

Dean's Newsletter

March 8, 2004

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Joint Clinical Program Planning by the School of Medicine and Stanford Hospital & Clinics

During the past several months, faculty and leaders in the School of Medicine (SoM) and at Stanford Hospital & Clinics (SHC) have been working together to establish strategic plans for clinical program development. On the broadest scale this has engaged discussions about the overall focus of adult clinical programs; the balance between primary, secondary and tertiary/quaternary care; the relative proportion between in-patient and ambulatory services; the location of clinical programs on the Medical Center campus or at off-site locations; and, in each sector, improving the quality of care and patient services. Embedded in these discussions is a deeper definition of the clinical mission of SoM and SHC and how this is likely to change in the years ahead.

It seems clear that emerging technologies that focus on minimally invasive diagnostic and therapeutic procedures will have an impact on where patients are treated and who will provide the care. Coupled with this are the aging population and its impact on the prevalence of various disorders along with the increasing chronicity of many diseases as treatments or interventions become more established and successful – even if not always curable.

Among the most important questions to be addressed is what will make Stanford Medical Center unique and how will it be differentiated from other local, regional and national clinical programs (and competitors). This is particularly germane in the Bay Area where large medical systems (including Kaiser and Sutter) dominate the health care market and, in many ways, seek to control the flow of patients to their own institutions. Locally, the Palo Alto Medical Foundation, which has had a long association with Stanford, is planning to expand its physician network, open one or more regional hospitals, and, with its corporate partner Sutter, have a

dominant role in the same regional catchment areas as Stanford. Thus, in some not insignificant ways, PAMF, by the choices they have made, also emerges as a regional competitor – which, at least in my opinion, is not the best way to serve our local community.

Setting a new standard for Stanford Medical Center requires that we provide state-of-the-art clinical care along with outstanding patient services, and that we further differentiate Stanford by providing diagnostic and treatment programs not available elsewhere. One of our greatest strengths is the exceptional research programs that exist at Stanford and, equally importantly, their potential for bringing discoveries from the laboratory to the clinic. Indeed, Translating Discoveries is the overarching theme that will define the School of Medicine and Medical Center in the first decades of the 21st Century. Our goals and objectives in this important area are delineated in our School’s Strategic Plan (see <http://medstrategicplan.stanford.edu>).

During the past 2-3 years, we have delineated several key areas for investment that are now embraced within the evolving Stanford Institutes of Medicine – which are designed to bring together basic and clinical science faculty in several important thematic areas where we have both the expertise and opportunity to truly make a difference in improving human health. Presently, four Institutes of Medicine are being developed, each having the opportunity to engage faculty from other Schools within the University (e.g., Engineering, Humanities & Sciences) to further develop unique opportunities for the future.

To make these programs meaningful to the Stanford Medical Center, we have worked diligently to align the Institutes of Medicine to the important clinical initiatives at both SHC and the Lucile Packard Children’s Hospital (LPCH). These connections provide the opportunity to create a continuum between research to patient care. They also provide special opportunities for educating our students, residents and postdoctoral scholars. The connecting points can be illustrated as follows:

SoM: Stanford Institutes of Medicine	SHC: Clinical Centers of Excellence – Service Lines	LPCH: Clinical Centers of Excellence – Service Lines
Cancer/Stem Cell Biology	Cancer	Cancer
Neurosciences	Neurosciences	Brain/Behavior
Cardiovascular Medicine	Cardiac	Heart
Immunity, Transplantation, Infection	Transplantation	Transplantation

The selection of these areas is not meant to preclude other important clinical disciplines. However, it is meant to identify those areas where we believe important opportunities exist and where Stanford can excel. Based on that, SoM and SHC have developed detailed inventories of key strategic initiatives within each of these four areas, focus that on the resources needed to make these programs successful (a separate planning process has been engaged for LPCH). These inventories include projections of clinical volume growth in each strategic area along with the incremental physician and professional staff that will be needed to achieve the projections. Also included are the capital requirements –for both facilities and equipment – as well the potential opportunities for technical advancement – including new innovations and opportunities for translational research.

