breakthrough

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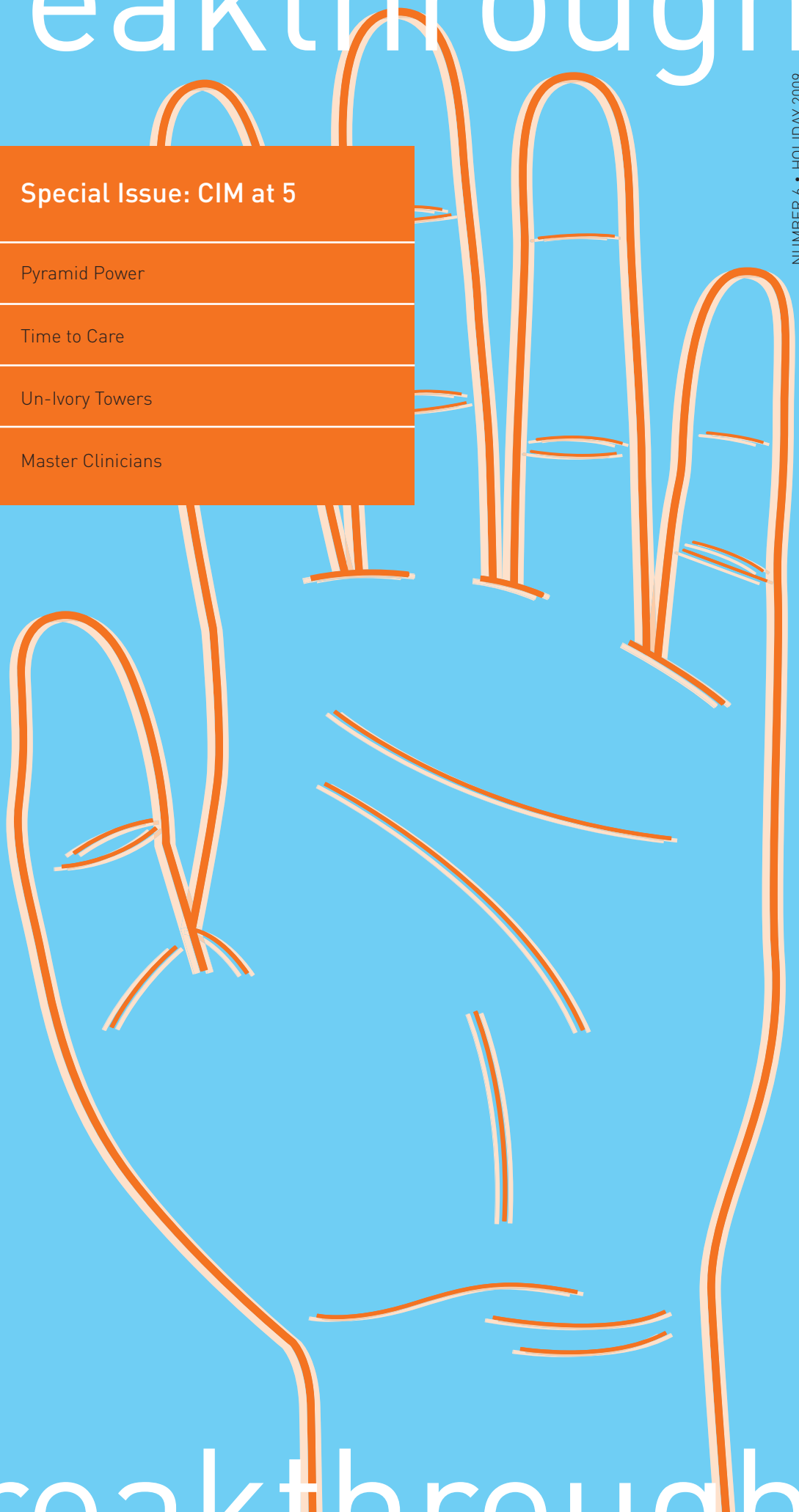
Special Issue: CIM at 5

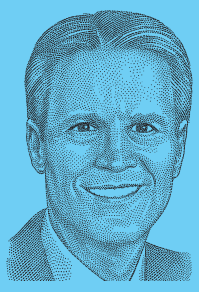


Medicine is a public trust

THE JOHNS HOPKINS CENTER FOR INNOVATIVE MEDICINE

breakthrough

In this issue



David B. Hellmann, MD., M.A.C.P.
Aliki Perroti Professor of Medicine; Vice Dean, Johns Hopkins Bayview Medical Center; Chairman, Department of Medicine

We Celebrate Five Years

This issue of Breakthrough celebrates a milestone for the Center for Innovative Medicine. We're five years old! When you get to a special marker in the road, it may make you think about how far you've come, and how far you plan to go – or you may just take a moment to enjoy the journey.

