Dean's Newsletter
February 22, 2010

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Transition in Leadership at Stanford Hospital & Clinics

Since the last edition of this newsletter, Martha Marsh, President and CEO of Stanford Hospital & Clinics (SHC), has announced her retirement. Ms. Marsh joined SHC on April 2, 2002 – a year to the day after I came to the Medical School as Dean in 2001. During the past almost eight years, she and I have worked extremely closely, and I have tremendous respect for her leadership, collegiality and friendship. I want to thank her for her many contributions to SHC, the medical school, university and community. It has been a privilege to work with her and her leadership team.

It is sometimes hard to remember how different things were in 2001-2002. We were in the immediate aftermath of the failed merger with UCSF, and the negative impact of the merger and de-merger on the morale, strategic direction and financial status of the medical center was profound and even palpable across the medical center and university. I certainly recognize that those who preceded us had worked diligently on behalf of the medical center and university through the tumultuous challenges that characterized American medicine during the 1990s. But the convergence of a multiplicity of external and internal forces and events threatened the future of Stanford Medicine at the dawn of the 21st century.

I surely do not believe or want to imply that the currently dramatically improved state of the medical center today is related solely to a small handful of individuals – in the hospital(s), school or university. But I do believe that the collaboration, coordination and shared efforts of our respective leadership teams – which extend to our clinical and basic science chairs, faculty, staff and students – have made a major difference for Stanford Medicine. As we begin 2010, we still face enormous challenges, but we are now on an incredibly stronger financial underpinning. The widening gulf that existed between our basic science and clinical faculty has been breeched, and the tensions between the medical center and university largely repaired. SHC now stands as an exemplar of high

quality patient care and a resource for innovation in clinical research. Despite the surprising commentaries from some members of the Palo Alto City Council, the Medical Center is increasingly respected and valued by our community locally and globally. I attribute many of these directional changes to Martha Marsh's leadership and our shared efforts.

A search is now beginning for the next CEO at Stanford Hospital. As is often the case, many in our community are stepping forth with their views, perceptions and recommendations about the type of leader needed and about whether our current organization optimizes our prospects for continued success. As I have written in the past, there are 132 academic health centers (AHCs) in the USA that are comprised of a medical school, teaching hospital and sometimes related professional schools (e.g., nursing, pharmacy, dentistry, public health). They include state and private schools and universities, together with teaching hospitals that either are owned by the university or are independent and connected to the medical school by various affiliation agreements. Some of these AHCs are governed by a single leader (e.g., an executive vice-president to whom the dean and hospital CEOs report), and others (like Stanford) have separate leaders for the medical school and hospitals. The organizational and governance structure is often designed to optimize coordination and integration – and it recognizes the frequent tensions (often financial) that exist between a medical school and teaching hospital. These tensions are real and are certainly challenged by the economic forces impacting patient care, research and education. Understandably, the tensions are less when resources are abundant and become more challenging during times of constraint – like the ones we are facing now and will continue to face for many years to come.

I do not intend to argue for the primacy of any one model of governance, nor do I believe that any organizational structure assures success. In the end it comes down to the individuals in leadership roles and how willing they are to communicate, collaborate and compromise. I know of no governance or organizational structure that overcomes non-collaborative individuals, and I also believe that cooperative leaders can transcend even imperfect organizational models. Because we are distinctive among our peers in how we are organized, I was asked a few years ago to reflect on Stanford as a Case Study. My opinion piece was published in **Academic Medicine** (2008;83 (9): 867-72). At the end of the article I listed 10 lessons learned (or at least ones I think I learned) during my time at Stanford. I think those lessons are relevant today and, in particular, are pertinent to questions of our future governance, organization and leadership. In that spirit, I repeat them here for your consideration:

(My) Lessons Learned

- Because AHCs are often highly matrixed by interdependent interactions and relationships between academic and clinical programs, they are also fragile and can be adversely affected when one mission gets off track or dominates the enterprise in an unhealthy way. This was true at Stanford Medicine when the merger with UCSF created distractions, financial losses, and distrust between the

faculty in basic and clinical departments and between the AHC and university. To overcome these challenges, a transparent and thoughtfully articulated plan was essential.

