

Dean's Newsletter

March 19, 2012

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The 2012 Internship Match

Friday, March 16th was “Match Day” for our graduating medical students. This is the day each year when graduating medical students across the country learn, at the exact same moment (9:00 a.m. PDT), where they will do their internships. Match Day is run by the National Residency Match Program (NRMP), which was started 60 years ago to address the intense competition that had emerged among teaching hospitals over the recruitment (and hiring) of interns. Despite a challenge in the US Supreme Court, the NRMP has been an institution – if not a tradition – in medicine since 1952. Anyone who has participated in the “Match” almost certainly remembers the exact moment and the details that surrounded opening the envelope that would indicate the hospital and program where they would spend the next several years of their life. It’s an indelible experience.

The NRMP uses an algorithm that matches a rank order list of preferences of the applicants for the teaching hospitals and training programs they wish to attend. The process is structured to place the applicant into her or his first choice and, if that is not possible, into her or his second choice and so on until the applicant obtains a “tentative match” or all the applicant’s choices are exhausted. Clearly the goal of the applicant is to achieve the highest preference possible – and to not go unmatched. According to the NRMP, *“matches are ‘tentative’ because an applicant who is matched to a program at one point in the matching process may be removed from the program at some later point, to make room for an applicant more preferred by the program, as described in the second case above. When an applicant is removed from a previously made tentative match, an attempt is made to re-match that applicant, starting from the top of his/her list. This process is carried out for all applicants, until each applicant has either been tentatively matched to the most preferred choice possible, or all choices submitted by the applicant have been exhausted. When all applicants have been considered, The Match is complete and all tentative matches become final.”* There is also a special process for the “couples” match for those who are eligible and chose to commit to it.

According to the NRMP the 2012 Match had more than 95% of the approximately 16,000 graduating seniors of US allopathic schools “match” to a residency program, the highest number in three decades. Overall in the 2012 Match there were 38,377 participants who applied for 26,772 positions. The other applicants included 2360 graduates of osteopathic schools, 4279 US citizens from international medical schools and 6923 non-US citizen/graduates of international medical schools. As in past years, dermatology, orthopaedic surgery, otolaryngology, plastic surgery, thoracic surgery and vascular surgery were the most “competitive” fields for applicants. Even though emergency medicine and anesthesiology programs each added incremental positions, all were filled. For US seniors who matched, 56.5% received their first choice and 81.6% received one of their top three choices. For non-US seniors, nearly 49% went unmatched. Our Stanford students achieved much higher-ranking preferences – but, as Dr. Charles Prober, Senior Associate Dean for Medical Education, pointed out at the Annual Match Day Celebration on Friday evening, what is most important is that the student and teaching hospital are happy with their new association and that each have a great experience during their years together. Each student is unique and virtually every training program offers important education and training opportunities.

All of our 75 Stanford participating students matched in 2012. Although students matched in 16 specialty areas, 23 (31%) matched in internal medicine, 9 (12%) students matched in radiology, 8 (11%) matched in pediatrics and 18 (24%) matched in all surgical specialties combined. There was a clustering of teaching institutions and geography with the three most popular programs being Stanford (22 students), Harvard (12 students) and UCSF (11 students). While graduating students will be distributed to 12 states, two states (California and Massachusetts) will host 55 (73%) of them. Here’s the list of graduating students and the institutions where they will begin their internship.

The Stanford School of Medicine 2012 Match List

<i>Amir, Omar</i>	Brigham & Women’s Hosp-MA	Internal Medicine
<i>Anavitarte, Adriana Pamela</i>	Stanford Univ Progs-CA	Pediatrics
<i>Arroyo, Anna Chen</i>	Stanford Univ Progs-CA	Internal Medicine
<i>Arumainayagam, Dinah Lukshani</i>	O’Connor Hospital-CA	Family Medicine
<i>Atmadja, Melanie Alexandra</i>	Stanford Univ Progs-CA	Pediatrics
<i>Badowski, Natalie Janet</i>	Stanford Univ Progs-CA	Emergency Medicine
<i>Barakat, Monique</i>	Stanford Univ Progs-CA	Internal Medicine
<i>Barreto-Chang, Odmara Liz</i>	Stanford Univ Progs-CA	Surgery-Preliminary
<i>Bauer Huang, Sarah Louise</i>	U Washington Affil Hosps-WA	Child Neurology
<i>Birnie, Krista Lauren</i>	Stanford Univ Progs-CA	Pediatrics
<i>Camara-Quintana, Joaquin Q.</i>	Yale-New Haven Hosp-CT	Neurological Surgery

