

Dean's Newsletter
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Planning For The Future

Six years ago, before I officially arrived at Stanford, I began the strategic planning that helps shape our agenda for *Translating Discoveries*. Most importantly, an integrated planning process that includes basic and clinical science faculty as well as students and staff has guided our subsequent planning and program development during the past several years and has made it more embracing, interactive and successful. While it is understandable that as individuals or groups we have a view and opinion about what is most important for Stanford, it is important to note that we have found ways to have a dialogue that considers shared goals and objectives and that sets priorities for how to achieve or fulfill them. This process has continued to evolve over the years, and in three weeks we will take yet another step when our department chairs, institute and center directors as well as students, fellows, staff and colleagues from our hospitals and university community assemble for the 2007 Strategic Planning Leadership that will be held February 1st-3rd. This will be another opportunity to test and challenge some of our assumptions and also to ask some of the big and important questions facing academic medical centers in general, and Stanford specifically. I will have more to say about the Retreat in subsequent Newsletters. In the interim, I want to convey some of my thoughts about a number of the major issues and challenges we face as we continue our journey with the Stanford School of Medicine and Medical Center. While this is hardly a complete listing, I believe it is important to share some of these thoughts with you – both for your information and also with the hope that you might offer some of your own thoughts and suggestions to me as well.

Education

At a university we generally think of students as those who are pursuing a specific degree. However at an academic medical center, our students and trainees are much larger in number and include, in addition to degree-seeking students, residents, clinical and research fellows. Taken together we have nearly 3,000 individuals who have come to Stanford for a degree, a certificate or the opportunity to work with one of our faculty. We are a small school of medicine in comparison to our peers, and our full-time faculty has numerous obligations to medical school and hospital teaching – including a number of undergraduate courses and educational programs. And while this is one of our most important missions, there is often no direct payment for teaching, and the time demands

for research and patient care, as well as other professional and personal obligations, continue to provide competing challenges. In fact, I would argue that allocating and protecting time for education and teaching is one of the most important responsibilities – and challenges – we face during the years ahead.

Medical Student Education: We continue to be fortunate in attracting outstanding students to join our medical school class. Since the introduction of the New Stanford Curriculum in 2003, with its focus on integrating basic science and clinical medicine and its requirement that all students must pursue a scholarly concentration, we have noted an improved alignment between our mission and goals and those of our students. In tandem with the continued evolution of the curriculum, we have also spent considerable effort in improving the advising system and in forging additional opportunities for students to benefit from the chance to engage in research and scholarship.

Going forward, we have further work to do to assure that each aspect of the curriculum is as excellent and engaging as possible. A particular challenge is the clinical rotations, which are not as uniformly excellent as I would like at this juncture, and which remain challenged by the time pressures facing many of our clinical faculty. Some of these pressures may be alleviated when the Learning and Knowledge Center is completed and robotics, virtual reality and simulation technologies provide new efficiencies. However, we are likely to continue facing the challenge of balancing the expectation of our faculty to deliver outstanding patient care with their role in clinical education and training – not only of medical students but also of residents and clinical fellows. Importantly, we also need to pay particular attention to developing and championing our students' skills in compassion and humanism and to value these as much as we do scientific and medical knowledge and technical proficiency

I, along with others, believe that we also need to do a better job of integrating a culture of professionalism into the education and training of our students and to make certain that these values are both inculcated and valued by our community of students and faculty. The bottom line is that we need a higher degree of accountability in our shared commitment to professionalism.

I also continue to be concerned that we need to be more rigorous in our evaluation of courses, interactions and each other. While I do not believe that it is necessary to introduce a traditional grading system, especially during the preclinical years, I do think we need to conduct student and faculty evaluations during clinical rotations in a more robust manner– and to hold to the highest possible standards of excellence.

