

Dean's Newsletter

April 27, 2009

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Swine Flu Alert

As you undoubtedly know by now, the White House issued a public health emergency notification on Saturday (April 25th) to activate federal resources to deal with the H1N1 flu outbreak that has arisen in Mexico and that has created significant concerns about the possibility of potential pandemic. The strain of the isolate from Mexico is H1N1 (which is the same as that which caused the 1918 pandemic), but it is not yet clear what level of similarity the new strain has to others in terms of virulence (although a number of deaths have been recorded in Mexico, albeit not elsewhere to date). The Centers for Disease Control and Prevention is posting the latest information on the outbreak, and it will be updated as new information becomes available. You can access that website at: <http://www.cdc.gov/h1n1flu/>.

The general guidelines for control of influenza include a number of simple steps. Here are the ones advised by the CDC:

I recognize that our physicians and students are well aware of these guidelines but I mention them for all readers of this communication.

CDC Influenza Precautions

Influenza is thought to spread mainly person-to-person through coughing or sneezing of infected people. There are many things you can do preventing getting and spreading influenza:

There are everyday actions people can take to stay healthy.

Cover your nose and mouth with a tissue when you cough or sneeze. Throw the tissue in the trash after you use it.

Wash your hands often with soap and water, especially after you cough or sneeze. Alcohol-based hands cleaners are also effective.

Avoid touching your eyes, nose or mouth. Germs spread that way.

Try to avoid close contact with sick people.

Influenza is thought to spread mainly person-to-person through coughing or sneezing of infected people.

If you get sick, CDC recommends that you stay home from work or school and limit contact with others to keep from infecting them.

I should also add that the Emergency Preparedness Operations from the Medical School, Stanford Hospital & Clinics and the Lucile Packard Children's Hospital are already in communication, along with the University, and further advice and guidance will be issued as new information becomes available.

Honoring Student Clinicians and Resident Educators

On Thursday, April 16th we hosted the third annual Student Clinician's Ceremony to celebrate the students who will be entering their clinical rotations this summer. This ceremony recognizes the important transition that takes place when medical students complete their preclinical years and prepare for the journey into clinical medicine. In the past this transition has been thought of as the second phase of medical school. I prefer to consider it as part of a continuum, since the goal is to continue to link and unite the insights from the basic sciences to clinical medicine. That said, for our students this transition constitutes a departure from the world of books, PowerPoint presentations, journal articles and discussion groups to the life and death struggles of individuals facing the challenges of acute and chronic diseases. They are moving from discourse and discussions that are often team based to the personal connections that ultimately constitute the doctor-patient relationship. They will also now experience a different form of learning – anchored in individual patients but expanded from the evidenced-based data they have been focused on to the “art of medicine” taught by residents and more senior physicians as well as nurses and other professionals.

Becoming a student clinician brings with it new responsibilities and accountabilities – and the need to acquire and perfect the knowledge of clinical medicine as well as the humanism and professionalism of the compassionate physician. This transition is a major inflection point in becoming a doctor, and I am very pleased that we are able to acknowledge and celebrate this with our students who begin their clinical rotations this summer. I want to commend them for the completion of their preclinical

years, wish them well in the USMLE Part 1 and share in the moment of their personal development in clinical medicine.

I also recognize that as our students enter the clinical world they will have special contact with both the patients in whose care they participate and the residents and fellows who also play an important role in shaping their knowledge and professional lives. I well recall the transition from medical student to resident even though (amazingly) it was some decades ago. I also recall the incredibly important role that residents play as teachers – to students, to each other, to their patients and to the faculty, nurses and broad medical care team – as shown in a longitudinal study I did during my own internship (*Pediatrics* 1975; 56:239-45). It was most appropriate, therefore, that an important feature of the Student Clinician's Ceremony was the presentation of this year's Arnold P Gold Foundation Humanism and Excellence in Teaching Awards to six outstanding Stanford Residents. This year's awardees include:

- *Dr. Megan Daly*, Resident in Radiation Oncology
- *Dr. Stephanie Fisher*, Resident in Obstetrics and Gynecology
- *Dr. Amy Gallo*, Resident in General Surgery
- *Dr. Zach Koontz*, Resident in Internal Medicine
- *Dr. Eleni Unos*, Resident in Dermatology
- *Dr. Amy McCammond*, Resident in Pediatrics

I add my enthusiastic congratulations to each of these outstanding residents and commend the students who selected them as this year's awardees. The important role of Residents as Teachers has been fostered by many professional societies and has had strong leadership at Stanford, thanks particularly to the pioneering efforts of Dr. Kelly Skeff, the George DeForest Barnett Professor in the Department of Medicine. Dr. Skeff is also the co-director of the Stanford Faculty Development Center for Medical Teachers.

