

# Dean's Newsletter

## October 24, 2011

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### **Beginning a Discussion about Academic-Industry Collaborations and the School of Medicine**

On Saturday morning, October 15<sup>th</sup>, we held the first of a planned series of think tanks and discussions on the broad topic of Industry-Academic Collaborations. Just over 30 faculty leaders, as well as leaders in industry, attended and participated in a far-ranging and exploratory dialogue. We considered examples of industry collaborations in other disciplines and medical schools, and, most importantly, we discussed what we might do at Stanford that would be unique to our culture and institution and that would foster and enhance productive, beneficial interactions.

Over the past several years much of the focus about industry and academia has been on conflict-of-interest (COI). And while these issues and concerns were and are still very real, we now have clear and transparent policies in place at Stanford. Thus the point of the October 15<sup>th</sup> Think Tank was not about COI but about how to foster productive interactions with industry partners with the goal of advancing the translation of discoveries into diagnostics, drugs, biologics and devices.

I noted in my introduction to the Think Tank that a number of peer institutions are seeking interactions with industry to create new funding sources to compensate for losses in sponsored research dollars. While we certainly want to explore new funding sources, the goal of the discussion was not about money *per se* – but about creating productive

collaborations. We already have some important models at Stanford, including SPARK (<http://sparkmed.stanford.edu/>), Biodesign (<http://biodesign.stanford.edu/bdn/index.jsp>), the Coulter Foundation program (<http://bioengineering.stanford.edu/coulter/>), and BioX corporate partnerships (<http://biox.stanford.edu/forum/index.html>). So the question is: what else should we consider that would be effective as well as unique to our institution and our setting in Silicon Valley, one of the major centers of biotechnology in the world? The goal of this first meeting was to layout ideas and suggestions – ideally “blue sky and green field” ideas - and to then probe and explore them more fully and deeply in the months ahead. We are also planning to continue the discussion at our Strategic Planning Leadership Retreat in January 2012.

I want to share with you some of the discussion items, comments and recommendations that were presented at the think tank for your reflection. As always I am very interested in any feedback or other offerings you would like to make – since this is very much in a formative process of development.

To frame the discussion we began our think tank with an update from Dr. Lynn Orr, Keleen and Carlton Beal Professor in Petroleum Engineering and Director of the Precourt Institute for Energy, about the Stanford Global Climate and Energy Project (GCEP), which is now in its 8<sup>th</sup> year. To initiate this project, four companies (Exon Mobil, GE, Toyota and Slumberger), each of which had well established, deep and capable research programs, collectively committed \$225 million over 10 years in a contract grant (not a gift and paying full indirect costs) to focus on reducing greenhouse gas emissions. This collaboration concentrates on research that will likely extend over decades and that is not immediately applicable (the equivalent of biosciences basic fundamental research). The funding has been used to support faculty proposals for what Dr. Orr referred to as “step-out” research – meaning projects on new ideas that generate new collaborations and programs that are outside or separate from a faculty member’s current research. This is designed to foster new innovations in areas that might be considered risky. In the Global Climate and Energy Project, Stanford owns the Intellectual Property (IP) from the research but companies can get royalties. While there are lots of lessons and issues that have been learned from these interactions, a key feature is that these companies are interested in funding the next generation of energy technology – seeking long term as compared to short term results.

The evidence to date is that GCEP funding has stimulated new areas of research and collaboration – and according to Jim Plummer, Dean of the School of Engineering, who also attended the Think Tank, it has transformed the focus of some departments at Stanford. In fact, in the physical and engineering sciences programs at Stanford, collaborations with industry are more the norm than they are in the biosciences – in part because companies are willing to invest in long term, more basic research and in part because when a technology is invented, it is easier to hand it off more cleanly to industry than is the case in the life sciences – where continued development is needed and human subjects become involved in the process of translating discoveries into products. Of interest, according to Dr. Plummer, in the School of Engineering, corporate funding supports around 40% of the research effort – compared to around 5% in the School of

Medicine. It should be noted most of the research funding to the School of Medicine comes from sponsored competitive funding. While the collaborations described by Drs. Orr and Plummer with industry partners have been highly successful to date, the question of whether these relationships will endure over time remains to be determined – since priorities change within industry, just as they do in academia. That said, the model of collaboration in global climate and energy research is informative and interesting.

