

Dean's Newsletter

October 25, 2010

Table of Contents

- A Discussion on The Future of Medicine and Healthcare
- Leadership Matters
- Some Thanks for the Visit by His Holiness the Dalai Lama
- Advocacy and Research
- Major Appointments
 - Mark Krasnow
 - Mike Longaker
- The Fall Issue of Stanford Medicine is Available
- Rathmann Family Foundation E4C Faculty Fellowship in Patient-Centered Care
- Upcoming Events
- Awards and Honors
- Appointments and Promotions

A Discussion on The Future of Medicine and Healthcare: Some Personal Reflections

On October 16th I participated in a *Presidential Colloquium on the Great Challenges of the 21st Century* at my medical school alma mater, the University of Rochester. Because 2010 is also my 40th year since graduation (no comments necessary), the Colloquium offered me an opportunity to review, through my own personal lens, some of the tremendous changes that have occurred in science and medicine and to reflect on what they might mean for the future of health care. Dr. Hugo Sonnenshein, President Emeritus and Adam Smith Distinguished Service Professor at the University of Chicago, served as the moderator of the Colloquium. Other discussants included Steve Goldstein, CEO of Strong Memorial Hospital, and Dr. Sanjay Gupta, Chief Correspondent for Health and Medicine at CNN.

A longitudinal perspective provides the chance to weave together some of both the positive and the negative events that inform us where we are today and to offer insights about some of the challenges and opportunities that lie ahead. The parallel and intersecting aspects of science and medicine are notable; considerable growth has occurred in the biomedical research enterprise as well as the medical care establishment since I entered medical school. Together they have shaped the medicine we deliver today and have helped define the academic medical centers where we carry out our work.

On the positive side, the public investment in science and medicine has placed the United States at the acme of global excellence. Central to this achievement has been the continuous funding of biomedical research, particularly by the National Institutes of Health and the National Science Foundation, along with other federal and state agencies, private foundations, industry and philanthropic support. Even though we have seen, in both the last decade and the current one, large positive and negative swings in the funding levels (as measured against inflation), the size of the biomedical workforce has grown (as

have many academic medical centers) and the pace of innovation and discovery has been startling and not infrequently breathtaking.

Because the expectations for the pace of medical advances by the public (and public funders) exceed the timeline required for discovery to reach maturation or application, it is easy to lose sight of how much progress has been made and what this signals for our future. Scientific discoveries can seem unconnected until one insight frames another in a new light, or lays the groundwork for a new understanding or scientific advance that sometimes makes sense only in retrospect. But the global leadership of the USA in scientific innovation and discovery is unquestioned – even with the increasing (and welcome) competition in basic research from centers throughout the world.

In contrast, as our excellence in science accelerated and yielded major payoffs during the past decades, a number of the outcomes of our investments in “healthcare” have been less salutary, despite the fact that the USA spends more on medical care than any other nation in the world. A fundamental issue is that we have lacked an organized healthcare system and have instead a patchwork quilt of public and private payers and not infrequently goals and objectives that can be perversely aligned between payers, providers and patients. Ironically, some of the very technologies and discoveries that have been developed to improve healthcare also drive up its cost– and some create distance and even barriers between patient and doctor.

While the Affordable Care Act (ACA) of 2010 seeks to remedy the ailments afflicting our healthcare system, most agree that it is just a beginning - and an expensive one at that. Cost control and a reformation of healthcare delivery are yet to come, but progress in these important areas is impacted by the economic downturn and the strong political sentiments and viewpoints governing public debate and discourse about the economy, our nation’s health and healthcare itself. The cost of healthcare is at the heart of the matter, but this is an issue that is seen differently by doctors, nurses and other professionals as well as by hospitals, insurers, industry, government and of course the public. Ultimately, controlling the cost of healthcare and reforming our delivery system will require everyone’s engagement – which seems destined to evolve slowly and painfully. But changes are necessary.