<i>Cardenas, Alexander Saul</i>	San Mateo Behavrl Hlth/Recvry Svcs-CA	Psychiatry
<i>Casto, Amanda Morgan</i>	Stanford Univ Progs-CA	Internal Medicine
<i>Chen, Christina Ann</i>	Santa Clara Valley Med Ctr-CA	Transitional
	Stanford Univ Progs-CA	Radiology-Diagnostic
<i>Chen, Yi-Ren</i>	Stanford Univ Progs-CA	Neurological Surgery
<i>Chow, Vinca</i>	Brigham & Women's Hosp-MA	Anesthesiology
<i>Chun, Carlene Lihalakha</i>	Oregon Health & Science Univ-OR	Internal Medicine
<i>Corcoran-Schwartz, Ian</i>	Stanford Univ Progs-CA	Orthopaedic Surgery
<i>Cord, Branden John</i>	Yale-New Haven Hosp-CT	Neurological Surgery
<i>Czechowicz, Agnieszka Dorota</i>	Childrens Hospital-Boston-MA	Peds/Childrens Hosp
<i>Davalos, Eric Andre</i>	Stanford Univ Progs-CA	Surgery-Preliminary
	Harbor-UCLA Med Ctr-CA	Radiology-Diagnostic
<i>Goldsmith, Elizabeth Sara</i>	U Minnesota Med School-MN	Internal Medicine
<i>Goldstein, Matthew Jordan</i>	Brigham & Womens Hosp-MA	Medicine-Primary/HVMA
<i>Gutierrez, Luis Balmore</i>	Santa Clara Valley Med Ctr-CA	Transitional
	UC San Francisco-CA	Radiology-Diagnostic
<i>Hemond, Christopher</i>	University of Hawaii-HI	Medicine-Preliminary
	Stanford Univ Progs-CA	Neurology
<i>Hillman, Robert Tyler</i>	UC San Diego Med Ctr-CA	Obstetrics-Gynecology
<i>Hoover, Paul</i>	Brigham & Womens Hosp-MA	Internal Medicine
<i>Insko, Megan Leigh</i>	Brigham & Womens Hosp-MA	Internal Medicine
<i>Jan, Taha</i>	Mass Eye and Ear Infirmary-MA	Otolaryngology
<i>Johnson, Thomas Michael</i>	Oregon Health & Science Univ-OR	Emergency Medicine
<i>Jones, Richard Hayden</i>	U Minnesota Med School-MN	Radiology-Diagnostic
<i>Juang, Jeremy Tehsun</i>	Brigham & Womens Hosp-MA	Anesthesiology
<i>Kleinman, Jonathan Thomas</i>	Exempla St Joseph Hosp-CO	Medicine-Preliminary
	UCLA Medical Center-CA	Neurology
<i>Link, James Thomas</i>	UC San Diego Med Ctr-CA	Internal Medicine
<i>Louie, Ryan K.</i>	University of Hawaii-HI	Psychiatry
<i>Mair, Robert DeWolfe</i>	Stanford Univ Progs-CA	Internal Medicine
<i>Mancuso, Michael Robert</i>	Stanford Univ Progs-CA	Internal Medicine
<i>Marshall, Eleanor</i>	Georgetown Univ Hosp-DC	Transitional
	U Texas MD Anderson Cancer Ctr-TX	Radiation-Oncology
<i>Martin, Marlene</i>	UC San Francisco-CA	Internal Medicine

