

Dean's Newsletter
November 23, 2009

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2009 Summit On Clinical Excellence

On November 19th the Stanford University Medical Center held its third annual Summit on Clinical Excellence. Sponsored by the School of Medicine, the Stanford Hospital & Clinics and the Lucile Packard Children's Hospital, this year's Summit focused on communications, teamwork and the ever increasing challenge of "hand-offs" in the clinical setting. Bryan Bohman, Chief of Staff at SHC, serving as the course director and moderator, did an excellent job in both capacities.

In my opinion, this was the best of the Clinical Summits to date, largely because it engaged a broad array of SUMC faculty and staff in its planning and leadership. One of the most striking and important features was the transparency and honesty about what is working at SUMC and, importantly, what is not working. Indeed the Summit began with a recitation of failures or near misses in clinical excellence and reflected a willingness on the part of our community to acknowledge our failings as a way to make future improvements.

It is clear that SUMC has made significant strides in quality excellence over the past three years. But it is also abundantly clear that much work remains – and, importantly, that continued efforts are needed to prevent backsliding. All faculty and staff must embrace a commitment to quality excellence. It is also clear that these efforts need support and commitment by institutional leaders. This was evident at the Summit by the

attendance and comments from members of the SHC and LPCH Board of Directors, including Mariann Byerwalter, Chair of the SHC Board of Directors, and John Lillie, Chair of the LPCH Board of Directors. CEOs Martha Marsh (SHC) and Chris Dawes (LPCH) also expressed their support to quality excellence. I offered my support as well and underscored that a commitment to excellence in the quality and excellence of patient care needs to be as embedded and embraced as is our very evident commitment to excellence in research. Creating a better balance of our missions at Stanford was a topic I addressed in some detail in my February 17, 2009 Newsletter.

In addition to excellent presentations by Clarence Braddock, Professor of Medicine and Medical Director for Quality at SHC, and Christy Sandborg, LPCH Chief of Staff, the Summit featured a presentation by Dr. Allan Frankel from the Institute for Healthcare Improvement and Division of General Medicine at the Brigham & Women’s Hospital in Boston on the critical role that communication plays in promoting or reducing errors. He demonstrated how critical teamwork is and showed how much the value of teams differs in the healthcare field compared to the airline industry, which has put a premium on teamwork and error reduction through communications, checklists and a culture that makes everyone responsible for assuring safety. In medicine this will require rebasing the traditional hierarchical order of medical practice to one that empowers all providers to engage in the identification and elimination of potential safety or quality errors without a fear of retribution or retaliation. To do this there needs to be interplay between the attributes of leaders, the norms of conduct of teams and the focus on improvement in the units responsible for safe, effective and quality driven patient care. Among the characteristics are:

Attributes of Leaders	Norm of Conduct of Teams	Improvements Sought by Units
<i>Ensure Respect</i>	<i>Plan Forward</i>	<i>Continuously Test</i>
<i>Ensure Psychological Safety</i>	<i>Reflect Backward</i>	<i>Relentlessly Seek to Improve</i>
<i>Set Expectations</i>	<i>Communicate Clearly</i>	
	<i>Resolve Conflicts</i>	

Improving communication among clinical teams at SHC and LPCH was an action item at the Summit. Multidisciplinary teams of physicians, nurses, and other healthcare professionals met in small groups to develop specific action plans addressing some of the most challenging areas of communication. The efforts they began at the Summit will be followed-up in the months ahead as their plans are further developed and then implemented.

Summits and retreats are helpful in bringing diverse communities together to share knowledge and experience and to develop plans for the future. They are successful if the plans are further developed and then brought to fruition. Clearly this is the challenge and the goal. But there can be no doubt that the November 17th Summit for Clinical Excellence highlighted important issues and created a forum for assuring clinical excellence.

Faculty Forward: School of Medicine Job Satisfaction Survey

One of my overarching priorities is to foster a workplace that is valued by our faculty, students and staff. There is no doubting that the pressures of an academic medical center are significant – especially during periods of constraint such as those as we have experienced in recent times. Nonetheless it is important that we continuously strive to do more to support our community and, periodically, assess how we are performing and what further might be done at the division, department or school-wide level. In 2007 Stanford participated in a pilot project of the AAMC and the Collaborative on Academic Careers in Higher Education (COACHE). I reported on the results of that survey in the February 17, 2009 Dean's Newsletter.

