

Dean's Newsletter September 8, 2008

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Transitions in Neuroscience Leadership at Stanford

Following the delineation in early 2002 of the School of Medicine's Strategic Plan, *Translating Discoveries*, we launched the Stanford Institutes of Medicine. The Stanford Institute for Stem Cell Biology and Regenerative Medicine, established in December 2002, was the first, followed in 2003 by the Neurosciences Institute at Stanford (NIS). These were followed in turn by the Stanford Cardiovascular Institute; the Institute for Immunity, Transplantation and Infection; and the Stanford Cancer Center, which became an NCI-designated Center in 2006.

I want to update you now on some programmatic and personnel transitions in our neuroscience leadership and initiatives. First, I want to thank Dr. Bill Mobley, the John E. Cahill Family Professor of Neurology and, by courtesy, of Neurosurgery, for his leadership as the first director of the NIS over the past five years. Dr. Mobley played an important role in bringing the neuroscience community together both within the medical school and across the university. Dr. Mobley's leadership resulted in a number of seed grants for innovative research and education, the development of new programs and centers, the recruitment of outstanding faculty (including most recently Dr. Tom Sudoff as the first Avrum Goldstein Professor), the opening of the new neuroscience research facility at the Arastradero Stanford Institutes of Medicine site, and, of course, the annual neuroscience retreats. I want to thank Dr. Mobley for his dedicated and important efforts as the founding NIS director.

I am also pleased to announce that Gary Steinberg, MD, PhD, the Bernard and Ronni Lacroute-William Randolph Hearst Professor in Neurosurgery and Neurosciences and Professor, by courtesy, of Neurology & Neurological Sciences, will assume the leadership of the Stanford Institute for Neuroinnovation and Translational Neurosciences (SINTN), which is an evolution of the NIS. Given Dr. Steinberg's remarkable accomplishments in building the Department of Neurosurgery over the past decade as well as his success as a leading investigator and outstanding (and highly active) clinical neurosurgeon, we are most fortunate to have him in this role. Dr. Steinberg will

spearhead a number of new initiatives – especially a new program in neuroregeneration as well as a collaborative effort that could form a Center for Neuroprostheses at Stanford. Please join me in welcoming Dr. Steinberg to this important new role.

I am also pleased to announce that Ben Barres, MD, PhD, Professor of Neurobiology and of Developmental Biology and of Neurology and Neurological Sciences, became the chair of the Department of Neurobiology on September 1st. Dr. Barres is not only an outstanding neuroscientist but also a leader in education (he founded the Masters in Medicine Program at Stanford) and a highly regarded teacher. In addition, he is an important advocate for women in science and medicine and an articulate spokesperson for science policy. I am pleased that Dr. Barres will be joining our leadership team and look forward to his broad participation in neuroscience as well as his engagement in addressing the challenges facing the school of medicine and the university. Dr. Barres succeeds Dr. Bill Newsome, Professor of Neurobiology and Member of the Howard Hughes Medical Institute, who has stepped down as department chair to lead a new BioX initiative called Neuroventures.

We are fortunate to have remarkable leaders in neuroscience at Stanford– and even more fortunate to have faculty and students across the university who are committed to this discipline. Without question neuroscience is one of the most important and exciting areas of investigation today, and Stanford is widely viewed as one of the national centers of excellence. With these new leaders and programs in place, I hope that our neuroscience community will achieve even greater things in the years ahead and that these new programs make the “sum much greater than the sum of all the parts” already resident at Stanford.

Stanford Medicine as a Case Study

As part of a series on the changing face of academic medicine, I was asked to write an article for **Academic Medicine** on *The Stanford University School of Medicine and Its Teaching Hospitals*. This was published in the September 2008 issue (Volume 83; pages 867-872). While this article is a personal reflection of the changes that have occurred at Stanford during my tenure as dean, it contains observations that may be of interest to you. In this article I review the history of Stanford Medicine, focusing particularly on the changes that have taken place in the past 50 years and also on the impact of major transformative events, including the merger and demerger with UCSF. I also address the challenges we face today and how we have approached them based on *Translating Discoveries*, the strategic plan I put into place shortly after my arrival in 2001. I further address the challenges we currently face and those that will assume prominence in the years ahead. The abstract of the article follows and provides a brief glimpse of some of the issues that are addressed.