<i>McClellan, Mary Kathryn</i>	UC San Francisco-CA	Family Medicine
<i>Montoy, Juan Carlos</i>	UC San Francisco-CA	Emergency Medicine
<i>Myall, Nathaniel James</i>	Stanford Univ Progs-CA	Internal Medicine
<i>Nguyen, David-Huy Nhu</i>	UC San Francisco-CA	Internal Medicine
<i>Pang, Wendy</i>	Stanford Univ Progs-CA	Internal Medicine
<i>Parker, Jennifer Janell</i>	Rush University Med Ctr-IL	Medicine-Preliminary
	Yale-New Haven Hosp-CT	Radiology-Diagnostic
<i>Pearl, Jeremy</i>	Kaiser Permanente-SF-CA	Medicine-Preliminary
	UC San Francisco-CA	Anesthesiology
<i>Pridgen, Brian Craig</i>	Stanford Univ Progs-CA	Plastic Surgery (Integrated)
<i>Prolo, Laura Marie</i>	Stanford Univ Progs-CA	Neurological Surgery
<i>Raghavan, Shyam Sampath</i>	UC San Francisco-CA	Surg-Prelim/Plastic Surge
	UC San Francisco-CA	Plastic Surgery
<i>Red Eagle, Alexander Robert</i>	Stanford Univ Progs-CA	Internal Medicine
<i>Renninger, Christopher Hunt</i>	Naval Medical Center (San Diego)-CA	Orthopaedic Surgery
<i>Saddic, Louis Alexander</i>	Brigham & Womens Hosp-MA	Medicine-Preliminary
	Brigham & Womens Hosp-MA	Anesthesiology
<i>Sagreiya, Hersh</i>	Abington Mem Hosp-PA	Medicine-Preliminary
	UPMC Medical Education-PA	Radiology-Diagnostic
<i>Salari, Keyan</i>	Massachusetts Gen Hosp-MA	Surgery-Preliminary
	Massachusetts Gen Hosp-MA	Urology
<i>Scahill, Michael</i>	UC San Francisco-CA	Pediatrics-Primary
<i>Schwartz, Judith Amanda</i>	UC San Francisco-CA	Pediatrics
<i>Selig, Sarah Jane</i>	O'Connor Hospital-CA	Family Medicine
<i>Sellmyer, Mark Anthony</i>	Kaiser Perm-Santa Clara-CA	Medicine-Preliminary
	Hosp of the Univ of PA-PA	Radiology-Diag/Resrch-5
<i>Sherman, Elena</i>	CA Pacific Med Center-CA	Medicine-Preliminary
	Stanford Univ Progs-CA	Neurology
<i>Silverio, Luz Maria</i>	UC San Francisco-CA	Emergency Medicine
<i>Stachur, Christina</i>	Stanford Univ Progs-CA	Anesthesiology
<i>Subrahmanian, Krishnan N.</i>	Baylor Coll Med-Houston-TX	Pediatrics/Global Health
<i>Sundberg, Michael Andrew</i>	Brigham & Womens Hosp-MA	Med-Peds/Harvard BWH/
<i>Tang, Chad</i>	U Texas Med Sch-Houston-TX	Med-Prelim/Radiation On
	U Texas MD Anderson Cancer Ctr-TX	Radiation-Oncology

<i>Wells, Cassia Anne</i>	NYU School Of Medicine-NY	Internal Medicine
<i>Whitney, Jane</i>	Childrens Hospital-Boston-MA	Peds/Childrens Hosp
<i>Winetsky, Daniel Eric</i>	Hosp of the Univ of PA	Internal Medicine
<i>Woo, Victoria Gah Hay</i>	UC San Francisco-CA	Obstetrics-Gynecology
<i>Yeh, Judy Y.</i>	Cleveland Clinic Fdn-OH	Obstetrics-Gynecology
<i>Zhu, Ruo Peng</i>	U Michigan Hosps-Ann Arbor-MI	Internal Medicine

In addition to the 75 graduating Stanford medical students who matched at various teaching hospitals, the Stanford Hospital & Clinics and the Lucile Packard Children's Hospital will be receiving new residents from across the country this summer. Based on comments from clinical department chairs and program directors, each discipline was enormously happy with its "match." Overall the match for our graduating students and for incoming ones to SHC and LPCH is outstanding. Congratulations to all.

USNWR Medical School Rankings – An Evolving Process

Another annual "rite of spring" that takes place with varying degrees of anticipation is the US News and World Reports (USNWR) ranking of graduate schools – which primarily means schools of medicine (and in particular the MD program of the school) along with schools of engineering, law, business, education. Graduate programs (i.e., PhD) in the biosciences are ranked less frequently and are not generally directly part of the "medical school" ranking *per se*. The topic of the USNWR rankings is one that I have written about frequently in the past, focusing primarily on the metrics that have long been employed that gave undue emphasis to size over quality, weighting too heavily the total amount of research funding from the NIH – which can be strongly influenced by the number of faculty. Over the years I have presented corrections to the ranking metrics, including balancing total research funding with the amount of competitive funding per faculty member, as has been done by USNWR in ranking schools of engineering. This and other changes were employed last year as well as this year and have provided some balance to the size and quality assessment. *Based on the metrics used for research medical schools, Stanford School of Medicine is ranked #4 by USNWR for 2012.* Of course each year is a new adventure.

