

# Dean's Newsletter

## February 21, 2012

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### **The Stanford Challenge and Stanford Medicine**

On December 31, 2011, Stanford University concluded its five-year Stanford Challenge Campaign, which began in October 2006 with the goal of raising \$4.3 billion. On February 7, 2012 President John Hennessy announced at a Gala Celebration at Maples Pavilion attended by donors, university faculty and staff and members of the community that the *Stanford Challenge* closed with \$6.2 billion “to seek solutions to global problems and educate leaders for a more complex world” (see: <http://thestanfordchallenge.stanford.edu/>). By every measure this is an extraordinary accomplishment as well as a tribute to the countless individuals who made gifts and donations, many of them quite exceptional. The School of Medicine participated in the University-wide Stanford Challenge and also exceeded its fundraising goal of \$991 million with a total of \$1.04 billion in cash received and \$1.22 billion in pledges and new activities at the end of December 2011.

The *Stanford Challenge* enabled transformations in people, programs and facilities across the University. At the School of Medicine, thanks to a number of principal gifts ranging from \$10 million to \$75 million, it made possible the initial phase of our medical school transformation in the form of the Li Ka Shing Center for Learning and Knowledge (LKSC) and the Lorry Lokey Stem Cell Research Building (Stanford Institutes of Medicine I). Also of major importance were the creation of two dozen new professorships (each at \$4 million) and exceptional contributions to major initiatives in Cancer (\$284 million), Cardiovascular Medicine, (\$54.7 million), Immunity, Transplantation, and Infection (\$82.4 million), Neurosciences (\$130.1 million), Stem Cell Biology and Regenerative Medicine, including the Lokey Building (182.2 million), and education, including the LKSC (\$83.4 million).

These are highly significant accomplishments, for which I thank our incredibly generous and grateful donors and community members as well as our talented faculty and

students – who were either the reason for the donations or who contributed to bringing them to fruition. I also thank the wonderful work of our Office of Medical Development. These gifts have been transformative – but they are also just a starting place for our future.

Over the past year we have also been transforming our Office of Development by better aligning it with Stanford Hospital and Clinics (SHC) as well as the University's Development Office, and with that we hope and envision that there will be a further transformation of Stanford University Medical Center over the next decade. Together with the leadership at SHC we are anticipating a Campaign for SUMC (whose official name is still being formulated) that will occur in two phases. The first phase will begin this year and extend over the next 2-3 years. A very significant portion of Phase I will focus on funding for the new Stanford Hospital, a \$2 billion construction project that is currently getting started. During Phase I, I am also asking our Development Office to give particular priority to raising funds for graduate education and for innovation funds for basic research, including faculty scholars and professorships for research faculty.

During Phase I, fundraising efforts for core programs in Cancer, Stem Cell Biology & Regenerative Medicine, Cardiovascular Medicine, Immunity-Transplantation-Infection and Neuroscience (focusing on clinical programs) will continue. We will also include in Phase I our programs in predictive medicine (including genomics, imaging and early diagnosis) coupled with our burgeoning efforts in global and population health sciences, including the transformation of health and healthcare delivery along with clinical and translational research (e.g., SPARK [<http://sparkmed.stanford.edu/>]). Highlighting these areas does not mean that other programmatic initiatives will not be pursued but that they will be guided by opportunity assessments. A broad opportunity and initiative assessment will be undertaken when a new dean arrives, and, following that, Phase II of the Campaign for Stanford Medicine will commence and likely continue for the subsequent 5-7 years. As it has in the past, the greatest fundraising successes will come from articulating a bold vision for how Stanford Medicine will transform the future. By doing so, we can build on our past accomplishments and use them to envision and then create the future.

Success in philanthropy is critical to the future success of Stanford Medicine. With the dramatic changes occurring in the support for research, the rising costs for education and the almost certain future declines in healthcare revenues, it is imperative that we protect our faculty as much as possible from the uncertainties of support from the public and private sectors, that we decrease the burden of debt for our students and the school, and support the most innovative and groundbreaking ideas possible. If the past helps predict the future, we have every reason to be optimistic.

### **“Occupy Medicine” is the Theme for the 21<sup>st</sup> Annual SUMMA Event**

With the Occupy Wall Street Movement that began in Zuccotti Park on September 17, 2011, the word “occupy” has taken on new meaning, including an association with the “we are the 99% slogan.” In less than six months there have been

nearly 3000 “Occupy” communities formed – mostly focused on social and economic inequities around the world. Disparities and inequities have been areas of great concern in medicine as well, and so it is significant that the 21<sup>st</sup> Annual Premedical Conference sponsored by the Stanford University Minority Medical Alliance (SUMMA) chose “Occupy Medicine” as its banner and theme. It has an important resonance.