There is wide variation in the governance and organization of Academic Health Centers (AHCs), often prompted by or associated with changes in leadership. Changes at AHCs are influenced by institutional priorities, economic factors, competing needs, and the personality and performance of leaders. No organizational model has uniform applicability, and it is important for each AHC

to learn what works or does not on the basis of its experiences. This case study of the Stanford University School of Medicine and its teaching hospitals—which constitute Stanford’s AHC, the Stanford University Medical Center—reflects responses to the consequences of a failed merger of the teaching hospitals and related clinical enterprises with those of the University of California-San Francisco School of Medicine that required a new definition of institutional priorities and directions. These were shaped by a strategic plan that helped define goals and objectives in education, research, patient care, and the necessary financial and administrative underpinnings needed. A governance model was created that made the medical school and its two major affiliated teaching hospitals partners; this arrangement requires collaboration and coordination that is highly dependent on the shared objectives of the institutional leaders involved. The case study provides the background factors and issues that led to these changes, how they were envisioned and implemented, the current status and challenges, and some lessons learned. Although the current model is working, future changes may be needed to respond to internal and external forces and changes in leadership.

I also include here the final section of the article, “Lessons Learned” – again, this is a set of personal reflections based on the experiences we have had at Stanford during recent years that others may find useful. These are less about lessons and more about key observations and requirements for assuring success – again, largely based on my personal assessment.

- *Because AHCs are often highly matrixed by interdependent interactions relationships between academic and clinical programs, they are also fragile and can be adversely affected when one mission gets off track or dominates the enterprise in an unhealthy way. This was true at Stanford when the merger with UCSF created distractions, financial losses, and distrust between the faculty in basic and clinical departments and between the AHC and university. To overcome these challenges, a transparent and thoughtfully articulated plan was essential.*
- *Overcoming a major disruption such as a failed merger requires a redefinition of the mission, goals, and objectives of both the medical school and the AHC. It requires buy-in from multiple constituencies including the basic and clinical science faculty, students, and staff. It also requires healing among communities that had felt disenfranchised or even abandoned by an institutional direction they did not understand or support.*
- *Communication is a key component of institutional transformation, along with clearly delineated plans that are modified and adjusted to accommodate to the various institutional constituencies and their not infrequently differing perspectives. This requires communication from the leadership that is transparent, engaging, informative and continuous.*

- *Institutional progress requires plans and objectives that are not only transparent but also achieved. Institutional ownership of the planning process and its deliverables is essential and should not be delegated to outside consultants or individuals who are not responsible and accountable.*
- *Transformational planning is a constant process with frequent ebbs and tides. Because of the diversity of talents, interests, and commitments at an AHC, it cannot be expected or anticipated that unanimity of opinion or support will be achieved. Difficult choices need to be made, priorities set, and accountability recognized. That said, progress is more possible when the institutional planning is adjusted to fit the culture, history, and values of the institution.*
- *Most AHCs have to make choices about their areas of focus and institutional priorities, because few are large enough to do everything. When there are internal or external constraints, forward planning is essential. Even if the plans are not fully achieved, they provide a foundation for future adaptation and modulation. During the past several years, the school's strategic plan, *Translating Discoveries*, has served as an anchor by which to align missions in education, research, and patient care.*
- *Understanding the inherent strengths and distinguishing features of an institution is also essential to successful planning. When Stanford's medical school began separating its functions and missions from its parent university, it lost the trust of the university faculty and became perceived as a liability rather than an asset. Efforts to better integrate the medical school with the missions of the university (through the BioX program, the department of bioengineering, and the Institutes of Medicine) have helped to overcome some of the misperceptions and have led to positive interactions that appeal broadly to university leaders and the community.*
- *Leadership models at AHCs are highly varied, and none are necessarily sustainable over time. Stanford's separate leadership of its medical school and two major teaching hospitals provides both strengths and weaknesses. Whereas the overall mission has been served because of the positive interactions of current leaders, this model is not necessarily sustainable, and it could be compromised by resource constraints that pit one mission against another or by changes in the individuals that alter the dynamics or trust of institutional leaders.*
- *Having the trust and authority of the university president, provost, and board of trustees is essential, especially when major changes are contemplated or being implemented. But, this trust is also subject to change and, thus, must be constantly reinforced by evidence of progress. Objective external evaluation of this project on a regular basis serves to validate the plans and the leadership. But it must be recognized that such external reviews can also result in changes in institutional direction or leadership as well – and, thus, this must be anticipated.*