Technology and the Rules on the Practice of Medicine at Stanford: A Reaffirmation

In the May 9, 2011 Dean's Newsletter, I reported the most recent version of the rules on the "Practice of Medicine" at Stanford as of that date. These rules focused on the sites and approved conditions under which Stanford School of Medicine faculty can practice medicine. However, technology is rapidly changing the practice of medicine, and I asked Dr. Norm Rizk, Senior Associate Dean for Clinical Affairs and Interim Chief Medical Officer at SHC, and Ann James, Senior University Counsel for Stanford University, to provide an update on how faculty can engage with on-line medical consultations. Here are their comments:

With the almost daily discussion of medical information being shared (sometimes appropriately, sometimes not) on Twitter, Facebook, e-mail, blogs and other forms of social media, it is hardly surprising that entrepreneurs are working to develop increasingly more sophisticated systems for communicating medical information online. Several companies are focused on the access for individuals to specialists for a second opinion at a fixed cost. The participation on such panels is attractive to many specialists, including our own faculty, but there are specific reasons why such participation is not permitted. Obviously one of our most valuable assets as an organization is the intellectual capital of our faculty and we cannot surrender it to external commercial entities.

The rules around this are designed to protect the School and two hospitals. Each clinician who is providing patient care services as part of their employment at Stanford is covered by the **Practice Policy for the Physicians and Psychologists in the School of Medicine** (<http://med.stanford.edu/academicaffairs/documents/rules-of-practice.pdf>).

All income from direct, indirect or consultative patient care services is part of practice income, which every practitioner assigns to either SHC or LPCH upon joining Stanford. There are specific and limited exceptions, which do not include such second opinion services. *Anyone seeking an exception must have the exception reviewed and approved in writing by the relevant Chair and Division Chief, and the Senior Associate Dean for Academic Affairs. Anyone who has a question about a specific arrangement can seek resolution with the Senior Associate Dean for Academic Affairs. And, SUMIT does not provide malpractice coverage for anyone who receives payment for patient care services outside the scope of the practice policy, thus placing anyone who does so participate at personal risk.*

The policy also addresses the specific situation of contact through the Internet, and provides a disclaimer for an answer if deemed appropriate.

We do recognize that this area of interaction is rapidly changing, and the School, in collaboration with LPCH and SHC, is actively working to develop a Stanford Medicine brand and online presence. As this new area of patient interaction develops and is launched, we will make sure faculty can fully participate, and do so in a compliant manner. In the interim, please remember the importance of privacy for personal health information, use social media appropriately—and if you have questions, please contact Dr. Norm Rizk (nrizk@stanford.edu) or Dr. David Stevenson (dstevenson@stanford.edu). There will be much more on these issues to come.

Progress on a Proposed Late Career Practitioner Policy

In 2007 I appointed a Senior Transitions Task Force and asked Dr. Gary Schoolnik, Professor of Medicine, to serve as chair of the group. After over a year of data gathering and deliberations, the Task Force presented a set of recommendations to the School of Medicine Executive Committee (see power point presentations at: <http://med.stanford.edu/academicaffairs/senior-faculty/task-force.html>). Among them was the recommendation that a web site be developed that collected on one site School and University information, resources and assistance to faculty who are transitioning in their careers or moving toward retirement (see: <http://med.stanford.edu/academicaffairs/senior-faculty/>).

I can now personally resonate with senior transitions – being both a “senior” and someone who will be transitioning over the next year or so. Each stage of our careers offers new opportunities – some more engaging and exciting than others – but each benefits from some planning and discussion with friends, colleagues and advisors. Given the number of “baby boomers” who will join the ranks of seniors over 65 years of age, as well the increase in longevity in the US and globally, we face numerous challenges as individuals and as communities – both local and global – as was highlighted in a 2008 issue of Stanford Medicine that was devoted to “*The Long of It: The World Turns Gray*” (<http://stanmed.stanford.edu/2008spring/>). These demographic changes pose challenges to our medical community as health care providers and eventually for all of us as healthcare recipients.