I've been doing a little of all three of these things. Our CIM , though just five, is connected to more than a century of Johns Hopkins history. The Johns Hopkins Hospital opened in 1889, when a group of people – faculty, administrators, trustees, and philanthropists – got together, decided to do something different for the sake of doing it better, and came up with some bold and important ideas. They redefined academic medicine. Johns Hopkins became, as they had hoped, "a model of its kind." When word spread about the Hopkins model – largely after an educator named Abraham Flexner wrote about it, and urged all hospitals to become more like Hopkins, or else be closed down – the public became engaged. This inspired more philanthropists to support the good work being done, and even greater good was achieved. I've always felt that these are enduring lessons for all of us in academic medicine: Try to do something important. If you are getting anywhere, tell people about it – not because you want to brag, but because people are genuinely interested. In fact, people are looking for universities to come up with new solutions for old problems. As you spread the word, if you're lucky, you will engage people who care, and who have the means to help with the mission.

In this special issue, we bring you up to date on four major initiatives we've begun within the last five years: The Aliki Initiative; our Pyramid model; our research cores; and the Miller-Coulson Academy of Clinical Excellence. The CIM is a place where remarkable people are doing extraordinary things. My hope is that as you read these pages, you will be captivated by the creative thinking, innovative solutions, and the responses these have generated.

As amazing as this journey has been, more wonderful, to me, is the generosity that has made it possible. Without the support of the philanthropists you will read about on these pages, we could not have come far at all. We would have had the good ideas, but no way to turn them into real projects that have the potential to transform the doctor-patient relationship, the culture of academic medicine, and the way clinical excellence is valued and rewarded.

We have also had support, from the very beginning, from our colleagues here at Hopkins. I would like to thank so many people: First of all, my partner in the CIM, Richard Paisner; Bill Brody, the former president of Johns Hopkins University, and Ronald Daniels, the current JHU President; Ed Miller, Dean of the School of Medicine; Ron Peterson, President of the Johns Hopkins Hospital; Greg Schaffer, the former President of Johns Hopkins Bayview Medical Center, and his successor, Rick Bennett. I am thankful for the stellar people who make Bayview an excellent place – scholars, educators, clinicians, nurses, social workers, technicians, administrative staff, security. They are all part of the community here, and part of the mission. And I would like to thank Janet Worthington, our writer, who tells the world what we do here.

What a celebration! How exciting that these projects – which started out as just ideas and wishes – have been successfully launched. Our journey has just begun. Thank you for sharing it with us.

David B. Hellmann, M.D.

WE BELIEVE

Medicine belongs to the public. Our mission is to create a different kind of academic medicine, to tear down ivory towers, share knowledge and dedicate ourselves toward one goal – making life better for patients.

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on the web

If you'd like to learn more about the Johns Hopkins Center for Innovative Medicine, please visit our website: www.hopkins-medicine.org/innovative

Idea Men

They talk. A lot. They kick around ideas, and draw inspiration not just from medicine, but from business and literature. Their ideas are helping to change the culture of academic medicine.

If it seems that the Center for Innovative Medicine has gotten off to a rollicking start, that's because it has. The spark came from one of David Hellmann's patients, Mrs. Anne Miller, who wanted to know why truly gifted clinicians are so hard to find (for more, see Page 18). The match was lit, in effect, in 2004 by Bill Brody, then President of the Johns Hopkins University, with these words to David Hellmann, Chairman of Medicine, and Richard Paisner: "Go and create a center." But it helped that the tinder and kindling were already set to go. That's because for most of the last 20 years, Hellmann and Paisner, a Washington, D.C.-based lawyer and businessman, had been throwing around ideas, talking, meeting with people at Hopkins and elsewhere, reading all kinds of books, and asking lots of questions – figuring out ways to reshape the century-old model of academic medicine to fit today's patients and families, doctors, and scientists. Recently, *Breakthrough* caught up with them to see how things are going. Here's some of that conversation:

Richard, you and David met in a pretty dramatic way. What happened?

RP: During the same week that Sadaam Hussein invaded Kuwait, I developed unaccountable, 104-degree fevers; I went through several months of the fevers coming, breaking, coming again, then going away for a few weeks, and eventually starting up again. Eventually, I wound up as an inpatient at Hopkins. Basically, I got the full workup, so everybody who might possibly be my savior came by and did tests and talked to me. One by one, they all said, "Gee, we're sorry, we wish you the best, but it's not our thing," and the only guy left standing at the end was David Hellmann a rheumatologist. I think he was left standing only because he couldn't without question say it was not an autoimmune disease. So he became my doctor.

Are you okay now?

RP: Thanks to the miracles of modern pharmaceuticals, I am fine. If I didn't take drugs, the fevers would come back. From time to time over the last 20 years, I've tried to taper off the medications, and the fevers come back quite quickly. There's no real diagnosis. I like to call it Hellmann's disease, he calls it Paisner's disease. There's no question that his care and Hopkins' care made it possible for me to have a productive life, which I know otherwise I couldn't have had.

