

# Dean's Newsletter

## April 18, 2011

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### **Dr. Alan Garber Named Provost of Harvard University**

On Friday, April 15<sup>th</sup> Harvard University President Drew Faust announced that Alan Garber has been appointed the next provost there. Dr. Garber is currently the Henry J. Kaiser Jr. Professor of Medicine and, by courtesy, of Economics; Professor of Health Research and Policy & Economics in the Graduate School of Business; and Senior Fellow at the Freeman Spogli Institute (FSI) for International Studies, and he is a much respected and beloved member of the Stanford community. While we always are disappointed to lose a valued colleague and distinguished faculty member, it is hard to not celebrate Alan's selection for this important new position – for which he is quite well suited.

Dr. Garber is a graduate of Harvard College, Class of 1976, and he received a PhD in economics from Harvard while he was completing his MD degree at Stanford. In 1986, following his internship and residency at the Brigham and Women's Hospital, he joined the Department of General Medicine at Stanford University. Over the past 25 years he has had a remarkably successful career that has intersected medicine, economics and health policy. He is deeply admired in the academic community for his broad medical knowledge, deep analytical thinking and ability to bridge broad intellectual disciplines and fields. He has also been a highly valued consultant and guide to health policy for political candidates and for the public and private sectors. His breadth and range of skills and knowledge make him exceptional and remarkably qualified to serve in the central role of provost of a major university. Harvard has been unique among leading

universities in selecting outstanding MD leaders as provosts, including the two most recent incumbents, Harvey Feinberg, now President of the Institute of Medicine, and Steve Hyman, a renowned neuroscientist and psychiatrist.

Without question Alan Garber's departure for his new position in Cambridge on September 1<sup>st</sup> will leave a major gap in Stanford's excellence in medicine, economics and policy. At the same time he will bring his unique skills to another great university. Naturally we will seek Alan's guidance, along with others, to consider how to retain and shape the excellent programs he and his colleagues have established at Stanford. But for now please join me in congratulating Alan Garber and in wishing him well for an exciting new journey.

### **Healthcare in the US: Past, Present and Future**

Dr. Rob Jackler, Edward C. and Amy H. Sewall Professor in Otorhinolaryngology and Chair of the Department of Otolaryngology, recently shared an interesting article from the New York Times on healthcare reform, which if you haven't seen you might find interesting. I thought you might be interested in a few excerpts from this report, and I am taking the liberty of copying the first couple of paragraphs and conclusion for your perusal.

*The results of America's first comprehensive survey of the economics of medical practice, made public last week by the committee on the costs of medical care after five years of study, reveal what may be described as a crisis in medical service.*

*They show that while the average pay of physicians and other health workers is not high and while the actual pay in individual cases is often insufficient, adequate medical attention is beyond the reach of many millions of people.*

*They reveal that while medical knowledge has been progressing rapidly for half a century or more, the application of that knowledge to the needs of the general public has lagged.*

*But when it comes to measures to meet the crisis there is disclosed a clash of philosophies, forcefully presented in the majority and minority reports of the committee. The majority group, expressing themselves in recommendations so sweeping as to come under the heading of revolutionary, see medicine as a social problem and responsibility, demanding reorganization and centralization. The minority see it as a function which can never be socialized, since in their opinion it must always resolve itself into a highly personal relation between physician and patient. There are already indications that the reports, in their radical divergence, will shake the medical world to its core.*

The lengthy article, which was written by RL Duffus, ends with a last paragraph entitled "A Challenge Presented," and I quote:

***“As the report puts it” Dr. Hamilton concludes, “the present situation presents a challenge. It is not a question of whether we can afford to pay for an adequate and comprehensive system of medical care. A social investment in health pays its own way and yields a surplus. The present system is a luxury which the American nation – rich as it is in resources – is too poor to afford”***  
***That the report is, as Dr. Hamilton says, a “challenge” has already been established by its reception. It is the opening gun in a battle between individualism and socialism in medicine which promises to be of long duration.***

The committee that was referred to above, and that led to this review, was chaired by Dr. Ray Lyman Wilbur and was financed by eight foundations. Dr. Wilbur was Dean of the Stanford University School of Medicine from 1911-1916 and then served as President of the University from 1916-1943 (during which time he was Secretary of the Interior from 1929-1933 [giving new meaning to multi-tasking]). *The New York Times* article referred to above was published on December 4, 1932.

