Laura is a great cheerleader…. She makes a lot of things happen. She gets a lot of things started…. What Laura wants to do, her ambition, which has probably been contaminated by that MBA degree, is to put some sense into medicine, to make it an objective science.

—Dr. Joe Gray, UCSF professor

Health care is at least a decade behind most of the American economy in the use of information systems…. Today's information systems won't get us where we need to go in the next 10 to 20 years, and what we really need to think about is the next generation information system.

—Dr. Jon Showstack, associate director for administration, Institute for Health Policy Studies, UCSF

I am flamboyant. I'm a theatrical person. It comes in handy for certain things. I'm good at selling my ideas and my vision. But it can hurt me because it can be in your face, and so you have to figure out when to turn it on and when to turn it off.

—Dr. Laura Esserman, UCSF professor

Dr. Laura Esserman, breast cancer surgeon, associate professor of surgery and radiology, and director of the Carol Franc Buck Breast Care Center at the University of California, San Francisco (UCSF) Medical Center at Mount Zion in San Francisco, walked briskly through the hallways of Mount Zion on her way to meet with Larry Lotenero, the Medical Center’s chief information officer (CIO). She was running late for the meeting — she was often running behind schedule — but that did not stop her from greeting staff and patients as she went by, occasionally following up with one of the staff about issues of patient care and administrative tasks. It was a typical day and Laura was dressed as she usually was, in pants and a blouse, large dangling earrings, and no doctor’s white coat or surgical greens. Esserman and Lotenero planned to discuss an information systems project that could fundamentally change patient care not only for breast cancer but also for medicine more generally. When Esserman had assumed control of the Center in 1997, she consolidated the two breast cancer clinics (UCSF with its hospital and facilities on Parnassus Heights and Mount Zion) at Mount Zion. She also
consolidated breast health services under one roof so that patients would not be “bounced
around” from one facility to another. Patients could see a radiologist, surgeon, oncologist, or
other specialist, get a mammogram and other tests all within one facility — a truly unique one-
stop-shop focused on coordinated and integrated patient care.

Despite Esserman’s success in establishing the Breast Care Center and building its staff, prestige,
and revenues substantially, she had a much larger vision that she wanted to achieve. She sought
to roll out the Breast Care Center’s integrated, coordinated model of delivering care to UCSF’s
other departments, particularly those dealing with other forms of cancer, as well as to other
breast cancer centers across the country. But even that was not enough for Esserman. A second
part of her vision was to build an advanced and robust information system to improve the quality
of medical care in order to decrease medical costs and improve mortality and morbidity rates. A
way to improve the quality of care, according to Esserman, involved the automated capture and
analysis of clinical data and treatment information and the use of information systems to share
these data and patient outcomes with both patients (to improve the quality of decision making) as
well as others at different medical institutions so research would be built into medical practice
and there could be more learning from experience. In the business world, this type of system had
been implemented; however, in academic medical institutions such as UCSF, this sort of system
seemed far removed from the typical paper-based medical records and an infrastructure that
sometimes had difficulty dealing with basic tasks such as billing.

Esserman had first come up with the idea of such an information system more than a decade
before but for numerous reasons the project had not moved forward as quickly as she had hoped.
Finally in early 2003, Esserman had prepared a grant proposal to the Department of Defense
(DOD) on her “informatics” project and successfully raised $7 million. She now had the
opportunity to prove the viability of her long-term vision. However, despite having raised
external funds to begin the project, she still had to attract resources from other units at UCSF, its
hospitals, and outsiders as well, and overcome internal resistance from some key hospital
administrators. During her meeting with Lotenero, a strong supporter of the project, Esserman
and Lotenero planned to strategize to determine how to best move the project forward, given the
political realities they faced.

**DR. LAURA ESSERMAN**

Laura Esserman was one of four children of a prominent automobile dealer in Miami, Florida.
Two of her siblings, one brother and one sister, were also physicians, and another sister had been
a trade negotiator during the Clinton administration. Laura graduated magna cum laude from
Harvard University in 1977 and received an M.D. from Stanford University in 1983 and spent
two years at Stanford in the Engineering Economic Systems department. She completed her
surgical residency at Stanford in surgery as well as a medical oncology fellowship (research)
with a specialization in breast cancer and continued working there through 1993 as she
completed her medical training. In 1993, Esserman completed her MBA at Stanford’s Graduate
School of Business while carrying a full workload at the Stanford Medical Center and caring for
her first newborn child. Although there had been some discussion of the possibility of her
staying on at Stanford, Esserman was concerned about the climate for innovation in the Stanford
Medical School at that time, and about her prospects in the Department of Surgery.\(^1\) Esserman felt she would be considered too junior to be allowed to take on real program building responsibility, might always be considered a “trainee,” and saw enormous resistance to change from her department chair and the faculty in oncology who were in charge of the breast cancer program.

In spite of the promise of significant financial support from a major donor if she remained at Stanford, Laura Esserman elected to move to Mount Zion in San Francisco to be part of the University of California, San Francisco in September, 1993. She saw several advantages of being sited at the Mt. Zion location and the appointment at UCSF. Mt. Zion was, at the time, a prestigious private hospital that had just been acquired by UCSF. It had a tradition of exceptional, warm, patient service. Academic medical centers often neglected the service aspects of patient care. Since a patient-centered approach was a key element of her vision, it seemed easier to bring academic and research excellence to a place where patient care was paramount than vice versa. Moreover, because Mt. Zion was physically separate from the main campus, there was the opportunity to build more of a “start up” operation away from the center where change was less welcome. Also, the surgery department chair at UCSF, who was to become dean, was taken with Esserman’s plans so she felt she would have a real opportunity to quickly assume a leadership role.

By 2003, Esserman held three major roles: 1) associate professor of Surgery and Radiology, a practicing breast surgeon and teacher, and an affiliate faculty member at UCSF’s Institute of Health Policy Studies, 2) director of the Carol Franc Buck Breast Care Center at the Mount Zion Medical Center, and 3) clinical leader of UCSF’s breast oncology program (research) (see Exhibit 1 for her resume). She was married to an attorney specializing in environmental law who worked as a senior legislative aide in Sacramento and had a second child, a boy.

Although she had numerous administrative responsibilities and was constantly pushing an ambitious agenda, Esserman kept connected and grounded through her surgery, and said she would never give up treating patients. Her administrative assistant Jemela Mwelu, a Reiki Practitioner who had worked for Esserman for about a year, described watching Esserman operate, something she had wanted to do after joining UCSF and something that Esserman was glad to make happen. Mwelu arrived at the operating room to find a young woman in her thirties facing a double mastectomy. The woman looked “afraid.” Mwelu described how Esserman came into the operating room, was totally aware of the feelings of the patient, and just stood next to her and began rubbing her hand and singing softly to her. As the woman began to relax, the anesthesia was administered and the operation proceeded. Later Esserman received a letter from the patient thanking her for her loving care and said Esserman’s singing to her was the last thing she remembered when she went to sleep and the first thing she remembered when she came back to consciousness in the recovery room.

