Dean's Newsletter
July 26, 2010

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Summer Schedule

Even though nothing really seems to ever slow down in the School of Medicine, and in fact many new programs begin in the summer, I have traditionally changed the frequency of the Dean's Newsletter from every other week to every 3-4 weeks during July and August. I doubt many of you are missing the more frequent transmissions, but I did want to remind you about the altered summer schedule and also that the regular biweekly one will commence in September. All that said, I hope you have some quiet and restful times during the remainder of July and in August.

Thinking About Postdoctoral Fellows and Scholars

As I noted in the May 14th Dean's Newsletter, "*Thinking About Learning*" is an imperative if we are to optimally serve the needs of future students – be they high school students, college undergraduates, medical or graduate students, postdoctoral scholars as well as clinical residents and fellows, and faculty and professionals in our community and beyond. This realization is prompted by the opening of the Li Ka Shing Center for Learning and Knowledge (LKSC), but also by our recognition that learning behaviors and teaching styles will continue to change, perhaps dramatically, in tandem with emerging technology and new knowledge. At the same time, the career pathways for those graduating from Stanford's degree and training programs will evolve with the economy and broadening opportunities.

Given these changes, we have planned three parallel tracks of discussion, review and assessment: medical student education, graduate student education and postdoctoral scholar training. The plan is to begin with separate discrete interdisciplinary "think tanks" between now and September that will delineate questions requiring more in-depth analysis and review during the fall and winter. My hope is that we will be able to bring

each of these three efforts into a more integrated discussion at our Annual Strategic Planning Leadership Retreat in January 2011.

On Saturday, July 17th, some 35 individuals, representing postdoctoral scholars, clinical fellows, faculty and administrative leaders as well as volunteer representatives from industry and career/employment centers convened in the LKSC Boardroom and engaged in a thoughtful, candid, far ranging and informative discussion about postdoctoral fellows and scholars at Stanford. I was pleased that we began our triad of think tanks with the topic of "postdocs," since this is not infrequently the group that feels the most disenfranchised, despite their importance to virtually every mission of Stanford Medicine. As I pointed out at the beginning of the "Postdoc Think Tank," there are nearly twice as many postdoctoral trainees in the School of Medicine as there are degree program students. For example, in this past year we had 1157 degree-seeking students (including 471 pursuing an MD or joint MD-other degree program, and 686 pursuing a PhD degree). Overall, our number of medical and graduate students is small compared to the other schools at Stanford. At the same time we have 2158 post-degree trainees, far more than in the other Stanford schools. This past year they consisted of 739 residents pursuing certification in medical, surgical and related specialties and subspecialties as well as 310 clinical fellows, each of whom do some research as part of their fellowship, and 1109 research postdocs.

Although there are differences in the programs and career paths for MD and PhD's pursuing clinical fellowships versus those in research training, there are also a number of overlaps in the issues these trainees face. Recognizing these commonalities, we made this initial think tank inclusive. Clearly, the overall portfolio of our more than 2100 postdoctoral trainees is quite diverse and has a number of subgroups and constituencies (e.g., those interested in academic careers versus other career pathways; those involved in clinical training versus pure research training; those international postdocs who come with an intention of returning to their home country versus those who are seeking a way to remain in the USA). For this initial discussion, though, I wanted to focus on a broad discussion of career opportunities and the goals and purposes for postdoctoral training.

In my opening comments, I reflected on the reality that the expectation for a postdoctoral fellowship has evolved over the past couple of decades from an optional training experience that only a small fraction of young scientists had into a virtual requirement of a bioscience career pathway. This has been coupled with increased lengths of training periods and, for a large number of trainees, more than one postdoctoral fellowship. While such fellowships provide opportunities for recent graduates to gain hands-on, on-the-job training and allow some to guide and even lead research programs, they also prolong the time spent as a trainee versus as an independent (or principal) investigator. This in turn has contributed to the fact that the average age of recipients of a first RO1 grant has risen to 42 years– which is quite concerning. Along with this reality is the fact that there are far fewer academic positions that postdocs can compete for, making the sometimes-presumed connection between graduate school and an academic position, tenuous or even illusory.

All of these factors lead to the important question of whether we (not simply at Stanford but collectively as a nation) are training too many postdocs. Put another way, should we reduce the number of postdocs who come to Stanford? Should there be some more organized admissions process to complement the decisions made by PIs that is based on need, funding and available resources? Should coordination occur at the department level or more broadly, as it does for our degree programs? We already limit the length of postdoc training to five years and disallow more than one postdoc; should those conditions be modified further? Although it has been tried before, the question of whether we should have a "Whitehead postdoc model" for selected trainees would benefit from renewed discussion. Alternatively, there are many other career pathways for postdocs (e.g., industry, education and beyond) for which we are not necessarily (or in an organized manner) providing education or preparation. Whether and how we should do this are important questions.