Without overstating the case, it is remarkable to note the parallels of the debate on healthcare reform that still exist today, nearly 70 years later. It is worth remembering that when Roosevelt constructed the New Deal (of which Dr. Wilbur was a critic) he was advised to leave healthcare reform off the table in lieu of other major social initiatives, including Social Security. Had healthcare in the US been addressed then we might not be having the debates that are taking place today.

The current set of challenges in healthcare reform was the topic of the Second Medical Staff Symposium held on April 5<sup>th</sup>, at which a panel led by Dr. Rob Jackler addressed some of the implications of healthcare reform for Stanford. Also participating in the panel were Drs. Alan Garber, the Henry J. Kaiser Jr. Professor of Medicine and, by Courtesy, of Economics; Professor of Health Research and Policy & Economics in the Graduate School of Business; and Senior Fellow at the Freeman Spogli Institute (FSI) for International Studies, and Dr. Arnie Milstein, Professor of Medicine and Director of the Clinical Excellence Research Center. Later in the week the Center for Health Policy at FSI and the Center for Primary Care and Outcomes Research in the Department of Medicine held events that focused on health policy issues in the US and globally. Similar discussions took place at the Board of Directors meeting of the Lucile Packard Children Hospital within the same week – underscoring the broad interest and implications of the healthcare debate.

And, of course, as these discussions have been taking place within our medical center, the debate in Washington has been filled with rhetoric and rancor, particularly over the past week – with polarizing commentaries on the Affordable Care Act of 2010, the economy and the major entitlement programs, especially Medicare and Medicaid. While Congressman Paul Ryan (R-WI) proposed the elimination of Medicare and Medicaid as part of 5-trillion deficit reduction package over the next decade, President Obama proposed preservation of these entitlement programs, albeit with reductions in

their spending. He further proposed strengthening the Independent Payment Advisory Board (IPAB), which is slated to begin in 2014 and which is charged with serving as a check on Medicare spending by removing some of the decision making authority from Congress and making payments more evidence-based.

Given the current and projected costs of healthcare it seems undeniable that we cannot afford to continue the discussion of 1932 another 70 years into the future. However, the debate does not seem destined for resolution in the immediate future.

## **NIH and Federal Research Budget for the Remainder of FY11**

I am taking the liberty of copying a recent update from David Moore of the AAMC (see: <https://www.aamc.org/advocacy/washhigh/>) since he nicely summarizes the impact of the recent federal legislative battle and resolution on NIH funding and other federal programs we in the AAMC rely on. It is worth underscoring that these results affect spending through the end of September 2011. The battle over the FY12 budget (which would begin on October 1, 2011 – unless there is another continuing resolution) is just getting underway and promises to be equally if not even more fierce and contentious.

The final bill includes \$30.7 billion for the **National Institutes of Health (NIH)**, a \$320 million (1.0 percent) reduction from FY 2010, including the 0.2 percent across-the-board cut. The bill specifies \$210 million in cuts from a pro rata reduction of all institute, center, and the Office of the Director's budgets, and \$50 million from the intramural buildings and facilities account. The bill does not provide funding for the Cures Acceleration Network and does not include the statutory mandates governing NIH grant numbers and size that were included in **H.R. 1** as passed by the House Feb. 19 [see *Washington Highlights*, Feb. 25].

H.R. 1473 specifies \$372 million for the **Agency for Healthcare Research and Quality (AHRQ)**, a \$25 million (6.3 percent) cut below FY 2010 levels. AHRQ is not subject to the 0.2 percent across-the-board cut because it is funded through a tap on all Public Health Service agencies rather than a direct appropriation.