As we age as physicians (or in any career path) it is important to be cognizant of our proficiency and skills, which will inevitably change for each of us, although the patterns and timing of change will vary in individual ways. While individual variation is likely, for those in some professions, such as commercial airline pilots, mandatory retirement takes place at age 65 (<http://www.leftseat.com/age60.htm>). While the work scope and responsibilities are clearly different for doctors compared to commercial pilots, medicine is also a life-and-death profession. However, there are no similar mandatory age limits to medical practice. Given the wide range of roles and responsibilities of physicians, which can include incredibly complex and intricate technical proficiency and the need for significant cognitive recall and reasoning, it seems reasonable for each of us to reflect on when – or if – it is time to transition from some or all of our clinical practice responsibilities.

Currently, including at Stanford, this transition decision is an individual one, although it is coupled with certification by local medical boards and credentialing committees. Certainly each of us will want to make a decision to retire from medical practice when we believe “the time is right” and especially when there is a concern about patient safety. However, I would quickly add that the boundaries around such decisions could become blurry. We also want career transitions to occur at a time that is respectful of the dignity and well-being of the individual physician and, ideally, that avoids having such a decision imposed. Given our ever-increasing longevity, the coming dramatic increase in Americans who will cross the age-threshold to 65 years and older (I am one of them), it is not surprising that many physicians wish to continue meaningful work and contributions beyond age 65. Also, the current economic conditions may lead individuals

to work longer into their senior years than they might have previously forecast or anticipated. Thus, it seems prudent to address planning for late career physicians in a thoughtful and proactive manner that is respectful to individual physicians and to the communities they serve.

Current estimates are that 20% of physicians nationwide are greater than 65 years old. While longitudinal data on physicians specifically are limited, it is clear that virtually all aspects of measurable cognitive functions (including inductive reasoning, spatial orientation, perceptual speed, numeric ability, verbal memory) decline after the age of 60 – a pattern that continues thereafter. While it might be argued that the pattern or rate of cognitive decline might be less steep or even more delayed in physicians, this would be a generalization that assumes that doctors have a different aging process than the general population – which is not likely. Moreover, it has already been reported that surgical complications occur at a higher frequency when performed by physicians older than 60 years of age and that medical boards tended to more frequently discipline physicians who were 40 or more years since graduation from medical school compared to those who were 10 or less years post training (6.6% versus 1.3%).

With this in mind, I appointed a Task Force in April 2011 to determine whether Stanford should develop a more formal policy for late career physicians and if so, how it should be formulated and implemented. Just as this Task Force was beginning its work, it was learned that the Medical Staff at Lucile Packard Children's Hospital (LPCH), under the chair of its President, Dr. Janesta Noland, was pursuing a policy in this area that was based on one prepared for several community-based children's hospitals. Given the integration of our faculty between LPCH and Stanford Hospital & Clinics (SHC) we agreed to work toward a shared policy that could be approved by the Medical Staff of each hospital (SHC and LPCH). The Task Force consisted of a multidisciplinary group that included:

- **Dr. Ann Weinacker**, Chief of Staff at SHC and Professor of Medicine, Chair of the Task Force
- **Dr. Kathy Gillam**, Senior Advisor to the Dean, Staff to the Task Force
- **Dr. Brian Bohman**, Associate Medical Officer and former Chief of Staff at SHC
- **Dr. Karl Blume**, Professor of Medicine Emeritus
- **Dr. Rusty Hoffman**, Chief of Interventional Radiology and Associate Professor of Radiology
- **Dr. Rob Jackler**, Sewall Professor and Chair, Department of Otolaryngology: Head and Neck Surgery
- **Dr. Ann James**, General Counsel
- **Dr. Tom Krummel**, Emile Holman Professor and Chair, Department of Surgery
- **Dr. Frank Longo**, George E and Lucy Becker Professor and Chair, Department of Neurology
- **Dr. James Mark**, Johnson and Johnson Professor of Surgery, Emeritus
- **Dr. Janesta Noland**, Chair, Medical Staff at LPCH and Adjunct Assistant Professor of Pediatrics

- *Dr. Kathy Renschler*, Community Physician and former Member, Board of Directors, SHC
- *Dr. Norm Rizk*, Senior Associate Dean for Clinical Affairs and Berthold and Belle N. Guggenheimer Professor of Medicine; Interim Chief Medical Officer at SHC
- *Dr. Gary Schoonik*, Professor of Medicine and of Microbiology and Immunology
- *Dr. Penelope Zeifert*, Clinical Associate Professor of Neurology

The Task Force reviewed all available literature and examined related policies that have been developed to date at other hospitals and institutions. It determined that Stanford should take a lead in developing a formal policy for late career physicians that provided guidance and credentialing oversight regarding their medical practice. A draft policy, which was intended to apply to all members of the Medical Staffs of both LPCH and SHC, was reviewed and approved by the leadership of the School of Medicine in November 2011. The Medical Executive Committee of the SHC Medical Board reviewed the policy on Wednesday, March 7th. It received conceptual approval with the expectation that the final policy would be implemented once all the details were refined. The policy is currently under review within the LPCH Medical Staff.

