

# Dean's Newsletter

## February 17, 2009

### *Table of Contents*

- The 2009 Strategic Planning Leadership Retreat
- Dean's Opening Presentation: Creating a Culture That Fosters Faculty Development and Success
  - Introduction
  - What We Know About How Our Current Faculty Feel About Their Career Development and Satisfaction
    - Pre-Retreat Survey
    - AAMC/COACHE Survey
    - Ethnographic Observations
  - How Our Unique History and Culture Have Shaped Who We Are Today
    - Evolution of the "Stanford Way"
    - External Factors Impacting Academic Medicine During the Past Five Decades
    - The Present Moment: Impact of the Present Economic Downturn
    - Demographic Contrasts Between 1959 and 2009
    - Some of Our Accomplishments During the Past Eight Years
  - Present and Future Challenges and Opportunities
- How We Can Create a Culture That Fosters Career Development and Success
- Event: Health Policy Forum
- Awards and Honors
- Appointments and Promotions

### **The 2009 Strategic Planning Leadership Retreat**

On February 6-7<sup>th</sup> nearly 100 leaders representing our faculty, staff, students and trainees, affiliated hospitals and university gathered for the Eight Annual Strategic Planning Leadership Retreat. This year we focused on the important issues of faculty development and career success. We decided to anchor the discussion at the department and division level since this is the site where faculty development begins and can be nurtured and sustained. We also elected to make this retreat more of a "bottom up" effort by engaging the attendees in an interactive process that identified key challenges and issues and then developed the first phase of planning activities that will be taken back to departments and divisions for further development and implementation in the months ahead. Major goals of the retreat were to build community interactions, foster cross-disciplinary dialogue, solicit creative and innovative ideas and recommendations and empower faculty, divisions and departments to engage in what we hope will be an ongoing cultural transformation.

To set the stage for the retreat and to place the issues we are facing into an historical as well as organizational context, I gave a presentation on "Creating a Culture That Fosters Faculty Development and Success." My goal was to offer a context for

addressing the issues we face today that takes into account our unique institutional culture. I am taking the liberty of providing an approximation of my remarks in the section that follows. Since the presentation was approximately an hour long, I must warn you in advance that the text is *long*. But I think it offers details and observations that are important to consider. I recognize that these are filtered through my personal lens – but I think they provide a starting point for discussion.

## **Dean’s Opening Presentation: Creating a Culture That Fosters Faculty Development and Success**

### ***Introduction***

In January 2002, we came together at the Carmel Valley Ranch for our first Strategic Leadership Retreat. We accomplished two important goals at that event. First, we built on the work of developing our strategic plan, “Translating Discoveries,” that had begun prior to the retreat. Second, and perhaps even more important, we had the opportunity to better understand the different but important roles we play as leaders in basic science, clinical science and patient care. What was then a somewhat divided leadership left the retreat more aligned and united – something we have strived to build on in the ensuing years.

In the subsequent seven years we have made major strides in a number of mission critical areas. But we also face significant challenges –driven in part by the dramatic changes that have occurred in our nation’s and the global economy as well as by the diminished level of support for science and technology that has characterized the past 8 years. We also face many uncertainties as we go forward – which makes it ever more important for our community to be aligned and unified in our commitment to the future. Whatever the changes in funding for research, or the consequences of health care reform, or the changing economic forces at Stanford and in the Bay Area may be, we need to chart our course and define our future destiny. That is our responsibility as the current stewards and leaders of Stanford Medicine

But we are a diverse community comprised of a wide range of individuals with quite different needs and expectations. These are not always aligned, and this misalignment creates additional tensions and underscores the importance of defining our mission in as inclusive a way as possible. Specifically, our community includes (many of whom are represented at this retreat):

- MD and PhD students
- Residents
- Postdocs
- Clinical fellows
- Junior, mid-career and senior faculty
- Basic science faculty (UTL, NTL)
- Clinical research faculty (UTL, NTL and MCL)
- Clinical care faculty (CE)
- Medical School faculty administrators – division chiefs, department chairs, deans

- University faculty and administrative leaders – deans, provost, president
- Board of Trustee members
- Administrative and support staff
- Hospital administrative leaders
- Hospital Board members

Members of each of these groups have different goals and expectations, both for their own careers and for how their needs and expectations intersect with others, positively and negatively. The reality is that the current composition of an academic medical center, coupled with its internal pressures and culture and the multiplicity of external forces acting on it, fosters tensions and pulls, which are felt at the individual level and which, when unaddressed or unacknowledged, can lead to significant anxiety and negative career satisfaction – at all levels and stages of career development.

We are also a decentralized organization, and much of the responsibility and accountability for career development resides at the department or division level. The department is also the place where transformation can occur– including the cultural transformation necessary to make Stanford the best institution it can be for the 21<sup>st</sup> century. That said, cultural change also occurs – and indeed must occur – at the individual level, and as noted earlier, we are comprised of individuals with significantly variegated goals and objectives.

This year we want to focus our efforts at this retreat on career development and the degree of satisfaction our faculty experience in pursuing their careers at Stanford. Of course all faculty members have individual stories and sets of circumstances– regardless of whether they are new or long-term members of the community and irrespective of career stage. Each has needs and expectations that are the result of who they are, the nature of their work, the culture of our institution and a panoply of external and internal forces. We can learn how our faculty are doing by sampling them at a point in time. But we can also learn by being cognizant of the institutional culture that has evolved at Stanford and the role it plays in setting expectations for success and in delineating who wishes to be part of our community.

This retreat is faculty-focused, but the culture that we will be considering involves everyone, and we welcome everyone’s active participation.

For this retreat we will follow a different format than we have in past gatherings. We will be working with Co-Vision, a company led by Lenny Lind. Co-Vision has pioneered “fast feedback” technology. Since 1991 they have supported over 3800 conferences, including the General Session of the 2005 World Economic Forum in Davos and the Clinton Global Initiative Meetings, among many others. I also want to thank **Julie Moseley, Hannah Valentine, Kathy Gillam, Christopher Gerlach and David O’Brien** for the work they have put into organizing this retreat. In addition, I want to thank our several chairs who played an important role in helping to gather insights from our faculty: **Jim Ferrell, Steve Galli, Ralph Horwitz, Karla Kirkegaard and Al Lane.**

And I want to thank **Kristin Goldthorpe and Mira Engel** for their work in supporting the Retreat.