How did you start working together?
DH: Richard and his business partner had been tech investors. One day, I mentioned that I had just become the Chairman of Medicine at Bayview, and his first response was, "Congratulations. What are your goals?" We haven't stopped talking since. He has had pretty broad experience, and has helped me learn to look at the world the way a business person does. I think our collaboration has made our work more effective, and has made it possible for us to bring people together from many walks of life who want to help change the culture of academic medicine. My mantra – what everyone who spends any time with me hears me say often – is that medicine is a public trust. The collaboration with Richard has made it possible for us to explain this better internally, as well as to people outside of medicine.

Here was an idea that was really challenging the way things had been done for 100 years. I expected to hear resistance. What I heard was excitement.

Around this time, you met the author and historian, Ken Ludmerer (twice nominated for the Pulitzer Prize, most recently for his book, *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care*), and you've said that talking with him helped bring what you and Richard had been working on into a new focus.
DH: Absolutely. I've been impressed with what I feel is a recurrent history lesson – that people come up with a solution to a problem, the problem changes, and people keep insisting on the same solution. There was lots of evidence that this was happening in health care. Ken Ludmerer and I were invited to a conference in Canada. Between meetings, we went on a hike, and as we walked, we talked about medicine, for several hours. I had always felt that health care works best when everybody involved – not just doctors, nurses, patients, and scientists, but even insurance companies and the agencies that fund research – respects the fact that medicine belongs to everyone. My conversations with Ken helped me crystallize my goal for Bayview – to make it a better public trust. Soon afterward, Richard and I met with Bill Brody, the President of Johns Hopkins University, to talk about funding some projects that would help our patients get better care. As often happens with either Richard or Bill Brody, the discussion got larger, and we wound up talking about how medicine needs to redefine itself.

And so the CIM was born. When did you know that you were on the right track?
RP: I knew the moment when I felt we actually had a chance to be successful. David was meeting with his division chiefs, and he was describing for the first time his idea for the Aliki Initiative. I was sitting in the back of the room, quite apprehensive, because I regard the Hopkins doctors as the best of the best, and here was an idea that was really challenging the way things had been done for 100 years. I expected to hear resistance, and what I heard instead was real excitement that something which could make it possible for doctors to practice medicine the way they always wanted to – the thing that brought them to medicine in the first place – was actually going to take place on the Bayview campus.

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So that was step one: David talking to his key people, and they are, to a person, enthusiastic and supportive. Step two happened last year, when Ken Ludmerer wrote that the Aliki Initiative is the most important innovation in graduate medical education in a generation. Then most recently, external validation: Dr. Charles B. Green, Surgeon General of the Air Force, who has absolutely no connection with us at all, read about the Aliki Initiative in *Pharos* (a journal for medical students and educators), then immediately wrote a letter to every doctor in the Air Force saying, "This is the way our doctors should be trained." That was spectacular. (U.S. Rep.) John Sarbanes has put the article and that letter in the Congressional Record. (See Page 25.)

David, you have said that you think of the CIM as a "good virus." What do you mean by that?
DH: The virus model is actually how I came up with the Aliki Initiative (see Page 10). My hope had been to completely transform the way we teach doctors, all at one time. I kept trying to save up money, to be in a position to clean the slate, and rewrite the entire curriculum. But after several years, I realized it was unlikely that we would ever be able to do it all over from the get-go. For one thing, in a traditional, large place, making sweeping change is difficult. Then one day, it dawned on me. How do viruses do it? They enter one cell at a time. In the best possible sense, the Aliki initiative really has done that, changing medicine one patient at a time, one doctor at a time. Many of the residents talk about having an "Aliki moment" – which basically means doctoring the way we should doctor – even before they get on the Aliki service.

This small-scale approach is the key to the success of our CIM council, too. No matter how large the CIM may ever become, I think the nature of our council will always require it to be of modest size. It has to be that size, so we can all fit in my office, and have tea and coffee, and rolls, and vibrant conversations about medicine, business, books – anything that can help us to think more creatively. That's a big part of it. I'm hoping that the ideas that we talk about in the council meetings will disseminate, replicate, and that, just as we've come up with the model of the pyramid (see Page 6), we will be able to create a whole bunch of pharaohs and pyramid builders.

I'm usually caught between my first impression that anything is possible, and my second impression, which is, how on God's earth can this ever occur?

You started the CIM with a few key ideas: That medicine is a public trust, that patients should know their doctor as a person, technology should be used wisely, and that building collaboration, by breaking down the ivory towers, is essential. Has it done the things you hoped it would do? Have you been surprised by anything?
DH: I think I didn't expect most of what's happened. I'm usually caught between my first impression that anything is possible, and my second impression, which is, how on God's earth can this ever occur? I don't think I could have envisioned that there would be such a wonderful group of such varied people working energetically together. I'm not sure I would have thought that we could have built major cores (see Page 14), or started the Miller-Coulson Academy of Clinical Excellence (se Page 18). I certainly have been awed, and humbled, by the generosity of the people who have donated funds to support our efforts. I never thought that, in the process, we would be building such strong ties with the Greek community, that (longtime U.S. Senator) Paul Sarbanes and John Sarbanes would be attending a dinner in honor of the Aliki Iniative. That the Aliki Initiative would be in the *Congressional Record*. I didn't know that the notion of medicine as a public trust would resonate with the faculty and staff as much as it has.

