

Dean's Newsletter
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Academic Medicine: One Country at a Time

On February 17th and 18th I had the opportunity to attend and participate in the Association of Academic Health Centers (AAHC) International meeting in Sydney, Australia. Over the past several years AAHC has brought together leaders from medical centers around the world to share knowledge and experience about the state of global academic medicine. This was the 2nd Asia- Pacific Meeting of the AAHC International. As the past Chair of the AAHC Board of Directors I have had the opportunity to participate in a number of these annual meetings and have been impressed by both the similarities and the differences in goals and objectives in different parts of the world.

Because the alignment of schools of medicine with other professional schools and teaching hospitals has existed in the US for than a century, it is easy to imagine that similar organizational structures exist worldwide. This is not the case, but it is notable that in the past decade a number of countries have worked toward creating academic health centers of various configurations. Of course, one must be quick to point out that in the US academic health centers are highly variegated in organization and governance as well as in goals and missions and size, scope and complexity. The adage that "if you have seen one academic medical center, you have seen one academic medical center" holds true in the US, but it also has an international correlation in that each country's efforts appear different from those of others. That said, there are some striking similarities as well.

For instance, it seems clear that nearly every leader of a medical school aspires to an organizational structure that brings alignment to the tripartite missions of education,

research, and patient care. The AAHC International meeting in Sydney focused primarily on Asia and the Pacific Rim and included discussions from leaders of developed and still developing nations. In some cases (e.g., China, Thailand) the size of hospitals frequently exceeds 2000 beds; in these settings the patient throughput is enormous, and it dominates the time and focus of the physicians. Similarly, the number of students is measured in the hundreds to thousands – clearly different from the experience in the US.

In other countries (Australia, New Zealand, Singapore), the size of the patient care facilities is measured in the hundreds of beds, but the services provided are influenced enormously by the geography (e.g., rural versus more urban settings) and of course the economy. Regardless, there is a common aspiration to demonstrate the value of the academic center – even when it barely exists. For example, in Australia the discussion about whether an academic center has true value to the community it serves – and even whether “academic” is an appropriate descriptor – is noteworthy. In Singapore, a decade of effort has now led to three and soon-to-be four academic centers that bring together medical school/university faculty with hospitals and government.

A common recognition among the AAHC meeting participants was the need to change the hospital-centric focus that has dominated the past decades to a more distributed delivery system. And, not surprisingly, there seems to be a common thread in the need to train and distribute more primary care physicians, to develop more teamwork between doctors, nurses and other health professionals and to focus more on prevention and population management than higher end care. That these themes were pervasive in virtually every nation represented at this meeting underscored a commonality in the state of healthcare that was surprising to me. Equally surprising were the difficulty of moving to effective “healthcare reform” in most nations and the similarity of the deeply divided opinions in other countries to the ones that have dominated the US with one exception. In most countries healthcare is seen as a human right – which is still a source of debate in US.

Whereas academic medical centers in the US are often self-governed, the roles of ministries of health and education have created more of a dividing line in many countries, separating the missions of education and patient care – a theme I noted when AAHC compared the state of academic health centers in Europe and South America to that in the US. At the same time, the seemingly global desire to better align research, education and patient care, to speak more effectively to improved models of healthcare delivery and to champion social justice as valued themes in academic medicine offer encouragement and promise for the future – even with the many challenges that need to be addressed during the years ahead.

The Coming Impact of the Elderly on Academic Health Centers

The topic I was asked to address at the AAHC International meeting in Sydney was the “The Academic Health Center and Problems of the Aging Population.” I thought this assignment was somewhat ironic since some decades ago my personal decision about caring for the elderly was to follow a career path in pediatrics! Now that I am officially

joining the ranks of the “elderly” (at least in a relative sense) and am increasingly cognizant of the healthcare challenges that lie ahead on both a personal and a societal level, this topic seems increasingly propitious. Further, the family-based care models that are so integral to the care of children with complex chronic disorders offer some insights and relevance to the management of the elderly. Needless to say, these issues will be of increasing importance to the future of Stanford Medicine as the demography of our population shifts and healthcare resources become challenged and constrained.

