

Dean's Newsletter

February 12, 2007

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Translating Discoveries – Leading the Way

On February 1-3rd we held our School of Medicine Annual Leadership Retreat – the sixth since my arrival at Stanford in April 2001. We have used these retreats to shape our strategic planning, report progress on school-wide initiatives and address important questions and challenges facing the school and medical center. While the composition of the participants changes slightly from year-to-year based on the topics being considered, the core group of 80-90 individuals includes chairs of basic and clinical departments, institute and selected center directors and other School leaders, hospital leaders, medical and graduate students as well as resident and fellow/postdoc organization leaders, university officials, and trustees or hospital board directors. This year we also invited several faculty leaders from other schools at Stanford. The group is diverse but also focused on helping us to make the Stanford University School of Medicine the best it can be. By design the schedule is fairly demanding – but since time is precious it is important to use our retreat time wisely to truly advance our programmatic initiatives. The theme of this year's retreat was "*Translating Discoveries – Leading the Way*," and it built on the Strategic Plan that grew out of our first retreat in January 2002 (see: <http://medstrategicplan.stanford.edu/>).

Challenges Facing Academic Medical Centers: A View from the East

This year we began the retreat with a presentation from Dr. Mark McClellan, a Stanford faculty member who has been on leave in Washington, where he served sequentially as the Commissioner of the Food and Drug Administration (FDA) and, until late in 2006, as the Director of the Center for Medicare and Medicaid Services (CMS). These two enormously important leadership roles equipped Dr. McClellan with a valuable perspective on issues facing critically important federal agencies and programs – as well as healthcare and biomedical research. Further, in each of his leadership positions, Dr. McClellan helped bring about significant changes and new programmatic initiatives.

Dr. McClellan began his remarks by addressing the funding climate impacting the NIH. He affirmed a message I have also conveyed in prior Newsletters (see <http://mednews.stanford.edu/releases/2006/december/year-review.html#nih>); namely, that

following the doubling of the NIH budget between 1990-2003, the subsequent years' budgets have been flat to decreased – especially when compared to the biomedical inflation index. The impact of this trend has raised significant and growing concern among the biomedical and bioscience community. Part of the challenge is related to the fact that nearly twice the number of grant applications are being submitted now compared to the pre-doubling era. . However, it is also increasingly apparent that grants scoring ratings that would clearly have been funded just a couple of years ago are now experiencing difficulty and that even highly established investigators are encountering problems in getting funded. This situation has been also further impacted by some of the political issues that recently surrounded the NIH Reauthorization as well as the perspective in the Congress that NIH had its doubling and now other federal programs need attention – an issue made more acute by the overall decrease in discretionary funding due to the war in Iraq, tax cuts and other federal initiatives. At the same time, the NIH has directed increased attention to promoting research and education in translational research and medicine. Dr. McClellan emphasized the importance for Stanford to seize these opportunities, especially given our focus and excellence in innovation and our proximity to the biotechnology community in Silicon Valley and the Bay area.

While Dr. McClellan did not forecast budget increases for NIH that bore any resemblance to the period of doubling, he did observe that increased support for the FDA is essential and that reform of this agency is likely to occur this year. He opined that Stanford should also align some of its clinical and translational research programs to benefit from changes at the FDA, especially in novel areas of clinical trial methodology, design and analysis that employs better use of biomarkers, genomics, imaging, and improved methods of statistical analysis. Given our focus in recent years in building the infrastructure and interdisciplinary organization to foster clinical and translational research, recently exemplified by the submission of our application for a Clinical and Translational Science Award (CTSA), I would certainly say that we have been oriented toward improving and advancing our efforts in this area of research – which is also important to our distinction and uniqueness as a medical center.

Beyond research and regulation, Dr. McClellan observed that there would be an increased focus on health care reform in the years ahead, which would address in particular coverage of the uninsured and cost containment. He noted that, while some of this reform may be initiated at the federal level, the major activities were likely to emerge from the states – as has recently occurred in proposals by governors in Massachusetts, California, New York and others. The major federal initiatives will likely concentrate on entitlement programs, particularly Medicare and Medicaid. Dr. McClellan offered his view that the Part D drug coverage initiated last year has been a success (although how much the pharmaceutical companies have benefited from this approach was not discussed). He noted in particular that a major area of reform will be in aligning Medicare payments to high value care and that this will mandate the need for metrics to measure quality and service – including clinical quality, patient satisfaction, prices and cost, among others. Indeed, “pay for performance” for hospital and physician services is already becoming a reality under Medicare (see: NEJM 2007; 356:515), and there is every expectation that it will be quickly embraced by private payers. Quality and service

data will be made publicly available by rating agencies – or by institutions – and there is every reason to expect that such data will influence consumer choice about where to seek their health care.

While challenges abound, Dr. McClellan observed that, given the changes underway, there are some important opportunities for Stanford. First, he underscored that Stanford should be a leader in translational medicine. While we have certainly played a leadership role in devices and other innovations, this role should extend to biologics and drugs and should be based on novel trial design, the integration of genomics, imaging, and biomarkers, and novel alignments with biotechnology. He also observed that we should use quality performance as a measure of distinction – and even as a competitive tool. Further work is to be done in novel approaches to education and training, especially outside of the traditional hospital environment. And finally, while attention to local and regional issues is important, Dr. McClellan also underscored that in the 21st century global engagements will also impact health care and will require our attention. Each of these important challenges will affect our future. Fortunately, each has been encompassed in one fashion or another in our strategic planning – and were topics for this year's Leadership Retreat.

State-of-the-School in 2007

Building on the challenges and opportunities that I believe affect each of our missions and that I commented on in my January 15th Dean's Newsletter I followed Dr. McClellan's presentation with a perspective that raised some of the important issues that would be discussed at the retreat. I began by underscoring that 2006 had been a truly remarkable year for the medical school and that the past 5-6 years have been ones of forward momentum, excitement and success on many different fronts. However, while it is important to recognize and celebrate our many individual and collective accomplishments, our future rests more on how we address new challenges and anticipate the significant changes that will emerge, both within and outside of our institution and community, both local and global. Hence I underscored that the purpose of this retreat was to focus on the challenges– and that while this might convey some negative overtones, it is important that, as stewards of the future of Stanford, we consider these issues and develop plans to address them, not simply to survive but to excel and serve as a role model among academic medical centers.

