past several decades, and since new technical innovations have opened new horizons and breached traditional boundaries, it is reasonable to ask whether even our leading academic medical centers and medical schools are structured in a way that will optimize their futures. I indicated to the School leadership that I intend to have a conversation about this issue with them over the next year and that I hoped they would approach this dialogue with open minds and creative vision. Because these questions are so important I want them to include our broader community of faculty, students and staff in the discussions as well.

While asking questions that force us to reconsider our present organization can be threatening, it seems imprudent and even irresponsible not to raise them simply because we might fear that the challenges they pose are too large or disruptive. Indeed, raising challenging questions does not compel an action or a direction *per se*. However, but as stewards of the future, it is essential that we critically evaluate how we can assure that Stanford is a role model for research-intensive schools of medicine for the 21<sup>st</sup> century.

As I engage in dialogue with school leaders and others, I am quite interested in getting feedback regarding the implications of revising certain aspects of our current model – or any alternates that might come forward – in relation to our primary missions in education, research and patient care. For example, a strength of the current

departmental based approach to the clinical training of undergraduate and graduate medical students, as well as residents and fellows, is the opportunity to develop skills in specific disciplines, or to focus on specific organ systems, technologies, procedures, or special patient populations. But science and medicine have become much more interdisciplinary in the last decades, even though much of the training has remained more linear and discipline specific. Indeed, for a school like Stanford, it is important to query how the educational paradigm can be changed and how we can develop students who will emerge with multiple skills and who will be poised to become future leaders and agents of change.

Novel and broad training opportunities should be accessible to students pursuing either an MD and/or a PhD degree. Further, clinical training should not be limited to the acquisition of one skill set when, in fact, many medical and surgical specialties are merging or blending. Certainly opportunities for cross medical training exist presently, but the need for these to evolve and develop more rapidly is heralded by the innovations that are changing the skills sets of previously discrete specialties or disciplines.

Further, educational opportunities should reach beyond the traditional department/discipline boundaries. PhD students would seem to benefit from more interdisciplinary training programs that provide an alternative to defined departmental offerings, as evidenced by the impact of BioX and the growth of successful interdisciplinary graduate programs at Stanford. To accomplish this might mean developing different ways of educating students within the current organizational structure. However, it could also mean realigning current departments or their functional units around interdisciplinary models. Whatever changes are made should be done to optimize flexibility and with the recognition that there will be further evolutions of current disciplines in the years ahead. The goal should be to allow programs to evolve and change with them, as compared to being bounded by them.

There is no doubt that basic fundamental research focusing on investigator-identified questions has made American science the strongest in the world. Such fundamental investigation should continue to be fostered and supported as the underpinning of our research enterprise at Stanford. At the same time, a number of important aspects of bioscience are becoming more team based and interdisciplinary. They are opening the door to new ways of thinking about how systems (from molecules and cells to organs, tissues and beyond) are organized and how they function. Thus, is not inappropriate to query whether AMCs are organized to be able to conceptualize and address the big health and big science challenges facing the world. These require variegated skills and knowledge – from basic and clinical science, as well as the physical and engineering sciences – to address. Can we currently pose and successfully address the “grand health and bioscience challenges” of the 21<sup>st</sup> century – and is this in fact what a medical school of an AMC should be doing? Should the teams addressing major issues arise spontaneously or should they be facilitated by new integrations, cross- talk and shared goals? Obviously we have already taken the lead in these new developments through the establishment of our Stanford Institutes of Medicine and, more recently, our Strategic Centers.

Moving from education and research to patient care, I would point out that many of the ways we currently carry out patient care in academic medical centers defy logic and present a confusing maze to patients and families. Clinical services are discrete, autonomous and sometimes redundant within the same medical center. Unfortunately, they do not always address what is needed from the patient's perspective, especially when medical conditions are complex and require team-based approaches. While the "cancer center" model has provided the most coordination in many AMCs, even these centers depend on the good will and cooperation of various departmentally based disciplines. The question is whether this model of care would be enhanced if in fact all the disciplines shared the same goals and objectives, and, in fact, further translated this alignment to education, training and translational research.

As a relatively small research-intensive school of medicine with a history of innovation and an entrepreneurial spirit, Stanford can serve as role model for appropriate change among AMCs. I have begun to hold discussions on this large and important topic and will continue to do so in the months ahead. I wanted to let you know that these discussions are going on and also to let you know that I will hold Town Hall meetings to give as many people as possible the opportunity to participate in the dialogue. In the interim, if you have comments to offer, please feel free to do so.