During the July 17th think tank we first discussed what is working and what needs work at Stanford. Naturally (and I think appropriately) there was much more focus on what needs work in order to build on the excellent foundation of science opportunity and the culture of innovation that already exists at Stanford. It is widely acknowledged that we possess the key building blocks and resources and the very fact that we are willing to engage in a dialogue about how to make things better is evidence of our commitment. It also seemed apparent that a number of the resources already available for education and career development are not as well appreciated as they should be – making continued communication a high priority.

Understandably, there are lots of issues that we would all acknowledge need work. Among these are the cultural perceptions of relative value by postdocs, faculty and our community. For instance, there seems little question that if one's intent is to pursue an academic career, the level of receptivity and acceptance by the Stanford community is greater than if one is interested in industry or another alternate career pathway. Clearly this is a generalization, since many faculty and labs are quite open and permissive to a wide range of career paths – but this is not consistent.

Another underlying theme was the question of the true purpose of a postdoc position. For example, is it really to further training and career development (in which case the focus is on the postdoc) or is it to further the work in the lab – both intellectually and in terms of expanding the workforce? A focus on enhancing training and career development leads to other issues, such as whether we need work on mentoring and career advice and development, along with improved communication about resources and opportunities. A major concern is the length of training, although this needs to be framed in the context of the overall career path (i.e., from high school through postdoctoral training). There is a need for consolidation and reorganization of the training pathway – rather than just adding more, as has been the case in the past and present.

There was a general consensus that the training period for postdocs is too long and that there are not sufficiently graduated levels of responsibility. This topic also

relates to the issue of whether selected postdocs can serve as principal investigators – an issue currently under discussion with the University Faculty Senate.

It was broadly recognized that the career goals of postdocs vary and that they may change over the course of the fellowship. While some postdocs enter with defined plans and in specific programs (this is clearly the case for clinical fellows), others begin with aspirations for one type of career but find that their interests or opportunities become quite different as their postdoc training continues. Building in more formal options for alternate career pathways was a topic of considerable discussion. While there is consensus that many skills acquired during graduate school and postdoctoral training are foundational, other skills, such as in leadership and particularly in business and entrepreneurship, require different types of exposure and training – either as part of a formal degree program or as part of a flexible training program. That said, it was also apparent that the time to address these issues is really during graduate and medical school and that increased attention to and focus on career opportunities, education and training should take place prior to beginning a postdoctoral program. Certainly this will be a topic for our future think tanks on medical and graduate student education programs.

Attention to the career development of women and minorities is an area requiring additional work. We are conversant with the many gender challenges that occur during academic careers and have focused attention on faculty development (see below). But many of these same issues apply to postdocs, and it is important to further assess and determine what we can do to ameliorate them. Also highlighted were issues of dual career families.

In the second part of the think tank we queried what we could do that would be "big and bold." We asked whether the current postdoc model could – or should – change, and, if so, how. In doing so we wanted to frame and craft the issues and questions that require additional study and input. We ended up with basically two approaches: enhancing the current model or reshaping the postdoc model for the future. Here is a distillate of the discussion – which will certainly require further elaboration. Needless to say we would appreciate your input as well.

Enhancing the Current Model

- **Career pathways**
  - ***Non-academic pathways***
    - Provide additional structured explorations of non-academic careers
      - Address cultural issues that discourage non-academic career choices and that may also discourage PIs from permitting postdocs to spend the time engaging in these explorations.
      - Mandate that PhD committees include discussions of different career pathways.
    - Tap into the pharma and biotech industries in the Bay Area
      - A forum of pharma, biotech – develop internships, teach classes could help launch novel programs.

        - Be cognizant and focused on focused career pathway as part of the selection process. For example:
            - Institutions like Stanford traditionally train postdocs interested in academic positions and thus our admissions program should focus on such individuals.
            - If a postdoc applicant is really interested in industry perhaps it is better for such individuals to do their training in a company.
        - Expand SPARK; have a self-sustaining program focused specifically on translating ideas to industry

    - **Academic pathways**
        - Departments/institutes could consider hiring assistant professors directly from graduate programs (i.e., without a postdoc). This would require a major cultural shift and would need careful assessment.
        - Create hybrid positions – opportunities to be in a position that is not a postdoc and not a faculty member, but with ability to apply for grants. An aspect of this is currently under consideration.
        - Encourage our postdocs to explore the academic opportunities that are emerging internationally.

- **Mentoring**
    - Mentoring by a team, not a single individual - untie postdocs from the single mentor model. This is not a new suggestion.
        - Establish mentoring committees for postdocs, analogous to the PhD thesis committee (The department of Chemical and Systems Biology has begun to have such committees.)
        - Establish a grants office for trainees in the SOM – assistance in applying for grants available to postdocs/PhD students, MD/PhD students.
        - Acknowledge the diversity of the postdoc population and tailor mentoring to take this diversity into account.
        - Provide guidance to faculty regarding postdoc mentoring.

- **Other ideas**
    - Limit the postdoc pool; have a rigorous review process for determining postdoctoral fellowship offers
    - Develop a "competencies model" for postdoctoral training.
        - Assure that assessment and feedback are part of any model.