The first phase of this integrated planning effort was presented to the SHC Board of Directors at a full day retreat on March 5th. Faculty leaders as well as SHC senior staff presented key elements of the plan as follows:

1. ***Neuroscience Strategic Plan*** was presented by Dr. Bill Mobley, Director of the Neurosciences Institute at Stanford and Professor of Neurology and Neurological Sciences, and Gary Steinberg, Professor and Chair of the Department of Neurosurgery.
2. ***Cardiovascular Strategic Plan*** was presented by Drs. Bobby Robbins and Alan Yeung, Co-Directors of the Clinical Cardiac Programs at SHC and Associate Professor of Cardiothoracic Surgery and Associate Professor of Medicine respectively.
3. ***Transplantation Strategic Plan*** was presented by Dr. Carlos Esquivel, Professor of Surgery, and Dr. Emmet Keeffe, Professor of Medicine.
4. ***Cancer Strategic Plan*** was presented by Dr. Richard Hoppe, Professor and Chair of the Department of Radiation Oncology and Chair of the Clinical Cancer Steering Committee. I am happy to note that Dr. Steve Leibel, who will be joining Stanford in July to become the first Ann and John Doerr Medical Director of the Clinical Cancer Program was also present for the discussion (see below for the announcement of Dr. Leibel's appointment).

In each strategic plan, program development in various subcategories was enunciated – casting a wide net for potential clinical development and translational research. In a sense, this phase of the planning exercise has defined a much broader landscape than is currently feasible. During the next several months, the strategic planning process will be further refined by prioritizing, within each major Institute/Center, the specific areas for further development, the likely return on investment and the resources needed to achieve a successful outcome. Clearly priorities will be needed in each of these four areas. Equally importantly, as this process unfolds, a further integration and refinement of the planning process will need to choose among and between the opportunities offered by each of the strategic plans so that an overall determination of resource investment can be determined. Also, in each case, priorities will be set regarding opportunities both for academic development as well as for financial value. The timeline for making these investments will also be determined during this process.

The process to date – and that for the future – will require close collaboration between the School and the Hospital. Because of the broad mission of the Stanford Medical Center, some of the final choices will be determined by the opportunities that specific programs offer for academic development, translational research and/or financial return. Accordingly, these decisions need to take into account both the academic as well as business-related needs of Stanford Medicine and the Medical Center.

Clearly, time is of the essence. It is essential that this process be fully completed within the next 3-4 months so that program development can be optimized. Naturally I will report back to you on the progress we are able to make in this important planning process.

Science and Politics

A couple of weeks ago, I had the opportunity to participate in one of the Practice of Medicine classes for our first year medical students. Together with Ryan Adesnik, Director of Government Relations, and Paul Costello, Executive Director of Communications and Public Affairs, we discussed a wide array of topics – including some of the ever-increasing concerns about science and politics. More specifically, those concerns have included the increasingly ideological approach to science being taken by the current federal administration. This not only involves positions on topics like stem cell research but also includes the appointment of individuals to advisory committees based on whether the individual supports certain policies – based not just on science but seemingly also religion and “ethics.” Just two weeks ago a group of leading scientists, including many Nobel laureates, expressed their concern about this current approach to science and politics in an open letter to the New York Times. Amazingly, just a week later, the administration announced that it was replacing members of the President’s Bioethics Council – in practice eliminating those who had dissenting views with new members who seemed to bring more conformance. This is, of course, shocking in its own right, and raises many concerns about an increasing blurring of science, politics, ideology and religion. Regardless of our beliefs – or even belief systems – this is something we should all be concerned about.