- *AHCs are likely to be especially challenged in the next decade, ironically because of the destabilization likely to occur from some of the forces they brought them into their current structure and function. For example, with the anticipated changes in Medicare and the reduced support of biomedical research from the NIH, the historically highly leveraged success of AHCs will be increasingly compromised. Likely, new models will need to be developed to sustain core missions in research and education as well as patient care. These external forces make ongoing institutional planning essential; without such efforts, inadvertent damage can easily occur. As mentioned above, despite their formidable strengths, AHCs are also fragile, and without planning and leadership, they can lose their focus, and potentially, their preeminence.*

If you have time to read the entire article, I would be appreciative. More importantly, if you have comments or your own reflections to offer, I would welcome them.

Children's Health Initiative Reviewed

Pediatrics and child health have undergone dramatic changes at Stanford and at the Lucile Packard Children's Hospital (LPCH) during the past decade. The major stimulus for the broad initiatives that have catapulted LPCH and Stanford pediatrics into ever-increasing prominence can be directly correlated with both the Children's Health Initiative (CHI) and the collaborations and interactions of the School of Medicine, LPCH and the Lucile Packard Foundation for Children's Health (LPFCH). Thanks to a nucleus grant from the David and Lucile Packard Foundation, along with the availability of matching funds for gifts raised by the LPFCH, more than \$500 million in endowment and expendable funds have been raised, making the CHI a unique resource for the success of LPCH and Stanford. The initial phase of CHI focused on the development of "centers of clinical excellence" at LPCH, along with the development of the infrastructure to support clinical research and the development of the medical and surgical specialties needed to enhance outstanding clinical care and help sustain the future of the clinical and academic programs in pediatrics and, more broadly, child health.

A key decision made when CHI was being initiated was to integrate pediatrics and the CHI with the broader initiatives of the medical school and university. Unlike other prominent children's hospitals that have created their own separate research initiatives and facilities, we felt that Stanford and LPCH would be better served by aligning their goals and creating a synergy between pediatric medical and surgical faculty with colleagues across the basic and clinical sciences in the School of Medicine and the broader community of the University. This strategy is clearly paying off.

The Clinical Centers of Excellence at LPCH have been aligned to the programmatic initiatives of the Stanford Institutes of Medicine, resulting in a bidirectional flow of knowledge generation and education. The resources generated by CHI has enabled the recruitment of outstanding pediatric leaders to direct LPCH Centers of Excellence who work in close partnership with Stanford Institute of Medicine Directors, as shown in the following table:

<i>The Children's Health Initiative</i>		<i>The Stanford Institutes of Medicine</i>	
Center of Excellence	Directors	Stanford Institutes of Medicine	Directors
<i>Children's Heart Center</i>	<i>Drs. Frank Hanley & Dan Bernstein</i>	<i>Cardiovascular Institute</i>	<i>Dr. Bobby Robbins</i>
<i>Transplant and Tissue Engineering Center</i>	<i>Drs. Ken Cox and Mike Longaker</i>	<i>Institute for Stem Cell Biology and Regenerative Medicine</i> <i>Institute for Immunity/Transplantation and Infection</i>	<i>Drs. Irv Weismann, Mike Clarke and Mike Longaker</i> <i>Drs. Mark Davis and Carlos Esquivel</i>
<i>Cancer and Blood Disease Center</i>	<i>Drs. Mike Link, Mike Cleary and Ken Weinberg</i>	<i>Stanford Cancer Center</i>	<i>Dr. Bev Mitchell</i>
<i>Brain & Behavior Center</i>	<i>Drs. Robert Fisher and Mike Edwards</i>	<i>Institute for Neuro-innovation & Translational Neuroscience</i>	<i>Dr. Gary Steinberg</i>
<i>Center in Pulmonary Biology</i>	<i>Dr. David Cornfield</i>	<i>Wall Center</i>	<i>Drs. Jeff Feinstein, Marlene Rabinovitch</i>
<i>Clinical Research Core</i>	<i>Drs. Christy Sandborg and Steve Alexander</i>	<i>SPCTRM and CTSA</i>	<i>Drs. Harry Greenberg and Steve Alexander</i>
<i>Center for Bio-Informatics</i>	<i>Dr. Atul Butte</i>	<i>Center for Clinical Informatics & Center for Biomedical Informatics</i>	<i>Drs. Henry Lowe, Russ Altman, Mark Musen</i>
<i>Center for Policy, Outcomes and Prevention</i>	<i>Drs. Paul Wise and Tom Robinson</i>	<i>Center for Primary Care and Outcomes Research</i> <i>Stanford Prevention Research Center</i>	<i>Dr. Alan Garber</i> <i>Dr. Steve Fortmann</i>
<i>Johnson Center for Pregnancy & Newborn Services</i>	<i>Drs. Druzin, Benitz and Stevenson</i>	<i>Programs in Developmental Biology, Genetics, Epidemiology</i>	