We then moved onto models closer to home that have been used for decades in the biosciences but that are undergoing some evolution and change in recent years. Some of these models are the large “money over the wall” programs that have existed in the past at some of our peer schools (e.g., Washington University, UC Berkeley, UCSF and Harvard among others) where large amounts (many tens of millions of dollars) were given to universities to promote research that might be relevant to industry. Indeed, there was a comparable experience at Stanford some years ago as well. The common wisdom is that, while this funding spawned some significant new research directions for academia, the payoff to industry in products that could be developed for clinical use has been negligible.

The question is what is happening now. Because there has been considerable press coverage about the successes at peer institutions about large amounts of money received from industry, we had an opportunity to learn more about some of these experiences as well. One clear lesson is that companies seek partnerships with specific faculty or, if there is a larger effort, they want to do so in a more business-imperative way. Unlike the long-term funding cycle that seems to be occurring in the physical sciences, the focus in the life sciences tends to be more short term and more product-specific – and funding is vulnerable if results don’t look as though they will lead to a marketable product. Thus, funding is not necessarily sustainable – unless one builds a major clinical research infrastructure as has been done at Duke, which has been highly productive but which operates more autonomously and, in the opinion of some, becomes a distraction to faculty from pursuing more fundamental research. Another important issue in these larger corporate initiatives is the governance as well as the management of the funds. While some of these efforts appear (at least in the press) to be trans-institutional, many are in fact driven by smaller groups of faculty.

In recent years at Stanford, industry interactions have been concentrated in individual faculty or groups of faculty, some of whom have formed collaborations with industry while others have formed companies. There are also novel programs such as SPARK (for diagnostics, drugs and biologics) and Biodesign (for med-tech), which have been quite successful and which have spawned similar programs at a number of institutions seeking to develop similar strategies. I hasten to add that SPARK and Biodesign are “uniquely Stanford” in their entrepreneurial focus, which encompasses bringing different communities together from within and outside of Stanford and fostering new products and devices, including a number of new companies.

Following the discussion of models from the physical and engineering sciences, a large Pharma collaboration with a specific medical school, and the innovative SPARK,

Biodesign, Coulter and other programs at Stanford, the remainder of the think tank was taken up with commentaries, perspectives, concerns and recommendations from the participants. Since we are not at the stage of formulating a Stanford plan (assuming we do get to that point) it seems more useful to simply share some of these perspectives – without attribution and commentary. Since I asked for the industry participants to speak first, their comments are provided first below; they are followed by other perspectives:

- A perspective from one industry attendee is that to be successful we should create a unit within the School of Medicine that selects promising ideas and then contracts research to take the idea or invention to the next level of development. This would require an oversight committee (including industry and faculty) and would either have to self-invest in product development or seek partners to create an investment pool.
- Another perspective is to do what we do well – basic discovery, which builds on the strength of Stanford faculty. This would not dismiss the prospect for large corporate funding sources (perhaps analogous to the Global Climate and Energy Project) but would simply foster the best contributions from the most creative faculty.
- It was suggested that a unique contribution for an institution like Stanford would be to create large clinical databases that could be mined for discovery or utilized to develop more novel approaches to clinical trial design.
- One industry participant, having heard about the existing SPARK program, advocated for “moving it to another level.” This would require an investment pool and would need to develop products through phase II if they are to be appealing to potential industry partners.
- A still different industry perspective built on the fact that Pharma (much of which has pulled out of research) is mostly interested in Phase II level interactions. To that end, this individual suggested establishing a structure that would not be run by faculty and that would provide the expertise and resources to move from scientific discovery to product development.
- Needless to say there were varied reactions to one or more of these proposals. While it was noted by several that the clinical trial infrastructure at Stanford needs further development, there was little support to move to a Duke-like model for clinical trials. Rather, the focus was on developing interactions across the university – doing “science without borders,” creating incubators with the engineering and physical sciences, and developing refinements in our clinical trial machinery.
- There were also varying degrees of concern and even admonition about the focus of the think tank discussions. These ranged from worries about whether corporate partners would seek to define the projects in the life sciences (unlike what was

described in the engineering and physical sciences) and also whether these relationships would have unintended consequences, changing our culture and negatively impacting the time that faculty can devote to basic discovery. A number of faculty expressed concerns that engaging in Phase II type research is outside our ideal area of focus and would negatively affect our academic enterprise. Needless to say, others felt that without more industry collaboration, we would lose creative faculty or miss unique opportunities. It was also noted that some Pharma could be willing to invest in basic research or seed funding – as has been observed with the BioX program.

