

Dean's Newsletter

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Table of Contents

The 2011 Strategic Leadership Retreat: Change in a Time of Change
Continuing Commitment to Leadership: Faculty Fellows 2011
Converging Perspectives on Valuing Patients
Medical and Healthcare Organizations Offer Support for the Affordable Care Act
Call for Nominations for the Augustus A. White III and Family Faculty Professionalism Award
Awards and Honors
Appointments and Promotions

The 2011 Strategic Leadership Retreat: Change in a Time of Change

We held our Annual Strategic Planning Leadership Retreat on January 21-22nd at Chaminade, in Santa Cruz. This was the tenth consecutive Annual Retreat since I joined Stanford in 2001 and, as with past retreats, it offered the opportunity to bring our broad Stanford Medicine community together for reflection, debate and strategic planning. Over the years each retreat has had a different focus, and the theme as well as the consequences and outcomes have varied considerably. What has remained a constant is the opportunity to bring together our diverse community, share different perspectives and forge new alignments around our individual and collective futures.

As highlighted in the end of the 2010 and beginning of 2011 Newsletters (*“Some Reflections on 2010: A Times for Ups and Downs”* and *“A Challenging But Still Hopeful Year”*) we are moving through of time of change – some of which is predictable and much of which is considerably less so. We remain committed to our fundamental missions but recognize that we will need to remain visionary, creative, flexible and entrepreneurial to sustain success.

The major goal for the 2011 Retreat was to define our future initiatives in education in the context of the changing landscape of healthcare delivery and our nation's investment and opportunities in research. We also wanted to further refine our efforts to provide broad opportunities as well as flexibility in career development. To that end, we benefited from five panel presentations and the rich discussion that followed, which helped provide both a framework and greater clarity for the specific action items that will follow from the retreat. The panels were as follows:

Panel 1. Flexibility in Faculty Careers – A Mandate for Cultural Change

This panel included presentations by Drs. Hannah Valantine, Senior Associate Dean for Diversity and Leadership; Christy Sandborg, Chief-of-Staff at Lucile Packard Children's Hospital and Professor of Pediatrics; Jennifer Raymond, Associate Professor of Neurobiology; Ron Pearl, Professor and Chair of the Department of Anesthesia; and Udaya Patnaik, Founder and Principal, Jump Associates. Dr. Valantine began the panel by underscoring that the primary purpose of the task force she and Dr. Sandborg are leading is to create a culture that is supportive to career flexibility. While it is important

to note that the School of Medicine has a number of existing policies that permit flexibility, the unfortunate reality is that most faculty do not take advantage of them. There is an accumulating concern that a culture that does not foster flexibility leads to turnover and discourages students and trainees from aspiring to or pursuing academic careers. If so, the consequences will be quite negative for the future of academic medicine. With that in mind, the task force is seeking to make the case for flexibility, identify best practices and define the needs of faculty.

The workforce and many work environments have changed over the past several decades. While there are clearly exceptions, there is a perception (which is supported by data) that a successful academic career is more achievable for men or for women who defer having children. This is not a reality we want to support or sustain.

The panel emphasized some of the important differences between basic and clinical science faculty in opportunities for flexibility. For example, basic science faculty may have more short-term flexibility but have less long-term flexibility compared to their clinical colleagues. This is related to the fact that basic science compensation is lower than for clinical faculty so that working part-time may not permit a livable wage. Further, the intense competition for research funding and the need to fund one's laboratory as well as salary means that if a faculty member reduces her or his time in research, it could prove impossible to sustain successful peer-reviewed research support, thus negatively affecting career development.

At the same time, it is also clear that there are lots of "jobs" that faculty do that, if done by others, would permit them to focus their attention on areas that are likely to have the biggest payoff for them both professionally and personally. Support for tasks from institutional resources, or greater salary support so that faculty were not as dependent on raising grant or clinical income, would be helpful in optimizing faculty time. In the end, time is the most precious resource for faculty, and currently it is deployed on both productive and less productive activities. Job sharing has been used in a number of industries, including in medicine, and can be successful, particularly when both partners share a common skill set. Understandably, it is more difficult when the patient population is very specialized and the skill set of the physician unique.

Another issue is defining what is actually meant in an academic setting by part time. Is part-time a portion of a 40, 60, 80 or more workweek hours? Also, how does one allocate time when one's job includes multiple activities (teaching, clinical, research, administrative, service)? Are all components of one's job reduced proportionally or are some simply eliminated? And in either case, what are the consequences to future promotion and career development, and how does this play out at the individual, division, and department level? It is also the case that individuals and faculty who are not participating in flexible hours are also affected by the choice or needs of their colleagues – and that they may respond with support or with anger and disdain. A change in the entire culture of an organization or even society may be required in order to achieve acceptance of flexible work schedules during different phases of career development.

Examples were cited of cultures of flexibility in companies and even countries (e.g., The Netherlands).

Because the solutions to this issue are so challenging, the task force has engaged the firm of Jump Associates, who will work with them over the next year to create options. Jump Associates is a consulting group that focuses on solutions to highly ambiguous problems, in which the key first step is really fully identifying the problem. This step, which might seem relatively straightforward, is more complicated in an academic medical center than in many settings because of the diversity and breadth of jobs, the range of needs, the internal and external pressures and expectations at the individual and institutional level, and the limitation of the resources that are needed to attenuate the problem or even help permit creative solutions. Despite these challenges, solutions are needed lest the opportunities of future generations of physicians and scientists, particularly women, become adversely impacted or even squandered.