RP: I can give you an example of the CIM council in action that crystallizes everything we're trying to do. At a recent meeting, (Chief of the Division of Rheumatology) Antony Rosen described his proposed center for inflammation and autoimmunity; before he did that, he spent probably half

an hour talking about the challenges to achieving collaboration in places like Hopkins. (Director of the Department of Psychiatry) Constantine Lyketsos and (Director of the Department of Neurology) Richard O'Brien were there, too; they and others are trying to create a new center on behavior and health, and they all began talking together. So the people trying to build two centers were helping each other figure out how to do it. That to me was really remarkable; that could not have happened five years ago.

Why not?
DH: Because it used to be that people didn't feel safe. The nature of academic medicine – academia in general – is that people are very protective of what's theirs; their turf, their research, their ideas. We have found that collaboration doesn't start until people can find a way around those barriers.

RP: David always says that what we lack at Bayview is a great coffee shop. There is lots of literature on corporate collaboration. There's been virtually nothing on academic collaboration; it's just starting to come out. One of the things the literature shows is that you need a place, a welcoming, collegial place, where people can sit down and talk. This is what happens at the cores we've set up. They're about research, but equally, they're about getting people from different disciplines into a physical location. And then they start talking to each other.

DH: At that CIM meeting, we had all these extraordinary, brilliant doctors, nurses, and administrators, and you could see the intensity in the room, as people tried to figure out, how do we make these centers successful. It was wonderful. Eric Howell (Chief of Collaborative Inpatient Medical Services) said afterwards, "I guess we don't need to build a coffee shop, we've got it right here." That was true. It was just exactly the environment we hoped to create.

RP: The thing is, in the business world, this is not news. In the business world, if you don't collaborate, you die; the company fails. People have to work together to get a complicated product off the assembly line. What the people at the CIM understand is that it's a very complicated world, and if you really want to put your patients first, you're going to have to work together, because that's the only way you're going to wind up with research that will truly help them. I think that was exactly Bill Brody's point all those years ago, that we weren't where we needed to be.

You guys have talked about how academic medical centers need to go from the acute to the chronic disease model. Can you explain this?
DH: Originally, the Johns Hopkins Hospital was set up to deal with acute diseases. People had infections and they died. Now, people live longer, but many of them develop at least one chronic disease. A system that was set up to deal with acute diseases 100 years ago just isn't set up to deal with chronic diseases. We need to change our mindset, from short-term visits to the long haul. It's more important now than ever that we get to know our patients as people, because as people live longer, and as we work to help them deal with diabetes, or heart disease, or any other long-term illness, we're going to be seeing a lot of each other. ■

What the people at the CIM understand is that it's a very complicated world, and if you really want to put your patients first, you're going to have to work together, because that's the only way you're going to wind up with research that will truly help them.

PUTTING THE PATIENT FIRST

PYRAMID POWER

To understand the need for the pyramid, first you have to understand the significance of the triangle. This isn't Geometry 101, and it's not something cryptic out of a Dan Brown novel. It's a whole new way to think about academic medicine.

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New problems deserve creative thinking and different solutions. When questions change, the same old answers don't work so well. This brings us to two models of academic medicine, both of them the brainchildren of Johns Hopkins physicians. One of them was developed when Hopkins Hospital opened more than a century ago; in its time, it was revolutionary, and was such a success that it remains the standard at teaching hospitals worldwide. It is represented by an equilateral triangle, showing a triple set of priorities. The order may vary from place to place, but the basic components are the same: Teaching, Patient Care, and Research.

The fact that these three goals seem self-evident shows us how far academic medicine has come. Before Johns Hopkins existed, medical education in this country was, for the most part, pretty dismal – leaning heavily on classroom lectures, with no science, no lab work, and no actual teaching how to take care of sick people. Fledgling doctors were sent out unprepared to treat the patients who trusted them. The Hopkins model established three key elements:

- Science as the basis for medical knowledge,
- Rigorous preparation in science as the prerequisite for beginning medical education, and
- The teaching hospital, an innovative fusion of hospital and medical school, as the best training ground for internship and residency.

The Hopkins model was so successful that in 1910, Abraham Flexner's famous report on medical education – which lambasted the awful state of American medical schools, in shocking detail – held it up as the ideal. Flexner recommended that all American medical schools either become more like Hopkins, with its rigorous scientific training and years of clinical "learning by doing" under skilled and careful supervision, or be shut down.

And, as historian Kenneth Ludmerer, the first Aliki Perroti Visiting Professor of Medicine, noted, Americans responded with a groundswell of outrage and pressure for change – because in the early 20th century, Americans viewed medicine as a public trust, and cared deeply about the types of doctors its schools were training. The Hopkins model became the standard throughout the United States.

Research, especially, tends to become an end of its own, and in the race for academic excellence, the idea that science is a means of achieving the *greater goal* – helping patients – can get pushed aside.