Esserman acknowledged that she had great technical surgical skills and vast knowledge of treatments for breast cancer: “UCSF is one of the best research universities in the country and I am considered to be one of the top people in breast surgery in the country. My patients really

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\(^1\) Her decision to go to business school had been frowned upon by the dean and her surgery department chair, although it was supported by the hospital CEO.
love me too because I respect their values and listen to them and they know I genuinely care about what happens to them.” Karen Lane, another surgeon at the Center, agreed: “When I worked at UCLA, I had several patients who went to UCSF to be treated by Laura [Esserman] and she had a great reputation and I had heard that she was excellent with patients. She took a lot of time with them and she was very innovative in the treatment of breast disease. She’ll do whatever it takes with patients, even have them over to her house, which is admirable, but something that other people aren’t willing to do. I was very impressed with her when I met her. I came here specifically to work with her.” Esserman would give patients her cell phone number and would take calls from residents and interns at nights and on weekends if they wanted to consult about a patient’s situation. Mwelu’s operating room experience was typical — Esserman often sang patients to sleep: “I love to sing. I sing at the operating table and to my patients and they all fall asleep on me,” said Esserman. “I think that in medicine, patients want to know that the doctor is smart, but more than that, they also want to know that someone cares about them and the person who is taking care of them is their advocate.” Because of her reputation and the reputation of the Center, Esserman and her team had operated on a large number of prominent, wealthy women over the years, and virtually all of them had become fans of her and her work.

Esserman’s personal style could best be described as lively, flamboyant, boundless energy, and a passion and commitment that sometimes polarized those who interacted with her. Debu Tripathy, an oncologist who had formerly worked at UCSF and had worked closely with Esserman provided his perspective: “Laura’s style is that she is very vocal and energetic. A lot of people love her, but for some people, her style appears to be pushy and arrogant. People who can envision a different future are attracted like a magnet to Laura, while other people who are embedded in the status quo wonder why in the world she is wasting time trying to change things that can’t be changed.” One physician found Esserman’s style complementary to her own: “I am fine with Laura’s personality because I don’t have any desire to be that way. For me it’s great. But I can see that if someone has a strong personality, and if they don’t agree with her, there could be some conflicts.”

Some people, such as another senior faculty member in oncology, had problems with Esserman’s style. Esserman explained: “She is very different from me. She wears suits every day and is very orderly. She knows how the system works and how to ascend the ladder within the system. That’s her style. I, on the other hand, reject all of those things.” Esserman provided an example: “Once I came out of my car wearing a purple coat and a purple hat and she looked at me with absolute horror and said, ‘Oh my God, Laura, you look like you just stepped out of the Wizard of Oz.’ She was horrified by this kind of representation. I’m flamboyant. It’s part of my theater background. I’m a theatrical person. I’m good at selling my ideas and my vision to some, but it can hurt me because it can be in your face and some people find me threatening. I’m a polarizing person, I admit it. I’m very direct and I say what I think.”

Esserman had obtained a fair amount of publicity for her work. For example, she was featured in an article in Fast Company in March 2002, and had a large story about her and the Cancer Center in the San Francisco Chronicle in 2002. She was very visible at national conferences and at the National Cancer Institute, where her ideas were attracting a great deal of interest. Esserman had many key national supporters such as Dr. Larry Norton, attending physician and member, Memorial Hospital, and Head of the Solid Tumor Division, Memorial Sloan-Kettering Cancer Center. Norton was on the Medical Advisory Board of the Breast Cancer Research Foundation,
an organization that awarded grants to researchers. “Larry is probably the leading spokesman in the country on breast cancer and he’s given me money and has helped me accomplish a lot of things,” said Esserman. “He has helped me push national clinical trials through the system. He wrote a letter of support for me and said that I was thinking of things far into the future. I have plenty of those people like Larry who think very highly of me.”

Many people at UCSF enjoyed working with Esserman and were intensely loyal to her. Tripathy said: “The hardest thing about leaving UCSF to go to UT Southwestern was that I would not be working with Laura anymore. I don’t think I’ll ever have a partner and professional colleague like her again. We worked so well together.” Lane commented: “She’s a very good mentor to me. She obviously has more experience than I do and she is always willing to talk to me about unusual situations or cases. We work as a team and she very much drives that.” Esserman inspired those who worked closely with her: “Faculty and staff view Laura as a leader and that’s why a lot of people come to work at the Breast Care Center,” said Meridithe Mendelsohn, Esserman’s assistant director. “Working in close proximity is appealing because she has so much energy and she engenders a truly collaborative environment.”

However, some saw Esserman as being fiercely loyal to her allies and supporters but not being very accommodating with those who crossed her. She admitted to having a quick temper: “Like my son, I have a problem with my temper. I get really pissed and I’m very quick to anger. One of the things I’ve learned is that I can’t get mad. I have to be strategic and ask, ‘Why is this not working?’ I have to mend my ways and count to 10. Now I ask Meridithe [Mendelsohn] to talk to people I’m frustrated with. I won’t make the immediate call when I’m angry.” Esserman mentioned that others had thought she was too vocal: “Dr. Larry Norton [one of her external supporters] has told me that I shouldn’t tell everyone everything that I’m thinking. I don’t think I do that, but I’ve still taken his comments to heart.”

Esserman’s passion and commitment also made it difficult for her to view things from other people’s perspectives: “The hardest thing for me to do is to put myself in other people’s shoes,” said Esserman. “I try to see things the way others see it, but I just don’t see it. The problem is that I see it the way I see it and I can’t see what they’re seeing. I can’t see what they’re nervous about. I’m working on this, but it’s really hard.”

Esserman was a woman of many talents and interests, both personally and professionally. In 2003, she and her husband were active in Senator Bob Graham’s campaign for the presidential nomination. The senator was a good friend of her father, and Laura believed that national politics was just one more avenue to pursue in order to affect health care in America. She also organized a series of policy discussions of the state of health care and what could be done to change health care policy, inviting people both from UCSF and others such as Alain Enthoven from Stanford. As she put it, “I’ve done a lot of things in my life. I’ve gone to medical school, I went to business school, and I did a little bit of theater. I’ve always wanted my own theater. Now I have one—the operating theater!”

However, at UCSF, many of Esserman’s colleagues felt that she was spread too thinly and she had problems delegating. Some, such as Mendelsohn, went so far as to call Esserman a “micromanager,” at times. Lane commented: “Laura doesn’t know how to say no. She just
takes on too much.” Tripathy commented: “Because Laura had a very wide array of interests that spanned from clinical, to informatics, to laboratory research, there was a concern, especially among the basic scientists, that she was spread too thinly. They were concerned that she was trying to be a practitioner of everything and would not be able to master a specific area. People were concerned about Laura’s scientific proposals when she was trying to develop her vaccine. She was interested in too many projects and had a lot of clinical interests. She was also interested in MRI imaging and how it could be useful in making decisions about patients. Some of her scientific credibility came into question.” Tripathy provided his opinion on Esserman’s research: “I think Laura is a visionary in her research—very creative in coming up with ideas. However, the negative is that she’s not focused enough when she pursues her hypothesis and what her specific aims are. In many cases, her hypothesis does not meet the scientific rigor of proof, but when one takes a step back, one can appreciate how the seemingly disparate aims can actually connect. What Laura needs is a team of people who can do the very specific experiments and work out all the details. Attention to detail may not be Laura’s forte. She has the ability to do these things, but her focus is much bigger.” Because most academic physicians excel by becoming experts in one scientific area, when people’s work spans many areas, the assumption is sometimes made that the work they are doing can not be good.