The Retreat participants engaged in a thoughtful discussion about how to overcome the current barriers and challenges and were asked to provide their written comments, which will be collated and codified to further inform the work of the task force. These and other inputs will guide the task force to more formal recommendations that they will bring forth over the next year. While it is clear that this is a very difficult problem, I did have the very definite sense that there is a strong willingness on the part of our school and institutional leaders to work toward solutions – a key first step.

Panel 2. The Evolving Landscape of Healthcare and Attempts to Reform or Change It

This panel was led by Dr. Arnie Milstein, Director of the Clinical Excellence Research Center and Professor of Medicine, and included Dr. Jay Battacharya, Associate Professor of Medicine; Dr. Woody Myers, Stanford Hospital and Clinics (SHC) Board of Directors and Stanford University Trustee Emeritus; and Dr. Kevin Tabb, Chief Medical Officer, SHC.

This panel began with a high-level review by Dr. Battacharya of some of the societal factors that allowed health care reform to happen now as compared to the many past failed efforts – at least to its current state of deployment. To a great extent the reform was driven by unsustainable rates of increase in the costs of care being borne by both the public and the private sectors. Coupled with this was the fact that more than 60 million Americans lack access to health care and that much of the care provided to uninsured people is paid for by those who have insurance. By 2014 this will be modulated by the availability of health coverage to approximately 35 million people through public programs (notably Medicaid) or through health insurance exchanges. At least a part of this increased cost will come from proposed reductions in Medicare, but this will come with a price – both in the care for poor people and in the public support (through Medicare) for graduate medical education.

Clearly, these changes will have important implications for academic medical centers, which will likely see a shift of poorer paying patients to their care, an increased demand for services and a decreased support for the education and training missions of

teaching hospitals. This will require changes in how academic medical centers carry out their work in patient care, education and research – with a larger focus on the management of populations and efforts to keep chronically ill patients out of high cost systems.

Dr. Arnie Milstein further reviewed some of the major implications of the Affordable Care Act (ACA) on academic medicine and highlighted two issues. The first is a projected shift of both public and private payers away from “fee-for-service” (which, parenthetically, has helped foster so many of the perverse incentives that are now featured in US healthcare) toward a payment system that will incentivize higher quality (based on comparative metrics) and lower costs. Secondly, as noted above, there will be a tighter linkage between any payments for graduate medical education (through Medicare) and evidence that the future physician workforce is able to work effectively and efficiently in the new and rapidly evolving quality/cost driven healthcare environment.

Dr. Myers, speaking from his perspective as a hospital Board of Directors member (and former leader of a major private insurance company), opined that, while the ACA is hardly perfect, it is a great start. He observed that Stanford Medicine has a number of things in its favor, including major improvements in recent years in our demonstrable quality and safety scores (to the point where we are now among the leading institutions in the country); a fully deployed electronic medical record system (also featured as one of the best in the nation); a major cultural shift toward disclosure and a culture that values integrity and the public trust; and a solid reputation and brand as Stanford Medicine (which can be built on and enhanced in the years ahead).

Dr. Myers also noted some major challenges, including the need to better define and then deploy our mission in primary care that will complement our excellent tertiary services; the regional challenges of distinguishing Stanford Medicine from the other major providers in the Bay Area (e.g., Kaiser and Sutter) that are increasingly consolidating the healthcare market. A key challenge is the need to build a new hospital and match excellence in our facilities to the excellence of our programs. This need is driven by both seismic as well as programmatic needs and will play an increasingly important role in our planning over the next several years.

Amplifying on the achievements that have been made in Stanford’s electronic medical record system over the past several years, Dr. Kevin Tabb noted that simply having such resources will not by themselves improve quality, efficiency and excellence. Achieving these goals also requires the right people, with the right ideas and vision and the ability to execute them efficiently and effectively. This is not simply a resource issue. It is also an area where critical thinking, evaluation and scientific rigor can make a difference – and which Stanford can also excel at if attention is appropriately focused.

These comments stimulated a broad discussion and I will share some of those important comments with you in future Newsletters.

Panel 3. Transforming Medical Education

This panel was led by Dr. Charles Prober, Senior Associate Dean for Medical Education and Professor of Pediatrics, along with Dr. Clarence Braddock, Associate Dean for Medical Education and Professor of Medicine ; Dr. Henry Lowe, Senior Associate Dean for Information Resources & Technology and Associate Professor of Pediatrics; Dr. Laura Roberts, Professor and Chair of Psychiatry and Behavioral Sciences; Dr. PJ Utz, Professor of Medicine; Chloe Chien, SMS 3 and President of the Stanford Medical Student Association; and Dr. Holbrook Kohrt, Clinical Fellow in Cancer Biology.

Dr. Prober began this panel with a reaffirmation of our mission statement for medical education: *To prepare physicians who will provide outstanding, patient-centered care and to inspire future leaders who will improve world health through scholarship and innovation.* Each word in this mission statement is important and helps define Stanford Medicine and our students. Dr. Prober reminded the attendees that our last major revision of the medical education curriculum was launched in 2003 (see: <http://med.stanford.edu/md/>) and still can be considered unique in its emphasis on scholarship and research. Since the new curriculum was launched, it has been enhanced by a number of important initiatives including the Educators-4-Care (<http://med.stanford.edu/e4c/>), Translating Discoveries (http://med.stanford.edu/md/curriculum/translating_discoveries.html), Criterion Based Evaluation (<http://med.stanford.edu/md/curriculum/CBEI/index.html>), Multi-Mini Interviews (<http://med.stanford.edu/ism/2011/january/interview-0110.html>), and the use of iPads in medical student education (<http://med.stanford.edu/ism/2010/september/ipads-0913.html>).

