

# Dean's Newsletter

## September 19, 2005

### *Table of Contents*

- More About Katrina
- CIRM Awards First Grants and Stanford Makes its Mark
- Planning for the Learning & Knowledge Center
- A Successful Year in Medical Development
- Update on the Center for Bioethics
- Women in Science
- Future Physician Workforce
- Stanford Goes to Washington
- Some Comings and Goings
  - Dr. Karla Kirkegaard Named Chair of Microbiology and Immunology
  - Dr. John Boothroyd Steps Down as Senior Associate Dean for Research
- Events

### **More About Katrina**

By now the pictures, images, devastation and failures that surround Hurricane Katrina have become ingrained into our national – and global – awareness. While reports in recent days are beginning to speak more optimistically about the rebuilding of New Orleans, the reality is that hundreds of thousands of citizens have been displaced and whatever reconstruction occurs will surely take many months, or years, and will cost hundreds of billions of dollars. The outpouring of good will and help from private citizens and public agencies across the country and around the world is gratifying. Nevertheless, many things we take for granted in our daily lives will be challenging to obtain or simply unavailable to our friends, colleagues and fellow citizens along the Gulf Coast for some time to come. I am pleased to report that many of our faculty and community physicians, along with other health professionals, have volunteered their time to provide service to the affected Gulf community.

A week or two ago many in our community asked whether medical schools across the country should help out by taking Tulane and LSU students, residents and fellows who were “homeless” following the hurricane disaster. As I indicated in my September 6th Dean's Newsletter, both schools had asked us to refrain from taking students while they assessed their future plans. That has now been done, and both Tulane and LSU have determined to remain open and to accommodate students and postgraduate trainees in programs they are re-establishing. To do this, Tulane is working with Baylor Medical School to support its preclinical students and, with the Texas consortium, to accommodate residents and fellows. LSU has moved its operations to Baton Rouge and it is also clear that it wants to continue to support its own programs. Clearly our efforts should be to help Tulane and LSU achieve their goals. The Association of American Medical Colleges (AAMC) has played a central role in communicating these plans to the nation and also in helping to serve as coordinating center and clearinghouse. During the AAMC

Board meeting I attended on Sept 14-15, the leadership also proposed ways of using program resources to help support students and trainees.

What is unclear at this point is what will happen to the faculty at Tulane and LSU. While the NIH is doing all it can to assist grantees and whereas faculty may be able to relocate temporarily to other centers, the clinical faculty are without an immediate home. Because it will take time for displaced citizens to return to New Orleans, for example, the clinical faculty will face the challenge of a dearth of patients to care for – with the obvious economic implications and consequences. Clearly this will have an impact on the financial well-being of the entire medical school. Given the obvious pressures and challenges that will unfold, it is likely that many of these faculty will seek to relocate to other parts of the country – or will be recruited, perhaps even opportunistically. While we surely cannot interfere with the right of individuals to pursue new career options, we do need to be cognizant of the implications of the loss of clinical faculty from these programs and try to devise ways to help – and not compromise - their immediate future.. There is not an easy solution to this dilemma, although we did come up with several ideas at the AAMC , such as short term sabbaticals for displaced faculty, that might help to sustain the integrity of these medical schools. Additional thoughts are welcome.

### **CIRM Awards First Grants and Stanford Makes its Mark**

Friday September 9<sup>th</sup> was a momentous day for the California Institute of Regenerative Medicine (CIRM) and its oversight Board, the Independent Citizens Oversight Committee (ICOC). And there was good news – especially for Stanford - as well as a persistent unfortunate reality.

The CIRM was born because a considerable majority of the citizens of California decided on Election Day, November 2<sup>nd</sup> 2004, to vote in favor of Proposition 71. With this vote of support, California assumed a leadership position in the debate on stem cell research and offered promise to its citizens and the nation that this important new area of research would be supported, at least in California. Indeed, when fully operative Proposition 71 will award \$3 billion of support for stem cell research in California over the next 10 years. And while a lot has happened since that momentous vote, the actual funding of research remains a promissory note – although one I have every confidence will be fulfilled. So while CIRM was officially born 10 months ago, it has not been given the life that our citizens voted for, primarily because of lawsuits filed by individuals and groups intent on stopping stem cell research.