- Overcoming a major disruption such as a failed merger requires a redefinition of the mission, goals, and objectives of both the medical school and the AHC. It requires buy in from multiple constituencies including the basic and clinical science faculty, students, and staff. It also requires healing among communities that had felt disenfranchised or even abandoned by an institutional direction they did not understand or support.

- Communication is a key component of institutional transformation, along with clearly delineated plans that are modified and adjusted to accommodate to the various institutional constituencies and their not infrequently differing perspectives. This requires communication from the leadership that is transparent, engaging, informative, and continuous.

- Institutional progress requires plans and objectives that are not only transparent but also achieved. Institutional ownership of the planning process and its deliverables is essential and should not be delegated to outside consultants or individuals who are not responsible and accountable.

- Transformational planning is a constant process with frequent ebbs and tides. Because of the diversity of talents, interests, and commitments at an AHC, it cannot be expected or anticipated that unanimity of opinion or support will be achieved. Difficult choices need to be made, priorities set, and accountability recognized. That said, progress is more possible when the institutional planning is adjusted to fit the culture, history, and values of the institution.

- Most AHCs have to make choices about their areas of focus and institutional priorities, because few are large enough to do everything. When there are internal or external constraints, forward planning is essential. Even if the plans are not fully achieved, they provide a foundation for future adaptation and modulation. During the past several years, the school's strategic plan, Translating Discoveries, has served as an anchor by which to align missions in education, research, and patient care.

- Understanding the inherent strengths and distinguishing features of an institution is also essential to successful planning. When Stanford's medical school began separating its functions and missions from its parent university, it lost the trust of the university faculty and became perceived as a liability rather than as an asset. Efforts to better integrate the medical school with the missions of the university (through the BioX program, the department of bioengineering, and the Institutes of Medicine) have helped to overcome some of the misperceptions and have led to positive interactions that appeal broadly to university leaders and the community.

- Leadership models at AHCs are highly varied, and none are necessarily sustainable over time. Stanford's separate leadership of its medical school and two major teaching hospitals provides both strengths and weaknesses. Whereas the overall mission has been served because of the positive interaction of current leaders, this model is not necessarily sustainable, and it could be compromised by resource constraints that pit one mission against another or by changes in individuals that alter the dynamics or trust of the institutional leaders

- Having the trust and authority of the university president, provost, and board of trustees is essential, especially when major changes are contemplated or being implemented. But, this trust is also subject to change and, thus, must be constantly reinforced by evidence of progress. Objective external evaluation of this project on a regular basis serves to validate the plans and the leadership. But, it must be recognized that such external reviews can also result in changes in institutional direction or leadership as well—and, thus, this also must be anticipated.

- AHCs are likely to be especially challenged in the next decade, ironically because of the destabilization likely to occur from some of the forces that brought them into their current structure and function. For example, with the anticipated changes in Medicare and the reduced support for biomedical research from the NIH, the historically highly leveraged success of AHCs will be increasingly compromised. Likely, new models will need to be developed to sustain core missions in research and education as well as patient care. These external forces make ongoing institutional planning essential; without such efforts, inadvertent damage can easily occur. As mentioned earlier, despite their formidable strengths, AHCs are also fragile, and without planning and leadership, they can lose their focus and, potentially, their preeminence, by an institutional direction they did not understand or support.

I am not certain how transportable these lessons will be to the future leaders of Stanford Medicine, but I do recognize that paying attention to history is an important way to avoiding future mistakes. That said, the future of the current organizational structure and governance of Stanford Medicine will rest heavily on the individuals who lead the school and the hospital in the years ahead. In that regard I hope that our recent past history will have an enduring value into the future.