We will provide a document at the end of the retreat that contains the outcomes of our discussions. These will take the form of nine specific action plans designed to address specific issues of departmental culture having to do with faculty development and career satisfaction. Most importantly, we will ask those of you who are department chairs to take these plans back to your departments and, in coordination with your division chiefs, review them with your faculty. Each department or division will choose one of these plans to develop further and implement. Over the course of the year each of you will present the results of your efforts to the Executive Committee. Thus, this retreat will set the stage for the important work that will happen at the division and department level over the next year and beyond. When we conclude tomorrow it will just be the end of the beginning.

To set the stage for the work we will do together this afternoon and tomorrow morning, I want to provide some summary comments from our colleagues about how they view their career development in the medical school. Of course, their reflections (both positive and negative) represent their personal perspectives, which are individual and highly varied. But they also reflect some common themes. Many of these themes emerged decades ago and have endured to the present moment. They are shaped by our institutional culture and how it has responded to both internal and external forces over the years. In many ways our history has predicted our current environment. But at this crucial moment our future depends on how – or whether – we change our culture – both as individuals and as an institution to adapt to our rapidly changing world.

***What We Know About How Our Current Faculty Feel About Their Career Development and Satisfaction.***

We have used several sources of information to assess what our faculty think, including:

- In anticipation of this retreat, we conducted a survey that attempted to assess perceptions and feelings about career support, satisfaction and success at Stanford. This survey had a response rate of 47%, or 559 respondents, who included UTL, NTL, MCL, and CE faculty. While this response rate is less than desired, it is still more substantial than many other surveys.
- The AAMC/COACHE Survey that was conducted in 2007 (I have written about this survey in previous Dean's Newsletters. In this survey we served as a pilot institution, and our faculty were compared to faculty at nine other medical schools, three of which (UCSF, Penn, UCSD), served as peer comparators. Since this survey had a response rate of just 38%, we want to be cautious about interpreting the results. It is best to look at them as trend data.

- During the summer of 2008 Hannah Valentine and I met with virtually all junior women faculty. We did so in groups of 4-6 individuals and engaged in a candid dialogue about the institutional culture and forces that either promote or impede individual career development and job satisfaction. Dr. Valentine and I are now meeting in small groups with all junior men faculty.

These three approaches were independent of each other, but their outcomes revealed some common themes that we might use to consider ways we might improve the future success and satisfaction for our faculty.

### *Pre-Retreat Survey*

Some important messages emerge from these data. For instance, overall, **85%** of respondents indicated that they would like to sustain their career at Stanford University. **75%** indicated that they were satisfied with their career and 8% were neutral – leaving **16%** who were dissatisfied. On the surface, then, most of our faculty appear to be satisfied – but since we want to foster the career development and, ideally, the job satisfaction of each member of our community, it is important to drill further into these data.

An important set of questions concerns how faculty members perceive the value their departments and divisions place on the research, teaching and clinical care missions, the clarity of the expectations around these missions, and the congruence of their own expectations with those of their departments/divisions. For instance, we commonly refer to Stanford as a research university and to our school as a research-intensive school of medicine. There is little doubt about this in the minds of our faculty, for whom **82-89%** recognize that their departments/divisions place a high value on research. In addition, **79%** of respondents (excluding Clinician Educators, whose response was lower) feel their departments/divisions' expectations regarding research are clear.

The results were similar for the clinical care mission; **82%** responded that their departments/divisions place a high value on this mission, and **85%** feel that the expectations for clinical care are clear. The teaching mission showed a similar alignment of value and expectations; however, teaching is less articulated as a value, and the expectations are less clear: only **65%** responded that their departments/divisions place a high value on teaching, while **71%** feel that the expectations regarding teaching are clear. Overall, **68%** of respondents said that the expectations of their department/divisions for their performance were congruent with their own.

At the same time many faculty do not feel well supported in their work. In fact, only **51%** of the respondents see their department as supportive, and less than half (**48%**) receives what they feel to be valuable career advice from their chair or chief. That said, **60-70%** feel that they can go to their chair or chief for career advice. **61%** feel that they will get feedback from their chair or chief, and **70%** believe their chair/chief would inform them if they were having problems. Interestingly, more than **90%** of the respondents attribute their success to their own personal drive and talent. About **75%**

believe that colleagues at Stanford or elsewhere have been helpful to career development. But **less than 50%** have mentors at Stanford or elsewhere.

**About 63%** of the respondents feel that the demands of their career impact negatively on their personal life. Moreover, only **46%** feel that they can discuss these concerns with their chair or chief. Overall, basic science faculty are more satisfied than clinical faculty and feel that they are more supported and more aligned to the missions of the school and their department than their clinical colleagues. Moreover, overall, women are less satisfied than men. They feel less aligned to the expectations of the department and appear less likely to have a defined career plan. Women feel less supported by their chair or chief, feel they get less feedback and are less likely to seek guidance from their chief. Women also feel more connected to the clinical missions and less to the research mission than men.

Clinician Educators (who are over-represented by women) appear to be the most disenfranchised group of faculty at this time. They are less clear about the expectations of their department than other faculty groups and are less likely to have clearly defined career plan. They also feel less clear about support from their department, chair or chief.

Finally, it is interesting to note what respondents identified as their sources for greatest joy in being at Stanford (in alphabetical order). They include:

- Collaboration – including interdisciplinary and cross campus opportunities
- Colleagues
- Culture and environment of one's department
- Patient care and clinical excellence
- Research
- Students and teaching
- The Stanford reputation

Similarly, respondents were asked to identify areas of frustration in their Stanford career. The responses included:

- Lack of support from school and department leaders
- Perceived inequities between different categories of fellows and faculty – clinical versus basic, men versus women
- Lack of resources to support career development –different reasons for basic and clinical faculty
- The pressures and expectations surrounding clinical care, including the support that comes from the two teaching hospitals - along with the perception that too little value is placed on clinical excellence.