So what has actually happened? The ICOC, which was officially appointed in December 2004 and on which I serve, has worked tirelessly to develop the infrastructure and guidelines to support outstanding stem cell research in California. Its financial resources are limited because the current lawsuits have held up the issuance of the bonds that will ultimately make the CIRM successful. Nevertheless, even in the face of this delay, the ICOC has accomplished a great deal. Perhaps most notably, the 29 member ICOC, comprised of leaders from academia, biotechnology and patient advocacy groups, has worked with a real spirit of zeal and commitment to make the CIRM successful.

Despite the sometimes relentless sniping in the press, the ICOC has identified an outstanding President in Dr. Zach Hall, and he, in turn, has appointed an excellent (although still skeleton) staff to run the institute. With input from numerous sources, the ICOC successfully carried out a competition for the permanent home for the CIRM, which will soon be located in San Francisco. The ICOC and CIRM helped generate a review on the “standards for conducting stem cell research,” initially under the auspices of the National Academy of Sciences and then through its internal Standards Working Group. Importantly, the ICOC worked diligently to develop the criteria for its grant review process and also to select the 15 member Scientific and Medical Research Funding Working Group, an extraordinary group of scientific and medical leaders from around the nation. This Group works in collaboration with patient advocacy members from the ICOC. The ICOC has also been working through other important issues related to governance, intellectual property and resource development, all while under fire from state legislators, legal groups and the press. Each of these groups has different motivations, but, regardless of their motives, none of this activity makes the efforts of the ICOC simpler or more successful.

And why was September 9<sup>th</sup> momentous for the CIRM? Simply because at long last the ICOC was asked to review the recommendations of the Scientific and Medical Research Funding Working Group on the 26 training grant proposals that had been submitted to the RFA from the CIRM (see the July 25<sup>th</sup> posting from the **Stanford Report**: [http://med.stanford.edu/spotlight/archive/stem\\_cell\\_grant.html](http://med.stanford.edu/spotlight/archive/stem_cell_grant.html)). The submissions were evaluated by the Working Group on the following criteria: the overall quality of the proposed training program, the qualifications of the program leadership, the research and training strength of the proposed mentors, the quality and diversity of the existing training programs, and the strength of stem cell research at the institution. Each proposal was carefully considered and then scored on a scale of 1-100, with 100 representing the best score for scientific merit. Based on the scientific ranking and then deliberative discussions with the disease-based patient advocate members of the ICOC, the final recommendations were brought forth to the ICOC. While the actual scientific ranking and related discussions took place in a closed session, all the remaining proceedings have occurred in public, and the results are published on the CIRM website.

Of the 26 proposals, 16 were recommended for funding (albeit several with reduced funding) and one with was approved “if funds were available.” When the recommendations were presented in a public meeting on September 9<sup>th</sup>, the ICOC discussed each proposal and voted, whether to accept or reject the recommendation of the Working Group. Individuals with defined conflict recused themselves from voting on certain proposals (e.g., I did not comment or vote on Stanford’s application). The recommendations were presented to the ICOC based on rating rank, with the highest score being 98 and the lowest “below 60.” I am very happy to report that Stanford’s score was 98. The public comments about the proposal noted that: ***“By all review criteria this application was deemed exceptional with the highest recommendation possibility. The program is of high quality and well integrated. The leadership and administrative support is strong and includes an internal executive committee and a committee of external advisors. The institution provides a strong environment that includes a***

*hospital, medical school, and internationally recognized tradition in both adult and embryonic stem cell research. No obvious weakness was evident.”*

Of course the success of the Stanford proposal is related to the outstanding faculty and staff who worked on the application. I particularly want to thank Dr. Michael Longaker, Deane P. and Louise Mitchell Professor of Surgery and Chair of the Program on Regenerative Medicine, along with Dr. Minx Fuller, Professor and Chair of Developmental Biology, and Dr. Irv Weissman, Karel and Avice Beekhuis Professor of Cancer Biology and Director of the Stanford Institute of Stem Cell Biology and Regenerative Medicine. Together with numerous colleagues in the School and University they brought forth a wonderful plan for training future investigators and leaders in stem cell research – and thus won the respect of an outstanding national review group.