The measure cuts funding for the **Health Resources and Services Administration (HRSA)** to \$6.261 billion, a \$1.2 billion (16.3 percent) cut below FY 2010. The HRSA administrator is tasked with developing an FY 2011 spending plan within 30 days of enactment to determine which programs within the agency will absorb much of the \$1.2 billion reduction. Shortly after H.R. 1473 was released, the House Appropriations Committee posted an accompanying **table** of suggested program cuts that proposes a \$164 million cut to the Bureau of Health Professions, the arm of HRSA that administers the Title VII, Title VIII, and Children's Hospitals Graduate Medical Education (CHGME) programs. Because the table only reflects the committee's assumption for how HRSA will implement the larger cut, final funding levels for the health professions, nursing, and CHGME programs will not be available until the agency submits its spending

plan.

H.R. 1473 rescinds \$1.2 billion (2.5 percent) from the **Department of Veterans Affairs (VA)** medical care accounts in FY 2011 and reallocates it for FY 2012 advanced funding. The bill provides \$52.8 billion for the VA medical care accounts in FY 2012, a \$5.8 billion (12.4 percent) increase over FY 2011 including the reallocation.

For FY 2011, the **National Science Foundation** is funded at \$6.806 billion, a \$65.75 million (1.0 percent) decrease from FY 2010-enacted levels. H.R. 1473 provides \$5.510 billion for NSF research and related activities, \$53.13 million (0.8 percent) below FY 2010.

For the **Centers for Disease Control and Prevention (CDC)**, H.R. 1473 includes \$5.649 billion, a \$748 million (11.7 percent) decrease from FY 2010 levels and CDC's lowest funding level since 2003.

With implementation of new food safety modernization legislation on the horizon, **the Food and Drug Administration** received one of the few funding increases seen in H.R. 1437, with funding increased to \$2.447 billion, a \$102 million (4.5 percent) over FY 2010.

H.R. 1473 does not include the legislative riders to defund the **Affordable Care Act (ACA, P.L. 111-148 and P.L. 111-152)**; prohibit funding to Planned Parenthood; stop the Education Department from implementing "gainful employment" regulations of proprietary colleges; and prohibit the use of federal funds for needle exchange programs that were included in H.R. 1.

As part of the final compromise on FY 2011 spending, the House and Senate agreed to vote on two enrollment resolutions on cutting abortion and health care spending. The House adopted a resolution (**H. Con. Res. 36**) that would block federal funding of Planned Parenthood. The House also adopted a second resolution (**H. Con. Res. 35**) that would block funding to implement the ACA. However, both measures failed to reach the agreed upon 60-vote threshold for passage in the Senate, sending the spending package to the president without the policy provisions.

H.R. 1473 also requires the Government Accountability Office (GAO) to report to Congress within 60 days of the bill's enactment on "an audit of expenditures made for comparative effectiveness research through funds provided to the Agency for Healthcare Research and Quality, the National Institutes of Health, or any other agency within the Department of Health and Human Services" under the American Recovery and Reinvestment Act of 2009 (**P.L. 111-5**) or the ACA. The report is to include a description of the expenditures made, the entities that received the funding, and the purpose of the funding.

The bill also includes a provision eliminating a requirement that the Secretary of Health and Human Services designate annual funding for each HHS agency's office of minority health. No funding is provided for the National Health Care Workforce Commission, the independent federal advisory body appointed by GAO in September 2010 [see *Washington Highlights*, Oct. 1, 2010].

To paraphrase Winston Churchill, it is not clear whether this is the end of the beginning or the beginning of the end – but no matter which it is, there are challenging times ahead for all of us, especially in academic medical centers.

### **Physicians and the Patient Experience**

In previous Newsletters the importance of addressing and improving the patient experience has been coupled with excellence in innovation, outstanding medical care, and quality and safety as a means of assuring the value we provide to patients and the community we serve. While there is no doubt that we are blessed to have faculty physicians who provide state-of-the-art and cutting edge medical care and procedures, it is also true that patients assess their experience in a hospital and medical center not only on their encounter with their physician but on the whole experience they have during the visit or stay. This includes everything from the quality of the parking and food services to the cleanliness and service of the facility. Their assessment includes how much time the physician spent with them and whether they felt listened to and cared for with humanism and professionalism. Obviously the patient experience is a complex interdigitation of services and functions provided by a wide range of medical center personnel and services.