SUMMA has become a pillar of excellence in education, advocacy and support at Stanford, and in its annual conference it has brought several hundred high school and college students to campus to become enlightened and better informed and prepared for careers in medicine. Classes and demonstrations provide practical tips to prospective students about applying to medical school, including the value of academic performance, the MCATs and application and interviewing skills. Perhaps even more importantly, I am sure that prospective students are inspired by the intelligence, energy, commitment and dedication of our Stanford University medical students, who spend countless hours and days preparing for the annual SUMMA event.

Special thanks and appreciation goes to Miquell Miller, SMS III, who served as the 2012 SUMMA Coordinator and whose energy and passion are infectious. I am always very appreciative of the incredible effort our students, faculty and staff put into the SUMMA Conference. I am also deeply moved each year by the life journeys of some of our students as they describe the many forces and challenges that have shaped them to date. This year we witnessed the moving personal commentaries of Zachary Hernandez, SMS II, Andre Jamaal Pinesett, SMS I, and Allison Kim Truong, SMS I. I can’t help but imagine that every student in attendance has his or her own personal story – and that we are each also inspired by those told by the “Faces” speakers.

Over the past decades Stanford has made a strong commitment to enhancing the diversity of its students and faculty – and significant progress has been made. We are grateful for the broad diversity of our current students, which enriches our learning environment – and we recognize that much still remains to be accomplished. “Occupy Medicine” is certainly about increasing diversity in medicine but, on another level, it can also symbolize the need to take medicine back from the market-based forces that have so damaged its values and its very moral compass over the past decades. Both are goals we aspire to as we work toward the day when Stanford serves as the model for health and health care locally, nationally and globally. That too is something that will require our commitment and shared efforts as a community of students, faculty and staff.

### **A Respectful Learning Environment for Our Students and Community**

I have written in the past about our commitment to a Respectful Workplace, that is, “a work environment that is conducive to teaching and learning, research, the practice of medicine and patient care”. But, in addition, a respectful learning environment must be one of our highest priorities. Our commitment in this area for medical students is codified in our Standards of Conduct for the Teacher-Learner Relationship, which is published in the MD Program Handbook and Policy Manual (see: [http://med.stanford.edu/md/policies/MD%20Program%20Handbook%202010\\_11.pdf](http://med.stanford.edu/md/policies/MD%20Program%20Handbook%202010_11.pdf)).

I bring these Standards to your attention because of the 2011 results of a survey administered annually by the AAMC to graduating medical students from all US medical schools. Nationally, there are some disturbing trends in the percentage of students who have experienced mistreatment during their training. “Mistreatment” in the survey includes verbal abuse or belittlement, inappropriate requests to perform personal services, and sexually inappropriate comments. Unfortunately, we are not free from some of these behaviors at Stanford. Among other questions, the survey asks about the learning environment, and students are asked whether they are aware of their schools’ policies regarding mistreatment. It turns out that in 2011 survey less than 70% of our students said they were aware of our policy, cited above. Of greater concern, some students reported mistreatment, particularly during clinical rotations and experiences. These results are cause for concern.

Every medical student and member of the instructional staff in the School of Medicine is expected to follow our policy, which lays out the School’s expectations for the proper treatment of students and the process for raising a concern if a student feels treated in a way inconsistent with our Standards. It is imperative that we have an environment that respects each individual and that promotes learning without fear of mistreatment or retaliation. This must be a priority for each of us, and I ask every member of our community to reflect on his or her behavior with a commitment to respect human dignity in educational and clinical interactions.

Under the leadership of Drs. Charles Prober, Senior Associate Dean for Medical Education, and Clarence Braddock, Associate Dean for Undergraduate and Graduate Medical Education, and Director, Stanford Center for Medical Education Research and Innovation, we are currently conducting an in-depth review of the full results of the 2011 survey, as well as similar surveys conducted of our residents and fellows by the ACGME. We will be communicating the outcome of this review in the months ahead and beginning a larger conversation across our entire medical center about how we can better meet our commitments to a Respectful Workplace and Learning Environment for all.

Because of the importance of this issue, I am copying below our Stanford Policy for your review:

## **Standards of Conduct for the Teacher-Learner Relationship Stanford School of Medicine**

### **1. STANDARDS**

- A. Stanford School of Medicine (SoM) is committed to providing a work and educational environment that is conducive to teaching and learning, research, the practice of medicine and patient care. This includes a shared commitment among all members of the SoM community to respect each person’s worth and dignity, and to contribute to a positive learning environment where medical students are enabled and encouraged to excel. *Given their roles in the educational process and their inherently unequal positions vis a vis students, all instructional personnel (including faculty, residents, and other members of the healthcare*

*team) are to treat students with courtesy, civility and respect and with an awareness of the potential impact of their behavior on such students' professional futures.*