While each of these programs constitutes another unique feature of the Stanford medical curriculum, there are a number of emerging themes and issues that make a case for change. These include a need to focus learning on patients and communities and on the use of new learning strategies coupled with more sophisticated methods for knowledge retrieval, integration and renewal. In addition, a fundamental underlying issue is that the time for medical education (from high school through fellowship) is too long and too disorganized and requires fundamental reassessment and reform.

Dr. Clarence Braddock put a fine point on the length of training by posing a basic question of whether knowledge acquisition should be time-based (as it largely is now) or competency based (which would permit different rates and paths for knowledge acquisition). The latter would permit coupling of rigorous knowledge and skill outcomes in a more flexible manner. In addition to individual learning, a greater emphasis on team-based skill acquisition and learning will be important. And, as noted in the panel on healthcare reform (see Panel 2) there will be a greater accountability for understanding the intersections of quality, efficiency, cost and value in clinical care delivery.

Among the major changes that are affecting knowledge acquisition are those related to Information Technology – including the electronic medical records, digitally-based means of acquiring information and the rapidly emerging opportunities for social

networking (well beyond and quite different from Facebook or Twitter). With that in mind we need to think of our students as creators of technology tools and not simply users. The novel uses of iPads by current first year medical students that transcend their expected use are reminders that innovation begins with our students. Dr. Lowe also commented on the transformative role that the Li Ka Shing Center for Learning and Knowledge is having – and will continue to have – on medical education in virtually every dimension (from video to simulation and beyond). These emerging technologies offer unique potentialities, opportunities and challenges for our future education programs – and are areas in which Stanford can be a global leader for innovation.

Despite these exciting changes and opportunities, Dr. Laura Roberts reminded us that the journey of medical education and practice is filled with stress and its consequences. She noted that as many as 40% of medical students (in general and not specifically Stanford) indicate depression and as many as 11% have considered suicide. As many as 50% of students meet criteria for “burnout” and 40% indicate problems with personal relationships. These stress metrics increase over time and continue through residency and well beyond. Indeed, it is well known that mental health issues, substance abuse and suicide rates are high in physicians compared to other professions. Dr. Roberts has observed that many students “suffer in silence” since there is a fear of discrimination or negative judgment. Awareness of these conditions needs to be part of the education process, and we need to train students and physicians for competency in dealing with them, including self-care. Developing role models and confidential pathways for intervention would also be important components of addressing this important issue.

Returning to Stanford’s unique mission in educating and training physician-scientists, Dr. PJ Utz called on us to renew and reaffirm a culture of innovation, risk-taking, creativity and flexibility. He recalled some of the experiences that were in place when he was a medical student at Stanford and focused in particular on the ever-increasing length of education and the lack of integration and coordination from high school through residency. He noted, as have others, that we have an opportunity at Stanford to better coordinate medical education across its undergraduate to graduate continuum, redefine the training of the physician-scientist and re-think the criteria for admission to medical school – and even its timing.

We also had an opportunity to hear a reflection on what medical education might look like a decade from now. Medical student Chloe Chien offered the first perspective. She argued for a “dedicated” teaching faculty who would serve as “coaches” to direct self-guided learning. This might be analogous to the Oxford model of learning or to an amplified and enhanced version of the Educators-4-Care program noted above. She also proposed that learning become more experiential, potentially including the acquisition of both basic and clinical knowledge at the point of learning – whether in the hospital or in the clinic. An additional perspective was offered by Dr. Holbrook Kohrt, who completed his MD, residency and fellowship at Stanford and who is now pursuing a PhD degree in the Advanced Residency Training at Stanford Program (see: <http://med.stanford.edu/arts/>). He reflected on the importance of using data to improving clinical care and of the need to better train our students to be managers and leaders who

run programs of different size, scope and mission. He pondered whether Stanford is a place to gain medical knowledge or to become a leader. He further underscored the importance of maintaining humanity in medicine and how technology can be an impediment to connecting doctors to patients (see below).

Panel 4. The Evolving Landscape of Biomedical Research and Innovation

We were pleased to have two outside leaders on this panel; they added a valuable national perspective to our discussion.. The first was Dr. Antonio Scarpa, Director of the Center for Scientific Review at the National Institutes of Health, and the second was Dr. Ann Bonham, the Scientific Director for the Association of American Medical Colleges (AAMC). Both Drs. Scarpa and Bonham had highly productive careers in research and academic medicine prior to joining the NIH and AAMC, respectively. Additional panel members included Dr. Ann Arvin, Vice Provost and Dean for Research and Professor of Pediatrics; Dr. Daria Mochly-Rosen, Senior Associate Dean for Research and Professor of Chemical and Systems Biology; and Dr. Harry Greenberg, Senior Associate Dean for Research and Professor of Medicine.

