

## Dean's Newsletter

### July 9, 2007

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#### **Board of Trustees Approves Plan to Help University Building Projects**

In the December 4, 2006 Dean's Newsletter I delineated the plans and timelines for physically transforming the School of Medicine and the Medical Center during the next 10-15 years. Among the major changes being planned are the new Learning and Knowledge Center (for which the preparative is already underway), the Stanford Institutes of Medicine (SIM) 1-3, and the Foundations in Medicine (FIM) 1-3. Some of these (e.g., the LKC and SIMs) are incremental new facilities, whereas others (e.g., the FIMs) are new facilities that replace ones whose life cannot be productively and financially extended (e.g., Gale, Alway, Lane and Edwards buildings). To make room for these new facilities, an exciting new master plan for the Medical School has been developed which, when completed, will result in a wonderful environment for learning and research that is closely aligned to patient care facilities, and that will serve future generations of students, faculty and staff deep into the School's next century. Equally important, the transformed medical school campus we are now developing will offer important connections and alignments to the University, particularly to the Schools of Engineering and Humanities and Sciences. These physical contiguities help make Stanford unique and promote and facilitate the exciting interdisciplinary programs in research and education underway and being developed.

In tandem with the developments on the School of Medicine footprint, we are also collaborating with the School of Engineering in the development of a new Bioengineering building that will be housed on the Science and Engineering Quad 2 (SEQ2). We are also working with our colleagues at the Palo Alto VA Medical Center to develop one or more research facilities that will facilitate and enhance selected areas of program alignment. It is important to point out that these exciting and transformative changes are guided by the results of our comprehensive Strategic Planning efforts over the past several years that helped define our overarching mission in *Translating Discoveries*, and closely connect our defined missions in education, research and patient care.

The construction plans of the School of Medicine are coupled with equally exciting and compelling plans at the Stanford Hospital & Clinics (SHC) and the Lucile Packard Children's Hospital (LPCH). To provide the highest quality patient care and service as well as meet California seismic mandates, SHC is planning a replacement hospital facility that will ultimately provide the most advanced patient care facilities available. Similarly, LPCH will be expanding its facilities so that it can continue to provide the most sophisticated and highest quality pediatric services. The timing of these new hospital facilities will also occur during the next 10-15 years. Thus at the conclusion of this process Stanford Medicine will be even better able to serve patients from our communities locally and beyond so that they will benefit from the important innovations and discoveries made by our faculty and students. Taken together we have crafted a bold vision for the future – but one that is compatible and consonant with a world-class institution and the spirit of the *Stanford Challenge*.

Needless to say, bold visions are also expensive and when the new facility and related infrastructure projects are combined, the cost for just the School of Medicine components of these projects is currently estimated at approximately \$1.3 billion in cost-inflation dollars. Of course we have coupled our facilities planning with equally comprehensive financial planning to assess the feasibility of these projects as well as equally detailed program planning to assure that the projected space will support our long-term program plans and requirements. While portions of these facilities will be funded through debt as well as school and departmental resources and from the President's fund, the largest source is projected to come from philanthropy. Accordingly, we have also been deeply engaged in expanding our Office of Medical Development and in working closely with both Medical School and University leaders to help raise the funds necessary to move these projects forward. This will be a constant and ongoing process but it is important to note that we are making real progress thanks to the efforts of many individuals – especially the wonderful members of our community locally and globally who are stepping forward to help support our facilities and programs. We are deeply appreciative of these wonderful gifts and contributions, and will do all we can to honor those who have placed their trust and resources in helping to make Stanford a leading research-intensive School of Medicine for the 21<sup>st</sup> century.