- B. Conduct inconsistent with this policy can occur in a variety of forms and may seriously impair learning. In particular, instructional personnel are expected to create an environment in which feedback regarding their performance can be given openly by students without concern for reprisal, and which is free of exploitation, harassment, impermissible discriminatory treatment, humiliation, or other mistreatment or abuse of medical students. Examples of conduct inconsistent with these standards might include:
- i. Sexual harassment
  - ii. Physical or verbal abuse
  - iii. Assigning duties as punishment rather than education
  - iv. Requiring a student to perform personal services (such as shopping or babysitting)
  - v. Unwarranted exclusion from reasonable learning or professional opportunities
  - vi. Evaluating or grading on inappropriate criteria (or threatening to do so)
  - vii. Harassment or discrimination on the basis of sex, race, age, color, disability, religion, sexual orientation, gender identity, national or ethnic origin, or any other characteristic protected by applicable law.
- C. Note: The expectations stated in this policy primarily relate to the standards of conduct for instructional personnel. For their part, medical students are expected to adhere to similar standards of respectful and professional behavior, including (but not limited to) the standards of conduct for students set forth in the MD Program Handbook: Procedures, Policies and Essential Information such as sections 2.9 (School of Medicine Statement of Professionalism), 2.10 (School of Medicine Technical Non-Academic Standards) and 6.2 (Evaluation of Performance in Clinical Clerkships).

## **2. GUIDELINES FOR APPLICATION**

- A. These standards of conduct are applicable to all SoM instructional personnel (including faculty, residents and other members of the healthcare team) in their interactions with Stanford medical students—whether on or off campus and whether in formal educational (such as clinical or classroom) or in social settings.
- B. In general, a determination of whether specific conduct is inconsistent with this policy will depend on a case-by-case analysis of the particular facts and circumstances, and the use of a “reasonable medical student” standard.
- C. Students subjected to abuse, discrimination, mistreatment or harassment have a right to seek timely and effective remediation with the full support of the SoM and Stanford University. In addition, retaliation and/or reprisals against an individual who in good faith reports or provides information in an investigation about conduct that may violate this policy is prohibited.
- D. Conduct inconsistent with this policy may consist of repeated actions or may even arise from a single incident if sufficiently egregious.
- E. In the review of conduct under this policy, other Stanford University and SoM policies and procedures (such as Stanford’s Sexual Harassment and Consensual Sexual or Romantic Relationships Policy) may become relevant.

- 3. THE RESPECTFUL EDUCATOR CONDUCT COMMITTEE (RECC)** The Respectful Educator Conduct Committee (RECC) is a standing committee to carry out the purposes and procedures set forth in this policy.
- A. The committee meets quarterly, and on an ad hoc basis if it is deemed necessary by the Chair.
  - B. The committee is chaired by the Associate Dean for Medical Student Life Advising, who is hereafter referred to as the Chair.
  - C. The composition of the committee includes the following as members:
    - i. The Chair
    - ii. One or more clinical students
    - iii. An Academic Advising Dean
    - iv. The Director of Graduate Medical Education (or designee)
    - v. The Director of Clerkships
    - vi. The Director of Educators for Care
    - vii. A Residency Training Program Director
    - viii. A Resident
    - ix. The Chair of the Physician Wellbeing Committee
  - D. The RECC will keep such confidential records of its proceedings as are appropriate to support its purposes of education and concern resolution.

#### **4. PROCEDURES**

The following procedures for handling incidents of potential violations of the Standards of Conduct for the Teacher-Learner Relationship place a strong emphasis on resolving complaints informally. The procedures include advising and mediation. It is important to note that the procedures do not preempt other formal or informal channels available within the University. ***It is recommended that students should -- as a first step-- contact the Chair of the RECC to review the various options that are available (on a confidential basis as that status is granted to the Associate Dean for Medical Student Life Advising – <http://med.stanford.edu/md/student-development/confidentiality.html>). The Chair of the RECC is empowered to explore with the student a plan of action that may include some or all of the steps described below.***

- A. **Informal** - Concern about potential violations may be handled by communication with various individuals, including but not limited to the following:
  - i. Direct discussion (by the student or others) with the alleged offender.
  - ii. Conversation (by the student or others) with individuals such as the chief resident, attending physician, clerkship director, and/or Educator For Care (E4C) faculty.
  - iii. The Chair of the RECC may present the concern to all or a portion of the RECC, and to such third parties that the Chair of the RECC deems appropriate for seeking an informal resolution.
  - iv. The Chair of the RECC also may in his/her discretion refer the matter to an alternate available University process or office, such as an existing grievance process or the Sexual Harassment Policy Office or the Director of the Diversity and Access Office.
  - v. Direct conversation by the student with confidential resources including but not limited to the Ombuds, Counseling and Psychological Services, and the Deans of Religious Life.

Informal solutions to address the problem may be recommended and/or pursued such as (but not limited to) systems changes or educational interventions. The

Chair of the RECC will be available throughout the process to discuss with the student the status of the matter, including any potential resolution.