During the next year we will be making decisions about whether to increase the size of our incoming medical school class. While many medical schools are exploring increases in class size from 15-30%, I do not share the view that such broad increments are needed without first addressing other important limitations of the health care system. Nonetheless, I do envision more modest increases in the number of incoming medical students at Stanford – perhaps from 86 to 100 new medical students each year. In doing

so, we would sustain our focus on educating and training future physician leaders, scholars and investigators – something I believe we can do uniquely well at Stanford.

Graduate Student Education. As you likely know we have approximately equal numbers of students pursuing PhDs as MD degrees. We also have an increasing number of students who are seeking dual degrees – and this is something we are fostering and promoting as a way of enhancing the unique potential of our students.

Appropriately, while the majority of our graduate students will continue to pursue careers in academia, many also ultimately seek opportunities in industry, education, public service or other venues. Creating options is the key. At Stanford we have both departmental based and interdepartmental degree programs. While these programs are successful, it is appropriate to consider how they can be further optimized, especially by greater interactions with programs across the university. We must also critically assess whether joint degree programs enhance or dilute the educational experience of our students. Further, we need to continue to assess whether our current programs optimize the opportunities and flexibility for our students to choose areas of study that differ from those that may have brought them to Stanford in the first place.

This past Fall we introduced a new program leading to a Master in Medicine degree to introduce graduate students to the challenges of clinical medicine with the goal of developing a cadre of basic scientists who are better poised to address fundamental problems in translational medicine and research. While we anticipate that this will serve only a subset of our graduate students, it does offer an opportunity to create further alignments between our basic and clinical science faculty and between the medical school and its clinical programs.

For all of our graduate programs, the cost of education is rising as financial support from the NIH and major foundations is declining. Clearly this is an important challenge that requires new approaches, including philanthropy, in order to assure that we can sustain these excellent programs into the future. We must, of course, address these challenges if we are to sustain our leadership in graduate education.

Postgraduate Education. Among the most important members of our academic medical center are our clinical and research fellows. While these individuals often play key roles in research and clinical programs, they rarely get the credit or accolades they deserve for the important clinical and scientific work they conduct. This is something we need to address. Indeed, without our fellows and postdocs, none of our programs would be as robust, vibrant or successful as they are. Despite the fact that fellows and postdocs represent the largest number of trainees in the medical school and medical center, their personal orbits tend to be around specific faculty or programs rather than with broader departments or the school. We need to find ways to better recognize - and support - our fellow and postdoc community. In addition to the professional challenges faced by fellows and postdocs, the long years of training and low levels of compensation impose a significant personal burden. I recognize that this is not easy to solve given all of our

financial constraints – but we must continue to do all we can to help address this challenge.

In addition, we need to address the compartmentalization of our undergraduate and postgraduate clinical training programs. Sustainance of an academic underpinning to clinical training is essential but harder to achieve in the current climate which imposes increased demands on residents and fellows and also limits their work time (albeit to 80 hours per week). It is my hope that we can create better alignments between our medical school curriculum, with its research opportunities, and the training and education of residents and fellows. To help address this I am creating the new position of Senior Associate Dean of Graduate Education, who will work closely with the Senior Associate Dean for Medical Education (now Charles Prober, who has replaced Julie Parsonnet in this role) and Senior Associate Dean for Graduate Education (now John Pringle). I am very pleased that Dr. Myriam Curet, Professor of Surgery, has agreed to take on this important role and will officially begin her work this April.

Continuing Medical Education. A number of leading medical schools and centers have nationally recognized programs in continuing medical education (CME). For a number of reasons I don't believe that Stanford is among them. Certainly we do have a number of distinguished department based programs but, for the most part, we have not excelled in CME. Last year we commissioned a task force to critically assess our CME programs. Based on the excellent and critical analysis this group conducted, it is clear that we have considerable work to do. Importantly, unlike our most successful peers in CME, we do not have a centrally coordinated effort with the appropriate standards and services. In fact, we now have a highly dispersed set of programs lacking central oversight or coordination across the Medical Center. That needs to change lest we fall even further behind in providing highly regarded programs in continuing medical education for the school and affiliated hospitals. In the near future I will be announcing how some of these changes will become actualized.

