Dean's Newsletter
February 8, 2010

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Translating Discoveries: the 2010 Strategic Leadership Retreat

On Friday, February 5th we held our Annual Strategic Planning Leadership Retreat. We brought together just over 90 leaders from the basic and clinical departments, the institutes and the Dean's Office, as well as faculty and staff leaders, student and postgraduate leaders, and leaders and officials from the hospitals, the SHC Board of Directors and the University. Because of the economic downturn, I decided to keep the retreat local and to reduce it from two days to one. It was held at the Quadrus Conference Center on Sand Hill Road, and we took as our theme *Translating Discoveries 2010*. Despite the truncated schedule I found that the retreat provided an outstanding opportunity to review our progress on some of the key initiatives regarding faculty development that were stimulated at the 2009 Strategic Planning Leadership Retreat and to focus attention on important themes for Stanford Medicine in the years ahead. I will give some of the highlights of the retreat in this newsletter and will plan to drill down on specific initiatives in forthcoming issues.

The retreat was bookended by thought-provoking presentations by two notable leaders. We opened with a talk by Dr. Rick Klausner, former Director of the National Cancer Institute (where I interacted with him quite closely) and past Executive Director for Global Health of the Bill and Melinda Gates Foundation. Dr. Klausner is presently serving as Managing Partner for The Column Group and serves as advisor to a number of world and government leaders on health, science and education. The retreat closed with a dinner presentation by Bob Klein, well-known in California as the leading force for Proposition 71 and President of the California Institute of Regenerative Medicine. Both Rick Klausner and Bob Klein are "out-of-the-box" thinkers, and each raised important questions, challenges and issues regarding the current status of biomedical research and its future – focusing on translational research – or, as Dr. Klausner refers to it, "translatable discoveries."

Rick Klausner highlighted the limitations of the current funding models for research – especially at the NIH. He also addressed the impediments of moving basic

science discoveries to clinical medicine, including the length of time and risks involved and how this is impacting the viability of the biotechnology industry. He advocated a shift in thinking to a greater focus on "problem solving" research. This would require a change in the ethos of the research establishment – away from the way scientists and clinicians currently think and interact and to the way technology transfer occurs. It would require thinking about different – and more broadly defined – funding sources (a theme Bob Klein picked up in his presentation at the end of the retreat). I have to admit that I resonated to Rick Klausner's problem solving approach, since I tried to invoke it nearly two decades ago in solving problems in child health. In fact I pushed it to the point of establishing a national network to address problem solving in pediatric research (the Glaser Pediatric Research Network), but the funding sources were not available to sustain the effort. Perhaps that is something that is changeable and that could promote this concept on a larger level.

As I noted, Bob Klein also pursued a theme of out-of-the-box thinking about how to fund biomedical research – and offered provocative perspectives on how research might be supported in the future based in part on how the model for Prop 71 and CIRM was formulated. The intriguing prospect of a global fund for biomedical research echoed some of the ideas put forth by Rick Klausner and provide the basis for further thinking and discussion.

We also had two truly outstanding scientific presentations that serve as exemplars of what makes Stanford such a remarkable institution. The topics were chosen to illustrate the connections between basic science and clinical medicine and how knowledge and experience on each side of this equation inform and stimulate the translation of discoveries. Mark Krasnow, Professor and Chair of Biochemistry, reviewed the evolution of his research in the development of the lung, which began in experimental models and has moved to the elucidation of this process in humans and which now has important implications for studying diseases like asthma and cancer. Karl Deisseroth, Associate Professor of Bioengineering and Psychiatry, demonstrated how his experiences with human depression prompted him to better understand current psychiatric therapies, which led to his fundamental discovery of optogenetics and the development of tools that help elucidate brain function. Both Mark Krasnow and Karl Deisseroth had training in medicine and science, and both recognize the importance of interactions and collaborations between basic and clinical science as well as interactions with faculty in other schools at Stanford in promoting new ideas and fostering the translation of their discoveries.