Tripathy felt that physicians like Esserman and himself often sacrificed their own publication and track records for the greater vision and for the greater good of the patients: “People such as Laura [Esserman] and myself empower people to get a lot of things done, but we ourselves may not develop the kind of track record that makes us look as good on paper. By working on visionary things, our own publication records may suffer. We believe in a greater cause and it’s truly unselfish, but we’ve made some sacrifices along the way.”

**ACADEMIC MEDICAL CENTERS AND UC SAN FRANCISCO**

The setting in which Laura Esserman worked, and the base from which she hoped to change fundamental elements of the practice of medicine, was the University of California’s medical campus in San Francisco. She believed that the prestige of academic medicine, particularly in one of the premier institutions in the U.S., would provide both visibility and access to colleagues that outweighed the constraints and bureaucracy that inevitably arose in large public universities. Others had made a different choice. Dean Ornish, for example, well known for his research, writing, and clinical practice focusing on the prevention and treatment of heart disease, operated what was essentially a private practice in Marin County, as did the late Dr. David Lehr of the Miami Heart Institute and co-owner of the Nathan Pritikin Longevity Center in Florida. It was obviously possible to set up a private foundation to attract donations and to operate both research and clinical practice separately from a large academic medical center, and Ornish, a friend of Esserman’s, had been encouraging her to do just that.

UCSF was an enormous organization — possibly the single largest employer in San Francisco — and in addition to having substantial facilities in Parnassus Heights it was the anchor tenant for a new biotechnology campus in the Mission Bay development near Pacific Bell Park. UCSF had an outstanding record of research and academic achievement. It owned patent rights and

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2 Much of this section is quoted directly or paraphrased from “Academic Medicine and Managed Care: An Uncertain Future,” http://www.amsa.org/programs/gpit/acadmed.cfm (May 29, 2003).
received royalties on some of the initial gene splicing work that resulted in companies such as Genentech. But the organization faced many problems and challenges. Some were endemic to being a public institution in a state such as California, which was facing massive budget deficits. Some were because of UCSF’s role as an academic medical center.

Academic Medical Centers (AMCs) were hospitals or hospital systems that were part of private or public universities, or sometimes independent hospitals affiliated with and serving as the major teaching institution for a medical school. AMCs such as UCSF had a special role in the American medical system as centers for medical research and also as the institutions that served as the primary training ground for physicians. AMCs also played another important role in society — serving the poor. They generally had the largest pool of physician labor available to care for the poor — namely physicians-in-training — and were often located in inner cities near America’s most vulnerable populations.

Between 1960 and 1990, AMCs grew in number and size in all three of their key components — research, education, and patient care. Research grew as the federal government invested more money through, for instance, the National Institutes of Health. Much as earlier government spending on defense had helped fuel the early rise of the electronics industry, government investments in medical-related research had helped fuel the development of a large biotechnology and medical device industry in the United States. Education grew due to the government’s population projections and its financial grants to subsidize the construction of medical school facilities. Finally, patient care/clinical faculty grew as Medicare and Medicaid programs expanded, which led to increased clinical revenues from the expansion of services to the poor and elderly.

Economic Challenges

Over the last decade, virtually all hospitals had experienced enormous economic challenges. AMCs, in particular felt squeezed in an increasingly bottom-line oriented hospital industry. Several factors contributed to their problems. AMCs typically had elaborate and highly decentralized financial structures that relied on profitable functions (clinical practice and funded research) to subsidize unprofitable ones (teaching and unfunded research). Moreover, all hospitals in the U.S. faced two sources of financial stress. First, between 1980 and 1995, total inpatient admissions per thousand population and average length-of-stay declined by about 20 percent each; consequently, inpatient days per thousand population declined by about 40 percent. Therefore, occupancy rates at U.S. hospitals were typically only around 60 percent and hospitals had large fixed costs that did not vary with occupancy. Second, ever since Medicare introduced diagnostic related groups (DRGs) in 1983 (the DRG system paid a hospital a flat fee per hospitalization based on the patient’s diagnosis, regardless of the services rendered or length of stay), reimbursement levels had been declining. Estimates from 1996 showed that Medicare and Medicaid paid only 88 percent and 82 percent of the cost of care, respectively. Hospitals lost money treating these patients; only by charging higher fees to private insurers, who typically paid 30 percent more than the cost of care, have they been able to recoup some of their losses. But private insurers and large buying groups were negotiating more aggressively. So hospitals

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3 The federal and state governments were the largest payors of health care services in the United States. The largest federal programs were Medicare and Medicaid. Medicare focused on the elderly and Medicaid provided health care coverage for the poor.
were not only seeing fewer patients for less time, they were getting less money for every patient day and service they rendered.

AMCs were in even worse shape. First, they treated a larger proportion of uninsured and government-insured patients than many private hospitals. Second, care at AMCs was more expensive than at comparable community hospitals. Teaching interns, residents, and surgical fellows required more time — in the operating room, doing examinations, and so forth. Doing trials of new drugs, equipment, and procedures also was expensive. It was increasingly difficult to get these expenses reimbursed or, more accurately, cross-subsidized. As a result, margins for major AMCs had declined across the board since the mid-1980s to levels significantly lower than those of non-AMCs. In some cases, AMCs in areas with high managed care penetration, such as the San Francisco Bay area in California, had actually begun to lose money. Increasing financial stringency sometimes pit faculty, administrators, and students against each other in a struggle to claim a share of a shrinking pool of discretionary funds.

**UCSF Medical Center at Mount Zion**

Mount Zion Hospital was established in 1887 as a voluntary, nonprofit hospital to render “medical and surgical aid and service to the needy and distressed sick of the community...without regard to race or creed.” San Francisco probably had too much hospital capacity coming out of the 1960s and a number of hospitals closed or merged during the 1980s and 1990s. Mount Zion, also facing severe financial problems, merged into UCSF on July 1, 1990, creating a new entity: the UCSF Medical Center at Mount Zion. Mount Zion then got caught up in the politics of one of the larger and most ill-conceived mergers of academic medical centers. On November 1, 1997, UCSF Medical Center and Stanford Medical Center merged their health care operations and subsequently operated as a single enterprise through March 31, 2000, when the merger was dissolved and several people associated with it lost their jobs. Although the goal had been to provide cost-effective health services, improve community access to the latest advances in medical science and maintain strong medical training programs in a challenging healthcare environment by achieving economies of scale through consolidation of programs, the merger was a financial and cultural disaster. In the fiscal year ending August 31, 2000, the combined hospitals lost $78.5 million. Mount Zion was blamed for $60 million of the loss, although many, including Laura Esserman, claimed that the number was bogus. In 1999, UCSF Stanford Health Care (as the combined entity was called) closed all of Mount Zion’s inpatient services such as the emergency room and hospital beds. Its outpatient clinics and the cancer center remained open. The closure of Mount Zion’s inpatient services was strongly protested throughout San Francisco.