Research

Enhancing Basic Research. There can be no question that the fundamental basis for Stanford's excellence as a medical school resides in our longstanding commitment to basic inquiry and to the superb faculty who have carried out basic research during the past decades. We are fortunate to have had an outstanding basic science community, and I am pleased that we have continued to recruit – and retain – an outstanding faculty. As a nation the United States has been a world leader in biomedical research, and, while that prominence is still sustained, we are all concerned that it is now challenged by the decline in funding from the NIH. There is hardly a faculty member who has not been touched by the current negative funding climate – or who does not have anxiety about its consequences. I have written frequently about this in the past and have also relayed some of the advocacy activities we have been carrying out to address the problem.

There are a number of converging factors to reconcile: a decrease in the funds available for the investigator initiated pool (i.e., RO1) that is manifested by fewer outstandingly scored research proposals being funded. At the same time the NIH – and a

number of foundations – has put a greater emphasis on more applied and translational research. I do not doubt the importance of this latter research, but we must raise serious concerns when it compromises fundamental investigation. While we need a balance, and while so-called big science can move fields with an alacrity that exceeds that of an investigator or even an institution, it is important to underscore that the most important and truly paradigm shifting discoveries have been done by single or small groups of investigators pursuing creative ideas. Thus we need to do all we can to preserve and indeed enhance our commitment to basic science research – and I am fully committed to doing so. While we all recognize that the funding climate is difficult, we need to engage our collective creativity to help Stanford overcome the perceived barriers and leap forward. This will likely require different ways of funding research and even rethinking the settings in which it is conducted. And while I don't want to minimize the challenges that lie ahead, I do think that we will find ways to succeed as we work together on this issue – not only within Stanford but also with our colleagues at other medical schools and universities as well as with those in biotechnology and industry – as we make the case for innovation (and the funding required to foster it) to state and federal government leaders.

Promoting Translational and Interdisciplinary Research. In tandem with support for basic science research and the recognition that the innovations and technologies we are able to translate today emanate from basic discoveries made years or even decades ago, we also need to be proactive in pursuing translational medicine. Indeed, translational medicine has been central to our overarching mission, and I believe it can further distinguish Stanford as a medical school and medical center. During the past several years we have taken a number of steps to further facilitate our success in translating discoveries. These include the creation and development of the Stanford Institutes of Medicine, our pursuit of becoming an NCI-designated Cancer Center, the provision of a number of pilot awards and grants to stimulate innovation and translational research – through the School as well as Bio-X – and the development of the infrastructure to support translational research, including SPCTRM and the Jill and John Freidenrich Center for Translational Medicine. During the week ahead we will take another major step as Dr. Harry Greenberg sends off the 741-page Clinical and Translational Science Award (CTSA) proposal that he and a number of other faculty have been working on during the past year. This is a major initiative, and, if we are successful, it will have a transforming impact on Stanford. As with other programs we have been developing, our interconnection and alignments within the school and across the university serve as a truly distinguishing hallmark of our CTSA application.

Patient Care

Improving Patient Care. Our mission in patient care is what separates and distinguishes us from the other six schools at Stanford. Since I have been at Stanford, a number of clinical programs have grown or have been developed, thanks to the outstanding leadership of the clinical chairs, both those who have been newly recruited and those who were already part of the school's leadership when I arrived. Indeed, the depth and excellence of many programs have increased enormously, and as a result of their success, we are now challenged by serious capacity constraints at Stanford Hospital & Clinics (SHC) as well as at the Lucile Packard Children's Hospital (LPCH). I am quite aware that

many of our faculty are working enormously hard in providing patient care – while still trying to sustain their research and education obligations as they endeavor to succeed in academic promotion or careers. Having myself continued to be part of the clinical care service, even if for a limited amount of time, I have observed directly the significant pressures, time demands and resource challenges our faculty face virtually every day. Moreover, over time, the acuity and complexity of the patients coming to SHC and LPCH have increased – and are likely to continue doing so in the immediate future.