- B. Formal** – If no resolution is reached and the student wishes to proceed with a more formal grievance or complaint process, the Chair of the RECC may refer the student to other existing processes or may (in an appropriate case) accept from the student a written grievance or complaint to use the procedure described below.
- i. The student should set forth in writing the substance of the grievance or complaint, the grounds for it and the evidence on which it is based, and the efforts taken to date to resolve the matter. It is at this stage that the matter becomes a formal grievance or complaint.
  - ii. The grievance or complaint document should be submitted to the Chair of the RECC. A grievance should be filed in a timely fashion, i.e., normally within thirty days of the end of the academic quarter in which the action that is the subject of the grievance or complaint occurred. A delay in filing may be grounds for rejection of that grievance or complaint.
  - iii. The Chair of the RECC will review the grievance or complaint and (if it reflects an appropriate use of the process) will then promptly (within 7 days) transmit the grievance or complaint to the Senior Associate Dean for Medical Education (SADME) for handling.
  - iv. The SADME shall promptly initiate a review, which should normally be completed within sixty days. The SADME may attempt to resolve the matter informally, and may refer the matter (or any part of it) to a grievance officer or other designee, who will evaluate and/or address the matter as the SADME directs. The SADME may also, in appropriate cases, remand the matter to the appropriate administrator (including to the administrative level at which the grievance or complaint arose) for further consideration.
  - v. In undertaking this review, the SADME (or his or her designee) may request a response to the issues raised in the grievance or complaint from any individuals believed to have information the reviewer considers relevant, including faculty, staff and students.
  - vi. The SADME (or his or her designee) shall issue his or her decision in writing, and take steps to initiate such corrective action as is called for (if any). Conduct meriting discipline shall be brought to the attention of the appropriate disciplinary process.
  - vii. Appeal
    - a. If the student is dissatisfied with the disposition by the SADME (or his or her designee), he or she may appeal to the Dean of the School of Medicine. The appeal should be filed in writing with the Dean within ten days of the issuance of the decision by the SADME (or his or her designee); a delay in filing the appeal may be ground for rejection of that appeal.
    - b. The Dean may attempt to resolve the matter informally, and may refer the matter (or any part of it) to a grievance appeal officer or other designee, who will review the matter at the Dean's direction. The Dean also may remand the matter to the appropriate administrator

(including to the administrative level at which the grievance arose) for further consideration.

- c. The Dean should normally complete his or her review of the appeal and issue his or her decision in writing within forty-five days. That decision is final. It is not subject to further review by any other University process.

#### viii. General Provisions

1. *Time Guidelines* – The time frames set forth herein are guidelines. They may be extended by the Chair of the RECC, the SADME or the Dean, as applicable, in his or her discretion for good cause (including for reasons relating to breaks in the academic calendar).
2. *Advisers* – A student initiating or participating in a grievance or complaint under this procedure may be accompanied by an adviser in any discussion with the Chair of the RECC, the SADME, the Dean, or their designees (such as a grievance or grievance appeal officer); such adviser must be a current Stanford faculty, staff member or student.
3. *Ombuds* – Students should be aware that the University Ombuds (<http://www.stanford.edu/dept/ocr/ombuds>) is available to discuss and advise on any matters of University concern and frequently helps expedite resolution of such matters. Although it has no decision making authority, the Ombuds' Office has wide powers of inquiry.
4. *Sexual Harassment and Disability related issues*- For further information and resources concerning sexual harassment, students should refer to the web page of the Sexual harassment Policy Office at <http://harass.stanford.edu>. For further information and resources concerning accessible education, students should refer to the web page of the Office of Accessible Education at <http://www.stanford.edu/group/DRC/>
5. *No retaliation*- Stanford University prohibits retaliation or reprisals against individuals based on their pursuit in good faith of a grievance or complaint under this procedure, or their participation in good faith in the grievance or complaint process.
6. *Standards for Review*- If the grievance or complaint involves a decision that is being challenged, the review by the SADME, as well as the review by the Dean on appeal, usually will be limited to the following considerations:
  - a. Were the proper facts and criteria brought to bear on the decision? Were improper or extraneous facts or criteria brought to bear that substantially affected the decision to the detriment of the grievant?
  - b. Were there any procedural irregularities that substantially affected the outcome of the matter to the detriment of the grievant?
  - c. Given the proper facts, criteria, and procedures, was the decision one which a person in the position of the decision maker might reasonably have made?

## 5. EDUCATION

The Stanford School of Medicine will provide ongoing education to promote a positive learning environment and discourage violations of the standards of conduct for the teacher-learner relationship. Such education serves several purposes. First, it promotes an environment of respect for each person's worth and dignity. Second, it informs students that there are procedures available for them to register concerns of educator conduct violations, which can be investigated and addressed without fear of retaliation. Third, it informs instructional personnel of the SoM's standards of conduct and procedures for responding to allegations of violations of these standards. This policy will be included in the MD Program, Resident and Faculty handbooks and posted on the medical school website. Educational sessions on this topic will be introduced during the pre-clerkship curriculum and readdressed early in the clerkship curriculum. Educational sessions on this topic will also be presented to educational personnel including but not limited to at forums such as resident orientation, department meetings, and staff meetings. The materials and methods for providing this education will be the responsibility of the Respectful Educator Conduct Committee.