Despite our progress to date, it is clear that the challenges before us are significant because of the size and scope of the transformative plan we envision. This is also true of the broader University's plans envisioned through the *Stanford Challenge*. While significant progress has already been made toward the \$4.3 fundraising goal that was announced with the Stanford Challenge in October 2006, it is widely appreciated that raising support for facilities is particularly difficult. Since it is recognized that committing significant resources to capital projects from operating and reserve budgets would require limiting program development throughout the university, the Board of Trustees has considered a number of options and alternatives. While one approach might be to fund projects through increased debt borrowing, this runs the risk of seriously impacting future resources that might be available for the University as well as the School of Medicine. There needs to be a balance between how much debt is leveraged to

support capital programs. Further, the Trustees, who are the ultimate fiduciaries for the University, want to be mindful of how resources from sources like endowments are available to future generations, as well as to those currently responsible for the stewardship of Stanford. Recognizing these challenges, the Board of Trustees announced a decision on June 13, 2007 to increase the endowment payout rate from 5% to 5.5% for the next five years. This increased payout will free up unrestricted funds that can be dedicated to support major facility projects. Because the annual returns on the “Merged Endowment Pool” has averaged 15% during the past 25 years, increasing the payout rate now will provide an immediate source of funds with relatively minimal impact on the long-term financial viability of the university’s endowment. This higher payout rate will be monitored closely with adjustments made should the current market forecasts change. With this decision, each school has been asked to develop plans by which unrestricted general funds can be used for major facility projects.

Because endowment income must be spent in accordance with the specific restrictions of each endowment (and there are over 6000 separate endowment accounts throughout the University!), it is envisioned that the incremental endowment income can be used in place of unrestricted school funds that would be allocated through the operating budget and related programs. Each School has been asked by the Board of Trustees to set up account(s) for the dollars that would be sequestered by this process and which would be used to help support major facilities. Because the School of Medicine is a “formula school”, we have been working on a plan that will permit us to achieve the directive of the Board of Trustees based on the School’s endowment resources – which were at \$2.13 billion as of April 30, 2007. The school’s endowment is located in a wide variety of accounts including central and department funds and endowed professorships— which in the aggregate will yield more than \$26 million in incremental payout per year under the new Board of Trustees’ policy. To assure that we can fulfill the Board of Trustees’ mandate, the Dean’s Office will be working with central funding sources as well as those held in departmental and professorship accounts to permit the appropriate exchanges to take place. Importantly this will **not** result in any decrement of funds coming to faculty, departments or school than would have taken place in the absence of this change in endowment payout policy – which is good news. Indeed had the Board of Trustees not taken this important decision, it is likely that reductions in general operating dollars would have been necessary to meet essential capital developments. Notably, these capital projects can also be envisioned as the conversion of selected financial assets into physical assets – both of which are part of the endowment we will leave to future generations of students and faculty.

While the implementation of this new policy will require the cooperation of faculty and departments, it offers an important step in helping to achieve the facilities plan that I outlined above. While we will continue to raise as many funds as we can from philanthropy, this new policy will reduce the need to leverage excessive debt and will help provide resources to support projects that may be less achievable from fundraising sources. It should be obvious that the Board of Trustees and University leadership will be closely monitoring how we utilize these resources and whether we are fulfilling their expectations based on this important financial decision. I am confident that we will do so

– and pleased that these new resources will help us with the transformative facilities plan that I summarized above and that I have discussed in more detail in prior Newsletters. Unquestionably this is a major step forward for the School of Medicine and the Stanford University.

### **Defining the Research Laboratory of the Future**

To help guide our thinking about the size and scope of the research laboratory of the future, I charged a group of faculty and staff to examine this issue. The goal of this committee was to offer as enlightened a view as possible on how we should best plan for new laboratory space – whether in the SIMs or FIMs – and how research space should be most optimally utilized in the decades ahead. A group of faculty and staff led by Nancy Tierney, Tim Gadus, John Pringle and Daria Mochly-Rosen grappled with these questions, sought advice from the research community at Stanford (over 200 faculty responded to a survey on this issue) and, based on this work, generated a thoughtful and helpful report. You can access their May 2007 report on “Defining the Research Facilities Model of the Future” at <http://medfacilities.stanford.edu/space/downloads/TaskForceReport.pdf>. I would encourage you to review their report and offer any additional comments you have to Nancy Tierney or John Pringle. In turn I want to thank all who worked on this committee or who contributed to the data collection. This work is already helping to shape our planning for future research facilities at Stanford.