It is also clear that we will be increasingly judged in our clinical performance and that we will be compared to other academic medical centers as well as community hospitals in the perceived quality of the patient care we provide. In fact, reimbursements for clinical service, modeled on the pay for service programs being instituted through Medicare, will be linked to quality measures. Moreover, reporting of comparative quality measures will be public – a trend that has already commenced and that will become further standardized in the years ahead. Accordingly, we must do everything we can (which means more than we are now doing) to foster and stimulate a climate of commitment and accountability to provide the highest quality care for patients. While I recognize that virtually every physician believes that she or he is already doing this, I fully expect that, when we are assessed and compared to each other and to peer institutions, areas of deficiency will be identified. While this may be understandable to some, it is not acceptable, and we need to have the highest level of commitment –from the community of faculty, physicians, and administrative leaders- to continuously assess and improve the quality of patient care and service we are providing. To help address this, Martha Marsh, President and CEO of SHC, and I have recently appointed a leadership committee led by Dr. Norm Rizk, Senior Associate Dean for Clinical Affairs, and Dr. Kevin Tabb (Chief Quality and Medical Information Officer for SHC) to make this both an institutional priority and a continuous improvement effort. Similar efforts have been underway at LPCH during the past several years, and they have led to highly successful achievements – which also clearly need to be sustained.

In looking forward, among the biggest challenges we will face in patient care delivery will be the capacity and resource constraints at SHC and LPCH. Both facilities are now nearly always filled to capacity, and limitations in their respective physical plants are becoming ever more apparent. While I am hopeful that these will be addressed by the hospital replacement plans that I shared with you in my December 4th Newsletter, the timeline for completion of these important projects is measured in years (if not decades), and thus the pressures will remain significant for the foreseeable future. While moving some clinical services to new offsite facilities, such as the North Campus in Redwood City, will help, we will continue to face significant pressures and limitations for many years to come. This underscores the need to plan continuously for service improvements that optimize efficiency as well as quality and patient satisfaction. Clearly these are very big challenges, and they will be made even more so by the funding climate facing hospitals and medical centers and the increasing cost for construction and program development. These factors highlight even more clearly the need to work closely and collaboratively with our hospital leaders and colleagues across the Stanford University Medical Center.

Linking Research to Patient Care. In addition to providing the highest quality patient care and service, one of the factors that will most distinguish Stanford from peer institutions will be the availability of novel and innovative treatments and disease prevention strategies. This is one of the reasons why “*Translating Discoveries*” is so important to the future success of Stanford Medicine. Indeed, in the absence of a commitment to research and education, even state-of-the-art clinical programs become obsolete – or undistinguished – in just a handful of years. Without question, what distinguishes academic medical centers, including Stanford, is the quality of discovery – and ultimately its application to improving patient care. Similarly, training and educating future generations of physicians and scientists also impact the reputation and excellence of academic medical centers and teaching hospitals. Stanford clearly excels in these areas – but sustaining these programs is challenging, especially when resources become constrained. That said, what will ultimately distinguish success from mediocrity is our broad institutional priority to ensuring that our academic and clinical programs are well aligned.

From an organizational perspective, we have linked our five Stanford Institutes of Medicine with the clinical centers of excellence at SHC and LPCH. This also helps to connect research and clinical leaders and to optimize ways to enhance and facilitate the communications between clinical and basic science investigators and educators. Indeed, without continued proactive efforts, it would be natural to expect the research and clinical care communities to diverge, given the limitation of resources and the demands on time they each face, albeit for different reasons. Thus, thoughtful efforts are necessary to create pathways for communication and also opportunities for collaboration, so that knowledge can be successfully transferred – and career development appropriately achieved.