In April 2009, Stanford was one of 23 medical schools that participated in the next phase of the Faculty Forward COACHE project. In this survey, locally coordinated by Dr. Hannah Valantine, Senior Associate Dean for Diversity and Leadership, we asked all faculty to participate (Investigators, Clinician Scholars/Investigators, Clinician Educators). Surveys were sent to 1,061 individuals, and responses were received from 467 (44%), including 54 (45.4%) of the 119 basic science faculty and 413 (43.8%) of clinical faculty. A disproportionate percentage of women (180/325 or 55.4%) compared to men (287/736 – 39.0%) responded.

Responses were grouped into nine themes, including the nature of the work; climate, culture, collegiality; collaboration/mentoring/feedback; promotion; compensation/benefits; recruitment and retention; governance and operations; clinical practice and global satisfaction. The data was presented in various ways, including peer and cohort comparisons, areas of strength and weakness and gender or minority status. In this update I want to share the categories in which Stanford was ranked first or second out of five in a peer group comparison and in the top half of the overall cohort. I think it is best to consider these results as global trends, although there is similarity to the earlier survey, giving this update some added strength. Here are the data in the aforementioned categories by strength and then weakness.

Areas of Strength (Top of the Group)

1. Nature of Work

- a. Value placed on research/scholarship at the medical school, department and division levels

2. Climate, Culture, Collegiality

- a. The intellectual vitality of departments
- b. That work is appreciated by patients, students and residents
- c. The culture of the medical school in cultivating interdisciplinary work, entrepreneurialism and excellence

3. Collaboration/Mentoring/Feedback

- a. Opportunities to collaborate with faculty in other departments in the medical school and with faculty in other schools at the university

4. Promotion

- a. The criteria for promotion around research and scholarship are clear
- b. The opportunities for professional development at the medical school level
- 5. Compensation/Benefits**
 - a. Positively seen (compared to peers) are housing benefits, tuition benefits, assistance with spousal hiring, parental leave, availability and the quality of childcare
- 6. Recruitment and Retention**
 - a. The medical school is seen as successful in hiring high quality faculty members – as are departments and divisions
 - b. Similarly, the school, departments and divisions are seen as successful in retaining high quality faculty members
 - c. Success is seen in retaining female faculty members
- 7. Governance and Operations**
 - a. Positively seen are communications from the dean’s office to the faculty about the medical school – including explaining overall finances to the faculty
 - b. Also ranked high are the dean’s priorities for the medical school and the pace of decision making at the school and department level
 - c. Faculty feel they can express their opinions about the medical school without fear of retribution
- 8. Global Satisfaction**
 - a. The department and medical school as a place to work
 - b. “If I had it to all over again, I would again choose to work at this medical school”
 - c. “If I had it do all over again, I would choose an academic career”

Areas of Potential Weakness (areas ranked low in comparison to peers and the entire cohort)

- 1. Nature of Work**
 - a. The number of hours worked in an average week and the control that one has over one’s schedule
 - b. The value the medical school and department (as well as the department chair and division chief) place on teaching, patient care, community service, administration
- 2. Climate, Culture, Collegiality**
 - a. How well one “fits” (a sense of belonging) in one’s department
 - b. The quality of personal interactions with departmental colleagues
 - c. Respect of departmental colleagues of “my efforts to balance work and home responsibilities”
 - d. The faculty in my department get along well together
 - e. My work is appreciated by my immediate supervisor
 - f. The workplace culture fosters collegiality or opportunities to all faculty regardless of race/ethnicity
- 3. Collaboration/Mentoring/Feedback**
 - a. Usefulness and frequency from unit head on career performance
- 4. Promotion**

- a. Criteria for promotion based on teaching, patient care, institutional service
 - b. Female and male faculty have equal opportunities for promotion rank.
 - c. Minority and non-minority faculty have equal opportunities for promotion in rank
5. ***Compensation/Benefits***
- a. Salary, health benefits and retirement benefits
6. ***Governance & Operations***
- a. The availability and quality of research space
 - b. The equity in distribution of research space among faculty
 - c. “My department does a good job explaining departmental finances to faculty”
 - d. Availability of administrative support to do one’s job
7. ***Clinical Practice***
- a. Support from administrative or office staff for ones clinical care activities
 - b. Opportunities for physician input in management decisions

