

## **Dean's Newsletter**

### **November 29, 2004**

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#### **The Holiday Season**

Some things are still incomprehensible to me. As I write this edition of the Newsletter while peering out my office window at clear blue skies that are without a hint of snow, it seems implausible that Thanksgiving has just passed and the Hanukah, Christmas and the New Year are just around the corner. It is hard to think of the winter holiday season without reference to one’s childhood memories (or, in my case, decades of an adult East Coast existence). For me, this season is associated with the coming of plummeting temperatures and rising drifts of snow. The fact that the dry brown earth around Stanford is springing forth new green tufts of grass evokes a different sense of the pending winter season! But regardless of the variations in the outside view, the inner peace of the Holiday Season is constant. I hope the Season will be a happy and joyous one for each of you.

#### **The Frustrations of Our Current Health Care “System”**

Over the last few weeks Stanford employees have selected their benefits, including health care coverage, for the 2005 year. With over 42 million Americans uninsured and many others only minimally covered by health insurance, this annual rite evokes a number of reactions. It is ironic that just weeks ago during the Presidential debates much was said about the state of America’s health care system – including many accolades about how we have the best health care system in the world. I wish that were true.

Certainly we have a highly technologically advanced health care system in the USA, and it is true that those with financial resources can access the very best health care perhaps anywhere. But this is not a universal or perhaps even an average story. Indeed I

would argue that we really don't have a health care system at all in the United States. What we call a "health care system" is in many ways an incidental by-product of wage control during the Second World War that resulted in health care coverage as an employee benefit. This employer-based system, with all of its imperfections, still defines America's health care system. It has been made significantly worse by the ill-founded notion that health care (and its costs) can be controlled by market forces as if it were a commodity. While it is true that market forces during the mid-1990s did transiently hold down rising health care costs, they also created a health care industry that has, to a large extent, both lost its way and fractured the public trust in medicine as a profession.

The last years have witnessed a system that, rather than asking what is best for the patient, largely creates competition around price. The ever-growing health care behemoths, rather than asking how to assure that an individual receives the best care, seek to control "market share", thus setting up a constant struggle between payers, providers and patients (now mostly referred to as "consumers"). Despite this competition around price, health care costs continue to soar and now represent over 15% of the GDP (more than any other nation) with no absolute population based benefits. Infant mortality remains below the top tier and longevity is better in many other countries. Of course we argue that we do not suffer a "socialized" system of health care, nor do we have rationing or restriction of services – or so it seems at the surface.

I expect that many of you felt challenged as you reviewed the various health care plans and options to select from in early November. While much appreciation must be given to Stanford Human Resources and University Leadership for working hard to make affordable options available to Stanford faculty, staff and students, the choices were often confusing and, especially for those with existing health issues, quite challenging. In many ways these offerings are part of a patchwork that merely applies a band-aid to a system that truly needs much more fundamental change. While the buzzword of the day is greater consumer participation (which I do believe is good), this is, in many ways, an effort to shift costs and burdens to the consumer while still sustaining (or is it protecting) the current dysfunctional system.

Efforts to develop a more rational health care system have certainly been pursued, although they have been largely foiled during the last several decades. They date back to efforts of Presidents Truman, Nixon and, perhaps most notably and recently, Clinton. Each failed due to the lobbying of special interests, including the insurance industry, the pharmaceutical industry and physicians. The lack of ability to resolve the current health care crisis, fueled of course by market forces, results in the current non-system. Sadly, I am not optimistic that there is yet the resolve in the nation to address the fundamental problems underlying American health care. Although I fully recognize that defining a system that will have broad appeal is Pollyannaish, it is time for communities and states to explore new pathways. Oregon has done that over the past decade with some success. Other novel approaches are needed. While I recognize the limitations, I think that a move toward a single payer system makes considerable sense at this time. There are many caveats – but given our current system, the benefits surely seem to have merit.

We stand at a remarkable crossroad. We are the beneficiaries of an extraordinary legacy of scientific discovery that has changed, and will continue to change, our approach to the diagnosis, treatment and prevention of human disease. The same country and economy that spawned and supported this scientific revolution have also been the custodian, perhaps inadvertently, of a health delivery system that appears to be fracturing and that, at a minimum, is creating classes of health care that stratify along lines of personal wealth. As a nation we can and should do better. I hope that we at Stanford can contribute to this debate and to efforts to promote a successful transformation in our health care system.