In the Sunday, March 7th Washington Post, an Op Ed piece was presented by Dr. Liz Blackburn, who was recently informed that she would no longer be a member of the President’s Bioethics Council. I am taking the liberty of sharing her Op Ed piece as it appeared in the Washington Post since it summarizes quite clearly why these current trends should alarm and concern all of us.

A 'Full Range' of Bioethical Views Just Got Narrower

By Elizabeth H. Blackburn

washingtonpost.com

Sunday, March 7, 2004; Page B02

The phone rang a few days after Sept. 11, 2001. It was Leon Kass, chairman of the brand-new President's Council on Bioethics, calling to ask: Would I join this White House-appointed federal commission charged with advising the president on ethical issues arising from advances in biomedical science and technology?

As a cell biologist who had spent years investigating causes of cancer and human aging, I had already begun thinking about the ramifications of such research. Like many people at that tumultuous time, I also felt eager to do something -- anything -- to serve a cause larger than myself. I understood that the council would include not just biomedical scientists but medical doctors, philosophers and legal and policy experts, and Kass assured me it would consider diverse views and avoid foregone conclusions. I agreed then and there to serve. Little did I guess that a scant two and half years later a White House phone call would notify me that my services were no longer needed.

In the weeks it took to finalize the appointment, I reflected on my decision. I knew that council discussions were likely to present challenges; for years Kass, a professor of social thought, had expressed views I believed to be unfriendly to many aspects of biomedical research and contemporary medicine. But I felt that as a seasoned scientist whose own work touched on these

areas, I could help the council distinguish between real, experimentally validated science and what amounted to sheer flimflam on issues muddled by competing voices and agendas, and little data.

In January 2002, the entire 18-member council met with President Bush at the White House. His initial directive was for us to report on the ethics of therapeutic cloning (also known as somatic cell nuclear transfer) and reproductive cloning. Therapeutic cloning involves making early-stage pre-implantation embryos for use as sources of stem cells -- for research and to be used in cures - - while reproductive cloning refers to the creation of cloned babies by transferring cloned embryos to a womb for gestation and birth. I was encouraged when Bush stressed that he wanted to hear the full range of views on those and other questions.

When I read the council's first discussion documents, my heart sank. The language was not what I was used to seeing in scientific discourse -- it seemed to me to present pre-judged views and to use rhetoric to make points. Still, the debates we had in the ensuing months proved far-ranging, and all comments were politely received. And, despite the betting of outsiders, 10 of the council's 17 members (one had retired) initially voted against recommending a ban on therapeutic cloning. A late change to the question being voted on turned the minority who were in favor of a ban into a majority of 10 favoring a four-year moratorium, an option the council had not discussed in meetings. But the report issued in July 2002 contained a breadth of views. It also contained a series of personal statements by council members, many of them dissenting from the report's official recommendations.

In the year and a half following that report, I began to sense much less tolerance from the chairman for dissenting views. I will focus only on embryonic stem cell research.

Work with animal models had been indicating the potential benefits of such research for more than two decades. More recently, breakthrough research had suggested for the first time that those avenues of investigation would be possible in humans, with revolutionary implications for health care. Yet at council meetings, I consistently sensed resistance to presenting human embryonic stem cell research in a way that would acknowledge the scientific, experimentally verified realities. The capabilities of embryonic versus adult stem cells, and their relative promise for medicine, were obfuscated. Although I was not able to attend every meeting, I engaged fully in preparations for the report: I read and assessed the published science, attended presentations on new research at national and international scientific conferences, and consulted with cell biologists, including stem cell biologists, across the country. The information I submitted was not reflected in the report drafts.

Clearly, the council's reports concerned politically charged topics. I knew that my views on cloning and stem cell research did not match those of either Kass or Bush, as I understood them: In his public statements, the president had supported banning therapeutic as well as reproductive cloning. Still, I was not prepared for the phone call I received at home from the White House on Wednesday, Feb. 25. The caller requested that on Friday afternoon I call the White House Personnel Office. No hint was given as to the reason. When I called, the director said that the White House had decided to "make changes" in the council and that it was adding new people to replace some individual members. I asked him whether this meant that my term on the council had terminated, and the reply was yes.