In a number of important ways, the results of the most recent survey mirror those of others we have conducted over the years. It is true (and appreciated) that we have made progress in closing some of the gaps in gender disparity. However, with respect to our core missions, we still have a culture where contributions to patient care and education do not appear to be as highly valued as are contributions to research. I have previously discussed this and won’t recite all the reasons this belief arose and why it continues to be fostered. And I do want to underscore that I too value contributions to research as a core value. That said, I also view contributions to education and patient care as equally important to the overall success of our medical school and medical center. In reviewing the data in more detail, I note that it appears that some of the perceptions that contributions to patient care and education are of less value than research contributions are arising at the department and division level. It is important for leaders and faculty throughout the school to foster a better sense that excellence in contributions in all of our missions contribute equally to our overall success.

Perceptions of what is valued are within our control and, just as we need to cultivate an environment that fosters excellence in quality in patient care (see above), so too do we need to foster a sense of balance and quality across all of our missions – another topic I have focused on in past Newsletters since this was also the topic of our 2008 Leadership Retreat. Career development and faculty support will also be an important ongoing initiative and a major topic for review at our 2010 Leadership Retreat.

Supporting the Research Mission in Academic Medical Centers

At the recent Association of American Medical Colleges (AAMC) meeting I chaired a session about how medical centers are preparing for changes in the support for research in the years ahead. There can be no doubt that the USA has excelled in biomedical research during the last half of the 20th century and the beginning of the 21st, largely through sponsored federal research support from agencies like the National Institutes of Health (NIH), the National Science Foundation (NSF) and, in defined areas,

the Departments of Energy and Defense, among others. This support led to the rapid growth of academic medical centers across the USA, evidenced by a more than tenfold increase in the size of faculty and the expansion of research facilities (some much more than others) at virtually every academic medical center.

Despite a research budget just above \$30 billion for the NIH in 2009 (not counting stimulus support from the *American Recovery and Reinvestment Act of 2009* [ARRA]), the competition for research support is significant and, even when successful and fully funded, institutions need to invest considerable additional resources from other sources in order to support a mission in research. The amounts and sources of cross-subsidization for research vary among institutions and generally include clinical income, gifts, endowment or institutional reserves and for some institutions, state support.

While this model has been highly successful for decades, the last several years have witnessed a number of threats to its sustainability. Among these was the downturn in research support to below inflation levels from 2003-2009 (coupled with a sometimes pernicious attitude toward science emanating from both the government as well as the private sector). The magnitude of this problem was significantly worsened by the economic downturn that reached crisis proportions in late 2008 and that resulted in major losses of endowments in universities, non-profit foundations and, in tandem, private and institutional philanthropy in support of research. The full impact of these dramatic funding reductions has been at least temporarily offset by ARRA, which has injected \$8.2 billion into biomedical research. Indeed ARRA funding has had a major positive impact on Stanford (as well as virtually every academic center) but this reprieve may be short lived since ARRA ends with fiscal year 2010. Accordingly, the amount of money that will support research in fiscal year 2011 remains unknown but must be a source of concern – given the overall national budget and looming extraordinary deficits.

There is already considerable debate about whether ARRA support has been meaningful. This question needs to be put into context. A study recently commissioned by the AAMC showed that the nation's 131 medical schools and 400 teaching hospitals employ 1.86 million full-time employees and are directly or indirectly responsible for 3.3 million full-time jobs. Based on the expenditures of academic medical centers the annual total economic impact is estimated as \$512 billion – which means that academic medical centers comprise 20% of the health-care sector of the economy (see <http://med.stanford.edu/ism/2009/november/academic.html> for further detail). ARRA funding has thus been directed to a significant segment of our economy. At Stanford we believe that ARRA has had a significant impact on our research programs and on the preservation and creation of jobs in our community, and we have recently posted a website that describes these positive effects (see: <http://med.stanford.edu/stimulus/>).

The immediate challenge – and the topic of my comments at the AAMC meeting – is how to prepare for the post ARRA funding environment, which begins next year. I highlighted ten issues that are worthy of consideration – all of which we are exploring at Stanford.

