

## **Dean's Newsletter**

### **April 7, 2008**

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#### **Maintaining Relationships**

On March 24<sup>th</sup> it was announced that Dr. Bryan Bohman has been elected Chief of Staff (COS) at Stanford Hospital & Clinics (SHC). Dr. Bohman received 53% of the 795 votes that were cast. For reference, all physician members of the medical staff, which includes faculty and community physicians, were eligible to vote. Excluding PhD and pediatric faculty, I estimate that approximately 680 faculty (including clinician-educators) were eligible to vote. Faculty comprise around half of the credentialed medical staff, although they care for approximately 75% of the patients admitted to SHC.

I offer my personal congratulations to Dr. Bohman and will certainly do all that I can to assist him in this important role and responsibility. For those who do not know him, Dr. Bohman is a community anesthesiologist; most recently he has served as the President of the Medical Staff. He played an important role in the revision of the SHC By-Laws that resulted in making the COS an elected rather than an appointed position (as has been the case until now) and in expanding the responsibilities of the COS, including appointment to the SHC Board of Directors.

While I am optimistic about the future, I do wish to share a concern. During the two week election period, there was considerable campaigning – which is good, since it heightened interest in the role of the medical staff. However, there were also a number of communications that tended to draw some sharp lines between the community and faculty physicians and that, to a degree, seemed to convey that the community doctors needed to unite to secure their leadership at SHC. I applaud the commitment of our community colleagues to SHC, but I am always distressed when communications become polarizing, as they sometime appeared to do in this election. Naturally we are all aware that elections can bring out the worst as well as the best among candidates and others involved in the process.

*Final Draft*

Of course I also recognize that there are considerable concerns about the future of SHC as it proceeds to a major renewal and rebuilding of its facilities in the years ahead. But I would hope that we would not devolve into the type of divided “town-gown” or community-faculty polarization that, unfortunately, has occurred at some points in the past. Accordingly, I call on each of us to do all that we can to maintain – and indeed improve – our relationships and interactions. With the state of health care as it is, and the many economic and professional challenges that stand before us, it is imperative that we work collaboratively and successfully on behalf of our patients, community, hospital and university.

In addition to the election of Dr. Bohman for the Chief of Staff, Dr. Geoff Rubin has been elected Vice Chief of Staff. He received 65% of the votes in a run-off election that concluded late last week. Under the terms of the revised By-Laws, the Vice Chief becomes the Chief of Staff in two years. Congratulations to Dr. Rubin. Now it is time to move on – with the goal of focusing on the goals of the entire medical center.

### **Laptops and Privacy**

Laptop thefts are a risk to research subjects as well as patients. Todd Ferris, Associate CIO – IT Services, has prepared the following information on what needs to be done to combat this distressing trend.

Recently the NIH made a public announcement that a laptop theft exposed research subject information. The laptop was locked in a car trunk and was password protected; nevertheless, it was stolen and the research subjects' information is considered compromised. (Full NIH press release can be found at:

<http://public.nhlbi.nih.gov/newsroom/home/GetPressRelease.aspx?id=2559>)

Unfortunately, this is just the latest high-profile laptop theft that has exposed sensitive information on patients, research subjects, or employees.

It is estimated that over 600,000 laptop computers are lost or stolen each year in the U.S. As more people use laptops as their primary, and often sole, computing device the risk of data loss and theft will increase. Never leave your laptop unattended in a coffee shop, airport bathroom, on a speaker's podium or in other public places. Laptops left in automobiles, even in the trunk, are particularly vulnerable. Laptops should be carried as hand luggage when traveling.

Backups of the data on your laptop are extremely important. Laptops have a higher likelihood of data loss, either due to rough handling or theft. Without a backup, your important data can be lost forever.