And what "changes" they were. I was one of just three full-time biomedical scientists on the council. William May, a deeply thoughtful, erudite theologian and medical ethicist, was also leaving. He, too, had often differed with Kass on issues such as the moral worth of biomedical research and the ramifications of trying to legislate such research. And he, too, had voted against both a ban and a moratorium on therapeutic cloning.

When I read the published views of the three new members (bringing the council up to its original total of 18 members), it seemed to me they represented a loss of balance in the council, both professionally and philosophically. None was a biomedical scientist, and the views of all three were much closer to the views espoused by Kass than mine or May's were. One, a surgeon who was not a scientist, had championed a larger place for religious values in public life. Another was a political philosopher who had publicly praised Kass's work; the third, a political scientist, had described research in which embryos are destroyed as "evil."

Why do I find the concept of banning embryonic stem cell research so troubling? Leon Kass has suggested that society should make decisions based on what he calls the "wisdom of repugnance." I think this is an unreliable kind of wisdom. Repugnance should serve not as a basis for any decision, but rather as a signal for honest, critical examination of what inspired it. In some instances, repugnance may indeed hint at moral qualms that will withstand the rigors of analytical questioning. But it may also simply reflect habit or custom.

I am convinced that enlightened societies can only make good policy when that policy is based on the broadest possible information and on reasoned, open discussion. Narrowness of views on a federal commission is not conducive to the nation getting the best possible advice. My experience with the debate on embryonic stem cell research, however, suggests to me that a hardening and narrowing of views is exactly what is happening on the President's Council on Bioethics.

On Super Tuesday, four days after the White House call, I stopped by the garage at a local house that served as my neighborhood's polling station. In the soft, early-evening light, it felt far removed from the brightly lit pomp and splendor of the White House I had visited two years earlier as a member of the Bioethics Council. Here in this garage, men and women also were volunteering their efforts, contributing to the civic good. They beamed and congratulated me when I mentioned that I, a native-born Australian, had recently become a U.S. citizen. A surge of appreciation swept through me as they went about their tasks, watchfully protecting due process. In this down-home setting, that charge suddenly felt so precious, and so fragile.

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NIH Roadmap and Other Initiatives

Recently the NIH has announced a major new granting initiative to promote nondisciplinary research. This program <http://nihroadmap.nih.gov/grants/index.asp> is likely to grow over the coming years. Other agencies are also placing new or renewed emphasis on the importance of large, multi-component research efforts. In order to facilitate Stanford faculty's ability to respond to these opportunities in a timely and efficient fashion we have initiated several support efforts.

First, an email based notification announcing the new opportunities will be distributed to all faculty on a weekly basis. Second, the School of Medicine is about to launch a web based interactive message board where faculty with interests in these various grant opportunities can identify one another and organize responses as they see fit. This message board will be available to all Stanford faculty. Finally, the School of Medicine has recently hired an administrator whose job will be to help organize and assemble large multi-faculty, multi departmental grant applications. This person could be available to assist on grant applications involving collaborations between SOM faculty and faculty in other schools.

We hope these interventions are useful and serve to promote and facilitate more interactive science.

Appointment of the Director of the Stanford Institute for Cardiovascular Medicine

I am extremely pleased to announce that Dr. Robert C Robbins, Associate Professor, Department of Cardiothoracic Surgery, has agreed to become the Director of the Stanford Institute for Cardiovascular Medicine. Dr. Robbins was recommended for this position, with great enthusiasm, by colleagues and leaders in cardiovascular medicine and research at Stanford.