## **The President's Budget, the NIH Budget and the Health of Our Nation's Investment in Science**

President Obama released his FY2013 budget on Monday, February 13<sup>th</sup>, which for the Department of Health and Human Services (HHS) projects \$941 billion in outlays. Of this, Medicare comprises 56%, Medicaid 30% and other entitlement programs 6%, leaving 8% of the HHS budget for discretionary programs – which includes NIH. We all recognize that there is a long journey of debate and negotiation (or not) ahead as the President's budget goes through the legislative process. But some issues are already notable – even if they become part of the political debate over the months ahead. First, the Obama Administration is proposing significant reductions in Medicare Indirect Medical Education (IME) payments and also a reduction in the support for Children's Hospital Graduate Medical Education (GME) support. Needless to say, the months ahead will almost certainly witness big debates on Medicare and other entitlement programs as the political debate about healthcare reform heats up with the pending Supreme Court hearing on the Affordable Care Act scheduled for this March and the Presidential elections in November.

The FY2013 President's budget proposes freezing the NIH budget at \$30.9 billion. While this is better than it might have been, several issues obtain. First, this proposal will also be subject to debate in the Congress. Second, even if the budget remains flat, the purchasing power of NIH dollars continues to decline. In addition, whatever budget is passed could be subject to a significant reduction (currently forecast at 8%) if the "sequester" goes into effect in January 2013 because of the failure of the so-called Super Committee to address the budget deficit agreement in 2011. This also comes on the heels of the Consolidated Appropriations Act, 2012 that was signed into law on December 23, 2011, which lowered the salary limitation on NIH grants from Executive Level I (\$199,700) to Executive Level II (\$179,700) and which went into a phased-in effect beginning with new grants beginning December 24, 2011 (see:

[http://grants.nih.gov/grants/policy/fy2012\\_salary\\_cap\\_faqs.htm](http://grants.nih.gov/grants/policy/fy2012_salary_cap_faqs.htm) for more details). This has an impact on faculty and institutions.

Although many details remain to be determined, current forecasts are that in FY13 NIH will discontinue out-year inflationary allowances for competing and continuation grants, reduce non-competing continuation grants by one percent below the FY12 level, and negotiate the budgets of competing grants to avoid growth. A further forecast of approaches to grant management being considered at the NIH are reflected in Dr. Sally Rockey's February 15<sup>th</sup> communication (<http://nexus.od.nih.gov/all/2012/02/15/president%E2%80%99s-2013-budget-and-nih-research-grants/>), which states that the NIH will continue current policies that allow new investigators to receive grants at rates equal to those of established investigators and will also “establish a process for additional scrutiny and review of awards to any principal investigator with existing grants of \$1.5 million or more in total costs” – a policy that has been in place at the National Institute of General Medical Sciences for some years. As you likely know, the NIH has been floating the idea of managing its grant portfolio by limiting the number of awards per PI, limiting the amount of funds/PI, and reducing or limiting the size of awards. They have already limited salaries of PIs, as noted above.

While it is understood that the continuing economic crisis and still looming deficit have led to these policies and others still to come, it is also clear that these events seriously threaten our nation's leadership and competitiveness in science and innovation. I wrote about this in an Op-Ed that was published in the January 31, 2012 San Jose Mercury News and that I include below in case you missed seeing it (see: [http://www.mercurynews.com/opinion/ci\\_19862392?IADID=Search-www.mercurynews.com-www.mercurynews.com](http://www.mercurynews.com/opinion/ci_19862392?IADID=Search-www.mercurynews.com-www.mercurynews.com) or below)

### **Budget Super Committee's Failure Puts Medical Research at Risk**

Because of our national investment in basic biomedical research through the National Institutes of Health, the United States is the world leader in discoveries in the life sciences. Americans have benefited from new treatments and cures that have improved the health of adults and children and prolonged many lives. Indeed, we are the envy of the world in discovery and innovation.

But we are now on a precipice. As a result of the inability of the so-called congressional Super Committee to deliver a budget proposal, lawmakers are required to make \$1.2 trillion in cuts, half from defense and half from domestic programs, including research sponsored by the NIH. Reducing our investment in medical research surely would slow the remarkable progress we have made in new fundamental discoveries that can ultimately improve the health of our nation's citizens.

Consider the evidence: The death rates for heart disease and stroke have fallen by 60 percent and 70 percent, respectively, since World War II. Over the past 15 years, the incidence of cancer is down by 11.4 percent among women and 19.2 percent among men because of better detection methods and more effective treatments. Today, individuals diagnosed in their 20s with HIV – once considered a death sentence – may receive antiretroviral therapy and live to age 70 or beyond. These and other advances in our health have been built on basic scientific research – work that may not have had a clear application when it was conducted but which opened the way to a better understanding of human biology. This knowledge then was translated into new tools or devices to diagnose, treat and prevent disease.