### ***AAMC/COACHE Survey Data***

It is important to add both some comparative texture as well as individual granularity to these data. While the COACHE survey had a lower response rate (38%), it is interesting to compare those elements in which our Stanford faculty felt more – or less – satisfied than their peers at Penn, UCSF and UCSD. These include the following:

**Stanford Faculty rated 25 items significantly *higher* than faculty at peer institutions:**

a. ***Satisfaction with:***

- i. Incentive compensation, such as bonuses
- ii. Housing benefits
- iii. Tuition benefits for dependents
- iv. Spousal/partner hiring assistance
- v. Parental leave policies
- vi. Availability of childcare offered by the medical school
- vii. Quality of childcare offered by the medical school
- viii. Institutional assistance in finding offsite childcare
- ix. Communication from the Dean's Office to faculty about the medical school
- x. The Dean's priorities for the medical school
- xi. The pace of decision-making in the Dean's Office
- xii. Opportunities for faculty participation in governance of one's department
- xiii. Communication from one's Department Chair to the faculty about the department
- xiv. The Department Chair's priorities for the department
- xv. How well the location of one's clinical practice functions overall
- xvi. The medical school as a place to work

b. ***Agreement that:***

- i. One's work is appreciated by one's patients
- ii. One's work is appreciated by the Dean's Office
- iii. The workplace culture of the medical school cultivates interdisciplinary work
- iv. The workplace culture of the medical school cultivates entrepreneurialism
- v. The workplace culture of the medical school cultivates excellence
- vi. The medical school is successful in retaining high quality faculty members.
- vii. One's department does a good job explaining its overall financial situation to the faculty
- viii. One's department does a good job explaining departmental finances to the faculty.

**In contrast Stanford faculty rated 12 items significantly *lower* than faculty at peer institutions:**

c. ***Satisfaction with:***

- i. The value the medical school places on teaching/education
- ii. The value the medical school places on community service
- iii. The value one's department places on community service

- iv. Usefulness of feedback from one's unit head on career performance
- v. The pace of one's advancement at the medical school
- vi. Health benefits
- vii. Opportunities for physician input in management decisions

d. **Agreement that:**

- i. One's work is appreciated by one's immediate supervisor
- ii. The requirements for teaching/education are clear
- iii. The requirements of institutional service are clear
- iv. The requirements for institutional service are reasonable
- v. The criteria for promotion are consistently applied to faculty across comparable positions.

### ***Ethnographic Observations***

It is also informative to reflect on the individual stories and concerns Dr. Valantine and I have heard directly from faculty – both in our meetings with junior faculty and more broadly. Without being simplistic, success and satisfaction ultimately comes down to the individual's expectations, career track choices, the level of support received in the division or department and the support received from faculty colleagues and institutional leaders. Of course personal pressures and challenges can dramatically alter the equation; these may include personal resources, spousal and partner relations, age and well being of children, impact of eldercare and the multiplicity of other factors that impact the lives of individuals at different stages of their career.

While it is important to focus on the concerns that are raised and reported, it is even more important that we do not approach our work by simply highlighting the negatives or complaints. Every job has stresses – and those in medicine and science are hardly exceptions. But I think we are better served by taking note of what does work and then thinking about ways of making those successful ventures the focus of our institutional culture.

In sum, these data affirm that, while we are all part of a common culture with widely recognized norms and expectations, we are also comprised of a variety of constituencies that have varying degrees of satisfaction, clarity, perceived support, and degree of connection to the school's missions. Some of these differences are related to individual perceptions, but many emanate from the Stanford culture – or the “Stanford Way” – that has evolved over the past decades. It is notable, for instance, that some of the areas of dissatisfaction are also congruent with our history and with the culture that has developed at Stanford Medicine over the past 50 years – especially the tensions between the value placed on research versus teaching and patient care.

## **How Our Unique History and Culture Have Shaped Who We Are Today**

### ***Evolution of the “Stanford Way”***

To a great degree the perceptions and views of our faculty colleagues today are products of our history and of the Stanford culture – sometimes referred to as the Stanford Way – that has evolved over the past 50 years, since the School of Medicine moved to the Palo Alto campus. Taking a moment to look back to the re-founding of Stanford Medical School in 1959 and to reflect on the forces that have shaped the school as a whole and the individuals who have been part of its community affords an opportunity to better understand some of its current and future challenges and opportunities.

The move of the medical school in 1959 was the fulfillment of the vision of key institutional leaders at Stanford who believed that the second half of the 20<sup>th</sup> century would offer opportunities in science and medicine that would benefit from the location of the medical school with the rest of the university. Most notable were President Wallace Sterling and Provost Fred Terman. Several key medical school faculty members also played a critical role, including Drs. Robert Alway (Dean during the transition), Henry Kaplan (who helped found the field of radiation oncology and whose research still stands as a paradigm of interdisciplinary investigation and innovation), and Avrum Goldstein (in pharmacology), among others.

These university and medical school leaders and others created a unique environment that continues to define us to the present moment. Its key elements included:

- A physical continuity between the basic and clinical sciences
- A co-location of the medical school to its major teaching hospitals
- A close proximity of the medical school to the university and especially to engineering and the biological and physical sciences.
- An entrepreneurial spirit that is committed to innovation and discovery
- A willingness to engage in interdisciplinary and multidisciplinary research

These factors and of course the individuals who came to Stanford as faculty, students and staff shaped the medical school agenda with a unique focus that has a number of characteristics, such as:

- Research, along with a commitment to scholarship, has been the defining value throughout these 50 years, and it continues to permeate the culture of both the medical school and rest of the university
- The focus has been on the accomplishments of individuals
- Recruitment of faculty is through national searches and an emphasis on recruiting individuals from outside Stanford (especially in the basic sciences)
- Placing a high value on being small and outstanding – this has defined the size of the faculty across the university, and it has had notable implications for the medical school, especially in limiting the size of the faculty through a billet cap

In the area of medical education, the initial focus was on training individuals who would pursue careers in science and academic medicine. The Five Year Plan was initiated as part of the relocation to Palo Alto. It evolved over the years to a “flexible curriculum” – which nearly became a non-curriculum. The next major reform did not occur until 2003, when the current “New Stanford Curriculum” was launched.