For example, clinical faculty cannot be successful as investigators or as educators if they do not have the time to carry out these activities. As increased demands for clinical service consume greater amounts of faculty time, and as clinical research or teaching become unfunded or under-funded mandates, sustaining linkages between academic and clinical opportunities becomes challenged. When not addressed proactively, clinical demands can swamp the time available for scholarship and research and lead to dissatisfaction or the inability to meet the criteria for promotion. This outcome can lead to problems in retention and to lost opportunities – for the individual and the institution - and thus represents an issue that we need to continue to work on. Of course, the bottom line is determining who can pay for or support these activities and, in making that determination, who is perceived to be valuable within the department, school and hospitals. This too will be one of the important issues we will be discussing at the upcoming Leadership Retreat – and it is also one that we will be focusing on for many years to come.

Continuing to Improve and Diversify our Faculty and Community

Although we seem large in size and complexity to the rest of the University, the Stanford School of Medicine and Medical Center is small in comparison to peer institutions. With just under 800 UTL and MCL faculty (with a cap of 900) and approximately 250 clinician educator faculty, we are still less than half the size of UCSF and less than 10% the size of Harvard Medical School. Accordingly, we must make critical decisions about each faculty appointment and reappointment and be sure that each is providing the highest degree of excellence possible. We also want to be a faculty that is as diverse as possible and that provides a panoply of skills and role models to our students and community.

By necessity we make strategic decisions about when to search for additional faculty and which areas we need to expand, renew or initiate. As we do so, we also want to be proactive in diversifying the leadership of the School and in developing the leadership skills and capacities of all of our faculty. To help with these efforts I created the new position of Senior Associate Dean for Diversity and Leadership and appointed Dr. Hannah Valentine to this role approximately two years ago. Since then we have developed clearer procedures for conducting faculty searches, particularly in the area of identifying as diverse a candidate pool as possible, and have launched a number of leadership development programs for various segments of our faculty. While we have made progress, we still have a long way to go. Without question enhancing diversity and leadership is not a point-in-time commitment but rather one that must endure as part of our institutional culture. It is certainly one of my highest priorities as well.

We are also continuing to grapple with ways of supporting our faculty and staff in light of the many demands they face in their professional lives and to doing what we can as an institution to address the issue of professional/family balance. This too is an ongoing struggle given the many pressures and demands faced by families for childcare and increasingly for eldercare. I do not want to be Pollyannaish or offer promissory notes that may be difficult or impossible to deliver. Indeed, improving diversity, promoting leadership and exercising better professional/family balance are difficult challenges, but they are ones I want to work on with you, for the sake of our collective future. That will likely require a number of cultural and procedural changes in our community, including the School of Medicine, the University and the hospitals. Further, improvements will take time – but we are committed to working on them.

Meeting Financial Challenges and Building Our Future

When the decision was made to move the School of Medicine from San Francisco to the Stanford campus nearly 50 years ago, a number of major challenges needed to be addressed that had significant impact on the then fledgling new medical school. New facilities were needed, new faculty members needed to be recruited – especially in the basic sciences- and lost members of the clinical faculty who remained in San Francisco needed to be replaced. The successful solutions to these very significant challenges helped establish the foundation that has defined the School of Medicine for the decades that followed. Now, nearly a half-century later, we face a similar set of challenges. Our education, research and clinical facilities are aging or are insufficient to meet our current and projected needs. While we have recruited wonderful faculty and students, we face

serious limitations in funding, both in research and in clinical care. These challenges are not unique to Stanford, but the resources needed to address them are considerable.