### **Getting Our Message to the Community on Hospital Renewal and Expansion**

As I described above, the Medical Center facilities plans include major capital projects for the School of Medicine, Stanford Hospital & Clinics (SHC) and the Lucile Packard Children’s Hospital (LPCH). These essential projects are critical to the future of the Medical Center and the communities it serves. While the entirety of the hospital renewal and replacement projects are all in the City of Palo Alto, the facilities projects of the School are only partly in Palo Alto (e.g., the Foundations in Medicine (FIMs) that replace the Gale, Alway, Lane and Edwards buildings); the remainder of the facilities projects (e.g., Learning and Knowledge Center and the Stanford Institutes of Medicine 1-3) are governed by the County of Santa Clara and the “General Use Permit (GUP).” Accordingly, together with the leaders at SHC and LPCH we have been working closely on the “Entitlement Process” with the City of Palo Alto. Because some of you reside in Palo Alto and others have friends and colleagues who do, it is important for each of us to be cognizant of the key reasons why the hospital replacement and renewal projects are so critical and essential to our community. I would like to share some of the reasons with you so that if you are queried, you can respond knowledgeably. Equally importantly I would hope that you would serve as an advocate for these important projects. If you have questions or concerns, please do not hesitate to raise them with me or other leaders in the Medical Center.

Among the major reasons why we (the School, SHC and LPCH) believe the Stanford renewal and replacement projects are so important are:

- **Our patients deserve the best medical care in modern facilities:** New medical innovations and discoveries emanating from basic and clinical research help to assure advances in patient care. Moreover, complex treatments available at SHC and LPCH require a new design for modern facilities. We want to ensure that our quality of care will continue to keep pace with cutting edge technologies and advances in new treatment strategies that optimize patient recovery. Our new facilities will take advantage of the tremendous benefits that emerge from having the hospitals and the School of Medicine housed together. It also means that medical breakthroughs developed at Stanford and in conjunction with the biotechnology and device industry that is uniquely available in Silicon Valley will thus be available in our immediate community.
- **We want to be here when you need us most:** Whether it's a personal emergency, a pandemic or environmental catastrophe (like an earthquake), we want to make certain that we're here for the Palo Alto and the surrounding communities – at the time they need us most. Right now we are turning away hundreds of patients who need emergency or state-of-the-art medical care because of the limitations on our facilities. Rebuilding our hospitals to make them earthquake safe and expanding our emergency capacity will ensure we will be available to help our community in the times of greatest need.
- **We need to take down the “No Vacancy” Sign:** The hospitals must have more space to meet the growing needs of our community. LPCH has an acute shortage of beds and has been forced to turn away critically ill children and refer them to other facilities. SHC cannot admit many adult patients because of a shortage of rooms. Moreover, better management of infectious diseases, single patient occupancy rooms – something that would exist in the new facilities - would facilitate medical and surgical treatments and patient recovery. In addition, the Emergency Medical Facilities for SHC and LCPH are seriously undersized and need replacement.

These are just some of the important factors that mandate the hospital renewal and replacement projects. This month SHC, LPCH and the School sent out some 80,000 copies of the first edition of Stanford Medicine News, a new publication designed to provide updates to the community on the important activities taking place at the Medical Center. Palo Alto is unique in having such an extraordinary medical resource in its own backyard and we need to do all we can to help educate our community about why the preservation and enhancement of the Medical Center is essential to the health and well-being of our community. I hope you will do all you can to help with this education process.