The commitment to clinical medicine has an uneven history. Initially the hospital was divided into a “community hospital” and a “university hospital.” Faculty cared for less than a third of the patients admitted to Stanford Hospital, in line with the initial understanding that community physicians would provide general medical care and faculty would focus on patient care in relation to their teaching and research missions.

For the first three decades following the move, all faculty were in two different lines, the University Tenure Line or the Non-tenure Line (Research, Teaching or Clinical). Recognition of the importance of a separate faculty line for individuals involved primarily in patient care did not occur until 1989, when the Medical Center Line (MCL) was created. The size of this line was driven largely by “business plans.” It grew significantly through the 1990’s, in contrast to the number of faculty in the other lines throughout the university, and was uncapped until 2004. In the School of Medicine there are now more MCL than UTL faculty (there are a very small number of Non-tenure- Line faculty in the School).

From its inception MCL faculty have been considered members of the University’s professoriate, (with various perceptions about what this meant), but they are not members of the “Academic Council,” which consists of Tenure Line and Non-Tenure-Line faculty. As a result, they were initially not eligible to serve on a regular basis as Principal Investigators (PIs), a role generally restricted to Academic Council members. In 2003, University policy was revised to include MCL as PI-eligible faculty. Nevertheless, for much of the first 15 years of the existence of the MCL, faculty in this line have felt second class – something which has improved, but which, unfortunately, has not disappeared.

In 2002 the School initiated the Clinician-Educator (CE) Line. Initial appointments to this line were of individuals already at Stanford as Staff Physicians. Our goal was to redefine the staff physician role by, among other things, laying out a career track for individuals whose focus was on providing the highest quality clinical care in an academic medical environment. At the same time we revised the titles and roles of the community physicians serving as Adjunct Clinical Faculty.

Our hope in establishing the CE Line was that individuals serving in these ranks would become valued members of the medical school community and would provide important knowledge and skills. However, many of our CE faculty feel that they are “second class” – that they are not valued in their departments or in the school and university. In many ways, these perceptions reflect a wider view about how clinical medicine is valued at Stanford University. While there is no question about the value of research, there is wide variation in the value that has been placed on clinical care – and on being an outstanding clinician. While this attitude has evolved over the years and has clearly been changing over the past decade, the perception that clinical care is valued less than research is still widely shared, and it does have a basis in fact.

This disparity in value is the counterpoint to what makes Stanford so strong as a research university. The culture and values of the university are in scholarship and discovery. While excellence in clinical care is valued, many in the university see this as part of being a good doctor – and they do not see the relevance of excellence in this domain to being a scholar or innovator *per se*. Moreover, the appointments and promotions process is largely oriented to scholarship and until recently has not put a premium on excellence in patient care (or even education). Department chairs and faculty themselves value the role of Clinician Educator differentially across the school. All of these factors inevitably have a negative and disheartening impact on how CEs perceive their value and role. Our goal is to give equal value to all faculty lines and all the roles they play – they are all equally critical to our success.

### ***External Factors Impacting Academic Medicine During the Past Five Decades In Clinical Care***

A number of external factors have also shaped the evolution and development of Stanford Medical Center during the past 50 years. For instance, 1959, the year the medical school moved to the Stanford campus, was a time of national prosperity. Unfortunately, development of a national health program had not been addressed as a part of the New Deal in the 1940s, and attempts to accomplish such a program had failed during the Truman administration – largely because of lobbying by the AMA. Medicare and Medicaid were established in 1965 and resulted in the expansion of academic medical centers across the nation. In fact academic centers have grown from less than 20,000 full-time faculty in the early 1970's to approximately 125,000 in 2007. This represents a four-fold increase in basic science faculty and a fourteen-fold increment in clinical faculty. Further, the social upheaval that occurred during the 1960s and 1970s changed the medical student culture and shifted the focus (to varying degrees) from the research focus of the Five Year Plan to more flexibility and an orientation to primary care medicine.

The conversion of traditional fee for service to managed care began in the late 1980s and early 1990s and had notable consequences, first in the Bay Area and then across the nation. In California and especially the Bay Area, a number of HMO and non-academic medical systems began a process of consolidation. Most notable among these were Kaiser and Sutter. Capitated health care began in the 1990's and while academic centers, including Stanford, were initially engaged, this did not play to their strengths. Also in the 1990's a number of academic centers, including Stanford, became increasingly competitive with community physicians or community hospitals. Several approaches were taken to address this – primarily by forming regional networks and systems. However, Stanford elected not to foster a relationship with a regional physician group – the Palo Alto Medical Foundation (PAMF). At that time PAMF, which was in need of cash for facilities, was eager to be assimilated into Stanford. When that failed, PAMF joined Sutter. This has had enduring consequences.

As competition increased in the 1990's and the tensions between payers (largely insurance companies but also Medicare) and providers became more acute, academic

medical centers took several approaches— some of which succeeded and many of which failed. One was to develop regional networks by purchasing community physician practices and/or community hospitals to create systems that would impact negotiations with payers. The University of Pennsylvania drove this model – and nearly collapsed as a consequence. Stanford (particularly SHC) bought a few practices, but they were not successfully managed and were divested in 2001.