If 2010 marked the 100th anniversary of the Flexner Report, which defined the structure, organization and even missions of academic medical centers in the US, 2011 marks the beginning of the first wave of the transition of the “baby boomer generation” to senior status. Over the next two decades the number of US citizens over the age of 65 years will increase from the mid-30 million to over 70 million individuals. Based on this bulge, senior citizens will comprise 20% of the population of the US (compared to about 12% today). These major shifts will have significant consequences for individuals, families, and communities – and of course for our healthcare system and the economy.

Each generation brings unique characteristics and some challenges that are different from prior ones. Relevant to family centered care, the baby boomers tend to have fewer children, higher divorce rates and greater geographic dispersion compared to prior generations. This reduces the numbers and accessibility of “informal” care providers traditionally comprised of family and friends. The healthcare “expectations” of the baby boomer generation are higher than for past seniors, and it is expected that they will be more likely to seek and use healthcare services. This is already an issue since seniors already disproportionately use healthcare services. For example, seniors account for 26% of doctor office visits and 35% of visits to nurse practitioners, even though they currently constitute about 12% of the population. Seniors also account for 35% of hospital stays, 38% of visits to emergency departments and 34% of drug prescriptions (mostly due to antihypertensives, antilipidemics, hormones, CNS and GI drugs).

With ever-increasing longevity, it is expected that the demand and expectations for medical services will increase and will be further fueled by changes in technology and innovations – as well as changing patterns of risk factors that predispose to chronic disorders. For example, the decline of tobacco use in the baby boomer generation will mean less lung cancer, cardiovascular and other smoking related disorders. While this is good news, its positive impact is challenged by the rapid increases in obesity we have seen in recent years and the impact of obesity on chronic health disorders (diabetes, cardiovascular disease, bone and joint abnormalities). With aging the impact of neuropsychiatric disorders, particularly depression, looms larger. Further, the prevalence of dementias and their associated effects on the integrity of the family and healthcare system will also increase.

The current economic downturn in the US, as well as globally, will also influence the care of the coming elderly population. Many emerging seniors have witnessed major erosions in retirement savings and have lost jobs and economic security – especially since life spans are projected to increase beyond the availability of personal savings for a

number of seniors. Loss of employment and state pensions aggravate this further and are the consequence of local-regional as well as national events and decisions.

The healthcare of individuals 65 years and older cannot be separated from the major issues and challenges that have surfaced during the debate on healthcare reform that led up to the Affordable Care Act (ACA) of March 2010. Despite the debate, often uninformed by facts, that the ACA was a “government takeover of the American healthcare system,” the reality is that federal and state entitlement programs (particularly Medicare and Medicaid) provide over half of US healthcare expenditures and are the major source of healthcare insurance for individuals over 65 years of age. Now in its 46th year, Medicare is the major provider of hospital, ambulatory and even nursing care programs for the elderly. In the aggregate Medicare provides more financial support per unit of care for inpatient and technical services than for ambulatory ones. At the same time, most teaching hospitals and physicians have concluded that reimbursements from Medicare are below the cost of services; this has led to a shift of costs and reimbursements to private payers.

With the looming US deficit (now over \$14 trillion) and the increasing call for deficit control, reductions in federal and state programs seem inevitable. Even though the currently proposed “\$100 billion budget reductions” are being debated in the US Congress, the reality is that these cuts would have little impact on the major entitlement programs (Medicare, Medicaid, Social Security), and it is implausible that these programs can remain untouched if true economic balance is to be restored. But the politics surrounding this debate are incredible and rancorous and best left out of this Newsletter. That said, one of the looming changes in Medicare is the coverage of the Graduate Medical Education (GME) payments to teaching hospitals, which have been embedded in Medicare since it was passed in 1965. Whether the funds for GME are decreased or redirected, the consequences for teaching hospitals and academic medical centers will be significant. Such changes are likely to unfold in one manner or another and will be driven, in part, by the reality that unless changes are made, the Medicare Trust Fund will be bankrupt in 2017-2019.