### **Addressing Diversity**

Enhancing diversity in the School of Medicine must be one of our highest priorities. While we have made some progress in the past several years, especially in recruiting enormously talented medical and graduate students, we are not performing as well with other trainees (residents/fellows) or with faculty and staff. To help us focus our efforts, a significant portion of this year's Leadership Retreat addressed diversity. We benefited enormously from the broad and deep perspectives of our guests, the well-known actor Anna Deavere Smith, Dr. David Satcher, 16<sup>th</sup> Surgeon General of the United States, and Dr. Freeman Hrabowski, President of the University of Maryland, Baltimore County. Their contributions, as well as the lively discussion they provoked, are well covered in the February 2<sup>nd</sup> issue of the Stanford Report (see <http://news-service.stanford.edu/news/2005/february2/med-retreat-020205.html>) and I encourage you to review this report. These are issues that require bold thinking along with a unified and focused commitment to change both now and over a long time horizon.

### **Stanford University Minority Medical Alliance**

On Saturday February 5<sup>th</sup>, the 14<sup>th</sup> Annual Premedical Conference sponsored by the Stanford University Minority Medical Alliance (SUMMA) drew more than 500 college and high school minority students seeking to learn more about medical school, including how to apply and make the transition to medical school. These conferences have been enormously successful because of the extraordinary dedication and commitment of our students, who organize, lead and conduct this important event. While all of the students and staff who participated in this event deserve our appreciation, I want

to acknowledge the SUMMA Coordinators: Matt Bucknor, SMSII (Student National Medical Association), Heather Fleharty, SMSII (Stanford American Indigenous Medical Students) and Mike Molina, SMSII (Latino Medical Student Association) for their special efforts.

Among the remarkable facets of this conference were presentations by three of our medical students, who reflected on their own lives and on how they each overcame adversity related to race, socioeconomic status or political oppression. Their stories were inspiring. They offered hope and engendered respect. I thank each of them for their honesty and integrity – and am confident that their reflections provided a beacon of hope for all in attendance.

Thanks to the efforts of many faculty, students, and staff, Stanford has continued to be a national leader in the diversity of its medical student classes. This level of success is now extending to graduate students as well. But we have a long way to go to show similar progress among postgraduate trainees or fellows. We are committed to making that progress. We clearly need to begin with fostering a pathway that provides opportunities for these talented students to continue their training at Stanford and, hopefully, become members of faculties at research-intensive medical schools, including Stanford.

## **Transition in Cardiothoracic Surgery**

On February 1<sup>st</sup>, the leadership of the department of Cardiothoracic Surgery changed from Dr. Bruce Reitz to Dr. Bobby Robbins. First, I want to thank Dr. Reitz for his dedicated leadership as department chair for the past 12 years. Dr. Reitz is one of the foremost cardiac surgeons in the world. He has played a major role in keeping Stanford at the forefront of education, research and patient care in cardiac surgery. As the Norman E. Shumway Professor, Dr. Reitz has not only provided departmental leadership but has also had a productive clinical and research career. He focused on mechanisms of allograft rejection for the heart and lung as well as the late chronic effects of rejection and its treatment and prevention. In addition to the respect in which Dr. Reitz is held for his remarkable clinical skills he is much admired as an individual of great integrity who leads by quiet example. I want to thank him on behalf of the School and University and wish him well as he begins a much-deserved sabbatical.

I am also enormously pleased that Dr. Bobby Robbins has agreed to become the next chair of the Department. After more than a yearlong national search chaired by Dr. Ron Pearl, Dr. Robbins emerged as the leader in the field and I am deeply gratified that he has accepted this important position. I have had the privilege of working with Dr. Robbins since he assumed leadership of the Stanford Cardiovascular Institute last April. He has proven himself to be a visionary, dedicated and much admired leader. I am quite confident he will play a major role in further developing the cardiothoracic surgical programs. I also anticipate that he will engage in creative and productive alignments with a broad array of colleagues from both the basic and clinical sciences as well as throughout the University. Dr. Robbins has been highly sought after for leadership

positions at a number of major academic medical centers across the USA and I am most pleased that he has elected to remain at Stanford. We are fortunate to have him and I look forward to working with him in the years ahead.