Leadership Transitions in the School of Medicine

The complexity of medical schools also require continuity of leadership over time – often much longer than leadership roles within universities, businesses or foundations. At the same time, changes in leadership are important opportunities for renewal and recalibration accompanied by regular processes of evaluation and assessment. In the Medical School all institutional leaders (i.e., basic and clinical department chairs, institute directors and senior decanal positions) are time-limited appointments – generally 5 year terms, albeit renewable up to defined limits. Many senior leaders at Stanford also

hold “at will” appointments, which means that they serve at the “pleasure of the president or the dean with the concurrence of the president.”

Transitions in medical school leadership are governed by tradition, policy, performance and personal career decisions. Conventionally, basic science chairs serve for single five-year terms and successors are chosen from within the department – often the associate chair assumes leadership for a five-year period. On occasion, some basic science chairs elect or are requested to serve a second term – but rarely if ever does chair service exceed 10 years. Clinical science chairs serve renewable 5- year terms with a maximum of 20 years. The School and University leadership believes that extensions beyond 20 years are not in the best long-term interests of departments or individuals.

The performance of department chairs and institutional leaders is evaluated annually with more detailed performance assessments occurring near the completion of a term. Even with outstanding performance it is valuable for institutions and individuals to be renewed at defined or not-to exceed intervals. While it is not mandatory, the convention at Stanford (and indeed for almost every medical school) is for clinical chairs to be selected by a national search. This permits institutions like Stanford to do all it can to engage the best leadership possible – and to also empower its clinical leaders through the search and selection process.

At the beginning of 2010 a number of clinical chairs positions are undergoing evaluation for potential reappointment. Others are under search (or soon will be) because the department chair has elected to step down or has reached the maximum duration limit. I hope to announce soon the new chair of the Department of Psychiatry and Behavioral Sciences, who will succeed Dr. Alan Schatzberg, who has served as chair so successfully for 19 years. I also expect to conclude the search for the next chair of the Department of Dermatology, given Dr. Al Lane’s decision to step down as chair after 14 years of service. A search committee has recently been formed for the next chair of the Department of Radiology to succeed Dr. Gary Glazer, who has led with excellence (and by exception) for 22 years. We hope to find Dr. Glazer’s successor by the time he completes his final term at the end of August 2011. In addition, Dr. Richard Hoppe has informed me that he plans to step down as chair of Radiation Oncology at the completion of his current term in August 2011, and we will soon be appointing a search committee for his successor. Each of these leaders has performed in an outstanding manner and we all owe them our respect and gratitude.

In addition, a number of clinical chairs have recently or will soon be reappointed to a second term, including Drs. Bobby Robbins, Chair of Cardiothoracic Surgery; Rob Jackler, Chair of Otolaryngology/Head & Neck Surgery; Dr. Bill Maloney, Chair of Orthopaedic Surgery; Frank Longo, Chair of Neurology and Neurological Sciences; and Dr. Jonathan Berek, Chair of Obstetrics & Gynecology. Dr. Steve Galli, Chair of Pathology, has recently completed an evaluation after serving for two terms and will be reappointed to a third term. Two other clinical chairs, Dr. Ron Pearl (Anesthesia) and Linda Shortliffe (Urology), are currently undergoing our evaluation process for potential reappointment. These evaluations, which are conducted through our Office of Academic

Affairs, gather input from within and outside the chair's department – a process that is helpful to the school and the individual.

Institutions like Stanford are built on individuals and leaders. I am deeply grateful to each of our leaders and also look forward to working closely with those who will join our leadership team in the future.