I highlighted ten issues that, in my opinion, serve as serious challenges and even threats to our future success. I chose these areas because of their importance, because they would be topics for discussion at the retreat and because we have the opportunity to anticipate and even solve them, even though there would be many difficulties and risks. Each of these ten issues maps to various aspects of our core missions, essential values, programmatic initiatives and areas of controversy and contention. Being frank and honest with each other is an essential step to addressing such challenges – and I wanted to be sure that they were laid out in a transparent and palpable manner. This is particularly noteworthy as we stand at the threshold of the School of Medicine's Centennial in 2008 and the 50th Anniversary of the School's move from San Francisco to Palo Alto in 2009.

The ten areas were: 1) Discovery and Translation, 2) Size and Connectivity, 3) Depth and Breadth, 4) Disciplinary and Interdisciplinary, 5) Excellence, Professionalism and Quality, 6) Diversity, Leadership and Balance, 7) Resources and Renewal, 8) Program and Capital Investments, 9) Internal and External Challenges, and 10) Moving Forward and Creating Our Future. Here I will simply highlight some of the observations, comments and recommendations I offered to the retreat participants:

1. Discovery and Translation:

There can be no question that the fundamental underpinning of medicine as a discipline and Stanford as an institution is a commitment to and recognition of the importance of discovery and basic science research. Excellence in curiosity-driven fundamental inquiry has been the defining signature of the medical school and is something to be proud of and to celebrate. Indeed it is notable that the faculty and leadership at Stanford have continuously renewed this commitment by recruiting outstanding faculty and by educating and training future leaders in the biosciences. So it is ironic that, at a time of extraordinary achievement, most recently evidenced by two Nobel Prizes in 2006, more NIH Pioneer Awards than any other medical school and a host of other faculty and students awards and recognitions, there is an air of anxiety and even some tension about whether our institutional commitment to discovery science remains unwavering.

Certainly a major contributing factor is the threat of decreased funding from the NIH, which is affecting the entire bioscience community. However, this is not the sole issue. Over the past several years we have emphasized “Translating Discoveries” as our banner and overarching mission, and this emphasis has been highlighted by the increased importance that the NIH has placed on translational and clinical medicine. While I believe that I have been consistent and clear in underscoring the reality that translational medicine today is built upon a foundation in discovery science and that fundamental research is the core and centerpiece of our mission at Stanford, I have been surprised that our own great basic science faculty at times feel less valued both within the school and in the university more broadly. While this is certainly not the case, one can recognize that perceptions are important, and our focus on translating discoveries as well as the University’s highlighting of the human health initiative as part of the Stanford Challenge may seem to some to undervalue discovery science. This requires attention.

I well recall that at the first Leadership Retreat I hosted, in January 2002, there was a cultural rift between the basic sciences and the clinical sciences. This situation was partly historical and had clearly been aggravated by the crisis emanating from the failed merger and then de-merger with UCSF. Indeed, one of the most important things to emerge from the 2002 Retreat and those that have followed has been the building of bridges and relationships between the basic and clinical science communities – and, in tandem, between the medical school and the rest of the university. As I noted at the retreat, sustaining these important relationships is essential to our success as an academic medical center and begins with mutual sharing and valuing of what each of us brings to the work of enriching the school of medicine. We are a community that must value both

discovery science and translational medicine and that benefits from improved understanding, collaboration and shared values.

But this does not necessarily happen naturally. It requires effort and indeed vigilance along with the recognition that we are a community of excellence built upon our shared missions in education, research and patient care. One does not supercede the other in overall institutional importance – and each requires commitment in order to attain balance. I am personally committed to achieving that balance and to making the whole greater than the sum of our parts. But I am also cognizant that without our mutual efforts fracture lines can emerge – which we simply cannot let happen.

2. Size and Connectivity:

I have previously noted that Stanford is one of the smallest Schools of Medicine among our peers – about 40% the size of UCSF and less than 10% the faculty of Harvard Medical School. I see our small size largely as an advantage, since it forces us to make strategic choices and to appoint the highest quality faculty we can find. While I say this carefully, I believe that we have been able to accomplish this more or less across the board in our basic science appointments, where careful searches seeking the best in a field guide the selection of faculty. And while we clearly strive to identify the strongest faculty in the clinical departments as well, these selections are also driven by programmatic needs and not infrequently by fewer prospects in a national pool of potential candidates. A reality is that the national pipeline of outstanding physician-scientists is limited and a number of medical and surgical disciplines have a relative paucity of clinician-scholars, clinician-investigators and clinician-educators. Additionally, in the development of clinical programs it is almost always necessary to have a critical mass in order to provide sufficient depth of excellence and clinical coverage. Moreover, given the complexity of medicine today, it is not feasible to eliminate selected disciplines to preserve size constraints and to maintain a high quality program, especially when the emphasis is on high-end tertiary level clinical care as is the case at Stanford. So, an obvious challenge stands before us in sustaining excellence and meeting programmatic needs in the context of our current Provostial cap of 900 UTL, MCL and non-tenure line faculty. This issue has significant immediacy since we are soon to cross the number of 800 full-time faculty. Based on our projections of faculty growth and programmatic development it seems likely that we will reach the cap within the next three years and perhaps sooner.

A relevant question is the basis for the current cap. The medical center clearly benefits from being part of a great university, and all of Stanford's seven schools are small when compared to peers. But they are also excellent despite their size, and it is part of our culture to value excellence and a relatively small size. It is important to recognize the importance of balance within the University, and it is true that, should the medical school exceed the 900-faculty cap, it will become more than half the size of the total faculty of the University. While this kind of ratio is the case at many medical schools and universities, it is not part of our Stanford culture – and I readily acknowledge that we must be mindful and respectful of this reality.

But it is also clear that the detailed program planning we have done during the past 2-3 years has identified important and challenging issues related to our size. These include: (a) the size of our education programs (e.g., possibly leading to an increase in the medical school class size); (b) the need to balance the proportion of UTL, MCL and CE faculty to sustain excellence in basic science as well as clinical performance; (c) the importance of fulfilling programmatic needs to sustain the clinical programs at SHC and LPCH (which over the next 10-20 years will almost certainly require exceeding the cap by 15%); and (d) the need to maintain a faculty size that will assure the close connectivity of the medical school with the rest of the university, so that we will not have to move research faculty “off campus” and, in doing so, lose the uniqueness that has defined our ability to carry out cutting-edge interdisciplinary research. Clearly size is both a source of strength – and a serious threat to our future excellence.