Best wishes to our students who will begin their clinical education – and the residents and faculty who will participate in their training and development as they grow in knowledge acquisition, professionalism and humanism.

Evaluating Student Clinicians

Traditions, especially when long-standing, can be an integral part of an institution's culture and can strongly influence individual expectations. When traditions come to seem like permanent fixtures they can sometimes get out of alignment to changing life and world events. The form and substance of traditions include values, events and cultural norms that are both stated and unstated and that may be adhered to strongly and sometimes unquestioningly. A long-standing and deeply held institutional tradition at Stanford Medical School has been avoiding formal evaluations that might create unwanted competition or negatively impact on the value of shared support among Stanford medical students. I value those assumptions and continue to support the avoidance of formal grades for preclinical studies. However, I have long felt that a more

formal evaluation process for clinical students is needed at Stanford, and I have expressed this view in numerous settings over the years I have been here.

There are obvious differences between preclinical and clinical studies and their immediate impact and outcome (also see above). The freedom to explore topics of interest, to study and learn at one's own pace and time line, to work in groups or alone in structured or unstructured ways: these work well for preclinical studies. And our students have a long history of mastering the preclinical sciences well and of demonstrating their acquired knowledge by outstanding performance on the USMLE Part 1. While I do not wish to suggest that the USMLE is the best metric of knowledge, it does provide a means for our students to be assessed in comparison to others taking this exam. While I recognize that there is a range of views about this, I do not see a need to recommending a change in the way preclinical students are evaluated.

However, the evaluation of clinical performance is another matter and, in my opinion, is closely linked to becoming the best physician possible. This is true for those studying to become doctors as well as for those who continue to study to remain excellent physicians. Today physicians are being evaluated for their performance, the outcome of which impacts their compensation as well as their reputation among their peers and the public. An outstanding doctor possesses knowledge that is constantly deepening and becoming more refined and informed by clinical experience as well as by awareness of the changing evidence-based disease literature and its relationship to the scientific underpinnings that define it. It also changes over time as a function of new data, research and clinical experience.

Knowledge in clinical medicine commences at the start of medical school but takes a new form when clinical rotations begin. The teachers of that knowledge include the patients the student encounters and the trainees and established (attending) physicians who participate in the care of the patient. It is informed by the medical and scientific literature as well as informal and formal interactions with residents, fellows, attending physicians, nurses and other health professionals. Assessing that knowledge can be objective (such as performance on knowledge based examinations) or impressionistic (based on interactions with one or more of the teachers noted above). Of course these are not mutually exclusive, and the best assessment of clinical knowledge (just like its acquisition) comes from objective measures as well as assessments by peers and supervisors.

A serious problem today is that the contact of a student with a team of residents and senior physicians is increasingly limited to short intervals because of work hour limitations and the more rapidly changing rotation schedules of attending physicians. In years past it was common for a team of medical students, residents and senior doctors to spend several weeks together in the care of patients and shared educational interactions. Today, such contacts are often for less than a week and are sometimes even shorter – making observed learning more limited and subjective. Moreover, this type of evaluation is potentially biased by favoring students whose personalities can lead to a style of presentation or interaction that implies more knowledge than might be actually be the

case. Conversely, such interactions can undervalue students who are more reserved, but whose actual knowledge is in fact quite deep. I do not want to suggest that the interactions and assessments by residents and attending physicians are not valuable – they are – but that they need to be part of a composite and coordinated evaluation.