As you know, over the past year we have established four Stanford Institutes of Medicine – three of which now have Directors. These are the Institute for Cancer/Stem Cell Biology and Medicine directed by Dr. Irv Weissman, the Neurosciences Institute at Stanford directed by Dr. Bill Mobley and now the Cardiovascular Institute that will be directed by Dr. Bobby Robbins. Over the next couple of months I hope to also name the director of the Institute for Immunity, Transplantation and Infectious Diseases. Together these four Institutes comprise our broad focus on *Translating Discoveries* and offer a linkage between our basic and clinical science faculty

along with connections to clinical programs at Stanford Hospital & Clinics and the Lucile Packard Children's Hospital.

A skilled cardiac surgeon, with expertise in heart transplantation as well as complex cardiac diseases, Dr. Robbins is also an NIH-funded investigator whose research is focused on heart transplantation (both in humans and preclinical models) and repair of heart injury using gene therapy or stem cells. He is also an outstanding and articulate leader and is working closely with his superb colleague, Dr. Alan Yeung, Professor of Medicine and Chief of the Division of Cardiology, each serving as Co-Directors of the Stanford Cardiac Center.

I also want to thank Dr. Judy Swain and the Executive Committee for the Cardiovascular Institute for all the excellent work they did during the past many months in helping to craft the fundamental components of the Cardiovascular Institute.

I look forward to working with Dr. Robbins and the members of the CV community to help Stanford achieve even greater distinction in this important area of medicine and science.

Appointment of Medical Director for the Clinical Cancer Center

I am very pleased to announce that Dr. Steve Leibel, currently the Chair of the Department of Radiation Oncology at Memorial Sloan Kettering Cancer Center (MSKCC), will join Stanford this July as the first Ann and John Doerr Medical Director of the Clinical Cancer Center.

Dr. Leibel, who was selected following a national search, is internationally recognized for his research and clinical care expertise. Dr. Leibel received his M.D. degree from UCSF where he also trained in Radiation Oncology. He has served on the faculty of the Johns Hopkins School of Medicine and UCSF and has been at MSKCC since 1988, where he is currently a Member. He has held numerous distinguished leadership positions, including President of the American Society for Therapeutic Radiology and Oncology; Board of Chancellors of the American College of Radiology; and Vice President of the American Board of Radiology. He has won the Teacher of the Year Award from the Association for Residents in Radiation Oncology and the Gold Medal Award from the American Society for Therapeutic Radiology and Oncology. His areas of research interest include the use of 3D Conformational Radiation Therapy along with a specific interest in prostate and brain cancer. Dr. Leibel is the author or co-author of over 150 original scientific publications, 75 reviews articles or book chapters and 5 books. He brings a strong record of knowledge and accomplishment in clinical research.

I also want to take the opportunity to thank Ann and John Doerr for their wonderful gift to the Stanford Medical Center that creates the first Medical Directorship. It is wonderful that Dr. Leibel will be the first incumbent of the Ann and John Doerr Medical Directorship.

I should also add that in addition to recruiting Dr. Leibel, we are also searching for a leading scientist who will become the Principal Investigator for our upcoming grant submission to the NIH that will (we hope) enable us to become an National Cancer Institute-designated Comprehensive Cancer Center. Our efforts in this important arena, currently being lead by Dr. Karl Blume, will complement the clinical programmatic planning noted above and, in the

aggregate, enable Stanford to emerge as an exceptional leader in cancer care, research and education.

Appointment of the Chair of the Department of Orthopedic Surgery

Although the search process has been a long one, I am very pleased to announce that we have successfully recruited a new Chair for the Department of Orthopedic Surgery. Dr. William Maloney will officially join Stanford in mid-July.