3. Depth and Breadth:

Our small size may limit our depth and breadth compared to peer institutions. But, as noted above, it compels us to focus on quality and to make strategic priorities. At the same time, it imposes a challenge to individual faculty, who, because of our small size, have multiple demands and expectations. While this is true for virtually everyone, there are additional pressures for clinical faculty, who are expected to demonstrate excellence and leadership in academic pursuits as well as in clinical care. In days past, many academic medical centers celebrated the “triple threat” physician-scientists, who were purportedly great investigators, teachers and clinicians. While I do not doubt that a few individuals can excel in all of these missions, the reality today is that, in order to be a great investigator or an outstanding physician, a sizeable portion of one’s time and effort must be concentrated and focused. We need to strive to set realistic expectations and align as optimally as possible the job expectations with realities for our faculty.

At Stanford there can be no doubt that the coin of the realm is excellence in research. And while this is very much what distinguishes us as an institution, we seem to spend less time than we might valuing the important contributions that faculty make in education and patient care. This has significant implications for how our appointment and promotion process is carried out – especially for clinical faculty. One of the reasons for this challenge is the lack of support and time available for clinical faculty to develop academic proficiency. When programs are limited by size and when patient volumes and demands continue to rise, as they have in recent years at both SHC and LPCH, clinical faculty have less time for scholarship – and are not supported to do so in our current fiscal environment. This becomes a self-fulfilled prophecy, in which busy clinical faculty become less engaged in the academic missions of research and education but feel the pressure to perform and the frustrations that emerge when they cannot do so as successfully as they might like – or our institution demands. Accordingly, if we are serious about having an excellent clinical faculty to complement our basic science faculty, it is important to provide time and support for individual scholarship. But the economic demands of clinical practice and the costs associated with “non-clinical time” pose serious challenges and limitations – which must be addressed.

This represents a threat on multiple levels: a failure to support a critical mass of individuals to sustain and enhance clinical excellence, an unstated understanding that excellence in research can compensate for a lesser performance in clinical acumen and skill, and an inability of motivated clinical faculty to not only be valued for the patient care they deliver but to do so with the greatest degree of excellence while also having protected time for research and education. If not addressed successfully a false hierarchy of perceived value may emerge that could defeat the opportunity to create a community of excellence across the domains of science and medicine. As with the potential dipole of discovery and translation or that of limiting size and scope, a lack of attention to supporting depth and breadth is something on which we must focus creatively – including developing new funding sources to support the academic development and careers of clinical faculty.

4. Disciplinary and Interdisciplinary:

Academic medical centers, including Stanford, are built on a foundation of disciplines in the form of departments – both basic and clinical. Many of these disciplines were formulated during the 20th century, and a number have evolved dramatically – or will do so in the future. Whereas most medical schools when I was a student had basic science departments of anatomy, physiology, pharmacology and the like, most have evolved to more interdisciplinary areas of focus – and at Stanford, these more traditional departments or disciplines have been supplanted by new departments and programs. At the same time, most clinical departments have retained their traditional components, even though newer technologies and innovations might benefit from realignments of these traditional units. I have raised this issue in the past but recognize that major shifts such as these have significant consequences. So the alternate question is how to balance the disciplinary foundations with crosscutting interdisciplinary themes – whether they are disease focused (as some of our Stanford Institutes of Medicine) or whether they cut across traditional disciplinary boundaries (such as stem cell biology, genomics, imaging, and informatics). While there is concurrence about the need for both traditional departments and interdisciplinary efforts (e.g., institutes, centers or programs like bioengineering and BioX), there are also tensions that exist between them. Sometimes these have to do with perceptions about what is most important or valued, whereas in other situations the potential allocation of resources (space, billets, dollars) creates the challenge.

As you know, at Stanford we are committed to supporting departments, institutes and selected centers, but I am well aware that simply stating this commitment does not dissipate the understandable competition for resources. We have tried to address this sense of competition by creating a working document to define the interactions between departments and institutes, but there is no question that strong views of primacy and relative importance persist. This is an internal challenge that we must continue to work on if we are to optimize our broader institutional success. For instance, while I have no doubt that we can make compelling cases to raise philanthropic dollars for specific faculty or departmental initiatives, it is big and bold ideas that leap beyond traditional departmental disciplines that engender the most excitement in donors capable of making major investments in our vision for the future. This has been very clearly the case with

the anonymous donor who had invested tens of millions of dollars in our stem cell program or the recent gift of nearly \$40 million for SIM1. So again, we need to find balance between our disciplinary and interdisciplinary initiatives, focusing foremost on how we improve our school – and medical center – as a whole.

5. Excellence, Professionalism and Quality:

I commented above on the importance of assuring excellence in all we do. I also noted that we have been particularly successful valuing and assuring excellence in research. While we have made strides in recent years, I don't believe that we have necessarily had the same laser focus for quality and excellence in our clinical care missions. As I noted in summarizing Mark McClellan's presentation, this is an issue that will take on increasing importance in the years ahead as physician and hospital quality metrics become compared, ranked and published. I should hasten to add that during the past several years there has been such a focus at the Lucile Packard Children's Hospital in conjunction with our pediatric faculty, and, as a consequence, LPCH stands at the acme of excellence when compared to peer institutions in a number of quality and service performance measures. And while there is unquestionable commitment by the leaders of SHC and the School to quality and service performance in the adult programs, there is work to be done to achieve the levels of success we can and must achieve.

In some ways the situation in which we find ourselves in this area may be linked to an occasional over-emphasis on academic performance for clinical faculty and perhaps an under-emphasis on metrics that support clinical leadership and excellence. Our promotions process, which has not evaluated clinical performance or excellence with the same rigor and robustness as scholarship, likely aggravates this. While this is not surprising in an academic institution, it is also not acceptable in an academic medical center striving to be the best among its peers. Accordingly, increased efforts are underway to develop a plan for improvement – which is all the more important in light of the clear emphasis that physician quality and hospital service will play in the immediate future. Again, these efforts will require a number of culture and programmatic changes, and the resolve to achieve success will be a serious challenge for individuals and our entire enterprise. But here we cannot fail.

I also noted that it is important to revisit how we evaluate the quality of clinical performance of our students and trainees. They are entering a new world of standards and expectations and we will not serve them well by not addressing this more formally. This too will require cultural changes – but here too we must be forward thinking and more cognizant of the world which lies ahead.