Accordingly, it is important to define more clearly the expectations of knowledge-based performance and how it is evaluated by each clinical rotation and to make certain that students are informed of how they will be evaluated at the outset of each clinical experience. When this is not done, “shadow” evaluation systems emerge (as they have in fact done) that lack transparency and comparability

A part of the evaluation process includes defining the objective metrics of knowledge in specific clinical areas (e.g., the “shelf exam” prepared by the National Board of Medical Examiners – or other defined objective knowledge-based tools). I know there is some debate about the shelf exam and its merits. While no exam is perfect, the shelf exam is broadly used, and it is a tool our clerkship directors should evaluate further. If there is a more valid assessment of clinical knowledge it can be substituted for the shelf exam. But there should be an objective measure of clinical knowledge that is taken seriously by all. At the same time, it is important to couple this objective measure of knowledge with the interactive assessment of clinical knowledge and performance that is gleaned from observations by residents and attending physicians as noted above. However, those assessments need to be better defined and understood by the students and the evaluators.

Excellent knowledge in a clinical subject matter should be an expectation for all of our students, but it is not the complete portrait of what constitutes an exceptional physician. Skills in communication, assessment of physical findings and diagnostic tests, the ability to formulate a diagnostic and treatment plan, and interactions with members of the care team, including evidence of compassion and humanism, are all features of being an excellent physician. These skills can also be learned and should also be evaluated. Excellent knowledge without professionalism and compassion is not sufficient to be an outstanding clinician. Similarly, compassion without excellent clinical knowledge is also insufficient.

Assessments of physicians’ skills are increasingly becoming part of the fabric of medicine. As noted above, these include assessments of quality of care metrics and outcomes that are being increasingly linked to payment and that are becoming more publicly available and accessible. So too are objective measures of knowledge and, increasingly, service to patients. I recognize that physicians and medical institutions are paying attention to such metrics for a variety of reasons; in my view, one of the most important should be the desire to be the best possible doctor in every domain of medicine.

At Stanford, the evaluation of students doing clinical rotations has been loosely constructed. In some clinical rotations, faculty and students have taken assessments of clinical performance seriously and have sought ways to define excellence. Indeed, in some rotations a shadow evaluation system has emerged, although in a not very

transparent way. However, in most rotations the process is more informal. There is an assumption by some that every student performs in an outstanding manner and thus no formal assessment is necessary. There is also a concern that a more formal assessment would create competition among students doing a clinical rotation, and thus negatively affect their collegiality or community or even change the culture at Stanford. There is a view that a lack of formal assessments is not a problem for students graduating from Stanford since they do well in the Residency Match. In this view, coming from Stanford is a sufficient indicator of excellence and is one that is widely appreciated by residency training programs around the country. After all, Stanford is unique among its peers.

While I agree that Stanford is unique, I do not agree with the view that clinical performance is always excellent or that the way we have been evaluating our students is widely respected and valued by our community – either within Stanford or around the country. Nor do I believe that our current system of “pass”, “marginal pass” (and/or the so called “N” grade) or “fail” is appropriate, sufficient, transparent or meaningful. Further I do not believe that this system fosters the best education and training for students doing their clinical rotations at Stanford – or in communicating performance to those who will be entrusted with continuing their future education.

Based on these observations and conclusions, I have had a series of recent meetings and discussions that confirm the changes in the assessment of clinical performance by Stanford students during their clinical rotations that I will highlight below. This includes concurrence by the clinical clerkship directors, the deans for medical education, the faculty advisors and the chairs of our clinical departments. In defining the changes that will occur I want to add that this will be a work in progress. I shared these policy changes at a Town Hall Meeting of medical students on April 20th and received many thoughtful and important questions. As I indicated to the students who were able to attend that Town Hall Meeting, we are receptive to their thoughts, recommendations and suggestions about how to make our evaluation system better but with one important caveat. The evaluation system for clinical performance is going to be changed. With that, here are some of the outlines of that change:

- The clinical clerkship directors have been instructed to develop a new system of evaluating clinical performance to be implemented in the summer of 2010. This new evaluation system will apply to all students entering clinical rotations at that time –thus, it applies to our current first year students as well as to students who will be emerging from their research experiences to begin clinical rotations in the summer of 2010. I fully recognize that first year students and those in multi-year programs entered Stanford with a different expectation, but I view the changes as something that will help them become better physicians and that will enable them to receive feedback that is more meaningful to their career development.
- Because we want to take the next year to refine the new evaluation system, it will not apply to students who will be entering clinical rotations in the summer of 2009, with some important caveats that I will comment on below.