"The triangle was a great innovation, and it solved the problems of 19th-century medicine that it was designed to fix," says David B. Hellmann, the Aliki Perroti Professor of Medicine, "the lack of science, and the huge distance between the best, the average, and the worst-trained doctors. Many fine advances in medical research and patient care are the result of this triangle." But medicine today is different in many ways from what it was when the triangle model was developed. For one thing, many of today's patients would be, frankly, oddities rarely seen in the 19th century. We live a lot longer – generally more than 80 years, compared to the life expectancy of just 35 years in the 1890s. Many of us face the challenges of multiple, chronic diseases – again, not such a problem back then, when mothers often died in childbirth, and many people were done in by acute infectious diseases. Few in the 19th century, in the age before antibiotics, lived long enough to battle heart failure or prostate cancer. Back then, there was no insurance, and the cost of medical care was relatively inexpensive; there just wasn't anything like a money-gobbling intensive care room, with monitors and ventilators; the idea of spending hundreds or even thousands on medical treatment was unheard of.

But one thing remains constant, says Hellmann, "and that is the belief that medicine is a public trust. How can we give people a higher dividend for their investment – not only from our patients and their insurers, but from their taxes, through Medicare and Medicaid, and the National Institutes of Health? How can we become better?"

Over the last five years, through the Center for Innovative Medicine, Hellmann has been studying academic medicine, and he has concluded that the triangle model lacks several key features – beginning

with a focus. "We need to have an epicenter, a single priority instead of three separate missions," he says. Hellmann proposes adding a new dimension to the model – making it a pyramid, with all sides pointing toward the patient. "Only one side of the traditional triangle explicitly focuses on the patient. The assumption is that the other two sides are focused on helping patients, but unfortunately, this is not always the case." Research, especially, tends to become an end of its own, and in the race for academic excellence, the idea that science is a means of achieving the greater goal – helping patients – can get pushed aside.

In the pyramid model, public trust is foremost, and "the pinnacle is occupied by the patient, family, and community," notes Hellmann. "Putting them at the pinnacle emphasizes that everything we do must benefit the patient, and society. The primacy of the patient needs to be explicit in every aspect of our work." Putting the patient first also means a renewed emphasis on costs, appropriateness and safety of care.

Another piece missing from the triangle is collaboration. Over the years, an increasing emphasis on scientific achievement has skewed the triangle academically, says Hellmann. "Research dominates the pathway to professional rewards. Not teaching doctors how to be caring clinicians, not *being* caring clinicians. Research receives the lion's share of the support for infrastructure." Instead of promoting collaboration, the current model tends to spawn jealously guarded academic fiefdoms and turf battles – again, because scientists lose sight of the bigger picture, and of what should be their goal. "Our great opportunity today is to confront the epidemic of chronic disease by helping people work together," says Hellmann. "There should be many opportunities for collaboration and synergy between doctors and nurses, doctors and patients, clinical and basic researchers in different disciplines, and among clinicians, scientists, and teachers. Answers to the health problems we face can only be achieved by teamwork."

By definition, the sides of the triangle meet only at one point. Also, the triangle emphasizes the special role of physicians, but doesn't highlight the critical work of nurses, physical therapists, pharmacists, administrators, and other staff. But in a three-dimensional pyramid, no wall stands alone. "Each wall of our mission must be strengthened by the other two, or the structure doesn't work. Because all sides are connected, this means that there are countless opportunities for collaboration."

Finally, the pyramid has a base. In this case, says Hellmann, it's made up of "our whole work force. The pyramid rests on a bedrock foundation of people working together for one greater good – the patient."

Johns Hopkins Bayview is uniquely suited as the birthplace for this new model, Hellmann adds, because of its rich heritage – as Hellmann puts it, its two strands of institutional DNA. "Not only are we the home of many Centers of Excellence, with $100 million in external funding, numerous award-winning teachers, and groundbreaking educational programs such as our Aliki Initiative, but this special place has never lost its beginnings as Baltimore City Hospital, with deep and vibrant community ties." ■

Adding Dimension, Step By Step

Hellmann and others at the CIM are working to change the academic culture at Johns Hopkins Bayview, "one step at a time," through programs including:

- **The Aliki Initiative, an innovative program to change medical education by giving doctors the time and opportunity to get to know their patients as individuals (see Page 10);**
- **The Miller-Coulson Academy for Clinical Excellence, which gives academic medical centers the tools to define, measure, and reward the most gifted, caring physicians (see Page 18);**
- **The creation of scientific and clinical research cores, powerful building blocks that create critical mass and generate scientific momentum (see Page 14).**

Finally, any new blueprint must be carried out by people who actually build the structure, says Hellmann. "Unlike the ancient pyramids, which were set in stone, the Bayview pyramid model will be a living one, where the faculty and staff are constantly seeking ways to raise the pinnacle of patient health higher and higher."