We also explored three major topics directly related to *Translating Discoveries 2010* through faculty panels that elicited great interaction and discussion. Background material was available to the participants, including excerpts from the recently published book The Vanishing Physician-Scientist (edited by Dr. Andrew Schafer. Ithaca: Cornell University Press, 2009). The panels included:

1. ***Educating Physician Scientists and Translating Scientists***. Panel members were Drs. Karl Deisseroth, Sam Gambhir, Geoff Gurtner, Seung Kim, Holbrook Kohrt, and Mark Krasnow.

2. ***What Are the Necessary Ingredients for Promoting Interdisciplinary and Interdepartmental Research and Education***? Panel members were Drs. Russ Altman, Jim Ferrell, Sherril Green, Karla Kirkegaard, Hugh O'Brodovich, and Anne Villeneuve.

3. ***How Can We Better Secure Faculty Success? Exploring Models for Mentoring and Career Development.*** Panel members were Drs. Steve Galli, Ann Leung, Frank Longo, Jody Puglisi, Christy Sandborg, and Mike Snyder.

We will be distilling the discussions that took place by these panels, and I will report on our synthesis, recommendations and action items in future newsletters. As I reflect on the overall discussion, I take note of the common threads that emerged from the discussion and that link these important topics. The first is how much the medical school benefits from being an integral member of a great university. The geographic proximity to the other Stanford schools fosters incredible interactions among faculty and students. In addition, the highly entrepreneurial spirit of our community and our desire to think boldly benefits enormously from the Stanford culture. Our shared focus on quality over quantity permeates the entire Stanford community. Of course that means that in a school like Medicine we have a number of important disciplines that are represented by only a handful (or less) of people. On the other hand, our small size promotes interactions and makes it important that each recruitment seek the very best – whether student, staff or faculty. Another important common thread is time and the many demands we all face in striving for excellence in our multiple missions. The limits of time are expressed differently in education, research and career development.

For example, there is no question that the length of time required to become a physician-scientist or a scientist focused on basic research and/or translational medicine is excessive. While efforts are being made to address this in different residency programs (e.g, cardiovascular surgery, neurosurgery and others) it is really the continuum from undergraduate (college) to medical and/or graduate school to postdoctoral training that poses the challenge. Each of these sectors is discrete and governed by different regulations and certifications. We have been discussing how to take some bold steps and develop new pathways toward educating and training future physician-scientists and translating scientists in a more focused and compressed manner. I truly think we have the opportunity to do something unique at Stanford, and this will surely be a topic for future exploration and discussion.

The limitation of time is certainly a factor in the ability of our faculty to engage in interdisciplinary research and education. This is true for faculty engaged in full-time research, but is particularly the case for those at the interface between research and patient care. Some of the hurdles can be overcome by seed funding that brings faculty and especially students and postdocs together to address novel research opportunities.

This can also be enhanced by shared faculty and student meetings within departments and facilitated by connections forged through the Institutes of Medicine, BioX or chance meetings among faculty and students. At the same time, the pressures of time (for writing grants, doing research, caring for patients, teaching) negatively affect opportunities to attend seminars or other events that might stimulate new knowledge or new possibilities for collaboration.

A number of concrete suggestions were put forth about how to deal with some of these challenges and they too will be discussed in future events and newsletters. A notable external validation of how well we are doing in interdisciplinary research and education – in fact likely far better than virtually any other institution – was also conveyed by one attendee. There is no question that we are more likely to highlight what is wrong than what was successful. So, it is important to point out the areas of achievement – even though we don't want to rest on laurels and do want to remain motivated to constantly strive to do better.

Not surprisingly, time is also a challenge in securing faculty success – both for faculty and for their advisors and mentors. We heard some important approaches to mentoring from departments that made this an area of focus following the 2009 Retreat. Indeed, evidence of success was forthcoming from both basic science departments as well as larger clinical ones. But there appears to be dissonance between the overall satisfaction of our faculty (where we score at the top in various comparisons with other medical schools) compared to perceived success in mentoring (where we seem to do less well). Whether this is a definitional problem or a real one is an important question, as is the degree of additional effort we should expend to promote even better outcomes. Because there is still considerable attrition of faculty out of careers as physician scientists or academic scientists, especially of women and members of underrepresented minority groups, I strongly believe we have much more work to do in this area – particularly for our clinician-scholars and scientists. In my opinion, we still need to address some novel and different approaches that run against current accepted norms – but I don't believe we can afford to not do this.