Appreciation for Stanford's Support to Haiti

The heartbreaking images of the tragic earthquake that struck Haiti just over a month ago still loom large in our minds. As is often the case, the media focused our attention intensely on Haiti in the first awful days and weeks following the earthquake, calling to our attention the hundreds of thousands of individuals who were killed or the millions who were injured or displaced by an earth-shattering event that took only tens of seconds to unleash its destructive forces. Also predictably, the media has now largely moved elsewhere and for many, the tragedy of Haiti recedes into memory banks well versed in world tragedies. Except, of course, for the survivors, who are impacted every moment of every day by the ongoing consequences of the earthquake. Their memories are very much in the present.

Heroic teams (including those from the Stanford University Medical Center – see: http://med.stanford.edu/ism/2010/february/haiti-follo-0208.html), along with global relief organizations and the economic support from nations around the world, dealt remarkably and admirably in providing food, water, medical care and other resources in the immediate aftermath of the tragedy in Haiti. Most have now returned home. They carry with them indelible memories of experiences that transcend even the worst human suffering than nearly any of us can imagine. However, the ongoing crisis requires continuing support – something that Dr. Michele Barry, Professor or Medicine and Senior Associate Dean for Global Health, immediately recognized when she helped stimulate the matching program that raised some $370,000 from the Stanford community for the Hôpital Albert Schweitzer (HAS) in Haiti. I have previously extended my own appreciation to the Stanford community for its contributions. I would now like to share a message of appreciation that Dr. Barry recently received from Dr. Ian Rawson, the Medical Director of HAS.

> Dear Michele,
>
> What a wonderful out pouring of concern and support you have encouraged from Palo Alto! This has inspired us - the demands on HAS have been enormous, and I continue to be awed by the response from everyone here at the hospital. Almost every employee has been affected directly by the quake - family members who have died or been displaced, and others who have come out from the capital to live in their lacours. And then they face the challenge of caring for patients with devastating injuries.
>
> Our major challenge now is the social and health concerns of the more than 20,000 internally displaced persons who have come out to the Valley, all of whom

need immunizations, primary care, food and jobs. The UN agencies look to us, as the major NGO in this region, to develop programs on their behalf. Our field staff has registered all of the IDPs in our electronic medical record system, so we can find them and fold them in to our support programs.

These are new challenges for HAS, and we would not have the strength or courage to take them on without the support from all of you at Stanford. Mere thanks do not suffice...

For some reason, I was not able to "copy all" on this message so I would appreciate it if you could forward this to your original addressees.

Best wishes,
Ian

If you are interested in learning more from the first experiences of the Stanford Medicine teams that provided medical care in Haiti, I call your attention to two upcoming presentations:

1. ***Dr. Paul Auerbach***, Professor of Surgery (Emergency Medicine), will speak at the Department of Medicine's Grand Rounds on Wednesday March 31st at 8 am in the Braun Auditorium
2. ***Dr. Robert Norris, Professor of Surgery (Emergency Medicine) and the ED Team*** will share their experience at an event sponsored by Martha Marsh (SHC), Chris Dawes (LPCH) and myself (SoM) at 5:30 pm on Thursday April 1st – also in the Braun Auditorium.

The Interface between Patient Care, Innovation and Research

One of Stanford's most distinguishing hallmarks is the spirit of innovation and discovery that permeates our institution. New insights can result from methodical experimentation or be triggered by a new or unanticipated observation. While we generally think about the "ah-ha" moment in relation to basic fundamental research, such insights can also emerge from an observation at the bedside – as the result of a procedure, device or medication (e.g., an "off-label use of drug or biological or a variation on an operative technique). In some cases these are extensions of standard patient care, but on occasion the lines between innovative patient care and research can get blurry, and sometimes the line can be crossed – often inadvertently, although with consequences.

Because we want to foster innovation in research and patient care as well as the safety and protection of individuals as "human subjects," we have recently appointed a task force to examine the broad issue of innovation and patient care. More specifically, this group is charged with creating a system that would determine when innovations in patient care should be defined as research and, as such, protected by institutional review and oversight. This task force is being coordinated between Stanford Hospital & Clinics

and the School of Medicine and is being led by Dr. Geoff Rubin, Professor of Radiology and Associate Dean for Clinical Affairs.