Not surprisingly, my prescription for change includes continued investment in innovation and discovery – although I would include innovation in healthcare delivery as an important accompaniment to innovations in science and medicine. Also not surprisingly, I view academic medical centers as playing a key role in these transformations – a view based on my own personal historical reckoning. During my presentation in Rochester, I gave a handful of examples– clearly only a microcosmic and personal view of the many macrocosmic changes that have occurred and that lie ahead.

- I recalled the incredible impact on me as a first year medical student when my preceptor, a pediatric hematologist-oncologist, took me to see one of his patients with newly diagnosed acute leukemia. I well recall my initial reaction to this

incredibly ill child and my inability to comprehend how a physician could care for dying children. Of course I didn't recognize during those seminal moments that my subsequent career of four decades would focus on childhood cancer and that I would be witness to discoveries and innovations by physicians and scientists that transformed this incurable disease into a treatable one. *I learned a number of additional lessons from this experience, including how cooperation and collaboration of teams of physicians, nurses, social workers and other professionals could form interdisciplinary teams to provide comprehensive care. I also learned that even complex care could be organized and guided by clinical protocols that improved treatment outcomes and permitted continued longitudinal learning. And, I learned the important connection between the care providers, child and family in the continuum of life and death. These lessons offer important ways to think about future healthcare delivery.*

- I recounted my first day of internship at the Children's Hospital Boston, when I attended a two-year old child with bacterial meningitis that, despite antibiotic therapy, had resulted in significant neurologic consequences for this previously healthy child. Fortunately, one of my early mentors was deeply engaged in developing a vaccine that would eventually prevent nearly all cases of *Hemophilus influenzae* meningitis and that would also provide insights for developing other important vaccines as well. *Here the lesson is that research aimed at root cause and prevention can have major public health benefits. It is evidence of the patient commitment of physician-scientists to discover innovations that could transform the course of a devastating disease. Rather than simply seeking new antibiotics, this investigator was committed to finding ways to prevent rather than just treat. This also required important collaborations between academia and industry. It is also a lesson that research can take years and even decades to reach fruition and that deeply committed investigators cannot be deterred by failure or satisfied with just the achievement of short-term goals. These are all important lessons for the future.*
- I noted that during my medical and post-graduate education there was no mention or even awareness of the disease that would dominate my research life for many years while I was at the NIH. That is because new or previously unrecognized diseases can emerge, as was the case with the Human Immunodeficiency Virus and AIDS. *There are many lessons that were learned with this unique disease, including the incredible social stigma that accompanied its diagnosis and that still lingers today. Devastating illnesses can evoke fear and stigma as well as compassion and care. There can be little question that we have made incredible progress in treating HIV infection and in preventing its vertical transmission from mother to child. Of note, this progress was largely facilitated by basic science discoveries that had taken place more than a decade before HIV was first recognized in the early 1980s, and by investigators who did not anticipate HIV/AIDS per se.*

Specifically, the recognition of retroviruses and, in particular, the enzyme reverse transcriptase, proved critical in accelerating the quest for diagnostics and therapies for HIV. This fact underscores the importance of basic research whose impact may not be immediately discernible even while it sets the foundation for future discoveries. HIV/AIDS also points out how travel has impacted emerging infections and how our global community still suffers incredible disparity in access to treatments and discoveries. We are further witness to globally transmitted diseases today, such as influenza, and will undoubtedly continue to face new challenges in the years ahead.