Dr. Scarpa offered a longitudinal perspective on NIH support for biomedical research from the 1990's through the present. He pointed out in particular that currently 10% of institutions receive approximately 80% of the research funding, although this has not changed substantially over a long number of years. He noted that the while it is less usual for NIH recipients to hold 3 or more grants, a number have two grants. He referred to the finding by Dr. Jeremy Berg [reported in *Nature* 468, 356-357 (2010)] that the productivity of investigators did not appear to increase with funding levels above \$750K, and he noted that some Institutes are assessing the number of grants an investigator should hold. In particular he highlighted the significant increase in the numbers of grants submitted to the NIH during the past decade – reflecting new investigators as well as multiple submissions. For the latter, he proffered that the new NIH scoring system is having an impact by promoting initial quality over resubmission.

Dr. Scarpa also highlighted the fact that the last decade witnessed a focus on supporting new investigators along with more transformative research. At the same time, he reminded us that prior success in NIH funding does not necessarily forecast future success; about 50% of investigators continue to be successfully funded some six years after their first NIH award. While this provides opportunities for new investigators, it raises significant issues for the longevity of a career in research. While Dr. Scarpa could not forecast the levels of future funding, it could be deduced that the current economy and political forces make incremental funding unlikely.

Dr. Bonham further underscored the fact that research funding, as well as support for higher education, will be challenged by the current economy and the projected \$14 trillion debt at both the federal and state levels. She noted that the debt will further impact the healthcare system and will decrease the clinical margins that have been used to cross-subsidize research and academic programs in the past. Dr. Bonham commented on the proposition by Bruce Alberts (*Science* 329, 10 September 2010) that the NIH should not

be expected to provide more than 50% of salary support to faculty and that institutions should provide more support. In fact when the AAMC tested this assertion they found that NIH funding accounts for approximately 35% of the salary support for faculty – lower than suggested by Alberts. (This has also been examined at Stanford with a similar finding.) However, it is also clear that there isn't enough money in the system, regardless of its sources, to support the research enterprise of the past and that changes and reforms are necessary.

One of Dr. Bonham's suggestions was to take advantage of the funds that will be available for outcomes and clinical effectiveness research through the ACA and Medicare. She also emphasized the importance of transparency, particularly in industry relationships, since the perception (and sometimes the reality) of inappropriate interactions with industry has colored the perception of the Congress about the biomedical research community. At the same time, developing new partnerships with industry and other funding sources should also be pursued.

Dr. Bonham underscored a point we have focused on in the past - that size is not the correct measure for success and that greater emphasis needs to be placed on quality of faculty and students. More specifically, the concept that growth is the metric for success needs to be challenged (which is something we have done for some time at Stanford). That concern about growth also needs to be carried over to our workforce – especially since the number of graduate students and post-doctoral fellows has nearly doubled in the past decade without evidence that there are jobs or opportunities for these students and trainees (see below).

Dr. Ann Arvin offered a perspective of the research funding and success data from the point of view of Stanford University – in addition to the School of Medicine. She affirmed that the submission of multiple grants has been a burden on faculty and also (as noted above) that Stanford is already providing more than half of the salary support to its faculty (in the aggregate). Data on the balance of corporate funding versus sponsored federal funding demonstrates that the preponderance of Stanford research support comes from federal compared to corporate sources (\$467 million versus \$67 million) but clearly both are important. The increase in support from the California Institute for Regenerative Medicine (CIRM) in recent years has also been significant. Dr. Arvin also highlighted Stanford's success in interdisciplinary research and the important opportunities for collaboration that exist with different Stanford Schools and Independent Labs, perhaps especially the Linear Coherent Light Source at SLAC.

Dr. Mochly-Rosen picked up the theme of research funding in relation to the School of Medicine and called for a renewed assessment of partnerships with industry. This is a theme we have discussed previously and have considered in relationship to regional partnerships. Clearly this will require further study and evaluation. At the same time, Dr. Mochly-Rosen pointed out that we need to become more efficient and wise about the use of our lab space (which is almost certainly underutilized today despite our funding levels) and that consideration needs to be given to the future size of research groups (e.g., number of benches per investigator, number of students/trainees,

administrative efficiencies). One area for focus is the efficiency of our 20 service centers, which carry an annual budget of \$20 million. The questions of consolidation of centers and of operating them on a more efficient schedule (e.g., 24/7) need assessment.

Both Dr. Mochly-Rosen and subsequently Dr. Harry Greenberg emphasized our opportunities in translational and clinical research, including population sciences, clinical effectiveness, outcomes and innovations in healthcare delivery. These are issues gaining focus at NIH, and we need to match them at Stanford by developing the workforce, skills and focus to compete for these funding sources and opportunities.

Panel 5. Thinking About the Future of Graduate Education and Postdoctoral Training

The final panel of the Retreat focused on graduate education and postdoctoral training and is an extension of the important issues about research funding and the size and scope of our research and education missions. This panel included Dr. John Pringle, Senior Associate Dean for Graduate Education and Professor of Genetics; Dr. Tom Wandless, Associate Professor of Chemical and Systems Biology; Dr. Dan Hershlag, Professor of Biochemistry; Dr. Tom Clendinin, Associate Professor of Neurobiology; Dr. John Boothroyd, Associate Vice Provost for Graduate Education and Professor of Microbiology and Immunology; Dr. Jim Ferrell, Professor and Chair of Chemical and Systems Biology; and Dr. Daria Mochly-Rosen, Senior Associate Dean for Research and Professor of Chemical and Systems Biology.