I have highlighted issues that were discussed to give you some texture of the dialogue that ensued. It is important to add that as long as we set clear priorities there is no reason to think that industry-academic collaborations are incompatible with our mission in basic discovery at Stanford. The question is: what can we do that is unique that will advance science, discovery and innovation and its translation to patients and the public good? Likely the needs and approaches of some members of our broad and diverse community (e.g., med-tech) will be different than other groups (drugs and biologics). Our unique strengths may lie in areas that build on our expertise in statistics, genomics, new approaches to study design and the emerging field of “regulatory science.” The use of our social networking technology could help identify areas for collaboration or interaction between faculty within Stanford or with potential industry partners. In addition, opportunities for novel exchanges and experiences for our students in industry settings– or for industry scientists in academic settings – are worthy of discussion, especially given the wealth of companies and programs in the Bay Area. Further, the potential for faculty to engage in the design and evolution of policies impacting drug and device development is yet another area for interaction and development.

In addition to our discussions at Stanford, I have also tried to foster dialogue on this topic in other venues, including the Association of Academic Health Centers and other organizations. The broad issue of academic-industry relations needs critical re-thinking and will likely be approached differently by different universities and industries. Whether we develop some overarching approach at Stanford – or do what we can to foster faculty driven initiatives or programs like SPARK and Biodesign, as well as the interconnections between molecular imaging, genomics and informatics that can lead to early disease detection, will be an important question. We will continue the discussions – and I hope you will feel free to add a perspective as well.

### **When Cure No Seems Longer Possible**

We all recognize that death is the inevitable consequence of birth and life. Understandably, we spend little time thinking about our own death or that of our loved ones – although this can change dramatically with unexpected illness or other catastrophic events. Of course, thinking about death is also influenced by age and by the societal events that impact individuals, communities and nations. Even in the face of adversity, denial of imminent death is more the rule than exception.

As physicians, the denial of the possibility of death can be a breach of our responsibility to care for patients holistically and through the course of illness with honesty, compassion and integrity. Physicians are educated and trained to heal and treat disease and often less equipped and comfortable with palliative and end-of-life care. That is a problem. It is easier for physicians and society to accept death when it comes at the end of a long life. But even here, the denial of death can be strong and deep in different cultures and communities.

The denial of death by physicians, patients and families is sometimes glaringly evident by the presence of patients in our intensive care facilities or acute care hospitals in the US whose prognosis for life is limited or dismal. Even more shocking is that nearly 40% of the hospitalized patients who are predicted by physicians to have less than a six month survival spend at least 10 days in an ICU before death – and more than half experience moderate to severe pain at the end of their life. These and related data formed the basis of an important discussion at the Stanford Hospital & Clinics Medical Staff Quarterly meeting that was led by Dr. Norm Rizk, Senior Associate Dean for Clinical Affairs, who is also a nationally renowned expert in critical care medicine. While all too many physicians are reluctant or fail to have “end-of-life” discussions with patients they are caring for – often for fear that such a discussion would diminish hope – the false expectations of patients and families is equally problematic. Sadly, both patients and doctors can become complicit in not discussing the prospect of death, thus robbing individuals and their families from a more peaceful death, ideally at home and with hospice care.

As a pediatric oncologist who has confronted death in children with cancer all too frequently, especially before more curative therapies were developed, it seems inconceivable to not engage with a family – or the patient in an age-appropriate manner – about the prospect of death when cure seems no longer possible. My view, and this is generally true for the pediatric oncology community more broadly, is that preparing children and their families for death is an essential responsibility – to preserve the dignity of the child. An equally important goal is to help the parents, family and the community to cope with the loss of a child knowing that they did all that they could to help their child fight disease – and face death when cure is no longer possible. With the availability of palliative care expertise by physicians, nurses and other providers, along with home and with hospice support, anticipatory and honest discussions about death and dying are as essential to the care of patients and families as are the initial discussions about diagnosis and treatment of illness and disease.