6. Diversity, Leadership and Balance:

I have highlighted previously that we have considerable work to improving the diversity of our faculty, especially given the success Stanford has achieved in the diversity of its students. I recognize that this must be viewed as a long-term commitment, and I am pleased with the efforts of our new Office of Diversity and Leadership and, in particular, of chairs and faculty leaders who have made special efforts to seek diversity in recruitments. We all agree that we must put excellence first – but we also acknowledge

that excellence and diversity are compatible, even if challenging to fulfill. This is an area where our active partnership and commitment will be essential, and where our success or failure is readily measurable. At this point we are nowhere near where we need to be, but I have confidence that there is a broad commitment to improve our diversity, because greater diversity will benefit our entire community and because it is the right thing to do.

In tandem with diversity, fostering leadership is another critical challenge. Certainly leadership takes many forms, such as leadership as a researcher or clinician or in directing or leading programs or initiatives. During the past couple of years leadership training and mentoring have taken place under separate and joint programs sponsored by the School, SHC and LPCH. Each has met with significant success, but there is work to do on two fronts: first, in creating opportunities for as many individuals to participate in leadership training and development as possible, and second, in benefiting from the skills gained in these programs by engaging more faculty in leadership opportunities. Each is important in further enhancing our school and medical center.

Fostering balance for our faculty, given the tremendous challenges faced in meeting rigorous academic and clinical demands, remains a largely unmet goal. I have previously addressed the issues related to creating a more flexible work environment, and reports of success have been noted in the Stanford Report (<http://news-service.stanford.edu/news/2007/january24/med-flexible-012407.html>). But these are exceptions. We really need to focus more on the cultural changes that are necessary and the perceptions that map to them. We also need to develop more resources that help young faculty, in my opinion particularly women, through more day care, financial support, time and more. Here one doesn't want to be Pollyannaish or engage in false promises. We simply need to do better – but I readily acknowledge that the pathway to doing so is neither clear nor easy. But this is a major challenge for all of us.

7. Resources and Renewal:

We are fortunate to be at Stanford, which is well endowed compared to most of our peer medical schools and which has many resources at its disposal – and the opportunity to develop new ones. However, all of our resources are limited and to some degree compartmentalized. As I have noted in other writings, I celebrate and support the success of faculty and departments in creating and developing resources and reserves that help to sustain and enhance their activities. At the same time, I know that unrestricted dollars are quite limited and that the central resources within the Dean's Office are shrinking due to programmatic and capital investments we have made to foster new programs during the past several years. Among my highest priorities is to develop additional resources to support our programs and needs throughout the school as well as at the hospitals and university.

The activities directed to securing these resources come in many forms and require many participants: advocating and taking leadership on national or regional initiatives that increase support for biomedical research (e.g., NIH, CIRM); addressing issues and constituencies that impact healthcare costs and revenues; wisely developing resources that may arise from discovery, patents and royalties; and raising support through medical

development from foundations, individuals and other philanthropic communities. Because our needs are so significant (see below) we have considerable work to do in this area. But carrying out this work is essential if we are to renew our investment in people and programs.

Ultimately, the contributions we make depend on the excellence of the individuals who are part of our community. It is expensive to recruit and retain the brightest and most creative scientists, physicians and leaders – but it is imperative that we make these investments if we are to enhance our future success. New recruitments not infrequently cost upwards of a million dollars, and new facilities to support education, research and patient care cost tens to hundreds of millions of dollars or more. This is also an enormously competitive process, and, hence, an important aspect of efforts at renewal must also be the education, training and development of future leaders who can help support Stanford as well as other programs around the world. We must also be cognizant of the very real internal tensions and competitions that arise when the need for new resources is significant and the sources from which they can be raised are limited.

While I have no doubt that we each want the success of Stanford to stand proudly, when it comes down to an individual philanthropic donor or foundation, there is an inevitable struggle in balancing the needs of an individual faculty member versus her or his department. Or there are struggles between departments, centers and institutes. Or there is competition between the academic programs championed through the school and the need for clinical facilities for the hospitals. Or there is tension between the medical center needs and those of the rest of the university. These tensions, conflicts and even confrontations are predictable and expected. But what will matter going forward is how we deal with them. If any one individual, group or constituency becomes too self-focused (or indeed selfish) we will not reach the levels of success we must achieve. This is a big challenge, and I don't want to glaze over it with denial or embellish it with hyperbole. It requires forthright discussions, compromises and a consistent focus on how we can help to assure that each member of our community thrives over time. That said, I view this as one of our biggest challenge during the years ahead.

8. Program and Capital Investments:

Coupled with the need and importance for creating new resources and making strategic investments to assure our renewal, we face the practical challenge of balancing our very real needs for facilities against those for programs and investments in people. In my December 4 2006 Newsletter, I laid out what amounts to a multi-billion dollar facilities renewal and construction program encompassing the School, SHC, LPCH and PAVAMC that will, hopefully, unfold over the next 10-20 years. Given the need to meet seismic requirements and the rapidly escalating costs of construction in the Bay Area and California (and also Stanford specifically), there is enormous pressure on each of the entities to find the fiscal resources to support new facilities. The sources include loans through debt financing, excess dollars from operations or reserves and philanthropic support. Because the financial demands on each entity are considerable, there will be a constant tension in balancing how much to invest in needed capital improvements versus people and programmatic needs.

Given the limited life-cycle of buildings, the changing requirements for supporting education, research and patient care and the lack of attention to addressing some of these important issues in the past, significant investments in facilities must be made. To do so will require a focus on compartmentalizing and directing funds that might otherwise be used for programmatic development. And here lies the obvious tension and challenge. If we simply focus on building facilities we run the risk of not adequately investing in our most important resource – creative, energetic and transformative people. Indeed, if we don't maintain some balance between these competing – but highly integrated needs – we could find ourselves with either great new facilities and less excellent (or fewer) individuals to occupy them – or with an inability to recruit or retain extraordinary individuals or to build exciting new programs, simply because we lack adequate space for research, teaching and patient care. This too will be a tough issue to deal with, and it will require leadership, compromise and understanding.

9. Internal and External Challenges:

Often institutions become united by external challenges, but they can also become distracted or fractured by internal differences. When both occur in tandem the results can be devastating. Without question we must anticipate and plan for a number of important external challenges, some of which I have already addressed. It seems inevitable that there will be pressures on research funding for years to come, and we are entering a cycle where clinical revenues will almost surely decline. Further, depending on the changes in healthcare systems and support in California, nation-wide or globally, potential significant rebasing of clinical financing may follow.