At least at one level, clinical innovation in patient care crosses over into "research" whenever it involves: the prospective intent to create new knowledge; a systematic approach to the selection, treatment and/or follow-up of patients (or subjects); outcomes measurement; and the potential or prospect for reporting the data publicly – in peer reviewed or other publication. When one or more of these conditions exist, the patient care should be formalized in a clinical protocol that is reviewed and approved by the Institutional Review Board (IRB).

The work of the task force is just beginning and will seek broad input. At its initial meeting, the task force enumerated five factors they deemed essential to an effective system that could distinguish patient care from clinical research – and especially activities that should be conducted under the umbrella of the IRB. These include:

1. Identifying procedures, therapeutic approaches, diagnostic tests, and preventions that either are or should be research
2. Confirming through peer review that the identified clinical activity fulfills the requirements for management under this process
3. Assuring that clinical activities are discontinued until an IRB approved protocol can be instituted and then only occur under that protocol
4. Assessing the results of the trial to determine if/when the investigational care may transition to routine clinical care
5. Recommending criteria for privileging physicians to provide the new "clinical innovation"

The group recognizes the importance of getting input from various clinical leaders as well as those with regulatory experience and oversight. Drawing on the experience of other academic centers and available reports (e.g., http://healthcare.partners.org/phsirb/inntherp.htm) will also be part of the process. At least as a start, the group identified some conditions that might trigger a determination of when clinical innovation is migrating to research and the need for IRB review and approval. These might include:

- The number of subjects who have undergone or expect to be undergoing the procedure/test
- A determination of whether reasonable physicians differ on the appropriateness of the care
- The likelihood that the innovation could cause harm versus benefit
- Whether the application of the innovation sufficiently prevalent that it can be studied
- The details of the Belmont Report (http://ohsr.od.nih.gov/guidelines/belmont.html#goa)

Clearly this is an important topic and one for which the committee is interested in

comments and recommendations. If you would like to offer opinions, perspective or guidance please contact Dr. Geoff Rubin at grubin@stanford.edu.

The Coulter Program – a Model for Seed Grants

At the February 19th Executive Committee, Dr. Russ Altman, Professor and Chair of the Department of Bioengineering, gave an update on the highly successful Stanford-Coulter Translational Research Grants Program. As noted on the website, the Stanford Coulter Program "funds projects proposed by multi-disciplinary teams of biomedical engineers and clinical scientists. The devices, diagnostic procedures and treatments that result from the work of these teams are intended to result in patents, spawn start-up biomedical companies and/or be transferred through licensing agreements to existing companies. The Stanford-Coulter program also seeks to raise awareness—on campus and beyond—of the importance of translational research through multi-disciplinary collaboration. Every aspect of the program is designed to increase, enhance and accelerate this process."

Dr. Altman gave amazing examples of proposals that this program has supported over the past several years, many resulting in major scientific papers, new products or companies or tremendous leveraging for competitive sponsored research funding. Virtually every proposal has included faculty members from the School of Medicine and Bioengineering. If you are interested in learning more about this program see: http://bioengineering.stanford.edu/coulter/aboutus.html.

I hasten to add that the Stanford-Coulter program is joined by a number of other seed grant programs sponsored by the Medical School or University (e.g., BioX programs, Stanford Institute of Medicine Seed Grant Programs, Children's Health Research funding, Beckman Center Interdisciplinary Translational Research Program, etc). These programs share in common their support for novel and innovative research and the prospect for bringing new teams of faculty together to engage in research that might not otherwise have happened. They all boast a tremendous leveraging effect as well. That said, these programs require considerable institutional commitment and it is timely that we review them more comprehensively to demonstrate their presumed impact and success.