While our Stanford proposal will eventually train six predoctoral, five postdoctoral and five clinical fellows and be supported by \$3,733,707 from the CIRM, the unfortunate reality is that no dollars will flow to us at this time. This is because the current lawsuits prevent the State from actually issuing the bonds that will fund the CIRM and its grants and programs. So, while we can celebrate an excellent review and an opportunity to begin training future investigators and leaders in stem cell biology and regenerative medicine, we must also mourn the fact that this important funding will be delayed until the lawsuits against Prop 71 have been dismissed. That said, it is important for our community and for the public to be aware that the CIRM and ICOC have done their best to honor the expectations of the citizens of California – something that a minority of individuals seem intent on thwarting. While I am confident that these current obstacles will eventually be removed, it is certainly unfortunate that we are losing precious time in moving these important training initiatives forward. But in the end I am also confident that reason will prevail and that Stanford will be able to fulfill its promise in training future leaders in stem cell research. Clearly this is important to Stanford, California and the nation. In the meantime, Drs. Margaret Fuller and Michael Longaker note that Stanford will begin holding a weekly seminar for all faculty members and students interested in regenerative medicine. The initial meeting is set for 4 p.m., October. 6th in the Clark Center.

### **Planning for the Learning & Knowledge Center**

Plans are moving forward for the School of Medicine’s Learning and Knowledge Center (LKC) and the Stanford Institutes of Medicine #1. While there is considerable work to be accomplished, it is our current hope that both of these new facilities will be completed by 2009. At this point, we have completed the program planning for the LKC. We presented this work to the University Cabinet on September 15<sup>th</sup> as a prelude to presenting it to the Land and Buildings Committee of the Board of Trustees on Monday, October 10<sup>th</sup>. If we receive approval to proceed, we will begin architectural competition for the LKC. We would hope to select the winning architect by year-end or early 2006. Assuming that we are successful with the funding plans, the design and construction phases will move forward with the goal of occupancy for the class entering in 2009,

which is also the 50 year celebration of the School of Medicine's move from San Francisco to the Stanford campus in 1959.

At this point in the planning, the LKC consists of both new and renovated space. The new building (120,000 gross square feet (gsf) on the site of the current Fairchild Auditorium) will be designed to be the "front door" to the School of Medicine – something that certainly does not exist today. It will consist of a ground floor housing a new Conference Center along with three floors and a penthouse level. These will house the Learning Environments on the first floor, the state-of-the-art digital Knowledge Management Center on the second floor, the Center of Immersive and Simulation-based Learning on the third floor and on the partial fourth floor, a range of reflective and study areas including a no tech zone and rooftop garden. The LKC will be virtually connected to the renovated library, student services and related support services that will be housed on the lower floors of the current Alway and Lane Buildings.

Planning is also underway for the for SIM1, which will house departmental faculty (both current and new) who are members of the Stanford Institute for Stem Cell Biology and Regenerative Medicine, the Stanford Comprehensive Cancer Center and the Neurosciences Institute at Stanford. In addition, the 200,000 gsf SIM1 will house a vivarium that connects to the Research Animal Facility (RAF). Indeed, one of the additional important components for the construction of both the LKC and SIM1 will be the design of infrastructure "connecting elements." These will provide communications (likely underground) for these buildings and, over time, other integrative features that will help unify the School of Medicine facilities.

The design and construction of these facilities will be expensive and will include costs for construction, renovation, and special equipment, as well as for the construction costs now associated with the General Use Permit (GUP) and other requirements. The total costs are getting close to finalization and include, at this point, \$128.1M for the LKC and the associated renovations in Lane and Alway, \$151.2M for SIM1 and approximately \$50M for the infrastructure connecting elements. In addition, over the next 10 years, the School will need to support the renovation of the remainder of the Grant, Alway, Lane and Edward buildings for seismic upgrades as well new laboratories and administrative space. And, not even included here are our future SIM 2 and SIM 3, which are also important to our future success. Clearly these are major costs and addressing them will require bold and concerted efforts.

Without question, philanthropic gifts are one of the important sources of funding we must develop. This is one of the reasons I have worked hard to champion a bold plan that we hope will engage our community and friends to support our visions for the Stanford Institutes of Medicine, Comprehensive Cancer Center and Education and Library programs. If we are to be successful, we will also need to engage the participation, contributions and efforts of our faculty, students and alumni. I am pleased to announce that Dr. Paul Berg has agreed to co-direct the Education and Learning Volunteer Leadership Council and, in this role, to help coordinate and champion our philanthropic efforts for the LKC and related programs. Of course I have been deeply and

extensively involved with these efforts to date and will be dedicating an ever larger proportion of my time to meeting our various fundraising needs and goals (see also comments that follow below on Medical Development).