Dr. Pringle began this panel by asking a series of important questions – many of which were forecast by prior panels in the Retreat and in other settings. These included: Are we training too many graduate students/postdocs? What is too many? Are we training them for the right things (i.e., academics versus other career pathways)? Has our academic focus and reward system over-emphasized research productivity over teaching? In addition to our commitment to graduate education, how can we impact postdoctoral training when so much of what happens in this area is influenced by the availability of grant support and decisions made by individual faculty and principal investigators?

In a thoughtful and provocative presentation, Dr. Tom Wandless began to answer these questions by emphasizing his commitment on a deeply personal as well as professional level to graduate students and their education. He described his perception of the differences in function and need of medical versus graduate education and highlighted the apprentice-based model of PhD education (which he also proffered was in need of a critical review in curriculum and focus). At the same time, he argued that the future of graduate education is challenged because of financial problems and disincentives that negatively affect students and programs. Specifically, in his view, the cost for a graduate student is considerably higher than that for a postdoc. Moreover, this cost has increased more than three-fold in the last 5-10 years. The fact that students need to be supported by NIH training grants impacts their ability to move from one lab or school to another and has a negative effect on their perceptions of Stanford. It also affects the morale and perception of faculty, who question whether the reward system values education and teaching.

Dr. Herchlag pursued this theme in his remarks. He began with the statement that graduate education is clearly a core mission of the School of Medicine, and he noted that we all want the best students and also all want them to have the most successful careers possible. But the fact that our graduate education programs are so dependent on training grants means that it is hard to support extremely promising students from outside the USA, which limits the pool of talent on which we can draw. That reality, as well as the cost of graduate education, is having a negative impact on the views of faculty, departments and potential students.

Dr. Tom Clandinin offered his perspective, which was consistent with those of Tom Wandless and Dan Hershlag, that the current financial model for graduate education is having a negative impact on teaching, mentoring and commitment. This has been made worse by the demands on faculty to write more grants and be more productive in their research— an issue that we believe will, unfortunately, only become more aggravated in a negative funding environment. That said, Dr. Clandinin stressed the importance of focusing renewed efforts on graduate student curriculum, didactic teaching, mentoring and career development – for both academic and other pathways.

Dr. John Boothroyd focused his remarks on two important aspects of postdoctoral training. The first was the annual mentoring meeting. He highly recommended that faculty take the time to meet annually with each of their postdocs, and he further recommended the use of the template for such meetings that was developed in 2005 by the Stanford Postdoc Committee. This template includes such pertinent discussion topics as a review of the postdoc's research and training over the past year, plans for the coming year, career goals, and areas to focus on for the coming year. He has found both the template and the meetings themselves very beneficial to his postdocs and to his role as their mentor. More information about the annual mentoring meeting can be found at http://postdocs.stanford.edu/faculty_mentors/support.html.

The second aspect Dr. Boothroyd discussed was the importance of increasing the diversity of our postdoc population. Currently 2.9% of our postdocs are underrepresented minorities. We need to do better, both because it is the right thing to do and because the national research agenda should reflect the entire range of perspectives that diversity brings. He offered suggestions to increase postdoc diversity, including learning from others, more successful programs, and providing staff time dedicated to this goal.

Dr. Jim Ferrell followed up on the topic of postdoc mentoring and described the relatively new programs the Department of Chemical and Systems Biology has initiated in this area. The department, which has 9 labs and 39 postdocs, recognized that, as difficult as things can be for grad students and med students, there is at least a structure for them that is broader than a single lab. As a result, they instituted the practice of having each faculty member review the progress of each of his or her postdocs at a faculty meeting once a year. This way all of the faculty know how the postdocs are doing and can offer suggestions and advice. In addition, postdocs must attend weekly departmental research talks, and the department provides food for monthly postdoc meetings.

More than that, the department has instituted a system of postdoc faculty committees. Each postdoc is required to set up a three-person committee consisting of the PI and two others, which can include faculty from other institutions. The committee meets sometime before the end of the postdoc's second year. While there was some resistance to this idea at the outset, now that the committees have started to meet, the response to them has been positive.

Dr. Daria Mochly-Rosen centered her discussion on the fact that many or even most of our postdocs are not going to end up in academic positions. She asked, What are we doing to help postdocs find their way? Our goal, she said, is to make them leaders in whatever they do. She noted that the dichotomy between academic and industry careers may be less clear than we usually think it is. For instance, such skills as managing and leading groups and working in teams may be more common to both career paths than we have thought in the past. It would be good for us to teach our students and postdocs how to do team-based research, which will serve them well no matter where they end up. Dr. Mochly-Rosen also challenged faculty to make sure that the high value they place on academic careers (because they are in them) does not bias their communications with students and trainees. Finally, she asked, who has the responsibility for the careers of our students and trainees? The individual? The School? Future employers? Considering this question may help us determine the types of programs and supports we should have in place at Stanford.

In addition to panel presentations and discussions, the Retreat attendees had time to gather informally. We had the pleasure of listening to a conversation with Adam Nagourney, the Los Angeles Bureau Chief for the New York Times, with Paul Costello, our Executive Director of Communications and Public Affairs, on a wide-ranging set of topics from violence and gun control, to the politics of healthcare reform, the press and presidents past and current, the economy, the state of California and the future.

I do want to thank everyone one who participated in the 2011 Retreat as a panel member or participant. And I especially want to thank the individuals who helped make the retreat so successful, especially Dave O'Brien, Kristin Goldthorpe, Mira Engel, and Kathy Gillam. There is an enormous amount of planning and logistics that go into making these events successful, and each of these individuals deserves our special thanks for their incredible efforts.