Phishing at Stanford

I assume you have similar experiences to mine. Every so often I get an email request that looks real and asks for a response. The latest had to do with my email storage being fully occupied – which made some sense since I file most emails. Thankfully, rather than responding to the query I checked with our Information & Resources Technology (IRT) support and learned that the messages I was receiving was phishing – and trying to induce me to provide information (which thankfully I didn't do and about which I try to stay vigilant). That said, it can be confusing. Accordingly I share the following advice message to all of you that comes from Ellen Amsel, Information Security Officer and Director of Information Security Services in the School of Medicine's IRT.

Emails have been circulating through the Stanford email system asking for your SunetID (userID) and password.

Stanford will NEVER ask you for this type of information, and it is important that you not provide it, EVER.

These emails are actually attempts (known as phishing) to get you to divulge your password so that the sender of the request can gain unauthorized access to your email and other computer accounts.

If you have erroneously responded to such an email with your SunetID and password, please contact us immediately (irt-security@lists.stanford.edu or eamsel@stanford.edu) so that we can assist you.

If you have a question regarding email that you receive, you are encouraged to contact IRT Information Security Services (irt-security@lists.stanford.edu) about this and we will respond promptly.

Please remember to safeguard your SunetID and password and not divulge it to anyone, even if the email appears legitimate.

Please pay careful attention to solicitations and if you have any questions contact our security service

Malcolm Gladwell and Medicine and the Muse

Dr. Audrey Shafer asked me to share the great news that **Malcolm Gladwell** (author of ***The Tipping Point, Blink, Outliers, What the Dog Saw***) will be this year's speaker at the Medicine and the Muse Symposium on Thursday, April 8th at 5 pm. Of note this event will also feature presentations, music and exhibits by Stanford Medical Students. Also, it will be held in the new Conference Center in the Li Ka Shing Learning & Knowledge Center – perhaps the first major event in this wonderful facility. The Symposium is free and open to the public. If you have any questions contact Paula Bailey at pbailey@stanford.edu.

Postdoctoral Fellowship Awards

The Office of Postdoctoral Affairs invites applications for the Spring 2010 cycle of the Dean's Postdoctoral Fellowships. The Dean's Fellowships were established to support the advancement of postdoctoral research training under a mentorship of a faculty member at the School of Medicine, through awards to current and prospective postdocs. Preference is given to junior postdocs and junior faculty mentors. The Fellowships are often used as seed money while outside funds are sought. Awards are made in the form of a stipend directly to the postdoctoral fellow, up to $20,000 per year for one year. Spring awards start in July 2010 through June 2011. A second year may be awarded on a competitive basis. Proposals should be submitted electronically online in addition to a paper submission to Teri Hankes in the Office of Postdoctoral Affairs by 12 noon,

Tuesday, March 16, 2010. Further information can be obtained at: http://postdocs.stanford.edu/scholars/fellowships_dean.html

Awards and Honors

- ***Dr. Harry Greenberg***, Joseph D. Grant Professor in the Department of Medicine and Microbiology & Immunology and Senior Associate Dean for Research, will be a recipient of the American Liver Foundation's Salute to Excellence Award "honoring those have made outstanding contribution to technology and medical innovation." A celebratory event will be held in San Francisco on Saturday March 13th. Please join me in congratulating Dr. Greenberg.

Appointments and Promotions

Gill Bejerano has been reappointed to Assistant Professor of Developmental Biology, effective 2/01/10.

Mary Kate Bundorf has been promoted to Associate Professor of Health Research and Policy, effective 2/01/10.

Miriam Goodman has been promoted to Associate Professor of Molecular and Cellular Physiology, effective 2/01/10.

Jorg Goronzy has been appointed to Professor of Medicine, effective 3/01/10.

Marcia Stefanick has been reappointed to Professor (Research) of Medicine, effective 2/01/10.

Mei-Chiung Shih has been reappointed to Assistant Professor of Health Research and Policy, effective 2/01/10.