Clearly these and related challenges will affect the tripartite mission of academic health centers in education/training, research and patient care – in general and specifically in the care of the elderly. Despite decades of knowing that the aging of the baby boomer generation and consequent rise in the population of elderly was coming, we in the US seem ill-prepared to address the challenges – in the education and workforce we have available, in our knowledge and research related to aging and the elderly and in our patient care services. Few medical schools and academic centers in the US have emphasized training in geriatric medicine or psychiatry – and yet the workforce needs will be significant. Currently there are just over 7000 geriatricians and approximately 1600 geriatric psychiatrists in the US. It is projected that we will need over 36,000 geriatric physician providers by 2030, but there is no real plan about how to achieve those numbers.

Even the physicians currently being trained in general and internal medicine have limited exposure to the care of the elderly, since most of their education takes place in the hospital setting and not in the ambulatory, home or nursing care facility. This problem is likely to worsen with the reduction of resident work hours that begins in 2012. But it will likely also be affected by the changes in the funding and expectations surrounding Medicare-supported GME. The needs for physicians (including psychiatrists) are just a small part of the workforce challenge, with a nearly 35% increase in the availability of nurses, social workers, psychologists, pharmacists, etc also being required. The importance of team based care, coordination and training is also incredibly important.

While some major insights on the biology of aging have emerged, and while the National Institute on Aging was founded as part of the National Institutes of Health (NIH) in 1974, basic and clinical research into aging and its related disorders is filled with major gaps in knowledge. This situation is further compromised by a paucity of physician-scientists and investigators who are focused on aging and geriatric research. And while this is an opportunity, the projected declines in funding, especially from the NIH, make these limitations loom even larger.

Of course the major challenges will be in the medical, surgical, emotional and behavioral care of the elderly – including their families, friends and communities. As noted, geriatric services at many hospitals are lacking and the relatively lower professional payments for geriatricians have been a disincentive to enter this field. Consequently most elders are cared for by teams of specialists in a manner that is more fractured, uncoordinated and expensive than it should be. Since most elders have one or more chronic illnesses, coordination and management is even more important. New models of care are essential, one being the Ambulatory ICU (A-ICU) championed by Dr. Arnie Milstein, Professor of Medicine and Director of the new Clinical Research Excellence Center at Stanford. A readable description of how this model works in practice is well described by Dr. Atul Gawande article entitled “The Hot Spotters” in the January 24th issue of the *New Yorker* (http://www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande). These principles of management are not unique to the elderly, and they can apply to individuals with chronic diseases who have high utilization of medical services. The importance of the A-ICU lies in the fact that about 10% of patients consume more than 60% of healthcare services and expenditures and that their careful management can lead to improvement their individual care as well as reduce healthcare costs.

Management of expectations will also be important. Technology and innovation have made diagnoses and treatments safer and more applicable to individuals previously considered too high risk for implementation. For example, endovascular access now makes possible heart valve repair in seniors who would not previously have been considered surgical candidates. The availability of new joints, new approaches to dementia and new cancer therapies, among others, is rapidly shifting the expectations of providers and patients. At the same time, quality of life issues around end-of-life care have been too neglected and, unfortunately, subject to political rancor. Perhaps the most well known example of the discord on this topic was the allegation that yearly

discussions with seniors receiving Medicare about “advanced directives” constituted a “death panel.” This position is most unfortunate, since the lack of advanced directives can mean unnecessary and unwanted care along with wrenching debates and discord within families and communities. That the Obama administration removed the requirement for advanced directive discussions for seniors that would have been mandated by the ACA just before it went into law is a testament to how charged this issue has become.

This decision is unfortunate. Here my perspective as a pediatric oncologist bears witness to how important such discussions are with families (an issue recently affirmed by the Association of Clinical Oncology) for adults with cancer (see <http://www.asco.org/ASCOv2/Press+Center/Latest+News+Releases/ASCO+Recommend+Steps+to+Improve+Doctor-Patient+Communication+about+End-of-Life+Cancer+Care>). The need for enhanced palliative care services and providers should be a high priority for academic medical centers and teaching hospitals since they help assure the dignity of individuals at all stages of life, especially when facing a life-threatening disease or condition.