While what we do as physicians is just a part of that patient experience, it is an important part – and in many ways it outweighs other components in the mind of the patient. Importantly, it is something we all seek to do well – although we may take it for granted or just assume we are doing it well. Further, the ability of any single physician to provide outstanding service is also affected by the extraordinary array of pressures each of us feels in our daily lives as doctors in a medical center caring for complex patients: the press and often multiple and simultaneous calls on our time, the demands of different masters (from academic to clinical and beyond), the fact that none of us work in isolation and that many of the services that define our performance can be the responsibility of others. All that said, there are a number of key roles we play as physicians, and these need to be considered both individually and as a members of a medical care team. An important question is whether there are ways to measure or monitor our performance and, if so, how such information might be shared in a way that is helpful and not accusatory or recriminatory. As with so many issues, we all make assumptions about our individual behavior and performance – but nearly all of us benefit from evaluating our performance in a comparative context that is data driven and transparent.

Based on these issues and concerns, this April the School of Medicine and Stanford Hospital & Clinics (SHC) are beginning a new project to distribute and share

patient satisfaction data with faculty physicians. Patient satisfaction data can be collected in a variety of ways, none of them perfect by any means. At SHC they are collected by Press Ganey metrics – a commercial entity that collects similar data from several thousand US hospitals. SHC sends out approximately 100,000 such Press Ganey surveys each year with a response rate of about 25%. While data are available on inpatient as well as outpatient services, the ability to tie the information to individual physicians is more evident in ambulatory settings. These data are available for most but not all outpatient departments (e.g., they are not currently available for radiology, pathology, pediatrics and psychiatry).

While a lot of data is collected, the decision has been made to limit reports to just a few scores – particularly those linked most closely with overall patient satisfaction. They include responses to questions like these: the patient’s likelihood of recommending the physician they encountered; the concern the physician showed for the patient’s questions or worries; how well the physician included the patient in decisions about his/her treatment; the value of the instructions the care provider gave the patient about follow-up care; and the amount of time the care provider spends with her/his patient. These (along with other questions) are rated on a 5-point Likert scale ranging from “very poor” to “very good” (the top score). In the ambulatory score the results track to the “care provider,” which is defined as the physician, nurse practitioner or physician’s assistant who treated the patient.

Comparison with national data shows that top-quartile institutions have “top-box” (leading indicator questions) scores of 85% in the questions noted above. Hence, for the purpose of SHC reporting, if scores in individual questions are 85% or higher they will be coded green whereas if they are less than 50% they will be coded red. To help each of us understand how we are doing on these five “top-box” questions, we will each receive reports of our own individual scores (coded green to red) around April 15<sup>th</sup> and then quarterly thereafter. It is of course recognized that some of the patient sample sizes will be small, especially if the number of patient encounters are limited. Attempts will be made to increase the sample size in the future – but clearly scores with small sample sizes should be interpreted with caution.

The primary purpose of sharing these data is to improve the patient experience and our work as care providers. The underlying principles for improving the patient experience include compassion and caring, professionalism and pride, teamwork and communication. They are built on a foundation of outstanding state-of-the-art and cutting-edge medical care that is delivered with high quality and safety. Each of these factors is important and, while each requires discrete attention, they are all important in order to maximize our excellence as a leading medical center. To help with this initiative, a number of on-line as well as information and discussion sessions will be held in the weeks ahead. This project will also be part of a larger initiative that will engage every employee at SHC and that we hope will enhance the quality and excellence of our services to patients and community.

## **Social Networking and the School of Medicine: 2.0 to 3.0 and Beyond**

At the April 15<sup>th</sup> Executive Committee meeting, Dr. Henry Lowe, Senior Associate Dean for Information Resources and Technology, and Michael Halaas, Chief Technology Officer, provided an interesting and informative update on the latest enhancements of the school's online Community Academic Profiles (CAP) system and a fascinating glimpse into further developments that are underway. The key to these is the marriage, as Dr. Lowe expressed it, of the CAP platform with social networking. Accomplishing this will open up entire new capabilities for communication and collaboration among all members of our community. It also bridges intergenerational thinking, comfort and utilization with information technology and especially the rapidly changing world of social networking – which is much more commonly used in age groups more akin to our students and junior faculty – although there is clearly overlap in both directions!