### **A Focus on Quality**

There is an increasing public focus on the quality of patient care being provided at community and teaching hospitals reflected in publicly accessible reports that compare

hospitals locally and nationally on various quality outcome measures. This is being coupled with an effort by a number of payers, including CMS (the Center for Medicare and Medicaid Services) to link hospital payments to comparative performance. Among the most well known sources now providing information about hospital and physician performance are the *University Healthcare Consortium*, *Leapfrog*, *Hospital Compare* and *US News & World Reports*. While some are reputation scores, an increasing number are based on more objective metrics of quality performance. Certainly among our very highest institutional priorities is the delivery of the highest quality patient care possible. But it is also clear that our reputation – and financial success as a medical center - will be strongly impacted by how we perform on a variety of quality metrics in comparison to peer institutions. Indeed recent months have seen dramatic reports of hospital success or failure based on how well institutions measure up to these comparative metrics. Needless to say, the scope and validity of the quality measures that are chosen by various organizations can impact outcomes – as can the types of patients and severity of illness being treated at any one center. While innovation and discovery are important aspects of our mission and can differentiate us from our peers, we also need to measure up on the comparative metrics that are being employed. And while many physicians and faculty may quickly retort that these comparative metrics are inappropriate for their type of practice or what they believe constitutes “state-of-the-art” care, especially if they are not rated favorably, such protestations will accomplish little other than deflect us from the reality that irrespective of our opinion, we must work to achieve success on the comparative metrics as a starting point. That said, we can also embrace quality measures into our culture and academic enterprise and thus help shape the national discourse taking place on which metrics to employ and what truly represents outstanding quality of care. But we will only have a voice that will be listened to when we offer our comments and recommendations from a platform of excellence in the defined metrics of quality.

Some of our plans and efforts to achieve outstanding quality of patient care were recently presented to the Board of Directors at SHC and LPCH as well as to the Medical Center Committee of the Board of Trustees. These have been based on joint efforts of faculty and school leaders and hospital leaders. A highly successful program focused on quality and safety has been in place at LPCH for the past 5 years and has yielded considerable success. Indeed, LPCH has received recognition from payers such as Aetna and Blue Shield for “Excellence in Patient Safety and Health Care Quality.” Moreover, LPCH recently ranked #1 in the nation by the Leapfrog Survey assessing evidence-based measures of quality and safety; it has also had the distinction of being a two-time winner of the “Race for Results” from CHCA and its national prominence has enabled LPCH to help shape the debate and discussion about efforts to improve patient quality and safety. Importantly, there is an alignment of faculty and hospital leaders at LPCH in these areas along with a culture of oversight and expectation by the hospital Board of Directors that helps assure continued process improvements. While the metrics used in assessing pediatric practice are simpler and perhaps less rigorous than those being employed at adult hospitals, LPCH is well positioned to continue to improve and to address the new challenges that will unfold in the years ahead.

During the past six months, leaders at SHC and the School of Medicine have worked diligently to develop additional programs and opportunities to enhance their integrated performance on meeting quality and safety metrics. These efforts will be overseen by the Hospital CEO and Dean and will regularly present progress reports to the SHC/SoM community and its Board of Directors. Dr. Kevin Tabb, Chief Quality and Medical Information Officer at SHC and Dr. Norm Rizk, Senior Associate Dean for Clinical Affairs, have overseen a comprehensive Working Group on Quality to generate programs and policies to improve patient quality for SHC. A number of clinical department chairs and hospital leaders participated in this process which made clear that to be successful in this arena, every chair, deputy chief and medical director needs to develop explicit requirements in patient quality for every member of the medical staff. To help facilitate this, we will seek ways for quality patient care performance to be integrated into both the appointment and promotions process for clinical faculty and also into incentive performance bonuses. In tandem, a curriculum will be developed on patient quality that will be used to teach and guide medical students, residents and fellows about the importance of a systematic approach to patient quality. Indeed it is recognized that these metrics will be a critical facet of patient care systems forever more.

To help monitor and facilitate the organizational and the cultural changes that are needed to create a broad medical center climate of quality, SHC is investing considerable resources to expand its quality improvement and patient safety department and to align these services the medical directors and clinical chairs to develop specific quality improvement plans, data analysis and reporting. Of course this will require clinical chairs to personally review and act on these data and to develop annual quality improvement action plans with clear timelines. To underscore the importance of these efforts, senior hospital leaders as well as chairs and school leaders will be evaluated on their performance (and that of their faculty and staff) and have a portion of incentive compensation linked to outcomes.