Reshaping the Model for the Future

- **Shorten training**
    - Undergraduate (or even high school) to PhD and postdoc
    - Undergraduate to medical school to residency

    - Diminish the status/privilege differences between the "silos" of phases of training (grad student vs. resident vs. fellow)
    - Shorten physician scientist training
        - Start earlier
        - Undergrad to med school (with a taste of research)
        - Then research (with or without a PhD)
        - Change the MD/PhD program
        - Deal with structural misalignments
        - Pilot this here at Stanford
        - Especially important for women and minorities

- **Look for gifted younger student**s – get them started early – undergraduates, and even earlier – Stanford Medical Youth Science Program, Stanford's Education Program for Gifted Youth.

- **Explore the Whitehead Fellows model** to create independence at an earlier stage of career development. Apparently this was tried previously at Stanford (in fact likely more than once) without great success. But further assessment and exploration could still be meritorious.

- **Change the balance of PhDs and postdocs**
    - Compared to other schools (like Engineering) the postdoc model is relatively unique to bioscience training. This may be inherent to the biosciences but other disciplines (like engineering) begin faculty appointments with no or much briefer postdoc training.
    - At the same time, the question of balance between graduate students and postdocs needs to be considered. Currently graduate students are more expensive compared to postdocs, but they are also vetted for selection in a more programmatic manner. They do not have the experience of postdocs and thus many will contribute less to the intellectual capital of the program. This cannot be an either/or scenario – but it is one of balance. Should we have more graduate students and fewer postdocs? That said, we still need to be cognizant of the career opportunities for either graduate and/or postdocs. It is certainly recognized that this is very hard to predict, but we need to take the limitations of opportunities seriously, especially during the current economic downturn.

Next Steps

Based on the helpful discussion we had at this initial think tank, we plan to further develop some of the important ideas and recommendations that came forward and then to look at their intersections with the parallel work that will take place for graduate and medical student education. As part of this process we will focus on the discrete training goals and career paths of PhD scientists, on one hand, and physician-scientists on the other. This consideration will include assessing the key objectives from the trainee perspective as well as that of the institution at a macro level and of the institutes,

departments and principal investigators who support and provide the foundations for postdoctoral training and development.

Clearly the length of training – especially when combined with undergraduate (college and even high school) and graduate education – is too long. A more coordinated view is important; it should have the objective of getting graduates to longitudinal career pathways much sooner, while also creating options so they can consider a diversity of opportunities, in academia, industry and beyond. To accomplish this we need to work on the institutional, organizational and federal regulatory rules and impediments that impact coordination and consolidation. Some of these arise from the discrete regulatory agencies and organizations that accredit or certify institutions or individuals; others come from government agencies, particularly the NIH, that affect the funding and flexibility of fellowships supported by training grants. We also have considerable work to do at the institutional level to address cultural assessments and expectations of what constitutes a respectable career pathway and to be more open to alternatives, be they in work schedule or ultimate direction. This is especially true if we are to more successfully support the careers of women and minorities.

Of course we also need to recognize that postdocs are an amalgam of different groupings and expectations, including MDs, PhDs and mixtures thereof. They also include individuals with differing expectations, from different parts of the world – some of whom have a position they will return to and others who are seeking a new home they can move to. Their needs and expectations are different, and the way they behave and interact with each other will differ as well. In tandem, the blend of cultures, ethnicities and languages adds diversity as well as complexity in communicating and in planning.

Over the next couple of weeks we will be communicating further with the individuals who attended the July 17th Think Tank. We will develop specific subgroups under the banner of "Postdocs" that will explore assigned topics in greater depth. We will then plan to coordinate their findings in reports back to the broader group and to those focusing on medical student and graduate student education. We will then bring the findings and recommendations to our Leadership Retreat in January and either implement those that seem appropriate or work further on the elements needing more discussion and exploration. I will do my best to share information with you and as always will appreciate your comments and recommendations along the way.

Academic Life: Flexible and Alternate Work Schedules

Faculty recognize the drill explicitly or implicitly. Success in academia requires, among other things, commitment, dedication, focus, energy, creativity, luck and time. For most faculty, time is a major issue – simply in the sheer number of hours per day and week that it takes to construct a portfolio leading to academic promotion and success. Time also means the need to achieve measurable success within 7-10 years from appointment as assistant professor to associate professor and tenure or, for clinical faculty, to a promotion that carries with it the possibility of reappointment. While the opportunities to discover, innovate, educate and care for patients can be exciting and

exhilarating, the pressure to demonstrate unique individual success to internal and external reviewers and evaluation committees also creates considerable stress. For many those pressures occur simultaneously with personal and family pressures, including childbirth and childcare and the concomitant financial and related pressures. The balancing between professional and personal demands and expectations can be exacting, demanding and rate limiting. They may even lead some of the most talented young physicians and scientists to never get on or to get off the academic train and seek non-academic careers - or to continue in academia, with sometimes destructive personal consequences.