- In some ways it is shocking – if not embarrassing – to admit that when I graduated from medical school, CT and MR scans had not yet become integral to the diagnostic imaging armamentarium. Over the ensuing decades these and other imaging technologies have transformed medical diagnosis and have led to tremendous progress in virtually every area of medicine – from diagnosis to treatment and prevention. But these rapidly changing technologies also pose a number of challenges. In addition to the promise that imaging technologies will move to the cellular and molecular level and technology, permitting opportunities for early diagnosis and intervention, the overuse of imaging and other technologies has also contributed to the rising costs of medical care. Imaging technologies have been the basis of competition among hospitals and providers, and they have sometimes negatively affected medical decision-making through overreliance on tests as well as by inadvertently separating the doctor from the patient. *Although an important lesson is that technology can rapidly change the diagnostic landscape, it can also elevate costs and contribute to perverse incentives. A lesson going forward is the importance of critically assessing new technologies and employing them on data driven standards that promote quality of clinical care. Another lesson is the importance of sustaining and valuing the important connection between doctor and patient, which technology can inadvertently interrupt – with a loss in the perceived value of a relationship that innovation cannot replace.*
- I also commented on the fact that when I was a medical student the “genetic code” was just being unraveled. Indeed, a palpable anticipation abounded that the rapidly evolving new knowledge would unlock the mystery of life. But as has happened over and over again, each new scientific insight takes us another step closer to the complexity of life and opens new paths and cycles of inquiry, discovery - and further inquiry. We recall the fanfare that surrounded the sequencing of the human genome and the expectation (at least by the media) that the alphabet of life would spell out opportunities for new drugs, diagnostics and treatments. While some of this has occurred and there is every reason to believe that over time major benefits will unfold, meeting public expectations always takes longer than initially anticipated. Looking back over the revolution in molecular biology that has unfolded in the last decades, the discoveries and their application to medicine have been truly awe inspiring – certainly when viewed with perspective. *But a constant lesson is how the hype of discovery, even if*

unintended, can raise and then dash public expectation and ultimately its support. There is a constant and nearly unquenchable thirst for news about science and medicine. There is also confusion, disenchantment and cynicism when promises exceed the timeline of reality. This is a road we seem to travel over and over again – whether it be in the utility of genomic testing to predict disease, or the prospect that stem cells will help correct or repair diseased organs or tissues.

I certainly believe that over time these discoveries will have a revolutionary impact on our approach to early diagnosis and prediction of risk, disease management, therapeutics and beyond. But it is important that we balance the risks and benefits of new discoveries and avoid a rush to commercialization or over-utilization that is not grounded in science and evidence. For example, as the prospect for full genome testing and genotyping become increasingly less expensive and more abundantly available, we need to assure responsible management of public expectation. This is a forum in which academic medical centers can play a particularly important role – whether it is in defining the appropriateness of genotyping, the prospect for regenerative medicine, or the myriad of other discoveries and innovations that will unfold in the years ahead.

These are just a small handful of personal examples. Countless others can be added and many readers will have personal reflections that extend well beyond my own. But the lessons are also clear. While innovation and discovery will shape the future of medicine, it is also important to rekindle, remember and re-introduce some of the lessons of the past, especially around the quality of the doctor-patient relationship.

I was fortunate as a medical student to be at a school that valued and championed the so-called biopsychosocial model and that focused on teaching students the art of listening to patients, taking careful medical histories in an open-ended fashion, and in carefully using the physical exam to extend medical diagnosis. I recognize that there were many technologies and tools that we lacked at that time – but ironically it was their absence that mandated more attention to listening, observing and directly interacting with patients. Of course there was also more time to do so, since the business of medicine was not yet in place.

I have spoken previously and written not infrequently about the importance of reconnecting science and innovation with humanism and professionalism. These attributes are all the more important as we face the soon to be rapidly changing landscape of healthcare – particularly given the response of the public and private sectors to the Affordable Care Act (ACA) and also the impact of declining funds for biomedical research from the NIH over the years ahead. Both of these factors have serious implications for academic medical centers – which, while only a small part of the medical enterprise, are the font of educating future students and trainees as well as in leading innovation and discovery and translating their findings into improving patient care. As I have previously highlighted, academic medical centers, along with other care systems, will be judged by the communities they serve on whether they are seen and valued as centers of innovation and discovery, are providers of outstanding state-of-the-art patient

care, offer the highest quality and safety, provide outstanding patient services and give evidence of cost-effective and value-added care. At Stanford we do well in some of these attributes but not in all. Going forward we will need to perform superbly in each and will need to have evidence of continuous improvement over time.