Without question much work needs to be done to adequately address the impact of the elderly on medicine in general and on academic health centers specifically. In 2007 the Institute of Medicine issued a visionary report entitled “Retooling for an Aging America. Building the Healthcare Workforce” (see: http://www.nap.edu/catalog.php?record_id=12089). The recommendations in this report are important, but achieving them is even more challenged in the current economic environment than in 2007– even as the ranks of the elderly continue to increase significantly, a trend that will persist for the next two decades.

At Stanford we too have much work to do in each of the areas discussed above. Thankfully there is a willingness to begin to address these challenges with the renewed and integrated planning that will define Stanford Medicine. Obviously our progress in this important area of medicine will be a topic for a future Newsletter.

Dr. Linda Shortliffe Completes Her Leadership of the Department of Urology

On March 1st Dr. Linda Dairki Shortliffe will step down as Chair of the Department of Urology, a position she has held for more than 15 years. She announced her decision last summer. Since then search for the next Chair of Urology has been underway under the leadership of Dr. Sherry Wren, Professor of Surgery.

Dr. Shortliffe has attributed her decision to enter medicine in general and surgery in particular to the influence of her parents, who as Japanese-Americans were held in internment camps during World War II. Her father was an engineer but, like many of his generation, he faced discrimination and loss of position and was intent on helping his own children seek career paths that would assure success and security. His message and counsel was heard and taken to heart by Dr. Shortliffe, who has had a distinguished

career in medicine and urology. A graduate of Radcliffe College, Dr. Shortliffe did her MD degree and Residency at Stanford and a Fellowship at the Children's Hospital of Philadelphia. She is Board Certified in Urology and Pediatric Urology and has held numerous leadership roles in both fields, including President of the American Board of Urology, President of the Society of University Urologists, Chair of the Urology Society Chairs & Program Directors and Chair of the American Academy of Pediatrics Urology Section. Dr. Shortliffe has also served as a Trustee of the American Board of Urology and Director of the American Foundation for Urologic Diseases.

In addition to important national leadership roles, Dr. Shortliffe has also been the recipient of numerous honors and awards. She has been consistently listed as one of the Best Doctors in America, has received the Asian American Faculty Award from Stanford, is a featured physician in the National Library of Medicine's "Changing the Face of Medicine" series and was named a William and Flora Hewlett Foundation Fellow at the Radcliffe Institute Center for Advanced Study at Harvard University.

Please join me in thanking Dr. Shortliffe for her significant leadership at Stanford and nationally over the past decades. We wish her continued success in her future endeavors – at Stanford and beyond.

Given Dr. Shortliffe's plans to step down on March 1st, we have together asked Dr. Joe Presti, Professor of Urology, to serve as the Interim Chair so that we can honor Dr. Shortliffe's time-line and plans. Dr. Presti is well known to the Department, having served in a number of leadership roles in the past for the Department of Urology, the Medical School and the Medical Center. He has agreed to serve in this capacity from March 1st until the time that a new Chair has been appointed and has arrived at Stanford.

The 2011 SUMMA Conference "It's About Time"

On February 12th the Stanford University Minority Medical Alliance (SUMMA: <http://summa.stanford.edu/>) held its 20th annual program "to increase the diversity in the health professions to better care for underserved communities". SUMMA is a student-led coalition that brings hundreds of minority undergraduate students who are interested in careers in medicine to Stanford to participate in shared learning and practical workshops on topics like: "Applying to Medical School," "MCAT Preparation," "Making Yourself a Better Applicant," "Women in Medicine," "Research Pathways and Summer Opportunities," and "Affording Medical School" among many others. This year's SUMMA program was organized and led by Fisayo Ositelu, SMS IV, and Joslyn Woodward, SMS III. Together with classmates and undergraduate volunteers they spent countless hours preparing for this very successful event – which was attended by hundreds of minority undergraduate students interested in a career in medicine. The message they conveyed was inspiring and thoughtful and focused on how to be successful.

Having attended a number of past SUMMA events, one of the most memorable aspects are presentations by several Stanford students about their personal journey to

medicine. This year's speakers included Kerry-Ann Stewart, SMS II; Lorenzo Deveza, SMS II; and Wendy Caceres, SMS V. Each offered a highly personal and poignant perspective on challenges they overcame on their journey to become a medical student. In addition to a number of faculty profiles and lectures, one of this year's keynote speakers was Alexander Red Eagle, SMS VII, an MD/PhD student whose background on Native American reservations shaped his interest in medicine and the research he is now conducting in the Department of Genetics.