### **Wishing Well to Dr. Judy Swain**

On November 18<sup>th</sup>, Dr. Judy Swain, the Arthur L Bloomfield and the George E. Becker Professor of Medicine and Chair of the Department of Medicine, announced her decision to become the First Director of the College of Integrated Life Sciences at the University of California, San Diego. This new opportunity will permit Dr. Swain, who has led the Department of Medicine as its chair for 8 years, to continue to foster the training and development of physician-scientists, an area that has been an important centerpiece of her distinguished career. I want to thank Dr. Swain for her many contributions and to wish the very best of continued success in her new position at her alma mater UCSD.

### **Special Thanks to Sharon Olsen**

I also want to publicly thank Ms. Sharon Olsen, who served as my Executive Associate until November 19<sup>th</sup> when she returned to Boston to serve as the Executive Assistant to the President of the Dana Farber Cancer Institute. I had the privilege of working with Ms. Olsen in Boston and at Stanford. While at Stanford she did an exceptional job in serving the Office of the Dean and the School of Medicine, and I want to thank her tremendously for those efforts. We wish her and her family well.

### **School of Medicine Budget Results for FY2004 and Forecast for FY2005**

The challenges related to the conversion of the University financial systems during the past year have posed particular difficulties to our financial management, including our ability to obtain accurate and timely end of the year data. But as of November 19<sup>th</sup>, the data were complete enough to permit Mike Hindery, Senior Associate Dean for Finance and Administration, to review the FY04 budget actual performance and FY05 budget with our Executive Committee. I want to share some of the high level results with you.

As you know, most of our School-wide investments are driven by our Strategic Plan *Translating Discoveries* (<http://medstrategicplan.stanford.edu/>), which serves as a guide to our immediate future. This plan addresses our goals and objectives in education,

research, patient care, community service, advocacy and public relations, etc. For FY04 (the year which closed on August 31<sup>st</sup>, 2004), we had projected a \$38M deficit (or use of reserves) in order to fund important initiatives. It turned out that at the close of the year, we finished the year with a consolidated surplus of \$7M. This was largely the result of revenues that could not be anticipated at the beginning of FY04, especially patent and royalty income, endowment performance, gifts, and patient care activities. While this is encouraging, it is difficult to extrapolate these positive revenue sources to future years and, in fact, our budget for FY05 (the year that began on Sept 1 2004 and which ends on August 31 2005) includes a \$20M deficit. Again this is based on major strategic initiatives that include the following:

***FY2005 Budget Strategic Initiatives***

<i>Stanford Institutes of Medicine and other Interdisciplinary Efforts (e.g., cancer center) and interim facilities development</i>	\$11,694,000
<i>Education: Learning Center, Community Service, Programmatic Initiatives</i>	\$3, 677,000
<i>Information Resources and Technology</i>	\$1,000,000
<i>Recruitments (chairs and faculty)</i>	\$11,792,000
<i>Essential Clinical Services Fund</i>	\$861,000
<i>Interschool Initiatives (Clark Center Operations, BioX, Bioengineering)</i>	\$4,343,000
<i>Operating Budget Transitions (based on smoothing of transition from FY04)</i>	\$2,285,000
<i>Miscellaneous (Support for Clinical Research, Diversity, Medical Development)</i>	\$2,872,000
<b>Total Strategic Initiatives</b>	<b>\$38,524,000</b>

These strategic investments are a vital component of our consolidated FY05 budget of \$816 million for the School (exclusive of the affiliated hospitals).

Overall the School remains financially healthy with an endowment balance (as of August 31, 2004) of \$1.404 B and consolidated expendable fund reserves of \$360,341,000. While this is encouraging, it is important to note that the majority of these endowment and expendable funds are in restricted pools and most reside in the departments. Thus their availability for new school-wide initiatives is limited.