Even when we try our best to protect our laptops, some will be stolen. While the likelihood that a thief will want the information on your laptop is very low, the reality is that California law requires us to notify research subjects and patients if their medical information was on a device that was stolen (regardless of the likelihood of the

information being accessed) unless the information is encrypted. If identifiable patient or research subject health information is stored on a laptop or any other removable media (e.g., USB drive, CD, portable hard drive), that information must be encrypted. (Stanford University policy:

[https://www.stanford.edu/dept/hipaa/policy\\_university/security/comput\\_estorage\\_device.html](https://www.stanford.edu/dept/hipaa/policy_university/security/comput_estorage_device.html)).

There is no single encryption method available that works for all situations on all laptops. There are many solutions available, from encrypting a single file to encrypting your whole hard drive. The School of Medicine has some recommendations for encryption at <http://med.stanford.edu/irt/security/protecting/laptops.html>

You can also find more general information about mobile computer security at [http://www.stanford.edu/group/security/securecomputing/mobile\\_devices.html](http://www.stanford.edu/group/security/securecomputing/mobile_devices.html)

Additionally, you can find detailed technical guidelines on encryption

at: [https://www.stanford.edu/dept/hipaa/policy\\_university/security/sg\\_encryption.html](https://www.stanford.edu/dept/hipaa/policy_university/security/sg_encryption.html)

Contact your local IT support person to help you choose and implement the encryption solution that best fits your needs. You can also contact the School of Medicine Service Desk at 725-8000. In the event of a lost or stolen laptop, contact the School of Medicine Privacy Officer at 725-1825.

## **Global Medicine**

The March 31-April 1<sup>st</sup> Association of Academic Health Centers (AAHC) annual meeting addressed "Building Academic Health Center Infrastructure Worldwide." I am a member of the AAHC Board of Directors, and I also participated on a panel on global research issues at this meeting. There is a wide range of activities being pursued by US Academic Medical Centers related to global health that are guided by quite different goals and incentives. They range from faculty-initiated collaborations in research and education to more organized institutional collaborations with one or more countries or international hospitals or medical schools. In some cases they involve management of clinical or other services and in a few instances include degree programs such as those administered by Weil-Cornell Medical School in Qatar and Duke Medical School's recently initiated MD degree program in Singapore.

Some US institutions appear to be motivated by a sense of mission to engage with the global community to extend their reputation and expertise. Others are motivated by the prospect of financial returns from international patients receiving services at their center or from profits emerging from clinical services provided abroad. At the same time, leaders from other nations look to the US to model the development of more integrated academic medical centers with the goal of better integrating research and education with patient care.

Important perspectives were shared not only about the programs established by affiliation with US Academic Medical Centers (US AMC) but also about the organization and challenges around academic medicine and health care in the United Kingdom, Israel,

China, Singapore, and Italy. Failures, as well as successes, were presented, and I concluded that, analogous to the mantra that “if you have seen one academic medical center, you have seen one academic medical center,” the same can be said for international programs and collaborations with US academic medical centers.

The meeting did help to affirm some conclusions I have previously drawn. Foremost among them, while appreciating the objectives of medical centers in running clinical services in various nations, I do not see this activity as consonant or even compatible with our mission at Stanford. Further, while the degree programs between Cornell and Qatar and Duke and Singapore are interesting, I do not see this as a path we should travel. Rather, it seems more prudent to stay focused on what we do well – training leaders in the biosciences and medicine and enhancing our commitment to discovery and innovation. Developing partnerships in these areas, as we have done with the India-Stanford BioDesign Program and with our education collaboration with Shantou Medical School in China, seems a more sensible route to travel. In addition, as we continue to develop our global health program at Stanford, it seems wiser to do so in collaboration with the rest of the university rather than simply as a medical school or academic health center. Understandably, our agenda at Stanford will be further shaped when we recruit the leader of the Global Health Program – the search to fill this position is now underway.