Recognizing that the attendees at the staff meeting were predominantly physicians who care for adults, I was struck by the differences between pediatric and adult medicine – and also by the considerable chasm that must be crossed to make palliative care a essential part of the dialogue between doctors and patients.

As a society, our ability to confront death remains shrouded by culture and belief systems. And of course we all must recognize that our individual confrontation with death is hard to anticipate – even if we feel informed and prepared. The different views

about death and dying is what made former Stanford faculty member and incredible artist Anna Deveare Smith's recent play "*Let Me Down Easy*" so remarkable and moving (see: <http://med.stanford.edu/121/2009/deveare-smith.html>). Witnessing death through the arts is a help – and further discussion and dialogue on this topic within our community seems important and needed. Hopefully the discussion led by Dr. Rizk is a beginning of more reflective discussions to come – and improvements of our ability to care for individuals when cure no longer seems possible.

## **Provost Announces the Search Committee for the Dean of the School of Medicine**

At the October 13<sup>th</sup> session of University Academic Senate Provost John Etchemendy announced the names of the search committee for the next dean of the School of Medicine as follows. As I have announced in prior communications, I will be completing my term as dean in the summer of 2013.

### **Co-Chairs of the Committee:**

- **John Etchemendy, PhD**, Provost and Patrick Suppes Family Professor in the School of Humanities and Sciences
- **Dr. Sam Gambhir**, Chair of the Department of Radiology and the Virginia and D.K. Ludwig Professor for Clinical Investigation in Cancer Research and Professor, by courtesy, of Bioengineering and Materials Science & Engineering

### **Committee Members:**

- **John Boothroyd, PhD**, Professor of Microbiology and Immunology
- **Karl Deisseroth, MD/PhD**, Associate Professor of Bioengineering and of Psychiatry and Behavioral Sciences
- **Stephanie Kalfayan, JD** Vice Provost for Academic Affairs
- **Holbrook Kohrt, MD**, Fellow, Department of Medicine (Oncology)
- **John Levin, JD**, Board of Directors, Stanford Hospital & Clinics and Former Trustee, Stanford University
- **Beverly Mitchell, MD**, Director, Stanford Cancer Institute and George E. Becker Professor in Medicine and Professor, by courtesy, of Chemical and Systems Biology
- **Norman Rizk, MD**, Senior Associate Dean for Clinical Affairs and the Berthold and Belle N. Guggenheimer Professor
- **Richard Saller, PhD**, Vernon R. and Lysbeth Warren Anderson Dean of the School of H&S and Kleinheinz Family Professor of European Studies
- **Christy Sandborg, MD**, Chief of Staff, Lucile Packard Children's Hospital and Professor Pediatrics
- **Lucy Shapiro, PhD**, Director, Beckman Center and Virginia and D. K. Ludwig Professor and Senior Fellow at the Freeman Spogli Institute for International Studies
- **Gary Steinberg, MD/PhD**, Director of the Stanford Institute for Neuro-Innovation and Translational Neuroscience, Chair, Department of Neurosurgery and Bernard and Ronni Lacroute-William Randolph Hearst

Professor in Neurosurgery and Neurosciences and Professor, by courtesy, of Neurology & Neurological Sciences

- **Hannah Valentine, MD**, Senior Associate Dean for Diversity and Leadership and Professor of Medicine

This information is shared with you with the approval of the Provost.

## **The Annual Open Enrollment for University Benefits has been Announced and Includes Increased Access to Stanford Faculty Physicians**

Every year at this time Stanford has its open enrollment period, during which members of the Stanford community sign up for the medical and other benefits offered by the University. For benefits that will become effective January 1, 2012, that period begins today and extends through November 15. This year there are changes to the medical benefits affecting many in our community that I want to make sure you are aware of. I highlight these changes since not infrequently faculty and staff sign up for health benefit programs that do not provide access to Stanford faculty physicians – should they want or need them. Importantly, changes in the plans being offered for 2012 will make it easier to gain access to Stanford faculty physicians.