We will also be looking to funding sources beyond the efforts of the School's Office of Medical Development. The University will be contributing a significant level of the funds it raises centrally to our LKC and SIM1 projects because of their alignment with the SEMC (Science, Engineering and Medicine Campus). We will also be using a considerable amount of debt financing support for construction and renovation costs (although we will have to service the debt financing). In addition, we will be calling on our various reserve accounts, including those held centrally within the School and those held in departments, to further assist these efforts. Our hope here, however, is to raise sufficient funds from philanthropic sources so as to minimize the impact on school/departmental resources.

A number of schools of medicine facing major building projects have encountered a challenge similar to ours – namely, that sufficient capital funds have not been accrued from operations to cover the massive construction costs. A couple of years ago, Johns Hopkins Medicine put into place an infrastructure charge of 20% on all non-capital philanthropic gifts. This has proven to be an essential component of their ability to raise construction and renovation funds that could not be achieved from other sources. When I was in Boston, Harvard and its major teaching hospitals had similar infrastructure charges that ranged between 13-20%. At Stanford, the infrastructure charge has just been raised from 6% to 8%. While I realize that this is a notable change, we are planning to raise the infrastructure charge beginning in FY07 by an additional 5%, to 13%, for 5 years for all non-capital gifts. I am well aware that this will have an impact on faculty as well as donors, but it is an essential ingredient to our success – as it has been for other schools around the country. Nonetheless, having been a faculty member and department chair prior to coming to Stanford, I well appreciate the impact of such changes. But, like other peer schools, we have no choice but to move in such directions if we are to help secure our future as a leading school of medicine.

Today, Stanford Medical School is quite dichotomized in its physical plant. We have some wonderful new facilities (e.g., Clark Center, CCSR, Beckman, Lucas and MLS); others that are adequate but with significant limitations (e.g., Fairchild Science Building and Auditorium); and a still significant amount of largely suboptimal space (especially in the Stone Complex housing the Grant, Alway, Lane and Edwards Buildings). It is essential that we renew and redevelop our facilities by new construction (which, unfortunately, is limited by space constraints through the GUP) and renovations. We all have immediate needs and priorities, but part of our job, as institutional stewards, is to plan and develop the resources for future students and faculty. We all want to be part of an institution that we can be truly proud of – which must include the facilities that it offers to its students and scholars. The LKC and SIM1 and related renovations in Lane and Always are the first major steps in achieving our new and revitalized campus. There is much to do to bring these to fruition. But this still represents just the beginning of a long but important role for Stanford Medicine in the 21<sup>st</sup> century.

## **A Successful Year in Medical Development**

I have noted in prior communications the planning underway to initiate a University-wide campaign that includes the School of Medicine and Medical Center. Indeed, we have made significant progress in developing an integrated fundraising plan that includes the School of Medicine and Stanford Hospital & Clinics and the School of Medicine and the Lucile Packard Children's Hospital. While we anticipate that the funds we raise will help all of our programs in the School, I recognize that to be successful, we need to be focused, and thus we have elected to concentrate in seven areas. These include our four Stanford Institutes of Medicine, the Stanford Comprehensive Cancer Center, Orthopedics and Sports Medicine, and Education. Each of these programs will require funds for new facilities and program development in research, education and patient care. I will have more to say about planning in these areas in the future.

But I want to report now that the School (and Stanford Hospital) enjoyed the highest level of fundraising activity in its history in the FY05 fiscal year, which ended on August 31, 2005. For the School of Medicine the total amount of new cash in FY05 was \$128M (compared to \$98M in FY04) – an increase of 30%. Equally, if not even more important, the “new activity” for FY05 (which includes pledges for future years) is \$116M compared to \$92M in FY04, an increase of 26%. This is excellent news! However, I would like to view it as just the beginning of our upward turn to significantly greater philanthropic activity.

Of course, raising new funds is not just about new money – it is about what those funds will be used for. For the School of Medicine, our goal must be to help nourish and enhance our mission-critical programs in education, research and patient care. At the end of the day, it is the lives that we affect and improve that will be the ultimate measure of our success.