- The new evaluation system should assess knowledge and clinical performance based on objective measures (e.g., the shelf exam or its alternative) as well as evaluations by residents and attending physicians. Such assessments must include all domains of clinical performance – from knowledge to professionalism and humanism. Further, those criteria need to be defined and shared with those doing the evaluations and ratings as well as with the students.
- The new evaluation system will apply to required rotations in 2010. In future years they will be extended to elective rotations (including sub-internships), although I would hope that the criteria would be applied to electives, etc by 2011.
- While the exact terms are yet to be defined, I instructed the clerkship directors to develop specific criteria for the following categories. I should quickly add that the actual terms can be changed – these names are placeholders that are meant to capture the intent.
 - Exceptional performance
 - Satisfactory performance
 - Marginal performance
 - Unsatisfactory performance
- As noted, initially these criteria will apply to only the required courses. The factors and metrics that define each category should have both common features across all clinical disciplines and also specific ones that are relevant to individual clinical rotations. The criteria for evaluating students will be made explicit to all students and faculty and should be readily accessible. They should also be made available at the beginning of each clinical rotation so that students understand the expectations and criteria by which they will be assessed.
- There will be no preset curve or limit on the number or percentage of students who can receive an Exceptional Performance during a rotation or during a specific year. For example, if all the students on a specific rotation fulfill the criteria for Exceptional Performance, they will all receive that rating. If none fulfill the requirements then none will receive it. We will not predetermine how many students during any given year will receive an Exceptional Performance rating in any rotation. And we will work with faculty to guard against any tendency or bias to limit or “curve” student performance. In the end, the evaluations should follow the criteria that have been established.
- Exceptional Performance should reflect accomplishments in all domains – knowledge, professionalism, quality and service. Excelling in knowledge alone or in professionalism alone will not merit an Exceptional Performance – it must reflect achievements in all areas.
- As part of the new evaluation system, faculty and students will be counseled on expectations. This includes not only the criteria for performance but also the need for an evaluation discussion and feedback at the beginning, at mid-rotation and at the conclusion of each rotation. We will certainly pay attention to inter-rater reliability issues that apply to all evaluation systems. This is one

of the reasons for using objective and defined criteria as well as knowledge metrics as part of the evaluation process

- The clinical performance will be a part of the overall student assessment. Other components include the preclinical experiences (including the USMLE Part 1), research and scholarship, participation in joint degree programs (where appropriate), assessment by faculty advisors and mentors, and narrative summaries of performance. All of this information will be shared with residency directors as part of the student performance evaluation (including in the “dean’s letter”). In doing so, we will also make residency directors aware of the changes we are making in the evaluation system at Stanford, to whom those changes apply and the time lines that are being employed. More specifically, we will share the specific criteria used to determine exceptional and satisfactory performance. Once we have this information, not sharing it would be dishonest and, in my opinion, inappropriate.
- As noted above, the new evaluation system will commence in the summer of 2010 for required clinical rotations and over the next year(s) will be rolled out to include electives and sub-internships. Students who are mid-way in their clinical rotations (that is, they began in 2009 or are returning to clinical rotations after an out-year) will have the same evaluation system in required rotations taken after summer 2010 as students beginning rotations for the first time in 2010. However, we will not share the rating of Exceptional Performance to residency programs for students who have already completed a year of clinical rotations. That information will be for internal use but could help shape the comments used in the students “dean’s letter”.

As I noted above, the clinical clerkship directors, led by Dr. Elizabeth Stuart, will be responsible for developing and recommending the criteria by which to assess each of the aforementioned performance domains over the next year. My plan is to make the criteria transparent and broadly shared by the early spring of 2010. That will also enable us to inform faculty and others who participate in the evaluation system about the expectations and criteria that will become effective in the summer of 2010. During that time there will be many opportunities for students to offer comments and suggestions for improving the system. What is clearly decided at this point is that we will be moving forward with these changes and with the time lines for implementation delineated above. That said, there are many details to be worked out, and we will be receptive to all constructive comments and suggestions. In closing, I want end where I began. My goal is to have systems in place that will help all of our students achieve their potential of becoming exceptional physicians.