Over the years we have spent considerable time and effort trying to find ways to support faculty and their career development – through our Offices of Academic Affairs and of Diversity and Leadership. A number of programs have been put into place in the medical school and university to reduce pressure, provide support (including information and resources) and extend the time to the promotion decision. Among the issues that have been addressed (with varying degrees of success) are maternity, paternity and adoption leave; extension of the tenure clock for family responsibilities; and childcare and related services. We have annotated our progress and failings in various leadership programs, opportunities and reports – including a number in prior issues of this Newsletter. While the Stanford School of Medicine currently permits part-time appointments and job-sharing on a case-by-case basis, such alternative work schedules are not common, and the "culture" does not readily embrace or support such appointments. That said, it is in my opinion that it is essential that we explore such alternative career pathways. They work in other settings, and we need to determine whether we can figure out ways of changing both the culture and career path options in the School of Medicine.

I have asked Dr. Hannah Valantine, Senior Associate Dean for Diversity and Leadership and Professor of Medicine, and Dr. Christy Sandborg, Chief-of-Staff at the Lucile Packard Children's Hospital and Professor of Pediatrics, to lead a task force to explore and develop Flexible Work Arrangements. These have been explored and occasionally implemented at other institutions of higher education, but they are not part of the medical school culture. However, I know from discussions with colleagues around the country that there is receptivity on the part of some schools and leaders to determine the feasibility and opportunities for flexible work arrangements as part of an overall agenda of improving faculty career development. To carry out this exploration at Stanford, Drs. Valantine and Sandborg will partner with other Stanford colleagues and will also engage with the American Council on Higher Education. I view this as a critically important project, and we will be giving it a high priority. I wanted to let you know that it is getting underway and that we will be seeking input, recommendations and hopefully some transformative thinking as we move forward.

Should We Hold Annual Meetings For Senior Faculty?

When we think of mentoring and career development our attention naturally and appropriately turns to junior faculty. But career development evolves over a lifetime, and plans and expectations change accordingly. Several years ago we appointed a Senior

Transitions Task Force led by Dr. Gary Schoolnik. I have previously reported the recommendations of that task force and we have developed a website (http://med.stanford.edu/academicaffairs/senior-faculty/) and resource center to help assist senior faculty with questions and concerns. The question has now arisen about whether we should codify this process further into an annual meeting – as we would do for more junior faculty. When we discussed this topic at a recent Executive Committee, we heard a range of perspectives and comments.

We all recognize that medical schools are different from other components of universities, in that nearly all medical school faculty are on "soft money" – which comes primarily from research grants or clinical income. As these sources become more constrained, the expectations held by a senior faculty member can become misaligned with those of colleagues or of her or his department. While many faculty plan for their own transitions, some find that difficult, even frightening – and, as a result, they exercise avoidance. We also recognize that senior members of our faculty have contributed significantly to all of the missions of the school, university and medical center. Many have helped define the excellence of Stanford as we know it today. We share a deep respect for past accomplishments as well as the recognition that future planning provides an insurance to disappointment or even disillusionment. The loss of competitive support for research or the decreased dexterity for technical procedures is an inevitable part of life. It is no different in cognitive and technical expertise than it is in sports or physical endurance. Having just completed the San Francisco Marathon yesterday, I am well aware of the boundaries of endurance. And of course we all need to consider and plan for transitions.

The question of whether senior faculty should have a counseling session, career guidance meeting or simply an annual discussion with their department chair evoked different viewpoints in the Executive Committee discussion. Some chairs felt it was an important part of their role and responsibility; others expressed concern that they were poorly-equipped or unprepared for such discussions, especially with faculty facing issues that were quite different than those they were more familiar with. Yet everyone agreed that at least an annual meeting with all faculty, including senior faculty, to review career plans and prospects was important and could avoid misunderstandings or even crises for individuals and organizations.

We focused on the issue of faculty transitions a few years ago first by acknowledging its importance and then by assessing its impact and coming up with recommendations and resources. We now recognize that there is more work to be done to implement an annual review and planning process for all faculty, regardless of the stage of the career. We further recognize that how this is done requires additional discussion and reflection, which we will share in future Newsletters.

Conflicts of Interest in Clinical Care Policies Further Codified by the AAMC

Stanford has been a leader in recognizing the importance of financial conflict of interests in research, education and patient care. In a number of ways the policies established by our faculty and endorsed by our community have helped set a national standard. National organizations including the Association of American Medical Colleges (AAMC) and the Institute of Medicine of the National Academy of Sciences have also set national expectations, guidelines and policies. The most recent is the June 30th report by the AAMC that "urges US teaching hospitals to establish policies that manage financial relationships between physicians and industry so that they do not influence patient care" (see: *In the Interest of Patients: Recommendations for Physician Financial Relationships and Clinical Decision Making*. https://services.aamc.org/publications/showfile.cfm?file=version163.pdf&prd_id=303&prv_id=375&pdf_id=163). Dr. Harry Greenberg, Senior Associate Dean for Research and Joseph D Grant Professor in the Department of Medicine, served on the advisory committee that formulated the AAMC report. Dr. Greenberg has also been among the leaders who developed Stanford's *Policy and Guidelines for Interactions between the Stanford University School of Medicine, the Stanford Hospital and Clinics, and Lucile Packard Children's Hospital with the Pharmaceutical, Biotech, Medical Device, and Hospital and Research Equipment and Supplies Industries ("Industry")"* that can be found at http://med.stanford.edu/coi/siip/policy.html.