In 2000, after the merger was dissolved and one year after winning the fight to close Mount Zion Medical Center to all but daytime surgeries and clinics, UCSF asked for state clearance to reopen

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4 Managed care was a system of health insurance characterized by a network of contracted providers providing health benefits to a defined population for a fixed payment. Health care services were typically controlled in a managed care plan through a network of primary care physicians often referred to as “gatekeepers.”

5 Hospitals in the Bay Area faced another additional cost—the seismic safety law, which required renovating or replacing hospitals over the next 10 years.

some of the hospital’s operating rooms and 30 of its beds. The turnabout was prompted by overbooking at the 22 operating rooms of UCSF Medical Center on Parnassus Heights. “For a host of reasons, we are busier than we have ever been before,” said Mark Laret, CEO of UCSF Medical Center.7

By 2003, Mount Zion was essentially back to where it was prior to closure, operating as a major acute care facility in the heart of San Francisco with referrals from all of Northern California—however, without an emergency room so that indigent patients would have less chance of being admitted. It was one of UCSF’s two key primary care sites (Parnassus was the other one). Its growing network of outpatient care included comprehensive diagnostic services, dermatology, general medicine, and sports medicine. It also had an Outpatient Surgery Center and Urgent Care Center. Much of Mount Zion was devoted to specialized centers and clinics. The most well-known was the UCSF Cancer Center, which won the National Cancer Institute’s highest designation — “comprehensive” — for innovative research and cutting-edge patient care. The center was dedicated to researching, diagnosing, and treating many forms of cancer. The Breast Care Center was a part of the UCSF Cancer Center. Other specialized centers included the National Center of Excellence in Women’s Health, a sleep disorders clinic, a multiple sclerosis center, a pain management center, and a center on aging.

Organizational Structure and Reporting Relationships

UCSF was divided into two parts, the Medical Center, headed by CEO Mark Laret, and the School of Medicine, headed by Dean Haile Debas, M.D. (Exhibit 2). Dean Debas was scheduled to step down in October of 2003 and be replaced by Dr. David Kessler, former head of the Food and Drug Administration. The Medical Center was the healthcare delivery institution and referred strictly to the clinic where physicians saw patients. The School of Medicine was the academic side — the medical, nursing, dentistry, and pharmacy schools where students were trained and where a lot of the research was conducted. Dr. Laura Esserman, as an associate professor of surgery, reported into the School of Medicine, although she also had obligations to the Medical Center and many of the people who worked with her actually reported into the Medical Center structure. Under the dean was the Department of Surgery (Nancy Ascher, chair), Department of Medicine (Margaret Tempero, hematology oncology leader), and the Cancer Research Institute, the research arm (Frank McCormick, director). Esserman had a large team of people that worked under and around her, including clinicians, outreach, researchers, administrators, and technical staff (Exhibits 3 and 4).

Ascher was Esserman’s “only boss.” “Nancy Ascher is the only person that I work for,” said Esserman. “She’s in charge of ‘supervising’ me. I also report to Frank McCormick of the Cancer Center.” Esserman reported “dotted line” into McCormick’s Cancer Research Institute. Margaret Tempero reported directly to McCormick as the deputy director and was the chief of the Hematology/Oncology Department. Tempero had “a foot in both the clinical cancer center as well as the research center,” according to Mendelsohn. “Our Breast Care Center falls under her in the Department of Medicine, because it includes breast oncology (medicine). We deal directly with Margaret’s direct report who is Eileen Cunningham, ambulatory services director.

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and temporary head of Cancer Center administration.” Thus in terms of the academic hierarchy, Esserman had to “deal” with the chair of her department, Nancy Ascher. She also had to deal with the dean of the School of Medicine and, to the extent she was going to build a multidisciplinary unit, the heads of the departments that oversaw those disciplines. As clinical leader of the breast program for the Cancer Center, Esserman reported on her activities to Joe Gray, the basic science leader of the breast cancer program and to Frank McCormick, director of the Cancer Center.

UCSF had a matrix structure that distributed control over human resources. Thus physicians such as Esserman could not control hiring and firing of her oncology related colleagues and physicians. Esserman also did not control salaries of those in the Breast Care Center, even though she was the director of the center. In fact, Margaret Tempero controlled key human resource decisions for oncology within the Breast Care Center, as Tempero was the deputy director of the overall Cancer Center. Joe Gray, UCSF professor, laboratory medicine and radiation oncology, commented on UCSF’s organization: “The medical center is organized by departments, not by programs. Money that derives from pathology, radiology, oncology, and surgery, for example, go to those different departments. Laura [Esserman] doesn’t have any control over these departments. This lack of control makes it really difficult to bring people together to achieve a common goal.” Jon Showstack, UCSF School of Medicine faculty member and professor at the Institute for Health Policy Studies agreed about the unclear lines of authority: “Turf is very important here at UCSF. However, the lines of authority are also somewhat unclear. Thus this leads to a lot of friction. For example, Laura’s Breast Care Clinic is not technically a part of the Cancer Center [run by Margaret Tempero] directly, but it’s still cancer-related, so there’s some overlap.”

**UCSF Organizational Culture**

The two most commonly heard words about UCSF were “bureaucratic” and “political.” “When I first arrived here, I quickly realized that this place was really thick with bureaucracy,” stated Meridithe Mendelsohn, assistant director of the Cancer Center and the person in charge of the myriad administrative details that vexed Laura. “I realized that UCSF was all about networking. It had nothing to do with what you knew, but who you knew.” Mendelsohn continued: “In the private sector, I could make decisions and then inform everyone of those decisions. But here at UCSF, everyone has to be involved and aware of all the details. It’s not very efficient. They want someone here who plays by all the rules and never asks for anything.” Others described UCSF as “filled with large egos [and with people who] think they have a right to be there.”

Gray said: “The only way to get anything done at UCSF is by force of personality.”

Mendelsohn provided an example: “Everyone who works in the Breast Care Center works for different entities. There are four different cost centers — the School of Medicine, the Department of Surgery, the Department of Medicine, and the Cancer Research Institute. Someone from the Department of Surgery came to me and didn’t want a person from the Cancer Research Institute reporting to someone in the Department of Surgery. Here at the Breast Care

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8 Priyanka Garg, Kristina Ho, Alex Kim, Sandy Rapkin, and Chuck Seiber, “The Radical Humanist: Dr. Laura Esserman,” Stanford GSB Power and Politics paper, March 15, 2002, p. 2. From their interview with Dr. Ernie Ring, director of Radiology, San Francisco General Hospital, former associate director of Mount Zion.
Center, we don’t care where the money comes from and it doesn’t make any difference to us who’s providing care or doing research. But to others here, it’s practically insurmountable because it’s not okay on paper according to UCSF policies and procedures. Our way of working doesn’t fit the bureaucratic model here at all. In an ideal world, we’d have our Breast Care Center and all the funding would be behind the scenes without the big divisions, so that we can truly work as a team.”

The incentives in academic medicine meant that each physician and each department was a shopkeeper. Physicians were evaluated based on revenue generated from the services that they provided. If a physician referred a patient to another physician, then he/she gave up the revenue from the patient. Those physicians and departments that generated more revenue would receive more compensation, lab space, clinical space, and so forth. “Physicians everywhere and at UCSF will absolutely respond to incentives,” according to Esserman. “They have to see X numbers of patients or they’re not going to make money. They have to do X number of procedures or they’re not going to make money. However none of these metrics are necessarily in the best interest of the patient.”

