

Dean's Newsletter

September 14, 2009

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Preparing for H1N1

With the influx of students expected over the next weeks and the change of seasons from summer to fall, concerns about flu and especially H1N1, will become an issue of increasing concern and attention. It is notable that during the summer months we have seen as much influenza at Stanford and LPCH as we generally do during the winter. Since April, more than 1 million Americans have contracted H1N1 and while the disease course has been generally mild, contrasts are often made to the 1918 H1N1 pandemic which also started in the spring but returned in the fall and winter with markedly increased virulence resulting in the worst influenza pandemic in recorded history. At least to date, the indicators suggest that while H1N1 will be common this fall and winter, its virulence and consequent mortality is likely not going to be greater than seasonal flu. That said, preparedness, attention to public health and vigilance is important. We share in this responsibility.

The Centers for Disease Control has published updated recommendations for H1N1, including the observation that as of August 2009, 98% of the influenza isolated in the USA is H1N1. A similar pattern is being reported from the southern hemisphere (where winter is coming to a close). While widespread cases of H1N1 have been reported, the “good news” is that the mortality rates observed to date have not been high (compared to initial fears) and the virus remains sensitive to two antiviral agents. While this is comforting, it must be recognized that the possibility for new and more virulent and/or drug resistant strains of H1N1 to emerge in the months and years ahead remains a major concern.

It is important that we keep up with the evolving nature of the H1N1 pandemic. Accordingly, I am including below the most recent summary from the CDC. I also suggest that you bookmark the CDC website regarding H1N1 (see: <http://cdc.gov/h1n1flu/recommendations.htm>) as well as a useful site entitled What To Do About the Flu (<http://www.flu.gov/>) that consolidates and coordinates various information sources.

First and foremost, there are simple things we all should do to decrease the spread of infections. The CDC provides a summary of these http://www.cdc.gov/flu/protect/habits.htm?s_cid=swineFlu_outbreak_003 and they are consonant with the practices being recommended at the Medical Center and University. They include the following recommendations:

Avoid close contact.

Avoid close contact with people who are sick. When you are sick, keep your distance from others to protect them from getting sick too.

Stay home when you are sick.

If possible, stay home from work, school, and errands when you are sick. You will help prevent others from catching your illness.

Cover your mouth and nose.

Cover your mouth and nose with a tissue when coughing or sneezing. It may prevent those around you from getting sick.

Wash your hands.

Washing your hands often will help protect you from transmitting and acquiring influenza and other germs.

Avoid touching your eyes, nose or mouth.

Germs are often spread when a person touches something that is contaminated with germs and then touches his or her eyes, nose, or mouth.

Practice other good health habits.

Get plenty of sleep, be physically active, manage your stress, drink plenty of fluids, and eat nutritious food.

In many ways these recommendations are similar to what we all learned from our “mothers and grandmothers” – but they do work. I particularly want to highlight the importance of staying away from work if you have symptoms of flu – an admonition that is of particular importance to those on the front lines of care (e.g., residents, fellows, nurses)

The CDC has also published guidelines on risk groups as well as the diagnosis and treatment of H1N1. Here is the summary of the CDC recommendations

<http://cdc.gov/h1n1flu/recommendations.htm>):