In nearly every way Stanford has already enacted the recommendations of the AAMC, and our experiences have been endorsed and followed by an increasing number of peer institutions. It is inevitable that similar policies will be implemented nationwide. While you can review the details of the report, I am noting below the recommendations (with my highlighted emphasis) so that you are familiar with the major topics of focus:

- Compensation mechanisms of academic medical centers should be aligned with the best interests of patients.
- ***Medical societies*** should set standards of addressing their own relationships with industry.
- Academic medical centers should address their ***physicians' financial relationships with industry*** in the context of the clinical care they deliver.
- Academic medical centers should address ***institutional financial relationships with industry*** in the context of the clinical care their deliver.
- Academic medical centers should ***disclose the industry*** ties of their physicians to their patient communities as one method, though not the exclusive method, of managing actual and perceived conflict of interest in clinical care.
- Academic medical centers should ***involve their patient communities*** in determining the manner in which financial relationships of its physicians and of the institution itself should be made available to patients.

This is a continuingly evolving issue – which has both good and troublesome features. I well recall a comment made a few years ago warning that if doctors and academic centers did not take charge of financial conflicts, legislation would do so. In part that has now happened as part of the healthcare legislation that put the Physician Payments Sunshine Bill proposed by Senators Grassley and Kohl into law. Unfortunately,

compliance regulations can also become too stringent and imposing, as appears to be the case with the current Notice to Proposed Rulemaking concerning *Responsibility of Applicants for Promoting Objectivity in Research for Which Public Health Funding is Sought and Responsible Prospective Contractors,* which was published in the May 21, 2010 Federal Register. In this case the proposed rules would prove extremely difficult and costly to implement and would have unclear benefits. To a certain extent they represent a response to political forces, and they show how policies can be imposed if academic centers are seen as less compliant or responsive to perceived conflicts of interests. Stanford and many other organizations are offering comments to this proposed rulemaking.

SHC Medical Executive Committee Offers Thanks and Appreciation to Martha Marsh

On July 7th Martha Marsh attended her last Medical Executive Committee (MEC) meeting as President and CEO of Stanford Hospital & Clinics. She retires officially at the end of August. In recognition of Ms. Marsh's eight years of service to Stanford Medicine, Dr. Steve Galli, Mary Hewitt Loveless, MD, Professor and Chair of the Department of Pathology, proposed a motion to the MEC upon the request of Dr. Bryan Bohman, SHC elected Chief of Staff. The motion was passed unanimously by the committee, and, since it captures the sentiments and views of the medical staff, I thought it would be nice to share it with you. Drs Galli and Bohman agreed that this motion could be published in the Dean's Newsletter.

I've (Dr. Steve Galli) been a member of this group long enough to know that when Martha Marsh arrived as CEO and president of SHC in 2002, the institution had recently emerged from the merger of Stanford and UCSF in what could be called "guarded condition" (and that is putting it mildly), and she learned that there was less than two weeks of cash on hand. I understand that there is a technical financial term for this situation: "Not good." To make a long story short, Martha's leadership resulted in a remarkable turn-around for SHC, that has a $1.9 billion operating budget in 2009-10, that has enjoyed four bond upgrades in nine years, and that now has 200 days of cash on hand.

However, Martha's most important contributions have gone far beyond restoring financial stability. Along with being named to *U.S. News & World Report*'s Best Hospitals list for the past eight years, SHC was selected as one the country's top hospitals in 2009 by The Leapfrog Group for "delivering the best quality care in the nation while attaining the highest levels of efficiency." During her tenure Martha enhanced hospital services to include a new cancer center, an outpatient center in Redwood City, and an electronic medical record system that earned the hospital the highest designation level — Stage 7 — from HIMSS Analytics Database, the industry organization focused on the use of information technology in health care. Stanford Hospital is the fourth health-care organization and one of

only six nationwide among more than 5,000 in the HIMSS Analytics Database to achieve this top-level designation.

In commenting on Martha and her accomplishments as CEO, Mariann Byerwalter, chair of the SHC Board of Directors, said: "Martha has been an extraordinary leader for Stanford Hospital & Clinics and has transformed the hospital in every area of performance. We are all extremely grateful to her and proud of the accomplishments she has achieved."