At about this time mergers among academic medical centers began; these have had varying successes and failures. The most notable success is Partners Healthcare in Boston – in part because it was never a merger – but also because it created incredible market clout in Massachusetts (although this is now being challenged by the state government). The most notable failure was UCSF-Stanford, partly because of how it was conceived, managed and executed, but also because of the significant cultural differences between the two member institutions and the lack of buy-in by clinical leaders. When these mergers or consolidations worked they have had significant financial benefits. In California, Kaiser and Sutter (with PAMF) continue to succeed. In Massachusetts, Partners has been a major institutional success. On the other hand, when they have failed, there have been major negative financial impacts. The Mt Sinai-NYU attempted merger was a major loss. Similarly, the merger between Brown and Tufts failed significantly. The CareGroup merger, which is now succeeding, nearly led to the collapse of two premier hospitals. The Stanford-UCSF merger had major negative financial consequences for both institutions – and also for individuals.

#### *In Research*

Just as clinical programs expanded and grew in academic medical center following the initiation of Medicare and Medicaid, so did research – largely because of its support from the National Institutes of Health. From the 1950's through 2003, basic and clinical research increased in academic medical centers. That said, successful funding and academic program development were concentrated in “research intensive” schools. Still, most medical schools were able to continue to expand research programs and facilities through this period in tandem with funding support from the NIH and key foundations. Even though the competition for research has had periods where funding has become extremely competitive, until 2003-2004 it had mostly kept pace with biomedical research inflation.

The period of 1998-2003 was the doubling of the NIH budget from \$13 to \$26 billion. Many medical centers assumed that this funding would continue indefinitely and expanded research faculty and new facilities. Stanford was not among these. Since 2003 the NIH budget has been essentially flat – which means that it has lost 13% of its purchasing power compared to 2003. The flat budget was initially the consequence of limitations of discretionary federal dollars along with a loss of confidence in the NIH from the Congress and a broader anti-science movement in Washington DC and beyond. The duration of this NIH budgetary decline is unprecedented and is now putting enormous pressure on faculty (as well as students) who are competing for shrinking pie of dollars. At the same time, a portion of the NIH budget has been redirected to translational and clinical research as well as to “big science.” As a result, reductions in

support for graduate students and for RO1 research (which has been Stanford's forte) have taken place during the past 5 years.

### ***The Present Moment: Impact of the Present Economic Downturn***

The major forces now shaping medicine and science at both the institutional and individual levels are economic. These took a distinct turn for the worse in December 2007 and, as is well known to everyone, the global events and worsening recession of the past year have had unprecedented negative impacts. Many factors are involved – some of which have already affected our situation and many others of which are likely to unfold. These are challenging the fundamental organizational model of academic medical centers and universities and include the impact of the downturn on endowment and financial reserves. The University and the Medical School (as well as the hospitals) have already lost about 25% of the value of endowment investments. The downturn has also impacted not-for-profit foundations that provide support for research, in some cases at an even higher percentage loss than Stanford's, which means that funding for research from foundations has and will continue to decline. When coupled with the loss of research dollars from the NIH, NSF and other federal programs, this additional loss of research support is serious, and the situation is still deteriorating. Overall Stanford had a decline in research support in 2008 – although the level of NIH support is up in the first quarter of 2009.

An exception to this trend is funding from the California Institute for Regenerative Medicine (CIRM). Stanford has competed very successfully for both programmatic and capital funding from this organization. But given the state of both the California economy and the bond market, it is uncertain how this program will be affected over the next years. (And the funding could potentially run out in 2014 unless the citizens of California vote in a new bond.) Gifts, which traditionally support research, education, faculty and facilities, are also now challenged with the global economic downturn. Clinical revenues are still meeting budget, but these are also threatened. As the economy worsens, discretionary care will be postponed, which will affect some clinical services more than others. In addition, as citizens lose jobs and, as a result, medical insurance, or as small businesses reduce their insurance coverage for employees, individuals will seek less medical care. At some point the numbers of uninsured patients will increase.

The entitlement programs are also challenged. The Medicare Trust Fund needs attention (it goes bankrupt in 2017), and there will be a great deal of pressure to address this program, which on a national level covers more than 40% of medical care costs – although this is closer to 25% at Stanford. But Graduate Medical Education (GME) support is embedded in Medicare, and, when reform occurs, it is likely that GME will be affected – which will have enormous consequences for all academic medical centers, including Stanford. Medicaid (in California this is Medi-Cal) is already a very poor payer, especially for physician services. Our state has the second lowest Medicaid (Medi-Cal) reimbursement in the nation. The major impact of this rate is on pediatric care, and

the most serious consequence of the economic downturn for us is an increase in the percentage of Medi-Cal patients seeking care.

Overall, then, there are a number of serious risks to the current integrity of the university, medical school (as a formula school) and major affiliated hospitals. Within this context, the next months and year will witness a number of new policies and programs designed to address past and current problems – some of these can and will help our community and the nation, while others will pose new challenges. Prominent among these is the Obama stimulus package, which may provide some relief for research programs. It seems clearest that this will be the case for research in energy and the environment. But a compelling case is being made for biomedical research, which might at least allow the NIH budget to keep pace with inflation, hopefully after an adjustment that makes up for the serious losses of the past several years. *(In fact, in the days following the retreat, the approved “Stimulus Plan” ended up with \$10 billion of incremental funding to the NIH, thanks largely to the efforts of Senator Arlen Specter – which is great news, but which carries some additional challenges that I will discuss in a future Newsletter.)*

Some health care reform seems likely – which is good news. But the way this unfolds could affect support for academic medical centers. The likely focus will be on improved health management rather than disease management. The payment system will likely be focused on quality outcomes. There will probably be greater oversight over technology and how it is employed. There may be adjustments to the payment schedules for primary care versus specialty or procedure- based specialties. Addressing medical workforce issues will involve developing new roles for physicians and other health professionals and may change the current roles, especially for primary care providers. So, the stimulus package has the potential to either improve or potentially worsen the various elements of our institutional financial picture noted above (investment returns, fundraising, federal and state support, etc).

### ***Demographic Contrasts Between 1959 and 2009***

In addition to the significant institutional changes that have occurred over the past 50 years, there have been very significant individual shifts that affect career development and overall career satisfaction – and that also impact the culture of institutions, which, in turn, of course, are ultimately created by the individuals who work in them. For example, in 1959, when the medical school moved to the Stanford campus, women comprised a very small percentage of the medical school and graduate school classes. This has changed dramatically during the past several decades, with women now comprising more than 50% of incoming classes.