THE ALIKI INITIATIVE

TIME TO CARE

How do you teach caring in a medical whirlwind? Slow down the pace. Give doctors time to know their patients as people, to talk to their families, to call or even visit them at home after they leave the hospital, to find out how they're doing, see how they live, and to make sure they're getting better.

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You're a resident, and here are some of the patients you'll be taking care of today. At first glance, they're an easy bunch to pin labels on: The man in the first bed is a smoker with heart trouble. The guy in the bed next to him is an alcoholic, with a fatty liver. The lady across the hall is a diabetic with circulation problems, who may also be going blind. But these quick descriptions – even when they're accompanied by thick medical charts – tell you much and nothing at the same time. Has the man tried to quit smoking? What's going on the other man's life that makes him keep drinking? Why hasn't the lady been able to control her diabetes? Where do they live? Are there lots of stairs? Can they get around easily? Do they have supportive family, or a friend, or a beagle for company – or are they alone? Are they struggling financially? Do you suspect depression? You see from the chart that they each take a goodly number of pills every day. Do they keep them in a reliable place, or scatter them around the house, or occasionally get them mixed up with their spouse's pills, which sit right next to them on the kitchen table in identical Rite Aid bottles?

Now, you're a patient, and here comes the doctor. Young. Will he be a patronizing know-it-all, lecturing you about your lifestyle choices? Will she check her watch after five minutes? Will he give a hoot about you at all as a human being? Will she write everything down, or will you end up just imitating a bobblehead, nodding like you understand, and trying to figure it out later? Whom will you call if you have questions when you go back home – and by the way, *when* exactly will you get to go back home?

Welcome to the world of inpatient medicine, where thousands of stories are told, and not told, every day. Where there are myriad opportunities, missed and taken, for meaningful connections – or, for signs and words to be lost in translation, as busy doctors do their best to help complicated patients in a very short period of time.

Nobody wants it to be this way; most doctors agree that this is not what they signed up for in medical school, and most patients would gladly volunteer a lot more information, if their doctor only asked the right questions, or if they thought the doctor really wanted to hear the answers.

If only there were more time. Now, thanks to support from a remarkable woman named Aliki Perroti, a philanthropist from Greece, there is. In 2007, the Center for Innovative Medicine launched the Aliki Initiative, a groundbreaking program that offers at once newfangled and old-fashioned medicine, designed for doctors to get to know their patients better. Its features include:

- Fewer patients for each doctor, so the doctor can spend more time with each one.
- Doctor-patient relationships that don't end when the patient is wheeled out of the hospital.
- Knowing the patient as a person, so that evidence-based medicine can be custom-tailored for individual needs.
- Wise use of technology.
- Patient feedback, as patients report how well their doctors did.

The lack of time is a burden on everyone. "It's a problem all across the country." says cardiologist Roy Ziegelstein, M.D., Co-Director of the Aliki Initiative. "Today's limits on duty hours promote more of a shift mentality in residents. There are more handoffs of care, combined with dramatically shorter-than-ever lengths of stay. Patients seem to be in and out of the hospital in a whirlwind, with more things being done to them in half the time. There's far less time for communication, and virtually no link to the rest of the patients' lives, after they leave the hospital."

Unfortunately, says David B. Hellmann, M.D., Aliki Perroti Professor of Medicine, Vice Dean of Johns Hopkins Bayview and Chairman of the Department of Medicine, "as skilled as many doctors and nurses are, even at a world-class medical center such as Bayview, they are overworked – and, as far as dealing with patients as individuals, under-educated. National statistics estimate that about 60 percent of all patients feel their doctors do not know them as individuals. Worse, only 40 percent of patients nationally receive care that is considered to be appropriate, based on scientific evidence. Thanks to the generosity of Mrs. Perroti, we have the opportunity to help change this."

Having her name used publicly is a fairly new phenomenon for Mrs. Aliki Perroti, a philanthropist who is well-known in her native Greece for quietly providing help to those who otherwise wouldn't receive it. Among other things, she has endowed a hospital there to serve the poor, and established an agricultural college for young people in Greece and the Balkan countries. But the hospital is named for her parents, and the agricultural college is named after her late husband. Only twice – both times at Johns Hopkins Bayview – has Mrs. Perroti allowed anything to be named for herself. David B. Hellmann, M.D., is the Aliki Perroti Professor of Medicine. "It is a great honor," he says. "Because of her generosity, I have the luxury of taking care of people with complicated problems regardless of their ability to pay. Even better, I get to do it in her name." And now, because of the Aliki Initiative, Mrs. Perroti's name has become synonymous at Hopkins with the very best kind of medical care, that happens when a doctor takes the time to get to know a patient as a person.

Ziegelstein says that teaching medical students and residents to diagnose a problem in the heart is fairly straightforward – it's all about listening. "But teaching these same young doctors to *have* a heart, however – to care about their patients, to listen to them, not with a stethoscope, but with a sensitive and compassionate ear – is much more subtle and complicated."

