

Dean's Newsletter

April 21, 2008

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Aging and the Medical Workforce

In the April 7th issue of the Dean's Newsletter I offered some comments and reflections on the medical workforce. A new report issued by the Institute of Medicine (IOM) on April 14th has further highlighted the issue of the medical workforce, in this case as it relates to the aging population. Indeed, Dr. Jack Rowe, who chaired the committee that produced the report, which is entitled "*Retooling for an Aging America: Building the Healthcare Workforce*" (see: <http://www.iom.edu/CMS/3809/40113/53452.aspx>), opened his presentation at the Council of the IOM I attended this past week by noting that the number of geriatricians in the US (currently 7100) has declined by 22% since 2000. The declines are even more acute for nurses' aides and home health aides. Since the population of older adults is forecast to grow to more than 20% of the US population over the next several decades, there will be serious shortfalls in the workforce available to provide medical care to the elderly. Parenthetically, the IOM report is also timely in view of the Spring 2008 issue of *Stanford Medicine*. Entitled "*The Long of It: The Globe Turns Gray*" (see: <http://stanmed.stanford.edu/2008spring/index.html>), the issue addresses a wide range of topics related to longevity.

The IOM Report "calls for bold initiatives starting immediately to train all health care providers in the basics of geriatric care and to prepare family members and other informal caregivers, who currently receive little or no training, in how to tend to their

aging loved ones. Medicare, Medicaid, and other health plans should pay higher rates to boost recruitment and retention of geriatric specialists and care aides.” In addition, the report proposes more stringent criteria to measure knowledge and competence in geriatric care. But the report also highlights an important systemic issue that limits attracting physicians and other professionals to geriatric medicine – the poor reimbursement to providers and care facilities.

For example, a general internist might earn an average of \$175,000 in 2005. However, despite extra years of training (beyond general internal medicine), a geriatrician’s compensation actually declined to \$163,000 in 2005 dollars. Similar salary discrepancies are also observed for nurses, pharmacists, social workers and others who specialize in geriatric care. One reason for this is the lower rate of reimbursement by Medicare for primary care – a factor that is likely contributing to the primary care workforce in the US – a topic I have also recently addressed. The problem is further exacerbated by Medicare’s focus on acute care rather than chronic management and lack of coverage for preventive services or non-physician providers as well as by the fact that the Medicare Trust Fund is slated to run out of money by 2019.

The IOM calls for significant progress by 2030 (which is pretty late given the current situation) and focuses on assuring greater competence in geriatric care, doing a better job in the training, recruitment and retention of the workforce and on creating improved models for health and health care for the elderly. As noted, many of the issues highlighted in this report are generic to our somewhat fractured health care system and are best seen as an important part of health reform. With that, we also need to assure that we are doing a better job in educating our students and trainees in geriatric care – and to caring for the elderly both in and outside of medical settings.

Continued Evolution of Conflict of Interest Issues

The past several weeks have seen the continued evolution of physician-industry interaction and conflict of interest issues. I have previously commented on the legislation introduced by Senators Grassley and Kohl entitled the “Physician Payment Sunshine Act” which would require pharmaceutical and device companies to disclose gifts or payments given to doctors. The Senate committee is extending this request to “medical education gifts,” which relates primarily to fees or gifts provided for continuing medical education (CME). The pending legislation surrounding this issue has prompted a number of drug and device companies to indicate that they will publicly disclose such gifts or payments, probably on their websites – although a national data base is likely to be forthcoming. As you know, Stanford came forth with restrictions on gifts from industry in its October 2006 Industry Interactions Policy (see: <http://med.stanford.edu/coi/siip/>) although this most recent issue has specifically addressed CME. The pending threat of legislation has prompted a number of companies to note that they will disclose payments more broadly, including those to disease advocacy groups as well as doctors. This is part of a continuing evolution of industry interactions with the medical profession.

And while modest by any standard, it is notable that the April 15th *New York Times* reported on three academic physicians who have elected to stop receiving gifts or payments from industry (<http://www.nytimes.com/2008/04/15/health/15conf.html>). They plan to sustain their interactions with industry but without personal compensation or payment. This is, of course, a personal choice, but I suspect that this trend too will continue.