To help further our efforts in quality it is also planned that SHC and the School of Medicine will create a Center for Quality and Effectiveness that will enable Stanford to lead in clinical quality and in research and scholarship for quality and effectiveness. This new Center will help develop processes and outcomes to assess clinical care, address the gap between outcomes achieved in clinical research and those achieved in clinical practice and help remediate the inequalities in health care access and outcome impacted by factors such as race, gender, and social class among others. I am pleased to note that Dr. Ralph Horwitz, Arthur L Bloomfield Professor of Medicine and Chair of the Department of Medicine has agreed to lead the development of the Center for Quality and Effectiveness.

It is also clear that being transparent about our outcomes and quality metrics, including both areas of success or failure, is of critical importance. Accordingly, a biweekly “quality alert” report is now being sent to hospital and faculty leaders. Moreover, within six months SHC plans to proactively publish institutional core measures of performance on its own website – a practice that has already been established at LPCH. In addition to regular communications and updates at departmental

meetings, the Council of Clinical Chairs, Board of Director meetings, etc., we will also host an annual “quality summit” that brings together faculty, community and hospital leaders to assess where we are – and where we need to go – to become a true leader in this emerging field.

Importantly a number of these activities, policies and programs have been or will soon be launched. While this is important it is abundantly clear that ongoing and across the board efforts will be needed if we are to be successful. Indeed, every community and faculty physician, each chair and medical director and hospital staff– together with School and Hospital – must be continuously engaged, responsible and accountable if we are to be successful. And there is no choice - successful we must be.

### **A Ban on Industrial Support is Likely to Extend to CME at Stanford**

In October 2006 the School of Medicine, together with the Stanford Hospital & Clinics and the Lucile Packard Children’s Hospital, took a national leadership position by instituting a ban on gifts from industry to support educational and related activities (see: Stanford Industry Interactions Policy at <http://med.stanford.edu/coi/siip/>). As we and other institutions, along with a number of regulatory and legislative bodies, examine the data on an additional issue – the interactions of industry with Continuing Medical Education (CME) - the findings are disturbing. In a Perspective article by Dr. Robert Steinbrook entitled “Commercial Support and Continuing Medical Education” in the *New England Journal of Medicine* (2005; 352:534-435 – see: <http://content.nejm.org/cgi/content/full/352/6/534>) it was noted that the majority of support for CME in the USA came from commercial sources – a trend which has continued and even accelerated in recent years - and that now accounts for nearly two-thirds of the cost of current CME activities. While industry claims that that they have a hands-off policy on how these funds are used, the reality appears to be much more intertwined – with promotion of speakers, topics, etc – with the money not infrequently provided through third-party sources.

Oversight of CME takes place through the Accreditation Council for Continuing Medical Education (ACCME), a regulatory body that has tried to create policies to protect the integrity of the education mission. In reality, many of the policies are adaptations to existing realities and raise the very real question of whether truly unrestricted pharmaceutical and device industry support for CME can be achieved in the current climate. While many CME activities take place under the banner of medical schools and teaching hospitals, it should also be noted that a number of for-profit CME organizations have been established that are actively and robustly supported by industry. In fact, in the absence of industrial support, most CME programs could not be solvent – or competitive.

Because CME is required for medical recertification, every physician is required to accrue CME credits each year. Medical schools and medical centers use CME for education as well as for marketing – and so does industry. The negative features associated with these interrelationships have prompted two recent Congressional

hearings, led by Senators Herb Kohl (D-Wis.), Max Baucus (D-Mont.) and Charles Grassley (R-Iowa). In fact, it seems only a matter of time before some forms of regulation are imposed. But regardless of such activities, it is both prudent and responsible for leading institutions to re-examine their CME programs, how they are configured, what they seek to accomplish, and how they are supported. I have asked Drs. Rob Jackler, our newly appointed Associate Dean for Continuing Medical Education, and Myriam Curet, Senior Associate Dean for Graduate Medical Education, to examine this issue and make recommendations to current practice within the next four months. As we did when we established our Stanford Industry Interaction Policy, I am interested in your thoughts and opinion on this topic and thus seek your opinion. Were we to ban industrial support for CME (unless it was clearly and unequivocally unrestricted) it would surely have a number of consequences – both locally and nationally. But it is important that we do the right thing to support the integrity of our programs and our missions in education.