It is likely the impact of the ACA will be expressed differently in various parts of the USA. The challenges will vary for different communities and, while some governing principles and complexities will be constant, individual adaptation will be essential. Clearly we can't simply react to the changes that will occur – we need to anticipate them and in fact lead them. We can of course learn from other peers and communities, but, in the end, we will need to chart our own unique course. This includes recognizing the very consolidated healthcare market that already exists in the Bay Area, where we clearly need to provide differential value. It means creating networks of primary care providers who are linked to our specialty services and of training the individuals who will be the future providers and innovators of science and medicine. It means paying careful attention to the size and scope of our faculty and workforce; calibrating and reassessing our programmatic and capital investments (both on campus and off-campus); developing new partnerships with industry and insurers using different expectations and metrics; and strategically planning the alignment of our clinical services as well as how they benefit from and contribute to innovation. And we need to consider novel ways of improving our healthcare delivery in a more team-based, protocol driven, evidence-based and value-added fashion.

I previously highlighted Atul Gawande's commentary on healthcare in his June 2010 New Yorker article entitled The Cost Conundrum (see: http://www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande). His work and that of numerous others point to examples around the country where lessons can be learned about the organization of medical care. The health care system in Grand Junction, Colorado has been cited as one example of lower cost and higher quality. While the conditions are radically different, some of the principles that have been put into practice there are worth highlighting, as was done by a Perspective by Thomas Bodenheimer and David West entitled "Low-Cost Lessons from Grand Junction, Colorado in the October 7, 2010 New England Journal of Medicine (<http://www.nejm.org/doi/full/10.1056/NEJMp1008450>). As noted by Bodenheimer and West: "*We believe that seven interrelated features of the health care system that may explain the relatively low health care costs could be adopted elsewhere. These are leadership by the primary care community; a payment system involving risk sharing by physicians; equalization of physician payment for the care of Medicare, Medicaid, and privately insured patients; regionalization of services into an orderly system of primary, secondary, and tertiary care; limits on the supply of expensive resources, including specialists, beds, and equipment; payment of primary care physicians for hospital visits; and robust end-of-life care. These features could be replicated in other markets — though generally not without political battles.*"

Even though many of the features of the ACA won't unfold for years, many observers note that changes are already underway and that they are unlikely to be

influenced by potential changes in the Congressional House and Senate in the upcoming midterm elections. They stand as reminders to take responsible leadership now as we work to shape and reshape the future of Stanford Medicine.

Leadership Matters

On Tuesday, October 19th I had the opportunity to participate in one of the “Fireside Sessions” of the Medical Leadership Development course, which is now in its third year. This year the course directors are Vitelio Rodriguez (SMS2), Takudzwa Shumba (SMS2), Matthew Goldstein (SMS6+) and Robin Eisenhut (SMS3). Ms Julia Tussing, Associate Dean for Educational Programs and Services, serves as the course Facilitator and Dr. Charles Prober, Senior Associate Dean for Medical Education, is the Faculty Director. The course (PEDS 201) includes six fireside chats with selected leaders who share their personal journeys and lessons learned along with six skill workshops that address topics like “What is Leadership?,” “Influence,” “Communication and Emotional Intelligence,” “Conflict Management,” “Self-Knowledge” and “Teams.” There are relevant readings and discussion groups – all aimed at introducing “fundamentals of effective leadership in the exciting and dynamic environment of health care. The primary objective of this curriculum is to provide students and residents with a theoretical and functional knowledge of leadership through participation in activities of self-discovery and leadership immersion.”

I was pleased to be part of this course and also deeply appreciative of the leadership of our students in organizing this year’s course, as well as those run previously by medical and graduate students. These programs help shape our future leaders – one of our primary goals and objectives in the medical school. These programs are complemented nicely by additional courses run by the Office of Diversity and Leadership under the leadership of Dr. Hannah Valentine, including the popular and highly successful “Faculty Fellows” program. Programs for leadership development are also offered by Stanford Hospital and Clinics and the Lucile Packard Children’s Hospital at Stanford.