Career development, success and satisfaction appear to be different for women versus men, especially for clinical faculty. This is the result of multiple factors, including differences in the styles, expectations and culture of women versus men and the impact and timing of family. A high percentage of women (not only in medicine) begin their family in their 30s – at the time when the pressures for career development are most

notable. Many more families are now dual career, with both spouses working full-time. This is not only a consequence of a desire for career satisfaction. It has also been economically driven – something likely to continue or worsen in the years ahead.

Since 1959 longevity has increased, and the expectations of faculty to continue their careers into their 70's and beyond has increased. Based on a 2007 survey of all School of Medicine faculty age 50 and older, approximately a third of faculty over 50 years – and continuing for each age cohort thereafter – have done little to no financial planning and have little sense of what it would take to retire – or when to do so. This issue is likely to become even more serious with the current economic downturn, since virtually everyone has seen a significant decline in his or her investments, retirement plans and savings. However, faculty continue to work not only for financial reasons – but more so because of their commitment and interest in their research or professional life.

Since 1959 the professional life of faculty in academic medical centers has changed enormously due to external forces impacting medical schools, teaching hospitals and academic medical centers. For example, expectations for clinical performance for faculty have increased and are accompanied by metrics for volume, clinical activity, quality and service. These expectations create a nearly constant tension for clinical faculty regarding what they need to do to be clinically successful (and earn their salary) as well as academically successful. The lack of time is a constant pressure. In addition, the competition for grant support has increased – especially in recent years – and is impacting all research faculty, all of whom spend an increasing amount of time writing proposals in order to support their lab or research program.

This problem is further aggravated by the financial model of medical schools in the United States, which are based largely on “soft money” from clinical income and grants to support salary and programs. This puts the onus on the individual faculty member and makes it difficult for individuals to spend time doing things that do not generate revenue – such as teaching, mentoring, or reviewing the grant applications or publications of junior faculty and students. The tension extends to the expectations for clinical faculty by teaching hospitals and their administration balanced against the expectations of their department leaders, the promotion process, etc. The pressures on virtually everyone have increased.

Medical schools and universities still put the greatest focus on the individual and his or her success and place less value on the contributions of teams, and there is little inclination to encourage, or even permit, faculty (including clinical faculty) to work part-time or to job share. In contrast, over the past decades there has been a shift in the expectations and desires of individuals entering medical or graduate school in how they see their future and what is likely to provide career success and satisfaction. A higher premium is now placed on work-family balance (by men and women). For medical school graduates, career paths that allow for more work/life balance have become more desirable and competitive and attract the most talented individuals. The orientation has been away from primary care specialties (including general surgery) and more toward specialty areas – particularly dermatology, radiology, radiation oncology, anesthesia and

surgical subspecialties. Some, but not all, of this is driven by student debt – which is a real factor. Of note, Stanford has among the lowest levels of student debt for medical students in the nation.

The length of training has also increased and has become a limiting factor. Limits on the amount of time residents can work set different expectations than in previous generations of physicians. For those who go into clinical practice, the expectation now is that they will work in a group practice/HMO or staff model and receive a salary. They also expect that they will be able to job share and have time off for personal interests. These goals carry over to expectations for work-life balance in academic medicine. For graduate students, there is an increased interest in pursuing careers outside of academia. Currently at Stanford about 50% of PhDs pursue academic careers. But with the current economic conditions, opportunities in academia will decrease. Furthermore, a recent survey of PhD students in the University of California system found that a significant majority of this group does not envision careers in academic medicine as friendly to work-family balance. This, along with many other factors, means that we need to train PhDs for multiple career pathways and opportunities.

### ***Some of Our Accomplishments During the Past Eight Years***

Many institutions respond to these internal and external pressures in a reactive way. Others work proactively to establish their goals and expectations so that they can better chart their future directions based on internal planning as well as the ever-changing external forces.

During the past 8 years we have tried to take the latter approach by establishing an institutional agenda that permits us to chart our own desired direction rather than to simply reacting to a direction imposed by others. Obviously adjustments must sometimes be made in such planning activities due to unintended consequences to internal constituencies or in response to anticipated –or unanticipated – external forces. As you all know, the degree and severity of the current economic down turn was not predicted – nor can we predict how and when things will improve. This uncertainty makes current and future planning even more important since, in its absence, we could end up a very different institution at the end of this period than we wish or expect to be.

A number of the plans and strategic goals set by faculty, students and staff over the past 8 years have contributed to our institutional as well individual success. They have helped re-define the medical school, and they contribute to how we are viewed in the other schools at Stanford, across the nation and around the world. Among these are:

- ***Education***

- The New Stanford Medical Education Curriculum
- Improved support for graduate student tuition and education
- The Masters in Medicine Program for PhD students
- The Advanced Residency at Stanford Program for clinical fellows

- ***Research***

- Supporting faculty and opportunities for basic science research – including support for recruitment and related resources
- Success in achieving a CTSA
- Success in becoming an NCI-designated research center
- Provision of seed grants through the Institutes and other institutional programs that foster innovative and collaborative research
- ***Patient care***
  - Coordinated strategic and programmatic planning with both SHC and LPCH
  - Improvement in the financial support for clinical faculty (to date with SHC and pending with LPCH)
  - Significant improvements in quality performance through collaboration with LPCH and SHC
  - Recruitment of clinical faculty and program leaders (including division directors and chairs)
  - In collaboration with SHC and LPCH, dramatic improvements in the financial performance of both institutions
- ***Interdisciplinary and programmatic initiatives***
  - Formation of the Stanford Institutes of Medicine and Strategic Centers
  - Founding and development of the Joint School of Engineering-School of Medicine Department of Bioengineering
  - Programs in IT including the Center for Clinical Informatics
- ***Academic development and the workplace***
  - Significant improvements in promoting a respectful workplace
  - Creation of the Office of Diversity and Leadership
    - Faculty Fellows Program
    - Coordination with SHC and LPCH Leadership/Mentoring Program
  - Development of an electronic faculty appointments and promotions process
  - Reclassification of academic appointments and tracks
- ***Integrated institutional and facilities planning***
  - School of Medicine Master Plan
  - Coordination of programmatic and capital planning throughout the medical center
- ***Improved interactions within the medical school and with the university – the basis for cultural transformation***
  - The divide between basic and clinical science leaders that was so dominant at our first retreat has been successfully repaired.
  - The negative relations with the greater university that existed during and following the merger and de-merger (and prior to that) has been very significantly reversed and improved.
- ***Improvements in communications within and outside Stanford***
  - A decade ago Stanford Medicine was portrayed quite negatively in the press, which tended to focus on its negative and hostile workplace and only in a limited way on the role that Stanford Medicine played in transforming health and science. That pattern of communication has been