Of note, a new plan called the Blue Shield Exclusive Provider Organization Plan (EPO) will be available for enrollment for 2012. This plan, like the currently available Blue Shield PPO plans, will provide Stanford faculty, staff and their families' access to Stanford faculty specialists without permission from their provider. This plan also continues access to the physicians at Palo Alto Medical Foundation. In addition, while there is no requirement to pick a primary care physician in either the EPO or the PPO plans, Stanford has primary care physicians with open practices. It should also be noted that Pacificare and Health Net will no longer be offered as a Stanford health option, and I hasten to add that these plans, now being discontinued, did not provide access to Stanford faculty physicians – and not infrequently resulted in concerns and disappointment when unexpected medical needs arose.

I am extremely pleased that, as a result of many months of significant effort on the parts of University and medical center leaders working collaboratively, we have a new way in which our employees can take advantage of the expertise of Stanford physicians. I encourage you to look carefully at the options in the materials that have been provided by the University and make the best choice for you and your family.

I also call to your attention the new program that Dr. Arnie Milstein, Director of the Clinical Research Excellence Center and Professor of Medicine, has established with the Medical Center and the University for the care of employees with chronic medical conditions. This innovative new clinical service will be based on a patient-centered intensive primary care model in which individuals with serious conditions (such as uncontrolled asthma or heart disease) will be able to receive focused care from a team that provides round-the-clock availability, home visits, regular support and coaching in self-management. We are also very pleased to have recruited Dr. Alan Glaseroff, a

nationally recognized leader in health care delivery, to direct this new clinical service along with Dr. Ann Lindsay (see: <http://med.stanford.edu/ism/2011/october/glaseroff.html>). This new service will begin around April of 2012 and is among a number of new healthcare delivery system innovations that will be unfolding in the months and years ahead at Stanford University Medical Center.

### **Update to the Executive Committee on the VA**

On Friday October 7<sup>th</sup>, Dr. Larry Leung, Chief of Staff at the VA Palo Alto Health Care System (VAPAHCS) and the Maureen Lyles D'Ambrogio Professor of Medicine, gave an update to the Executive Committee on the VAPAHCS. I am pleased to provide Dr. Leung's summary of his presentation for your review.

The mission of the VA is to provide Veterans world-class care that improves their health and well being and to be a leader in education and research. In 1995, the Veterans Health Administration (VHA) underwent a successful transformation, including emphasizing chronic care and preventive medicine, installing an electronic medical record and instituting quality performance metrics. As a result, VHA now delivers high quality and efficient patient care comparable or superior to many private health care delivery systems. Within the VHA system, is recognized as a flagship.

VAPAHCS, under Director Lisa Freeman, provides care to 82,000 enrolled Veterans. There are three inpatient divisions, at Palo Alto, Menlo Park and Livermore, and seven community-based outpatient clinics, extending from Monterey to Sonora. A major thrust of the clinical program is Process Improvement, utilizing the Toyota Lean approach, under the direction of Dr. Paul Helgerson, Associate Chief of Staff (ACOS) for Process Improvement. Dr. Steven Asch was recently recruited to become the Director of Health Services R&D program and the ACOS of Clinical Effectiveness.

We have a strong collaborative partnership with the SOM. There are approximately 90 UTL and MCL faculty based at VAPAHCS, representing almost all the clinical disciplines. Many SOM faculty conduct their research programs primarily at the VA. VHA recently launched a major genomics initiative "Million Veterans Project (MVP)" in which one million patient DNA samples will be collected over the next several years. In collaboration with Drs. Michael Snyder, Chair of the Department of Genetics, and Wing Wong, Chair of Department of Statistics, and with the support of Dean Pizzo, VAPAHCS received funding from VHA to set up a Genomics and Informatics Coordination Center at Palo Alto.