1. ***Recruiting and retaining the most talented individuals:*** While we have had to impose a hiring freeze during the past two years (especially for basic science faculty), we are hopeful that we will be able to resume hiring selected junior faculty in the next couple of years. We recognize that they are our future lifeblood and best source for continued excellence in discovery and innovation. But we also recognize that considerable institutional resources are needed to recruit the most talented junior scientists. In tandem, we continue to work on retaining our most talented faculty, and we recognize that our faculty are often considered targets of opportunity by other institutions. Successful retention includes providing interim support for faculty whose research funding may have temporarily lapsed. More importantly, it includes fostering an environment that remains attractive and stimulating to the most exciting investigators.
2. ***Being selective in the number of faculty recruited at any one time:*** While there is a need to create a critical mass and to sustain excellence in defined areas, it is also true that searching for the best faculty requires time and effort and that ultimate selectivity cannot be compromised. If a search fails to define a candidate of exceptional excellence, it is better to pause and start over rather than to make a compromise that might sacrifice future excellence. A common theme among our departments is the desire to find someone “better than themselves” who provides new talents and skills. This requires considerable effort, and running too many searches at once can dilute focus and lead to inadvertent compromise.
3. ***Being thoughtful about the overall size of the faculty:*** A common refrain among medical schools is an expressed desire to grow their faculty and become more prominent in the NIH rankings of institutional funding. I think this is not a wise focus. It is far better to fall short on total funding in favor of having individual faculty who are highly supported and competitive for peer-reviewed funding. This may mean limiting the growth of faculty – which is very much part of the culture at Stanford. However, this view is not shared at most medical schools. I would argue, though, that when resources are constrained – as they are likely to be in the years ahead – it is preferable to have fewer faculty who are each highly competitive and accomplished than to have a larger number of faculty who may compete only on the margin during times when funding pay lines are reduced. I do recognize that most institutions and leaders do not share this perspective – but it should at least be considered.
4. ***Being careful about the size and amount of research space:*** A frequent hallmark of success is the number of buildings devoted to research and the amount of laboratory space available to individual investigators. Indeed, a number of institutions have viewed the number of construction cranes on site as a measure of institutional success and even excellence. I would argue to the contrary. It is preferable to have more limited space that is fully occupied and supported than to have excess capacity. Further, it is likely going to be important to reconsider the amount of space and people any single faculty member or investigator can support.

At Stanford we have long employed space charges to place a premium on research space and have tried to plan new space based on clear faculty projections. We are also focused on supporting common space and shared equipment. Going forward we need to be more focused on reducing the cost of research by faculty, departments and centers. The concept of building space with the hopes of recruiting faculty who will bring considerable research funding with them is a somewhat dangerous strategy and will likely become even more hazardous in the years ahead. I recognize that peer institutions may not share this point of view, but I think it too deserves consideration.

5. ***Reducing expenses:*** I know that individual investigators exercise considerable rigor in controlling research expenses. But I am also confident that, just as in every other endeavor, better ways to reduce administrative expenses and overhead are achievable. This will require considerable effort and planning, since expense control has not been a focus (or even a sought after characteristic) of most faculty – who are appropriately more interested in advancing discovery and innovation. Working more creatively with teams focused on expense reduction and even incentivizing success are strategies that need to be pursued.

6. ***Creating expectations:*** There are major differences in the amount of institutional support provided to faculty in a medical school in comparison to other parts of a university. In fact it is almost invariably considerably less for faculty in medical schools. We think it is important to have defined expectations about how much of a faculty member's compensation and support should be based on grants. This is graded according to faculty seniority and ranges 40 to 60% (or more) for more senior faculty. Clearly this is a source of stress at times when grant funding is diminished, and thus it is important to have some base of support for research faculty as well as resources for bridge funding to cover lapses in funding.

At Stanford we have a defined bridge-funding program in place that, thankfully, has been relatively infrequently used to date. Fortunately, nearly every faculty member who has received funding from this source has been able to restore research funding over time. But there needs to be an expectation that, if grant funding is not successful after bridge funding (and assuming no other extraordinary factors), reductions in compensation are to be anticipated. That is, there cannot be an expectation that research faculty who are not able to support their salary and programs can depend on departmental or institutional support. It is best when this is baked into the culture and is applicable to all faculty members.