The Stimulus Stimulates NIH Applications

No one in academic medicine is unaware of the looming impact of the ARRA (American Recovery and Reinvestment Act) on science and technology – and the NIH specifically. After six years of funding levels below inflation, ARRA has added \$10.4 billion to the NIH for research, equipment and construction, with the important caveat

that it be spent before September 2010. Information about funding opportunities has been flowing fast and furious, and there is a lot of helpful information and updates about ARRA opportunities on the Research Management Group (RMG) website (see: http://med.stanford.edu/rmg/funding/nih_recovery%20act_funding_opps.html). These are complemented by Jeanne Heschle's frequent updates about ARRA and other funding opportunities. Indeed, over the past weeks faculty have been busily writing grants and proposals for the first wave of submissions; these include Challenge Grants and Administrative Supplements, which are due Monday, April 27th. This is the first wave of submissions, with more to come in the months ahead. To prepare for the April 27th submission deadline RMG staff have been working late into the night during the past two weeks processing grants for submission. We are extremely appreciative of their efforts and those of the other support teams who are working hard to help faculty compete for ARRA funding.

The actual number of grants that will be submitted continues to change day by day. As of Saturday, April 25th there were 207 Challenge Grants moving to the final process for submission – with more expected in the next days. In addition, RMG has already submitted 89 Administrative Supplements and 28 Shared Instrument Grants. And there will be more supplements, GO (grand opportunity) grants, major facility, faculty search and other grants forthcoming – in addition to the regular run of RO1 and related grants. This is truly an unprecedented time in every way – and certainly one that will achieve one of the major ARRA goals of preserving and creating jobs, as well as supporting science and technology – and hopefully ultimately advancing medical care and treatment.

I want to begin by thanking *Kathleen Thompson*, Director of RMG, and *Sonia Barragan*, Associate Director, for leading this effort and for helping to assemble and train a great group. *Jeanne Heschle* has done a great job in communicating all of the announcements from NIH and in helping to set up a very helpful website. I also want to thank all the RMG Staff and support staff who have been working so tirelessly to get grants ready for submission to NIH:

- ***RMG Team Managers*** - Amy Barelli, Luke Delong and Gabriela Valencia
- ***Research Process Managers (RPM)*** - Nadia Burke, Gayle Campbell, Josephine Dao, Linh Dinh, Karen Fisher, Candy Housholder, Javier Illueca, Gladys Morales, Karen Mulkey, Linda Murtagh, Natalie Muzzio, Dymphna Nagar, Elaine Nguyen, Mary Palmer, Tracy Reynolds, Randy Rodriguez, Andy Roybal, Bach-Hong Tran, and Anna Eredia (Temp).
- ***RPM Associates***- Michael Canizares, Cecilia Fajardo, Martha Galvez, Teresa Hinkle, Valentin Salazar, Rolanda Smith.
- ***CT Group*** - Debbie Leong-Childs, Ruth Bondy, Diana Cook, Amanda Graves, Marta Krupa-Pionowska, Julie O'Neill, Elizabeth Sotelo, Karen Wong, Anne Anastasi.

- **Administrative Staff** - Laura Butler, Mila Dacorro, Mario Garcia, Colleen James, Karen Kellner, Tiffany Binderup

Staff in academic departments have also worked diligently to meet the NIH deadlines. These include Ophelia Zalamea, Susan Kopiwoda, Sue Elliott, Kathy Fisher, Tara Trim, Diane Bush, Hoa Nguyen and Manolia Margolis.

We also want to thank the many people who have worked hard and whose names we haven't mentioned. Again, special thanks to all – and best wishes to our faculty in winning new NIH awards.

Stanford Graduate Students Featured in Open Lab Visits

On Saturday, April 18th the Bioscience Programs held an “open lab event” showcasing the work done by Stanford graduate students. This event was originally championed by Dr. Andy Fire, Professor of Pathology and of Genetics, as a way of better educating the community about basic science research and the excellence of Stanford’s graduate student programs. With the assistance of Denise Ellestad, Senior Director of Development Programs, and members of the Office of Medical Development, an excellent program was configured that proved highly successful.