I want to thank all those who have contributed to this year's success. First and foremost is our faculty, who do the wonderful and exciting work that so many individuals and foundations wish to support. I also want to thank our Office of Medical Development, a program that has been in significant transition. Mr. Doug Stewart became the Associate Vice-President for Medical Development in October 2004 and has done a wonderful job in focusing the team on our important fundraising goals. Further, he has been recruiting exceptional leaders and individuals to join the OMD staff who will clearly make major contributions in the future. But for this year, we must also thank the current and past members of OMD who have worked diligently and very hard to make a difference – which they indeed have. I also want to thank Mr. John Freidenrich, the leader of our new Leadership Council, who will certainly play a critical role in helping to guide our interactions with community leaders and supporters in the future. Finally, I want to thank the support and assistance of the Office of Development led by Martin Shell along with John Ford – their support and confidence has been wonderful and is much appreciated.

All that said, the new fiscal year began on September 1<sup>st</sup> and we have a new hill to climb. I remain deeply committed to working directly with our OMD and to do everything I can to help us achieve new and greater goals for this year and beyond. Naturally I will count on your help as well.

## **Update on the Center for Bioethics**

On Thursday, September 8<sup>th</sup> the Steering Committee for the Stanford Center for Bioethics, chaired by Professor Hank Greeley, met to review the status, progress and future directions of the Center. Dr. David Magnus, Associate Professor of Pediatrics, reviewed the important accomplishments of the Center for Bioethics faculty in genetics, neuroethics, stem cell research and other important biomedical ethical issues. Despite the small size of the Center, under the leadership of David Magnus, the significant contributions of the faculty and members of the Center have attracted national praise and respect. This is measured by the Center's activities in hosting important consensus conferences, writing important opinions in leading journals, creating exciting documentaries and engaging the scientific and public communities around significant ethical dilemmas. The Center's leadership in prominent biomedical journals as well as high impact scientific journals, including *Science* and *Nature*, is particularly notable.

Importantly, the Center has had significant engagement in the education of medical students and undergraduates as well as bioscience students. The revamping of the required course on the "responsible conduct of research," which is now conducted in small groups, is an excellent example of progress. The role of the Center in the Human Biology Concentration in teaching "Foundations of Bioethics" is another excellent example.

In addition to research, scholarship and teaching, the Center also provides important services to our community. These include bench side consultations for investigators, clinical ethical consultations, grand rounds and service on important committees, including the stem cell efforts at Stanford as well as in California and nationally. Importantly, the Center has also developed a number of outreach programs to the community through opinion pieces in major newspapers, appearances, and lectures. All of these are directed at heightening awareness and understanding of significant ethical issues.

## **Women in Science**

In the August 19<sup>th</sup> issue of **Science** (309:1190-1191) Jo Handelsman et al provided a policy forum update entitled "*More Women in Science*." This brief but important article underscored the fact that there is no convincing evidence to support a hypothesis that the representation of women in science is limited by innate ability. Between 1970-2003, there has been a 30-fold increase in the number of PhDs awarded to women in engineering. Despite this there remains a disproportionately low number of women in senior academic ranks compared to those who are entering the PhD pipeline. The authors offer four factors that likely contribute to this disparity and offer some

suggestions for dealing with it. Since I am committed to improving the career paths for women in the School of Medicine I believe it is important to take heed of these observations.

First, Handelsman notes that the pipeline challenge is not simply about numbers. Perhaps more importantly, it reflects the fact that women may not be encouraged to pursue academic careers or may lack sufficient female role models. To address this issue, specific programs designed to encourage female students that also prepare them to become faculty members are important. Along these lines, junior women scientists benefit from advice about how to invest their time and how to manage the requests for serving on committees, etc that may negatively impact their early career development (while not addressed in this report, I believe this applies to clinical science faculty as well).

Second, the authors note that women attribute their exit from academia to hostility from colleagues and “a chilly campus climate,” which may be less visible to me. While this may be difficult to measure, I believe it is likely operative at Stanford given the comments made by women in the 2003 Quality of Life Survey carried out by the Provost’s Advisory Committee on the Status of Women. I would hope that we have made some progress in addressing this but I would not, unfortunately, be surprised if it still persisted. Obviously this is something we must address more successfully.

In tandem with the “climate conditions” for women, Handelsman et al note the impact of “unconscious bias.” They cite data showing that evaluators give lower ratings on CV’s, journal articles, etc. if they are told that the person being assessed is a woman than if they are told the person being assessed is a man. Accordingly, it may be important to understand how to overcome such negative bias. This has been effectively done at some institutions and is something we should address at Stanford.

The fourth issue addressed by Handelsman et al is “balancing family and work” which, without question, remains a very significant challenge and for which the burden still falls too disproportionately on women. Here the broader University should assess its current programs and perhaps initiate new ones to further address these work/life balance issues.