Tripathy also cited publication and grants as key metrics at UCSF: “A lot of academic medical centers use conventional metrics such as publication and grant support — that’s pretty much it. They don’t care about how you teach, how much patients like you, or how much employees like you. These things just don’t get recognition in the academic world. When people look only at conventional metrics, I think they’re only getting part of the picture, but that’s how it still works.” Lotenero also emphasized the importance of research at UCSF: “UCSF is a community of researchers first, and a medical center second. Even though we are a top medical center, you better be a good researcher here. Those are the real keys to the kingdom.” Gray commented: “UCSF has a strong basic science program and thus the campus is pretty much run by the basic sciences community versus physicians. This means that the environment doesn’t support translational research such as cancer research as much as it could. The university doesn’t care how much money you get and they don’t care whether you run a successful clinic or not. It’s nice if you do, but they really look at your science. This means that if you’re going to do a clinical study, first, is it scientifically interesting? Second, have you set it up in such a way that you answer the questions clearly that you set out to answer? Is it statistically properly powered? Have you applied all the research tools that you have at your disposal properly and effectively?” The quality and quantity of scientific research drove key factors such as resource and space allocation.

**Laura Esserman’s Vision**

Laura Esserman wanted to: 1) build a comprehensive breast care center (and roll out the model within other departments at UCSF and at other breast cancer centers at other hospitals) and 2) build a sophisticated and robust framework supported by an information system that served multiple purposes ranging from maintaining electronic patient records to capturing and sharing patient information for driving innovation in patient care and current and future research (Exhibit 5). The intent was to create a knowledge management system, based on the re-engineering of clinical care delivery, that enabled the measurement of quality, rapid integration of research into
patient care, and the sharing of information for patient care collaboration and research on populations of patients.

Comprehensive Clinical Care: Carol Franc Buck Breast Care Center

The Carol Franc Buck Breast Care Center at the UCSF Comprehensive Cancer Center was designed to meet the needs of patients with breast problems, breast cancer, or general concerns about breast health. When Esserman first arrived at UCSF, the Breast Care Center was a disparate collection of breast services with no centralized administration—there were at least three surgical clinics, two separate mammography suites, and two separate medical oncology clinics. The normal process for a woman who developed a breast lump was to get “bounced around.” She would first see a doctor who felt her lump and then head to another facility to receive a mammogram. Once she received her mammogram, she would be referred to a surgeon. The surgeon saw the patient but needed a copy of the mammogram, and thus needed to contact the radiology facility. The surgeon conducted a biopsy and then sent the patient home to wait for the biopsy results. After that, the patient returned for surgery and the surgeon would then refer her to a radiation therapist and/or a medical oncologist (at various other sites) so that she could receive her post-operative therapy. During this process, medical records moved around various facilities and were not always readily available for analysis. Often patients had to gather their own records, films, and pathology slides, sometimes even in the same institution.

When Esserman assumed control as the director of the Breast Care Center in 1997 (the former chief of Breast Services left the organization because he was resistant to the reorganization), she quickly consolidated breast services and worked with the administration to consolidate the two breast cancer and mammography clinics in San Francisco (UCSF and Mount Zion) at Mount Zion. Esserman wanted to put “everything under one roof,” according to Tripathy, who had worked closely with Esserman on the project: “We wanted to have one person answer the phone who also helped the patient schedule her X-rays. We wanted to have one set of patient records. We wanted to all work together and have conferences about the patient so that we could coordinate care.” Esserman had used a $4.3 million DOD grant called “A New Vision for Breast Care” to re-engineer the Breast Care Center’s clinical processes and integrate the activities of an interdisciplinary group of physicians and scientists specializing in breast care.

Esserman described the important changes she and her colleagues had made: “When a patient comes into the Breast Care Center, I can walk around the corner and look at her films that day. While she’s in the room, we can do a biopsy and get the diagnosis in 5 minutes. We have a gynecologist on staff that specializes in fertility issues for women with breast cancer and I have a psychologist and genetic counselor on staff that is one of the nurse practitioners. The patient stays in the same place and doesn’t need to go anywhere. We’ve organized all the care around her.” Other features of the Breast Care Center included a healing garden, café, information resource center, and a boutique with specialty bras, prostheses, scarves, wigs, books, flowers, and gift items. Patients could also access support groups, nutritional counseling, and educational programs at the Center.

Esserman also created projects such as the Tile Project and supported others such as the Quilt Project. The Tile Project created a way for patients, family, and friends to come together and tell their stories, which were then inscribed onto large ceramic tiles. The tiles adorned the entry
corridor within the Breast Care Center. The Quilt Project, run by Cindy Perlis from Art for Recovery, gave patients the opportunity to each create a quilt block with a personal message on it that expressed their emotions: pain, joy, anger, and hope. Professional quilters then completed the quilts. The 35 completed quilts traveled around the country and were featured every year in San Francisco’s Susan G. Komen Race for the Cure event. Esserman took the lead in physically redesigning the Breast Care Center with aesthetically pleasing tiles, carpet, and other features in warm tones after moving the Breast Care Center to the new UCSF Comprehensive Cancer Center building at Mount Zion in November 2000. She chose much of the décor personally, to make it less institutional. She raised private money for the renovations so that she had more freedom to make these changes.

According to Mendelsohn, since Esserman’s changes to the Breast Care Center, patient throughput increased from 175 visits per month in 1997 to 1,300 visits per month in 2003, thus becoming a significant revenue generator for UCSF and a highly visible program in the community and nationwide. The increased patient volume was also critical for the reorganization of services. Moreover, the Breast Care Center had become an important research center, growing from two to three open clinical trials to over 30 active clinical trials. If the grant’s hypothesis proved correct — that a single-site integrated program offered advantages to the patient over a decentralized system — the center would potentially serve as a national model to other institutions.

**Information Systems Project**

As early as 1993, Esserman’s vision encompassed transforming breast cancer care and using information systems to improve the medical care system, a system that she felt simply did not work. Lotenero explained: “At the Breast Care Center, I think Laura’s done as much as she can in the process improvement area without the use of technology. Now we’re trying to add significant changes in the systems so that the experience of her, her staff, and most importantly, the patients is fundamentally transformed.” Esserman felt that within the existing system the costs of medical care were extremely high, but had little impact on mortality. She believed that making improvements in the quality of care was an overlooked area in the medical industry, but was the key to improving medical care and solving the nation’s healthcare problems. A way to improve the quality of care, according to Esserman, required automated capture and analysis of clinical data and information. As summarized in Esserman’s grant proposal: “We believe that a regional collaboration of breast cancer specialists, supported by a robust informatics network that brings data collection, workflow and modeling to the point of care, will be accepted and utilized effectively. Such a system will improve quality of care by providing physicians with analytical tools for assessing risk, tailoring treatment decisions (decision support) and improving practice patterns; by engaging patients in their treatment decisions; by facilitating accrual to clinical trials; and by providing more current and reliable data to regional tumor registries and national databases. We want to design, build, and test an integrated system that will support decision making at the point of care and enable feedback on performance.”

