

Dean's Newsletter

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Paul Khavari, MD, PhD Named Next Chair of Dermatology at Stanford

I am very pleased to announce that Dr. Paul Khavari, currently the Carl J. Herzog Professor of Dermatology and Chief of the Dermatology Service at the VA Palo Alto Health Care System, will become the Chair of the Department of Dermatology at Stanford. He will begin his new responsibilities on July 1st, succeeding Dr. Al Lane, who has served as chair of the department for the past 14 years.

I would first like to thank Dr. Lane for his exceptional leadership and for bringing the Department of Dermatology at Stanford to a pinnacle of excellence. Dr. Lane is very much respected and admired by his department, his colleagues at Stanford, and those across the nation for his contributions as an academic leader and clinical investigator. He was recently the recipient of a major disease team award from the California Institute of Regenerative Medicine and will continue to provide guidance, mentorship and oversight for the department's clinical research efforts. We owe Dr. Lane a huge debt of gratitude and I ask that you join me in thanking him for his wonderful accomplishments.

Dr. Khavari is also one of the most respected academic leaders in dermatology in the nation. It comes as no surprise that the Search Committee for the Chair of Dermatology, which was led by Dr. Christy Sandborg, Professor of Pediatrics and Chief-of-Staff at the Lucile Packard Children's Hospital, identified Dr. Khavari as an excellent candidate. His academic and clinical credentials are indeed notable. A Phi Beta Kappa graduate of Stanford in Biology and History, he went on to receive his MD degree from Yale, graduating AOA, and then did an internship in medicine and residency in dermatology at Yale. He then returned to Stanford, first to do a PhD in gene regulation with Dr. Gerry Crabtree in the Department of Pathology and then to join the VA and the Department of Dermatology as an Assistant Professor in 1993.

Dr. Khavari's subsequent research on the gene regulatory control of epithelial growth and carcinogenesis and his work on the development of new molecular therapeutics have won him national acclaim and numerous awards. These include the US Presidential Early Career Award for Scientists and Engineers, the Shannon Award from

the NIH, a Young Investigator Award from the Department of Veterans Affairs, a Junior Faculty Scholar Award from the Howard Hughes Medical Institute, the American Dermatologic Association Young Leader Award, the American Academy of Dermatology Marion B Sulberger Award, the Society for Investigative Dermatology William Montagna Award and election to the Society of Clinical Investigation and the American Association of Physicians. Dr. Khavari became the Herzog Professor of Dermatology in 2003. In addition to his accomplishments in research, he has established a premier clinical program in dermatology at the Palo Alto VA. Equally importantly, he has been the mentor and research advisor to an ever-increasing number of undergraduate, medical and graduate students and is thus creating a legacy of continued excellence.

I am extremely pleased that Dr. Khavari has accepted our invitation to lead the Department of Dermatology, and I am confident that he and his colleagues will do an outstanding job. Finding the best leaders and faculty for our medical school community is among our most important responsibilities, and I want to thank the Search Committee for their dedicated efforts in assembling an outstanding slate of potential candidates. In addition to Dr. Sandborg, the members included Ben Barres, Jonathan Berek, Sarah Donaldson, Patricia Engasser, Minx Fuller, Charlotte Jacobs, Renee Reijo Pera, Susan Pfeffer, Kevin Tabb, Jim McCaughey and Kunle Ogunrinade (SMS representative). I also want to thank Kendra Baldwin from the Office of Institutional Planning for her outstanding contributions in supporting the Search Committee and the candidates.

Protecting the Privacy of Our Colleagues and Co-Workers

At some point each of us will face a medical crisis or problem involving ourselves or a family member, friend or colleague. We will each have different ways of dealing with such an event – but each of us will want the right to protect our privacy unless we make the decision to share the news with others. From time to time you may become aware that a co-worker or colleague is facing a medical challenge. However, unless you have been personally informed or received expressed permission to do so, it is imperative that you not share or discuss such personal information – with co-workers or with the individual. This is a violation of personal privacy and HIPAA and should not occur. Even though it may seem “caring” to reach out to a friend or colleague about his or her personal well-being, you should not do so unless personally and specifically invited. I offer these comments because I have heard from a number of faculty who are facing a medical challenge about how distressing it is to them to be approached by colleagues in the workplace when they have made an individual decision to keep their medical information private or personal. We each deserve respect, privacy and discretion regarding personal matters. Just as we must protect the privacy of our patients, we also need to protect the privacy of our colleagues in the workplace.