Dr. Lowe pointed out that social networking has been perhaps the most transformative of all the IT-enabled tools. For instance, there are currently 600 million Facebook users (250M added in 2010), 190 million Twitter users (100M added in 2010), and in 2010 there were 25 billion tweets. In fact, social networking overtook email in 2009. 83% of Fortune 500 companies use at least one form of social media. And, although we may have the impression that younger people are the primary users of social media, the average social network user is 37 years old (although I must say that in my book that still counts as “young!”). Social networking is clearly the new communication and collaboration platform. Given this, it is crucial that we take advantage of its capabilities in the context of our values, policies and goals. If we do not, we will find that members of our community will go elsewhere to use social media, with potentially negative consequences for such sensitive and regulated information as patient data.

The current version of CAP, version 2.0, was released in June 2010. It includes all School of Medicine faculty and students and all postdoctoral scholars at the University. It has a secure Stanford-only interface as well as a publicly assessable interface, mentoring functions, and a section where research opportunities can be posted. Currently, 75% of faculty, 69% of postdocs and 65% of students have profiles, for a total of 4337 profiles. I suspect that many of us are still not actively using this resource to its full potential.

The 2.0 version also has an enhanced capability for connecting faculty, students and trainees based on common research areas. It uses a vector space algorithm to calculate “similarity” scores between CAP profiles based on Shared MeSH publication topics in PubMed. It displays the top ten similar CAP profiles and can be used to explore CAP using publication topics as one of many potential linkages. This feature is updated daily based on CAP PubMed citations.

While CAP 2.0 added many new features to the initial CAP, the pace of technology advance is so rapid that IRT has been working on yet the next version for many months. The first phase of version 3.0, which IRT is calling *Collaboration Community*, is scheduled for release in the summer of 2011. It will include new profiles for staff, bringing the total potential number of profiles to roughly 10,000. In addition, there will be Twitter-style activity feeds, the ability to follow individuals and comment on the posts of others, and share documents and URLs, among other features. The second phase of

this release, scheduled for the fall of 2011, will include the capability to form groups with privacy settings and increased search capability, as well as ongoing enhancements based on community feedback.

The potential uses for these exciting new capabilities include:

- Research proposal collaboration
- Educational and mentoring collaborations
- Medical student collaboration on clinical care teams
- Intra- and inter-departmental staff collaboration
- Expertise finding
- Formation of affinity groups for information sharing
- School-wide messaging (e.g. announcements, policies etc)
- Departmental communications

However, Michael Halaas also pointed out issues to watch and assess, such as:

- HR, policy and cultural issues
- The need for a critical mass of adoption
- Demographic differences in usage
- Community-driven behavioral norms

It is clear that ongoing assessment and fine-tuning will be required as our community begins to use these new tools, which although they pose some challenges, have the potential to transform once again our ability to communicate and collaborate. Thanks to Dr. Lowe and Michael Halaas for their intriguing look into a future that is, in some ways, already here.

## **Innovation, Intellectual Property and Patents**

Innovation and discovery are major themes being promoted by the Obama administration, and they are clearly pursuits we carry out with great success at Stanford. The Bayh-Dole Act of 1980 gives universities, small businesses and non-profits intellectual property (IP) control of their inventions and other IP that result from federal funding (e.g., from NIH). This has revolutionized the role of universities in moving discoveries and innovations from academia to industry – benefitting the government’s investment in research and rewarding the faculty and university for new innovations. It also helps to promote economic development and has helped spawn local as well as national businesses with significant economic development.

One of the important steps toward commercialization of university discoveries takes place through the Office of Technology and Licensing (OTL), which is best of class at Stanford. A key part of this is seeking and acquiring a patent for a new discovery – which is an important protection of IP and a key step for garnering funding for product development. One of the challenges has been the timeline for patent review and approval. Because this process is critical to promoting innovation and helping to fulfill the objectives of the Administration in accelerating economic recovery through science, Stanford was fortunate to host a workshop done collaboratively with the United States Patent and Trademark Office.