7. ***Leveraging funding:*** We have had an active program of providing modest and competitive seed grants to faculty who are addressing new research themes, especially if they are interdisciplinary and/or create bridges between basic and clinical faculty. While results are still somewhat anecdotal, it appears that these seed grants leverage about a 5-10 fold success in subsequent peer-reviewed funding support. They also enable faculty who would not otherwise have

necessarily worked with each other to connect – and that opens new venues for innovation. We have not done enough to support program project grants or big science efforts, since that has run against our traditional institutional priorities and culture. But we are doing that more selectively and will need to put more effort into that in future years – especially if that becomes an increasing focus of NIH support.

8. ***Seeking new funding sources:*** It is also important to seek new sources of funding that can complement or create synergies with traditional federal sponsored research. These might come from non-profit foundations or industry (although attention to potential conflict of interest and intellectual property are important caveats). In California, we have been major beneficiaries of state support for research, especially through the California Institute of Regenerative Medicine (CIRM). CIRM is supported by the 2004 Proposition 71, which allocated \$3 billion to this endeavor. Other states have also begun supporting research in stem cell biology; Texas has recently begun a major funding program for cancer research. These state funding sources are important and can compensate for reductions in federal support. But they may create inadvertent disparities across the nation and could even lead to an expectation that states should fill in the shortfalls of the federal investment in research – which would be potentially dangerous for the future prominence of the USA in biomedical research.

In addition to state, foundation and industry support, it is likely that clinical income will also continue to be sources for funding research at academic medical centers. However it should be expected that this source will be impacted over time by health care reform, which will lead to reduced payments to medical centers and narrower margins. Significant healthcare reform is a clear priority, but it will have consequences on the research mission of many academic centers, especially those that have relied on clinical income as a source for research support.

9. ***Creating buffers:*** Our hope before the economic downturn was to create a buffer for our faculty by raising gifts to support and even endow graduate education. We also hoped to generate significant philanthropic support to provide graduated endowment support for junior faculty that would increase with promotion and tenure. This remains a priority, but our timeline is delayed by the economic downturn. In future years we will hope to generate such support for our medical school faculty in order to provide better insulation against the undulations in sponsored research support.
10. ***Advocating for research funding:*** In addition to doing all we can to better manage our institutions and support our faculty and students, it is essential that leaders of academic medical centers and faculty do all they can to advocate for more stable research funding that, at a minimum, keeps pace with inflation. It would be a tragedy if the economic forces now at play resulted in a deterioration of the unique role the USA has played in advancing research discoveries and

innovations. We need to do all we can to support this unique contribution to global health and security.

I have provided a high-level outline of some of the issues we need to address. The list is certainly not comprehensive and the examples are incomplete. But I hope they foster discussion and also attract comments and suggestions about how we can better support our research mission in the years ahead. Please don't hesitate to offer input and suggestions.

What Students and Trainees (and the Rest of Us) Need to Know about Privacy and Security

In recent weeks several issues have emerged that prompt a review of privacy and security issues that should be available to and known by our learning community. The following list has been generated and provided by the Office of General Counsel, and I provide them for your consideration.

1. **“Need to know” access:** Under federal and state privacy requirements, you cannot access anyone's identifiable health information (“protected health information” or “PHI”) without written authorization, unless you have a need to know for a permissible reason. For medical students, permissible reasons include: (1) treatment of a patient for whom you have responsibility; and (2) participation in Stanford training programs (*e.g.*, classroom lectures, case studies, morning reports, student presentations, and clinical instruction in the treatment setting). There are a limited number of other permissible reasons to share PHI, such as if it is required by law or necessary for certain health care operations in which you are participating (such as quality-of-care reviews). Research access is addressed below.

Note that PHI is defined *extremely* broadly. It includes not only patient name, medical record number, and contact information, but even initials, treatment dates, birth date, patient zip code, images, a relative's name or identifiable information, and other information that, together with what is otherwise known, could reasonably be used to identify a person. PHI is protected whether the person is living or deceased. PHI can be in any form: written, electronic, or verbal.