When Rankings Become Self-Serving or Misinformed Promoters of Bias

I have written all too frequently about the methodological problems associated with the rankings of US medical schools by US News & World Report (USNWR). One of the most serious problems with the USNWR ranking is the way research success is defined and quantified. The emphasis in the methodology for research-intensive medical schools is on size instead of quality, and there is a significant focus on the total amount of

funding from the National Institutes of Health – a number that is proportional to the size of the faculty as well as to each institution’s focus on “big science” versus innovative research. Because Stanford is among the smallest research-intensive medical schools in the nation, we simply cannot compete with institutions like UCSF, Penn, Hopkins and Harvard that are twice to ten times its size in faculty numbers in the total amount of NIH funding. Nor can we compete in faculty student ratios – which is also related to faculty size.

In addition to the quite imperfect and in some ways distorted ways of measuring success in research, it is particularly distressing when the calculations themselves have serious flaws. Over the past several years Stanford has occupied the number 6-7 position in the USNWR ranking for research-intensive schools. In the latest 2009 ranking, Stanford fell to number 11 – which certainly seems implausible, since conditions simply don’t change that quickly. This prompted us to completely reanalyze the methods and calculations used by USNWR, including the error of rounding fractional differences to whole numbers - creating compression and distortion of scores. Using a more correct approach (even with the flawed assumptions used by USNWR) Stanford would remain solidly in the number 6-7 spot. But this not the real point, since the more important issue is the imperfect manner used to assess research. It is interesting to note that USNWR uses a more balanced approach to assess research in schools of engineering. For these schools, total institutional research funding is combined with research funding per faculty member along with the percentage of faculty who have been elected to the National Academy of Engineering. These last two measures constitute more objective reflections of faculty quality and achievement than simply the total amount of NIH dollars received by the institution.

It is notable that Stanford Medical School ranks number 1 in the amount of research funding per faculty member. And if the percent of Stanford faculty who have been elected to the National Academy of Science or the Institute of Medicine of the NAS were included in the ranking (as for Engineering), Stanford would likely do quite well. These metrics are far better indicators of research quality and would provide more useful information to prospective students (the audience USNWR professes to be addressing) about the quality of a research faculty than the approach currently employed by USNWR. I will make these and related points when I meet with USNWR in mid-July while I am in Washington.

Ironically, additional confusion on the ranking debate was recently added by a report in the June 15th issue of the *Annals of Internal Medicine* by F. Mullen et al entitled “*The Social Mission of Medical Education: Ranking the Schools*” (2010; 132:804-812). While perhaps well-meaning, this report further distorts reality by defining “social mission” as a measure of the percentage of graduates of a medical school who practice primary care, who work in health professional shortage areas, and who are underrepresented minorities. I certainly do not question the importance of producing more primary care physicians or for providing medical care for the underserved. These are enormously important issues. But it seems far too narrow to restrict the definition of the “social mission” of medical education to these metrics. Nor does it seem prudent to

employ them across all medical schools – as if each had (or even should have) the same social mission. Indeed, if that were the case, medical education would be reduced to standards that would stifle innovation. We certainly need more primary care physicians, but we also need more physician scientists, and we need to continue to replenish our supply of innovators, leaders and specialists. Indeed, I would argue that training and educating physician scientists and leaders in medicine and healthcare are very much part of a broad social mission.

I surely understand the need to create order and I recognize the natural tendency to rank or prioritize outcomes. But I question whether rankings like those done by USNWR or the more recent “social mission” ranking provide any real enlightenment or benefit – or whether it simply permits bias to rule or promotes marketing opportunities.

Draft Publication of the ACGME Duty Hours Task Force Recommendations

On June 23rd, the 16- member Accreditation Council on Graduate Medical Education (ACGME) published for comment its recommendations on Resident Duty Hours. This has been a much discussed and anticipated report, especially following the 2008 publication of the Institute of Medicine Report *Resident Duty Hours: Enhancing Sleep, Supervision, and Safety* seemed to herald further restrictions to the “80 hour work week” that became the rule in 2003. There has been considerable commentary by virtually every professional society and group about this matter, most calling for more attention to fatigue management and resident supervision than to further restrictions on work hours *per se*. The ACGME recommendations are based on very broad feedback and a thoughtful review of comments from every constituency and can be viewed at <http://acgme-2010standards.org/>.