The 2011 Retreat raised many important issues and challenges that are core to our mission and future. Over the next weeks we will further codify the recommendations and action items that were enunciated at the retreat and then prioritize them into the ones that we will work to address over the months ahead. Clearly (and as always) there is much work to be done if we are to "change in a time of change" – and do so successfully and in a manner that helps Stanford to lead change rather than follow its consequences.

Continuing Commitment to Leadership: Faculty Fellows 2011

The Faculty Fellows Graduation Dinner on January 18th offered some additional perspectives on the importance of leadership, mentoring and career development. This was the sixth Faculty Fellows Program established by the pioneering work of Dr. Hannah Valentine, Senior Associate Dean for Diversity & Leadership and Professor in the Department of Medicine (Cardiovascular Medicine). As in past years, an outstanding group of faculty came together over the course of a year and shared experiences from each other and from senior leaders at Stanford University (a number of whom shared their personal “leadership journey” as a vehicle for promoting insight and discussion). Importantly, each Faculty Fellow was assigned to one of four Mentors (the 2010 Mentors included Drs. Heidi Feldman, Professor of Pediatrics; Phil Lavori, Professor of Health Research & Policy; Christy Sandborg, Professor of Pediatrics; and David Stevenson, Professor of Pediatrics) and met in small groups to further refine their knowledge of Stanford and career development. An important part of the program is the facilitation of career development insights and discussions with the Faculty Fellow’s department chair and/or division leader. These career development and counseling meetings have been organized in an outstanding way thanks to the leadership of Julie Moseley, Director of Organizational Effectiveness.

In addition to the increased awareness each Faculty Fellow has developed about the opportunities for them at Stanford and their sense of community with each other and with their mentors, I was really struck by how deeply engaged each department chair or chief was in fostering and supporting the Faculty Fellow they had nominated for the program. Leadership and mentoring have many components and attributes as well as meanings and perceptions. Among the most important attributes of a successful senior leader in academic medicine is the willingness to put the career development of junior faculty among their highest priorities. This means guiding junior faculty colleagues, helping them to network successfully, and perhaps most importantly, creating opportunities for important leadership opportunities at the division, department or even institutional level. What was perhaps among the most exciting parts of the graduation program was the consistent and deeply felt commitment of senior faculty to their junior colleagues – with clearly articulated expectations and opportunities for their future development and success.

Congratulations to our 2010 Faculty Fellows, including:

- ***Amin Al-Ahmad***, Assistant Professor, Department of Medicine (Cardiology) – *nominated and mentored by Dr. Paul Wang*
- ***Eliza Chakravarty***, Assistant Professor, Department of Medicine (Rheumatology) – *nominated and mentored by Dr. Gary Fathmann*
- ***Alan Cheung***, Assistant Professor, Department of Otolaryngology (Pediatrics) – *nominated and mentored by Dr. Rob Jackler*
- ***Robert Dodd***, Assistant Professor, Department of Neurosurgery – *nominated and mentored by Dr. Gary Steinberg*
- ***Hayley Gans***, Assistant Professor of Department of Pediatrics (Infectious Diseases) – *nominated and mentored by Dr. Bonnie Maldonado*

- **Neeraja Kambham**, Associate Professor, Department of Pathology – *nominated and mentored by Dr. Steve Galli*
- **Jonathan Kim**, Assistant Professor, Department of Ophthalmology - *nominated and mentored by Dr. Mark Blumenkranz*
- **Maarten Landsberg**, Assistant Professor, Department of Neurology – *nominated and mentored by Dr. Greg Albers*
- **Jason Lee**, Assistant Professor, Department of Surgery (Vascular Surgery) – *nominated and mentored by Dr. Ron Dalman*
- **Christopher Longhurst**, Clinical Assistant Professor, Department of Pediatrics – *nominated and mentored by Mr. Ed Kopetsky*
- **Merritt Maduke**, Assistant Professor, Department of Molecular & Cellular Physiology – *nominated and mentored by Dr. Brian Kobilka*
- **Karen Parker**, Assistant Professor, Department of Psychiatry & Behavioral Sciences – *nominated and mentored by Dr. Allan Reiss*
- **Anna Penn**, Assistant Professor, Department of Pediatrics (Neonatology) – *nominated and mentored by Dr. Bill Benitz*
- **Matthew Strehlow**, Assistant Professor, Department of Surgery (Emergency Medicine) – *nominated and mentored by Dr. Bob Norris*
- **Lu Tian**, Assistant Professor, Department of Health Research & Policy – *nominated and mentored by Dr. Phil Lavori*

Despite the challenges we face, the future seems secure with the continued emergence and development of new faculty leaders. Each brings a unique set of skills and talents in highly diversified areas of science and medicine. Collectively they will join the Faculty Fellows who have graduated before them – and together we all hope they will impact our institution and all whom it serves.

Converging Perspectives on Valuing Patients Entrusted in Our Care

Two perspectives, one from a leading physician-author and faculty member and the second from a new hospital CEO, offered converging and shared perspectives on valuing the patients we serve.