These alignments have helped forge important collaborations among numerous faculty and students across the school and university that have enhanced pediatric and child health research. The progress being made in these areas was reviewed by the Pediatric Medical Advisory Committee (PMAC) on September 4-5th as part of their ongoing evaluation process. The PMAC includes Dr. Tom Boat, who serves as chair of the PMAC

and who is currently Executive Associate Dean for the University of Cincinnati College of Medicine and immediate past director of the Children's Hospital Research Foundation and Chair of Pediatrics at the Children's Hospital Medical Center of Cincinnati. Dr. Boat is also a member of the School of Medicine's National Advisory Council. Other PMAC members included Dr. Doug Jones, Professor of Pediatrics at the University of Colorado, where he also served as chair of Pediatrics from 1990-2005; Dr. Ora Pescovitz, President and CEO of Riley Hospital for Children where she is also Executive Associate Dean for Research Affairs at Indiana University School of Medicine; and Dr. George Gittes, Professor of Surgery at the University of Pittsburgh. The PMAC heard updates and presentations from each of the Center and Program leaders as well as the leadership of LPCH, LPFCH and the Medical School. I gave a presentation as well as participated in some of the discussions.

While we will need to wait to get the formal report from the PMAC, I think it is safe to say that the progress that has been made through the CHI is quite impressive. Indeed, when we recently carried out the search for the chair of Pediatrics, I heard from virtually every finalist candidate that LPCH and Stanford are viewed as having one of the most dynamic and rapidly rising programs of excellence in the nation. I am sure that is what helped us to recruit an excellent chair in Dr. Hugh O'Brodovich as well as the many faculty leaders who have joined Stanford and LPCH during the past 7-8 years.

That said, it is clear that there are important challenges and opportunities to be met. While we have achieved excellence in a number (but not yet all) of the major clinical programs, there are real needs in bolstering the research faculty, recruiting junior physician-scientists and in re-developing the training programs for residents and fellows. Thankfully there is again concurrence among the leaders of LPCH and the School about these initiatives, and we are committed to increasing our academic research programs by 50% and also to recruiting and developing the future leaders in child health research and science. These efforts will be enhanced and facilitated by the development of a Child Health Research Institute that will build on the CHI and take it to another level. Work on this project is being led by Dr. O'Brodovich and will be discussed in future Newsletters.

For now I think it is clear that we can look back on the last decade of Stanford/Packard Pediatrics with pride. But we must also look forward to taking the CHI to a new level by further developing its academic performance and success. Thankfully the leaders and institutional commitments to do so are in place and eager to move forward.

Comparative and Real Success in Medical Development

At the Executive Committee on Friday, September 5th, Doug Stewart, Associate Vice President and Director of the Office of Medical Development (OMD) gave an update on our accomplishments during the past fiscal year (which ended on August 31st) and put our medical development success in a broader context by comparing our results to those of other institutions around the nation.

The good news is that the School of Medicine had another banner year in private fundraising support. Indeed, it was our second-best year ever, with new gifts and pledges totaling \$220.9 million. Our record of \$246.4 million was set last year. Doug observed that our achievements this past fiscal year are particularly noteworthy given the economic slowdown – but I would note that the impact of the slowdown may be felt more strongly in this next and immediate future years. I would also add for context that it was only a few years ago that the School of Medicine routinely saw new gifts and pledges of approximately \$100 million per year. In truth our OMD was not operating very effectively at that time, and I believe we are also now witnessing the results of our investment in leadership in medical development and the recruitment of a development staff, the configuration of the needed infrastructure supports and, of course, the committed efforts of many of our faculty and our wonderful campaign volunteers.