Having decided that a policy should be put into place, the Task Force and Medical Staff review committees had considerable discussion about what the age threshold should be. It is also important to note that this policy does not preclude the need to be attentive to younger physicians about whom concerns for fitness of duty are raised and who would need to be considered on an individual basis through the Credentials Committee. The most appropriate age for beginning mandatory routine examination of late stage physicians is not fully defined by existing data, and the Task Force determined that they would begin with physicians aged 75 and older. This decision was partly influenced by the fact that Alzheimer's disease, the most common cognitive disease of aging, is more likely to occur in individuals aged 75 and older. At this time only a minority of the active medical staff are age 75 or older— although this number will likely increase given the reasons mentioned above. The Task Force also recognized that the age criterion could be changed in time as experience and data on the use of the policy accrued – making this more of a pilot policy at this juncture.

With all this in mind, the **SUMC Late Career Practitioner Policy**, assuming final approvals, will apply to all members of, and applicants to, the medical staffs of SHC and LPCH who are 74.5 years of age and older. For these practitioners, medical staff credentialing privileges (not employment) will be based on a peer assessment of clinical performance, a physical examination and cognitive screening. These evaluations must indicate that the practitioner has no detected physical or cognitive problem that might interfere with the safe and effective provision of care under his or her current privileges (for current members of the medical staff) or those being requested by new applicants to the medical staff. As currently conceptually envisioned:

- **Three qualified members of the medical staff members will perform a peer-assessment of the practitioner or applicant. The Stanford University School**

of Medicine Clinical Excellence Core Competency Evaluation will be used for this purpose.

- **A complete history and physical assessment by an approved physician examiner.**
- **A cognitive screening will be performed by an approved examiner**

The review and examinations would be carried out with strict confidentiality, and the outcomes would serve to guide the credentialing process and well as the scope and duration of clinical privileges. For physicians aged 75 and older, this three-part evaluation would take place every two years. The date that this policy will go into effect remains to be determined but, assuming final approvals, it will be in the 2012 calendar year.

The Task Force and the Medical Executive Committees recognize that adopting this policy opens a number of questions and would set a standard that is not part of medical credentialing at most institutions across the United States. Developing this policy was undertaken with concern for patients who seek medical care at SUMC and for physicians who practice on our medical staff.

I want to thank the members of the Task Force and, in particular the leadership of Dr. Ann Weinacker along with the outstanding support of Dr. Kathy Gillam, for their thoughtful and comprehensive review of this important and challenging issue and recommendations they have brought forth. I also want to thank Dr. Janesta Noland for her leadership at LPCH and for the collaboration of the Medical Staff leadership at SUMC, both that of LPCH and of SHC. The date of implementation of an approved policy will be announced in a subsequent newsletter.

More Discussions About Bicycle Safety On Campus

I have written all too frequently about bicycle safety on campus and my concerns for those in our community of students, faculty and staff who take personal risk by not wearing bike helmets, or who engage in other unsafe behaviors, or who endanger others by not obeying traffic safety rules. In fact, for what it's worth, I have contributed nearly 20 articles and pleas about bike safety in the Dean's Newsletter alone over the past decade. In part this is because there are hundreds of bike collisions (involving bikes, cars and pedestrians) each year and because a number of these collisions result in serious injury (including head trauma, fractures, etc). There are now more than 13,000 bicyclists on campus each day. This is good news since it means that car trips are being reduced as a source of campus transportation.