Approximately 35 guests from the community first heard a broad introduction to the Stanford Bioscience Program from Drs. Andy Fire, Ron Kopito (from the school of Humanities & Sciences), Steve Quake (Bioengineering) and Carla Shatz (BioX) and were then divided into nine groups. Each group toured a specific lab with a faculty guide, met with graduate students and postdocs in that lab and observed demonstrations of their work. These were hands-on visits, and from the reports I have already heard from some of our visitors, they were exciting and very well received. The lab visits were followed by an interactive lunch with the students and visitors – again very well received.

In addition to thanking our faculty and the Office of Medical Development, I want to particularly thank our graduate students for their spirited and inspirational presentations and discussions. They included the following:

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| • Sherlock Lab (Genetics): | Dan Kvitek, Jared Wenger, Yuba Kobayashi |
| • Kay Lab (Pediatrics): | Neil Phillips |
| • Herschlag Lab (Biochemistry): | Sergey Solomatin, Max Greenfeld |
| • Straight Lab (Biochemistry): | Kirstin Milks, Ben Moree |
| • Kornberg Lab (Structural Bio): | Dave Bushnell, Dong Wang, Brian Gibbons |
| • Boothroyd Lab (Micro/Immuno): | Matt Anderson, Yi-Ching Ong |
| • Kopito Lab (Biology): | E Greenblatt, S Trevino, R Tyler, J Olzmann |
| • Utz Lab (Medicine): | Alvina Chu, Jordan Prize |
| • Spudich Lab (Biochemistry): | J Min Sung, P Chuan, S Sivaramakrishnan |
| • Steinman Lab (Neurology): | S. Bronwell, B deJong, M Han, B Axtell, P Ho |
| • Frydman Lab (Biology): | Steffanie Duttler, Bryan Chen |

- Quake Lab (Bioengineering): Aaron Streets, Paul Blainey, Angela Wu
- Luo Lab (Biology): M Spletter, L Sweeney, J Wu, L Liang
- Nusse Lab (Developmental Bio): Xinhong Lim
- Fire Lab (Pathology): Eleanor Marshall, Poornima Parameswaran

Thanks to all for a great event. The next similar event will be held on June 3rd.

Dr. Michele Barry Joins Stanford as Senior Associate Dean for Global Health

I am very pleased to announce that on May 1st Dr. Michele Barry will join Stanford as the Senior Associate Dean for Global Health and also the Director of Global Health Programs in the Department of Medicine. The Senior Associate Dean position is a newly created post that reflects the School and Medical Center's commitment to the importance of education, research and patient care issues related to global health. While a number of our faculty are involved in research in global health and others conduct education and patient care activities in a wide variety of international settings, we have lacked a central or coordinating office or an individual identified to lead the School's efforts in this increasingly important area. Dr. Barry is an ideal choice for this role and we are fortunate and thrilled to have her joining Stanford.

Dr. Barry joins Stanford from Yale where she has been a Professor of Medicine and Global Health and Director of Yale's Office of International Health. At Yale she has also directed the Yale/Johnson and Johnson Physician Scholar Award program that has sent over a thousand physicians to work overseas to strengthen health infrastructure. Dr. Barry has enormous personal experience working, conducting research and teaching in international areas. In addition, she is an expert in tropical medicine and emerging infections as well as in the health problems of developing nations consequent to globalization. Importantly, she is highly regarded for her scholarship, research and leadership. She is a member of the Institute of Medicine of the National Academy of Sciences, where she has been chair of the IOM's Interest Group on Global Health, Infectious Diseases and Microbiology. She has served as the President of the American Society of Tropical Medicine and as the Executive Board Chairperson of the Professional Education and Training Committee at the International Society of Travel Medicine.