Activities that do not meet the “need to know” standard include, for example: using electronic medical record systems to look up a patient for whom you have no treatment responsibility; talking with a family member or friend about a patient case with any reference to PHI; forwarding to or discussing PHI in a School of Medicine chat room or on a social networking site such as Facebook; and sharing PHI with anyone, even at Stanford, who does not have a specific job-related need to know.

2. **Minimum necessary:** You may use, share, or access only the minimum necessary PHI. Accessing more than the minimum necessary PHI is against the law. If you are helping to treat a patient, the minimum necessary could be the full medical record. In contrast, if de-identified information suffices for some educational activities or presentations, or very minimal PHI could be used, then that is all that you may use. Note that Stanford privacy policies restrict the use of certain PHI (such as mental health information) for training or educational purposes; this reflects stricter confidentiality requirements for sensitive information.

3. **Research:** If you are conducting any research using PHI, you need prior IRB approval. Even before you initiate your research, if you need to know whether there are enough patients with a specific condition to propose a research study, you must have prior IRB approval and/or approval of the School of Medicine privacy officer; you cannot search the electronic medical records to find this out without prior written approval.

In many studies, the IRB requires researchers to obtain written authorization from individuals to use their PHI for research. The IRB may waive authorization (e.g., in retrospective record studies) if legal criteria are met. Keep documentation of your IRB approvals, both for general recordkeeping purposes and so that you can show your access was permissible if any question is raised.

4. **Security:** Use excellent judgment and follow Stanford security policies to protect the security of PHI. Do not share your password; you will be deemed responsible for access to PHI under your login name. Do not take patient information home or away from the School or Hospital unless it is properly secured (e.g., encrypted for electronic files and a locked container for paper). Avoid using PHI in emails if possible, and if it is necessary, use secure email and follow Hospital patient-email policies.

If you learn of a possible breach of privacy or security, report it immediately to the School of Medicine or Hospital privacy officers at 650-725-1828 or 650-724-2572. Federal and state laws require Stanford to investigate and report breaches very quickly to the government and affected individuals, so it is critical for you to share any information about such an incident immediately with the above contacts.

5. **Legal and public relations risks to you and Stanford:** As electronic medical record systems proliferate and high-profile privacy and security breaches in California and elsewhere have occurred, federal and state officials have enacted new privacy and security laws, which are being aggressively enforced. Significant fines (thousands to millions of dollars) may be imposed on individuals and institutions for a breach or other violation of privacy and security laws, depending on the severity and circumstances. The California Department of Public Health reports individuals who have violated privacy laws to the relevant

licensing boards for review and disciplinary action. In addition, privacy and security breaches are posted on state and federal government websites, and institutions have a legal duty to notify the media of certain breaches.

As one example of the dramatic change in the enforcement climate, federal rules formerly excused a violation if a health care provider did not know of the privacy violation, and could not have known of it even through reasonable efforts. Now, even though the provider did not know of the breach, that same scenario triggers fines, although at a lower level (\$100-\$50,000 per violation) than if the facts show a knowing violation.

Your best protection is to access, use, or share only the minimum necessary PHI, and then only when you have a permissible need to know. Use de-identified information, or encrypted PHI, whenever possible. Keep any PHI secure to avoid unintentional access or a breach.

Some Notable Recent Events

1. ***Frontiers in Human Health***: On November 11th we hosted the first in our new series of cutting edge science and medical topics for the community. This first program focused on Regenerative Medicine and was designed to describe the importance of basic research in creating new knowledge in its own right and as a source of potential and future improvements in human health. This was a dinner event (paid for by the more than 300 attendees) that featured prominent faculty at each table to foster discussion and dialogue. The event also featured an interactive dialogue on regenerative medicine by three faculty members representing different fields and disciplines. They included ***Ben Barres***, MD, PhD, Professor of Neurobiology, Developmental Biology and Neurology and Neurological Sciences (and Associate Member of the Neurosciences Institute); ***Jennifer Cochran***, PhD, Assistant Professor of Bioengineering; and ***Marius Wernig***, MD, Assistant Professor of Pathology (and Member of the Institute for Stem Cell Biology and Regenerative Medicine). Following brief comments and reflections on their own work, Paul Costello, Executive Director of the Office of Communication and Public Affairs, led a panel discussion with Drs. Barres, Cochran and Wernig as well as with the audience. It was a highly successful event – also evidenced by the fact that more than 100 individuals were on a waiting list to attend. We will be doing a series of similar events in the future.
2. ***Women's Cancer Center: Under One Umbrella***: Thanks to the outstanding efforts of a volunteer host committee led by ***Lisa Schatz*** along with Co-Chairs ***Susie Fox, Lainie Garrick, Lisa Goldman and Dianne Taube*** and an excellent committee as well as outstanding support from our Office of Medical Development, we hosted a terrific event benefiting the Women's Cancer Program at Stanford. I should quickly add that this event was catalyzed by the participation