As I hope you know, we are committed to making improvements in our programs in diversity and leadership. Our commitment clearly and prominently includes women in science and medicine. Dr. Hannah Valentine, who was recently appointed to serve as the Senior Associate Dean for Diversity and Leadership, has been developing a strategic plan that she and I both hope will provide programs to address issues like those discussed above. I will be sharing those with you in the coming months. But it is clear that our ultimate success requires broad institutional enlightenment and commitment at every level. I view this as extremely important and am counting on our entire community to contribute to these efforts. These are issues that should be important to everyone – and their solution will further enhance the quality of our School and University.

## **Future Physician Workforce**

Over the years there have been a number of studies and reports about physician workforce projections. Most have turned out to be incorrect in one way or another. A somewhat different slant on this topic was presented at the Administrative Board Meeting for the Association of American Medical Colleges that I attended on September 14-15. Specifically, the discussion focused on the question of whether allopathic schools of medicine in the USA should expand by 10-15% to meet projected patient care needs anticipated during the next 10-20 years. These projections assume increased numbers of elderly patients and of individuals with chronic diseases.

At the present time, there are places for about 8000 graduates of non-LCME accredited medical or osteopathic schools in LCME certified graduate medical education programs. Put another way, approximately one-third of residency programs are being filled by students graduating from Caribbean (i.e., “offshore”) schools, which are not reviewed by the LCME or osteopathic schools within the USA (as well as some international schools). Both the offshore and the osteopathic sectors have been increasing in size during the past 10-20 years, while the number of allopathic medical schools has remained relatively static at about 125. The offshore medical schools account for 5% of the graduates entering LCME/ACGME approved residency programs, while the schools of osteopathy account for 11% of the individuals entering residency programs. Neither type of school follows the model of our allopathic medical schools, which are unique, of course, because of the research they perform and the research faculty who comprise them. In fact, most of the schools of osteopathy send their students to allopathic schools or hospitals for their clinical training programs. At the current time, only 64% of the graduates entering LCME/ACGME internship/residency programs come from our LCME accredited allopathic schools. This proportion has been decreasing as the offshore schools in the Caribbean and the schools of osteopathy increase their class size. Of additional note, the fact that the Caribbean and osteopathic schools do not have research programs, and in some cases do not even have significant clinical faculty, means that they are much less expensive to operate – and easier to expand.

So an important question is, if there is a need for additional physicians in the workforce, should they come from our allopathic schools or from other sources? We do know that these students perform far differently on the USMLE exams and that the GPA and MCAT scores of those entering offshore or osteopathic schools are far lower than those admitted to US allopathic medical schools. Indeed, most of the students pursuing offshore or osteopathy schools (between 63-94%) applied to allopathic schools but did not achieve admission. A related question, therefore, is what happens to the graduates from the nation’s Graduate Medical Education programs. Do those individuals who trained in the Caribbean schools or schools of osteopathy compensate for prior weaknesses by doing the graduate medical training in LCME/ACGME programs? And what kind of physicians do they become?

Interestingly, when I asked whether students entering Caribbean or osteopathic schools were more diverse or filled special niches, I learned that neither of these possibilities is the case. In fact, those entering Caribbean schools are less diverse, and the

financial situation is such that they have to have more resources to pay for their education than those entering US allopathic schools.

Further, while it is important to evaluate the workforce needs for physicians, it is also important to assure that, if we (as a nation) expand our class sizes, we really are meeting the important needs of the future. Clearly, these needs will include physicians doing clinical care, but it is not yet clear whether they will turn out to be needs in primary vs specialty care or in rural vs urban settings. In the past, expanding the numbers of graduates of medical schools has not necessarily altered the career paths chosen or the areas of the country where physicians have chosen to practice. Further, in addition to clinicians, we also need to assure that we are developing more physician-scientists for the workforce – an area of critical importance in its own right and of special interest to Stanford.

I share this information with you because I think it raises a number of important questions. Clearly we need more data regarding the outcomes from LCME/ACGME graduate medical training programs, as I mentioned above. But we also need to be clear about what we seek to achieve by expanding our workforce. If we decide to do so, should all schools participate? At this point, the AAMC is requesting that we increase our class size by about 15%. Should we do this at Stanford – and at what cost and with what goals? I am interested in your reactions, thoughts and recommendations.