## **Planning an Agenda for Regenerative Medicine**

On Monday January 31<sup>st</sup> a “Working” Retreat on Regenerative Medicine was held in the Clark Center Auditorium. This retreat, organized by Michael Longaker, Chair of the Program Advisory Committee on Regenerative Medicine (PRM) under the auspices of the Cancer/Stem Cell Institute, along with Drs. Linda Giudice and Julie Baker, Co-Chairs of the Human Embryonic Stem Cell/Nuclear Transplantation Operations Subcommittee. The retreat featured an overview of the Institute by Dr. Irv Weissman and the PRM Subcommittees on Education (Dr. Minx Fuller), Research (Dr. Roel Nusse), Bioethics (Dr. David Magnus), Facilities (Dr. Michael Longaker) and Human Embryonic Stem Cell Operations (Drs. Linda Giudice and Julie Baker) (see additional background details in the January 10<sup>th</sup> Dean’s Newsletter.

Because there are so many legal, regulatory and political issues surrounding the burgeoning field of human embryonic stem cell research I asked Dr. Ann James, Office of the General Counsel, to offer a summary of the presentation she delivered at the Retreat. I would encourage anyone interested in human stem cells or who is considering working in this area to read Dr. James’ thoughtful summary which follows below:

Human embryonic stem cell (hESC) research would likely be only another, albeit exciting and promising, avenue for research, were it not for the dramatic step taken by President Bush on August 9, 2001. In his presidential directive, Mr. Bush made a political determination on a scientific avenue of research, and strictly defined the stem cell research that can be funded by federal funds. Federal policy, as defined by Presidential order, is: “No federal funds will be used for: (1) the derivation or use of stem cell lines derived from newly destroyed embryos; (2) the creation of any human embryos for research purposes; or (3) the cloning of human embryos for any purpose. Today’s decision relates only to the use of federal funds for research on existing stem cell lines derived in accordance with the criteria set forth above.”

The hESC lines then derived were relatively few, fewer than the Administration had announced, and were all grown on murine feeder cells, offering the possibility (now established) that all could be infected with animal viruses. The scientific community, along with the families of those for whom stem cell research offered the possibility of therapies and even cures, aligned in California to produce Proposition 71, providing 3 billion dollars for research in this area. The purpose of this initiative is to fund research to “develop life-saving regenerative medical treatments and cures”, placing the focus on translational medicine.

As Proposition 71 became law, the scientific community in its various academic homes began to consider what the federal ban on funding for research on “non-approved” hESC lines would mean. California, by statute, permits such research, and provides relatively few statutory requirements. However, the ban on direct and indirect use of funds requires a ‘clear policy’ for investigators, as the NIH has indicated.

NIH has provided some guidance on how to handle such costs, and there is precedent for such allocation. Privately funded research such as that done by Howard Hughes Medical Institute fellows is carved out from the University’s indirect cost calculations, and the equipment and supplies funded separately, so this process is not new for Stanford. OMB Circular A-21, Cost Allocation Standards, is the principal guidance for calculation of indirect costs.

The NIH provides answers to some, but far from all, frequently asked questions (FAQs) on its web site (<http://stemcells.nih.gov>). Strict compliance with A-21 is required. For example, there is no requirement that hESC research or research costs be physically segregated if cost allocations are appropriate. As the FAQs remind us: “If direct costs of ineligible hESC line research are properly allocated and negotiated, and negotiated F&A rates properly applied, then the F&A costs of hESC research will be deemed to have been allocated properly, and no federal F&A funds will be deemed to have supported such research.”

An NIH-funded investigator also may be engaged in ineligible hESC line research “so long as his or her salary is allocated between the two activities in accord with his or her effort.” This places even greater focus on the importance of allocation of effort, and the proper documentation of any reallocation required when beginning research in such research.

To assure that these requirements are met, Stanford is developing a policy that will address four key areas: tracking all such research done at Stanford, special training for anyone doing work with stem cells, special operating procedures, and compliance. To assure that such research is done, as California requires, with “full consideration of ethical and medical implications”, a special research panel will be charged with such oversight. This policy, as approved by the Deans of Medicine and Research and reviewed by key faculty members, will be presented to the Committee on Research on February 16, and then be processed through approval by the *Senate of the Academic Council*. In addition to the adoption of this policy, detailed procedures will be developed to provide more concrete guidance for investigators, likely supplemented by our own set of FAQs to address specific questions and give more guidance as the interpretation of the ban is better understood.

Our goal is to collaborate with other institutions, both in California and across the county, to share, as much as possible, our analysis of the requirements for proper management of such research. NIH is now reviewing its guidance in

response to specific questions received as the focus on hESC work has increased. However, such guidance is unlikely to be provided for some time, given that the Department of Health and Human Services has a new Secretary, who has strong views on such research and will likely become involved in any guidance issued.