and attendance of Academy Award winning actress *Nicole Kidman* and her Grammy Award winning husband *Keith Urban*. Ms. Kidman has been a long-time friend and supporter of *Dr. Jonathan Berek*, Professor and Chair of Obstetrics and Gynecology at Stanford and director of the Women's Cancer Center. In addition to wonderful comments by Ms. Kidman, which were especially laudatory about Dr. Berek and his wife Deborah, the event also featured a performance by Keith Urban. And as wonderful as these were, most moving were the comments *Dr. Ellie Guardino*, Assistant Professor of Medicine, who recounted her commitment to improving the lives of women facing breast cancer through research and its ultimate application to patient care. Her message was made even more poignant by her recounting of her own recent struggle with cancer and how it transformed her life and family – and led to a rededication to being a physician- scientist who helps others. Dr. Guardino's comments reminded us why our cause and mission are so important. And the several hundred attendees who were the beneficiaries of this moving benefit will hopefully be even stronger advocates and supporters of the Stanford Cancer Center.

3. ***Alumni Gathering in Boston:*** On the evening of Sunday, November 15th, the Stanford Medical Center Alumni Center hosted an event in Boston in conjunction with the annual AAMC meeting. Nearly a hundred alumni (out of the over 400 in the greater Boston area) attended. *Dr. Linda Clever*, Associate Dean for Alumni Affairs, hosted the event, which permitted alumni to reconnect and refresh their memories of their time at Stanford. I gave an update on our activities, especially in education, and we had a terrific discussion with Stanford alumni across many generations.
4. ***Team Science Training 2009:*** During the week of October 26th, over 60 faculty, students, and staff gathered at Quadrus Conference Center to participate in the medical school's first ever "Team Science Training Program." This course was led by Dr. Margaret Neale, a professor of organizational behavior at the Stanford Graduate School of Business. Sponsored by the Career Development and Diversity portion of the Stanford Clinical and Translational Science Award (CTSA), the program was designed to equip scientific teams with the knowledge and tools needed to improve their productivity.

Given the importance of teamwork in the conduct of clinical and translational research, this type of training will continue to be an important focus of the current CTSA. More information about the Team Science Training Program is available at: <http://med.stanford.edu/diversity/ctsa/pastprograms.html>

Upcoming Events

Stanford Health Policy Forum:

Key Challenges in Pharmaceutical Regulation

A Discussion with Donald Kennedy, PhD, President Emeritus of Stanford University and John C. Martin, PhD, Chairman and CEO, Gilead Sciences

Moderated By **Daniel P. Kessler**, Stanford University

Wednesday, December 9, 2009

11:00 a.m. to 12:30 p.m.

Clark Center Auditorium

This forum is free and open to the public, however due to space limitations, please RSVP online at <http://www.stanfordtickets.org/> or visit <http://healthpolicyforum.stanford.edu/> Additional information on Stanford Health Policy Forums can be found at <http://healthpolicyforum.stanford.edu/or> or by calling 650-725-3339.