## **Stanford Medicine Goes to Washington**

On Monday, September 12<sup>th</sup> we hosted our first “Stanford Medicine in Washington” to inform and hopefully excite members of the press and the Congress on the exciting work that is going on at Stanford. Thanks to the efforts of Paul Costello, Executive Director of Communications and Public Affairs, and members of his staff, we put on a one-day symposium focusing on the general theme of Personalized Medicine. It was an excellent program, thanks to our faculty who traveled to Washington just for this session (<http://news-service.stanford.edu/news/2005/september14/med-seminar-091405.html>).

The program we presented was far-ranging and included the Future of Imaging and Molecular Imaging by Dr. Gary Glazer; Innovations in Cardiovascular Medicine by Dr. Charlie Taylor; Novel Approaches to the Diagnosis, Classification and Treatment of Cancer by Drs. Stephanie Jeffrey and Ron Levy; the Importance of Stem Cell Biology and the Discovery of Cancer Stem Cells by Dr. Mike Clarke (who is joining our faculty from the University of Michigan); Important Challenges in Health Care Policy and Ethics by Drs. Laurence Baker and David Magnus. I also gave a presentation on the Current Status of American Healthcare.

In an effort to further engage the press and Congress in positive ways, we are planning a similar visit next year, and we will also host a similar event on the West Coast in the spring. Not only is this type of outreach important in its own right, it should also help us in enhancing our efforts in medical development. Indeed I see a close linkage

between our efforts in communications, government relations and philanthropic activities. I want to thank our Communications and Public Affairs and Government Relations staff members and, of course, our faculty for their important contributions to this and related events.

## Some Comings and Goings

- ***Dr. Karla Kirkegaard.*** I am very pleased to announce that Professor Karla Kirkegaard has been named the new chair of the Department of Microbiology and Immunology. Dr. Kirkegaard succeeds Mark Davis, who became Director of the Stanford Institute for Immunology, Transplantation and Infection earlier this year. Dr. Kirkegaard has been a member of the Stanford faculty since 1996, when she was recruited from the University of Colorado. She did her undergraduate work at UC Berkeley, received her PhD at Harvard and then did postdoctoral training with David Baltimore at MIT. She initially joined the UC-Boulder faculty in 1986 and began her work in the genetics and biology of viruses – especially polio, picornoviruses, coxsackie, and hepatitis C, among others. Some of her laboratory's recent work has emphasized studies of the mechanism of the poliovirus RNA-dependent RNA polymerase and its cooperative interaction with template RNAs, as well as the inhibition of protein secretion and evasion of the cellular immune response by nonenveloped RNA viruses. Dr Kirkegaard has also been Associate Chair of the Department since 2004 and has made numerous contributions to science, training, and the School. I am very pleased that Karla has agreed to serve as chair of Microbiology and Immunology.
- ***Dr. John Boothroyd.*** I want to thank Professor Boothroyd for the wonderful job he did as Senior Associate Dean for Research and Training during the past three years. His leadership and engagement in the important transitions taking place in the School of Medicine, including the establishment of our new Stanford Institutes of Medicine and a range of interdisciplinary research and education programs, have been notable. I am deeply appreciative of all of his efforts. Indeed John has served the School in a number of leadership positions during the past decade and understandably, at this juncture, has decided to refocus his efforts on his laboratory research and teaching. As a member of the department of Microbiology and Immunology, he will direct his energies to the study of the biology and genetics of *Toxoplasma*, an area where he has already achieved international acclaim. We will miss John and his very effective leadership, and I want to thank him again for all that he has done to support the School – and for all that he will do in the future as a prominent faculty member. Thanks, John.

## Events

- Stanford University Medical Center’s Community Lecture Series presents “Ears to You!” at 7 p.m. on Wednesday, October 5<sup>th</sup> in the Clark Center Auditorium. Dr. Robert Jackler, Sewall Professor and Chair of the Department of Otolaryngology – Head & Neck Surgery, will discuss how advances in bioscience and technology promises to conquer hearing loss. For more information, call 650-234-0647.
- “National Health Cares About Domestic Violence Day” will be held on Wednesday, October 12<sup>th</sup>. On that day Stanford’s OB/GYN department will have displays representing different departments set up outside the hospital cafeteria. Healthcare professionals will be present, as well as educational materials and resources for the public, including a scenario CD for MDs on how to quickly and efficiently screen for domestic violence in a clinic setting, and a sample screening protocol.