To convey the MEC's appreciation to Martha, I propose the following motion:
Motion: The Medical Executive Committee, on behalf of itself, the medical staff and employees of Stanford Hospital & Clinics, and the patients we serve, wish to thank Martha Marsh deeply for her eight years of leadership of SHC as CEO, for her unflagging efforts to ensure that SHC provide the highest standards of excellence in patient care, for her determined and effective restoration of the financial health of SHC, for her vigorous pursuit of improvements in SHC facilities, operations, programs, quality of care, information technology, and patient services, and for her work with Dean Phil Pizzo and LPCH CEO Chris Dawes in their efforts to make Stanford University Medical Center much more than the sum of its parts. If one of the tests of effective leadership is leaving an institution in better shape than one found it, there can be no doubt that Martha Marsh has passed that test with flying colors. The MEC wishes all the best for Martha and her family as she enters the next phase of her life, and bids her farewell rather than goodbye, hoping to see her return to Stanford to witness the completion of the new hospital which she got off to such a good start.

Improving the Patient Experience

Academic medical centers should be graded on how well they do in several key areas. Innovation, including both discovery and the translation of knowledge from research to the patient, is a defining feature of an academic medical center and is one where Stanford does particularly well. Another is the delivery of state-of-the-art medical care, and here Stanford does quite well and has made numerous strides, particularly in the last decade. We still have work to do in recruiting and developing excellence in the broad dimensions of clinical medicine – which is especially challenging for a small medical center. Third, medical care needs to be delivered with outstanding quality and in the safest ways possible. This is always a challenge when the complexity of care is high and the number of providers multiple and variegated. Stanford has made considerable progress in improving and even leading in this area over the last years.

A fourth key area, which works in conjunction with outstanding quality in the delivery of care, is the creation of a setting in which the patient experience and service are exemplary and appreciated. Here we have done more poorly and certainly inconsistently. There are outstanding examples of success but too many of suboptimal performance – by the entire medical team and the institution – which also needs to include service in ambulatory as well as inpatient settings. We need to do better. And

fifth, the cost of care needs to be as low as possible and competitive with other providers to make value added meaningful and successful.

Each of these key components (innovation, state-of-the-art patient care, high quality, outstanding patient service and competitive cost) is important both individually and as a component of our overall success as an academic medical center. They are all critical, although their perceived values will impact constituents differently. For example, we will be evaluated by our academic peers on the depth and excellence of our discoveries and innovations. The expertise of our physicians and providers will affect our reputation among our clinical colleagues and will impact referrals and clinical interactions. Patients and our community will judge us by how well we do in service and the quality of their experience, whether in outpatient or inpatient settings. In many ways the patient experience can have an even larger impact on perceived value than whether we are great in innovation or other facets of academic medicine. And of course payers, both public and private, will assess us on cost, although this will increasingly be combined with quality and clinical outcomes. Many of these changes will unfold over the next decade as healthcare insurance reform, provider reform and cost control converge to change the landscape of medicine in the USA. These are changes that need to happen – but they will be challenging.

While we have lots of work to do, the first step in progress is recognition of the need for change. Evidence of this is clearly present in the types of recruitments that clinical departments have made in recent years or that they are planning for the future. The combined efforts of the hospital and school have led to improvements in quality and clinical outcome, but much work remains to be done. It is our intent to make considerable progress in the areas of cost, efficiency, effectiveness and provider delivery through the new Clinical Effectiveness Research Center that has been recently established and that will be led by Dr. Arnie Milstein. In addition, over the past several months a new effort shared by SHC and the School of Medicine on "The Patient Experience" has been established as a major initiative that will focus on all sites and programs of Stanford Medicine. This includes ambulatory programs for which a new outpatient clinic program and Clinical Advisory Council has been established, the first meeting of which was held on July 19th.

It is our expectation that these concerted efforts will improve the overall patient experience and the quality, effectiveness and cost of care at Stanford Medicine. An important aspect – and indeed a key ingredient – will be the necessary cultural transformation by all of us to focus on a more patient centric care model, something I wrote about in the December 1, 2008 Newsletter in a piece entitled "Professionalism and Patient-Centricity, much of which is still timely and relevant today. Within that context I was pleased to see the message from Drs. Ann Weinacker, Vice Chief of Staff, and Bryan Bohman, Chief of Staff, offering vignettes and insights on this critically important issue. I am taking the liberty of copying it below and hope each of you will think about it with serious intent.

From Drs Ann Weinacker and Bryan Bohman to the Medical Staff

It is easy to get so caught up in the work of taking care of patients that we forget the common courtesies of quality care. But try this: Introduce yourself to every patient you care for, and include the nurses in your rounds every day. These are two initiatives currently underway on all inpatient services at Stanford, and are designed to improve patient satisfaction with their care. Unfortunately we have a long way to go to make our patients as comfortable as they should be. When asked to comment on his experience here, one patient said, "The doctor who took call for my surgeon on a day off never even introduced himself – just barged in and pulled up my gown." Another said, "Don't you guys ever talk to each other?"