Dr. Maloney was an undergraduate at Stanford, received his MD degree from Columbia University and then returned to Stanford for his residency in orthopedic surgery. He then did a fellowship in hip reconstructive surgery at the Massachusetts General Hospital and then returned to Stanford and the Palo Alto Medical Foundation before leaving for St. Louis in 1996. He is currently The Charles and Joanne Knight Professor of Orthopedic Surgery and Chief-of-Service and Head of Joint Replacement Surgery at Washington University and the Barnes-Jewish Hospitals. Although he was originally identified by the search committee as its leading candidate nearly two years ago (!), a number of both professional and personal issues impeded his recruitment at that time. Thankfully, in the intervening period, we have been able to successfully resolve these issues and I am extraordinarily pleased that Dr. Maloney – who was our first choice at the outset of this process – has now been our successful selection as chair-select at the conclusion of the search. We will welcome him with great enthusiasm as he arrives this summer.

Interview Weekend for the Biosciences

Beginning March 4th through the weekend, some 267 prospective bioscience graduate students arrived on campus to complete their interviews with faculty in the School of Medicine, Humanities and Sciences and our new Department of Bioengineering. This group of students has already passed the hurdle of having an application strong enough to warrant in-person interview as well as the opportunity to learn more about the graduate programs in the biosciences.

It was an intense but exciting experience for all - including a dinner event on March 4th featuring research posters by our faculty and students that fostered dialogue and demonstrated the extraordinary breadth of research opportunities at Stanford. March 5th was for interviews – providing both prospective students and faculty the opportunity to define mutual interests and help discern whether Stanford is the optimal environment for future career development. There was also a brunch on Saturday morning to share Stanford's commitment to enhancing diversity and to supporting students through their education and research experiences. I am confident that by the end of the weekend, prospective students had a much deeper appreciation of the outstanding opportunities available at Stanford. Next comes the difficult decision by faculty and departments about which students to offer acceptances to – all of which will happen within the next week. The word on the street was that the overall quality of the prospective applicants is outstanding – which is certainly excellent news for further enhancing the overall success of Stanford.

The Respectful Workplace

As you know, assuring that we have a “respectful workplace” is one of our highest priorities. During our faculty briefings on the Respectful Workplace over the past year, we have been asked about retaliation as well as about what happens to those who falsely accuse others of wrongdoing. I felt it was important to address those questions with you.

Retaliation against an individual who in good faith reports or provides information in an investigation about behavior that may violate University policy related to sexual harassment, discrimination, health and safety and whistleblower protected activities is against Stanford University policy and is against the law; it will not be tolerated. At the same time, the University does not tolerate false accusations that are not brought forward in good faith. Intentionally making false reports or providing false information is grounds for discipline. These types of cases -- which fortunately are few in number --are managed on a case-by-case basis within the parameters allowed by Stanford University policy and the law.

In case you have wondered about these important issues, I hope that this helps provide some background information.

Affirmative Action Recruitment for Staff Members in the School of Medicine.

In prior communications I have highlighted the importance of having a diverse workplace and have shared our efforts in enhancing diversity among our students, trainees and faculty. While we have made some progress, we still have lots to do to make our school truly diverse.

In addition to our efforts with faculty and students, we are also very committed to enhancing diversity among the staff of the Medical School. In a memo sent to all department administrators last month, the University and School of Medicine have staff affirmative action hiring goals for 2004. Job groups identified as key foci for hiring minorities and women. These include many administrative management positions: DFAs; financial, technical and university managers; administrative services administrators; public relations officers; and administrative deans, among others. Along with Mike Hindery, Senior Associate Dean for Finance and Administration, we want to take this opportunity to reaffirm to the School of Medicine community that our commitment to attaining and maintaining a diverse workforce is strong and continuing.

We encourage all members of the School of Medicine community to support our shared efforts in this regard by helping us to identify and recruit qualified individuals who would bring diversity to our workforce. We also welcome ideas or suggestions for broadening our outreach efforts. Please contact your compensation specialist or Lois Benzel (lbenzel@stanford.edu) in the Human Resource Group with your ideas.