In sum, we covered a fair amount of ground in some important areas of academic medicine. I have touched on a few highlights and am purposefully leaving the details for additional distillation and refinement – with the goal of setting some new priorities that we can focus on over the months ahead. Clearly more to follow!

Federal Budget for Science and the NIH: The Ups and Downs

During my 23 years as an Intramural Investigator at the National Institutes of Health (NIH) there were lots of ups and downs in NIH funding. But the downs were usually short-lived, rarely exceeding two years, and the ups were generally modest, generally at or slightly above inflation. Overall the NIH budget climbed over time – but slowly, and when I left Bethesda for Boston in 1996, the overall NIH budget was just over $13 billion. At that time the NIH enjoyed strong bi-partisan support, and the promise that science would yield discoveries that would improve the lives of patients across a

number of serious human diseases loomed large. While it now seems like ancient history, this was also the time when the public and the Congress were learning about the human genome, and the "big science" effort to sequence the genome was often heralded with promissory notes of how cures would soon follow the unraveling of the language of life. It was also during this time that new treatments were changing the outcomes for patients with HIV/AIDS – a disease that had only been recognized some 15 years previously and that had captured the public's attention and fears.

Advocacy for biomedical research was supported by a large number of quite varied disease advocacy groups – especially cancer, AIDS, and diabetes – and was joined by the scientific community, universities, research institutions and beyond. This led to the plan to double the NIH budget over a five-year period, which began in 1998 and continued through 2003. Expectations for the impact of this significant incremental funding on the creation of new diagnostics, therapies and preventive strategies were high and were fueled by promises, even if well intentioned, that exceeded reality. In retrospect, it cannot be seen as a surprise that, in 2002 and 2003, the Congress began asking for the breakthroughs and cures emanating from the doubling. While much important work was accomplished, the reality is that tangible deliverables of the translation of basic research into clinical care often require years and sometimes decades. As a community we did not do a good job of delivering that message – and, in fact, we spent too time focused on the promise that research discoveries would reap benefits in ways that were really unrealistic. We should not forget that lesson.

As a consequence, from 2003 through 2009, when the American Recovery and Reinvestment Act of 2009 (ARRA) was launched as part of the "stimulus plan," the NIH budget had been held flat for 6 years – losing some 17% of its buying power in 2008 compared to 2003. The consequences of flat funding for faculty, trainees and institutions across the nation were significant. These were made even worse by the anti-science mood that was increasingly expressed from Washington but also observed in many sectors of our country. Not surprisingly the mood of many scientists was worried and sometimes gloomy, and the pressures to submit more and more grants for less and less funding eroded much of the enthusiasm of years past. That changed in 2009 with the $8.2 billion that the NIH was to spend over two years to support biomedical research, coupled with an administration that clearly signaled that it values science and innovation. The medical and scientific community once again rose to the occasion and savored the increased funding.

From the moment the ARRA funding began there was anxiety about what would happen in FY2011 – when the two years ended. Some believed that the ARRA funding would reset the NIH "base" at $37-40B, making up for the losses of 2003-2008, and "right size" our scientific enterprise. There is no question that, like medical schools across the country, Stanford has benefited from the ARRA support (see: http://med.stanford.edu/stimulus/ on "Investing in Medicine"). Others, and I admit I was in this group, did not see the resetting of the NIH base as likely, given the overall economic climate. In fact, a number of colleagues and I would argue instead that sustainable funding that kept pace or exceeded inflation would be more important for our

scientific enterprise than the boom or bust cycle that has characterized the last dozen years.

Of course hopes of even keeping pace with inflation seemed low when the President announced a freeze on spending (with some notable exceptions) last week. Forecasts for NIH looked gloomy indeed. And while they are still below where we would like, the fact that the President's budget proposed an increase for NIH is further evidence of the Administration's support for scientific research. With the release of the budget this past week, NIH is slated for a $3.2% increase over last year's base to $32.089 billion. This increase is at the projected level of the Biomedical Research and Development Price Index (BRDPI). Further, the President's budget proposes a 6% increase in training grant stipends and a 2% increase in the average noncompeting and competing RPG. Given how funding for nearly all other programs is likely to fare, this must be seen as good news and as a vote of confidence for science – even though it will still put a lot of pressure on faculty and trainees competing for grants.