We must begin to communicate better with each other, with patients, and with nurses. Soon, all SHC attendings, housestaff, fellows, and students will have baseball card style "team cards" to distribute to patients to help them to know who their doctors are, but that is only the beginning of communicating effectively. It is also important to tell patients what role you play on their health care team and who will cover for you when you are off or leaving the service, to let them know what tests they will have and when they will get the results, and to actively include nurses when making rounds and discussing patient care. As simple as it sounds, these things are not routine practice in our hospital, but they can ultimately make patients happier and save you and the nurses valuable time.

Compared with other academic medical centers, our patient satisfaction scores put us in the bottom 30 percent for inpatient and Emergency Department care and the bottom 10 percent for outpatient care. Our greatest shortcomings relate to our failure to recognize patients as people who are vulnerable, uncomfortable, and often afraid of how an illness will change their lives. Most inpatients at Stanford have so many doctors involved in their care that many of them can't identify who is in charge. Introducing ourselves consistently and including the nurses as we make plans won't solve all our problems, but it's a start. We still have a lot of work to do.

If you have ideas for improving the patient experience at Stanford, we would like to hear your suggestions. Thanks.

Stanford Medicine and the Future of Teaching Hospitals and Medicine

The summer issue of *Stanford Medicine* (http://stanmed.stanford.edu/2010summer/), a collaborative project between the Stanford School of Medicine and the Stanford Hospital & Clinics, looks at the *"Metamorphosis of Teaching Hospitals"* and the lessons they can teach us during the era of healthcare reform. Thanks again to the fine editorial work of Roseann Spector and Paul Costello, this issue addresses a wide range of topics, including a timely and thoughtful report by Jonathan Rabinovitch entitled Transformers (see:

http://stanmed.stanford.edu/2010summer/article1.html) that reviews the intersections of evidence based medicine, quality and performance, information technology and the culture of clinical - it is definitely worth reading.

Awards and Honors

- Thanks to a unique collaboration between Professor Rob Jackler, Chair of Otolaryngology/Head and Neck Surgery, and Professor Eric Knudsen, Department of Neurobiology, both holders of Sewall Professorships, endowment funds from these professorships were recently combined to create two new Sewall Professorships. These new professorships were bestowed on:
    - ***Dr Stefan Heller***, Sewall Professor of Otolaryngology and of Molecular and Cellular Physiology, and
    - ***Dr. Tony Ricci***, Sewall Professor of Otolaryngology and Molecular and Cellular Physiology.

  Please join me in congratulating Professors Heller and Ricci and in thanking Professors Jackler and Knudsen, all now united in sharing the appellation of a Sewall Professor in the School of Medicine.
- ***Dr. Wing Hung Wong*** has been elected as a member of Academica Sinica, the national academy of the Republic of China (Taiwan). It supports research activities in a wide variety of disciplines, ranging from mathematical and physical sciences, to life sciences, and to humanities and social sciences. Congratulations to Professor Wing Wong.
- ***Scope***, produced by the ***School of Medicine's Office of Communication*** **and Public Affairs**, has one first place in the "Halls of Research" category in the 2010 Health and Life Medical Blog Awards, which recognize the top blogs run by academic institutions that make medical issues accessible to the general public. Congratulations to Scope and the Office of Communication and Public Affairs.
- ***Dr. Jonathan S. Berek***, Professor and Chair of the Department of Obstetrics and Gynecology, and the Director of the Women's Cancer Center of the Stanford Cancer Center, has been given the **2010 John C. Fremont Pathfinder Award.** The annual award "honors native Nebraskans who have made outstanding contributions to mankind that exemplify the vision and courage of John C. Fremont." The award was conferred this month at a special ceremony in Fremont, Nebraska. Congratulations to Dr. Berek.
- ***Dr. Raj Rohatgi,*** Assistant Professor of Medicine and by courtesy, of Biochemistry, has been awarded the 2010 Pew Scholar in Biomedical Sciences. Congratulations to Dr. Rohatgi.
- ***Dr. Julie Theriot***, Associate Professor of Biochemistry and of Microbiology and Immunology, has been awarded the Kaiser Foundation Award for Excellence in Preclinical Teaching. Congratulations to Dr. Theriot.
- **2010 OCH CTSA Seed Grant Awards:** The Office of Community Health (OCH) is pleased to announce the recipients of the 2010 OCH CTSA Seed Grants. This funding will be used to form new community-based partnerships, enhance existing partnerships or support the development, implementation or evaluation of a community-based research project. This year's award recipients include:

- **Lisa Chamberlain**, MD, MPH, Assistant Professor of Pediatrics, School of Medicine and **Elizabeth Barnert**, MD, MS Pediatric Resident, School of Medicine, partnering with **The Mind Body Awareness Project** for: Evaluation of a one-day intensive mindfulness-based training program for incarcerated youth in San Mateo County.
- **LaVera M. Crawley**, MD, MPH, Assistant Professor of Pediatrics, Stanford Center for Biomedical Ethics, partnering with **Circle of Care Program, East Bay Agency for Children** for: Building Mutual Capacity for Community-Based Outcomes Research in Pediatric Bereavement.
- **Sun H. Kim**, MD, MS, Assistant Professor of Medicine, Stanford University Medical Center, partnering with **San Mateo County Behavioral Health and Recovery Services** for: Improving Metabolic Health in Patients with Severe Mental Illness.
- **Abby C. King**, PhD, Professor of Health Research and Policy and Medicine, Acting Director, Stanford Prevention Research Center, School of Medicine and **Christopher D. Gardner**, PhD, Associate Professor of Medicine, Stanford Prevention Research Center, School of Medicine, partnering with **San Mateo County Health System and BRIDGE Housing Corporation** for: Developing Community Participatory-Based Neighborhood Audit Tools to Promote Healthful Eating and Active Living in Local Counties.
- **Dee W. West**, PhD Professor, Department of Health Research and Policy, School of Medicine and **Bang Hai Nguyen**, DrPH , Consulting Assistant Professor, Department of Health Research and Policy, School of Medicine, partnering with **Community Health Partnership** for: Sustaining Community-Academic Partnerships to Conduct Community-Based Participatory Research.

Congratulations to all of the OCH CTSA Seed Grant recipients!

Appointments and Promotions

Gregg A. Adams has been promoted to Clinical Assistant Professor (Affiliated) of Surgery, effective 10/10/09.

Robin F. Apple has been reappointed to Clinical Assistant Professor of Psychiatry and Behavioral Sciences, effective 6/01/10.

Julius A. Bishop has been appointed to Assistant Professor of Orthopaedic Surgery at the Stanford University Medical Center, effective 8/01/10.

JW Randolph Bolton has been reappointed to Clinical Assistant Professor of Cardiothoracic Surgery, effective 7/01/10.

David B. Camarillo has been appointed to Assistant Professor of Bioengineering, effective 9/1/11.

Zhen Cheng has been reappointed to Assistant Professor (Research) of Radiology, effective 9/1/10.

Susan Crowe has been reappointed to Clinical Assistant Professor of Obstetrics and Gynecology, effective 7/01/10.

Maximilian Diehn has been appointed to Assistant Professor of Radiation Oncology, effective 7/1/10.

Martha R. Dorn has been reappointed to Clinical Assistant Professor (Affiliated) of

Genevieve D'souza has been promoted to Clinical Assistant Professor of Anesthesia, effective 7/01/10.

Rajesh Dtoh has been appointed to Assistant Professor of Medicine at the Stanford University Medical Center, effective 7/01/10.

Nattoha Funck has been reappointed to Clinical Assistant Professor (Affiliated) of Anesthesia, effective 9/01/10.

Rajnish A. Gupta has been appointed to Clinical Assistant Professor of Dermatology, effective 7/01/10

Jon-Erik Holty has been appointed to Clinical Assistant Professor (Affiliated) of Medicine, effective 5/01/10.

Christine A. Keeling has been appointed to Clinical Assistant Professor (Affiliated) of Radiology, effective 7/01/10

Ruth B. Lathi has been reappointed to Assistant Professor of Obstetrics and Gynecology at the Stanford University Medical Center, effective 7/01/10.

Theodore Leng has been promoted to Clinical Assistant Professor of Opthalmology, effective 7/01/10

Eleanor G. Levin has been reappointed to Clinical Professor (Affiliated) of Medicine, effective 9/01/09.

Jafi A. Lipson has been appointed to Assistant Professor of Radiology at the Stanford University Medical Center, effective 8/01/10.

Richard D. Mainwaring has been reappointed to Clinical Assistant Professor of Cardiothoracic Surgery, effective 7/01/10.

Melanie A. Manning has been reappointed to Clinical Assistant Professor of Pathology and of Pediatrics, effective 8/01/10.

David G. Mohler has been promoted to Clinical Professor of Orthopaedic Surgery, effective 12/01/10.

Mindie H. Nguyen has been reappointed to Assistant Professor of Medicine at the Stanford University Medical Center, effective 7/01/10.

Michael J. Ostacher has been appointed to Assistant Professor of Psychiatry and Behavioral Sciences at the Veterans Affairs Palo Alto Health Care System, effective 7/01/10.

Ravi Prtoad has been reappointed to Clinical Assistant Professor of Anesthesia, effective 9/01/10.

Ruchir Shah has been appointed to Clinical Assistant Professor (Affiliated) of Medicine, effective 5/01/10.

Lawrence C. Siegel has been reappointed to Clinical Assistant Professor (Affiliated) of Anesthesia, effective 9/01/10.

Geeta Singh has been reappointed to Clinical Assistant Professor (Affiliated) of Medicine, effective 9/01/09.

Marc Thibonnier has been appointed to Clinical Professor (Affiliated) of Medicine, effective 5/01/10.

Wolfgang Winkelmayer has been appointed to Associate Professor of Medicine, effective 7/1/10.

David J. Wong has been appointed to Clinical Assistant Professor of Dermatology, effective 7/01/10.

Paul Cameron Zei has been promoted to Clinical Assistant Professor of Medicine, effective 8/01/10.