More than \$1.5 billion of construction is undergoing at the Palo Alto and Menlo Park campuses. An 80-bed acute psychiatric hospital will be completed in 2012, and a Polytrauma and Blind Rehabilitation Center will be completed in

2014. These buildings will be followed by a new research building in 2016 and an Ambulatory Care Center in 2017.

We are proud to serve our Veterans and our clinical and research programs will further enhance our patient-centric care and consolidate the partnership between the two institutions.

### **Dr. Griff Harsh will Succeed Dr. Rob Jackler as the Associate Dean for Continuing Medical Education**

Beginning January 2012, Dr. Griff Harsh, Professor of Neurosurgery, will succeed Dr. Rob Jackler as the Associate Dean for Continuing Medical Education in the School of Medicine. I want to first thank Dr. Jackler along with Terri O'Grady, Executive Director, and the CME team for doing a terrific job over the past several years. When their work began the CME office was in significant disarray and the models for supporting CME were challenged. With diligence and considerable effort, Dr. Jackler, Ms. O'Grady and their colleagues have achieved Accreditation with Commendation from the Accreditation Council for Continuing Medical Education. This is a tribute to their outstanding work on behalf of the School of Medicine, and we owe them our gratitude and appreciation.

Dr. Harsh has a long history of commitment to excellence in education serving as Vice Chair for Education in the department of Neurosurgery since 2006, where he is also a Professor. Dr. Harsh is a summa cum laude and Rhodes Scholar graduate of Harvard College and received his MD from Harvard Medical School. He trained at the National Institutes of Health and UCSF and was on the faculty of UCSF and Harvard before joining Stanford in 1998. Dr. Harsh is a highly respected member of the Stanford community, and I am very pleased he has agreed to take on this important responsibility. As Associate Dean he will report to the Senior Associate Dean for Medical Education, Dr. Charles Prober.

### **Guidance to Faculty Regarding Participation in Internet Services Offering Medical Consultations**

Without question technology is rapidly changing the way we access medical information and how patients seek advice and consultation from physicians. Also without question, potential infractions of patient privacy and confidentiality loom ever larger and should be a constant source of concern and vigilance for each of us. Further, what a faculty physician can do when requested to provide service as a consultant or resource over the Internet is a highly important question. This issue has recently raised concerns when a number of our faculty received invitations to join a new company that provides online video chatting "with top specialists" from around the country. Because this rapidly emerging intersection of technology, entrepreneurship, and the practice of medicine opens a new set of questions about medical care and physician/patient relationships in the 21<sup>st</sup> century, we sought an opinion from our Office of Academic

Affairs and the Office of the General Counsel at Stanford. They have offered the position that I now share with you.

As physicians, we must protect the public as well as our individual and institutional responsibility. The “on-line” chatting being proposed and promulgated raises a number of fundamental issues that include: when does the interaction with a doctor and an individual (in this case electronically connected) constitute the practice of medicine? What are legal requirements for state licensure? What are the rules governing telemedicine? When is malpractice coverage available? If protected health information is shared or exchanged, is there assurance that it is encrypted and knowledge about how it would be stored or exchanged beyond the “chat”? And, do such exchanges conform with or violate contractual regulations within employer practice plans? Of course, these are just some of the questions that are raised. Because this is a new area, the Dean's Office asked a number of our legal, risk management, and Stanford Practice Plan experts for their opinions about such interactions. In doing so it was posited that there are significant potential risks to faculty members if these on-line interactions are determined to be the practice of medicine.

The consensus that emerged from this review is that these types of Internet “chats or consultations” would most likely be treated as the practice of medicine, and are thus governed by the Rules of Practice for the Physicians and Psychologists in the School of Medicine ([med.stanford.edu/academicaffairs/documents/rules-of-practice.pdf](http://med.stanford.edu/academicaffairs/documents/rules-of-practice.pdf)). **Based on the reviews and the Rules of Practice, the School of Medicine will not support the decision of a faculty member to join this type of business at this time.** Clearly, there is significant interest in the expansion of physician/patient interaction in social media, and the School will continue to explore these opportunities.