Further, in light of the inquiries from the Inspector General as well as the Grassley committee, the NIH has issued regulations establishing standards and procedures for institutions that apply for funding (see: http://www.access.gpo.gov/nara/cfr/waisidx_06/42cfr50_06.html) and has posted a fact sheet to address some of the most commonly asked questions (see: <http://grants.nih.gov/grants/policy/coifaq.htm>). In addition to the “institution” questions there are a series of queries and facts for investigators that you may wish to familiarize yourself with. These include the following – the responses to which can be found at the NIH site noted above.

1. Who is required to disclose financial interests?
2. Who is considered an “Investigator” for this purpose? Is it only the Principal Investigator?
3. I am a post-doctoral fellow receiving funding from the NIH. Does this regulation apply to me?
4. I am a graduate student working on research funded by the NIH. Am I subject to the requirements of the FCOI regulation?
5. I am a collaborator/contractor/subcontractor/subrecipient performing research funded by the NIH but am not employed directly by the Institution that received the award. Does this regulation apply to me?
6. Which financial interests do I need to disclose?
7. What about assets held by my spouse or children? Are they included?
8. Does this include salary paid me by my Institution as an Investigator?
9. To whom should I report my financial interests?
10. When should I report these interests to the Institution?
11. What happens if my financial situation changes during the award period?
12. I am an investigator in an NIH-supported clinical trial network. My network has developed a study-wide policy for the trial that requires me to disclose my Significant Financial Interests to my network’s steering committee/operations office on an annual basis. Do I need to disclose my Significant Financial Interests to my Institution as well?
13. I’ve heard there is a special requirement for clinical research? Is this true?
14. I have heard about changes in the conflict of interest regulation for Investigators employed at the NIH. Do these apply to me?
15. I have been asked to give a paid presentation at and participate in a review of a non-profit research Institution. Do I need to report the income I receive from these activities?
16. Am I required to disclose interests in mutual funds?
17. What about stock options?

18. What about “blind trusts”? Are those included in this regulation?
19. Is income from royalties included in this regulation?
20. Are foreign investments (e.g., shares in a foreign corporation) covered by the financial disclosure requirement?

I feel confident that many will find these questions have relevance to them and their work. Please note that most are captured in Stanford’s Conflict of Interest Policies (see: <http://med.stanford.edu/coi/>) and that our on-line “Tips for Avoiding Conflict of Commitment and Interest” may also be informative to you (see: <http://med.stanford.edu/coi/tips.html>).

Changes in the Opportunities for Clinician Educators

To fully meet and address our missions in education, research and patient care, we need a faculty that is expert in each domain and who interact and collaborate successfully. Our overarching goal of “making and translating discoveries” is grounded in basic research and also includes interdisciplinary research, education and patient care. Investigators, clinician-scholars/investigators and clinician-educators each play an important role individually and collectively.

When I arrived at Stanford in 2001, many viewed the Medical Center Line, which had been in existence for a decade (and is now referred to as Clinician-Scholar/Clinician Investigator Line), as “second class.” Since then we have made considerable progress in making these faculty an essential component of our professoriate, beginning with the Academic Senate approval of Principal Investigators status in January 2003 and also by the interchangeability of the UTL and MCL faculty billets based on the scope and appropriateness of responsibilities rather than a preformed categorization.

Unfortunately, while the role of the Clinician-Scholar/Clinician Investigator has become more valued, misperceptions and misunderstandings now seem to abound regarding the Clinician Educator Line, which we introduced in July 2004. This is unfortunate, since I certainly view members of the Clinician Educator faculty as valued and important members of our medical school community. Indeed, Clinician Educators play important roles in a number of clinical departments (e.g., Pediatrics, Anesthesia), where they are highly valued and fully embraced. Unfortunately, other clinical departments have relatively few Clinician Educators and some even express a bias against them, which is most unfortunate. Importantly, Clinician Educators receive among the highest scores for medical student clinical teaching and are valued patient care physicians.