In addition to funding for NIH, other components of biomedical research and healthcare sector were included in the President's budget, including:

- Health Professions: Title VII and Title VIII health professions education programs indicates a 2.2 percent increase over FY 2010NHSC

- The National Health Service Corps budget is proposed for a 19% increase over FY10 – to $169 million

- The Agency for Healthcare Research and Quality has the largest percent increase (53.9%), an increment of $214 million to a proposed $611 million in FY 2011

- The President's FY 2011 budget also requests a 1.5% increase for research at the VA, bringing the total to $590 million for VA research.

Overall, these current proposals are much more favorable than what many of us assumed just a week ago – even if less than what was hoped for two weeks ago. Of course these remain budget proposals and there is a lot of political maneuvering that will occur before the FY11 budget is fully defined. But at least the NIH is projected to keep pace with BRDPI. Hopefully we can get back to a time of more sustainable funding – and put the up and down rollercoaster behind us. And as noted earlier in this newsletter, we also need creative new ways to foster biomedical research funding – perhaps on a global level.

Translating Breakthroughs in Stem Cell Research

At the CIRM (California Institute for Regenerative Medicine) meeting on February 4th, the translational research project led by Dr. Al Lane, Professor and Chair of Dermatology, was presented at a public forum. Dr. Lane, together with his colleagues Dr. Anthony Oro, Associate Professor of Dermatology, and Dr Marius Wernig, Assistant Professor of Pathology, discussed how they are building on nearly two decades of basic research to translate their discoveries to treat the dominant form of epidermolysis bullosa (EB). This tragic disease occurs in both a dominant and recessive form (which is the most severe) and has devastating consequences for affected children. Over years of remarkable research the Stanford team has developed an understanding of the molecular underpinnings that define this disease and have developed two approaches – one based on gene therapy and the second utilizing induced pluripotent stem cells (iPS). The latter approach resulted in a major disease team award from CIRM (one of four received by Stanford faculty: http://deansnewsletter.stanford.edu/archive/11_09_09.html#3 and see: http://med.stanford.edu/ism/2009/october/cirm.html). The story told by Drs. Lane, Oro and Wernig is inspirational – and was made even more so by Ms. Lynn Anderson, President and Founder of the EB Medical Research Foundation – who recounted the incredible struggle of her two children, both of whom ultimately died of EB after years of suffering. The potential for hope emanating from basic and translational research serves as an exemplar of our mission at Stanford and our goal of finding treatments that improve the lives of adults and children facing serious and catastrophic disease.

Healthcare: The Role of Protocols and Comparative Effectiveness Research

Rest assured. I won't offer any forecasts (and not even many comments) about where healthcare reform stands at this point – other than how relative it all is. Before the Senate election in Massachusetts I confess to being disappointed with how little the Senate and House Bills contained any substantive reform. Now even they look like an advance compared to where things now stand!

Regardless of what comes out of the Congress or Washington, it is important that we focus on doing what is right for health care: providing the best and most advanced clinical care possible, with outstanding quality and service and at the lowest cost possible. Coupled with this is continuing to innovate and bring knowledge from research to the patient. Also key is moving away from the perverse incentives that "fee for service" fosters to evidence–based care that improves health and does not overuse technology, expensive resources or tests and resources that are really not necessary.

I have long felt that one way to accomplish some of these goals is to take a lesson from how children with cancer are treated in the USA (and even worldwide). For decades, the vast majority of children with cancer have been enrolled in multicenter cooperative group protocols that assess and compare the current "state of the art" to something better. Sometimes that means more or different therapy and sometimes it means less treatment. But the overall formats of care (which diagnostic tests are indicated and when they need to be repeated; which technologies need to be deployed and when; which treatment schedule is used and how it is monitored and modified; what constitutes

a positive or negative outcome) are organized by approved protocols. While some may view these as recipes for care, they actually serve to organize and codify complex regimens into clinical trials that optimize treatment as well as improve knowledge and advance the state of the art. Perhaps more than in any other area of medicine, protocol based therapy and clinical trials have become the accepted standard in pediatric oncology and, I believe, have also contributed to the sequential improvements that have occurred over the past several decades in childhood cancer. It has also been demonstrated that simply being treated on a protocol improves outcomes – probably by better organizing and codifying the interventions that are employed.