- Treatment with oseltamivir or zanamivir is recommended for all persons with suspected or confirmed influenza requiring hospitalization.
- Treatment with oseltamivir or zanamivir generally is recommended for persons with suspected or confirmed influenza who are at higher risk for complications (children younger than 5 years old, adults 65 years and older, pregnant women, persons with certain chronic medical or immunosuppressive conditions, and persons younger than 19 years of age who are receiving long-term aspirin therapy).
- Persons who are not at higher risk for complications or do not have severe influenza requiring hospitalization generally do not require antiviral medications for treatment or prophylaxis. However, any suspected influenza patient presenting with warning symptoms (e.g., dyspnea – shortness of breath) or signs (e.g., tachypnea, unexplained oxygen desaturation) for lower respiratory tract illness should promptly receive empiric antiviral therapy.
- Clinical judgment is an important factor in antiviral treatment decisions for all patients presenting for medical care who have illnesses consistent with influenza.
- Treatment should be initiated as early as possible because studies show that treatment initiated early (i.e., within 48 hours of illness onset) is more likely to provide benefit.
- Treatment should not wait for laboratory confirmation of influenza because laboratory testing can delay treatment and because a negative rapid test for influenza does not rule out influenza. The sensitivity of rapid tests can range from 10 % to 70%. View information on the use of rapid influenza diagnostic tests (RIDTs).
- Testing for 2009 H1N1 influenza infection with real-time reverse transcriptase-polymerase chain reaction (rRT-PCR) should be prioritized for persons with suspected or confirmed influenza requiring hospitalization and based on guidelines from local and state health departments.
- Groups at higher risk for 2009 H1N1 influenza complications are similar to those at higher risk for seasonal influenza complications.
- Actions that should be taken to reduce delays in treatment initiation include:
 - Informing persons at higher risk for influenza complications of signs and symptoms of influenza and need for early treatment after onset of symptoms of influenza (i.e., fever, respiratory symptoms);
 - Ensuring rapid access to telephone consultation and clinical evaluation for these patients as well as patients who report severe illness;

- Considering empiric treatment of patients at higher risk for influenza complications based on telephone contact if hospitalization is not indicated and if this will substantially reduce delay before treatment is initiated.
- In selected circumstances, providers might also choose to provide selected patients at higher risk for influenza-related complications (e.g., patients with neuromuscular disease) with prescriptions that can be filled at the onset of symptoms after telephone consultation with the provider.
- Antiviral chemoprophylaxis generally should be reserved for persons at higher risk for influenza-related complications who have had contact with someone likely to be infected with influenza.
- Based on global experience to date, 2009 H1N1 influenza viruses likely will be the most common influenza viruses among those circulating in the coming season, particularly those causing influenza among younger age groups. Circulation of seasonal influenza viruses during the 2009-10 season is also expected. Influenza seasons are unpredictable, however, and the timing and intensity of seasonal influenza virus activity versus 2009 H1N1 circulation cannot be predicted in advance.
- Persons with suspected 2009 H1N1 influenza or seasonal influenza who present with an uncomplicated febrile illness typically do not require treatment. However, some groups appear to be at higher risk for influenza-related complications.
- Currently circulating 2009 H1N1 viruses are susceptible to oseltamivir and zanamivir, but resistant to amantadine and rimantadine; however, antiviral treatment regimens might change according to new antiviral resistance or viral surveillance information.
- Information on the dose and dosing schedule for oseltamivir and zanamivir is provided in this document. An April 2009 Emergency Use Authorization authorizes the emergency use of oseltamivir in children younger than 1 year old, subject to the terms and conditions of the EUA

I also call your attention to the excellent presentation on H1N1 recently given by Dr. Bonnie Maldonado, Chief of Pediatric Infectious Disease and Professor of Pediatrics (see: <http://med.stanford.edu/121/2009/maldonado.html>) and to the Stanford Medicine website on H1N1 (see http://stanfordmedicine.org/getting_care/influenza.html).

While none of us can predict exactly how this flu season will resolve, I do think that Stanford Medical Center and University are well prepared. The planning and coordination for emergency preparedness over the past years, together with the real-life dress rehearsal that began with the outbreak on H1N1 in April, has led to heightened

preparations and coordination within the medical center. The efforts of Dr. Kevin Tabb, Chief Medical Officer at SHC, Dr. Christy Sandborg, Chief of Staff at LPCH, Dr. Eric Weiss, Medical Director of Disaster Planning along with infectious disease specialists Drs. Lucy Tompkins and Bonnie Maldonado, are particularly appreciated. In addition to the excellent preparative efforts, considerable research activity on influenza is underway at Stanford from a variety of different angles and disciplines (see: <http://med.stanford.edu/ism/2009/september/flu-tip-sheet.html>).

While there are reasons for concern, there are also grounds for optimism, including the prevention and treatment programs now in place, the process plans for screening and evaluating patients seeking medical care and the very real prospects for an H1N1 vaccine in the next couple of months. That said, our success during the flu season will largely rest on the self-care and prevention exercised by our medical staff and community. This includes early recognition of flu-like symptoms that should prompt care providers to stay home to avoid more widespread treatment. It includes frequent hand cleansing – which should be at the 100% level. There is simply no excuse for falling short of this goal. And it will include complete compliance with immunizations once the flu vaccines become available.