As is often true, I was intrigued by the way health care has or is evolving in other nations and how some assumptions or perceptions run counter to reality. There is no doubt that we can learn much from other nations' experiences, and I doubt we will really be able to speak about global health until the exchange of information and experience is really bi-directional. In fact, I was intrigued that much of the discussions at the AAHC meeting focused on the knowledge US AMCs could export or the clinical revenue they might import. From my point of view this is too unidirectional. We should also be preparing for the prospect that other nations may seek to export their knowledge and programs to the US or that clinical programs and care will move from the US to other nations – as is already beginning to happen. While we have much to offer in biomedical research, we might also learn a lot from other nations about the delivery of health care and even the education of doctors. In doing so we would really be promoting global medicine.

## **The Medical Workforce**

I have addressed some of the issues surrounding the Physician Workforce dilemma in past issues of the Dean's Newsletter. Specifically, during the past year the Association of American Medical Colleges (AAMC) (see: <http://www.aamc.org/workforce/start.htm>) has proposed addressing the projected shortfall of physicians (which for primary care physicians could be 85,000 or more by 2020) by increasing the size of medical school classes by 30% and by supporting the establishment of several new medical schools. In fact, both of these recommendations are underway, although I am not convinced that either will truly solve the problem. The reality is that there is a shortage of primary care physicians (as well as certain specialty

physicians), and the data emerging from the National Residency Match Program (including that of two weeks ago) continue to demonstrate that fewer graduating medical students are seeking careers in primary care.

A number of factors contribute to this trend, among which is the relative low compensation for primary care physicians in comparison to that achieved by medical and surgical specialists. Lifestyle issues also contribute to student choice of career pathways. Our medical workforce in the USA is increasingly becoming one dominated by specialists. While this has relevance to the management of patients with complex chronic disorders, it still leaves unsolved the availability of well-trained primary care physicians who can coordinate medical care and provide a “medical home” for patients. Indeed many of you are aware of the difficulty in finding a primary care physician in the Bay Area – a problem heightened by the increasing number of general internists as well as other practitioners who are opting for smaller, concierge practices.

Because we have not mandated – nor likely will we want to do so – the career choice of graduating medical students, I find it hard to imagine that the workforce issues will be solved successfully simply by graduating more medical students. It seems probable that medical school graduates will continue to choose career paths based on the perceptions and experiences that emerged while they were medical students. Even if a student entered medical school with the goal or expectation of becoming a primary care physician, it seems likely that she or he will chose a specialty over primary care by graduation, unless the compensation, lifestyle and career satisfaction of a primary care physician is improved and enhanced. This is addressed, in part, in a recent editorial in JAMA (2008; 299:1595-1597) by Baron, RJ and Cassel, CK entitled “*21<sup>st</sup> Century Primary Care: New Physician Roles Need New Payment Models.*” Clearly this issue needs serious attention.

Further, it seems narrow minded to address the healthcare workforce issue by focusing solely on producing more doctors. This is not to question that there are likely to be real shortages of physicians in the future. My concern, as already noted, is that simply increasing the number of doctors will not, by itself, solve either the nation's projected workforce needs or the geographic distribution of doctors. Expectations about the numbers of MDs, compared to other practitioners, will also be influenced by whatever changes occur in health care reform in the years ahead. They may also be impacted by the evolving goals and expectations of other health care professionals.

For example it is of interest that the Council of Advancement of Comprehensive Care (CACC) is promoting a new degree path for nurses called the Doctor of Nursing Practice. Indeed, on April 4<sup>th</sup> “the CACC and the National Board of Medical Examiners (NBME) today announced that they have reached an agreement to develop and administer a Certification Examination for Doctors of Nursing Practice (DNP). This competency-based examination, which will be administered to DNP graduates for the first time in November 2008, will assess the knowledge and skills necessary to support advanced clinical practice. It will be comparable in content, similar in format and will measure the same set of competencies and apply similar performance standards as Step 3

of the United States Medical Licensing Examination (USMLE), which is administered to physicians as one component of qualifying for licensure” (see: <http://www.pr-inside.com/print517127.htm>). While it is likely that many on the MD side of equation will argue against this additional expansion of the role of nursing, I do not see that position as reasonable assuming that the competencies for general primary care are fully embraced and individuals possessing the DNP degree truly fill the critical void now left in primary care.