At the same time virtually everyone I have spoken with reports personally observing unsafe riding behavior by faculty, students and staff. It's not just the absence of bike helmets that is of concern. Increasingly cyclists are "multi-tasking" – including talking on cell phones, texting, eating or drinking – sometimes engaging in more than one of these unsafe behaviors at the same time. Equally worrisome is the lack of attention to traffic laws – not stopping at stop signs, failing to yield when making turns, driving at

unsafe speeds and, especially concerning, not using any lights or reflective gear when riding at night – including on the public roads on the campus. While obviously subject to sample bias, every night when I drive from the medical school to my residence on campus, I make it a habit to count the number of bikers who wear helmets or who have lights or obey safety laws. Unfortunately that number has **not** changed over nearly a decade – and is still about 1 in 10 riders. Interestingly, similar informal “personal surveys” by others come amazingly close to my tallies.

The unsafe cycling practice on campus is not just by students – it is also carried out by faculty and staff. And it occurs at the medical school – where one would like to think there would be a higher awareness and attention to personal safety. After all, a serious fall and injury can be life and career changing.

Amazingly, unsafe bicycle safety continues despite enormous – even heroic – efforts by the University Bicycle Safety Program (http://transportation.stanford.edu/alt_transportation/BikingAtStanford.shtml). Over a number of years significant efforts have been undertaken in education, engineering, encouragement and enforcement. The importance of bike safety is part of the orientation of incoming Stanford students – and which results in 85% of freshman students learning about bike safety and literally thousands of free bike lights being given to students each year. Safety classes abound, competition (with prizes) to foster greater bike safety between undergraduate dorms are popular - but without a sustaining impact on helmet and light use or attention to traffic rules. In fact, while nearly all students admit they have learned something new from bicycle safety classes, few actually practice the lessons in their daily riding activities. Over the past years the University has put efforts into creating safer bike circulation routes on campus and has tried to make the campus as friendly as possible to bikers. In fact, Stanford has been designated the first and only Platinum Level Bicycle Friendly University by the League of American Bicyclists through 2012. But bicycle “friendly” is not the same as “bicycle safe.” Unfortunately, not paying attention to safety rules also occurs despite increased efforts by the Stanford Public Safety (aka the police) to enforce safety and traffic rules.

How about bike safety among our medical school students? I reported in the August 29th DNL (http://transportation.stanford.edu/alt_transportation/BikingAtStanford.shtml) that three of our SMS 2 students, Anthony Kaveh, Sneha Shrestha and Nancy Yerkes, worked collaboratively with Ariadne Scott, Stanford’s Bicycle Safety Coordinator, to promote the use of helmets and lights by all incoming MD students in 2011. As part of this program every medical student was given a helmet, bike light and safety instructions. All signed a pledge to wear the helmet and use the light. You might ask, what has happened as a result of these good deeds and intentions? A student sponsored and led survey was sent to each of these same medical students in January 2012 – just 4 months after the orientation program and student safety affirmation noted above. The survey had a 100% response rate but observed that 57% of the first year medical students reported that they “always” wore a helmet and 49% said that they “always” used bike lights at night. While it is true that an additional number of students indicated that they “almost

always” used helmets or lights, the “always” percentage is really the important metric. Based on other experiences, even these results are likely to deteriorate over time.

Clearly we need to do more to achieve bicycle safety at Stanford. Surely more education helps, but we also need to work collaboratively to ensure that there is greater compliance and enforcement with safety to traffic rules, lights, helmets and safe riding habits. We all need to be advocates for safety and to take note when our colleagues and friends are being unsafe – and whenever possible provide counseling and more. I would hope that the medical school community could play more of a leadership role in modeling bicycle safety. We would all hate to see bike safety come to heightened attention because of a serious injury to one of our students, co-workers, friends or colleagues.

Seed Grants Promote Innovation and Interdisciplinary Research

Over the past decade both the Medical School and University as a whole have developed a number of programs that provide competitive seed grants to faculty who are addressing new research themes, especially if they are interdisciplinary and/or create bridges between basic and clinical faculty. The School of Medicine seed grant programs, which are based largely in our Institutes of Medicine, Strategic Centers and Spectrum, share in common their support for novel and innovative research and the prospect for bringing new teams of faculty together to engage in research that might not otherwise have happened. Some, especially in recent years, have focused on seed grants to junior faculty. In addition, Bio-X has a significant seed grant program, as does the Beckman Center for Molecular and Genetic Medicine, the Children’s Health Research Institute and the Stanford-Coulter Translational Research Grants Program, among others.