The University also has several leadership development and networking programs, three of which include participation of faculty and staff from throughout the university. This year several School of Medicine faculty and staff as well as staff from Stanford Hospital and Clinics and Lucile Packard Children’s Hospital have been selected for one of these three programs, including:

- **The Stanford Leadership Academy:**
 - *Douglas W. Blayney*, Ann & John Doerr Medical Director-Stanford Cancer Center and Acting Professor of Medicine and Oncology, Stanford Hospital and Clinics
 - *Timothy Carmack*, Chief Financial Officer, Lucile Packard Children's Hospital
 - *Edward Kopetsky*, Chief Information Officer, Lucile Packard Children’s Hospital

- *Beverly S. Mitchell*, George E. Becker Professor in Medicine and Professor, by courtesy, of Chemical and Systems Biology, School of Medicine
- *Kim Pardini-Kiely*, Vice President for Quality and Clinical Effectiveness, Stanford Hospital and Clinics
- **The Stanford Fellows:**
 - *Renee Pera*, Professor of Obstetrics and Gynecology, School of Medicine
 - *Tom Rando*, Deputy Director-Stanford Center on Longevity and Professor-Neurology and Neurological Sciences, School of Medicine (Continuing for a second year)
- **Leadership@Stanford**
 - *Heidi Heilemann*, Associate Dean for Knowledge Management and Director of Lane Medical Library, School of Medicine
 - *David O'Brien*, Director-Office of Institutional Planning, School of Medicine

Clearly these various programs give evidence of the commitment of the School, Medical Center and University to leadership development and training. These programs help with acquisition of new skills as well as opportunities for interaction and networking across the campus – all of which should hold Stanford in good stead over the challenging years ahead.

Some Thanks for the Visit by His Holiness the Dalai Lama

On October 14-15th, His Holiness the Dalai Lama returned to Stanford after five years to participate in three public events on the theme of “Compassion, Science and Society.” On the morning of the 14th he was welcomed in Maples Pavilion by President Hennessy before speaking to an audience of over 6,000 on the subject of “The Centrality of Compassion in Human Life and Society.” That afternoon he spoke to 1200 students at Memorial Church as the Rathbun Visiting Fellow, where he gave this year’s “Harry’s Last Lecture on a Meaningful Life.” The next day he took part in an all day conference at Memorial Auditorium on the “Scientific Explorations of Compassion and Altruism.” Over 1600 people heard reports by neuroscientists, psychologists and educators as well as the Dalai Lama’s comments, questions, and dialogue with the presenters. Thursday’s events are described in greater detail in this Stanford Reports story: <http://news.stanford.edu/news/2010/october/dalai-lama-speaks-101410.html>. The conference is well summarized on the School of Medicine’s blog (<http://scopeblog.stanford.edu/archives/2010/10/dalai-lama-and.html>). By every account this was a highly appreciated and successful visit.

These events required many months of planning by numerous individual throughout the University. I want to begin by thanking Dr. Jim Doty, Director of the Center for Compassion and Altruism Research and Education (CCARE: <http://ccare.stanford.edu/>), and Dr. Gary Steinberg, Director of the Stanford Institute for Neuro-Innovation and Translational Neuroscience, for leading the effort to bring the Dalai Lama back to Stanford. I also want to thank the Reverend Scotty McClellan, Dean for Religious Life, and his office for their incredible engagement. Ms. Elaine Enos,

Executive Director of Stanford Events, worked tirelessly to coordinate the incredible array of issues needed for a “head of state” visit. In the medical school I want to extend my deepest thanks to Dr. Kathy Gillam, Senior Advisor to the Dean, and Ms. Kristin Goldthorpe, Project Manager in the Dean’s Office. Their contributions were incredible and helped contribute to the success of the visit.

Advocacy and Research

At each meeting of the Independent Citizens Oversight Committee (ICOC), the governing board for the California Institute of Regenerative Medicine (CIRM), a public scientific and patient advocacy presentation is given. This helps educate the ICOC as well as give purpose to its work in overseeing the nation’s largest program in stem cell biology and regenerative medicine. I have been an appointed member of the ICOC since 2004 and have attended hundreds of meetings over the years. I was particularly touched by the presentation that took place on October 21st in Los Angeles on the topic of Neuromyelitis Optica (NMO). This is a rare disease, but it has devastating consequences for those affected by its major manifestations of blindness and paralysis. Like many orphan diseases, there is often a paucity of investigators and a lack of funding. That was clearly the case for NMO until a small number of parents became advocates and created a foundation to bring investigators together, support their research and help move the agenda forward. The Guthy-Jackson Charitable Foundation was created by parents Bill Guthy and Victoria Jackson (www.guthyjacksonfoundation.org) and has had an impressive impact.