Special thanks again to all of the students who contributed to the 20th SUMMA event and to the impact it may have on the careers of future minority students in medicine.

A Refreshing View on Rankings

Over the years I have written all too frequently about the influence and fallacies associated with ranking medical schools, focusing particularly on US News & World Reports. Of major concern has been the weight given to size over quality as measured by faculty numbers or the total amounts of funding from the NIH. I have pointed out the fallacies of this weighting and have shared those concerns with you as well as USNWR. I remain hopeful that our recommendations will affect the methodology used by USNWR in future years.

A more refreshing and broadly generalized perspective on the volatility of rankings based on how the metrics are chosen or biased is presented in a recent article by Malcolm Gladwell entitled "The Order of Things" in the *New Yorker* (February 14 & 21, 2011; http://www.newyorker.com/reporting/2011/02/14/110214fa_fact_gladwell). Gladwell illustrates how subjective decisions can influence the rank order of sports cars, universities and law schools (too bad he didn't chose medical schools). His portrait is amusing as well as informative, and it helps put the issue of rankings in perspective. That said, the human urge to order things – including in hierarchical fashions – seems to run deep, and I suspect that even the logic of Gladwell won't change the "order of things" to everyone's satisfaction. Put another way, it is important to remind ourselves how volatile and subjective rankings can be – but also how much they appeal to the human desire for order and the "financial impact of things – at least in the profits that the rankings bring to the rating groups (including USNWR).

Introducing Michele Schiele as the Senior Associate Vice President in the Office of Development

In 2010 the School of Medicine passed the \$1 billion mark in the current Stanford Challenge \$4.3 billion campaign that is drawing to completion at the end of 2011. Following the conclusion of the Stanford Challenge, Stanford Medicine (including the School of Medicine and Stanford Hospital & Clinics) anticipates a continuing and enhanced Campaign for Stanford Medicine. In addition, the Lucile Packard Children's Hospital is engaged (with the School of Medicine) in its Breaking New Ground campaign.

In an effort to facilitate collaborations and interactions among the Offices of Medical Development (at SoM), the Office of Hospital Development (at SHC) and the Office of Development (at Stanford University), I am pleased to introduce Michele Schiele, who joined Stanford at the end of January as the new Senior Associate Vice President in the Office of Development. Ms Schiele joins Stanford with a distinguished career in philanthropic funds development. She led two successful fundraising campaigns at the University of Chicago Medical Center (UCMC), both of which exceeded their goals. Under her leadership the Development Office of UCMC grew from 28 to 75 staff members. In 2003, she launched an innovative, well-received event series, Discovery & Impact, through which physicians and researchers share their visions of 21st Century medicine with civic leaders and prospective donors. In 2007 she accepted development responsibility for all of the University's science priorities.

In addition to her work in fundraising, Ms Schiele served as finance director for U.S. Senate and Congressional candidates in Rhode Island, Washington, DC, and Illinois. And as a measure of endurance, she has finished two Chicago Marathons, several triathlons and continues to compete in races with her husband and two sons.

Please join me in welcoming Michele Schiele to Stanford.

The March of Dimes and Stanford Announce a Unique Collaboration

Preterm birth is the leading cause of neonatal death, a major contributor to infant and child morbidity, and the primary determinant of social disparities in perinatal and young child health outcomes in the United States. Moreover, preterm birth has persistently increased in frequency in the United States despite efforts of individual investigators and agencies to identify etiologic factors and interventions to prevent it. It is therefore important and exciting that The March of Dimes Foundation has approved Stanford's application to establish a transdisciplinary March of Dimes Prematurity Research Center at Stanford University School of Medicine. The Foundation is committed to supporting the Center through an initial grant of \$2 million in 2011 with the intent to continue funding through 2020. This is a unique collaboration, and it is a tribute to the vision and hard work of a number of faculty – and especially Dr. David Stevenson, MD, Vice Dean and Senior Associate Dean for Academic Affairs, The Harold K. Faber Professor of Pediatrics and Professor, by courtesy, of Obstetrics and Gynecology, who will be the Principal Investigator for this project. Dr Gary Shaw, DrPH, Professor of Pediatrics, and Dr. Paul Wise, MD, MPH, the Richard E. Behrman Professor in Child Health, Senior Fellow at FSI and Professor, by courtesy, of Health Research and Policy, will serve as Co-Principal Investigators in collaboration with senior investigators from throughout the School of Medicine as well as the University.