Also, we face a number of challenges going forward,. One is the likelihood that our revenues from patent and royalty income will decline (although this is always unpredictable), that NIH funding will be more limited (the most recent news on the FY05 NIH budget is that it will rise by only 2.1%), and that costs will continue to increase, especially for programmatic and capital needs. Further, we are facing a number of key department chair recruitments (e.g., Cardiothoracic Surgery and Neurology and Neurological Sciences are moving to chair selection, the Obstetrics and Gynecology search is just getting underway and new searches are now planned for Medicine and Pediatrics that will commence at the beginning of the year).

The major reason we spent so much time developing our strategic plan was to allow us to guide our future purposefully and with explicit and shared goals. –The strategic plan continues to provide the foundation for our budget decision making process, so that now and in the years ahead we can assure that the Stanford School of Medicine is sustained and enhanced as one of our nation’s premier medical schools.

## **Launching the School of Medicine Initiative on Immersive and Simulation-Based Learning**

In my last Newsletter I provided information about a set of activities planned for the November 15<sup>th</sup> launch of the School’s initiative on Immersive and Simulation-based Learning. Dr. David Gaba, Professor of Anesthesia and recently named Associate Dean for Immersive and Simulation-Based Learning, reported back that the morning activities drew a crowd of over 150 guests. They included Stanford faculty and students, alumni, interested friends of the school, industry partners, and academic partners from around the country and colleagues from our teaching hospitals. Key speakers included Dr. Gaba, the Directors of our founding simulation centers, and Ajit Sachdeva, MD, Director, Division of Education, American College of Surgeons. One highlight was an impassioned presentation from Dr. Amitai Ziv, MD, Director, Israel National Simulation Center, Chaim Sheba Medical Center, who presented examples of the comprehensive immersive learning and simulation center that he and others have created for the unique demands in Israel. Archived streaming video of the presentations can be viewed on the Web at: [http://med.stanford.edu/irt/immersive/launch\\_video/](http://med.stanford.edu/irt/immersive/launch_video/)

The morning session was followed by a lunch panel discussion attended by approximately 85 Stanford faculty, visiting academic and hospital colleagues. The panel included Jeff Driver, JD/MBA, Director of Risk Management for both SUH and LPCH, Julie Parsonnet MD, Senior Associate Dean for Medical Education, Kelley Skeff, MD, PhD, Internal Medicine Residency Director and Director of the SFDC, Geoff Lighthall, MD, Assistant Professor of Anesthesia & Intensive Care, who is a developer of simulation courses in critical care, and Dr. Ziv. The questions and discussions focused on the practical issues of appropriate and effective application of ISL techniques, simulation training as a tool for risk management and reduction of medical error, simulation as a tool for assessment of clinical trainees and practitioners, and pathways for providing resources and faculty development to underpin new initiatives in ISL.

An additional note – on the Sunday prior to the public launch activities, the School of Medicine and the Office of Government Affairs hosted the second discussion of the AIMS group (Advanced Initiatives in Medical Simulation). This group is focused on developing a national agenda around the development of medical simulation techniques for a variety of health care applications in education, training, performance assessment, and research. AIMS intends to raise the visibility of simulation in the federal government with the hope of stimulating greater funding for research, pilot projects, and the support of students and post-doctoral fellows in this arena. The meeting was highly successful, and Stanford will continue to play an important role in the AIMS process.

## **More About HIPAA and Data Security – What’s Coming in 2005!**

At the November 19<sup>th</sup> Executive Committee meeting, Dr. Henry Lowe, Senior Associate Dean for Information Resources and Technology, and Dr. Todd Ferris, Director of Privacy and Data Security, provided an update on the status of the School’s activities in the area of data security. By way of context, Dr. Ferris pointed out that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposed significant security regulations. Indeed we are required to be in compliance with these regulations by April 21<sup>st</sup>, 2005. In addition, there are numerous other new regulations that cover protected information, which includes, in addition to patient medical information, research subject information, Social Security numbers, student records, and banking information, and Stanford intellectual property.

Historically, however, academic institutions have not focused on computer security. Now, computers and the use of the Internet have become almost required to operate academic institutions. In addition to the laws requiring data security, there has been an almost exponential increase in viruses, worms, and malicious hacking that the School must combat. In order to deal with these changes, the School must make a transition from a previously open academic computing model to a secure computing model. The challenge is to create a flexible secure computing model that accommodates the needs of faculty, staff, and students. However, we will also have to change some of our day- to-day behavior. And we must do this!