A report done in 2001 by the Institute of Medicine, called "Crossing the Quality Chasm," names patient-centered care as one of six core aims for the health care system, Ziegelstein notes. "How do we focus on that aim in the fast-paced world of hospital medicine, and how do we re-design the training of doctors, so they develop the skills and attitudes they need to practice patient-centered care? The Aliki Initiative was designed with this in mind."

Doctors and patients often come from very different backgrounds. This may be the first time some residents really come to appreciate that many people have to think hard about whether or not to fill a prescription.

Residents on the Aliki Service have half of the usual number of admissions. This gives them the time to go the extra mile. They call patients who have left the hospital, to see how things are going. They check in with the patient's primary care doctor or home-health nurse.

Doctors and patients often come from very different backgrounds. This may be the first time some residents really come to appreciate that many people have to think hard about whether or not to fill a prescription. If you're someone whose fixed income is already stretched to cover rent and food, sometimes medicine can seem more like a luxury than a necessity – especially if you feel that maybe you can get along without it, or that you can get by with just taking half the dose prescribed. "There's usually a good reason when a patient doesn't get a prescription filled," says Ziegelstein.

In just two years, the Aliki Initiative has already begun changing the culture of medicine at Hopkins. "What's amazing to me," says Cynthia Rand, Ph.D., and Co-Director of the Aliki Initiative, "is how quickly and extensively the term 'Aliki' has crept into our language as a distinct, meaningful verb or adjective, not just the name of a program." To "Aliki-ize" means to transform or revise. An "Aliki-like" activity puts the emphasis on the doctor-patient relationship, and an "Aliki moment" is a special flash of connection between doctor and patient. The Aliki Initiative even shows up on Google.

Making a Difference

These are early days yet for the Aliki Initiative. It's still a fledgling project that has yet to withstand the test of time. Even so, Ziegelstein, Rand, and others have been working hard to gauge its progress among patients and doctors. They are particularly encouraged by early indications that the Aliki Initiative might benefit some high-risk patients, including people with congestive heart failure. "Heart failure can cause severe shortness of breath and fatigue," explains Ziegelstein, "and it is one of the most common reasons – especially for older people – to

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RESEARCH CORES

UN-IVORY TOWERS

Why is collaboration so important to the Center for Innovative Medicine? The quintessence of the CIM's nature, in fact, is that it is the "un-ivory tower." And of all the aspects of academic medical culture the CIM is working to change, this may be the toughest nut to crack.

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At an academic medical center, many investigators tend to feel very alone, says Antony Rosen, M.D. For the last several years, as the Mary Betty Stevens Professor and the Director of the Division of Rheumatology, Rosen has worked to build bridges between faculty and among disciplines. His efforts at – as he puts it – tearing down brick walls and smoothing potholes have met with such success that he has also been named the Deputy Director of Innovation at Bayview, and he is the Hugh and Renna Cosner Scholar in the Cosner Center for Translational Research. "Translational research, by its nature, exists only through collaboration," he says. "There is no way for an idea that's generated by taking care of a specific patient and condition to move from physician, to scientists in the laboratory, to clinical studies in other patients, and hopefully back to that patient, without people working together."

If a shared idea turns out to be really great, who gets dibs?

And yet, still entrenched is the institutional environment that "requires that *individuals* succeed, rather than groups," Rosen adds. It's almost counter-intuitive – and potentially risky – in many academic circles for young faculty, hoping to move up the promotional ladder, to want to share ideas. This is especially true in today's climate, when tenure is difficult, and faculty must justify their keep by producing publications and winning grants. If a shared idea turns out to be really great, who gets dibs? Who nabs the coveted "first author" position on the paper – an item bean-counted by promotion committees? If technology develops from the idea, who gets the patent? "People tend to keep their ideas to themselves," says Rosen. "They don't share freely enough; instead, they worry that someone may steal something."

As if the establishment of little, protective fiefdoms weren't enough, there is a separate problem: Myopia. "When you're involved in a small area of research, you lose the focus on the patient," says Rosen, "not out of self-centeredness, but out of habit. You get so caught up in your own little piece of the puzzle that you lose sight of the bigger picture." Rosen believes the key to innovation is to identify barriers that "prevent people from doing what is so obviously the right thing to do – to collaborate, and to focus on issues that are most relevant to improving our patients' lives." In his division and elsewhere, he is working with people who "tend to stay within their comfort zones," and helping to smooth the roadblocks to collaboration. Rosen has been able to concentrate on this with the help of private support, from philanthropists Esther Pearlstone and David Lowe, in addition to the Cosner family. "Getting people to work together is a whole lot easier," he says, "if you have the resources to make it happen."

Cores: Collaboration Magnets

Nowhere are the CIM's goals for collaboration more in evidence than in the research cores it has helped to develop. These cores are the polar opposites of academic isolation. If they're done right, research cores are like magnets, attracting people from different disciplines, with different areas of expertise. Working together, they can accomplish something greater than they could otherwise.