### **Smoke Free Medical School Goes Into Effect in August**

In the April 9<sup>th</sup>, 23<sup>rd</sup> and May 21<sup>st</sup> Dean's Newsletters, I highlighted some of the recent debates and discussions that have taken place in recent months on the tobacco industry, focusing more specifically on whether or not universities should accept funds for research from this entity. I also noted that even though the University elected to sustain its policy stating that "*individual scholars should be free to select the subject matter of their research, to seek support from any source for their work and form their own findings and conclusions*", on a related matter, the School of Medicine's Executive Committee agreed that it was appropriate to extend the non-smoking policy to cover the entirety of the medical school campus – both inside and outside. This is part of a broader effort to do what we can to promote health among our faculty, students and staff – which includes fostering some activities (like exercise and proper nutrition) and avoiding others (like smoking). Our "Tobacco Free Campus" policy will go into effect on August 1<sup>st</sup>. I will be sending you more specific information about what this will mean – especially the boundaries for smoking on the medical school campus.

To that regard it is interesting to note that the Cleveland Clinic has just announced a new nonsmoking hiring policy that commenced on July 1<sup>st</sup> that will ultimately restrict employment to individuals who are unwilling to cease tobacco use through smoking cessation programs. The basis for this decision rests on their commitment as an institution to promote healthy living – especially recognizing that smoking contributes to a number of serious chronic as well as life-threatening illnesses that cost approximately \$75 billion annually in direct and indirect medical costs. Their goal is to play a more proactive role in reducing health care costs by promoting health and wellness.

Clearly the Cleveland Clinic has taken a much stronger stand than we are taking on the issue of tobacco use. But I hope that the policies we are putting into place in the School of Medicine will help reinforce that smoking is seriously detrimental to health. Coupled with that message will be a series of resources that will appear on a new website to help members of our community engage in smoking cessation programs or pursue

other health improvement activities that better promote individual and our collective wellness.

## **Planning for the Future: Appointment of a Senior Faculty Transition Task Force**

There is broad consensus about the importance of mentoring and counseling at the early stages of one's career in medicine and science. There is also recognition that mentoring and career guidance is helpful – and indeed important – throughout one's career. But there is little if any attention paid to guidance or mentoring that may take place at the later stages of one's career. Given the fact that many scientists and physicians are living longer – and working longer – the lack of such guidance is a problem – or at least a challenge.

The need to better formalize our approach to senior faculty transitions was illustrated to me in a discussion that I had with Dr. Gary Schoolnik, Professor of Medicine (Infectious Diseases and Geographic Medicine) a few months ago. Dr. Schoolnik pointed out that he was at an interesting point in his own career – he is well-funded by the NIH, highly productive as an internationally recognized physician and scientist, but cognizant that now entering his early sixties, he should be giving some thought to his own transitions – as a faculty member, investigator, clinician and citizen. But he was also aware that there were no defined individuals or programs to whom he might turn for advice. As we discussed this important topic together with Dr. Harry Greenberg, Senior Associate Dean of Research, I felt that this was an issue that requires some thought and a more formalized approach. Simply put, there is every reason to be as responsive to senior faculty and the issues they face in their lives and careers as we are to more junior faculty and trainees.

Accordingly, I asked Dr. Schoolnik to serve as the Chair of a Senior Faculty Transitions Task Force and also appointed Dr. Kathy Gillam, Senior Advisor to the Dean to serve as Co-Chair. Members of the Task Force include Professors John Boothroyd, Regina Casper, Linda Cork, Harry Greenberg, Peter Gregory, Bob Lehman, Michael Levitt, Jim Mark, Chirsty Sandborg and Stanley Schrier along with staff members Rob Krochak, Ellen Waxman and Sam Zelch.