It will be important for each of us to stay informed and to do our part in protecting ourselves, each other and our community.

Whither or Whether Healthcare Reform

In my July 6th *Dean's Newsletter* I drew parallels between the healthcare debate and the hot and stormy weather in DC where the debate would rage. In retrospect I would have to say that my “weather” forecast was directionally correct but did not predict the heat of the debate or the lack of clarification and accuracy of the discussion or the thunderous allegations that were made – many of which were aimed at generating fear rather than rational thinking. Until the President made his speech before the Joint Session of Congress on September 9th, it seemed as if any chance for serious healthcare reform was going down the proverbial storm drain. And while an opportunity for some progress again seems possible, the chances for serious reform seem less hopeful than in the spring. For example, the public insurance option, which I believe is important to serious insurance industry reform, seems much less likely to be part of whatever healthcare reform occurs in 2009. The fact that it is so threatening to the insurance industry is an indicator of how much it might change the status quo – which we all recognize is unsustainable.

As the glow of President Obama's healthcare address begins to fade, the voices of the major constituencies (often through teams of lobbyists) are trying to reshape the discussion and the prospects for reform. One of the voices that is less clearly aligned to its own constituency is that of the American Medical Association (AMA). While the AMA certainly is a voice that deserves to be heard, it should not be conveyed as “representing American doctors” – which it does not. Of course this leaves the question open about whether any organization or professional group does speak for the majority of

physicians. Indeed the very fact that there is no such group means that doctors are not directly shaping healthcare reform and that those who are at the table may be representing the interests of a relative minority.

While not a broadly representative group, the “Physician’s Foundation”, a non-profit organization established in 2003, issued a report on September 9th on issues it felt were relevant to healthcare reform. These resulted in six major goals:

1. Physician workforce

Undertake a major expansion of the physician workforce by enlarging the infrastructure of medical school and residency education. Many actions will be necessary, but removing Medicare’s caps on support for residency positions is essential. Because these efforts will not reach fruition for fifteen years or more, other near-term strategies will be needed.

2. Team building

Build the workforce of midlevel practitioners, particularly nurse practitioners and physician assistants, who will be critical members of clinical teams and important providers of primary care. Simultaneously build the workforce of nurses, aides, technicians and others, and downstream tasks from more highly trained clinicians to those who have less-complex training but the requisite skills to provide care competently.

3. Primary care

Build a broad system of front-line primary care and public health services that reach deep into communities and that recognize the varied patient needs in different income groups.

4. Specialty mix

Faced with physician shortages, emphasize physician training in areas where physicians are uniquely capable of providing care, predominately in the medical and surgical specialties. At the same time, reshape the career paths of generalist physicians to take advantage of their capacity to manage chronic illness and multisystem diseases and their parallel abilities to give consultative support to midlevel primary care providers.

5. Education

Shorten the length of medical education from premed through residency, and realign medical education with the realities of clinical practice and the necessary roles of physicians in the future in both urban and rural settings.

6. Autonomy

Equip physicians with better information technology and more access to medical effectiveness research, but do not burden physicians with practice incentives that fail to recognize the vast differences in socioeconomic characteristics among patients and among regions. At the same time, create a Medicare reimbursement formula that is grounded in the reality that physician services will continue to grow in quantity and complexity. And recognize that, ultimately, physician autonomy is the friend of quality.

A number of these recommendations are sound and relevant, whereas others (such as the need to expand the number of medical schools or medical school class size) may be less well founded. Nonetheless, a number of these goals align to recommendations from other organizations, including the Association of Academic Health Centers (AAHC), for which I currently serve as Chair-Elect of the Board of Directors. Specifically, AAHC concurs that comprehensive health workforce reform is essential to any broader healthcare reform agenda. Importantly, AAHC believes that the policymakers currently involved in developing healthcare reform legislation are focused on two discrete issues (the supply of primary care and the reform of graduate medical education) without addressing the broader spectrum of health workforce challenges. Accordingly, AAHC has recommended the creation of a national health workforce planning committee to develop and implement the integrated, comprehensive national health workforce policies necessary for healthcare reform to succeed. In parallel, AAHC has underscored that reimbursement reforms should support and not undercut the national workforce priorities or the financial integrity of the nation's academic medical centers.