Over the past 5 years the School of Medicine has allocated over \$15 million to Institutes and Centers for seed grant programs. Most all of the grants are modest in size but nearly all have an important and significant leveraging impact. A total of 220 seed grants have been awarded over the past 5 years, and, to date, 140 publications and 81 successful follow-on funding proposals have resulted. While it is hard to say with certainty that the seed grants accounted for successful competition for larger sponsored research awards, there seems little doubt that they have created a greater climate of collaboration, interaction and innovation throughout the Stanford community. These funds are best viewed as an investment in the future of our research mission, from basic research through translational to clinical research, and I encourage faculty to apply for them. The School’s Research Management Group maintains an extensive list of seed grant opportunities (<http://med.stanford.edu/rmg/funding/internalfunding.html>) for this purpose and I hope you will take advantage of the information available there.

Baxter Foundation Visits Stanford for the 52nd Time

Just a year after the School of Medicine was relocated from San Francisco to Palo Alto in 1959, the Baxter Foundation began making investments in Stanford to support medical and graduate student education, faculty scholar awards and capital support. The Foundation was established in 1959 by Delia Baxter in memory of her husband, Donald, a distinguished physician, engineer, and scientist who pioneered the commercial

formulation of intravenous solutions based on his experiences as an Army doctor during World War I. The Baxter Foundation has no ties to the company and is committed to making annual gifts to selected medical research and education initiatives and institutions.

Stanford has been one of the longest beneficiaries of these gifts. The trustees of the foundation, Don Haake, Dick and Martha Haake, and Jim and Jane Russell, have not only been responsible for the annual gift decisions but have been personally invested in the students and faculty receiving the awards. Indeed, over the years they have spent time visiting with potential recipients, learning about the work being conducted and making the Baxter Foundation personally meaningful to each of its annual awardees.

This year the Foundation also celebrated the 10th Anniversary of the Donald E. and Delia B. Baxter Foundation Laboratory in Stem Cell Biology, which was established in 2002 and which has been ably led by Dr. Helen Blau, who is also the Donald E. and Delia B. Baxter Foundation Professor at Stanford. Based on the comments of Don Haake, who spoke for the Foundation at a ceremony in the Lorry Lokey Stem Cell Research Building, the Foundation is deeply appreciative and admiring of the work that has been done over the past decade in the Baxter Lab and also of the many students and faculty the Foundation has supported over the past 52 consecutive years. This is quite an incredible partnership for which we are deeply appreciative.

Upcoming Events

The Department of Chemical and Systems Biology, through its Sterling Visiting Professorship Program, cordially invites you to attend two lectures by Alyson Shotz, this year's visiting artist from March 26-30, 2012. These lectures are free and open to the public.

Alyson Shotz is an artist whose work frequently intersects art and science. She has exhibited around the world and her work is in the collections of many museums including the Solomon R. Guggenheim Museum, the Museum of Modern Art, San Francisco and The Hirshhorn Museum, among others.

During her residence, Ms. Shotz plans to investigate the relationship between empirical research, observation and experimentation in art and science as a means to new discoveries. The students will join her in producing a series of experiments in hot glass and microscopic photography.

For more info on the artist's background please visit:

http://www.derekeller.com/alysonshotz_work.html

Monday, March 26 at 11:00am

“The Ethereal Invisible: an Overview of the Artists work“

Munzer Auditorium

Friday, March 30 at 2:30pm

“Looking for Undiscovered Realities: Finding and/or Failing, followed by a presentation of the student collaboration”

Munzer Auditorium

The Friday lecture will be followed with a reception in CCSR (outside 3130) at 4:00pm.

For more info on the artist’s background please visit:

http://www.derekeller.com/alysonshotz_work.html

If you have questions or need more information, please contact Stuart L. Jeung @650.736.2999 or stuartj7@stanford.edu

Awards and Honors

The recipients of the 2011 School of Medicine SPIRIT Award and the Inspiring Change Award were recently announced and will be formally celebrated (along with our valued staff) at the Dean’s Staff Recognition Program celebration on Thursday, March 29, 2012 in the Li Ka Shing Center for Learning and Knowledge from 4:00-6:30 p.m. This year the SPIRIT Award recipients include:

- ***Ross Colvin***, Department of Neurosciences-IDP
- ***Kerry Garcia***, Department of Obstetrics/Gynecology

The winner of the Inspiring Change Leadership Award is:

- ***Felicia Gentile***, Department of Comparative Medicine/Veterinary Service Center

Congratulations to each of these winners!!