Virtually simultaneously, the New England Journal of Medicine published an on-line summary, including a helpful table comparing the 2003 ACGME requirements to the 2008 IOM recommendations and the proposed 2010 ACGME requirements. I am taking the liberty of copying the table from the NEJM on-line summary below since it provides an excellent comparative summary.

From: Nasca, TJ, Day, SH, Amis, S for the ACGME Duty Hour Task Force, “The New Recommendations on Duty Hours from the ACGME Task Force” published in the June 23rd on-line New England Journal of Medicine (<http://content.nejm.org/cgi/content/full/NEJMs1005800>).

Table 1. Comparison of Selected Sections of the Proposed ACGME Requirements with the 2003 Standards and the IOM Recommendations.*

| Category | ACGME 2003 Requirements | IOM 2008 Recommendations | Proposed 2010 ACGME Requirements |
|---|---|--|---|
| Supervision | Programs must ensure that qualified faculty provide appropriate supervision | Residency review committee should establish measurable standards of supervision according to specialty and level of training Residents in first yr must have immediate access to in-house supervision | Residents and attendings should inform patients of their role in the care of each patient Supervising faculty should delegate portions of care to residents Senior residents or fellows should serve in a supervisory role for junior residents Progressive responsibility for care must be assigned by the program director and faculty Residents are responsible for knowing the limits of their scope of authority Programs must set guidelines as to when residents are expected to communicate with supervisors Faculty assignments should be of sufficient duration to assess residents' knowledge and skills Programs must observe the following three classifications of supervision: level 1 — direct supervision (the supervising physician is physically present with the resident and patient); level 2 — indirect supervision; level 2a — supervising physician is on site and available to provide direct supervision; level 2b — supervising physician is available by phone and available to provide direct supervision; level 2c — oversight (the supervising physician reviews procedures and encounters after care is delivered) During the postgraduate yr 1, residents must have supervision level 1 or 2a |
| Workload | Learning objectives must not be compromised by excessive reliance on residents to fulfill service obligations Assignments must recognize that faculty and residents collectively are responsible for patient safety and welfare | Resident workload should be adjusted and work that is of limited or no educational value limited Residents should be provided with adequate time for patient care and reflection Appropriate limits on caseload should be set, taking into consideration complexity of illness and residents' competency | The workload for each resident must be based on level of training, patient safety, resident education, severity and complexity of patient illness, and available support services (specialty-specific guidelines to be enumerated by each specialty review committee) The learning objectives of the program must not be compromised by excessive reliance on residents to fulfill nonphysician service obligations |
| Maximum hr/wk | 80/wk, averaged over 4 wk | 80/wk, averaged over 4 wk | 80/wk, averaged over 4 wk |
| Maximum length of duty period | Continuous on-site duty, including in-house call, must not exceed 24 consecutive hr Residents may remain on duty up to 6 additional hr to participate in didactic activities, transfer care of patients, conduct outpatient clinics, or maintain continuity of medical and surgical care No new patients may be accepted after 24 hr of continuous duty | Extended duty must not exceed 16 hr, unless a 5-hr nap is provided; 5-hr nap must be included in 80-hr limit; after 5-hr nap, resident may continue for up to 9 more hr for a total of 30 hr No new patients after 16 hr Extended duty (e.g., 30 hr with 5-hr nap) must not occur more frequently than every third night; averaging is not allowed | Duty periods of residents in postgraduate year 1 must not exceed 16 hr Intermediate-level and senior residents (postgraduate yr 2 and above) may be scheduled for a maximum of 24 hr of continuous duty; programs must encourage residents, as professionals, to use alertness-management strategies to maintain alertness in the context of patient care responsibilities; strategic napping, especially after 16 hr of continuous duty and between 10 p.m. and 8 a.m., is strongly suggested Residents may remain on site for periods of no longer than an additional 4 hr to provide for the transfer of care and must not attend continuity clinics after 24 hr of duty In unusual circumstances, residents may remain beyond scheduled hr to continue to provide care for a single patient; justifications are limited to required continuity of care for a patient who is severely ill or whose condition is unstable, academic importance, or humanistic attention to the needs of a patient or family; residents cannot be compelled to spend these additional hr |
| In-hospital on-call frequency | Every third night, on average | Every third night; no averaging | Intermediate-level and senior residents (postgraduate yr 2 and above) — every third night (no averaging) |
| Minimum time off between scheduled duty periods | Adequate time for rest and personal activities must be provided, consisting of 10 hr off between all daily duty periods and after in-house call | Time off must be provided as follows: 10 hr off after regular daytime duty period 12 hr off after night duty 14 hr off after an extended duty period, and must not return before 6 a.m. the next day | Residents in postgraduate yr 1 should have 10 hr off and must have 8 hr free of duty between scheduled duty periods Intermediate-level residents should have 10 hr off and must have 8 hr between duty periods and 14 hr free of duty after 24 hr of in-hospital duty Residents in the final yr of training should have 10 hr free of duty and must have 8 hr between scheduled duty periods Review committees may create standards that allow residents to return to work in less than 8 hr under the monitoring of the program director |
| Maximum frequency of in-hospital duty | Specialty-specific requirements apply | Night duty must not exceed 4 consecutive nights and be followed by a minimum of 48 continuous hr off (after 3 or 4 consecutive nights) | Residents must not be scheduled for more than 6 consecutive nights of night duty (night float) (the maximum no. of consecutive wk of night float and maximum no. of moonlight float per yr may be further specified by the specialty review committee) |
| Mandatory off-duty time | 24 hr off per 7-day period, averaged over 4 wk, inclusive of call | 24 hr off per 7-day period; no averaging; one golden weekend per mo† | 24 hr off per 7-day period (when averaged over 4 wk); home call cannot be assigned on these free days |
| Moonlighting | Moonlighting must not interfere with residents' ability to achieve the goals and objectives of the educational program Internal moonlighting must be considered part of the 80-hr limit | Internal and external moonlighting count as part of 80-hr limit Residents must receive permission from program director to moonlight, and resident performance will be monitored to ensure no adverse effects from moonlighting | Internal and external moonlighting are to be included in 80-hr limit Residents in postgraduate year 1 must not be permitted to moonlight, internally or externally |
| Duty-hr exceptions | Review committee may grant exceptions | Review committee may grant exceptions | Duty-hr exceptions to 88 hr per week averaged are permitted |