The next months will be a time of heightened debate, lobbying, policy clarification and position entrenchment. At the end I hope we won't lose sight of the primary issues that underpin the need for healthcare reform – including a rebasing of the role of physicians in the delivery of patient care as well as in research and education. I also hope that the voice of physicians will be heard in more representative ways – something we can all contribute to through our specialty and professional societies. Let's hope that at year's end we will see evidence of healthcare reform that is blooming or at least budding – and hopefully not withering, as has been the case in recent months. It is time to move forward.

Medical Students Learn About As Well As Initiate Leadership Roles

A major goal of our education programs has been to educate and train future leaders in medicine and science. It is particularly gratifying when students take on and promote major leadership initiatives. There are many examples of this at Stanford and I want to highlight a recent one.

On September 8th a 12-week student directed course on “Medical Leadership Development” commenced under the leadership of three medical students and a surgical resident. Matt Goldstein (SMS5), Robin Eisenhut (SMS2), Tiffany Castillo (SMS4) and Bernard Palmer, MD. serve as Course Directors along with Dr. Charles Prober, Senior Associate Dean for Medical Education as Faculty Director and Julia Tussing, Associate Dean for Education Programs and Services, as Course Facilitator. The primary objective of the curriculum “is to provide students with a theoretical and functional knowledge of leadership through participation in activities of self-discovery and leadership immersion”. The program consists of “fireside sessions” with leaders in academic medicine who share a personal journey of their career and the lessons they have learned along the way. I had the privilege of being the first speaker with subsequent sessions to be given by Drs. Sherry Wren, Clarence Braddock, Lisa Chamberlin, Ralph Horwitz, Oscar Salvatierra and Charles Prober. Alternating with these presentations and discussions are skill

workshops based on defined issues and challenges in leadership and readings that provide background and data to enlighten the issues and discussions. This is an excellent program and while the participation is limited to just a dozen students, I am certain that each will have a rich and informative experience. I want to offer my gratitude and commendation to the course directors for their initiative in bringing this course to fruition.

Conflicts by Big Pharma Have Consequences

Over the past several years we have had a substantive discourse about conflicts of interest and the intertwining of industry support into education, research and patient care. These prompted us to take important stands on industry interactions (see: <http://med.stanford.edu/coi/siip/>) that have banned certain activities (e.g., gifts, “free lunches,” ghostwriting) and curtailed others (industry support for continuing medical education). We have done these in order to separate the role of physicians as scientific advisors and consultants to industry from that of marketing for industry. While most physicians believe that they are not likely to be biased or influenced by industry marketing tactics, the reality is, unfortunately, quite different.

Although we would all like to believe that individual and institutional integrity prevails in medicine and science, remarkable examples of where this has not been the case serve to underpin the importance of Stanford’s Academic Industry Interactions Policies. The case of the drug Neurontin illustrates this point as well-illustrated by C. Seth Landefeld, M.D. and Michael A. Steinman, M.D. in a case study entitled “*The Neurontin Legacy — Marketing through Misinformation and Manipulation*” that was published in the January 9, 2009 issue of the *New England Journal of Medicine* (see: <http://content.nejm.org/cgi/content/full/360/2/103>). Following the oft-quoted adage that history predicts the future, Pfizer Pharmaceuticals was fined \$2.3 billion this past week for following a similar strategy to inappropriately (and apparently illegally) market their drug Bextra – even after receiving the admonitions for the strategy they pursued for Neurontin. These strategies included enlisting physicians as paid “consultants” and spokespersons for their drugs, enticing them into becoming involved in marketing. And this is not unique to Pfizer since similar strategies were described in early September for Forest Laboratories in their marketing plan for the antidepressant Lexapro. Their marketing strategy also included payments to doctors to induce them to prescribe Lexapro. It is alleged that the Forest Laboratories plan included spending tens of millions of dollars to doctors to give “education lectures” to their peers about Lexapro or to provide “education lunches” as well as CME activities for doctors that included marketing their drug.