At the first Stanford Hospital & Clinics Medical Staff Quarterly meeting on Tuesday, January 11th, Dr. Abraham Verghese, Professor and Senior Associate Chair in the Department of Medicine, spoke eloquently about the importance of connecting to the patients we care for through the ritual, tradition and intimacy of the physical examination. An initiative which Dr. Verghese and his colleagues have launched to teach the fundamentals and art of the physical exam are embraced in the “Stanford 25” (see: http://medicine.stanford.edu/education/stanford_25.html), which can be observed in video demonstrations (see: <http://stanford25.wordpress.com/>) and which Dr. Verghese and Dr. Ralph Horwitz described in an essay in the December 2009 issue of the British Medical Journal entitled “*In Praise of the Physical Examination*” (see: <http://www.bmj.com/content/339/bmj.b5448.full>). In addition to the value of a careful history and physical examination in establishing a diagnosis and plan of management, often with less expense to the healthcare system, Dr. Verghese also underscored the

impact of this “ritual” (as he referred to it) in establishing a strong doctor-patient relationship.

Dr. Verghese gave his remarks to a standing room only audience at the Li Ka Shing Center for Learning and Knowledge, and it was clear that his message resonated with all in attendance. In a number of important ways his simple message rekindles the professionalism and humanism that led most physicians to enter medicine in the first place. The pressures that time and expectations place on physicians to see more and more patients in shorter and shorter amounts of time, along with technologies that often separate rather than connect physicians to their patients, have led to frustration and disillusionment that have become an increasingly felt product of medical encounters – or the lack thereof. Dr. Verghese’s message about using the tools of the physical exam to reconnect the doctor and patient is important and empowering as we seek ways to increase the personalization and patient-centricity of Stanford Medicine.

From a different perspective, it was important to hear Amir Rubin, our new President and CEO of Stanford Hospital & Clinics, address the Council of Clinical Chairs on Friday, January 14th on his commitment to enhancing and improving the patient experience – “one patient at a time.” He spoke clearly and with conviction about the importance of stellar patient experience to the overall success of a medical center, and he provided concrete details about how he and his colleagues helped move the UCLA Medical Center to the top ranks of patient satisfaction. But Mr. Rubin has not only conveyed his commitment to making this a priority at Stanford, at this meeting and elsewhere – he has already begun this process in meetings with physicians, nurses and staff throughout SHC. Thankfully, efforts put into place over the past year led by Drs. Ann Weinacker, Bryan Bohman and Sridhar Seshadri will complement in important ways this significant initiative from our new CEO.

It is both important and affirming to have a prominent physician and an administrative leader address the future of Stanford Medicine from a converging perspective – patient excellence, one patient at a time. Focused improvements in enhancing the patient experience will be essential to our future. So too will be exceptional innovations and discoveries in science and medicine coupled with excellence in the provision of state-of-the-art care by outstanding physicians and healthcare providers, with the highest level of quality and safety in an optimally valued and cost-based manner. Each of these is an essential feature of the Stanford Medicine we are endeavoring to create together.

Medical and Healthcare Organizations Offer Support for the Affordable Care Act

In a largely partisan fashion, the United States House of Representatives voted on January 19th to repeal the Affordable Care Act. Ever since the passage of the ACA in March 2010 there has been incredible public discord about healthcare reform. Much of this has come from the political side of the equation and relatively little from the medical and professional groups who represent America’s doctors, hospital and healthcare providers. While I fully recognize that there was a political agenda by the White House

Office of Communications in sending out a list of medical groups and organizations that have offered their support for the Affordable Care Act, it is still notable to review some of the organizations that have taken a stand on this important issue. Accordingly, I am sharing that list with you, unedited and simply as information:

- **American Nurses Association**
 - "...[W]e believe that a vote for repeal would be a devastating step backward."
- **American Medical Association**
 - "The AMA does not support initiatives to repeal the Affordable Care Act. Expanding health coverage, insurance market reforms, administrative simplifications and initiatives to promote wellness and prevention are key parts of the new law that reflect AMA priorities."
- **American Academy of Family Physicians**
 - "A repeal of all provisions in the Patient Protection and Affordable Care Act will return our health care system to its previous trends of unsustainable, increasing costs and ever-growing numbers of under- and uninsured Americans. It will have negative consequences on Americans' access to needed health care for years to come."
- **American College of Physicians**
 - "ACP believes that Congress should preserve and - as necessary - improve on these and other important reforms created by the Affordable Care Act, not repeal them."
- **Association of American Medical Colleges**
 - "The nation's medical schools and teaching hospitals stand behind the Affordable Care Act. Ensuring that all Americans have health care coverage is a moral imperative for our nation, and enactment of the Affordable Care Act was an important step toward that goal."
- **National Association of Community Health Centers**
 - "From the perspective of community health, however, the new law moves our nation to the goal of more affordable and accessible health care for all people and we stand strongly in support of it."
- **American Osteopathic Association**
 - "The Affordable Care Act made fundamental and important changes in our health care system that will improve the health of our patients individually and our nation as a whole."
- **Catholic Health Association**
 - "On behalf of the Catholic Health Association of the United States (CHA), the national leadership organization of more than 2,000 Catholic health

care systems, hospitals, long-term care facilities, sponsors, and related organizations, I strongly urge you to maintain support for efforts to improve and strengthen our nation's health care system by opposing the legislation before the House to repeal the Affordable Care Act (ACA)."

- **American Public Health Association**

- "Implementation of the Affordable Care Act is critical to addressing a number of the biggest challenges facing our health system including the escalating costs associated with our health care system, uneven quality and more than 100,000 deaths due to medical errors, discriminatory practices by health insurance providers and the shrinking ranks of the nation's primary care providers. The enactment of the Affordable Care Act begins to shift our health system from one that focuses on treating the sick to one that focuses on keeping people healthy and addresses these challenges."