As she gets ready to begin her new role at Stanford, Dr. Barry has laid out some short and longer term objectives based on the many meetings and discussions she has had with faculty, students and staff throughout the Stanford community. A primary goal is to create the Office of Global Health, which will anchor the school's efforts and create synergies with the greater university and especially the Freeman-Spogli Institute for International Studies at Stanford. Part of this effort will be developing a global health web portal codifying faculty activities to make them accessible and engender collaborations and interactions. Dr. Barry also hopes to bring scholar award programs to Stanford that will permit resident trainees as well as faculty members to work in a number of international sites. She is also anticipating programs for medical students and this summer will be helping to facilitate the "Global Health Services Corps" at Stanford,

which helps place college students in various sites around the world. Applications for this summer's program are now closed, but Dr. Barry will outline opportunities for future programs after she arrives.

Dr. Barry has informed me that she plans to initiate a seminar series in September that will focus on the broad aspects of global health – from medicine to engineering and environmental sciences as well as ethics, economics, policy and other important topics. This will be open to students, residents and faculty. Details will follow.

In addition to these immediate goals, Dr. Barry has begun to layout her longer-term objectives, which I know she will be eager to share in the months ahead. In the meantime I hope you will join me in welcoming Dr. Michele Barry to Stanford.

Rising in the Ranks in US News & World Reports

I admit to having a challenging relationship with the USNWR annual ranking of medical and graduate schools over the years. As I have discussed in prior Dean's Newsletters, a major concern has been the weight given to total NIH funding, which favors schools with large faculty numbers. Obviously this has a negative impact on smaller research-intensive medical schools like Stanford, whose faculty numbers are half to 10% of those at peer institutions. I was relieved a couple of years ago when the editors of USNWR changed the methodology to include NIH research grants per faculty member, where Stanford does extremely well. However, the relative blending of total NIH funding and funding per faculty member still favors size as a surrogate for quality.

Despite my concerns, it is (at least on a relative scale) good news that the Stanford School of Medicine rank rose to #6 in the 2009 USNWR listing that was published on April 23rd (in truth, we are "tied" for sixth with Duke, U. Washington and Yale). The major methodological factors used in the ranking include quality assessment (which is really a reputational score), research activity (which is really a 2:1 blending of total funding and funding per faculty member), student selectivity (which includes admitted students GPA, MCAT scores and acceptance rate) and faculty resources. Clearly some of the important measures are missing – like what happens to students who graduate and the degree of indebtedness incurred by students, among others.

Regardless of whether one likes the methodology used in these rankings, it is clear that the core factors reflect the success and accomplishments of our students and faculty and that is something very much worth valuing – above and beyond any score. I do very strongly believe that we have the best students and faculty and, in my opinion, on that score we are #1!

While the MD part of medical schools are ranked annually by USNWR, the PhD graduate programs are ranked less frequently. These rankings, when they are done, are based mostly on a reputational score. The last time the biosciences were ranked was in 2007. At that time Stanford was #1 overall with specialty rankings of #1 in biochemistry/biophysics/structural biology, genetics/genomics/bioinformatics; #2 in

immunology/infectious disease and microbiology and in neuroscience/neurobiology; and #3 in cell biology and molecular biology.

So, despite all my misgivings, Stanford is doing quite well – thanks to our faculty and students.

Some Notable Events

- ***The 2009 Beckman Symposium*** led by Dr. Lucy Shapiro, Ludwig Professor of Developmental Biology and Director of the Beckman Center, was held on April 13th and addressed Global Health and Emerging Infectious Diseases. The symposium featured experts from academia, foundations and industry and addressed a wide range of topics, from the use of genomic approaches to emerging infectious disease surveillance and discovery to major themes in global health challenges including tuberculosis, HIV, cholera, salmonella and vaccines. It was an outstanding symposium thanks to the leadership of Dr. Shapiro and the co-sponsorship of the Stanford Institute for Immunity, Transplantation and Infection.
- ***The East-West Alliance*** held its third annual meeting at Stanford from April 15-16 and focused on longevity and aging from the molecular and cellular determinants of aging to the social issues and disparities that impact longevity, the workforce challenges in addressing an aging population and the economic and societal factors the result from increasing longevity. This two day symposium was coordinated by the East West Alliance, a federation of institutions around the world that have received gifts or support from the Li Ka Shing Foundation – which, for Stanford, includes gifts for the Learning and Knowledge Center and a professorship currently held by Dr. Alan Yeung and past support for hepatitis research.
- ***Stanford Alumni Experience The Cutting Edge***. On Saturday, April 25th, nearly 200 alumni and family members participated in a unique hands-on experience hosted by the Alumni Association. Called The Cutting Edge, it enabled small groups of visiting alumni to participate in up to three interactive sessions that ran that gamut of Stanford Medicine. Sessions were led by Stanford faculty and included such wide ranging topics as “Biotechnology: Filling the Education Gap” to the use of a “Simulation-based Endovascular Curriculum on Trainee Performance and Clinical Outcomes in Vascular Surgery” to the use of “Small Interfering RNA as a Therapeutic Modality” or “Imaging Using Molecular Spies”, “The Biomechanics of Human Motion”, “Visual Anatomy: Past, Present and Future” or “Personalized Medicine”. It was a great program and I want to thank Dr. Ross Bright, the Alumni Association and the Office of Medical Development – which did an incredible job with all the complicated logistics. This was a great way to reacquaint alumni with each other and with the present and future of Stanford Medicine.