While it is unlikely that these changes will occur precipitously, and most will unfold over years, it is essential to do all we can to anticipate them. This means continuing to consider ways to support faculty through potential lapses in grant funding or even declines in overall research support. It means thinking more creatively about how and where we conduct research, whether we rethink the size of research programs or the lab space that supports them. It means giving thought to the scope and size of our education programs and how they are balanced. It will mean accommodating to potential losses of funding for graduate medical education and the need to think critically about how future clinical programs are coordinated. It will require considerable planning regarding the use of information technology, for both academic and clinical programs, and for how we will relate to the global community as part of a world that is becoming more connected – and flatter (as well described by author Thomas L. Friedman). And of course it means being thoughtful and flexible about new facilities, especially with respect to timelines and adaptability, recognizing that considerable flexibility is lost once architectural plans are completed or construction begins.

Our ability to respond to external challenges will be proportionally linked to how well we can coordinate our internal ones and whether we can stay true to our mission as a research-intensive medical school and medical center. It is of course easier to do this when resources for each of our missions – in education, research and patient care – are abundant. But as the resources become challenged and more limited in one or more areas,

tensions arise that pit one group against another. We recognize these tensions will be inevitable and that they can create fracture lines that we will need to anticipate and plan for.

10. Moving Forward and Creating Our Future:

An important part of shaping our future, rather than simply reacting to a series of external and internal pressures and demands, is being clear about what we seek to be – both as individuals and as an institution. That is why I have felt that the simple exercise of strategic planning is so important. It is not that a plan is created that lasts forever – or even for years. Rather, a plan compels us to communicate and to better understand where we are aligned and where we are not. Of course this is complicated when multiple missions must be served and, in particular, when there are valid and different interpretations and viewpoints on what should be done, on what timetable and by whom. The yearly exercise of coming together as a leadership group is simply one way of creating alignments. Of course, considerable work must be done throughout the year to sustain those alignments, create new ones or repair the understandable fractures that will inevitably transpire.

To move forward successfully as individuals and institutions we must understand each other's needs – and equally if not more importantly respect them. Whether it is discovery or translational science, the size and scope of our research, education and clinical missions, the depth and breadth of faculty or programs, or the balance between our disciplinary or interdisciplinary efforts, it is important that we assure excellence, professionalism and quality along with effective leadership, increased diversity and an effort to create balance. Doing so will enable us to address the important needs to foster renewal and to garner the resources that support both programmatic and capital needs. Perhaps most importantly we must be sure that we limit internal tensions and fractiousness so that we more effectively address the internal and external challenges we will face in the years ahead. It is with that in mind that we elected to focus on a number of important questions and issues – the responses to which will determine our ability to serve as a leader that creates change and becomes a role model among academic medical center.

The Questions and Issues

In order to address some of the major challenges facing the School during the years ahead, we decided to construct the retreat around six panel presentations, each focusing on a series of major issues. However, we didn't want the discussion to be dominated by the panel. Rather we wanted to make each session as interactive as possible with the retreat participants in order to foster as much dialogue as possible – and of course to be sure that we permitted expression of differing views and the airing of important questions and possible action items. The major goal in raising the issues we chose was to begin a new process of interactive planning designed to develop potential solutions and action items. Thus the major points and issues that arose during the panel discussions are being collated and codified. They will be used to launch new strategic planning groups to help guide future program developments in the years ahead.

Accordingly, I will only share the major questions that each panel posed and leave for future reports how we will go about addressing and solving these important issues:

Panel #1: How do we sustain and enhance our strengths and excellence in basic science research in the current NIH funding climate?

Panel chair Dr. Daria Mochly-Rosen (Senior Associate Dean for Research and faculty member in Chemical and Systems Biology) and panel members Ben Barres (Neurobiology), Steve Galli (Pathology), Stuart Kim (Developmental Biology), Roel Nusse (Developmental Biology), Lucy Shapiro (Developmental Biology) and Irv Weissman (Pathology).

Among the major questions the panels considered were:

- *What should we be doing to provide an environment that continues to support innovation, excellence and scientific breakthroughs in a declining funding environment?*
- *In what ways can we ensure that the most talented and creative scientists see Stanford as the place where they will be able to do their best work?*
- *How can we develop and optimize core technologies to enhance basic research? (Will the methods that produced success in the past continue to work as well in the future?)*
- *What can we do to promote changes in NIH grant review and fund policies?*

Panel #2: What do we need to do to optimize and align educational programs across the University?

Panel chair Dr. Charles Prober (Senior Associate Dean for Medical Education and faculty member in Pediatrics) and panel members Charlie Anderson (Graduate Student in Biological Sciences), Myriam Curet (Surgery), Mark Horowitz (School of Engineering), Larry Kramer (Law School), Michael Longaker (Surgery), Julie Parsonnet (Medicine), John Pringle (Genetics) and Keyan Salari (Graduate Student in Genetics).

Among the major questions the panel and participants addresses were:

- *In what ways does it make a difference to our educational programs that the School of Medicine is part of the broader Stanford University community?*
- *How can our relatively small School of Medicine increase our educational impact?*
- *How do we augment the teaching skills and opportunities of our residents, fellows and postdocs?*

Panel #3: What do we need to do to optimize and align clinical and translational research between our departments and institutes?

Panel chair Dr. Harry Greenberg (Senior Associate Dean for Research and faculty member in Medicine) and panel members Prista Charuworn (Medical Fellow), Mark Davis (Microbiology & Immunology), Ralph Horwitz (Medicine), Tom Krummel

(Surgery), Rich Lewis (Molecular & Cellular Physiology), Frank Longo (Neurology) and Bobby Robbins (Cardio-Thoracic Surgery).

Included in the major questions to this panel and participants were:

- *Where does clinical and translational research fit in the various missions of the clinical departments, basic science departments and institutes?*
- *What is needed to make institutes succeed as clinical and translational research engines?*
- *How can we best evaluate and allocate institutional resources (core services, pilot funding, clinical research space, philanthropy dollars, etc) to clinical and translational research between institutes and departments?*

Panel #4: What do we need to do to ensure that the “Stanford Culture” encourages translational and interdisciplinary research across the University and also fosters career development and success?

Panel chair Dr. David Stevenson (Vice Dean and Senior Associate Dean for Academic Affairs and faculty member in Pediatrics) along with panel members Ann Arvin (Pediatrics), Bill Mobley (Neurology), Rick Myers (Genetics), Channing Robertson (School of Engineering), Hannah Valantine (Medicine) and Richard Zare (Chemistry – School of Humanities and Sciences).

Among the questions discussed were:

- *How can we ensure an appropriate balance between team-based and individual scholarship?*
- *How can we adapt the “up or out” rules to the needs of a more diverse professoriate?*

Panel #5: What do we need to do to optimize the connections between our research and clinical programs?