Dr. Paul Yock, Director of the BioDesign Program and Martha Meier Weiland Professor of Bioengineering and Medicine, hosted a special panel discussion that featured David Kappos, Undersecretary of Commerce for Intellectual Property and Director of the United States Patent and Trademark Office (USPTO). Mr. Kappos delineated some of the challenges he has faced since he assumed his position in 2009 (e.g., the USPTO has over 700,000 patent filings waiting decision, a process that can take 5 or more years). Importantly, he announced a number of initiatives he has put in place to streamline the work of the USPTO, to make submissions and reviews more automated and efficient, and be more responsive to the engine of innovation.

Most importantly, Mr. Kappos and the staff of the USPTO who participated in the various workshops on April 13<sup>th</sup> sought to listen to members of academia and the Silicon Valley community about ways the USPTO could work more effectively and collaboratively. Where clearly much work and many obstacles remain, the fact that the USPTO is willing to reach out to constituents and to be more responsive to their concerns is an important step. In addition to thanking Dr. Yock, special thanks for arranging this important dialogue also go to Kathy Ku, Director of the Office of Technology and Licensing, and Dr. Ann Arvin, Vice Provost and Dean for Research at Stanford and Lucile Salter Packard Professor of Pediatrics.

## **A New Chapter in COI Inquiries?**

The Association of American Medical Colleges (AAMC) held its Forum on Conflict of Interest in Academe (FOCI) Meeting in Philadelphia on April 10-12<sup>th</sup>. Dr. Norm Rizk, Senior Associate Dean for Clinical Affairs and Berthold and Belle N. Guggenheimer Professor of Medicine, and I participated in different panel discussions at the meeting. Also in attendance from Stanford were Barbara Flynn, Manager of the COI Program, Shannon Shankle, COI Analyst, and Dr. Harry Greenberg, Senior Associate Dean for Research and the Joseph D. Grant Professor of Medicine and of Microbiology and Immunology, who is also a member of the FOCI Academe Steering Committee.

The agenda was wide ranging and included COI at the institutional level, in clinical practice and education and in relation to the NIH, industry (including start-ups) and devices, as well as purchasing. One of the more startling comments came from Gardiner Harris, Public Health Reporter for *The New York Times*, during the panel I participated in. Specifically, Mr. Harris noted that from his perspective a bigger issue than COI with industry will soon be in the public eye.. It has to do with physicians and Medicare expenditures around clinical practice conflicts. While he didn't reveal the specifics, he did indicate that *The Wall Street Journal* is in possession of considerable data and that reports will be forthcoming. If true this would be concerning – especially in light of the long saga of conflict revelations during recent years, coupled with the scrutiny that Medicare is now under. Clearly not a comforting situation – but one we will learn more about as details come to light.

## **Frontiers in Human Health**

On April 6<sup>th</sup> we hosted another in our series of Frontiers in Human Health, this one focused on “Translating Medical Discoveries.” Over 350 members of our community attended the event in the Li Ka Shing Center for Learning and Knowledge for dinner, discussions, presentations and more discussion. One of the features of the Frontiers events is the opportunity for guests to join a discussion with one or more faculty members who are seated at each table of ten. This is a great opportunity for dialogue and discussion as well as introducing the community to our Stanford Medical School faculty.

Dinner and table discussions were then followed by three presentations. One from Dr. Jim Ford, Associate Professor of Medicine (Oncology), Genetics and, by courtesy, Pediatrics, focused on how his team developed a novel new therapy (PARP inhibitors) now under study for women with so called “triple negative” breast cancer. It is based on his laboratory research and the opportunity to translate discoveries made there to patients. Dr. Kari Nadeau, Assistant Professor of Pediatrics (Immunology and Allergy) and, by courtesy, Otolaryngology, addressed the work she and her colleagues are doing on asthma and on the important but under-researched area of severe food allergies. Finally, Dr. Bill Robinson, Associate Professor of Medicine (Immunology and Rheumatology), addressed the common problem of osteoarthritis and how new approaches to intervention might be developed that would be based on a better understanding of the basic mechanisms responsible for this all too common impairment that occurs with aging.

Following the presentations, Paul Costello, Executive Director of the Office of Communication and Public Affairs, led a roundtable question and answer discussion – first with the presenters and then with the audience. This facilitated a lively and engaging dialogue.