The Association of American Medical Colleges (ACGME) has already issued a statement endorsing the ACGME proposed duty hour requirements (see: <http://www.aamc.org/newsroom/pressrel/2010/100623.htm>). The draft ACGME standards are available for public comment through August 9, 2010 (see: <http://acgme.org>) and, when finalized, will be put into effect in July 2011.

Evaluation of Medical Student Performance During Clinical Rotations

In tandem with the proposed requirements for resident duty hours, the ACGME also published criteria for evaluating residency programs and resident performance. Expectations for knowledge-based assessment as well as professionalism mirror a number of criteria that will be employed in our medical student CBEI (Criterion Based Evaluation System - <http://med.stanford.edu/md/curriculum/CBEI/index.html>) program, which begins on June 28th. Following the decision more than a year ago to institute a more formal evaluation of clinical performance during core clerkships, a thoughtful, careful, comprehensive and engaged task force led by Dr. Elizabeth Stuart, Clinical Associate Professor of Pediatrics, has done an exceptional job in defining the criteria that will be used to evaluate student performance in Internal Medicine, Pediatrics, Surgery, Neurology, Obstetrics and Gynecology and Psychiatry. Dr. Stuart has kept students and faculty informed about the policies and procedures being utilized through numerous committee meetings, town halls, presentations to the Clinical Clerkship Program Directors, Faculty Senate and Executive Committee as well as postings on the CBEI website.

I want to thank Dr. Stuart for the exceptional progress that has been made and for the leadership and integrity that has been employed along the way. I am cognizant that any change brings questions, concerns and anxieties, especially for our students and faculty. But I am confident that the appropriate steps have been taken to address these concerns and that the process will be monitored carefully and adapted as appropriate. That said, I also believe that this is an incredibly important step in assuring that our students are being prepared to become outstanding physicians in every domain and dimension and to demonstrate their skills, knowledge and professionalism to the fullest extent possible.

Measuring Academic and Faculty Success

Over the past year we have continued efforts to support faculty development and success. A number of departmental task forces were engaged in this effort following the 2009 Strategic Planning Leadership Retreat and over the past 8 months we have had a number of these reports presented at our Executive Committee. On June 4th we heard reports on “creating a culture that fosters faculty success” from the Departments of Urology and Radiation Oncology. I want to offer special thanks to Craig Comiter, Associate Professor of Urology and Albert Koong, Associate Professor of Radiation Oncology, for sharing the initiatives they led in their respective departments.