Panel chair Dr. Norm Rizk (Senior Associate Dean for Clinical Affairs and faculty member in Medicine) with panel members including: Steve Alexander (Pediatrics), Chris Dawes (LPCH), Henry Lowe (Medicine), Bill Maloney (Orthopedics), Martha Marsh (SHC), Bev Mitchell (Medicine) and Gary Steinberg (Neurosurgery).

Some of the questions considered by this panel and the participants included:

- *In order to support the clinical and translational research mission of the medical center, what features need to be included in the design of the new SHC and LPCH facilities?*
- *How can we ensure the physician coverage (i.e., critical mass) needed to sustain and grow our clinical programs while also supporting non-clinical (i.e., academic) time for physician faculty engaged in clinical and translational research?*
- *What can be done to better connect SHC and LPCH patient information systems with the patient populations needs our clinical and translational research programs?*

Panel #6: What do we need to do to facilitate School of Medicine facilities expansion and renewal?

Panel chair Philip Pizzo (Dean and faculty member in Pediatrics) along with Ryan Adesnik (University Federal Relations), Marcia Cohen (Finance & Administration), Rob Jackler (Head & Neck Surgery/Otolaryngology), Mark Krasnow (Biochemistry), David Lennox (University Architect), Bobby Robbins (Cardio-Thoracic Surgery), Doug Stewart (Medical Development)

Among the questions that were discussed were:

- *Should we proceed with a plan that requires some of our research programs to be offsite- whether at the VA, North Campus or elsewhere?*
- *How can we approach the use and management of SUMC space in new ways that will ensure its mutually beneficial and efficient use?*
- *The facilities plan is bold and significant – but also very expensive. What are the risks for proceeding with a plan that will require major fund raising as well as support from the Dean’s office, departments and university?*

Your Input is Requested

The questions posed above represent an important sampling of the issues discussed at the retreat. I am extremely interested and eager to get as much feedback as possible from throughout our Stanford community. Accordingly, I would encourage students, residents, fellows/postdocs, faculty, staff and alumni to give me their thoughts about any or all of these questions. You can respond to me directly (ppizzo@stanford.edu) or, if you prefer, to Mr. David O’Brien, Director of Strategic Planning (dob@stanford.edu). This is not a gratuitous request – I am truly interested in your feedback and input and believe it will help me to consider additional views and perspectives that can help shape our future as a leading School of Medicine.

Next Steps

We had engaging and robust discussions about each of the questions posed above and additional important issues that were raised. After the discussion points and questions are collated into sets of action items and issues to be addressed, we will assemble work groups comprised of members of our community to address the various issues and action items and develop recommendations. It is conceivable that we will resolve some of these issues in the next months, whereas others may take a year or more. Regardless, we will seek to make progress on a number of fronts since that is the only way that we can assure that we are truly serving as active stewards of our collective future.

Faculty Fellows Program a Success

During the past couple of years the School of Medicine, Stanford Hospital & Clinics and Lucile Packard Children’s Hospital have all initiated leadership development programs. While each of these programs has a different focus and set of objectives, they share in common a commitment to preparing a new generation of institutional leaders and creating a supportive and even nurturing community. Among these programs is the

Faculty Fellows Program that was initiated and launched by Dr. Hannah Valentine, Senior Associate Dean for Diversity and Leadership and Julie Mosely, Manager of Organizational Effectiveness for the School of Medicine. In this program a group of 16 faculty met regularly to learn from experienced leaders and to receive mentoring and guidance about leadership, both individually and collectively.

On Monday evening January 29th a “graduation” dinner for the Faculty Fellows was held, which I felt was celebratory and inspirational. All of the fellows shared how they felt the experience of being in this program had changed them and what that might mean for their role as future leaders. Importantly, virtually every individual commented on the important role that their mentors had played in their personal development and how they felt part of a new community – and part of the School of Medicine. Equally importantly, the mentors and faculty came from both basic and clinical science backgrounds, but that distinction diminished in importance as basic science mentors worked with clinical faculty and vice versa – further affirming the importance and possibility of fostering a unified community of excellence at Stanford.

I want to thank in particular Hannah Valentine and Julie Mosely for the tremendous efforts they put into developing this program. Every participant sang their praises – and quite appropriately so. I also want to thank the Faculty Mentors who contributed time and energy to making this program successful. This years faculty mentors included:

- Ann Leung, MD, Professor of Radiology
- Suzanne Pfeffer, PhD, Professor and Past Chair of Biochemistry
- Oscar Salvatierra, MD, Professor of Surgery
- Gary Steinberg, MD, PhD, Professor and Chair of Neurosurgery and Neurosciences

I also want to list the 2006 Faculty Fellows so that those of you interested in participating in future programs can learn more directly about their experiences. They were:

- Janice ‘Wes’ Brown, Associate Professor of Medicine
- James Chen, Assistant Professor of Chemical and Systems Biology
- Clifford Chin, Associate Professor of Pediatrics
- Myriam Curet, Professor of Surgery
- Ricardo Dometsch, Assistant Professor of Neurobiology
- Romona Doyle, Associate Professor of Medicine
- Tracy Doyle, Assistant Professor of Pathology
- Iris Gibbs, Assistant Professor of Radiation Oncology
- Sabine Girod, Assistant Professor of Surgery
- Hayes Gladstone, Assistant Professor of Dermatology
- Anthony Oro, Associate Professor of Dermatology
- Minnie Sarwal, Associate Professor of Pediatrics
- Erick Sibley, Associate Professor of Pediatrics

- Eric Sokol, Assistant Professor of Obstetrics and Gynecology
- Karl Sylvester, Assistant Professor of Surgery
- Sharon Williams, Assistant Professor of Psychiatry

I am proud of the contributions made by each of these individuals to work on behalf of making Stanford a better institution, and I hope that in the years ahead we will continue to benefit from the transfer of knowledge and skills for noted leaders to the next generation of leaders.

Doctors and Industry: Lessons from the Past

Over recent years there has been considerable attention to the role of doctors in marketing and industry relations. And while our attention has focused on the role of gifts and other financial inducements that lead physicians to cross the boundary between being objective health care providers and being industry marketers (something that we are working to ban at Stanford – see <http://med.stanford.edu/coi/siip/>), Rob and Laurie Jackler have reopened a window into the amusing and disturbing role that doctors played in helping the tobacco industry to promote smoking. Their fascinating work can be seen at the Lane Library and is described on our website at: http://med.stanford.edu/about_photo/. It is a remarkable albeit sad history and serves as reminder of why doctors should not cross the line between being health care providers to marketing drugs and devices – or, in the story told by the Jacklers, promoting something that was ultimately shown to be a serious health hazard.