Overall this was a terrific event and, in addition to the speakers and all the faculty who took the time to attend the event and participate in discussions, I also want to thank our outstanding Medical Development staff for all that they did to make this so successful. In particular I want to thank Caitlin Davis, June Lang, Jon Pierucci, Erik Rausch, Michele Shiele, Deb Stinchfield and Terri Tarantino.

## **Stanford School of Medicine Admit Weekend**

On April 7-9<sup>th</sup> Stanford students, faculty and the Office of Admissions hosted a weekend of information and events for nearly 100 students who have been admitted to Stanford School of Medicine and who elected to return for another visit. According to Dr. Gabe Garcia, Director and Associate Dean for MD Admissions and Professor of Medicine, this was the largest group of returning students for “Admit Weekend” he could remember. This certainly suggests that a large number of our accepted students are interested in attending Stanford. During their weekend the Admit Students had an opportunity to learn more about the curriculum and the full range of services and activities at the medical school, medical center and university. Every effort was made to have lots of interactions with current students – including attendance at the School of Medicine Talent Show!

To date, the admitted students consist of 52% women, 48% men and 20% from groups underrepresented in medicine. However, since the students don't have to give us a final answer about whether they are coming to Stanford until May 15<sup>th</sup>, this is just a snapshot. The full portrait will not be known until we have the final acceptances and final numbers in mid-July.

## **Stanford Alumni Weekend**

Exactly one week after “Admit Weekend” the Stanford University Medical Center Alumni Center (SUMCC) hosted its Annual Weekend led by Drs. Bill Rhine, MD’84, SUMCC President, and Linda Clever, MD’65, Associate Dean for Alumni Affairs. More than 350 Medical School alumni returned to Stanford for the weekend’s events and festivities – including two graduates from the Class of 1946. Alumni took part in seminars, discussion groups, and tours and shared meals and social events with classmates and colleagues.

A highlight of the weekend was the “Stanford at the Leading Edge” symposium on Saturday morning, April 16<sup>th</sup>, which focused on Translating Discoveries: Brain, Body and Soul. It included a plenary session by Dr. David Spiegel, Director, Center on Stress and Health, and Medical Director of the Stanford Center for Integrative Medicine. Dr. Spiegel is also the Associate Chair of the Department of Psychiatry and Behavioral Sciences and the Jack, Lulu and Sam Willson Professor in the School of Medicine. Following Dr. Spiegel’s presentation, alumni had the opportunity to attend two seminars, choosing from the following outstanding speakers:

- **Dr. John Adler**, Co-Director, Stanford CyberKnife Center and Vice Chair of the Department of Neurosurgery and the Dorothy and Thye King Chan Professor
- **Dr. Helen Blau**, Director, Baxter Laboratory for Stem Cell Biology and the Donald and Delia B Baxter Foundation Professor
- **Dr. Sean Mackey** (Resident in Anesthesia’98 and Fellow in Pain Management’98), Chief of the Division of Pain Management, Director of the Stanford Systems Neuroscience and Pain Lab and Associate Professor of Anesthesia
- **Dr. James Doty**, Director of the Center for Compassion and Altruism Research and Education, Stanford Institute for Neuro-Innovation & Translational Neurosciences and Clinical Professor, Department of Neurosurgery
- **Dr. Tom Schall’88**, President and CEO, ChemoCentryx
- **Dr. Saki Srivastava**, Chief, Division of Clinical Anatomy, and Associate Professor, Department of Surgery
- **Dr. Gary Steinberg**, PhD’79, MD’80, Resident in Neurosurgery’83, Director, Stanford Institute for Neuro-Innovation & Translational Neurosciences, Co-Director, Stanford Stroke Center, Chair, Department of Neurosurgery and the Bernard and Ronni Lacroute-William Randolph Hearst Professor, Department of Neurosurgery.

Special thanks to each of the faculty members who made presentations to the alumni – which I heard from many were very well received. I want to offer my particular thanks to the Class Representatives for their work on the Alumni Weekend and to the many members of the Office of Medical Development who worked so diligently to make the weekend successful. Among others I want to thank Patrick Delahunt, Barbara Clemons, Bruce Bingham, Jon Pierucci and Terri Terrantino (and her group) from Medical Development and once again, Drs. Rhine and Clever. Our alumni are among our most treasured groups and I am confident that events such as this recent Alumni Reunion Weekend help affirm that reality.