This is a story told over and over again. I remember it well from the early days of Pediatric AIDS when the Elisabeth Glaser Pediatric AIDS Foundation was created to promote research and bring investigators from different fields to focus on a new and challenging problem. There is no question that patient advocacy has helped shape our research agendas and has created alignments between patients, parents, scientists, physicians and public and private funders. I have tremendous respect for each of these programs and what they have been able to accomplish. I only wish we didn’t need to learn the lesson over and over again. The need to bring researchers together from different institutions to focus attention and effort on new (or even old) diseases is something we should clearly understand. Ironically, each new effort seems to recreate past insights and demonstrate the important connection between those impacted by serious illness with those who have the potential to impact its clinical course.

I once tried to address this need by establishing a more generic research network to be ready and able to tackle new problems as they arose by aligning major children’s research programs. This was the Glaser Pediatric Research Network – but in the absence of specific disease advocates there was no ready way to sustain the infrastructure needed to keep the network active. Thus we seem destined to have to create and recreate specific efforts. Even so, as they arise they are meaningful and important – as was the experience of the Guthy-Jackson Foundation noted above.

Major Appointments

I am pleased to announce two major faculty appointments to important leadership programs in the School of Medicine:

- **Dr. Mark Krasnow**, Professor and Chair of the Department of Biochemistry and Investigator in the Howard Hughes Medical Institute, will serve as the Executive Director of the Vera Moulton Wall Center (<http://wallcenter.stanford.edu/>). In this capacity he will oversee the Center's research programs and help align them to the clinical programs led by Dr. Jeff Feinstein, Associate Professor of Pediatrics. The Wall Center is now part of the Cardiovascular Institute at Stanford.
- **Dr. Mike Longaker**, the Deane P. and Louise Mitchell Professor and, by courtesy, Professor of Bioengineering and of Materials Science and Engineering, has been named the Co-Director of the Stanford Institute for Stem Cell Biology and Regenerative Medicine. In this capacity he helps shape the Institute's efforts in translational medicine and discovery. Dr. Longaker is also the Director of the Program in Regenerative Medicine. He was named Vice Chair of the Department of Surgery this past June and also serves as the Director of the University-wide Initiative on Human Health.

Please join me in thanking and congratulating Drs. Krasnow and Longaker for their willingness to serve in additional leadership positions. We are fortunate to have them in these roles.

The Fall Issue of Stanford Magazine Is Available

The Fall issue of Stanford Magazine has just been released and is on its way to readers now. It is also online at <http://stanmed.stanford.edu>. The theme of this issue is "The 'me' in medicine – personalizing treatments." The lead piece is a feature about the use of genome analysis to uncover the cause of a teenager's sudden death — a story revealing the practical and ethical challenges of whole-genome sequencing. There is also a story on gene-targeted treatment for triple-negative breast cancer and an article that looks beyond genes to describe a newly discovered type of molecule - called lincRNA - that tells our genes what to do. The issue also has a piece on the Genomics and Personalized Medicine course offered last summer that includes comment from the faculty and students who participated in the class. I have previously commented on the issues surrounding the question of whether students should be given the opportunity to have their genotypes analyzed and I was pleased to see this thoughtful article. Congratulations to Rosanne Spector, Editor, and all those who worked on this edition, for another excellent issue of Stanford Magazine.

Upcoming Events

United Nationals Film Festival

Wednesday, October 27th

4:00 pm

Li Ka Shing Center

Free admission

The United Nations Association Film Festival (UNAFF) will, for the first time, show screening of three films at Stanford Medical School's state-of-the-art Li Ka Shing medical school building, a natural home to the themes of health and human rights that are a common thread in these films. From the voices of former child slaves in Sudan, to the plea of a mother determined to protect her daughter from the dangers of genital cutting, to the travels of a retired man who bikes 20 km each day to bring AIDS treatment to his community, these three films are a testament to the power of human will and determination.