Unfortunately, these changes, like those that have occurred in recent years and others likely to follow, are responses to the pervasive market-driven health care system that has evolved in the US. As such they do not necessarily represent what is best from an overall health care perspective - but rather what is achievable. I would hope, of course, that the organization of our health care might be framed more responsively and responsibly and less reactively. But I recognize that is unlikely – but some more thoughtful incremental change might occur when our nation’s health care debate becomes more focused, bi-partisan and more results oriented.

### **Reflections on Stem Cell Research in California and at Stanford**

On April 3-4<sup>th</sup> Dr. Irv Weissman, Ludwig Professor and Director of the Stanford Institute on Stem Biology, and I participated in the East West Alliance meeting held in Cambridge (UK). The East West Alliance brings together a number of centers and nations who have received support from the Li Ka Shing Foundation and is focused on four major areas: cancer, stem cell, infection and immunity, and aging. The Alliance includes the University of Cambridge, University of California at Berkeley, University of Toronto, University of Manitoba, the University of Hong Kong, the Chinese University of Hong Kong, Institut Pasteur, Shantou University and Stanford.

This year’s Alliance meeting was focused on stem cells and imaging. As you know, support for embryonic stem cell research has been a topic of debate and discussion in the US, where federal support remains restricted, in contrast to the more positive promotion of stem cell research that has occurred in the UK and in Asia. This prompted me to review the situation in California, as well as at Stanford, where Proposition 71 and the California Institute for Regenerative Medicine (CIRM) have played a significant role in stimulating and supporting stem cell research. I gave a report on this topic at the East West Alliance meeting.

As you will recall, the CIRM was established in November 2004, when nearly 60% of the California electorate voted for the bond that would provide \$3 billion for stem cell research in California universities, research institutes and biotechnology companies. I have had the privilege of serving as one of the 29 members of the Independent Citizen’s Oversight Committee (ICOC), the governing body that oversees the CIRM. During the past 41 months, the ICOC has put together the infrastructure as well as policies and procedures for CIRM activities. Their activities have included establishing external scientific review groups and task forces and workgroups that have defined short and long-term strategic initiatives as well as grants and other support for education and training, innovation, and basic and translational disease-based research.

Unfortunately, lawsuits challenging the constitutional authority of Proposition 71 limited use of the bonds until mid- 2007, although limited funding commenced in 2006 thanks to “bond advancement notes.” Since then, CIRM has been moving forward steadily, and it now has the potential to enable California to be a word leader in stem cell research. To date CIRM has awarded support for training grants, seed (innovation) grants, comprehensive institutional grants, stem cell techniques, shared resources and new faculty scholars. Importantly, announced new program support includes funding for the development of new cell lines, development of tools and techniques, planning for disease teams, additional new investigator support and, importantly, grants for major facilities. Indeed, Stanford looks forward to learning in May the results of its application for a major facility award.

Given the late start in funding due to the litigation, the CIRM has made great strides to date, with \$259,724,943 having been awarded to 22 institutions for 156 grants. Stanford faculty has been particularly successful to date, having received 15.9% of the total dollars and 15.3% of the grants. Of course, the funding is only a reflection of the more important metric – the quality and significance of the research and the development of future leaders in bioscience and translational research.

In addition, we learned on April 5<sup>th</sup> that the Major Facilities Group announced the recommendations that will be made to the ICOC for the 12 applicants for major facility grants. Stanford has come out at the top of the list with a recommended funding of \$47.5 million. This is of course wonderful news, although the decision will not be finalized until the May ICOC meeting. It is important to acknowledge the considerable efforts of the many faculty and staff who worked on this application – and I will be more explicit about thanking them once the final decisions are made in May. But for now this is great news.