reversed, because of the improvements in our work place and the contributions of our faculty and also because of the efforts of our Office of Communications and Public Affairs.

- ***Leadership in public policy and related initiatives***
  - Stanford has played a leadership role in advocacy and support for research at both the state and national levels and in efforts to reverse the anti-science views that have been so dominant during the past 8 years.
  - Stanford has played a leadership role in addressing issues of conflict of interest in education, research and patient care.
- ***Success in fundraising***
  - During the last several years Stanford Medicine's success in fundraising has grown to become among the best among medical schools in the nation.

Within this context, the challenges facing us focus on what we need to do to make our institution as strong and successful as possible. To accomplish this mission we need to make the careers of faculty, students and staff as successful and fulfilling as possible. This will be particularly challenging given the forces now in play.

### **Present and Future Challenges and Opportunities**

Taken together, our history and its evolving culture, our workforce and its evolving composition and the external and internal forces impacting academic medicine in general and Stanford in particular, converge to present us with significant challenges as well as important opportunities. We are fortunate in being an institution whose mission is well-defined and whose faculty both recognize and feel aligned to that mission. But we are also an institution comprised of different constituencies with different goals, expectations and perceived support and recognition. Going forward we must seek to make Stanford Medicine as outstanding as possible – and one whose whole is clearly greater than the sum of its parts.

Achieving this goal will require support and recognition for all members of our community – even though their individual goals and objectives may vary. Such support begins at the individual level and is best expressed at the unit, division and department level. It mandates the focused engagement of our chairs, chiefs and leaders. It will require valuing all members of the community and recognizing that we cannot be a great medical center just because we do world-class research. We also need to deliver world-class clinical care and do so with excellence in quality and service. We must make education a valued priority. And we must recognize and support the different needs of our basic science faculty, our clinical faculty, and our clinician-educator faculty, as well as women and men faculty. Finally, we need to recognize and accommodate the need to balance professional careers with personal and family balance and, more broadly, to shape a work force that is suited to the pressures and demands of the 21<sup>st</sup> Century.

Based on these findings and issues, we can begin to set some goals and priorities that should become the responsibility of our units, divisions, and departments and their leaders. Some initial suggestions for discussion and action include:

- Given the pressures for research funding resource limitations, how can our divisions and departments better assure that our graduate students, postdocs and research faculty will be successful in their research careers?
  - How can the division or department best guide junior faculty to do world-class research and also balance their lives?
- Given the demands and pressures on our clinical science faculty, what innovative things can the division and department do to improve the quality of their professional life as well as their work-life balance?
  - Examples might include development of part-time appointments or even a “job-share” program.
- Being a great academic medical center requires that each member of our community feel valued and that everyone embraces shared missions and goals. While there is alignment around the importance of research, there appears to be lesser value given to our patient care mission – and this is felt particularly by Clinician Educators.
  - At the unit, division, department level, what can be done to better value and engage clinician educators? How can we transform our culture to such that Clinician-Educators feel and more valued member of our Medical School/Medical Center community?
- Given the economic challenges that stand before us, how can divisions and departments better align the constituencies that support missions in research, education and patient care – recognizing the multiple pulls and expectations coming from the medical school, the teaching hospitals and the university?
- What kind of interdisciplinary community building groups can be put together to foster interaction among otherwise diverse members of our medical school, medical center and university?
- Career development and faculty satisfaction evolve over time and throughout the span of one’s career. What cultural changes are needed at the unit, division and department level to provide mentoring and guidance for faculty during the various stages of their career – junior faculty, mid-career and senior faculty? Even more fundamentally, what cultural transformations are necessary to make this a shared responsibility and accountability between faculty and department leaders?

As you can see, we have an ambitious agenda – which we will begin to address during the rest of this retreat. However, the retreat is only the first phase of what will be an on-going set of initiatives at the department and division level that will indeed create a culture in our school that fosters faculty success.

## **How We Can Create a Culture That Fosters Career Development and Success**

Following my address (see above) the retreat attendees first identified a long list of issues and topics related to career development. From this list they voted individually for their top choices, which were distilled to a “Top 9” list. The attendees then broke into nine work groups that each addressed one of these important issues and themes and developed suggested action plans. The nine topics were:

- Valuing clinical care
- Mentoring
- Valuing collaboration
- Increasing the value of teaching
- Leadership diversity
- Clinician Educators
- Faculty development in times of financial constraint
- How to change the paradigm of the ideal worker: Designing new ways of working differently
- Metrics of faculty success

During the next weeks we will be asking each division and department to decide on one of these issues/topics to develop further and implement. Later in the year we will plan presentations from the departments and divisions that have worked on common themes and issues to share best practices and to thus advance our efforts to transform our culture to better foster career development and satisfaction for our faculty at all stages of the career pathway.

## **Upcoming Event**

Stanford Health Policy Forum: “AIDS: More Than A Virus”  
Wednesday, March 11  
11:00 am – 12:30 pm  
Clark Center Auditorium

The second event in the inaugural year of the Stanford Health Policy Forum series will feature a conversation with Dr. Peter Piot, one of the world’s leading AIDS policy experts, Dr. Piot, who recently completed 13 years directing all United Nations AIDS programs, will address the necessity of tackling the political and economic factors that contribute to the epidemic’s continuing proliferation. In a candid discussion with Paul Costello, Director of Communications for the Stanford School of Medicine, Dr. Piot will address AIDS as “more than a virus” before dialoguing with the audience.