To facilitate a greater engagement of Clinician Educators with the Medical School professoriate, David Stevenson, Vice Dean and Senior Associate Dean for Academic Affairs, Harry Greenberg, Senior Associate Dean for Research, and Ann Arvin, Vice Provost and Dean of Research, and I met with the Provost to discuss the role of Clinician Educators in clinical trial research. Based on that discussion the Provost has approved that Clinician Educators who are at the rank of Clinical Assistant Professor, Clinical

Associate Professor and Clinical Professor may serve as a Principal Investigator for the Stanford site on multi-center, industry-sponsored clinical trials. To enable this to occur, a Clinician Educator faculty member needs to submit a waiver request to her or his department chair. In turn the chair must verify that the Clinician Educator will have protected time to conduct the clinical research and that she or he is qualified to serve as a site PI. Approvals will be through the Senior Associate Dean for Academic Affairs and the Senior Associate Dean for Research (see: <http://med.stanford.edu/rmg/piwaiver.html>).

Hopefully these actions will provide another opportunity to bring our community into closer alignment and to foster our shared missions in education, research and patient care

Support for Graduate Students

As many of you know, in October of 2006 the NIH implemented a cap on tuition reimbursement of \$16,000 for new and renewing NSRA training grants. This adds an even greater financial strain on programs with graduate students on training grants, many of which are already struggling under the existing shortfall in both tuition and stipend support. The total School of Medicine tuition cap impact in FY07 was \$192,000 (in addition to the existing shortfall in both tuition and stipend), but will rise to \$1.2 million in FY08. Importantly the impact of the NIH cap is projected to increase to \$3.5 million by FY12, at which point all training grants will have come under the cap.

To help address this important issue we have been working for over a year to define both short and long term solutions. We are grateful to the Provost and the Office of Graduate Education for making funds available from the Stanford Graduate Fellowship (SGF) program that will help mitigate the shortfall over the next five years. In fact, the Provost has committed \$4.5 million in SGF funds to be distributed from FY08-FY12 to schools with training grants, based on the number of training grant students as of August of the prior year.

In addition, beginning in Autumn Quarter 07-08, SGF support will provide 100% of the tuition cost of SGF fellows, which eliminates the need for the 19% School of Medicine tuition contribution for those students; the annual savings in the School of Medicine will be \$250,000 a year, and I have committed to reroute these dollars also towards graduate student support.

For longer-term solutions, we have done a detailed review of all endowments committed to education and focused on those that could have an expanded purpose. This has required considerable time and effort and I am appreciative to the role that Sam Zelch, Chief Financial Officer and Assistant Dean for Fiscal Affairs, and his team played in this review. They have identified approximately \$66 million of endowment that can be allocated to support graduate education and related programs. Indeed, this will yield approximately \$3.6 million per year, of which we will allocate approximately \$2.9 million in annual income to support graduate student training grant tuition support. This should help to provide a long-term solution to the challenges that arose from the NIH

tuition cap. We will also allocate approximately \$0.7 million annually to help support other important graduate education programs including the ARTS (Advanced Residency Training Program at Stanford – see below), the Masters in Medicine and the Medical Science Training Program (MD-PhD).

I hope that these allocations will provide some relief for faculty who support graduate students through training grants. In addition, we will also commit ourselves to seeking philanthropic support for our graduate education programs, and I hope that faculty will join with me and our Office of Medical Development to help raise those funds.

Applications for the ARTS Program are Invited

Current Stanford residents and clinical fellows interested in combining clinical training with advanced research training are invited to apply to the Advanced Residency Training at Stanford (ARTS) Program (see: <http://med.stanford.edu/arts/> for more details).

The ARTS program offers the opportunity to obtain a PhD degree during or upon completion of residency or clinical fellowship. The program begins with approximately 12-48 months clinical training toward board certification in any area of interest, followed by research training in a graduate program in the Schools of Medicine, Engineering or Humanities and Sciences at Stanford University. The ARTS program will provide tuition, stipend and health benefits to successful applicants. Dr. Sam Gambhir, Professor of Radiology and Bioengineering, is the Program Director. The application deadline is October 1, 2008 for applicants who seek to begin their PhD coursework in the Fall of 2009.