Counsel and advice is available. Questions can be directed to a variety of knowledgeable faculty and staff at Stanford: for scientific issues, Linda Giudice, Julie Baker, Roel Nusse, Michael Longaker, and Irv Weissman; for overall issues under the University policy, Ann Arvin, Assistant Dean of Research; for legal questions, Ann N. James in the Office of General Counsel. None of these individuals will have all the answers, but are committed to assisting the Stanford community by finding answers. General information will be provided through a web site, and updated as more questions are asked and answered. The critical requirement is to ask the questions, not hope for forgiveness for errors; in return, Stanford is committed to responding to its scientific community as quickly and effectively as possible in this time of uncertainty.

While we can take the position that management of hESC under the ban is a cost issue, it has far greater implications for adverse publicity, investigation, and even effect on the Proposition 71 funding opportunity. There is no room for error.

Proposition 71 itself effectively creates an organization intended to respond to the purposes of funding otherwise unfunded research and to seek both therapies and cures. The Independent Citizens' Oversight Committee (ICOC) governs the California Institute for Regenerative Medicine (CIRM). This 29 member body was appointed by the Governor, other designated State officers, and by the Chancellors of the UC System. The statute was guided by the goal of funding great science, but written with a keen political sensitivity to the fact that the citizens of California are entrusting this body with oversight of three billion dollars in public money, and accountability is high.

The ICOC includes the designees/appointees from academic medical and research institutions, from one life science commercial institute, and from ten advocacy groups. Both the chair and vice-chair, chosen from among the ICOC members, were required to have had experience with stem cell research advocacy. A staff and a President, for which position the ICOC is now recruiting, will manage the day-to-day operations of the CIRM.

The ICOC is subject to the Bagley-Keene Act, California's open meeting act, to assure transparency in decision-making. All the usual functions of a board of directors are assigned to the ICOC, which will report at least annually to the State on its work in a prescribed format. The ICOC will oversee operations, set plans for research and management of financial issues, determine research standards and grant awards, name working groups and set guidelines, request issuance of bonds and borrow from the Pooled Money Investment Board. Conflict of interest issues must be resolved or managed under the direction given

by the statute. The ICOC will determine how intellectual property is to be handled, based on the statutory requirement to balance the State's interest in sharing in revenues that might come from such research with the need to avoid hindering essential medical research. This required balancing will likely result in an arrangement similar to that now in place between academic medical centers and the VA system, but there is no determination on this issue yet.

The Medical and Scientific Accountability Standards defined by the Statute address such issues as informed consent, payments (no compensation for donors, but expenses can be covered), patient privacy, and a time limit on what cells can be used (8 to 12 days, excluding time frozen). Such standards will be expanded by the ICOC, as guided by the recommendations of its working group on accountability. Central to the ICOC's role is appointment of the three Scientific and Medical Working Groups. These include Research Funding, Accountability Standards and Research Facilities.

The conflict of interest standards for the groups will be based on those for NIH scientific review committees, and overseen by an ethics officer from the ICOC. The working groups are not public officials and not subject to open meetings/records requirements, but recommendations to the ICOC are subject to the open records requirement. A group will report to the ICOC if a majority of a quorum approve, but also may issue a minority report if 35% of the members so choose.

The accountability standards group will recommend scientific, medical and ethical standards, and advise all other Groups on ethical and regulatory issues. This group will have 19 members, of which 5 will be ICOC members from advocacy groups, 9 will be nationally recognized stem cell scientists/clinicians, 4 medical ethicists, and the ICOC chair.

The research funding group will have 23 members, of which 7 will be ICOC members from advocacy groups, 15 will be scientists nationally recognized in stem cell research, and the Chair of the ICOC. This group will recommend criteria, standards, and requirements for funding applications and awarding grants. The group will also recommend awards for research, therapy development, and clinical trial grants and loans, as well as set the standards for evaluation of grantees, and conduct peer group progress oversight reviews of grantees. The 15 scientists will score for scientific merit, using such criteria as the quality of the proposal, potential for significant results, timetable, importance of objectives and innovativeness of research. While the group and the ICOC will give high priority to research not otherwise funded, research that represents a vital research opportunity may be funded if 2/3 of a quorum recommends approval. The questions on what will be funded, when and in what format are not yet answered (and neither this or other groups have yet been appointed).