Doug also reviewed the remarkable progress we have made on the School's two current major capital projects: the Li Ka Shing Center for Learning and Knowledge (LKSC) and the Stanford Institutes of Medicine 1 (SIM1). I have personally spent a great deal of time and effort on each of these projects, and I am gratified that we can see the light at the end of the tunnel on both. Doug reported that we now have gifts and pledges totaling \$49.4 million for the LKSC (compared with only \$12 million a year ago). This brings us nearly to our original fundraising goal of \$50 million, and, equally importantly, we now are confident we will reach our expanded goal of \$57 million. Given the perceived difficulties of raising gifts for an education facility, achieving this level of success is particularly gratifying – and gives evidence that we can succeed when we have bold and important ideas to present to the community – as is clearly the case for the LKSC.

The SIM1 fundraising progress has been equally impressive. One year ago we had gifts and pledges totaling \$63.5 million toward our original goal of \$100 million. However, when the cost of the building was actually defined we needed to expand that goal to \$130 million. Today we count \$113.1 million toward that expanded goal and are confident that we will achieve at least \$125 million of it by years end. By the way, this does not include the \$43.5 million facilities grant award we have received from the California Institute of Regenerative Medicine. I also hasten to add that we will be soon announcing the naming donor for SIM1, and clearly this will be a moment for celebration and appreciation.

Doug also shared with the Executive Committee an analysis of comparative data collected by the Association of American Medical Colleges (AAMC) about fundraising results and development costs at our national peer institutions. Here too the results are impressive: during the latest year available (Fiscal Year 2007), the Stanford School of Medicine was in the top five programs in the country in total private (cash) support and, in the top 10 among the 119 institutions reporting their data -- a group that includes Johns Hopkins, Memorial Sloan Kettering, M.D. Anderson, Massachusetts General Hospital – institutions that are not only much larger than Stanford but which also have had more long-standing development operations. During the past few years we

have invested considerable resources in Medical Development – beginning with our recruitment of Doug Stewart as Director and followed by the rebuilding and expansion of OMD. But even with that our staff size and cost of fundraising remains among the lowest of our peers – another testament to our current success.

Of course I want to congratulate Doug Stewart and everyone in the Office of Medical Development for their efforts and professionalism. I also want to thank our department chairs, institute directors and faculty, who have played a key role in raising private support for both our programs and facilities. Without their excellent work and many contributions we could not succeed – and certainly would not have as compelling a story to tell. Most important, I want to thank the donors and community members – locally and globally – who have confidence in Stanford and whose generosity enables us to recruit and retain the best faculty and build world-class research and educational facilities for the 21st Century. These resources make possible our work preparing tomorrow's medical and scientific leaders, preventing and curing disease, and improving human health in our community and around the world.

Importance of Data Security: Laptop thefts –an Increasing Problem with Significant Consequences

Since the last issue of the Dean's Newsletter, a press release from our Office of Communications described what is likely to be an increasing and very worrisome problem. Here is an excerpt from that release:

On August 17, 2008, an automobile belonging to a physician faculty member at the Stanford University School of Medicine was broken into and all of the contents stolen, including a laptop computer.

A thorough review of the computer backup files revealed that a small amount of medical information about some patients was stored on this computer. Although the computer was securely configured (including password protection), the patient information was not encrypted as required by Stanford University policy.

It is highly unlikely, although possible, that someone could gain access to this information. In an abundance of caution, the School of Medicine has notified patients whose information was included in this particular computer file that this incident occurred and has apologized to them for any inconvenience or concern this may cause. Letters were mailed on September 3, 2008. Only those patients potentially affected by the incident will receive letters.

The information on the laptop was collected by the physician when visiting patients for treatment in a nursing home, assisted living facility, or as a hospital or home visit. The information was for billing purposes only and was not a detailed medical record. It was a spreadsheet that included names, Stanford

medical record numbers, dates of visits, ages, billing codes and limited diagnosis information related to these visits.