### **Annual Luncheon with Emeritus and Senior Faculty**

On October 12<sup>th</sup> I had the privilege of attending the Annual Lunch for Emeritus and Senior Faculty luncheon. It is always an honor to meet with the faculty and spouses who are able to attend and who have played such a major role in making Stanford a great institution. Universities and medical schools like Stanford enjoy a rich heritage, which we celebrate too infrequently. The opportunity to share the state-of-the-school with our long-time faculty and to benefit from their special perspective and experience is both humbling and extremely helpful. I want to thank them for taking the time to attend this annual event and for both listening and making valuable comments and recommendations.

### **Li Ka Shing Among the Recipients of the 2011 Carnegie Medal of Philanthropy**

On October the 20<sup>th</sup> I had the pleasure of attending the Tenth Anniversary of the Carnegie Medal of Philanthropy celebration at the New York Public Library in New York City. The Carnegie Medal of Philanthropy, the most celebrated award in philanthropy, was established in 2001 to mark the centennial of Andrew Carnegie’s retirement from business and the beginning, in earnest, of his efforts to distribute his fortune in a manner that would, in his words, “do real and permanent good in this world.”

This year, Mr. Li Ka Shing was one of the 10 recipients to receive this award. What was striking is how many of the recipients (who in addition to Mr. Li included the Crown Family; the Danforth Family; Fiona and Stanley Druckenmiller; Fred Kavli; the Lauder Family: Evelyn and Leonard Lauder, Jo Carole and Ronald Lauder; Pamela and Pierre Omidyar; the Pew Family; and the Pritzker Family) have come from immigrant families or who, like Andrew Carnegie, earned their wealth and then became remarkably philanthropic. Further, their contributions have provided incredible contributions to higher education, science, medicine, peace and social justice. Equally, virtually each of those awarded the 2011 Carnegie Medal of Philanthropy, along with a number of past recipients, have made donations to Stanford University, which makes our connection to the Medal notable and important. What is also striking is that even during times of economic downturn, such as the past several years, philanthropy has been sustained – a tradition that has been deeply rooted in America and that has contributed significantly to our universities and research institutions as well as the arts and humanities.

It was just a year ago that we officially dedicated the Li Ka Shing Center for Learning and Knowledge (see: <http://lksc.stanford.edu/>) and had the opportunity to honor and thank Mr. Li at Stanford (see: <http://lksc.stanford.edu/li-ka-shing.html>). When I was growing up in New York City in a first generation family with limited resources, institutions like the New York Public Library were not only iconic – they were transformational to individuals, and they opened the doors to learning and opportunity that would not have otherwise been possible. It was a moving experience to be back in that magnificent building, which is still accessible to every individual who seeks entrance, and to witness the impact that it – and the public library system that Andrew Carnegie helped spawn – has had on the life of our citizens and nation.

Li Ka Shing grew up in poverty and became a self-educated entrepreneur and among the world's most successful businessmen. He became philanthropic early in his life – as soon as he began earning money – and that pattern has continued throughout his life. To date, the Li Ka Shing Foundation has granted over US \$1.6 billion to charitable causes throughout the world including our Li Ka Shing Center for Learning and Knowledge, which has become a centerpiece for the School of Medicine. We remain extremely grateful to Mr. Li for his wonderful contribution that made the LKSC become a reality. Also attending this wonderful event in NYC was Dr. Alan Yeung, the Li Ka Shing Professor and Chief of the Division of Cardiology in the Department of Medicine, who has been instrumental over the years in the success of our fundraising efforts. In the spirit of Andrew Carnegie, individuals like Mr. Li, who dedicate their private wealth to the public good, do very much change the world. And we are grateful.

## **The Launch of CAP NETWORK**

Building on the success of the School's Community Academic Profiles (CAP) system, this past weekend a new platform for online collaboration called CAP NETWORK was launched <http://med.stanford.edu/ism/2011/october/cap-1024.html>. Integrated into the CAP system and leveraging the powerful paradigms of social networking, CAP NETWORK incorporates searchable online profiles for all members of

the School of Medicine, including staff for the first time, bringing the total number of people in the system to nearly 10,000. Added to these profiles are a new private Stanford-only collaboration environment that includes features commonly found on sites such as Facebook and Twitter. The CAP NETWORK environment will only be available to the Stanford community and we hope it will provide a safe and secure way for the community to interact and work together in new ways. The major features of this system include:

- Rich online profiles for all staff, faculty, postdocs and students in the School of Medicine. (~10,000 people)
- The ability to post updates, share files and photos with interactive commenting and "liking".
- The ability to "follow" others and receive updates about their activities.
- Support for creating groups that can be private with controlled membership or open to anyone in the community.
- Access to the social network features using an app for all common phones and tablets, and a stand alone desktop client.