Honoring Stanford Alumni: The Sterling Awardees

The Stanford University Medical Center Alumni Association honored two prominent graduates of the School of Medicine with the JE Wallace Sterling “Muleshoe” Lifetime Alumni Achievement Award. This year’s awardees are:

- **Paul M Ellwood, Jr, MD ’53**, advisor to seven presidential administrations on health care, planner for the National Center for Health Services Research and Development (now known as AHRQ), founder of the Jackson Hole Group on health policy research, founding member of the National Association of Rehabilitation Centers and Clinical Professor of Pediatrics, Neurology and Physician Medicine and Rehabilitation at the University of Minnesota. Dr. Ellwood currently lives in Wyoming and is still actively engaged in health care policy through his Health Leaders InterStudy (<http://home.healthleaders-interstudy.com/index.php>).
- **Robert Schimke, MD ’58**, renowned scientist and Stanford faculty member who served as Chair of the Department of Pharmacology and, subsequently, of the Department of Biological Sciences. His research contributions have been recognized by numerous awards and honors, including the Sloan Prize, election to the Institute of Medicine and the National Academy of Sciences, and presidency of the American Society of Biochemistry and Molecular Biology.

Awards and Honors

Dr. Shreyas Vasanawala, Assistant Professor of Pediatric Radiology at the Stanford University School of Medicine and Co-Director of Pediatric MRI at Lucile Packard Children’s Hospital, was awarded the Lauterbur Award by the Society of Computed Body Tomography & Magnetic Resonance for his scientific paper “Faster Pediatric MRI with Compressed Sensing”. His collaborators included Marcus Alley, PhD; Gary E. Gold, MD; Robert J. Herfkens, MD; John Pauly, PhD; and Michael Lustig, PhD. The Lauterbur award is presented annually for the best original research in MRI, and this is the first time the Lauterbur award has recognized fundamental research performed by a faculty member at a children’s hospital. Congratulations, Dr. Vasanawala.

2009 Paul & Daisy Soros Fellows

We have just learned that Stanford is again the recipient of four new Soros Fellowship “awards "designed to assist immigrants and their children prepare for opportunities for leadership in their various fields in the United States." This year’s recipients include:

- **Ronald Wakim Alfa** - born in Santa Ana, CA (his parents from to the US from Lebanon), is currently an MD/PhD student at Stanford
- **Michael Chiu** - born in La Jolla, CA, (his parents came to the USA from Taiwan and Hong Kong) is studying medicine at Stanford

- ***Edward Pham*** - born in Ho Chi Minh City, Vietnam, is currently studying medicine at Stanford
- ***Roberto Valladares*** - born in Santa Monica, CA (his parents came from Guatemala) is currently studying medicine at Stanford

Please join me in congratulating these 2009 Soros Fellows. This year's Fellows were selected from 750 applicants. Of all the Soros Fellows from 1998 to the present who have studied medicine, 24% had or are attending Stanford Medical School.

Appointments and Promotions

- ***Ravindra Majeti*** has been appointed to Assistant Professor of Medicine, effective 5/01/09.
- ***Rajat Rohatgi*** has been appointed to Assistant Professor of Medicine, effective 5/01/09.
- ***Anne M. Villeneuve*** has been promoted to Professor of Developmental Biology and of Genetics, effective 5/01/09.