It did not contain dates of birth, insurance information or other personal medical information, nor did it include Social Security numbers, banking information or anything that would put individuals at risk of identity theft.

There was no indication that medical information was the reason for this theft. However, there is a very small chance that the information could be used to attempt to commit medical identity theft, which occurs when someone assumes another person's identity for the purpose of receiving healthcare services using stolen health insurance information.

The risk of medical identity theft in this instance is very low because the Stanford medical record number could not be used to obtain healthcare services elsewhere. Stanford will place a record of this incident in the charts of approximately 400 patients who could be affected and has advised these patients to keep a copy of the incident notification and to request a copy of their medical records if they have any concerns about fraudulent activity. Telephone and email assistance are available at 650-725-1828 and medprivacy@stanford.edu.

According to Dr. Henry Lowe, Senior Associate Dean for Information Resources and Technology, it is estimated that more than 600,000 laptop computers are lost or stolen each year in the U.S., with more than 10,000 laptops lost every week at U.S. airports. As more people use laptops as their primary, and often sole, computing device the risk of data loss and exposure will increase. There is a similar risk associated with the use of other portable computing/storage devices, such as USB thumb drives, portable hard disks, CDs, DVDs and Smartphones (like the iPhone and Blackberry). When loss occurs sensitive information may be accessible to whoever comes into possession of the device.

The risks associated with sensitive information falling into the wrong hands are well documented, including identity theft, health insurance fraud, loss of privacy and financial loss. It should be noted that there are very clear University policies regarding data protection (see <http://adminguide.stanford.edu/63>). I would **strongly advise** that you review these policies since individuals found to have violated these policies may be subject to removal from the Stanford network, access revocation, corrective action, and/or civil or criminal prosecution. Violators may also be subject to disciplinary action up to and including dismissal or expulsion. Furthermore, any University School or Department found to have violated this policy may be held accountable for the financial penalties and remediation costs associated with a resulting information security incident.

Based on this the following recommendations are offered:

- **Never leave your laptop, smartphone or portable storage device unattended** (even for a moment) in a public space, especially a coffee shop, airport bathroom, or a speaker's podium. Devices left in automobiles, even in the trunk, are particularly vulnerable. Devices should be carried as hand luggage when traveling.
- **Backups of data are extremely important.** Portable devices have a higher likelihood of data loss, either due to rough handling, loss or theft. Without a backup, your important data can be lost forever. Ensure that you have a backup solution in place, it has been tested, and it works.
- **Unless absolutely necessary, never store sensitive information on a laptop, smartphone or other portable storage device. If you must store sensitive data on such a device, University policy states that the data MUST be encrypted.** In the case of medical information (and financial information) on a lost or stolen device, California law requires us to notify research subjects and patients (regardless of the likelihood of the information being accessed) unless the information is encrypted.
- While there is no single encryption method available that works for all situations on all devices, there are a number of free solutions available, from encrypting a single file to encrypting your whole hard drive. Per Drs. Lowe and Ferris, School of Medicine has recommendations for encryption at <http://med.stanford.edu/irt/security/protecting/laptops>. **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 (IRT) Service Desk at 725-8000 for advice and support. In the event of a lost or stolen laptop, smartphone or other portable storage device, contact the School of Medicine Privacy Office at 725-1828.
- You can also find more general information about mobile computer security at http://www.stanford.edu/group/security/securecomputing/mobile_devices. Additionally, you can find detailed technical guidelines on encryption at: https://www.stanford.edu/dept/hipaa/policy_university/security/sg_encryption.
- **Again, 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/computer-storage_device).