If you are interested please contact the ARTS Program Office for more information. You can call (650) 724-9139 or email: sofias@stanford.edu

Stanford Institutes of Medicine 1 (SIM1) Continues to Move Forward

A number of individuals have asked me whether the large excavation site near campus drive is for SIM1. The answer is no. That site is part of the Connectivity Project and will be the new loading dock for many current and all new buildings. The loading dock also connects to a series of underground tunnels that will deliver supplies to school buildings in the years ahead. We expect that this project will be completed by the end of the year.

At the same time we are indeed making progress with SIM1. The site for the future 200,000 gross available square foot (gasf) building is now marked off just south of the CCSR, and the program planning and architectural design are nearly complete. The latest architect renderings were presented to the Land and Buildings Committee of the University Trustees on August 8th and were well received. A website for the building will

soon be set up, but I am providing a couple of the most recent renderings here for your information.

View of SIM1 from the Academic Walk

QuickTime™ and a
decompressor
are needed to see this picture.

View from Campus Drive (moving west)

QuickTime™ and a
decompressor
are needed to see this picture.

The design of SIM1 will serve as the prototype for future research buildings, including the other SIMs and the Foundations in Medicine (FIM) buildings. We currently anticipate groundbreaking for SIM1 to take place this summer and for the project to be completed in 2010.

Changes in NIH Peer Review is Coming

In the November 5th Dean's Newsletter . I discussed some of the potential changes to the NIH peer review system. And in the March 10th issue of the Newsletter I outlined the proposed changes in peer review that were publicly posted and sought comments that we could share with NIH. I received very few comments. Over the past weeks I have spent time with various leaders at NIH discussing the proposed changes and offering data to place some of them in a reasoned context. Based on those discussions, it seems clear that the process for change in peer review is on a fast track and that some of the recommendations will be brought forth more formally in the next month. While a number of the proposed changes are likely to be helpful, some are potentially more challenging. We will monitor this issue and get back to you as information unfolds. But do be prepared for some changes in the peer review process in the not too distant future.

Of course the major change that everyone is hoping for is an increase in the NIH budget. But, as I have also said in numerous settings, that seems unlikely given the current economic situation, even with a change in administration and more political support for NIH. Virtually every leader I have spoken with in DC fears that there is simply not going to be the discretionary funding available to address the NIH funding level for some time. The impact of this is already noteworthy - since the flat funding began in 2003, the NIH has lost more than \$3.6 billion in purchasing power. Changes in peer review, even if well intentioned, could have unintended consequences, making it important for all of us to carefully assess the proposed changes.

Security and Information Technology

In the most recent issue of the Dean's Newsletter I featured a commentary on laptop security based on recommendations from Dr. Todd Ferris. This issue has become increasingly more contentious with recent thefts of laptop computers from NIH scientists that contained patient-related clinical trial data. This follows the highly publicized case that occurred on January 20, 2007 when a laptop containing patient data was lost at the Birmingham VA, which prompted very strong reactions from the VA leadership and from the Congress. There is no question that IT security, especially of patient information, must be protected. There is also no question that such information is now contained on a number of servers and computers within academic medical centers and that even with encryption there is not likely to be truly de-identified data. At the same time, despite recent computer losses, there has not yet been theft of patient sensitive or related information – although this is certainly not a reason for not exercising rigorous security measures.

On Friday, April 18th I attended a special meeting hosted by the AAMC and the VA to discuss the current data security. While some of the more stringent rules within the VA have created heightened anxiety and frustration for VA scientists and physicians, along with tensions between VA and academic affiliates, it is also quite clear that issues

of security and information technology cannot be viewed as a VA-specific issue. Indeed it impacts the entirety of our academic medical centers and universities as well.