- The metrics used in the Department of Radiation Oncology focus on clinical care, teaching, research and service. The proportional weight given to these categories

varies according to the faculty line and the percent effort projected for each of these missions. Based on this, the department has developed detailed and specific metrics for each faculty line and rank as a guide to evaluating performance. The department recognizes that the specificity of such metrics should be used as a tool and guide and not as a substitute for informed judgment.

- The Department of Urology reviewed the literature on metrics to assess faculty performance in mission related categories like research, teaching, service (and citizenship) as well as job satisfaction and personal fulfillment. Again the metrics they defined were presented as guides for faculty and related to the culture of the department.

The discussion that followed the presentation underscored that metrics vary among faculty lines and ranks as well as by departmental culture and discipline. Transparency to individual faculty about which factors are deemed important for his or her own success is important. For example, while everyone recognizes that the quality of a research contribution is more important than quantity, it is often noted that junior faculty have a hard time discerning what defines “high quality publication” or whether there is some threshold number needed for promotion. Clearly it is not possible to spell these out with comforting specificity – making it all the more important for junior faculty to have regular discussions and feedback from their advisors or supervisors. A continuing source of confusion also relates to the value placed on “collaborative” research versus individual contributions. Despite our focus on interdisciplinary research and collaboration, the culture of universities (including Stanford) still places a premium on individual contributions. This too is a work in progress.

Dedication of the C.J. Huang Asian Liver Center

On Wednesday, June 9th, Dr. Sam So, the Lui Hac Minh Professor in the Department of Surgery and the Director of the Liver Cancer Program, hosted the official opening of the New Asian Liver Center (ALC) at Stanford. Dr. So also directs the Asian Liver Center that is housed at 490 South California Avenue in Palo Alto. This event was also organized to thank and acknowledge the generosity of Dr. and Mrs. C.J. Huang, who played a key role in launching the Asian Liver Center in 1996 and whose generosity helped support the Center’s new location. The Huangs were celebrated as “Honorary Founders.”

This event was also provided an opportunity to thank Dr. So and his colleagues for their tremendous leadership and contributions in calling attention to the impact of Hepatitis B on liver cancer, especially in Asia. The Asian Liver Center has led vaccination programs to prevent Hepatitis B, especially in the Asian communities in the Bay Area and through major initiatives in China. The Asian Liver Center is a wonderful demonstration of a faculty member’s ability to influence the prevention of a serious human through commitment, research and advocacy.

Awards and Honors

- **Dr. Richard Tsien**, George T. Smith Professor in the Department of Molecular and Cellular Physiology, is the recipient of the 8th Annual George E. Palade Gold Medal Award, along with co-recipients Drs. Bill Catterall and Walter Boron. The committee was very impressed by Dr. Tsien's work leading to the discovery of the N-type calcium channels. Dr. Tsein will be honored at an awards ceremony held in this fall.
- **Dr. Pat Basu**, Attending Physician, Department of Radiology, has been appointed a White House Fellow and Special Assistant to the President. This is a highly competitive recognition and we are proud of Dr. Basu's success.
- **Dr. Ron Garcia**, Senior Lecturer and Director, Center of Excellence, is one of three recipients of The California Wellness Foundations 2010 Champions of Health Professions Diversity Award that recognizes "exceptional individuals who demonstrate leadership in important health issues."
- The Board of Directors of the Baxter Foundation has selected the 2010 Baxter Faculty Scholars. They are:
 - **Manish Butte, MD, PhD**, Assistant Professor of Pediatrics, and
 - **Fan Yang, PhD**, Assistant Professor of Orthopaedic Surgery and Bioengineering
- **Dr. Sam Gambhir**, Virginia and D.K. Ludwig Professor of Cancer in the Department of Radiology, and his colleagues have been awarded a new U54 from the NIH as a Center for Cancer Nanotechnology Excellence. This grant will likely approximate \$15 million over the next 5 years and will bring together faculty from the departments of Radiology, Medicine, Obstetrics and Gynecology as well as other faculty in the Schools of Medicine and Engineering.

Appointments and Promotions

Cristina Alvira has been appointed to Assistant Professor of Pediatrics, effective 7/01/10.

Marc A. Coram has been reappointed to Assistant Professor of Health Research and Policy, effective 6/01/10.

David Paik has been reappointed to Assistant Professor (Research) of Radiology, effective 6/01/10.

Laura W. Roberts, has been appointed to Professor of Psychiatry and Behavioral Sciences, effective 9/01/10.

Daniel Spielman has been promoted to Professor of Radiology, effective 7/01/10.