For instance, today's lifesaving treatments for HIV were built upon advances in a basic understanding of how the immune system works. I witnessed this personally when I began my own work in pediatric AIDS, which would not have been possible without the basic science discoveries about retroviruses that took place more than a decade before HIV was even known. Similarly, at Stanford, work aimed at understanding how immune cells recognize antibodies ultimately led to a groundbreaking treatment for non-Hodgkin's lymphoma, as well as other debilitating conditions.

Innovation and discovery not only improve human health, but they also are vital to jobs and economic recovery. One recent study noted that nearly a half-million jobs across the country were directly or indirectly supported by NIH funding. Overall, NIH funding produced nearly \$70 billion in new economic activity in 2010. Here in California, the effect of this research accounts for \$5.3 billion in economic activity and 35,734 jobs. An additional effect on medical research and jobs in California has taken place because of our residents' investment in stem cell research through Proposition 71, making us the world leader and principal beneficiary of this incredibly important research agenda.

President Barack Obama and Congress need to remember that the U.S. Medical research enterprise is an economic juggernaut and the envy of the rest of the world – a leadership position that no one wants to lose. More important, both the President and Congress should think about how the health of future generations depends on the basic research being done today. Cuts to our basic biomedical research today may save money in the short run, but it will come at the cost of our most precious resource: the health and well-being of our children and grandchildren

Clearly the months ahead will be important in clarifying the impact of the NIH budget and other funding sources on our research mission. There is no question that this is a time of increased stress for our faculty and that, despite their enormous talents and accomplishments, the current and almost surely continuing funding environment will impact a number of them quite directly. Certainly we want to do all we can to protect our faculty from these funding challenges, but there are obvious limits to our discretionary

resources. That is why raising funds for innovation and for the support of research faculty through faculty scholar awards and professorships is such a high priority for all of us.

### **Coming in 2013: Liaison Committee on Medical Education Re-accreditation**

The Liaison Committee on Medical Education (LCME) is the national body that accredits all medical schools in the United States and Canada; it is jointly sponsored by the Association of American Medical Colleges (AAMC) and the American Medical Association (AMA). Medical schools are required to renew their accreditation with the LCME a minimum of every 8 years. The last accreditation Stanford received from the LCME was in October 2005, and therefore our re-accreditation is due to occur no later than October 2013.

As a part of the re-accreditation process, all schools are required to engage in a comprehensive self-study, followed by a site visit from the LCME. The entire re-accreditation process typically lasts about 18 months. Although activities around the LCME re-accreditation process have already begun, I want to let you know that we will be officially launching our self-study in May 2012, with self-study teams beginning to meet in the Fall.

The self-study process is comprehensive and will require the participation of many of our faculty, staff, and students. In the coming months, we will be appointing several self-study teams, each charged with reviewing specific components of our medical education program. As a part of this process, our students will also undertake an independent (and confidential) self-study that provides an avenue for them to assess their own educational experience.

Although these activities are required for re-accreditation, they do afford the opportunity, using the accreditation standards as benchmarks, to focus on continuous quality improvement of our medical education. Of course, we have been doing continuous improvement even without an immediate LCME review – but we will be able to do this more comprehensively. While it also will appear to many of us that we just completed the LCME review, the reality is that we are now ready for another reaccreditation cycle!

Dr. Charles Prober, Professor of Pediatrics and Senior Associate Dean for Medical Education, will be the faculty lead for the 2013 LCME re-accreditation project. Aarti Porwal, Manager of Strategic Initiatives in Education in the Office of Institutional Planning, will serve as the lead administrative coordinator. I will continue to update you as we progress in our re-accreditation efforts.

### **The Senate's H.E.L.P. Committee Holds Hearings on Pain in America**

On February 14<sup>th</sup> I had the opportunity to testify before the US Senate H.E.L.P. (Health, Education, Labor and Pensions) Committee led by Senator Tom Harkin (D-IA) on the topic of “Pain in America: Exploring Challenges to Relief.” My testimony reflected the work of the Institute of Medicine’s reported entitled “*Relieving Pain in*

*America: A Blueprint for Transforming Prevention, Care, Education and Research.*” A summary of the testimony I submitted to the Senate H.E.L.P. Committee follows:

Summary of the Presentation of Philip A. Pizzo, Dean of the Stanford University School of Medicine, on the Institute of Medicine Report “*Relieving Pain in America*” to the US Senate H.E.L.P Committee on February 14, 2012

I would like to share with you some of the conclusions and recommendations from the Institute of Medicine Report on *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research*. This 2010 Patient Protection and Affordable Care Act required that HHS, through the NIH, charge the IOM to conduct this study. I served as the chair of a 19-member committee that initiated its work in November 2010 and delivered the final report to the Congress and NIH in June 2011.