Awards and Honors

- ***Dr. David Relman*** was named the first Thomas C. and Joan M. Merigan Professor: The event formally announcing Dr. David Relman as the first Merigan Professor was notable and significant on multiple levels. First, the new professorship is named in honor of Dr. Tom Merigan and his wife Joan. As you likely know, Tom Merigan is one of the world's pioneers in infectious disease research with a particular focus on chronic viral infections, especially hepatitis and HIV/AIDS. His contributions are nonpareil. In addition to the honor of an endowed chair that recognizes Dr. Merigan, it is also notable that the financial source for the chair comes from his own personal resources and those of his family and friends. Clearly this is a wonderful affirmation of a life committed to science that will now be sustained in perpetuity. Dr. Relman, in his still relatively short career, has opened new vistas to the novel diagnosis and pathogenesis of bacterial disorders and to the greater role of bacteria in global ecology, biodiversity, biosecurity and beyond. The new chair provided a wonderful opportunity to celebrate both the career of Tom Merigan and the exceptional contributions of Dr. Relman. Please join me in extending our appreciation to Tom and Joan Merigan and our congratulations to Dr. Relman.
- ***Dr. Lucy Shapiro, Virginia and DK Ludwig Professor of Developmental Biology and Dr. Harley McAdams, Professor of Developmental Biology*** are the 2009 co-recipients of the 2009 John Scott Award. This prestigious award was first given in 1834. Previous recipients include such notable inventors and discoverers as Madame Marie Curie, Thomas Edison, the Wright brothers, and Jonas Salk, among others. Drs. Shapiro and McAdams received the 2009 John Scott in recognition of "their application of electrical circuit analysis to genetic networks, which enlightened our understanding of living cells." The award was presented on November 20th in Philadelphia.
- ***Dr. Craig Miller***, the Thelma and Henry Doelger Professor of Cardiovascular Surgery, received the Eugene Brauwald Academic Mentorship Award from the American Heart Association on November 15th for "his exceptional 30-year

record of training, mentoring and enriching the career development of emerging cardiovascular surgeons and researchers.”

- **Dr. Sandy Napel**, Professor of Radiology, has been elected to the College of Fellows of the American Institute for Medical and Biological engineering (AIMBE). Located in Washington, D.C., AIMBE is the leading advocacy group for medical and biological engineering and is comprised of some of the most important leaders in science and engineering, the top 2% of medical and biological engineers.
- **Alan M. Garber**, Henry J. Kaiser Jr. Professor and Prof of Medicine &, by court, of Economics, HRP & Economics in the GSB & Senior Fellow at FSI & SIEPR and Stanford Health Policy Director, has been awarded the Society for Medical Decision Making’s career achievement award. Presented at the SMDM annual conference, the award recognizes senior investigators who have made significant contributions to the field of medical decision making.

2009 CTSA Seed Grant Awardees: The Office of Community Health is pleased to announce the recipients of the 2009 CTSA Seed Grants. These awards provide research/project funding for Stanford faculty to form new community-based partnerships, enhance existing partnerships or support implementation of a community-based research project with community-based organizations in San Mateo or Santa Clara counties. This year’s award recipients include:

- **Lisa Chamberlain**, M.D., MPH , Assistant Professor of Pediatrics and **Meg Itoh**, M.D., Pediatric Resident, Lucile Packard Children’s Hospital for: Understanding the Lives and Health Needs of Refugee Foster Care Youth in Santa Clara County
- **Halsted R. Holman**, M.D. , Professor of Medicine, Emeritus for: Improving Care for Chronic Disease through a Community Partnership
- **Samuel So**, M.D., FACS, Director, The Asian Liver Center at Stanford University for: Studying the Efficacy of Education and Community Center Vaccination and Screening Services to Reduce Chronic Hepatitis B
- **Dee West**, Ph.D. Professor, Department of Health Research and Policy and **Bang Nguyen**, Dr.PH , Consulting Assistant Professor, Department of Health Research Policy for: Building Community Academic Partnerships for Cancer Control Research
- **Eunice Rodriguez**, Dr.PH , Associate Professor, Department of Pediatrics and Center for Education in Family and Community Medicine and **Nancy Morioka-Douglas**, M.D., MPH, Clinic Professor, Clinic Chief, Stanford Family and Community Medicine for: Refining and Disseminating HealthyU: A Health Science Learning Journey

- **Michaela Kiernan**, Ph.D. Senior Research Scientist, Stanford Prevention Research Center for: Translation of Group-Based Behavioral Obesity Treatments to Extend Community Reach

Congratulations to all.

Appointments and Promotions

- **Michael Dake** has been appointed to Professor of Cardiothoracic Surgery, effective 12/01/09.
- **Craig Levin** has been appointed to Professor (Research) of Radiology effective 12/01/09.