9 Laura Esserman, DOD grant proposal, BC022339, p. 2.
provide a framework for quality improvement, and 2) that decision support tools to tailor intervention to individual risk, biology, and preferences, would change treatment and decisions.

From a patient’s perspective, Esserman’s vision meant that in addition to having access to a multidisciplinary set of doctors housed in one location, diagnosed breast cancer patients would have access to a multimedia resource of real-time diagnoses, treatment, and success-rate data from thousands of cases like their own. When a patient arrived at the hospital to receive treatment instructions, instead of listening to a physician’s monologue, she would be handed a printout that included the diagnosis; patient-specific data (size and spread of tumor, when it was discovered, and the name of the treating doctor); statistical information generated from clinical-research databases (such as the number of similar cases treated each year and details about survival rates); treatment options; and the risks and benefits associated with each treatment. The goal was to change the physician’s role to one of educator and collaborator in making treatment decisions and manager of the patient’s case.

Behind Esserman’s vision was her belief that a single doctor wasn’t always equipped to make the best decision. “Very often doctors recommend a particular treatment because they’re more familiar with it,” said Esserman. “But we should be advocates for our patients, rather than our specialties.”

Esserman continued: “A medical opinion is really just one physician’s synthesis of the information. So you need a way to calibrate yourself — a way to continually ask, ‘Are there variations among the group of doctors that I work with? Am I subjecting people to procedures that turn out not to be useful?’….With tools like these, we have the opportunity to bring learning back in real time to the practice of medicine and patients have the opportunity to get a second — and even a third and a fourth — opinion while their primary doctor stands by.”

Esserman said: “We’ve made a computerized version of the medical record and that’s it. But how is this helpful? How does this help us manipulate knowledge and learn? We need knowledge transfer systems.”

**Obstacles and Issues**

The way Laura Esserman negotiated the UCSF environment was often counter to the culture at UCSF and to academic medicine in general. Tripathy explained: “The traditional model of investigative success at UCSF and at other places is that you write grants that are very focused and your funding should come from NIH (National Institutes of Health) because it’s the most prestigious grant-making institution. Laura’s vision and style was very different than the convention. The fact that Laura was interested in a lot of things went counter some others’ vision of how one should succeed academically. I think the others did have some merit in their arguments, but I probably didn’t feel as negative about it as Laura did. I think there are multiple ways to succeed academically and I always wished some of Laura’s colleagues could be a little more open.”

Esserman’s decision to pursue an MBA at Stanford also went counter to convention. She had decided to attend business school to learn how to make better management decisions.

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11 Ibid., p. 108.
In a bureaucratic organization filled with rules, forms, and procedures, Esserman was not big on nailing down or communicating details. Lotenero noted: “Laura’s a big thinker with huge aspirations. She can articulate the big picture in the blue sky really well, but she has more difficulty nailing down the details of what it takes in a one, two, three, four, five step process to get there. We hear all the time around here that ‘she loses me,’ ‘I can’t follow her,’ or ‘she’s so blue sky.’ Sometimes she’s so confusing that people actually think that she’s trying to pull the wool over them or that she has another agenda. She’s definitely not linear and people get really frustrated with her.” Gray agreed: “When she presents, most of the time, it comes across as not fully thought-out. It’s difficult to get out of her a clear, coherent, written, understandable vision of what she has, what she needs, and why she needs it. I think that’s her biggest single obstacle to getting things to really go forward. In general, Laura doesn’t calmly and clearly present her plans. What we have here is a campus of extremely busy people. If you don’t go in and present in a very well thought-out clear manner, they’ll dismiss it. It’s just because they don’t understand it.”

Esserman felt strongly about improving processes at UCSF and if she felt a process was not optimal, she often found creative ways to go around existing rules and processes. Esserman commented on her place in the power structure at UCSF: “When Margaret Tempero was looking for a deputy, I used to want that position and obviously they wouldn’t ask me,” said Esserman. “My ideas seem way too wild for that position. And now I’ve realized that I really don’t want that position because it’s all about the status quo and I don’t want to do that. I’ve realized that I don’t need it and I don’t want it. I’m actually delighted to be where I am. I don’t want to be in the power structure, unless the power structure is going to be the way that I would envision it. But it’s not right now, so that’s fine.”

In addition, Esserman faced enormous technological challenges. Information systems in healthcare were developed initially to serve as bill-paying systems. Not until the 1990s did medical record systems become automated at all. The automation was still extremely primitive and included photocopying medical records and placing them into a computer system. “Even today’s so-called electronic medical record (EMR) systems are pretty dumb systems,” said Showstack. “At UCSF, we have not been able to track patients and their services because patients may have different record numbers in different clinics.” Gray described additional key technical issues: “One problem is a lack of a common vocabulary. How do you describe the pathology report in a way that’s understandable to everyone within a hospital and intra-hospital? I can assure you that when you take three pathologists and have them describe something, they will come up with four different descriptions. Also, in a university system it’s sort of free enterprise. As a consequence it’s really difficult to impose rules. So everyone has sort of invented the rules themselves in little bits and pieces. So you have this huge distributed semi-functional enterprise. You can’t just say some day, let’s stop and do it a different way. You have to put a system into place, make it work for everybody. We can’t just stop doing medicine. So it’s very difficult to do this. I think Laura needs $100 million dollars and 100 people to accomplish what she wants to accomplish, especially if she wants to include experimental research data.”

Lotenero reflected on the people challenges of Esserman’s information systems project: “This project is causing a real problem here because Laura’s trying to set up a research lab in an
Dr. Laura Esserman (A) OB-42A

operational setting. If she were conducting this project down in Genentech Hall at our Mission Bay facility, none of this would seem so far reaching. But when you take this leading edge vision and put it in the middle of a stodgy operation, people just recoil from this. People don’t even think we have a current generation system set up and so they don’t even want to think about a future generation.”

Specifically in terms of people challenges, Esserman faced credibility challenges: “I think what Laura’s trying to do [systems project] is visionary and laudable. However, Laura’s been trying to do this systems project ever since I’ve known her, which must be 10 years,” said Gray. “She’s gone through a lot of different versions but we’re not any farther along today than we were when we started. At one level, Laura’s cheerleading, but not actually designing it. Either she’s going to have to make it happen, hire somebody who can make it happen, or stop doing it. The other problem is that you need to be dean or chancellor, or somebody like that to actually make that happen at her level. But Laura’s trying to make it happen. I think that is a task that is way beyond her.”

In order to achieve success, Esserman needed the support of key internal constituents. The challenge was that Esserman had historical conflicts with key administrators. Esserman defended herself: “I really cringe when people call me a radical because I don’t want to be labeled that way. I don’t see this information systems project as being very radical. It’s just common sense.” Key internal constituents included figures at the Medical Center: Mark Laret, CEO; Alan Glassberg, clinical director of the Cancer Center; Ken Jones, CFO; and Eileen Cunningham, Ambulatory Services director. Key figures in the UCSF School of Medicine included: Haile Debas, dean; Nancy Ascher, chair; Margaret Tempero, Hematology Oncology leader and deputy director of the Cancer Center; Frank McCormick, director; and Alan Venook, deputy, Clinical Research Office.