## Upcoming Events

### 28th Annual Stanford Medical Student Research Symposium

Thursday, May 12 | 3:00 -- 6:00 PM

Ballroom, Li Ka Shing Center for Learning and Knowledge (LKSC)

Faculty and students are invited to hear students present their posters and answer questions about their research. Approximately, 30-40 medical students, both MD and MD/PhD will showcase their original medical research projects carried out in laboratories, clinics and the community - locally and abroad. These projects from the medical student body demanded that students identify and research contemporary health issues that affect individuals and communities as a whole. After closing remarks at 5:45 PM, the Stanford University Medical Center Alumni Association will announce the students with the outstanding research posters, capping the event.

For information about this event, please contact Beth Leman ([leman@stanford.edu](mailto:leman@stanford.edu)).

## Awards and Honors

- **Dr. Steve Galli**, The Mary Hewitt Loveless, M.D. Professor and Chair of the Department of Pathology has been named the recipient of the 2011 Scientific Achievement Award from the World Allergy Organization (WAO). The WAO is an international umbrella organization comprised of 84 regional and national allergy and clinical immunology societies from around the world.
- **Dr. Marilyn Winkleby**, Professor of Medicine at the [Stanford Prevention Research Center](#) in the Department of Medicine, received the inaugural Dr. Augustus A. White III and Family Faculty Professionalism Award, which was celebrated at a lovely event on Friday, April 15<sup>th</sup> in the Faculty Club. This award resulted from a generous gift from Dr. Gus White to foster and celebrate diversity and professionalism at Stanford. Dr. White also celebrated his 50<sup>th</sup> anniversary of his graduation from Stanford Medical School. He was the first African American graduate of Stanford and has had an incredibly illustrious career with major leadership roles at Harvard Medical School and nationally. His new book, *Seeing Patients: Unconscious Bias in Health Care*, describes his journey through medicine and helps understand the power of commitment and leadership in the face of adversity.

Dr. Winkleby is a most deserving first recipient of the Gus White Faculty Professionalism Award. Her research has focused on understanding the disparities that affect the health of ethnic minority and low-income populations. Dr. Winkleby is the Director of the Office of Community Health, which has had a major impact on the school and community since it was founded. She is also the co-founder of the [Stanford Medical Youth Science Program](#) (SMYSP), a 5-week summer residential program for low-income and under-represented minority high school students who are interested in pursuing careers in medicine or science. This program has been an incredible success since it began 24 years ago. Indeed, 100% of the 524 students who have completed the SMYSP have graduated from high school, 86% have graduated from a four-year college (of which 43% have attended medical school or graduate school) and 42% are becoming or have become health professionals. This is an extraordinary accomplishment and is worth celebrating in its own right – and now even more so with the Gus White III Professionalism Award.

- ***Dr. Steven Quake***, Lee Otterson Professor in the School of Engineering and Professor of Applied Physics and, by courtesy, of Physics, learned of two significant awards within two days. First, Dr. Quake will receive the 2011 Promega Biotechnology Research Award from the American Society of Microbiology and the American Academy of Microbiology. In addition, Dr. Quake will also be the recipient of the Raymond and Beverly Sackler International Prize in Biophysics - a prize which rewards outstanding scientists of 45 years or younger. This year's award focuses on "Innovative Physical Techniques in Biology."

Please join me in congratulating Drs. Galli, Winkleby and Quake for their well deserved recognition and awards.

## **Appointments and Promotions**

**Bruce L. Daniel** has been promoted to Professor of Radiology, effective 5/01/ 2011.

**David F. Fiorentino** has been promoted to Associate Professor of Dermatology and, by courtesy, of Medicine, at the Stanford University Medical Center, effective 4/01/ 2011.

**Andrew J. Patterson** has been reappointed to Associate Professor of Anesthesia and, by courtesy, of Surgery, at the Stanford University Medical Center, effective 4/01/ 2011.

**Homero Rivas** has been appointed to Assistant Professor of Surgery at the Stanford University Medical Center effective 4/01/ 2011.