Updates from the Executive Committee: A Report on Supporting Clinical and Translational Research

At the Executive Committee meeting on Friday February 20th, we heard a very helpful presentation from Dr. Steven Alexander, Professor of Pediatrics, and the Translational Research Task Force. This group has representation from Stanford University as well as the School of

Medicine, Stanford Hospital and Clinics, and the Lucile Packard Children's Hospital. The members of the Task Force, in addition to Dr. Alexander, are: Dr. Brandy Sikic, Connie Hartnett, Steve Jung, Dr. Harry Greenberg, Rodney Johnson, Pamela Webb, Nick Gaich, Carole Klove, Nancy Lee, Dale Jung, David Haray, and Gary May.

I should note that the impetus behind the formation of the Task Force was:

- To establish a management structure to ensure the efficient processing of clinical and translational research proposals, ethical conduct of research and efficient translation of emerging treatments to clinical use at Stanford, and,
- To pursue the development of the research facilities and infrastructure required to support the effective collaboration of bioscientists and clinical scholars.

Early on in the work of the Task Force, a Clinical Trial Risk Assessment found several aspects of clinical trials work at Stanford that needed remediation, including the budget process; procedures of invoicing, tracking and collections; and communication and coordination between the School of Medicine and the hospitals. The Task Force has made significant progress in establishing procedures for improving performance in all of these areas.

Additionally, the Task Force has established protocols to take advantage of allowable Medicare reimbursements for certain items and services used in qualifying clinical trials. These include a decision making protocol to determine whether a clinical trial qualifies for Medicare Reimbursement for Routine Costs and a decision making protocol to determine routine costs of a qualifying clinical trial.

Finally, the Task Force has developed a Principal Investigator (PI) Checklist and a Clinical Trial Pre-Award Process for assuring that all aspects of the trial have been thoroughly understood and planned for. These include scientific issues, the safety of study subjects, conflict of interest, financial and other resource issues, the separation of routine case from experimental care, and ethical issues. Going forward, all PI's will complete the PI Check-list and the Clinical Trial Pre-Award Process. The new procedures are currently being piloted with a selected group of faculty. Full implementation is expected in two to four months.

The Task Force has accomplished an enormous amount since its inception. It is continuing to work on additional improvements in such areas as a hospital billing policy and procedure model and an integrated training and education program. All of these improvements will enhance our ability to carry out clinical trials, which are crucial to our success in translational medicine.

Announcement: The Katherine D. McCormick Lecture

The 28th Katherine D. McCormick Lecture will be given March 30, 2004, 12:00-1:00 in the Fairchild Auditorium. This year's Lecture is being cosponsored by the Cancer Biology Seminar Series and will be given by Carol Prives, Ph.D.

Dr. Prives is the DaCosta Professor of Biology and the Chair of the Department of Biological Sciences at Columbia University. She is the recipient of an NIH Merit award and in 1998 was awarded an American Cancer Society Research Professorship. In 2000 she was

elected to the American Academy of Arts and Sciences. She is internationally recognized for her work on the p53 tumor suppressor gene. Her Lecture is entitled, "*Regulation of the p53-Mdm2 circuit: a major checkpoint in mammalian cells.*" All are welcome.

Honors and Awards

I am very pleased to let you know that **Dr. Matt Bogyo**, a still new Assistant Professor in the Department of Pathology, has been appointed as a 2004 Searle Scholar. Congratulations to Matt.

Appointments and Promotions

- **Judith Ford** has been promoted to Professor (Research) of Psychiatry and Behavioral Sciences, effective 3/1/2004 to 2/28/2010.
- **Edward Graves** has been appointed to Assistant Professor of Radiation Oncology (Radiation Physics), effective 3/1/2004 to 2/28/2007.
- **M. Peter Marinkovich** has been promoted to Associate Professor of Dermatology, effective 3/1/2004.
- **William Weis** has been promoted to Professor of Structural Biology and, by courtesy, of Molecular and Cellular Physiology, effective 3/1/2004.