The basic premise of the proposed initiative is that the etiologic pathways of preterm birth involve highly interactive biologic and environmental processes that will not be adequately addressed by the search for singular risks by isolated disciplines. Rather, it is based on a commitment to craft investigational collaborations, integrated datasets, and innovative analytic tools that are capable of generating coherent insights out

of complex, intensely interactive pathways of effect. Initial inquiries into pattern recognition, bioinformatics and the human microbiome will be integrated using new technologic capabilities and unique population-based databases to create a pioneering transdisciplinary scientific initiative that leads to the understanding and prevention of the persistent problem of preterm birth.

This is the kind of research that Stanford faculty are uniquely qualified to carry out. This Program is directed at generating and testing new hypotheses and investigational strategies through a highly innovative collaborative transdisciplinary structure that integrates and utilizes powerful new informatics capabilities with an unprecedented array of ethnically-diverse, biologic, clinical, and environmental population-based datasets. Obviously more to follow in the future!

Celebration of the (Future Sarah Donaldson)-Jacob Haimson Professorship in Radiation Physics

On February 10th we had the pleasure of formally celebrating the first endowed chair in radiation physics in the US. The Jacob Haimson Professorship was established in 2008 with gifts from Dr. Sarah Donaldson, the Catherine and Howard Avery Professor, and Dr. Jacob Haimson. Upon Dr. Donaldson's retirement from Stanford (hopefully not for some time), the name of the chair will be changed to the Sarah S. Donaldson and Jacob Haimson Professorship. The first incumbent of the Jacob Haimson Professorship is Dr. Lei Xing, Director of the Division of Radiation Physics in the Department of Radiation Oncology.

The Haimson Professorship brings together a number of important threads in the history of Stanford Medicine. Dr. Haimson first came to Stanford in 1958 at the invitation of Dr. Edward Ginzton, Professor of Physics and collaborator to Dr. Henry Kaplan, the first Chair of Radiation Oncology (and initially Radiology as well), whose work led to the first linear accelerator in the US. Dr. Haimson focused his work on the design of electron microwave linear accelerators, and he is world renowned for his contributions. His collaboration and interactions with Drs. Ginzton and Kaplan not only helped define the field of radiation oncology but also contributed significantly to the strength of the School of Medicine at the time of its move from San Francisco to the Stanford campus. The ultimate joining of Sarah Donaldson to the Haimson Professorship offers a further connection to the pioneering work of Kaplan and colleagues in the treatment of Hodgkin's Disease – and to Dr. Donaldson's work on pediatric Hodgkin's Disease as well as virtually every aspect of pediatric oncology.

Dr. Xing is a highly acknowledged leader in radiation physics whose work is focused on image guided radiation therapy. He is the co-author of a definitive work on this topic entitled Image Guided and Adaptive Therapy published in 2010.

Please join me in thanking Drs. Haimson and Donaldson and in congratulating Dr. Xing.

Remembering Dr. Gregory A. Feldman, MD, 1977-2010

I did not have the privilege of knowing Dr. Greg Feldman personally during his life, but I quickly appreciated the incredible impact he had on his many colleagues, friends and patients as a trainee in the Department of Surgery at Stanford at the time of his untimely death. Simply put, he was widely recognized throughout Stanford as one of the very finest surgical trainees and physicians as well as an incredibly respected human being. When his Stanford colleagues learned of Greg's sudden and unexpected death in Chicago, where he had gone for additional fellowship training, it sent a shockwave of sorrow, disbelief, guilt and deep mourning through his former colleagues and friends that was deeply felt on many complex levels. The recognition of his enormous promise was immediately coupled with the despair over his act of dying, which served as a grim reminder of how fragile the boundary between life and death can be. On February 9, 2011 a memorial service was held in the Li Ka Shing Center to "Celebrate the Life of Gregory A Feldman, MD, 1977-2010." Resident colleagues, faculty, nurses and his family offered tributes.