These are overt if not flagrant examples of a problem that has become all too pervasive. And I am sure it is not unique to these pharmaceutical industries or these drugs. One can only hope that these practices are becoming past tense – but they do serve as stark reminders of how subtle influences that are financially motivated can have a big impact on physicians, patients and the cost of medicine. They further underscore why our

Stanford Industry Interactions Policies are the right thing to do for the profession of medicine now and into the future.

Paying Attention to Professional Compliance

The number of new compliance requirements for which faculty must receive training or whose policies they must adhere to is daunting. Over the years compliance has become one of the major time and resource drains for physicians and scientists as well as institutions. While a case can be made for the importance or validity of each compliance requirement, when viewed in the aggregate they can be a source of frustration. But they are also important in protecting patient safety or the safety of the community in which we work.

Among the many compliance requirements to which we must adhere is that for professional billing integrity. This involves making sure that when a physician bills for a clinical service, she or he does so at the correct level of service complexity (and time allocation) and that this is adequately supported and documented in the patient's medical record. Some of the regulations that guide professional fee billing are clear and straightforward but others are less clear or self-evident, making it easy to make mistakes in documentation. Two years ago both Stanford Hospital & Clinics and the Lucile Packard Children's Hospital launched an education and monitoring program related to assessing, monitoring and improving compliance in professional billing. Over this period, the Medical Center Compliance Office formulated a number of education programs and guides which were shared with faculty physicians at the clinical division and department level. Overall, some 1129 physicians participated in this training. Based on this, the office of compliance then audited the medical records of individual providers and gave feedback on an individual level about each physician's performance. This review constitutes the baseline evaluation and this program has now been completed. Based on this, each physician provider who works at either SHC and/or LPCH has received (or soon will receive) the feedback for their specific specialty area (by division or department) and their individual performance. With this, the compliance department plans to review additional charts that should reflect the physician provider's knowledge of areas for personal improvement. Since each of us should be striving for being as close to 100% accurate in performance as possible, I want to take this opportunity to remind all physicians to review their individual results and to work with the guidance materials they have received to make further performance improvements. At a time of increased public scrutiny, it is important for each of us as individuals as well as for our institutional performance to be as accurate as possible. Thanks for your work in this important area – and for your continued efforts in the future.

The Year Closes and Opens for Medical Development

Among the many consequences of the economic downturn that began so dramatically in September 2008 is the impact on philanthropy. Over the years we have been blessed to have individuals in our community and beyond who have given generously to support our faculty, students, programs and facilities. Indeed the Stanford

we know and love today is a reflection of the gifts we have received from individuals, foundations and corporations. As the economic consequences of the current recession have unfolded, individuals and foundations have lost extraordinary amounts of wealth. And while many have found ways to sustain their gift giving – or to even initiate new ones – we are well aware of how difficult this is given the current times. Indeed, we each know this quite personally since virtually everyone has been touched and impacted by the economic downturn.

Within this context, I provide below our fundraising results for FY09 (which closed on August 31, 2009). I should begin by saying that despite the incredibly volatile and negative economic forces, the School of Medicine has done well in cash received - even when compared to last year (FY08) – which was among the best years on record. This is of course a tribute to the incredible generosity of individuals who care deeply for Stanford and its future. It is also an affirmation of the remarkable work being done by our Office of Medical Development, our many extraordinary community volunteers, led by John Freidenrich, and our faculty and students – who are the reasons why gifts are given for education, research and clinical care. I thank them all.