Finding the balance between the need to build new facilities and the need to support the recruitment, retention and program development of faculty and initiatives will surely be an ongoing challenge. We are fortunate in having a significant endowment, even though nearly 86% of it is restricted. In order to plan for our future as wisely as possible, we have developed a 10-year financial plan that is based on a number of relatively conservative assumptions. In tandem, we have developed a bold estimate of our philanthropic needs that is part of the Stanford Challenge, which commenced in October 2006. Among our greatest challenges is the need for new facilities and, accordingly, we have also developed a comprehensive 10-20 year plan that I outlined in my December 4, 2006 Newsletter. While there is no question that these needs are daunting, we are already making important progress, and I am optimistic that we will ultimately be successful. But I have no illusions: I doubt we will follow the shortest distance between two points as our route to success. However, given my avocation as a marathoner, I am also confident that we can make it across the finish line as long as we maintain a reasoned pace and not lose sight of our goals – however distant they may seem to be at times. That is one of the reasons why thoughtful planning (a surrogate for training) is so necessary – but so too is constant adaptation to the conditions and challenges we will surely face at different stages of this journey. Just as our predecessors helped shape and define Stanford Medical School 50 years ago, we now have the obligation to serve as the stewards of its next 50 years. With a lot of hard work – and considerable patience – we will succeed.

Reaching Out to Our Communities

I have previously discussed some of the challenges we face in overcoming the tide of public opinion regarding science and religion or in the federal support for biomedical research or the vicissitudes of our currently deficient health care system. These and many other issues require our ongoing interaction with various public and private constituencies. Thankfully, during the past several years Stanford has played an important role in a number of highly relevant public issues and debates. We are fortunate in having an excellent Office of Communications and Public Affairs whose dedicated staff has helped us enormously in getting our messages out to various communities. Most importantly, we have benefited from the thoughtful voices of numerous faculty and student leaders who have provided education, information and advocacy.

We will, of course, have to make our communication efforts even more robust. Whether in local issues regarding the important need for hospital renewal and facilities expansion to support the health care needs of the citizens of Palo Alto and our surrounding communities, or the stem cell debate in California or at the federal level, or the importance of biomedical funding from the NIH, states and private foundations, or the ethical issues governing research and professional behavior, or the need for a dramatically improved health care system, we have expertise and experience that we can – and must – add to the local and national dialogue.

In addition to the mandate for education and advocacy, we must also reach out to our communities for philanthropic support. This is more important than ever – and our success will be closely tied to how compelling and exciting our mission and opportunities are to those who will lend their support. Here too I believe we have done a terrific job of defining what we can accomplish in education, research and patient care and the unique role Stanford can play. There is no question that we will be competing against many other worthy causes, but I think we have an enormous amount to offer – as long as we stay aligned and clear in the messages we convey and in the motivations that guide them.

Stanford Medicine as A Role Model

When all is said and done, we need to remember why what we are doing is so important. As a small research-intensive School of Medicine, Stanford has the opportunity –and I believe obligation –to serve as a role model. We have worked diligently to define and fulfill our mission *to be a premier research-intensive medical school that improves health through leadership and a collaborative approach to discovery and innovation in patient care, education and research.*

While the tide of cynicism about health care, the ethical behavior of doctors, and the quality of and safety of the care they deliver, as well as the wave of anti-science sentiment that has swept policy-makers and citizens, have had a chilling impact, they do serve to underscore the work we need to do to gain the public trust in support of medicine, science and Stanford. While we are not alone in this struggle, I think we can – and must – be a leader and role model for others. In the last several years we have made some important inroads and have had significant accomplishments, but much remains to be done. So, as we begin a new year and look forward to the future, one abiding objective is to do all we can to make Stanford a role model for academic medicine – because it is the right thing to do and because we can accomplish this if we work creatively, thoughtfully and together.

Changes in Leadership

New Chair of Bioengineering: As most of you know, Scott Delp and Paul Yock asked to step down as Chair and co-chair of Bioengineering at the end of 2006. They have held these positions since the department was founded several years ago. By any measure the department is on a remarkable path to success. A set of absolutely amazing new faculty have been hired. The best Bioengineering graduate students in the country now choose Stanford as their destination. A new graduate curriculum has been developed. The idea of a department positioned between two schools has become an exciting role model for interdisciplinary activities at Stanford. And the department has become a centerpiece of the recently launched university campaign.