I found the discussions to be helpful and thoughtful as leaders of the VA and various university/medical school, NIH and AAMC leaders shared experiences and sought solutions. It was generally agreed that all institutions need an IT security blueprint and that this must be coupled with a plan for a cultural transformation about data safety, one that recognizes that we are in a new day of both information access as well as oversight scrutiny. Accordingly, we all need plans for implementing the blueprints and plans.

It is also clear that IT security must find a balance. There is simply no “zero risk” scenario that is workable. It is imperative that the research must continue and that relationships and data sharing between VA and university affiliates must be assured. A firewall that simply surrounds the VA and excludes the academic center is simply not workable. At the aforementioned meetings, examples of successful partnerships between the VA and university/medical school leaders at both the University of Pennsylvania and Yale were described. Their success included very close and effective working relationships between the leaders and community. It required developing an inventory tool to assess the highest risk situations, since it is clear that risk stratification is essential in moving forward. This further involved a critical review of investigator laptops and desktops to assure that they contained the appropriate encrypted software and that higher risk servers met criteria of the FISMA (Federal Information Security Management Act) or at least had a path to achieving such an accommodation. In some cases this involved an external audit.

I am aware that our Stanford IRT and data security groups have done an excellent job to date in data security and that there are ongoing efforts to secure patient sensitive data within the medical school and also with our VA colleagues. But it is also clear that this will require ongoing efforts, since it is unlikely that any uniformly applicable solution exists. But if there is a willingness to engage collaboratively, it is also clear that progress can – and indeed must - be made. This collaboration will require faculty involvement as well as that of IT and university leaders to be successful.

Cancer Center Holds Another Successful Member Retreat

On April 7th the Stanford Cancer Center held its 2008 Member Retreat featuring presentations on Cancer Imaging and Early Detection, Women’s Cancers, Opportunities for Genetics and Population-Based Research, Molecular Therapeutics, New Initiatives for Immunology Research and a number of breakout discussions on topics ranging from cancer stem cells to cancer survivorship. This year’s keynote speaker was Dr. John Niederhuber, Director of the National Cancer Institute, who commended Stanford for its progress as a cancer center and also addressed some of the important challenges and opportunities that lie ahead. It is gratifying to note how the Cancer Center at Stanford is maturing and is attracting an ever-larger faculty group committed to cancer research, care and prevention. I offer my special thanks to Dr. Irv Weissman, Ludwig Professor and

Director of the Stanford Cancer Center and Dr. Bev Mitchell, Becker Professor of Medicine and Deputy Director, Stanford Cancer Center.

Upcoming Events

All-School Centennial Celebration Luncheon This Wednesday! All faculty, students and staff are encouraged to come to the Dean's Lawn (Campus Drive and Roth Way) this Wednesday, April 23rd between 11:30 am and 1:30 pm for a barbeque lunch.

This special gathering is to commemorate the 100th anniversary of the School of Medicine. In addition to tasty food, there will be a ragtime band adding a "Centennial touch" to the day. There will also be a display of items going into a time capsule to be opened in the year 2108. You are encouraged to bring an item that reflects the "Spirit of 2008" to include in the capsule. There will be guest books circulating at the luncheon for your entries. Additionally, we are starting to receive predictions for 2108 and memories of life at the School of Medicine on the Centennial Web site at <http://med.stanford.edu/centennial/guestbook.html>.

For more details on the lunch, shuttle service (between the main campus and offsite locations) and other Centennial events, see the Centennial Web site at <http://med.stanford.edu/centennial/events.html>.

The Centennial web site has also been updated with new stories. In the "Centennial Spotlight" is one of Stanford's and the world's top scientific leaders, Paul Berg, PhD. Included is information on Dr. Berg's science, as well as his philanthropy, plus a very special video he produced in 1971 to explain protein synthesis in layman's terms. In addition there is the story behind the J.E. Wallace Sterling Muleshoe Lifetime Achievement Award (to be present at the upcoming Alumni Weekend) and a look towards our future with the Learning and Knowledge Center.