Esserman had gained the support of Mark Laret, Alan Glassberg, Haile Debas, Nancy Ascher, Frank McCormick, and Larry Lotenero. Esserman commented specifically on Lotenero: “Without Larry, there would be no project. He’s my mole in the organization. He’s the most visionary and capable person and very unbureaucratic.” Lotenero planned to provide some of his people’s time in IT to work on Esserman’s project. Esserman also received cautious approval for the project from Mark Laret, UCSF’s CEO. Esserman said: “I was feeling some resistance from Margaret Tempero for the information systems project so I went to Mark Laret and I told him that approval has to come from him and I wanted him to anoint me and he finally said ‘okay,’ but I could tell that there was anxiety that I was going to blow up the building or something.” Laret supported Esserman’s project because he understood the importance of investing in the IT of the future; but only as long as future projects were not pursued at the expense of existing systems issues, according to Lotenero. Powerful supporters included Haile Debas, the Dean of the School of Medicine. Esserman had initially joined UCSF because Debas supported her vision. One interviewee provided his perspective: “Laura’s clinic brings in a lot of money for UCSF and surgeons also bring in more money, as surgery gets reimbursed pretty well. She is thus very important to Mark Laret and the people who run the hospital. That may even be why they like her.”
However, Esserman had varying degrees of challenges with Margaret Tempero, Ken Jones, Eileen Cunningham, and Alan Venook. One person said: “I think Laura is very effective in some situations and absolutely paralyzed in other situations.” Lotenero commented on Esserman’s relationship with Ken Jones: “Ken Jones is not really against Laura, per se, but as the CFO, he worries about the finances of the Breast Care Center. I don’t think he has any qualms about her as a physician. He’s just worried about the dollars and the bottom line. Ken could definitely impede Laura in getting what she wants done.” Lotenero also discussed Eileen Cunningham: “Eileen Cunningham has to focus on the operational work. She deals with the people that work in the Medical Center in Laura’s Breast Care Center. So naturally, if we’re changing things that have to do with the Breast Care Center, she wants to know about it and be a part of it. She is extremely frustrated by someone who would even consider wanting to go off and change the way the work is done. This just makes her crazy.” Showstack said: “Laura has not been as successful in getting the support of people outside of the Department of Surgery or on the academic side and within the hospitals and clinics or one step down from the central administration (e.g. the administrator of the clinics). It’s an interesting question as to why Laura gets support at the high level and rubs some people the wrong way at the lower level.”

Esserman was particularly challenged with Margaret Tempero, who some described as “cold,” “proper,” and “rigid.” Others described Tempero as “well-loved” and having a “great sense of humor.” Esserman explained: “I’ve heard through others that Margaret [Tempero] thinks that she needs to constantly bail me out and that she has to corral me. Her impression is that I have a lot of great ideas, but can’t deliver. One interviewee elaborated: “It’s strange here at UCSF because where I used to work doctors didn’t overtly criticize one another, but here I saw a physician openly criticize Laura in a meeting in front of other people stating that Laura sets all these things in motion and causes all kinds of problems and how Margaret always has to bail her out.” Gray provided his perspective on Tempero: “Margaret has a huge task on her hands in terms of trying to get the oncology program to be financially sound. Thus she’s not blessed with fat resources. She has to make a lot of hard choices. I think that she probably isn’t as open as you might like in terms of what your own agenda is. But in general I think that she means well and has been effective doing what her job is to do. Margaret’s position in the Cancer Center is such that she has sort of the same job that Laura does except at a larger scale — that is to bring together a whole bunch of people in different departments. She is the division chief of only one of those, which makes her job very difficult. I think she’s supportive of Laura’s vision, but I’m not sure that she understands the details well enough to be fully supportive.” Esserman realized that she needed to improve her working relationship—real or perceived—with Tempero.

**WHAT NEXT?**

As Esserman sat down in CIO Larry Lotenero’s office, she wondered what they could do to overcome the challenges that she and her information systems project faced. Esserman was proud of her accomplishments at UCSF in terms of the cutting-edge Breast Care Center that she and her team had developed and shaped. However, she would not be satisfied until she could accomplish the rest of her vision — implementing a complex information system to complement the Breast Care Center. She also knew that UCSF administrators would be watching her very closely and monitoring her successes and failures.
Exhibit 1
Dr. Laura Esserman Biography

Associate Professor, Surgery and Radiology, UCSF; Director, Carol Franc Buck Breast Care Center, UCSF/Mount Zion Medical Center; Affiliate Faculty, Institute for Health Policy Studies, UCSF

Program Member, UCSF Comprehensive Cancer Center; Clinical Leader, Breast Oncology Program

Director, Carol Franc Buck Breast Care Center, UCSF Comprehensive Cancer Center

Member, UCSF Program in Biological and Medical Informatics (BMI)

Education

Harvard University, A.B., 1977, History of Science
Stanford University, M.D., 1983, Surgery
Stanford University, School of Business, M.B.A., 1993, Health Policy

Professional Experience

1985-1988
Postdoctoral Fellow, Dept. of Medicine, Division of Oncology, Stanford University School of Medicine

Resident in General Surgery, Stanford University School of Medicine

1990-1991
Chief Resident in General Surgery, Stanford University School of Medicine

1991-1993
Consultant, Stanford University Hospital, Cost Benefit Issues in the ICU

1991-1993
Staff General Surgeon, Palo Alto Veteran’s Administration Hospital

1991-1993
Trauma Surgeon, Santa Clara Valley Medical Center

06/92-8/93
Clinical Assistant Professor of Surgery, Stanford University Department of Surgery

09/93-9/97
Assistant Professor of Surgery, Director, Breast Care Center, UCSF/Mount Zion Medical Center
05/97-present
Director, Breast Care Center/Clinical Leader Breast Cancer Oncology Program for Cancer Center

06/96-present
Affiliate Faculty, Institute for Health Policy Studies

06/98-present
Associate Professor of Surgery, Joint Appointment in Radiology

**Honors & Awards**

Harvard University-Sophomore Standing, 1974
Harvard University-Susan B. Anthony Potter Prize, 1975
Harvard University-Magna Cum Laude, 1977
Katherine McCormick Award, 1988
Hartford Fellowship in Health Policy, 1991-1993
NFME Award (National Foundation for Medical Education), 1991-1993
Research Most Likely to Change Breast Cancer Management: Honorable Mention, BCRP, 1999

**Selected Publications**


Source: http://cc.ucsf.edu/people/esserman_laura.html.
Exhibit 2
UCSF Organization: General

Source: UCSF.
Source: UCSF.
Exhibit 4
Key Players’ Biographies

Mark Laret, CEO Medical Center
Mark R. Laret, chief executive officer of UCSF Medical Center and UCSF Children's Hospital, is responsible for the administration and day-to-day operations of one of the most distinguished health care institutions in the world. The medical center includes the medical practices of more than 900 physicians, a 500-bed hospital and outpatient clinics in more than 75 specialties. Prior to joining UCSF in April 2000, Laret was chief executive officer for five years of UC Irvine Medical Center, a 460-bed primary and specialty care hospital in Orange, California.