	FY 09 <i>(September 1 2008 through August 31 2009)</i>		FY 08 <i>(September 1 2007 through August 31 2008)</i>	
	\$\$	# of Gifts	\$\$	# of Gifts
Cash Received	\$129,402,173	8,993	\$141,670,248	9,463
Foundations & Associations	\$56,132,438	1,621	\$46,654,109	1,454
Bequests	\$13,345,140	210	\$26,110,938	76
Corporations	\$14,551,498	624	\$12,074,162	602
Individuals	\$45,373,097	6,538	\$56,831,039	7,331
New Activity	\$140,015,962	8,592	\$225,217,685	9,457
Foundations & Associations	\$66,664,782	1,566	\$53,043,079	1,436
Bequests	\$13,345,140	210	\$26,110,938	76
Corporations	\$15,393,998	619	\$15,821,662	593
Individuals	\$44,612,042	6,197	\$130,242,006	7,352

At the same time I have major concerns for the FY10 fiscal year that began on September 1, 2009. In many ways FY09 success is a reflection of gifts made before the economic downturn. In contrast, the dramatically lower “New Activity” reported in FY09 is a better predictor of current and future pledges and commitments. Most notably, although not surprisingly, is the dramatic fall off in new pledges by individuals in FY09. Of course I remain hopeful that as the economy begins to improve the individuals who have supported us in the past will be in a better position to do so in the future. And, of course, we hope that we will identify new donors who will be excited by our vision and

goals and who will invest in our future success. Needless to say we will do all we can to make this happen.

Thanks to Ross Bright, MD

Dr. Ross Bright has served as the Associate Dean for Alumni Affairs for nearly two decades. On September 1st he turned over the reins to Dr. Linda Clever and on Saturday September 12th the Alumni Associations Governing Council honored him for his enormous contributions over so many years of change and opportunity. I also had the opportunity to thank Dr. Bright for his devotion and dedication to our current students, recent and past alumni. He has been a passionate advocate for enriching the engagement and participation of alumni in the School's mission and he was instrumental in extending the alumni association to embrace graduate students, residents and post-doctoral fellows among the Stanford Alumni. These important contributions are eclipsed by his vision of finding a vehicle to communicate more directly to alumni and to engage their voice in these communications, culminating in the alumni magazine "*Bench and Bedside*" which was his brainchild and which he championed through its inception and the first four issues that have now been published. Indeed *Bench and Bedside* will be a living legacy for alumni – and a reminder of the dedication and commitment of Dr. Ross Bright as Associate Dean for Alumni Affairs. Please join me in thanking and acknowledging Dr. Bright.

Call for Nominations! 2010 Faculty Fellows Program

The Office of Diversity and Leadership has announced the launch of the 2010 School of Medicine *Faculty Fellows Program*. Now entering its fifth year, the program will focus on a select group of Assistant and Associate Professors as Faculty Fellows for the 2009-2010 academic year. The purpose of the Faculty Fellows program is to identify and develop a diverse group of faculty with the potential to become our future leaders.

During the yearlong program, Fellows attend monthly dinner meetings with key University leaders including President John Hennessey, Provost John Etchemendy and Dean Philip Pizzo. Each speaker shares their "Leadership Journey" and engages fellows in a discussion about their leadership philosophy, strategy and style. In addition, Fellows participate in small monthly mentoring groups led by a senior Professor; and in a structured Career Development Planning process with their division chiefs or department chairs to craft a specific, career development action plan which the fellow will implement over the subsequent year.

If you are interested in being nominated for this opportunity, ask your Department Chair or Chief to nominate you. Criteria to apply:

- Assistant or Associate professors
- Demonstrated interest in, and potential for leadership
- Respected by colleagues
- Has the ability to influence others
- Can advocate for change
- Values diversity

- Thinks strategically and systemically
- Interested in taking on leadership roles in the future

Further information, future meeting dates and application can be obtained at:
http://med.stanford.edu/diversity/leaders/fellows_nominations2010.html

Upcoming Events

Stanford Health Policy Forum on the Key Challenges in Pharmaceutical Regulation will take place on **Wednesday, September 30, 2009, from 11:00 a.m. to 12:30 p.m. at the Clark Center Auditorium**, Stanford University. This forum is free and open to the public. However due to space limitations, we ask that you RSVP online at <http://www.stanfordtickets.org> or call the Stanford Ticket Office at 650-725-2787.

This forum will be a discussion with Donald Kennedy, PhD, President Emeritus of Stanford University and John C. Martin, PhD, Chairman and CEO, Gilead Sciences, and will be moderated by Daniel P. Kessler, Stanford University, focusing on the handling of some of the key challenges in regulating the pharmaceutical industry by the federal government. For information on the Stanford Health Policy Forums, please visit <http://healthpolicyforum.stanford.edu/> or call 650-725-3339.