While the use of social networking tools is increasingly common in our personal lives, their use in professional settings is only just beginning to be explored and the School's deployment of such a platform to a broad academic community is innovative.

We expect to learn much in the coming months as CAP NETWORK is put to use across our varied missions. We have formed a CAP Advisory Committee consisting of representatives from a wide spectrum of the School of Medicine community to help guide the project.

The CAP NETWORK project is being developed and operated by the School of Medicine's Office of Information Resources and Technology (IRT).

For more information about CAP Network visit <http://med.stanford.edu/cap/index.html>

### **Information Security Day**

On November 9th, the Information Resources and Technology (IRT) Information Security Services will host the Second Information Security Day: an event to educate the Stanford Medicine community about computer security in a friendly and accessible way. Given the numerous challenges and issues that continue to arise of HIPPA, students, staff, and faculty are invited to attend.

According to Ellen Amsel, Director, Information Security Service, this year's theme is focused on social networking, its security pitfalls, and how to use it safely and responsibly. The event will take place on Wednesday, November 9th, from 10:00am - 2:30pm in Alway M106. To register for this year's ISD, visit: <http://med.stanford.edu/irt/security/isd.html>

### **Three Faculty are Elected to the Institute of Medicine**

On October 17<sup>th</sup>, three distinguished Stanford School of Medicine faculty members were elected to the Institute of Medicine of the National Academy of Sciences. As noted in the announcement of the 65 new members “election to the IOM is considered one of the highest honors in the fields of health and medicine and recognizes individuals who have demonstrated outstanding professional achievement and commitment to service.” As noted by Dr. Harvey Fineberg, President of the IOM, “each of them stands out as a professional whose research, knowledge, and skills have significantly advanced health and medicine, and their achievements are an inspiration.” This years newly elected Members of the IOM are:

- ***Dr. Margaret (Minx) Fuller***, Professor of Developmental Biology and of Genetics
- ***Dr. David A. Relman***, Thomas M and Joan C. Merigan Professor of Medicine and of Microbiology and Immunology
- ***Dr. Abraham Verghese***, Professor of Medicine and Senior Associate Chair for the Theory and Practice of Medicine, Department of Medicine

Each of these newly elected members has made exceptional contributions in different areas of art and science of medicine (see: <http://med.stanford.edu/ism/2011/october/brief-iom-1017.html>). Please join me in congratulating them.

### **Awards and Honors**

- ***Dr. David Stevenson***, Vice Dean and Senior Associate Dean for Academic Affairs and Harold K. Faber Professor of Pediatrics and Professor, by courtesy, of Obstetrics and Gynecology, received the prestigious Jonas Salk Leadership in Prematurity Prevention Award from the March of Dimes on October 20th in an event in Washington, DC. This is a wonderful and well-deserved honor for Dr. Stevenson. Please join me in congratulating him.
- ***Dr. Gary Nolan*** was honored at an investiture event to celebrate his being named the Rachford and Carlotta Harris Professorship. I had the pleasure of knowing Mr. Harris prior to his death in 2010 at 98 years of age. Mr. Rachford’s grandson Tristan Harris, a 2006 graduate of Stanford, represented the family and offered reflections on his grandparents who contributed the professorship. In addition to his other awards, Dr. Nolan was honored as one of the top 25 inventors at Stanford.
- ***William C. Fowkes***, Professor Emeritus of Family Medicine, received the 2011 John W. Gardner Visionary Award from the Pathways Hospice Foundation for his dedication to end of life care. Dr. Fowkes founded Family Medicine at Stanford as well as the Family Medicine Residency now at O’Connor Hospital in San Jose.
- ***Dr. George Caballero***, Resident in Anesthesia, and ***Dr. Alex Macario***, Professor of Anesthesia, have been awarded the American Society of Anesthesiologists’ Professional Diversity Mentorship Award.