The charge to this Task Force is to come up with policies, procedures and resources through which advice and guidance can be provided to senior faculty about career and life planning. For some faculty this might involve changing the size or scope of their research - which could mean downsizing for some or increasing the allocation of their effort for others. Similarly this might result in changes in clinical activities and responsibilities or different roles in education or administration. For other senior faculty this may mean opportunities outside of medicine in either the public or private sector. The Task Force is cognizant that a number of factors impact a senior faculty member's decisions and options – including personal factors (e.g., marital status, personal finances, health and family issues, etc.) and professional issues (e.g., research funding, size of lab group, clinical activities and proficiencies, etc.). There is also a broad range of desires

and expectations – some individuals wish to continue working whereas others contemplate retirement or some transition. That said, we anticipate that these issues will increase in the future as our faculty ages and as longevity permits individuals to stay in the workforce much longer than in previous generations. Interestingly, as we were preparing our agenda for this Task Force I noted that some of the issues we are concerned about have a broader platform as pointed out in a recent editorial in the June issue of Nature Medicine (2007; 13:649) entitled “The Young and the Restless” (see: <http://www.nature.com/nm/journal/v13/n6/full/nm0607-649.html>) which unfortunately pits young faculty against old – but also raises important issues and needs for senior faculty.

From my point of view the major reasons for addressing this important issue is to be proactive and helpful. I am well aware that the decisions about transition are highly individualized and I want to underscore that when I refer to transitions I am **not** specifically highlighting retirement or becoming *emeritus* per se. Indeed I would argue that most of our senior faculty are more interested in how their personal transition, whatever form it takes, is associated with new opportunities and challenges – whether in education, research, patient care or other activities within the university or community. My hope is that our Task Force will help guide the kinds of resource or mentoring/career advice programs. Indeed we should be thinking about making Senior Transitions another exciting facet of a career in academic medicine and science.

The Task Force is already engaged, gathering data and setting agendas. I hope that we will have more to report on this important issue later this year.

## **Upcoming Events**

The first of the Outdoor Summer Science Talks at the Cantor Art Museum was very successful. Everyone is invited to attend the next sessions, which are free and open to the public.

### **Outdoor Science Talk 2 - Recent Advances in Heart Surgery**

*Dr. Robert Robbins*

Thursday, July 12<sup>th</sup>, 7pm

### **Outdoor Science Talk 3 - Cool Hands, Better Performance**

*Professor H. Craig Heller*

Thursday, July 26, 7pm

### **Outdoor Science Talk 4 - Drugs: One Size Does Not Fit All**

*Dr. Russ Altman*

Thursday, August, 9<sup>th</sup>, 7pm.

## **Awards and Honors**

- **CIRM Awards**

As you will hopefully recall from prior Newsletters, Stanford has been extremely successful in successful awards from the California Institute for Regenerative Medicine. What is likely less apparent, but equally important, is that our Research Management Group (RMG) has also been a leader in working through the administrative and financial issues related to the applications – such that Stanford will be the first to receive the funding for these awards – which is great news. So, in addition to thanking our faculty I also want to thank our RMG staff for their leadership and diligence that has helped make us a leader in science and research administration!

- **Dr. Marilyn Winkleby**, Associate Professor of Medicine and Director of the Stanford Medical Youth Science Program, in collaboration with Drs. PJ Utz (Medicine), Barry Starr and Rick Myers (Genetics) and Parvati Dev (SUMMIT) received the wonderful news that their proposal is one of 31 in the nation that will receive funding from the Howard Hughes Medical Institute “to provide a unique opportunity for the biomedical research community to provide hands-on experiences and rich content to students and teachers, extending their impact to a broader range of the education continuum.” In this competition, 297 institutions were invited to submit proposals and based on these submissions, HHMI has awarded \$1.5 billion in grant support (Stanford will receive \$748,330).