### **Updated SMP Shuttle Schedule**

Now that the administrative staff at Stanford Menlo Park has settled into their new offices, some changes have been made to the shuttle; the new schedule is on the website home page at <http://med.stanford.edu/smp/>. Please take this opportunity to visit the new offices.

### **Upcoming Events**

#### **April Centennial Events**

As our Centennial observance continues, we're looking forward to our all-school party on Wednesday, April 23, 11:30 a.m. -1:30 p.m. All faculty, students and staff are encouraged to come to the Dean's Lawn (Campus Drive and Roth Way) for a barbecue lunch. In addition to tasty food, there will be a ragtime band adding a “Centennial touch” to the day.

In addition, as mentioned in the last Newsletter, we will be collecting items for a time capsule to be opened in 100 years. Attendees are encouraged to bring a

contemporary item that reflects the "spirit of the present" for the capsule that will be opened in the year 2108. Items for the time capsule don't have to be related to the medical school but can simply represent the spirit of our times. Some suggestions include: a Stanford ID badge, a personal statement of "Life at Stanford in 2008," predictions for 2108, photographs or CDs, electronics (such as memory sticks), course catalogues or periodicals. Items may not be perishable or contain liquid and must be no bigger than a cubic foot. Items will be collected and displayed on a table at the lunch. There will also be guest books available to sign with written memories or predictions for 2018. You are also encouraged to submit your predictions and memories to the Centennial Web site at <http://med.stanford.edu/centennial/guestbook.html>.

Since we want everyone to come to this special event, there will be shuttle service available to and from each off-site location. For more details on the lunch, shuttle service and other Centennial events, see the Centennial Web site at <http://med.stanford.edu/centennial/events.html>.

During the same week the Basic Mechanisms in Immunity and Infection Symposium, another Centennial event, will take place on April 24-25 in the Clark Auditorium. Additional information is listed in the "Upcoming Events" of this Newsletter.

Finally, our Centennial web site has just been updated with new highlights including a focus on minorities in medicine, including information about Stanford programs that foster growth in this area. In addition there is an interesting look at medical instruments over the years and a look at Match Day 2008, the immediate future for our graduating seniors.

**Basic Mechanisms in Immunity and Infection Symposium**  
**April 24-25, 2008**  
**Clark Auditorium**

The Basic Mechanisms in Immunity and Infection Symposium will highlight several major advances in our understanding of the genes and gene products that comprise the immune system and its normal response to foreign invaders as well as its aberrant response in auto immune diseases. There will be four sections covering Innate Immunity: Cellular Immunity mediated by T cells and B cells; the molecules determining immune cell trafficking in the organism; and the events that lead on the one hand to complete tolerance to self proteins, and on the other hand, to evasion of these tolerance mechanisms resulting in auto immunity. In addition to Stanford faculty, the list of speakers includes Drs. Lalita Ramakrishnan from the University of Washington, Jean-Pierre Casanova from the University of Paris, Andrew Chan of Genentech, Harold von Boehmer from Harvard, Diane Griffin from Johns Hopkins and Hidde Ploegh from MIT. For additional information about the Symposium, contact Michele King at [michele.king@stanford.edu](mailto:michele.king@stanford.edu); phone: (650) 498-3084.



## **Awards and Honors**

- **Jonathan Pollack, MD, PhD**, Associate Professor of Pathology is one of thirteen recipients of a 2008 Clinical Scientist Award in Translational Research of the Burroughs Wellcome Fund. Congratulations to Dr. Pollack.
- **Ron Alfa**, first year medical student, has been selected as the 2008 nominee by the Osler Medal Committee of the AAHM. He has been awarded the Osler Medal for his essay "Redefining Inert: The Birth of the Placebo in American Medicine." Congratulations, Ron.