The facilities group will have 11 members, including the Chair of the ICOC, 6 members of the funding group, and 4 real estate specialists. This group will recommend criteria, requirements and standards for funding of facilities. Milestones and timetables must be established, and priority will be given to those that can be completed in two years. Renovation as well as new construction may be funded. Only non-profit organizations can apply for facilities funding. Matching funds (at least 20% of the award) are required, and there will be priority for those applications that have higher matching fund amounts.

Proposition 71 created the ICOC with the purpose of finding therapies and cures, of understanding hESC capabilities as a primary focus (since this research cannot be funded through any federal program), but, as the name suggests, is intended to focus effort and scientific talent on regenerative medicine. The Stanford Program on Regenerative Medicine serves as the locus for this research at Stanford, to provide information, to encourage collaboration, and to assist the University to give clear direction for conduct of hESC research to its community through policies and procedures.

I want to thank Dr. James for her contribution as well as all who organized and participated in the retreat. It was highly informative. A subsequent retreat will be planned to highlight scientific accomplishments and opportunities, and I will let you know further details about this as they become available.

### **Conflict of Interest Reporting**

You likely know that over the past weeks the NIH Director's decision to ban virtually all industry related or sponsored outside activities for NIH employees has attracted wide attention. A number of factors contributed to this severe restriction, including the failure of some individuals to disclose potential conflicts of interest. At Stanford we have clear policies governing conflict of interest (see recent update in the January 24<sup>th</sup> Dean's Newsletter. In the next couple of weeks all faculty will be asked to complete their annual disclosure – which is mandatory. Please attend to this as soon as it arrives. Failure to comply will have serious consequences. If you have any questions please check with Barbara Flynn, Manager of the Conflict of Interest Review Program ([barbara.flynn@stanford.edu](mailto:barbara.flynn@stanford.edu)). Thank you in advance for your cooperation.

### **Upcoming Research Opportunities for Residents and Fellows**

At the February 4<sup>th</sup> meeting of the Executive Committee, Dr. Harry Greenberg, Senior Associate Dean for Research, Graduate Education and Postdoctoral Affairs and Dr. Sam Gambhir, Professor of Radiology, presented the current planning to institute a program in which a selected number of residents and fellows would, in addition to completing their clinical programs, also complete a doctoral degree in a basic science discipline. The model for this program is the Specialty Training and Advanced Research program at UCLA.

The motivation for developing this type of program is that new strategies are needed at Stanford for better linking residency/fellowship training programs with basic science and translational research. Further, residents and fellows may benefit tremendously from having sustained research experiences while completing their clinical training, including the ability to get a Ph.D. Issues that would need to be resolved include funding sources for such a program, tuition issues at Stanford, and the establishment of links beyond the School of Medicine.

The Executive Committee was enthusiastic about pursuing the development of such a program. We will keep you apprised of further progress. In the meantime, if you have comments or suggestions about this idea, please be in touch with Dr. Greenberg at [Harry.Greenberg@stanford.edu](mailto:Harry.Greenberg@stanford.edu).

### **Electronic Health Records**

On Friday February 4<sup>th</sup> Dr. David Brailer, National Coordinator for Health Information Technology, US Department of Health and Human Services, gave the inaugural lecture for the Center for Clinical Informatics Seminar Series on the topic "Towards a National Model of the Electronic Health Record". In addition to presenting a thoughtful overview of this topic, Dr. Brailer had an engaging conversation with interested members of the Stanford community. The video of Dr. Brailer's lecture is available at: [http://clinicalinformatics.stanford.edu/scci\\_seminars/02\\_04\\_05.html](http://clinicalinformatics.stanford.edu/scci_seminars/02_04_05.html)

### **2005 Health Care Symposium**

On Wednesday January 26<sup>th</sup>, students from the School of Medicine and the Graduate School of Business collaborated on the 2005 Stanford Health Care Symposium entitled "Five by Twenty: Five Ideas That Will Revolutionize Health Care by 2020." The Symposium featured a number of exciting plenary addresses and panels. I had the opportunity to chair an interesting panel entitled "Better, Faster, Cheaper? Process Innovation in Drug Design and Development". This was an impressive event and I want to acknowledge the important role that Farzad Soleimani, SMSII played in its organization and coordination.

### **Stanford Medicine Focuses on the Nation's Health Care System**

The Winter 2005 issue of Stanford Medicine is hot off the presses and on-line at <http://mednews.stanford.edu/stanmed/2005winter/>. This issue has a special focus on "*The Nation's Health Care System: A Ticking Time Bomb?*" It provides a thoughtful overview of the current status and challenges of our health care system and offers valuable perspectives from Jan Van Lohuizen, the President's pollster, and by Dr. Mark McClellan, chief administrator of Medicare/Medicaid. It is an issue definitely worth reading. I want to offer my compliments and appreciation to the editorial board of Stanford Medicine and to its editor Roseanne Spector. Thanks also to the leadership of Paul Costello, Executive Director of Communications and Public Affairs.