Construction and Safety Issues and Concerns

I am sure that I don't need to tell anyone about all the construction events and challenges underway with the completion of the "Connectivity Project" (new loading dock and tunnel system), the Li Ka Shing Center for Learning and Knowledge (whose

“steel phase” will be completed in the next weeks and will be capped off by its red roof!), and the large foundation being dug for SIM1 (whose still phase will begin in October). With all of this going on, you may have also observed the new enclosed pedestrian pathway from the Via Ortega and Campus Drive intersection to the sidewalk along the Clark Building. While it may be tempting to do otherwise, it is important for pedestrians to use this walkway and, more importantly, to stay out of the very limited area for delivery and construction vehicles that is right next to it. Also, I must underscore that bicycles are prohibited from riding in this pedestrian pathway. Accordingly, for everyone’s safety, if you are coming through this area and have a bicycle, please get off your bike and walk it to the pedestrian path until you reach the Clark Center sidewalk. With this in mind – and for your safety and that of your colleagues - I have been advised by our Facilities Group and the Construction team to ask you to please observe the following:

The area formerly known as the School of Medicine parking lot south of Fairchild Science and West of the Clark Center is now a CLOSED construction lot open only to authorized construction related personnel and both construction and School of Medicine delivery vehicles and personnel. It is critical that for both safety reasons and to expedite construction that no other vehicles try to use this lot and that bicycles and pedestrians only travel in the marked areas.

According to Maggie Saunders, feedback is continuing to be received and recommended changes will be posted on the LKSC website (see: <http://lksc.stanford.edu>). New signage and postings for safe circulation will go up over the next week and we hope that this will improve the safety and traffic in the areas.

Of course I am sorry about all these inconveniences that arise with major construction – but hopefully these will be offset with the new LKSC and SIM1 when they are completed in 2010. These will certainly be followed by a number of other major construction projects at the School and hospitals during the next decade – so continued awareness of safety and cooperation among walkers, cyclists and construction teams will be needed for many years to come. Your cooperation is deeply appreciated!

Awards and Honors

Dr. Denise Monack, Assistant Professor of Microbiology and Immunology, has been selected as the Terman Fellow for the School of Medicine. Dr. Monack will now receive \$125,000 per year for the next three years. Congratulations, Dr. Monack.

John Cooke, MD, PhD, Professor of Medicine (Cardiovascular Medicine) and his research group have received the annual "Best Research Award" from the Peripheral Arterial Disease Coalition, in recognition of his group's discovery of a novel biomarker for PAD using SELDI-TOF proteomic profiling (Wilson et al, Circulation, 2007) The award will be presented at the Coalition's annual meeting in Washington DC on Sept 8, 2008. The PAD Coalition is a non-profit alliance of 75 leading health

organizations, health professional societies, and government agencies including the National Institutes of Health that have united to reduce the morbidity and mortality associated with PAD (<http://www.PADCoalition.org>). Congratulations, Dr. Cooke.

Dr. Bilal Shafi, a recent graduate of the Biodesign Innovation Program, has been recognized by *Technology Review* magazine as one of the world's top innovators under the age of 35 for his work in medical device development. The **TR35** honors an elite group of accomplished young innovators that are poised to have a dramatic impact on the world. Dr. Shafi has recently returned to complete his residency at the University of Pennsylvania, and will be honored at the EmTech Conference at MIT in September. Congratulations, Dr. Shafi.

Appointments and Promotions

- **Michael Champeau** has been promoted to Adjunct Clinical Professor of Anesthesia effective 9/1/08.
- **Charles DeBattista** has been promoted Professor of Psychiatry and Behavioral Sciences at the Stanford University Medical Center, effective 8/01/08.
- **Robert L. Dodd** has been appointed to Assistant Professor of Neurosurgery and, by courtesy, of Radiology, at the Stanford University Medical Center, effective 8/01/08.
- **Daniel Garza** has been appointed to Assistant Professor of Orthopaedic Surgery and of Surgery at the Stanford University Medical Center, effective 8/01/08.
- **Raphael Guzman** has been appointed to Assistant Professor of Neurosurgery at the Stanford University Medical Center, effective 8/01/08.
- **Steven Machtinger** has been promoted to Adjunct Clinical Associate Professor of Pediatrics effective 7/1/08.
- **Harise Stein** has been promoted to Adjunct Clinical Assistant Professor of Obstetrics and Gynecology effective 8/1/08.
- **Charles Wang** has been promoted to Adjunct Clinical Assistant Professor of Anesthesia effective 9/1/08.
- **Ronald W. Witteles** has been appointed to Assistant Professor of Medicine (Cardiovascular Medicine) at the Stanford University Medical Center, effective 8/01/08.
- **Hsi-Yang Wu** has been appointed to Associate Professor of Urology at the Lucile Salter Packard Children's Hospital, effective 9/01/08.