Stem Cell Policy Symposium: Understanding the Scientific and Legal Challenges Ahead

The Stanford Journal of Law, Science, & Policy presents this public symposium on **Friday, October 2, 2009, from 8 AM to 5 PM at the Stanford Law School**. **Dr. Irving Weissman**, *Professor of Pathology, Director of the Institute of Stem Cell Biology and Regenerative Medicine, Stanford University*, will be the keynote Speaker,

To get more information on the Program and register online to save your spot please go to <http://www.stanford.edu/group/sjlsp>.

To present a poster, please submit abstract to: stemcell.sjlsp@gmail.com

Run for Your Life! Stanford Emergency Medicine 5K/10K Race

Come "Run for Your Life!" on a USATF certified 5K/10K course through the beautiful Stanford campus and help support Stanford Emergency Medicine on **Sunday, October 11, 2009, at 9 am** at Pac-10 Plaza, Stanford University. Fees are: 5K- \$25, 10K- \$35. Register at www.stanfordrunforyourlife.com or by calling Stanford Ticket Office 650.725.2787

Every registered participant will receive a race t-shirt and a water bottle courtesy of Equinox! If you are affiliated with Stanford University Medical Center enter the promo code "SMED" during registration to receive a \$10 discount.

Rather volunteer at the event than run? Email anastasia.stamos@stanford.edu

Stanford School of Medicine's Eighth Annual Fall Forum on Community health and Public Service

On **Tuesday, October 27th, 2009, from 5 – 7 pm** at the Francis C. Arrillaga Alumni Center at 326 Galvez Street, the Fall Forum will celebrate student contributions to community health through public service and community partnership research.

Keynote address by Sergio Aguilar-Gaxiola, MD, PhD, Professor of Internal Medicine, School of Medicine, University of California, Davis and Founding Director of the Center for Reducing Health Disparities at the UC Davis Health System:
http://och.stanford.edu/fall_forum.html. The event is free and open to the public.

If you have any questions, please contact Fall Forum coordinators: Dinah Arumainayagam (dinah.arum@gmail.com) and Vinca Chow (vincachow@gmail.com)

Appointments and Promotions

Melissa T. Berhow has been reappointed as Clinical Assistant Professor of Anesthesia, effective 10/16/09.

Lynn Cintron has been appointed as Clinical Assistant Professor (Affiliated) of Anesthesia (Pain), effective 9/01/09.

Ninad Dabadghav has been reappointed as Clinical Associate Professor (Affiliated) of Surgery, effective 9/01/09.

Kay Daniels has been promoted to Clinical Professor of Obstetrics and Gynecology (Maternal-Fetal Medicine), effective 9/01/09.

Lyn M. Dos Santos has been reappointed as Clinical Assistant Professor of Pediatrics (General Pediatrics), effective 7/01/09.

Claudia Greco has been appointed Clinical Associate Professor of Pathology, effective 8/16/09.

Michelle C. Holmes has been appointed Clinical Assistant Professor (Affiliated) of Surgery (Emergency Medicine), effective 7/01/09.

Melissa Hurwitz has been promoted to Clinical Associate Professor of Pediatrics (Gastroenterology), effective 9/01/09.

Judith Keddington has been reappointed as Clinical Associate Professor (Affiliated) of Surgery, effective 9/01/09.

Tina T. Lee has been appointed as Clinical Assistant Professor (Affiliated) of Psychiatry and Behavioral Medicine, effective 8/01/09.

James S. Lin has been appointed Clinical Assistant Professor (Affiliated) of Surgery (Emergency Medicine), effective 7/01/09.

Janice Lowe has been reappointed as Clinical Professor of Pediatrics (General Pediatrics), effective 9/01/09.

Patrick D. Soran has been promoted to Clinical Assistant Professor of Anesthesia (Cardiac Anesthesia), effective 10/01/09.

Scott Sutherland has been promoted to Clinical Assistant Professor of Pediatrics (Nephrology), effective 9/01/09.

Nancy Yuan has been reappointed as Clinical Associate Professor of Pediatrics (Pulmonary Medicine), effective 8/01/09.