An important question is whether this model can be accepted beyond pediatric oncology – an issue I have raised previously in this newsletter. There is no question that the pediatric oncology community has accepted protocol-based therapy as the standard. And there is no question that nearly all the rest of medicine has not gone down a similar pathway – including adult oncology. Thus, the introduction of protocol based regimens in various other diseases as the standard approach would require considerable organization as well as a culture change. Most physicians remain convinced that they must individualize care for each patient they treat, and they often eschew the concept of treatment algorithms or guidelines that emerge from clinical effectiveness studies. Indeed this became a political hot button during the health care debate last year. This issue was raised again in an opinion piece by Dr. Jerry Groopman in the February 11th issue of ***The New York Review of Books*** (see: http://www.nybooks.com/articles/23590). Dr. Groopman raises strong concerns about the wide use of clinical guidelines emanating from expert panels (he particularly raises concern about government panels) and cites some of his own errors in formulating specific guidelines for hematopoietic cytokines. I find many of his arguments compelling, but I see them as different from the use of clinical protocols in pediatric oncology, in which they serve as a dynamic form of clinical effectiveness guidelines. They are generated by experts and monitored for outcome, and they form the basis for future investigations and interventions.

As the healthcare debate recalibrates and rebases, I do think it would be interesting to test how well the protocol-based approach used in pediatric oncology can be used in other disciplines. Coupled with interactive electronic medical records, such protocol-based approaches could build in metrics for quality, utilization and better cost control. This approach does not require overregulation and it is compatible with individual decision-making whenever the conditions so require. It is a model worth exploring.

Developing a Community Network

For more than a year the leadership of the School of Medicine (SOM), Stanford Hospital & Clinics (SHC) and the Lucile Packard Children's Hospital (LPCH) have been exploring ways to reach out to physicians in our communities, both locally and regionally. The overarching goal is to create more effective communications with community physicians – especially those doing primary care – and to create alignments that improve the outcomes of the patients they serve. A number of mechanisms to foster a community network are being explored, and the opportunities for sharing information and

technology are being evaluated. To help this initiative, Dan Ginsburg, Chief Operating Officer for SHC, announced this past week the appointment of Mr. Bruce Harrison as the Executive Director for the affiliate network currently in formation by LPCH, SHC and SOM. Mr. Harrison was previously Senior VP and Chief Administrative Officer for WellStar Physicians Group, a multi-specialty medical group with over 400 providers, 80 locations and 1.2 million annual visits in Marietta, Georgia. He also previously held administrative positions at Scripps Clinic and Research Foundation and UC San Diego Medical Center. He will be joining SHC on February 15th. As details about the community and affiliated network are further defined, I will communicate them to you in future newsletters.

Tuition Changes for Medical Students

More than a year ago, Dr. Charles Prober, Senior Associate Dean for Medical Education, appointed a "Tuition Committee" to consider restructuring the tuition program at the medical school. It was felt that the current structure, which comprises 13 quarters at full tuition and additional quarters at a reduced rate called TMR (Terminal Medical Registration), was too complex and didn't compare easily to the tuition structure at other medical schools. TMR was originally put in place many years ago to encourage students to spend a fifth year doing supervised research at the school; however, it is confusing because the benefit of lower tuition does not come while the student is doing the research, but rather at the end of his or her clinical years. In addition, it falsely represents Stanford as one of the most expensive schools among our peers, since comparisons are calculated based on tuition in the first three quarters of attendance, which does not take into account the TMR savings that comes at the end of the MD journey at Stanford.