I want to commend Rob and Laurie Jackler for their efforts to share this story with us.

Connecting Our Elements: Progress on SIM1 and the LKC

The following information is provided by Maggie Saunders, Program Manager for the Learning and Knowledge Center and the so-called Connective Elements Project. Because construction on the connective elements project will begin this spring, it is important you become more aware of what is about to transpire. The good news is that we will soon be getting underway with the first steps in our facilities master plan. Over time this will redefine our medical campus. The other good news is that you can look at this next phase as a health improvement opportunity since it will increase your walking and exercise program. Of course that means that the bad news is that a number of parking spaces will be disappearing, and this will require you to do some planning. Here's the report from Maggie Saunders:

Many of you have heard about or participated in the Connective Elements and/or the Learning and Knowledge Center (LKC) projects. The LKC project will be a new building constructed on the site of the Fairchild Auditorium. It will house new classrooms, an immersive and simulation-based learning center, a conference center, a cafe, the Dean's Offices, student study and social facilities. We have just completed the schematic design phase for LKC project and will seek Design

approval at the Land and Buildings Committee meeting of the Board of Trustees on February 12th. We hope to break ground on the LKC during spring or summer of 2008.

The Connective Elements or CE project, however, will start construction imminently. The CE Project addresses numerous site issues, foremost among them to create a front door to the School of Medicine. A secondary goal of the CE project is to move most service and delivery for the School of Medicine into the underground tunnel network accessed through a central loading dock facility. To accomplish these two goals we need to complete an additional, and significant, utility relocation project and build a new stretch of tunnel in front of the CCSR building. We have just completed the design phases for the Utilities Relocation project and hope to secure project approval at the February 12th Land and Buildings Committee meeting.

We will begin construction with enormous excitement and some trepidation. With construction will come at least three years of dust, noise, and controlled chaos. We will see a significant change in the parking situation to which we have become accustomed. The School of Medicine, as is true of the other Schools at the University, will be moving the majority of its parking to the perimeter of the School outside of Campus Drive. The main parking lot will become a front entry plaza, green lawn and the site of SIM1 and the Central Loading Dock. In short, the parking will move to the next closest areas including the surface parking lots at Stockfarm and the corner of Panama and Campus Drive as well as the parking garages on Roth Way, Stockfarm and in front of the Stanford Hospital. Maggie Saunders has been working with Parking and Transportation to develop the interim parking plans during construction as well as a long term parking plan. There will be a number of efforts to communicate the plans with the School of Medicine community: a Town Hall Meeting on February 26th at 11:30 a.m. in Fairchild Auditorium, as well as signs, departmental presentations and e-mail notices.

In addition to parking there is a significant and concerted effort to clear the tunnels, currently used for storage and -80 freezers. The new model for receiving and delivery to the School requires that the tunnels be dedicated to delivery vehicles and pedestrian traffic. The items in the tunnels have been inventoried, and the lab managers responsible for the inventory have been assembled into a working committee. This group is actively working to identify which items can be emptied and prepared for disposal versus those that must be retained and relocated. Please work with your lab managers to expedite this process as soon as possible.

But on the whole, the excitement far outweighs the trepidation. Towards the end of April we will break ground on the utilities relocation project. This project precedes the CCSR tunnel, Central Loading Dock and the LKC. We anticipate that the utilities work will be mostly completed by Fall 2007 at which time we

will begin construction on the new Loading Dock and the tunnel in front of CCSR. Construction of the LKC and SIM1 will follow soon after completion of the dock and tunnel. When the LKC, Connective Elements and SIM1 are complete there will be a new “front door” to the School of Medicine, with a sign, “Stanford University School of Medicine.” In addition to the new facilities in the LKC and SIM1, there will be a beautiful green lawn and entrance plaza marking completion of the first quad in the School’s long-range facilities master plan.

Stanford Institute on Immunity, Transplantation and Infection Hosts Mini-Med School

On Monday evening February 5th the Stanford Institute for Immunity, Transplantation and Infection (ITI) hosted a community education “mini-med school” entitled *Playing Defense: Understanding your Immune System*. The evening began with a keynote address by ITI Director Mark Davis on “*Making the Most of the Body’s Own Defenses*.” This set the stage for three breakout sections that focused on interesting and exciting areas of research and clinical care. These included:

- Immunity: led by Drs. Gary Fathman, Mark Genovese and PJ Utz
- Transplantation: led by Drs. Andrew Bonham, Stephan Busque and Sam Srober.
- Infection: led by Drs. Karla Kierkegaard, Jose Montoya, David Relman and Lucy Tompkins

Over 200 hundred members of the community attended the evening’s events. I had the opportunity to move among the breakout sessions and was impressed and pleased by the quality of the presentations and discussions – and of course by the interest and appreciation of our community.

Thanks to our Office of Medical Development and especially Ms. June Lang for coordinating this special evening event.

Clinical Transformation at LPCH

The Clinical Transformation Program (CTP) at the Lucile Packard Children’s Hospital (LPCH) involves the implementation of a new care delivery and documentation model supported by a patient-centric electronic health. One of the critical goals of the CTP is to improve patient safety. Dr. Jin Hahn, Professor of Neurology and Neurological Sciences and of Pediatrics and, by courtesy, of Neurosurgery at the Stanford University Medical Center, asked me to update you on the current program status and I thank him for providing the information that follows (also additional background information on the Clinical Transformation Project can be found at:

<https://intranet.lpch.org/links/projectLog/2006q4.html#20061205ctpUpdateAppreciation>.

During past year the project team has been busy activating CDC Growth Charts, Document Imaging, Transfusion Services Orders and Results, and Automated Results Notification via Pager. These are significant accomplishments and I certainly want to commend Dr. Hahn and his team for the progress they have made.