At UCI, Laret is credited with instituting aggressive marketing, quality improvement and customer service initiatives. In 1999, Laret was named Orange County "Manager of the Year" by the Society for Advancement of Management. He serves on the executive committee of the board of the University Healthsystem Consortium, an organization of 70 of America's elite university medical centers. Laret also served as deputy director of UCLA Medical Center and chief executive officer of the 900-physician UCLA Medical Group. At UCLA, Laret helped build the regional referral network and was responsible for UCLA's acquisition of Santa Monica Hospital in 1995. Laret earned his bachelor's degree as a Regents Scholar at UCLA and his master's degree as a Haynes Foundation Fellow at the University of Southern California. Both degrees are in political science.

Haile Debas, Dean of UCSF School of Medicine
Haile T. Debas, M.D., currently dean of the UCSF School of Medicine, served as the seventh chancellor of UCSF. An internationally renowned surgeon, scientist, and teacher, Dr. Debas agreed to accept the appointment for a period of one year. Serving as both chancellor and dean, he played a key role in all of the major initiatives of the campus, including the development of UCSF Stanford Health Care, a new major site for biomedical research at Mission Bay, and the development of the UCSF Comprehensive Cancer Center. During his tenure, UCSF became one of the country's leading centers for transplant surgery, the training of young surgeons, and basic and clinical research in surgery.

Dr. Debas served as chair of the UCSF Department of Surgery from 1987 until his appointment as dean in 1993. Dr. Debas' other major initiatives include the development of the UCSF AIDS Research Institute, a redesign of the UCSF Human Genetics Program, and important changes in the medical school curriculum. He resigned effective September 1, 2003, and was replaced by Larry Kessler, former FDA commissioner (prominent in the fight against the tobacco companies) and former dean of the Yale Medical School.

Margaret Tempero, Deputy Director UCSF Comprehensive Cancer Center and Chief of Medical Oncology
Dr. Margaret Tempero is deputy director of the University of California at San Francisco (UCSF) Comprehensive Cancer Center and professor and chief of the Division of Medical Oncology. Upon her arrival at UCSF in January 2000, she was named the Doris and Don Fisher Distinguished Professor in Clinical Research. Prior to her appointment at UCSF, she was professor of medicine and held the Distinguished Cancer Research Professorship at the University of Nebraska Medical Center. She was the deputy director of the NCI designated Cancer Center at the University of Nebraska and served as the interim Cancer Center director for three years.

Dr. Tempero is an accomplished clinical and translational scientist. She served as the principal investigator of a Special Program of Research Excellence for pancreatic cancer and is considered to be among the national leaders in gastrointestinal oncology. She has been a pioneer in the application of radioactivity tagged antibodies for cancer therapy. In recognition of her clinical science expertise, she co-directs the Methods in Clinical Cancer Research Workshop co-sponsored by the American Association for Cancer Research and the American Society of Clinical Oncology. She was also chosen to lead a Special Emphasis Panel for NIH funding for clinical science and recently chaired a special NIH initiative to establish research priorities in pancreatic cancer.

Dr. Tempero is vice chairman of the board of the National Comprehensive Cancer Network. She also serves on the board (and in 2003 was president) of the American Society of Clinical Oncology, the most prestigious oncology society with over 40,000 members, and on the board of Scientific Counselors which is advisory to the intramural programs of the NCI. She holds or has held editorial positions on numerous prestigious journals such as Cancer
Research, Journal of Clinical Oncology, Clinical Cancer Research and the American Journal of Medicine. She is credited with over 100 original articles and book chapters.

In addition to establishing and coordinating a new research program in gastrointestinal cancers at UCSF, Dr. Tempero also assists Dr. Frank McCormick in the overall direction, administration and strategic planning for the Cancer Center. She represents the clinical components of the Cancer Center on all major UCSF committees and Task Forces. She also interacts with all Cancer Center programs to foster and develop clinical and translational science.

Nancy Ascher, Chair UCSF Department of Surgery
Dr. Nancy Ascher, chair of the UCSF Department of Surgery, has devoted her career to transplants and transplant research. Ascher served on the Presidential Task Force on Organ Transplantation and the Surgeon General’s Task Force on Increasing Donor Organs. She currently is the chair of the Secretary of Health and Human Services Advisory Committee on Organ Transplantation. She is a fellow of the American College of Surgeons and has membership in numerous other medical societies. She has taken an active leadership role in the American Society of Transplant Surgeons activities and is a pastpresident.

Ascher is a graduate of the University of Michigan, Ann Arbor, where she also received her medical degree. She completed a general surgery residency and clinical transplantation fellowship at the University of Minnesota, where she later joined the faculty and became clinical director of the Liver Transplant Program. She is certified by the American Board of Surgery.

Jon Showstack, Associate Director of IHPS
Dr. Showstack is associate director for administration of IHPS (Institute for Health Policy Studies). He co-directs Health of the Public: An Academic Challenge, a program that is assisting academic health centers incorporate a population perspective into their education, research, and patient care programs. His research focuses on institutional change strategies, factors that influence the cost and use of medical technologies, and the cost and effectiveness of medical care, particularly for minority and other disadvantaged populations.
Exhibit 5
Carol Franc Buck Breast Center Unique Programs

High-Risk Program
A multidisciplinary breast cancer screening and prevention program for women classified as being at high risk of developing breast cancer.

Same-Day Assessment Program
A specialized program to evaluate and diagnose abnormal mammograms and breast lumps the same day you are seen. The one-day program includes consultation with surgeon, radiologist, and pathologist.

Psychosocial Program
A 12-week personal support and lifestyle intervention program, including two unique approaches to providing care for women with breast cancer.

Follow-Up Program
A program designed to meet the needs of all patients who are a year out from their cancer diagnosis, including educational materials, clinical exams, and monthly question/answer sessions with physicians.

General Breast Cancer Care
We utilize advanced surgical techniques to treat a new diagnosis of breast cancer, including skin-sparing mastectomy and sentinel lymph node dissection. Through the use of clinical trials, we are constantly testing new therapeutic agents to treat advanced disease. Our physicians also encourage patients to work as advocates to improve clinical trials, and they are actively involved in public policy development, especially focusing on issues surrounding mammographic screening.

Research
In addition to state-of-the-art clinical care, our physicians and scientists conduct research projects aimed at:

- Identifying the fundamental genetic components that cause cancer, and the specific pathways that can be targeted for treatment
- Understanding what can be done to prevent cancer
- Changing the order of therapy (surgery last) to provide a much shorter trajectory for learning about how to tailor new biologic therapies to prevent cancer and cancer progression.
- Understanding basic biology and harnessing it in the clinical arena to develop new and different strategies for breast cancer treatment
- Understanding the importance of patient decision making and psychosocial support on breast cancer outcomes
- Using economic and decision modeling to assist in strategic introduction of technological innovations

Focus on the Individual—The Whole Patient
In addition to the clinical activities, Cancer Center physicians work to ensure a wide range of psychosocial support services for patients and their families. These individuals are specially trained to deal with the complex emotional and psychological problems which frequently accompany a cancer diagnosis. Whether it is access to support groups, individual counseling or help with physical appearance while undergoing cancer treatment, our specially trained and sensitive staff are ready to cater to your many individualized needs.

Source: http://cc.ucsf.edu/clinical/breast.html and Laura Esserman.