The Tuition Committee comprised staff from Educational Programs and Services, including Financial Aid, Admissions, and others; and over a dozen students. This group concluded that the structure should be changed to reflect the goals of greater simplicity and comparability by smoothing the tuition rate across all years, incorporating the lower TMR into all quarters. The resulting structure eliminates TMR and institutes a research rate, which (we hope) motivates students to stay for an additional year of research by matching the timing of a reduction in tuition with the research. The result is a tuition rate that is more than 5% lower than the expected rate in each of the first 13 quarters, saving students money in the initial years of their education. For students taking the additional year of research—which the vast majority of our students do—a combination of the low research rate plus Medical Scholars funding is expected to make that year free of cost, including covering a standard cost of living amount. The new tuition structure applies only to incoming students, beginning next fall (August 2010).

The AAMC reports tuition rates for medical schools according to the first three quarters of tuition, so these changes will more accurately represent Stanford's cost relative to our peers in the thirteen-school consortium; rather than being viewed as the third most expensive school, after Washington University and Case Western, we are likely to be closer to the middle of the pack, nearer Harvard, Penn, and Duke. Over a full four-or five-year degree program the new structure costs slightly more than it would have

under the current structure for a typical student. We believe that our position relative to peer institutions will remain positive, and we anticipate that our graduates will continue to have among the very lowest debt in the country.

To Be Shod or Not To Be Shod

Like many endurance athletes who read Christopher McDougal's now popular book entitled Born to Run: A Hidden Tribe, Superathletes, I have been toying with the idea of whether to try to run barefoot instead of with my trusted Asics Nimbus 11. McDougal tells the story of the Tarahumara tribe in Mexico who run astounding distances on a daily basis with minimal injury. In addition to a fascinating story, the book takes on a theme that has become a sports cult passion; namely, that the introduction of cushioned running shoes in the 1970s – which have become more elaborate and cushioned since then – serve to promote more injury than they prevent. Since I have been wearing various evolutions of these running shoes – indeed since the 1970's – and have had my fair share of injuries, it is hard to not question whether things would be different in a non-shod state. Alternatively, I wonder whether I'd still be doing 50-70 miles per week (as I continue to do decades later) had I not had the advantage of modern running shoes.

The speculation offered by McDougall was intriguing but now takes a more significant twist with the publication by DE Lieberman et al of "Foot strike patterns and collision forces in habitually barefoot versus shod runners" in the January 28th issue of ***Nature*** (see: http://www.nature.com/nature/journal/v463/n7280/pdf/nature08723.pdf). Since these data fly in the face of all that we have been taught about running shoes (albeit largely through marketing) it will be interesting to see how these observations impact behavior – as well as future generations of running shoes. Given the number of runners among our faculty, students and staff I am confident this new report – and the blogs and hype around it – will provoke questions and debates and, I hope, some additional research.

It's always fascinating to see how new data can upset prior "truths." But as we all know, the half-life of most new knowledge is all too short.

Mini Med School Website Is Launched

As I have described in previous newsletters, we are offering, in partnership with Stanford Continuing Studies Program, a three quarter mini med school course that was very well received by our community. The fall quarter is now available through Stanford iTunes at this web site: http://med.stanford.edu/minimed/. The winter quarter course currently in progress will be added early in the spring quarter, and the spring quarter will be added early in the summer. This is a great opportunity to see some of the school's most distinguished faculty discuss their areas of expertise, and I am very pleased that we can make their presentations available to all.

Awards and Honors

- ***Branimir I. (Brandy) Sikic***, Professor of Medicine (Division of Oncology), Associate Director of the Cancer Center, and Director of the Clinical and

Translational Research Unit, has been awarded the Presidential Medal for Science and Medicine from the President of Croatia, Stjepan Mesic. The Presidential Medal recognizes his achievements in cancer research, and his contributions to medical education and cancer care and prevention in Croatia. One of the key outcomes of a meeting between the Croatian government and the US National Institutes of Health in 2007 was a law banning cigarette smoking in public places throughout the country. Congratulations, Dr. Sikic.