The current year we will bring additional major enhancements. Care Provider Order Entry (CPOE) will be launched in the autumn of 2007 and will replace paper-based orders. Physicians and other providers will be entering their orders directly into LINKS on LPCH inpatients. Physicians will be able to enter orders from all hospital locations as well as remotely. Verbal orders will only be accepted in limited situations, such as if the care provider is scrubbed, in code situations, or has no LINKS access. Further information about these new functions of LINKS can be found at: <https://intranet.lpch.org/links/projectLog/2006q4.html#20061205ctpUpdateContents>

Design teams have focused on several critical aspects of successful CPOE implementation including application design, building electronic order sets, and ensuring adequate access to computer devices. The CTP has completed the Planning and Design Phases and is now in the system Build Phase. Dr Hahn and his team will be sending regular communications to the LPCH Medical Staff to update you on the progress they are making. Satellite locations, such as Packard at El Camino, will be brought on-line after stabilization of Phase 2 on the main campus. Changes will be phased in gradually, taking into consideration numerous factors and concurrent changes within LPCH. Additional changes in functionality will be introduced throughout the next several years. These include outpatient CPOE and other ambulatory care workflow enhancements. LPCH is beginning to plan for the future.

Concurrently Stanford Hospital & Clinics is also busy at work on its EPIC implementation and clinical transformation projects and I will provide updates about their progress in subsequent Newsletters.

Offerings and Performances in the Arts and the Humanities

Dr. Audrey Shafer, who directs the Scholarly Concentration in Arts, Humanities and Bioethics, asked me to inform you about some exciting offerings that are coming up in the next couple of months. These include:

- **Wednesday, February 21st at 12:30 pm**, a violin concert will be given by *Jennifer Wey*, associate concertmaster of the San Francisco Symphony Youth Orchestra will be given in the Stanford Hospital Atrium as part of the Bing Music Series and thanks to a generous gift from an SHC employee who wished to remain anonymous – but to whom we offer our sincere appreciation.
- **Thursday, February 22nd at 5pm** *Dr. Richard Kogan*, celebrated concert pianist, psychiatrist and Director of the Human Sexuality Program at New York Presbyterian-Weil Cornell Medical Center, will deliver a concert and lecture entitled “Music and Medicine: the Life, Art and Illness of George Gershwin”. This event will take place in the Fairchild Auditorium.

- **Wednesday March 7th at 5pm**, The Writers Forum @ Stanford School of Medicine will be held in the Fairchild Auditorium and will include readings by:
 - **Dr. Daniel Mason** (UCSF '04), Palo Alto native and author of the national best seller, "*The Piano Tuner*", will read from his new book "*A Far Country*".
 - **Joshua Spanogle**, Stanford Medical Student and author of the medical thriller "*Isolation Ward*" will read from his forthcoming book, "*Flawless*".
 - **Dr. Audrey Shafer**, Associate Professor of Anesthesia and director of the Stanford Arts and Humanities program, will read from her recently published children's novel entitled "*The Mailbox*".

In addition to these exciting offerings, I have previously mentioned that the School is hosting some new plays that confront biomedical issues which you might enjoy attending. <http://mednews.stanford.edu/releases/2007/february/plays.html>. They are on February 22nd and March 15th.

Awards and Honors

- **Ann and John Doerr Medical Directorship.** On Thursday evening February 8th Martha Marsh and I had the opportunity to formally thank Ann and John Doerr for their \$4 million gift to establish a medical directorship in their name that will be held by the director of the clinical cancer center. The first incumbent of this new directorship is Dr. Steve Leibel. It was a wonderful opportunity to acknowledge the most appreciated donation by the Doerrs and also to celebrate and honor the contributions of Dr. Leibel as the first Ann and John Doerr Medical Director.
- **Michael T. Longaker, Deane P. and Louise Mitchell Professor in Plastic and Reconstructive Surgery**, has been elected to the position of President of the Society of University Surgeons 2007-2008 as the 69th President. The Society of University Surgeons (SUS) is widely recognized as the world's premier organization dedicated to the advancement of surgical sciences.

Appointments and Promotions

- **Deborah M. Alcorn** has been reappointed to Associate Professor of Ophthalmology, effective 2/01/07.
- **Jenifer L. Culver** has been promoted to Clinical Assistant Professor of Psychiatry and Behavioral Sciences, effective 2/01/07.
- **Jessica S. Donington** has been reappointed to Assistant Professor of Cardiothoracic Surgery, effective 2/01/07.

- **Jonathan D. Feldman** has been promoted to Clinical Associate Professor of Pediatrics, effective 4/01/06.
- **Howard Fenn** has been reappointed to Clinical Associate Professor (Affiliated) of Psychiatry and Behavioral Sciences, effective 09/01/06.
- **Neville H. Golden** has been appointed to Professor of Pediatrics (Adolescent Medicine) at the Lucile Salter Packard Children's Hospital, effective 2/01/07.
- **Christoph B. Egger Halbeis** has been promoted to Clinical Assistant Professor of Anesthesia, effective 2/01/07.
- **Thomas H.S. Hsu** has been reappointed to Assistant Professor of Urology, effective 2/01/07.
- **Booil Jo** has been reappointed to Assistant Professor of Psychiatry and Behavioral Sciences, effective 4/01/07.
- **Tracy Kuo** has been promoted to Clinical Assistant Professor of Psychiatry and Behavioral Sciences, effective 1/01/07.
- **Nancy Morioka-Douglas** has been promoted to Clinical Professor of Medicine, effective, 09/01/06.
- **Jane Morton** has been reappointed to Clinical Professor of Pediatrics, effective 11/16/06.
- **Yasodha Natkunam** has been promoted to Associate Professor of Pathology effective, 2/01/07.
- **Sunita Pal** has been promoted to Clinical Assistant Professor of Radiology, effective 2/01/07.
- **Jeffrey H. Reese** has been promoted to Clinical Professor of Urology, effective, 09/01/06
- **Hamed Sajjadi** has been reappointed as Clinical Associate Professor (Affiliated) of Otolaryngology – Head and Neck Surgery, effective 5/01/07.
- **Kathryn J. Stevens** has been reappointed to Assistant Professor of Radiology, effective 2/01/07.
- **Lindsey GC Vokach-Brodsky** has been promoted to Clinical Associate Professor of Anesthesia, effective 10/16/06.

- ***Douglas Wallace*** has been appointed to Clinical Associate Professor of Cardiothoracic Surgery, effective 1/16/07.
- ***Stephen Bryan Williams*** has been promoted to Clinical Assistant Professor of Medicine, effective 1/01/07.
- ***Dean Winslow*** has been reappointed to Clinical Professor (Affiliated) of Medicine, effective 09/01/06.
- ***Frances Wren*** has been appointed to Assistant Professor of Psychiatry and Behavioral Sciences, effective 2/01/07.
- ***Joseph C. Wu*** has been appointed to Assistant Professor of Radiology, effective 2/01/07.
- ***Imad Yamout*** has been promoted to Clinical Assistant Professor of Anesthesia, effective 10/16/06.