In order to be compliant with the new regulations, the School must implement 18 standards, 42 implementation specifications and 10 policies, which themselves contain 6 guidelines. For example, in the administrative area, the School must have documented policies and procedures for day- to- day operations, managing the conduct of employees with electronic patient health information, and managing the selection, development, and use of security controls. Physically, we must have in place security measures meant to protect our electronic information systems, as well as related buildings and equipment, from natural hazards, environmental hazards, and unauthorized intrusion. Furthermore, we must ensure the compliance of our workforce. For desktops, laptops, servers, and PDAs, all devices that may hold protected information need to conform to the computing device policy and guidelines. This includes: anti-virus, patch management, disabling unused devices, and strong passwords. Devices that are mobile must encrypt any protected information stored on the device.

In fact, within the School of Medicine there are approximately 200 “information systems.” Each will have a formal risk assessment and a remediation plan developed. Currently the systems in the IRT data center are being reviewed. Soon departmental systems will be reviewed. Training modules are being developed to assist in implementing the new policies and guidelines. These are projected to be ready for use by early December. In addition, IRT is launching a central help desk in January that will help coordinate activities of local support personnel. IRT will also provide training for

local support people on securing systems. In addition, IRT is adding firewalls, intrusion detection, and is more aggressively monitoring for malicious activities to the School's network.

This is obviously a huge effort and is one that will require understanding and flexibility on all our parts. Drs. Lowe and Ferris and their colleagues in IRT have made enormous progress in moving the School to full compliance with the new regulations. We will keep you informed of further developments.

### **Work-Life Balance: The WorkLife Office at Stanford University**

At a recent Dean's Staff meeting, Ms. Teresa Rasco, Director of the WorkLife Office at Stanford University, presented an overview of the many programs and services her Office provides. The mission of the WorkLife Office is to support "the University's academic mission through direct services and by developing collaborative partnerships within Stanford and the surrounding community to assist faculty, staff, and students in navigating the competing demands of their work, study, personal and family lives." A large component of the Office's programming consists of resources and services for and about children, including on-site children's programs (day care, pre-school, and after school), back-up child care, parent education programs, the Child Care Subsidy Grant Program, and the Adoption Reimbursement Program. At the other end of the continuum, the Office provides educational programs and referral resources for elder care and caregiver services and has a link to Avenidas, which provides individual and family services to seniors throughout the Mid-Peninsula area.

In the Dean's Staff discussion it was noted, in our fast-paced academic culture, trade-offs between work and family can be difficult to negotiate. I want to make it clear that, in my view, family issues should take a priority wherever feasible. Supervisors need to be sensitive to these issues and work with their staffs to allow them, as much as possible, to attend to family obligations, such as illness of a child, without facing, or worrying that they will face, negative consequences at work.

We also noted that members of the Stanford community might not be aware of the many resources available through the WorkLife Office. In my view, the work of this Office is critically important to the success of the School and the University, and I encourage everyone to take advantage of its services. The web site for the Office is <http://worklife.stanford.edu>.

### **Awards and Honors**

- *Dr. Arthur Kornberg*, Emma Pfeiffer Merner Professor of Biochemistry, Emeritus, has received the Osaka Sakura Award and has been also

named an honorary member (one of only 20) of The Japan Academy.

Congratulations to Dr. Kornberg for his continuing accolades to a remarkable career in medicine and science.

- **Dr. Gerry Reaven**, Professor of Medicine Emeritus, has been awarded the Ellen Browning Scripps Medal for 2004, which recognizes an individual who has made a significant contribution to the care of patients and the advancement of medical science. In addition, Dr. Reaven also recently received the Astute Clinicians Award from the NIH that acknowledges a clinical scientist who has conducted research that has had a big impact on medicine. Congratulations to Dr. Reaven for these two very special awards.

### **Appointments and Promotions**

- **Howard Chang** has been appointed as Assistant Professor of Dermatology, effective 12/1/2004.
- **Tobias Meyer** has been promoted to Professor of Molecular Pharmacology, effective 12/01/2004.