An anonymous poem entitled "*A Life That Matters*" expresses a relevant theme for this somber occasion, and I am taking the liberty of including it here:

*Ready or not, some day it will all come to an end.
There will be no more sunrises, no minutes, hours, days.
All the things you collected, whether treasured or forgotten
will pass to someone else.
Your wealth, fame and temporal power
will shrivel to irrelevance.
It will not matter what you owned or what you were owed.
Your grudges, resentments, frustrations,
and jealousies will finally disappear
So, too, your hopes, ambitions, plans
and to-do lists will expire.
The wins and losses that once seemed so important
will fade away.
It won't matter where you came from,
or on which side of the tracks you lived.
At the end, whether you were beautiful or brilliant,
male or female, your skin color wont matter.*

*So what will matter?
How will be the value of your days be measured?
What will matter is not what you brought,
but what you built;
not what you got, but what you gave.
What will matter is not your success, but your significance.
What will matter is not what you learned,*

*but what you taught.
What will matter is every act of integrity, compassion,
courage or sacrifice
that enriched, empowered or encouraged others.
What will matter is not how many people you knew,
but how many will feel a lasting loss of you when you're gone.
What will matter is not your memories, but the memories
that live in those who loved you.
Living a life that matters doesn't happen by accident.
It's not a matter of circumstance but of choice.*

I thank Dr. Tom Krummel, Emile Holman Professor and Chair of the Department of Surgery, and his colleagues throughout Stanford for bringing the community together for this celebration of life for Dr. Greg Feldman, who lived a life that mattered. The friends of Greg have launched a memorial site in tribute to him: gregfeldmanmemorial.org.

Upcoming Events

Skill Building Workshop: "How to Improve Scientific Writing Skills"

Thursday, March 10th

5:30 – 7:30 PM

[Always Building](#), M1-112

This workshop, which has been immensely well received, will present six practical techniques to improve clarity and conciseness across all sections of journal manuscripts & grants, and demonstrate why and how to use these techniques. Registration is open to all faculty.

Michaela Kiernan, Ph.D., who will lead this workshop, is a Senior Research Scientist at the Stanford Prevention Research Center (SPRC) at the Stanford University School of Medicine. She received her PhD in social/health psychology from Yale University and has expertise in research methodology and statistics. She is also a standing member of an NIH study section.

Faculty are encouraged to bring postdocs who work with them to increase writing efficiency within their lab group. We hope you will be able to join us! Attendance is limited to 60.

If you are able to attend, please register for this workshop here:

<https://www.onlineregistrationcenter.com/register.asp?m=275&c=5>

Awards and Honors

- **Dr. Larry Steinman**, Professor of Neurology, will be the recipient of the 2011 Charcot Prize, which is awarded every two years for a lifetime achievement in

outstanding research into the understanding or treatment of Multiple Sclerosis (MS). Since 1969, the Charcot Award has recognized the significance of Jean Martin Charcot's studies into neurological diseases and his pioneering work, which led him to be among the first to match specific anatomical lesions to a variety of neurological disorders, including MS. The winner is invited to give the Charcot Lecture at the European Committee of Treatment and Research. While I know Dr. Steinman will make the point that his best work is ahead of him it is still wonderful that this prestigious award is also recognizing his past contributions. Please join me in congratulating Dr. Steinman.

- ***Dr. David Stevenson***, Vice Dean and Senior Associate Dean for Academic Affairs and The Harold K. Faber Professor of Pediatrics, will receive the 2011 Maureen Andrew Mentorship Award from the Society of Pediatric Research. This award recognizes individuals who have served as exemplary mentors for trainees and junior faculty who have successfully developed investigative careers in the field of child health research. Dr. Stevenson will receive the award at the upcoming Society for Pediatric Research meetings to be held April 30-May 3 in Denver. Congratulations to Dr. Stevenson for this well deserved recognition.

Appointments and Promotions

Tirin Moore has been promoted to Associate Professor of Neurobiology, effective 2/01/11.

Rebecca Smith-Coggins has been appointed to Professor (Teaching) of Surgery, effective 2/01/11.