- **Asian and Pacific Islander American Health Forum**

- "Almost 60 percent of Asian Americans receive health care coverage through their employers and the last thing we should be doing is weakening the ability of small business owners to provide quality health care to their employees. We must not place the interests of insurance companies ahead of small businesses, our communities, and our families. When insurance companies are free to pursue profit without accountability, people have fewer choices, fewer options, and little recourse. We can't let that happen."

- **Doctors for America**

- "As doctors, we see how our broken health care system is failing patients and health care providers. Passing and implementing the Patient Protection and Affordable Care Act is an important first step to fixing a broken system, and we must continue to move forward. Repealing the health care reform law will only move our health care system backward – and millions of patients simply can't afford that. We urge the new Congress to work with patients and providers to improve the health reform law so we can build a health care system that works for everyone."

- **National Hispanic Medical Association**

- "NHMA supports the Affordable Care Act as it is a step forward in caring for the health of the underserved communities and all Americans. Investing in the health of Americans, our most valuable resource, is sound policy and a wise course of action when so many diseases are preventable and treatable. For this reason we ask you to cast a vote against H.R.2."

Call for Nominations for the Augustus A. White III and Family Faculty Professionalism Award

The Stanford Community is invited to submit nominations for the Augustus A. White III and Family Faculty Professionalism Award. This award recognizes outstanding work by a Stanford Medical School faculty member or members whose work helps reduce health disparities and/or enhances the effectiveness of underrepresented minorities through research, education, mentoring or service to the university community. The recipient(s) substantially broaden and deepen the excellence and influence of underrepresented minorities, whether faculty, fellows, residents or students. The recipient (s) may also have diminished differences in health care and health status ascribable to culture, religion, race and other factors.

The first African American graduate of Stanford Medical School in 1961 and the first African American Chair of the Department Orthopaedic Surgery at Harvard Medical School, Augustus A. White, III, M.D., Ph.D, has been a pioneer and role model for underrepresented minorities in academic medicine. Dr. White is also passionate about eliminating health disparities and believes in the importance of underrepresented minority students and faculty in achieving this goal. In collaboration with Dr. White, Stanford School of Medicine has established the Dr. Augustus A. White III and Family Faculty Professionalism Award. This award, administered by the Office of Diversity and Leadership seeks to identify outstanding individuals who make major contributions toward eliminating health disparities, through their research, teaching, mentoring, and by example.

WHO MAY NOMINATE: Any member of the Stanford community (student, faculty or staff) may nominate an individual (or team) whose contributions fit the descriptions above.

HOW TO NOMINATE: Submit a statement that summarizes the activities, contributions and achievements that stimulate the nomination; a biographical sketch of the nominee or leaders of the team; and letter of support (a maximum of 3) that attest to the nominee's demonstrable major contributions and sustained achievements in research, teaching, mentoring or university community service that contribute to strengthening underrepresented minorities in health care and/or eliminating health disparities. Please send your nomination material to the Office of Diversity and Leadership at the School of Medicine (attention: Jennifer Scanlin, Office of Diversity and Leadership, MC 5216 (for US mail send to 291 Campus Drive, LK3C14, Stanford, CA 94305). Email nomination letters may be sent to: jscanlin@stanford.edu. All nomination letters must include the name and position of the nominator and be received by **February 28, 2011**. The confidential nature of the material will be respected.

SELECTION PROCESS: Nominations will be reviewed by the **Dr. Augustus A. White III and Family Award** Committee. The award recipient will be announced by March 30, 2011. The award will be presented at an inauguration celebration on the Stanford Campus on April 15, 2011.

Awards and Honors

Preetha Basaviah, Clinical Associate Professor in the Division of General Medicine / Department of Medicine, received the Northern California SGIM Region Clinician Educator of the Year Award in November, 2010. Dr. Basaviah serves as Course Director of “Practice of Medicine”, a two-year pre-clerkship clinical skills course, and as one of the Educator for CARE advisors at the medical school. Congratulations, Dr. Basaviah.

Appointments and Promotions

Rajni Agarwal-Hashmi has been promoted to Associate Professor of Pediatrics at the Lucile Salter Packard Children’s Hospital, effective 1/01/11.

Martin S. Angst has been promoted to Professor of Anesthesia at the Stanford University Medical Center, effective 1/01/11.

Ronit Ben-Abraham-Katz has been promoted to Adjunct Clinical Associate Professor of Medicine, effective 11/01/10.

Eran Bendavid has been appointed to Assistant Professor of Medicine, effective 1/01/11.

Suzan Carmichael has been appointed to Associate Professor (Research) of Pediatrics, effective 1/01/11.

Ricardo Dolmetsch has been promoted to Associate Professor of Neurobiology, effective 1/01/11.

Brendan Carvalho has been promoted to Associate Professor of Anesthesia at the Stanford University Medical Center, effective 1/01/11.

Kathleen Eldredge has been promoted to Adjunct Clinical Assistant Professor of Psychiatry and Behavioral Sciences, effective 11/01/10.

Jesse K. McKenney has been promoted to Associate Professor of Pathology and of Urology at the Stanford University Medical Center, effective 1/01/11.

Neda Pakdaman has been promoted to Adjunct Clinical Assistant Professor of Medicine, effective November 1, 2010

George P. Yang has been promoted to Associate Professor of Surgery at the Veterans Affairs Palo Alto Health Care System, effective 1/01/11.