While many people have contributed to launching and growing this new department, Scott and Paul have been the two individuals most responsible for its success. All of us owe them a tremendous amount for the energy and enthusiasm they

have provided. Both of them expect to remain fully active in the department going forward.

Professor Jim Plummer, Dean of the School of Engineering and I are delighted to announce that Dr. Russ Altman has agreed to be the next Chair of Bioengineering. Russ will hold a joint appointment between Bioengineering and Genetics, with Bioengineering as his primary department (just as Scott holds a joint appointment between Bioengineering and ME). Russ brings a very high level of enthusiasm for the department and a vision for its future that will lead it to the next level of stature and accomplishment. Looking forward, there are tremendous opportunities for Bioengineering, including establishing an undergraduate major, designing and occupying a new building in the SEQ II, and continuing to recruit spectacular new faculty to Stanford.

Please join Jim Plummer and me in thanking Scott and Paul for the spectacular job they have done leading the department since BioE's founding, and in welcoming Russ to his new role as Chair of Bioengineering.

New Chair of Developmental Biology: We are enormously fortunate to have a terrific department of Developmental Biology at Stanford that was initially founded and led by Dr. Lucy Shapiro. For the past four years Dr. Minx Fuller has done an excellent job in serving as chair of Developmental Biology and has overseen the recruitment of outstanding new faculty and students. The department continues to thrive. Minx also served as a wonderful institutional leader and I am appreciative of her many important recommendations and accomplishments. But after four years of service, Dr. Fuller decided that it was time for her to focus her energies on her own research and teaching. Thankfully, Dr. Roel Nusse, who previously served as chair, has agreed to once again assume that mantle of leadership. I am enormously grateful to Roel and I know that the faculty in Developmental Biology are also appreciative of his renewed leadership. Again, I want to thank Minx Fuller for all of her efforts and contributions and welcome Roel to his new leadership role.

New Senior Associate Dean for Graduate Medical Education: On October 9 2006 I announced two of the three individuals who will figure prominently in defining medical and graduate student education at Stanford and also forecast the importance of creating a new position to better align residency, fellow and continuing medical education with the school's academic programs. I am very pleased to announce that Dr. Myriam Curet, Professor of Surgery, has agreed to assume these new roles starting in April 2007. Dr. Curet is a highly regarded educator who has won numerous awards as a teacher both nationally and at Stanford. She is strongly and passionately committed to education and has already served the School admirably as Associate Dean for the past two years. I am extremely pleased that she has agreed to take on this important and exciting new role and look forward to working with her in the years ahead – and most importantly, to the success that she will achieve for our medical center.

Awards and Honors

Helen M. Blau, Ph.D., Donald E. and Delia B. Baxter Professor and Director of the Baxter Laboratory in Genetic Pharmacology, has been re-elected to the governing council of the prestigious Institute of Medicine of the National Academies. Dr. Blau has served on the IOM Council since 2004 and has been elected for a second three-year term as a member of the Council's executive committee, which provides oversight for all of the institute's activities.

Dr. Alice S. Whittemore, Professor of Health Research and Policy, has been awarded this year's NCI Women in Cancer Search award, and in that capacity has just given the Rosalind Franklin lecture on "Preventing deaths from Breast and Ovarian Cancer." Congratulations, Dr. Whittemore.

Norbert Pelc, D.Sc., Professor of Radiology and Bioengineering, and by courtesy Electrical Engineering, has been elected to the College of Fellows of the American Institute for Medical and Biological Engineering (AIMBE). Membership is awarded to "leaders in the field [who] have distinguished themselves through their contributions in research, industrial practice and/or education." The award will be conferred at the Institute's annual meeting in March 2007. Congratulations, Dr. Pelc.

Appointments and Promotions

Marc Coram has been reappointed to Assistant Professor of Health Research and Policy, effective 1/1/2007.

Bingwei Lu has been reappointed to Assistant Professor of Pathology, effective 1/1/2007.