And, as a final note, you can now download our custom Centennial logos from the Centennial web site <http://med.stanford.edu/centennial/logos> These designs can be used on print (ie. letter head) and other communication.

The 2008 Symposium on Improving Diversity in Graduate Education: The Annual Symposium on Improving Diversity in Graduate Education will be held on Monday, May 5 at Noon in Munzer Auditorium and will be followed by a reception in the Dean's Courtyard. This year's speaker will be Tyrone Hayes, PhD, Professor of Integrative Biology at UC Berkeley. The title of Dr. Hayes presentation is "*All Men are Created Equal and Other Truths We Hold to be Self-Evident.*"

Dr. Hayes will also be the Biology Department Seminar Speaker on May 5 at 4:15pm in Hewlett 201 where he will speak about "From Silent Spring to Silent Night: A Tale of Toads and Men." The Symposium is sponsored by the School of Medicine Office for Graduate Education and School of Humanities and Sciences Biology Department. For more information please contact Anika Green, agreen1@stanford.edu

The Stanford Digestive Disease Center will hold its Annual Symposium on May 3, 2008 at Hewlett auditorium, in honor of Dr. Stanley Falkow, the Robert W. and Vivian K. Cahill Professor. This year's Symposium is entitled *Through the Intestinal Tract with Gun and Camera*.

Dr. Falkow will give a presentation of the same title. Other scientific luminaries who will be presenting at the symposium include Philippe Sansonetti of Institut Pasteur, Paris; Brett Finlay of University of British Columbia, Vancouver; Jeffrey Gordon and Virginia Miller of Washington University, St. Louis, along with Stanford faculty speakers Gary Schoolnik, David Relman, Denise Monack and Manuel Amieva (Symposium 2008 Director). Dr. Harry Greenberg is the director of the DDC. The Symposium is co-sponsored by the Institute for Immunity, Transplantation and Infection (ITI) and the Department of Microbiology and Immunology.

Awards and Honors

- **Dr. Lucy Shapiro**, the Virginia and DK Ludwig Professor of Developmental Biology and Senior Fellow at the Freeman Spogli Institute for International Studies has been awarded the Charles and Martha Hitchcock Professorship for 2008-09 by the University of California (UC). Since it was established nearly a century ago, the Hitchcock Professorship has become one of the most distinguished endowments at UC and has featured a number of distinguished past winners such as Neils Bohr, Robert Oppenheimer, Noam Chomsky and Steven Chu. Dr. Shapiro adds to this list of luminaries and we offer her our congratulations and admiration.
- **Dr. Stanley Rockson** was named the first holder of the Alan and Tina Neill Professorship of Lymphatic Research and Medicine at a wonderful event held in the Cantor Arts Museum on Friday April 11th. This new professorship was a gift of Alan and Tina Neill, who have personally experienced the challenges of lymphatic disease. Through this professorship they have highlighted the importance of research in lymphatic disorders and have honored Dr. Rockson, one of the world's leading experts in this important but understudied area of medicine. Please join me in congratulating Dr. Rockson and in thanking the Neill family for their wonderful contribution.
- **The Stanford Pain Management Center** is being honored as one of six centers of excellence in the nation by the American Pain Society for its successful multidisciplinary approach to alleviating the suffering for patients afflicted with chronic pain disorders. The Stanford Pain Management Center treats 6,000 patients a year who are seen by a multidisciplinary team of doctors, psychologists, physical therapists and occupational therapists. Please join me in congratulating Dr. Sean Mackey, MD, PhD, chief of the Division of Pain Management at Stanford Hospital & Clinics and associate professor of anesthesia at the Stanford

University School of Medicine along with his colleagues for this wonderful recognition.

Appointments and Promotions

- *Debra M. Ikeda* has been promoted to Professor of Radiology, effective 4/01/08.
- *Edward E. Manche* has been promoted to Professor of Ophthalmology at the Stanford University Medical Center, effective 4/01/08.
- *Stanley G. Rockson* has been promote to Professor of Medicine (Cardiovascular Medicine) at the Stanford University Medical Center, effective 4/01/08.