- ***Sarah Geneser***, PhD, postdoctoral fellow in the Radiological Sciences Laboratory, was awarded a Dean's Postdoctoral Fellowship from the Stanford School of Medicine, to model the impact of hormone replacement therapy on breast cancer risk and progression to better understand the physiological effects on breast tumor development. She is working with Dr. Sylvia Plevritis to investigate the impact of mammography screening and treatment on breast cancer incidence and survival.
- ***Hua Fan-Minogue,*** PhD, Stanford Molecular Imaging Scholars Program (SMIS) Fellow in the Multimodality Molecular Imaging Lab, was awarded a Travel Fellowship from the Helena Anna Henzl Gabor Young Women in Science Fund to attend the American Association for Cancer Research (AACR) 101st Annual Meeting 2010.
- ***Norbert Pelc,*** ScD, professor of radiology and bioengineering, was elected to the position of Third Vice President of the Radiological Society of North America.
- ***Rebecca Rakow-Penner,*** MD/PhD candidate in biophysics and graduate student in the Radiological Sciences Laboratory, was selected as a finalist for the Young Investigators' W.S. Moore Award in clinical science. Finalists will be given the honor of presenting their papers at the upcoming Joint Annual Meeting of the International Society for Magnetic Resonance in Medicine-European Society for Magnetic Resonance in Medicine and Biology (ISMRM-ESMRMB), which will be held in Stockholm, Sweden, May 1-7, 2010.
- ***Ying Ren,*** MD, radiologist at Sheng Jing Hospital of China Medical University and postdoctoral scholar in the Translational Molecular Imaging Lab headed by Dr. Juergen Willmann, has received the 2010 Stanford Dean's Fellowship for her research proposal entitled "Evaluation of Activity and Remission of Inflammatory Bowel Disease by Molecular Targeted Microbubble-Enhanced Ultrasound in a Mouse Colitis Model."
- ***Arne Vandenbroucke***, PhD, postdoctoral scholar in the Molecular Imaging Instrumentation Lab, received a three-year postdoctoral fellowship from the Department of Defense (DOD) Breast Cancer Research Program (BCRP) of the Office of the Congressionally Directed Medical Research Programs for his research proposal entitled "Commissioning and Characterization of a Dedicated High-Resolution Breast PET Camera."
- ***David Wang***, MD, fourth-year radiology resident, has won two awards: a Radiological Sciences of North America (RSNA) Travel Award for Young Investigators in Molecular Imaging and a World Molecular Imaging Conference Travel Stipend. David received these awards for his research on gene therapy using ultrasound and custom-made microbubbles, which serve as carrier vehicles for therapeutic delivery.

Congratulations to all!

Appointments and Promotions

Marian M. Adams was promoted to Clinical Associate Professor of Pediatrics (Neonatal and Developmental Medicine), effective 1/01/10.

Cathy Angell was reappointed as Clinical Assistant Professor (Affiliated) of Pediatrics (Neonatal and Developmental Medicine), effective 1/01/10.

Scott D. Boyd was appointed to Assistant Professor of Pathology at the Stanford University Medical Center, effective 1/01/10.

Ian P. Brown was promoted to Clinical Assistant Professor of Surgery (Emergency Medicine), effective 12/01/09.

Jennifer L. Carlson was promoted to Clinical Assistant Professor of Pediatrics (Adolescent Medicine), effective 1/01/10.

Ian Carroll was appointed to Assistant Professor of Anesthesia at the Stanford University Medical Center, effective 1/01/10.

Lorinda Chung was reappointed to Assistant Professor of Medicine at the Veterans Affairs Palo Alto Health Care System, effective 1/01/10.

Rebecca E. Claure was reappointed as Clinical Assistant Professor of Anesthesia (Pediatric Anesthesia), effective 1/15/10.

Stanley Deresinski was appointed as Clinical Professor of Medicine (Infectious Diseases), effective 1/01/10.

Gundeep Dhillon was reappointed to Assistant Professor of Medicine at the Stanford University Medical Center, effective 1/01/10.

Chrysoula Dosiou was reappointed as Clinical Assistant Professor of Medicine (Endocrinology, Gerontology and Metabolism), effective 1/01/10.

Ram Duriseti was reappointed as Clinical Assistant Professor of Surgery (Emergency Medicine), effective 1/01/10.

Gary Fanton was reappointed as Clinical Professor of Orthopaedic Surgery, effective 12/01/09.

Howard H. Fenn was reappointed as Clinical Associate Professor (Affiliated) of Psychiatry and Behavioral Sciences, effective 9/01/09.