## Living Better, Living Longer

As part of our ongoing educational programs for the community, an evening session entitled “Living Longer, Living Better” was held on Monday January 24<sup>th</sup> in the Arrillaga Alumni Center. This informative seminar included a panel discussion on longevity that featured Drs. Laura Carstensen, Tom Rando, Bill Mobley and Peter Pompey. In addition small group discussions were held on a number of interesting topics, including:

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|---|---|
| <i>Incontinence/Sexuality</i>             | Dr Bertha Chen, Assistant Professor of Obstetrics/Gynecology        |
| <i>Managing Chronic Pain</i>              | Dr. Sean Mackey, Assistant Professor of Anesthesia                  |
| <i>Vision and the Aging Eye</i>           | Dr. Mark Blumenkranz, Professor and Chair of Ophthalmology          |
| <i>Memory Loss and Again</i>              | Dr. Jerry Yesavage, Director, Alzheimer’s Disease Center            |
| <i>Preserving Cognition/Mental Health</i> | Dr. Barbara Sommer, Director, Stanford Geriatric Psychiatry Program |
| <i>Joint Replacement</i>                  | Dr. Stuart Goodman, Professor of Orthopedic Surgery                 |

I want to thank the speakers and organizer for this very successful program.

## Community Lecture Series Addresses Skin Cancer and Other Disorders

On Wednesday evening February 2<sup>nd</sup>, our community lecture series focused on skin diseases – from basic science to clinical problems including melanomas, non-melanoma skin cancers to wrinkling and aging. I want to thank our three speakers (Drs. Hayes Gladestone, Tony Oro, and Susan Swetter) for their excellent presentations and for the time they spent lecturing and answering questions raised by community guests.

## Awards and Honors

- **Sarah S. Donaldson**, Catharine and Howard Avery Professor of Radiation Oncology received the Elizabeth Blackwell Award from the American Medical Women's Association (AMWA), at their 2005 annual meeting in Washington DC. This award memorializes Elizabeth Blackwell, the first woman to earn a doctor of medicine degree. The Blackwell medal is the AMWA's highest award identifying a female physician who has made an outstanding contribution to the cause of women in medicine. In receiving this award, Dr. Donaldson is recognized for her numerous accomplishments as a physician, researcher, and author, demonstrating exceptional achievements and commitment to medicine. Congratulations to Dr. Donaldson.
- **Dr. Willard Fee** was honored by faculty, alumni and friends of the department of Head & Neck Surgery on Tuesday January 25<sup>th</sup> by the dedicated the Department’s

Library to him. Dr. Fee has had a highly respected career on the faculty of Stanford and played a major role in shaping the current department and numerous trainees. Dr. Michael Johns, Executive Vice President for Health Affairs and Director of the Robert W. Woodruff Health Sciences Center, offered serious as well as humorous reflections of Dr. Fee's remarkable career based on their long personal and professional relationship. Congratulations to Dr. Fee.

- **Dr. Lucy Shapiro**, Virginia and D. K. Ludwig Professor and Senior Fellow, by courtesy, at the Stanford Institute for International Studies and Director of the Beckman Center, has been named the 2005 recipient of the National Academy of Science's Selman A. Waksman Award in Microbiology "*for her pioneering work revealing the bacterial cell as an integrated system with transcriptional circuitry interwoven with the 3-D deployment of regulatory and morphological proteins*". Of note, Dr. Shapiro is the first woman scientist to receive this award since it was first given in 1968. One might say that it is about time! Congratulations to Dr. Shapiro for another wonderful honor.

## **Appointments and Promotions**

- **Jeffrey Axelrod** has been appointed Associate Professor of Pathology, effective 2/01/2005.
- **Jeffrey Glenn** has been reappointed Assistant Professor of Medicine (Gastroenterology), effective 9/01/2005.
- **Miriam Goodman** has been reappointed to Assistant Professor of Molecular and Cellular Physiology, effective 2/01/2005.
- **Albert Koong** has been reappointed to Assistant Professor of Radiation Oncology, effective 9/01/2005.
- **Philip Lavori** has been appointed Professor of Health Research and Policy, effective 2/01/2005.