Based on their proposal, the Stanford plan “will help sustain, integrate, and expand three exceptional biomedical outreach programs in the fields of Medical Sciences, Immunology, and Genetics within the Stanford University School of Medicine. The three existing programs will form the foundation for integrated and new activities for high school students, teachers, Stanford students, families, and the community that are not possible through the individual programs. The Initiative will offer scientific training to high school students, with a special emphasis on low-income and ethnic minority students who are in great need of science education. Centered in Santa Clara County, California, the Initiative will draw on local scientific resources and expertise to specifically target the County’s large underserved population and will expand activities to the 11 under-resourced high schools in the San Jose East Side Union High School District that serves 20,000 students.”

This is exciting news for Dr. Winkleby and her collaborators and will permit them to continue offering exciting programs to students and our community. Please join me in congratulating Drs. Winkleby, Utz, Starr, Myers and Dev.

## **Appointments and Promotions**

- **Stéphan Busque** has been reappointed to Associate Professor of Surgery (Transplantation), effective 7/1/07.

- ***Eliza F. Chakravarty*** has been reappointed to Assistant Professor of Medicine (Immunology and Rheumatology), effective 7/1/07.
- ***Lisa J. Chamberlain*** has been appointed to Assistant Professor of Pediatrics (General Pediatrics) at the Lucile Salter Packard Children's Hospital, effective 6/1/07.
- ***James Chang*** has been promoted to Professor of Surgery (Plastic and Reconstructive Surgery) at the Veterans Affairs Palo Alto Health Care System, effective 6/1/07.
- ***Alexander D. Colevas*** has been appointed to Associate Professor of Medicine (Oncology) and, by courtesy, of Otolaryngology – Head and Neck Surgery, effective 6/1/07.
- ***Tina Cowan*** has been reappointed to Associate Professor of Pathology and, by courtesy, of Pediatrics (Medical Genetics), effective 7/1/07.
- ***Lauren Gerson*** has been promoted to Associate Professor of Medicine (Gastroenterology & Hepatology), effective 6/1/07.
- ***Iris Gibbs*** has been promoted to Associate Professor of Radiation Oncology, effective 7/1/07.
- ***Louis P. Halamek*** has been reappointed to Associate Professor of Pediatrics (Neonatology) at Lucile Salter Packard Children's Hospital and, by courtesy, of Obstetrics and Gynecology, effective 6/1/07.
- ***Paula J. Hillard*** has been appointed to Professor of Obstetrics and Gynecology, effective 7/1/07.
- ***Susan Hintz*** has been promoted to Associate Professor of Pediatrics (Neonatology) at the Lucile Salter Packard Children's Hospital, effective 6/1/07.
- ***Kathleen Horst*** has been appointed to Assistant Professor of Radiation Oncology, effective 7/1/07.
- ***John R. Huguenard*** has been promoted to Professor of Neurology and Neurological Sciences and, by courtesy, of Molecular and Cellular Physiology, effective 7/1/07.

- ***Ruth B. Lathi*** has been appointed to Assistant Professor of Obstetrics and Gynecology, effective 7/1/07.
- ***Henry Lowe*** has been reappointed to Associate Professor (Research) of Medicine (Medical Informatics), effective 7/1/07.
- ***Eric W. Olcott*** has been reappointed to Associate Professor of Radiology at the Veterans Affairs Palo Alto Health Care System, effective 6/1/07.
- ***Daniel Palanker*** has been promoted to Associate Professor (Research) of Ophthalmology, effective 7/1/07.
- ***Christopher K. Payne*** has been reappointed to Associate Professor of Urology, effective 6/1/07.
- ***Priscilla S.A. Sarinas*** has been reappointed to Associate Professor of Medicine (Pulmonary and Critical Care Medicine) at the Veterans Affairs Palo Alto Health Care System, effective 6/1/07.
- ***Glyn Williams*** has been reappointed to Associate Professor of Anesthesia, effective 6/1/07.
- ***Sherry M. Wren*** has been promoted to Professor of Surgery at the Veterans Affairs Palo Alto Health Care System, effective 6/1/07.
- ***Wei Zhou*** has been appointed to Associate Professor of Surgery (Vascular Surgery) at the Veterans Affairs Palo Alto Health Care System, effective 7/1/07.