Space in the Clark Center Auditorium is limited, so if you are interested in attending, please RSVP online at

<http://www.stanfordtickets.org/tickets/calendar/view.aspx?id=2443> or call the Stanford Ticket Office at 650-725-2787.

## Awards and Honors

- **Dr. Ralph Horwitz**, the Arthur Bloomfield Professor and chair of the Department of Medicine, learned that the ACGME Residency Review Committee approved all of the residency and fellowship programs with high distinction. This is an honor that reflects well on the department, division chiefs, program directors, faculty, staff, residents and fellows. Congratulations to all.
- **Dr. Tom Krummel**, the Emile Holman Professor and chair of the Department of Surgery, has been selected to receive the 2009 Santa Clara County Medical Association “Outstanding Achievement in Medicine” Award. Congratulations to Dr. Krummel
- **Dr. Ron Levy**, the Robert and Helen Summy Professor and chief of the Division of Medical Oncology in the Department of Medicine, will receive the King Faisal Award in Medicine in March 2009. Congratulations to Dr. Levy.
- **Dr. Tirin Moore**, Assistant Professor in the Department of Neurobiology, is among the 18 individuals who have been honored with an award from the National Academy of Sciences (NAS). She has received a Troland Research Award for her fundamental and insightful contributions to our understanding of the neuronal mechanisms that control directed visual attention. This award is given annually to young investigators to recognize unusual achievement and to further their research within the broad spectrum of experimental psychology.

## Appointments and Promotions

- **Jennifer M. Abidari** has been reappointed as Clinical Associate Professor of Urology (Pediatric Urology), effective 9/01/08.
- **Rodney Altman** has been reappointed as Clinical Assistant Professor of Surgery (Emergency Medicine), effective 12/01/08.
- **Kae Bendixen** has been reappointed as Clinical Assistant Professor (Affiliated) of Obstetrics and Gynecology, effective 1/01/09.
- **Jonathan E. Benjamin** has been appointed to Assistant Professor of Medicine at the Stanford University Medical Center, effective 2/01/09.
- **Cheryl Branson** has been reappointed as Clinical Assistant Professor (Affiliated) of Obstetrics and Gynecology, effective 1/01/09.

- **Michael J. Bresler** has been reappointed as Clinical Professor of Surgery (Emergency Medicine), effective 9/01/08.
- **Robert Castro** has been appointed as Clinical Professor of Pediatrics (Neonatal and Developmental Medicine), effective 2/01/09.
- **Stephanie Chan** has been promoted to Clinical Associate Professor (Affiliated) of Medicine (General Internal Medicine), effective 12/01/08.
- **Jing Wang Chiang** has been reappointed as Clinical Assistant Professor (Affiliated) of Obstetrics and Gynecology, effective 10/10/08.
- **Elizabeth G. Corrin** has been promoted to Clinical Assistant Professor of Psychiatry and Behavioral Sciences (Child Psychiatry), effective 9/01/08.
- **Glenn DeSandre** has been promoted to Clinical Assistant Professor (Affiliated) of Pediatrics (Neonatal and Developmental Medicine), effective 2/01/09.
- **Frederick M. Dirbas**, has been promoted to Associate Professor of Surgery at the Stanford University Medical Center, effective 2/01/09.
- **Marthand Eswara** has been reappointed as Clinical Assistant Professor (Affiliated) of Pediatrics, effective 9/01/08.
- **Christophe Gimmler** has been reappointed as Clinical Assistant Professor (Affiliated) of Medicine (General Internal Medicine), effective 9/01/08.
- **Dita Gratzinger** has been appointed to Assistant Professor of Pathology at the Veterans Affairs Palo Alto Health Care System and at the Stanford University Medical Center, effective 2/01/09.
- **Rami Keisari** has been reappointed as reappointed as Clinical Assistant Professor (Affiliated) of Pediatrics (Pulmonology), effective 2/01/09.
- **Rohit Khosla** has been appointed to Assistant Professor of Surgery at the Stanford University Medical Center and at the Lucile Salter Packard Children's Hospital, effective 2/01/09.
- **Edward Klofas** has been reappointed as Clinical Associate Professor of Surgery (Emergency Medicine), effective 9/01/08.
- **Sanjay Kurani** has been reappointed as Clinical Assistant Professor (Affiliated) of Medicine (General Internal Medicine), effective 12/01/08.

- ***Santhi Lingamneni*** has been promoted to Clinical Assistant Professor (Affiliated) of Medicine (General Internal Medicine), effective 2/01/09.
- ***Mendy Boettcher Minjarez*** has been promoted to Clinical Assistant Professor of Psychiatry and Behavioral Sciences (Child Psychiatry), effective 2/01/09.
- ***Miguel Moreno*** has been promoted to Clinical Assistant Professor (Affiliated) of Pediatrics, effective 2/01/09.
- ***Pravene A. Nath*** has been appointed as Clinical Assistant Professor of Surgery (Emergency Medicine), effective 1/01/09.
- ***Anna A. Penn*** has been reappointed to Assistant Professor of Pediatrics, effective 4/01/09.
- ***Kathleen L. Poston*** has been appointed to Assistant Professor of Neurology at the Stanford University Medical Center, effective 2/01/09.
- ***Daniel L. Rubin*** has been appointed to Assistant Professor of Radiology, effective 2/01/09.
- ***David Schneider*** has been promoted to Associate Professor of Microbiology and Immunology, effective 2/01/09.
- ***George Sternbach*** has been reappointed as Clinical Professor of Surgery (Emergency Medicine), effective 9/01/08.
- ***Clifford Wang*** has been promoted to Clinical Associate Professor (Affiliated) of Medicine (General Internal Medicine), effective 9/01/08.
- ***Lei Xing*** has been promoted to Professor of Radiation Oncology, effective 2/01/09.