Karen J. Friday was reappointed as Clinical Professor (Affiliated) of Medicine (Cardiovascular Medicine), effective 1/01/10.

Kathleen Fujino was promoted to Clinical Assistant Professor (Affiliated) of Obstetrics and Gynecology, effective 9/01/09.

Joyce Fu-Sung was appointed as Clinical Assistant Professor of Obstetrics and Gynecology (Maternal-Fetal Medicine), effective7/01/10.

Gregory H. Gilbert was reappointed as Clinical Assistant Professor of Surgery (Emergency Medicine), effective 9/01/09.

Lucinda Hirahoka was appointed as Clinical Assistant Professor of Medicine (General Internal Medicine), effective 2/01/10.

William A. Jensen was reappointed as Clinical Professor (Affiliated) of Medicine (Pulmonary and Critical Care Medicine), effective 9/01/09.

Daniel T. Kato was reappointed as Clinical Assistant Professor (Affiliated) of Obstetrics and Gynecology, effective 9/01/09.

Sandhya Kharbanda was appointed to Assistant Professor of Pediatrics at the Lucile Salter Packard Children's Hospital, effective 1/01/10.

Carl M. Kirsch was reappointed as Clinical Professor (Affiliated) of Medicine (Respiratory and Critical Care Medicine), effective 9/01/09.

Birgit Maass was appointed as Clinical Assistant Professor of Anesthesia (Pediatric Anesthesia), effective 3/01/10.

Anthony Mascola was reappointed as Clinical Assistant Professor of Psychiatry and Behavioral Sciences (Behavioral Medicine), effective 9/01/09.

Mirna Mustapha was appointed to Assistant Professor of Otolaryngology , effective 2/01/10.

Sonya Misra was reappointed as Clinical Assistant Professor (Affiliated) of Pediatrics (Neonatal and Developmental Medicine), effective 1/01/10.

Jayakar Nayak was appointed to Assistant Professor of Otolaryngology – Head and Neck Surgery at the Stanford University Medical Center, effective 1/01/10.

Sachie Oshima was reappointed as Clinical Assistant Professor of Surgery (Emergency Medicine), effective 9/01/09.

Periklis Panousis was promoted to Clinical Assistant Professor of Anesthesia, effective 4/16/10.

Jeffrey S. Peterson was reappointed as Clinical Assistant Professor of Surgery (Emergency Medicine), effective 9/01/09.

Jennifer M. Phillips was promoted to Clinical Associate Professor of Psychiatry and Behavioral Sciences (Adolescent Psychiatry), effective 1/01/10.

Craig S. Rosen was promoted to Associate Professor of Psychiatry and Behavioral Sciences at the Veterans Affairs Palo Alto Health Care System, effective 1/01/10.

Josef I. Ruzek was appointed as Clinical Professor (Affiliated) of Psychiatry and Behavioral Sciences, effective 12/01/09.

Gaetano J. Scuderi was promoted to Clinical Assistant Professor of Orthopaedic Surgery, effective 1/01/10.

Jeannie L. Seybold was promoted to Clinical Assistant Professor of Anesthesia (Pediatric Anesthesia), effective 2/10/10.

John L. Tatman was reappointed as Clinical Assistant Professor (Affiliated) of Obstetrics and Gynecology, effective 9/01/09.

Hyma T. Vempaty was appointed as Clinical Assistant Professor (Affiliated) of Medicine (Blood and Marrow Transplantation), effective 10/01/09.

Wen-Kai Weng was reappointed to Assistant Professor of Medicine at the Stanford University Medical Center, effective 1/01/10.

Thomas Wentzien was promoted to Clinical Associate Professor (Affiliated) of Medicine (Cardiology), effective 8/01/09.

Sarah R. Williams was reappointed as Clinical Assistant Professor of Surgery (Emergency Medicine), effective 9/01/09.

Steven T. Woolson was reappointed as Clinical Professor of Orthopaedic Surgery, effective 1/01/10.

Kristen Yeom was appointed to Assistant Professor of Radiology at the Lucile Packard Children's Hospital, effective 1/01/10.