We found that the magnitude of pain in the United States is astounding. More than 116 million Americans have pain that persists for weeks to years. That this number does not include children, individuals in nursing homes or chronic care facilities, prisons or the military, makes the impact even more significant. The total cost of pain is \$560-635 billion per year. This is higher than the costs of cancer, cardiovascular diseases and diabetes together. This includes nearly \$100 billion annually from federal and state budgets. The Committee fully recognizes the magnitude of these expenditures and appreciates that more effective and efficient approach to pain management and preventions must consider cost as well as effectiveness.

The Committee was charged to review and quantify the public health significance of pain, identify barriers to pain care, determine special populations impacted by pain, identify the tools and technologies to treat pain and enhance pain research along with public-private partnerships in support of pain research, care and education.

In preparing its report we reviewed the literature, held public meetings and workshops, received testimony and comments from more than 2000 Americans, and commissioned a review on the economic burden of care. We concluded that relieving acute and chronic pain and the resultant suffering will require of cultural transformation in how pain is perceived and judged both by people with pain and by the health care providers who help care for them. The overarching goal of this transformation should be gaining a better understanding of pain of all types and improving efforts to prevent, assess and treat pain. The Committees report offers a blueprint for achieving this transformation that included 16 recommendations that addressed the public health challenges, pain care and management, the education of patients, communities and providers and that addressed research needs and opportunities. To help establish priorities, the IOM Committee recommended that four of its 16 recommendations be implemented by the end of 2012 and that the

remaining twelve recommendations be completed before the end of 2015 and then be maintained on an ongoing basis. These recommendations are as follows:

***Immediate – Complete by the end of 2012***

1. The Secretary of HHS should create a comprehensive population-level strategy for pain prevention, treatment, management and research
2. The Secretary of HHS along with other federal, state and private sector entities should develop strategies for reducing barriers to the care of pain – focusing in particular on populations disproportionately affected by and undertreated for pain
3. Through CMS, the VA, DoD, health care providers, insurers and others - support collaboration between pain specialists and primary care clinicians, including referral to pain specialists when appropriate.
4. The Director of the NIH should designate a lead institute at the National Institutes of Health that is responsible for moving pain research forward, along with an increase in the support for and scope of the Pain Consortium. This should involve pain advocacy and awareness organizations and should foster public private partnerships

Twelve other recommendations focus on public health, clinical care, education and research issues that should be completed by 2015. Taken together, these recommendations serve the goal of creating a comprehensive, population-level strategy for pain prevention, management and research. The scope of the problems in pain management is daunting, and the limitations in the knowledge and education of health care professional are glaring. But the medical community must actively engage in the necessary cultural transformation to reduce the pain and suffering of Americans. Importantly the cultural and social transformation needed to alleviate pain in America will require the collaboration of the healthcare provider community with patients and their families who are suffering from pain, including their communities, professional societies and advocacy organizations as well as state and federal government. New public private partnerships and a broad concerted level that addresses pain as a public health initiative as well as an individuals source of suffering will be necessary if we are to make progress in alleviating pain. We must all be part of the dialogue and the solution.

The Senate H.E.L.P. Committee hearings were recorded on C-SPAN (see: <http://www.c-span.org/Events/Senate-HELP-Committee-Looks-at-Medical-Costs-for-Chronic-Pain/10737428332-1/>) and included testimonies from:

- Lawrence Tabak, DDS, PhD, Principal Deputy Director, National Institutes of Health
- Philip Pizzo, MD, Dean, Stanford University School of Medicine
- William Maixner, DDS, PhD, Director, Center for Neurosensory Disorders, University of North Carolina at Chapel Hill
- Christine Veasley, Executive Director, National Vulvodynia Association

- John Sarno, MD, Professor of Clinical Rehabilitation Medicine New York University School of Medicine.

The testimonies and commentaries were far ranging and, not surprisingly, most poignantly expressed through the voices of individuals suffering from chronic pain. Ms Veasley was an articulate spokesperson for patient needs and for research – both basic and clinical.

While not myself a pain expert, I have become increasingly informed about the magnitude of pain in America and the need to address it more fully. Hopefully the IOM Report and its recommendations, coupled with actions by the Congress and the Department of Health and Human Services, will take action on the important needs that have been identified. Fortunately for our own community, we have one of the nation's most articulate and respected leaders in pain medicine and research, Dr. Sean Mackey, Associate Professor and Chief of the Pain Management Division at Stanford. Dr. Mackey was a member of the IOM Committee on Pain in America and contributed significantly to its work and recommendations. His work at Stanford and nationally give hope that progress will be made on this important and under-appreciated problem in the years ahead.

### **Approved Uses of Stanford University School of Medicine Logo**

The Stanford University School of Medicine logo is well-established and familiar to us – we see it every day on our web site (including the home page of this Newsletter), on our buildings and in written materials. But not everyone may be aware that the use of our logo and name is governed by University policy ([http://adminguide.stanford.edu/15\\_5.pdf](http://adminguide.stanford.edu/15_5.pdf)), and that it is the responsibility of each member of the School of Medicine community to use the logo and Stanford name correctly. The University has assigned responsibility for approving the use of Stanford's name and "marks" used in connection with medical activities to the Dean of the School of Medicine.