At 5:45 pm there will be a discussion panel with Stanford faculty, followed by a reception with the filmmakers at 7:00 pm. For more information please contact Shah Ali at shahali@stanford.edu.

Reception: New Exhibit in the History of Neurosurgery at Stanford

Friday, October 29

3:00 pm

Lane Library

The Department of Neurosurgery at the Stanford University School of Medicine has distinguished itself in clinical care and research in neuro-oncology, pediatric neurosurgery, stem cell research, and many other areas. But did you know that teaching and training in neurosurgery at Stanford can be traced back to San Francisco in the 1890s at Cooper Medical College, the predecessor institution to Stanford's School of Medicine? The Stanford Medical History Center and Lane Medical Library are proud to present an original exhibit on the history of neurosurgery at Stanford. The exhibit is now on display on the first floor of Lane Medical Library, near the main entrance. This is the first in a new series of exhibits on the history of the Departments and programs in the Stanford University School of Medicine that will be featured in Lane Library.

Dr. Gary Steinberg, Chair of the Department of Neurosurgery, will speak at a reception at the exhibit on Friday, October 29 at 3:00 p.m. For more information about the reception or the exhibit, please contact Drew Bourn, Curator at the Stanford Medical History Center in Lane Library, at dbourn@stanford.edu or (650) 725-8045.

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Final Draft

Rathmann Family Foundation E4C Faculty Fellowship in Patient-Centered Care

The Stanford School of Medicine Office of Medical Education is pleased to announce the **Rathmann Family Foundation Educators-4-CARE (E4C) Fellowship in Patient-Centered Care**. This program will provide the part-time salary support for a Stanford faculty, fellow, or chief resident to pursue further study and activities focused on the promotion of patient-centered care in medical education. Areas of focus may include instructional design, curriculum development, or evaluation. Alternatively individuals may have topical areas of focus, such as clinical skills, compassion and humanism, or professionalism.

The program will provide funding for protected time for one year to support directed readings under the supervision of the faculty directors of the program, participation in ongoing curriculum development in undergraduate medical education in the area of patient-centered care, and development and conduct of a scholarly project in medical education related to patient-centered care. The fellow will participate in the Educators-4-C.A.R.E. (E4C) program, serving as a mentored preceptor with selected E4C faculty in educational activities that are part of the E4C program. The program will provide \$50,000 in salary support for one year, plus up to \$5,000 in project support for the fellow's project.

Interested individuals should submit the attached application, CV, and cover letter **by Friday, December 17, 2010** to:

Clarence H. Braddock III, MD, MPH, FACP
Professor of Medicine and Associate Dean, Medical Education
Office of Medical Education
Stanford School of Medicine
251 Campus Dr., MC 5404
Stanford, CA 94305-5404
E-mail: cbrad@stanford.edu

Awards and Honors

- **Dr. Hannah Valantine**, Senior Associate Dean for Diversity and Leadership and Professor of Medicine, is the recipient of one of six Pathfinder Awards recently announced by the NIH to support innovative approaches to increasing diversity in the nation's scientific workforce (see: <http://med.stanford.edu/ism/2010/october/diversity.html>). Dr. Valantine will receive \$2 million over three years to explore ways of helping female faculty overcome "stereotype threat" that could impact their career development. This is an extremely important issue, and Dr. Valantine is playing an increasingly significant role in advancing this field – and helping our faculty. Please join me in congratulating Dr. Valantine.

- **Dr. Carlos Bustamante**, Professor in the Department of Genetics, was named a MacArthur Fellow on September 27th (see: <http://med.stanford.edu/ism/2010/september/bustamante.html>). Because of the timing of the announcement, I did not get to congratulate him in the DNL and want to take this opportunity to do so. This is a wonderful accomplishment. Dr. Bustamante joins Drs. Per Harbury and Julie Theriot, both in the Department of Biochemistry, who were named MacArthur Fellows in 2005 and 2004 respectively. Congratulations to Dr. Bustamante.
- **Dr. Tom Krummel**, the Emile Holman Professor and Chair of the Department of Surgery and the Susan B. Ford Surgeon-in-Chief at the Lucile Packard Children's Hospital, was elected the President of James IV Association of Surgeons, which was founded in 1957 to develop closer ties between surgeons and to sponsor visiting fellowships for outstanding young surgeons. Congratulations to Dr. Krummel.