I am pleased to announce that we now have a "**Logo & Name Use Guide**" online (<http://med.stanford.edu/logo/>) that briefly outlines the guidelines that will assist you when you seek to use the School logo and name, whether on a website or a tote bag. However, it is important to underscore that you may only use the School of Medicine logo in conjunction with academic and research-related events. Moreover, if the logo will appear externally (outside of Stanford), a draft copy showing how the logo will be used needs to be submitted to the [Dean's Office](#) for review. Please direct additional questions regarding the School of Medicine logo to [Kristin Goldthorpe](#), Project Manager in the Dean's Office. Thanks to Kristin for developing this very useful resource. I urge you to review the Guide and refer to it any time you plan to use the School logo or name for external purposes.

### **Celebrating Two Dozen Years of Contributions by Dr. Richard Tsien**

On Tuesday, January 31<sup>st</sup> the Department of Molecular and Cellular Physiology celebrated Dr. Richard Tsien's more than two decades of exceptional contributions to

Stanford and the world of science and medicine. Of special significance, Dr. Tsien founded the department in 1988 and served as its first chair. More broadly, his remarkable career has traversed basic and clinical sciences, has touched countless of medical and graduate students, impacted scores of trainees, faculty and staff and has resulted in major insights and discoveries that have brought distinction and many honors and awards. In August 2011 Dr. Tsien became the Inaugural Director of the new Neuroscience Institute at the NYU Langone Medical Center and, since January 2012, the Druckenmiller Professor of Neuroscience there. Until assuming his new leadership position, Dr. Tsien was the George D. Smith Professor at Stanford. Colleagues from throughout the Stanford community joined the celebration to thank Dick Tsien for his exceptional contributions and to wish him, his wife Julia, and their family joy and success in this exciting new chapter in their lives.

### **Awards and Honors**

- ***Dr. Norbert Pelc***: On February 9<sup>th</sup> the National Academy of Engineering announced the election of 66 new members (see: [www.nae.edu](http://www.nae.edu) <http://www.nae.edu>), including Dr. Norbert Pelc. Election to the National Academy of Engineering is among the highest professional distinctions accorded to an engineer. It honors those who have made outstanding contributions to "engineering research, practice, or education, including, where appropriate, significant contributions to the engineering literature," and to the "pioneering of new and developing fields of technology, making major advancements in traditional fields of engineering, or developing/implementing innovative approaches to engineering education." Dr. Pelc is Professor and Associate Chair for research in the Department of Radiology and Professor of Electrical Engineering (by courtesy) at Stanford University. He is cited by the NAE for development of algorithms and technologies for MRI, CT, and hybrid X-ray/MRI imaging." Please join me in congratulating Dr. Pelc for this major honor.

### **Appointments and Promotions**

**Steven Artandi** has been promoted to Professor of Medicine, effective 2/1/2012.

**Zev D. Bryant** has been reappointed to Assistant Professor of Bioengineering, effective 3/1/2012.

**Kim R. Butts Pauly** has been appointed to Professor of Radiology, effective 2/1/2012.

**Annelynn Chang** has been appointed to Assistant Professor of Dermatology at the Stanford University Medical Center, effective 2/1/2012.

**Christopher H. Contag** has been promoted to Professor of Pediatrics and of Microbiology and Immunology and, by courtesy, of Radiology, effective 1/1/2012.

**Edward Damrose** has been promoted to Associate Professor of Otolaryngology – Head and Neck Surgery, effective 2/1/2012.

**Peter Fitzgerald** has been reappointed to Professor (Research) of Medicine, effective 2/1/2012.

**Garry E. Gold** has been promoted to Professor of Radiology and, by courtesy, of Orthopaedic Surgery, effective 2/1/2012.

**Edward Graves** has been promoted to Associate Professor of Radiation Oncology, effective 2/1/2012.

**Henry H. Hsia** has been reappointed to Associate Professor of Medicine at the Stanford University Medical Center, effective 2/1/2012.

**Jennifer Johns** has been appointed to Assistant Professor of Comparative Medicine at the Stanford University Medical Center, effective 2/1/2012.

**Gordon Li** has been appointed to Assistant Professor of Neurosurgery at the Stanford University Medical Center, effective 2/1/2012.

**David H. Liang** has been reappointed to Associate Professor of Medicine at the Stanford University Medical Center, effective 3/1/2012.

**Claude M. Nagamine** has been reappointed to Assistant Professor of Comparative Medicine at the Stanford University Medical Center, effective 2/1/2012.

**Harlan Pinto** has been reappointed to Associate Professor of Medicine and, by courtesy, of Otolaryngology – Head and Neck Surgery, at the Veterans Affairs Palo Alto Health Care System, effective 3/1/2012.

**Aaron Straight** has been promoted to Associate Professor of Biochemistry, effective 2/1/2012.