Appointments and Promotions

Maria D. Allo has been reappointed as Clinical Professor (Affiliated) of Surgery, effective 9/1/2010.

Douglas Blayney has been appointed to Professor of Medicine at the Stanford University Medical Center, effective 10/01/10.

Michelle T. Cao has been promoted to Clinical Assistant Professor of Psychiatry and Behavioral Sciences, effective 10/16/2010.

Jeffrey Chi has been promoted to Clinical Assistant Professor of Medicine, effective 10/1/2010.

Kathleen M. Corcoran has been appointed as Clinical Assistant Professor of Psychiatry and Behavioral Sciences, effective 11/1/2010.

Melanie R. De Guzman has been appointed as Clinical Assistant Professor (Affiliated) of Obstetrics and Gynecology, effective 9/1/2010.

Cynthia L. Detata has been reappointed as Clinical Assistant Professor of Obstetrics and Gynecology, effective 9/1/2010.

Manuel Garcia-Careaga has been reappointed as Clinical Professor of Pediatrics, effective 4/1/2010.

David R. Drover has been reappointed to Associate Professor of Anesthesia at the Stanford University Medical Center, effective 11/01/10.

Robert M. Holaway has been appointed as Clinical Assistant Professor of Psychiatry and Behavioral Sciences, effective 10/16/2010.

Frederick Hopkins has been appointed as Clinical Associate Professor (Affiliated) of Obstetrics and Gynecology, effective 9/1/2010.

Nasha Nasim Sabery Khavari has been appointed as Clinical Assistant Professor of Pediatrics, effective 11/1/2010.

Tzielan Lee has been promoted to Clinical Associate Professor of Pediatrics, effective 10/16/2010.

Hau Liu has been reappointed as Clinical Assistant Professor (Affiliated) of Medicine, effective 9/1/2010.

Deirdre J. Lyell has been promoted to Associate Professor of Obstetrics and Gynecology at the Stanford University Medical Center, effective 10/01/10.

Friedrich Moritz has been reappointed as Clinical Assistant Professor (Affiliated) of Anesthesia, effective 9/1/2010.

Mary E. Norton has been appointed to Professor of Obstetrics and Gynecology and, by courtesy, of Pediatrics, at the Stanford University Medical Center, effective 10/01/10.

Jongsoo Park has been promoted to Associate Professor of Neurosurgery at the Stanford University Medical Center, effective 10/01/10.

Donald Schreiber has been reappointed to Associate Professor of Surgery at the Stanford University Medical Center, effective 11/01/10.

Paul J. Sharek has been promoted to Associate Professor of Pediatrics at the Lucile Salter Packard Children's Hospital, effective 10/01/10.

Nayan Sivamurthy has been reappointed as Clinical Assistant Professor (Affiliated) of Surgery, effective 2/1/2010.

Shannon S. Sullivan has been promoted to Clinical Assistant Professor of Psychiatry and Behavioral Sciences effective 10/16/2010.

Noushafarin Taleghani has been promoted to Clinical Associate Professor of Surgery, effective 9/1/2010.

Kimberly Valenta has been promoted to Clinical Assistant Professor of Anesthesia, effective 11/1/2010.

Volney Van Dalsem III has been reappointed as Clinical Associate Professor of Radiology, effective 9/1/2010.

Nancy Ewen Wang has been promoted to Associate Professor of Surgery at the Stanford University Medical Center, effective 10/01/10.

Lynn M. Westphal has been reappointed to Associate Professor of Obstetrics and Gynecology at the Stanford University Medical Center, effective 3/01/11.

Sang Hoon (Jonathan) Woo has been promoted to Clinical Assistant Professor of Medicine, effective 10/1/2010.