The first core established through the CIM has been the highly successful Genomics Core. If the CIM had a playbook for getting things done right, what's happened here would be Chapter One. Because of the CIM, a confluence of events – in a sense, a "perfect storm" – occurred, matching a promising scientist with big dreams, an immunogeneticist named Kathleen Barnes, with a philanthropist, Mrs. Joan Carl. Her late mother, Mary Beryl Patch Turnbull, had been a patient of David Hellmann, M.D., for many years; Mrs. Carl wanted to honor her mother's memory by supporting research in her name.

Barnes was almost at the point of leaving Bayview, because of a tempting job offer from another university. A few of her colleagues, determined to help her stay, asked what appealed to her about the other offer. Barnes – who had limited lab space, not much equipment, and a small-scale research program – told them that it was the chance to build a genetics and genomics program from scratch. Her colleagues, including Rosen, David Hellmann, M.D., and Bruce Bochner, M.D., with support from Mrs. Carl, came up with a plan to help her do that here. They provided the infrastructure, and Barnes came up with a business plan. Then another philanthropist, David Lowe, stepped in with a generous donation. Among other

If they're done right, research cores are like magnets, attracting people from different disciplines, with different areas of expertise

things, Lowe's support has allowed the creation of the Lowe Family Genomics Center. Building on this rich support, Barnes has turned this Center into a campus-wide research powerhouse that has gained nearly $25 million in outside funding.

Genomics is the study of the entire genetic blueprint, the chemical owner's manual that delineates how each of our cells makes specific building blocks. These blocks are strings of chemicals, identified with letters, and they seem endless. The genetic string is so daunting, and impenetrable, that genomics would be impossible without computers. Fortunately, there are landmarks; one is a variation called a "SNP," (pronounced "snip"), and searching for these SNPs is like looking for a single misspelled name in the phone book. Recently, in work funded by the National Institutes of Health, Barnes has completed the first genome-wide study looking for clues to heart-lung diseases in people of African-American and African-Caribbean descent. The gigantic study involved 2,000 volunteers and 650,000 SNPs, and Barnes is now working to decipher the 1.3 billion pieces of data that the study has generated.

But Barnes' own research is just part of what the Genomics Core has to offer. She and her colleagues have been able to help other scientists look for genetic components to many forms of illness, including how the body ages, and why some people tend to become frail, and others don't. The Genomics Core, says Hellmann, has proven to be "one of the great areas that has brought people together at the Center for Innovative Medicine, facilitating the work of many departments, divisions, and disciplines."

The second major core has been the Proteomics Core. It, too, was made possible with the help of a private philanthropist, Dan Amos, who helped fund the lab and some expensive equipment needed by Jenny Van Eyk, Ph.D., the Core's director. Van Eyk – on the faculty in cardiology, biological chemistry, and biomedical engineering – is one of just a few scientists worldwide who are experts on looking at proteins, and translating what their presence in the blood has to say about disease (in fact, she wrote the first textbook on proteomics). She is also director of one of only 10 centers funded by the National Heart, Lung and Blood Institute, the Hopkins NHLBI Proteomics Center.

Van Eyk describes the constantly changing stream of proteins in the blood as a tickertape that tells the story of your body. For example, in someone who has a chronic illness, snapshots of key proteins in the blood vary, depending on whether or not the disease is active or in remission. Certain proteins, made only by the heart, appear in the blood when someone is having a heart attack. Proteins are made by the genes. If DNA is a giant script, Van Eyk says, then proteins are the actors that bring it to life – except the script is always changing, and these tiny actors have many costume changes, and appear in multiple forms.

Among other work, Van Eyk and her colleagues develop biomarkers – identifying one specific protein, or a modified protein, or a group of proteins. Biomarkers can be diagnostic, to help tell if someone has a specific condition, or prognostic, to help predict what may happen in a person who is at risk. They can also help monitor how well a treatment is working, or determine whether a disease is in remission. In a nutshell, proteomics involves taking a sample of proteins in the blood, or in a few cells, and shining a powerful laser at it. The laser hits the proteins, smashes them, throws them onto a screen, and where they land is an indication of their size. Each protein thus makes a one-of-a-kind fingerprint; each disease has different protein fingerprints – moreover, each stage of a disease is slightly different, with its own set of fingerprints.

"What Jenny is doing is great science," says Hellmann. "She brings people together, scientists and physicians in many different disciplines, all to help patients have a better chance of overcoming disease, or even preventing a major episode of illness."

The CIM has also helped make possible cores in cell sorting, imaging, and histology. "All of these are success stories," says Hellmann, "because when investigators from different disciplines work together, and the atmosphere is one of cooperation rather than competition, the spirit of collaboration actually facilitates the work, and everybody wins." ■


Rx

MILLER-COULSON ACADEMY

MASTER CLINICIANS

What if you could write your own prescription for a great doctor? What qualities would you look for? Someone who cares would be nice; someone who's discerning and wise, with a good bedside manner. Someone good at explaining, who takes a few minutes to listen. Marcus Welby. Is that too much to ask?

CONTINUED FROM PAGE 19

Having a great doctor is not too much to ask – especially in academic medicine, and especially at the Center for Innovative Medicine, where we believe medicine is a public trust. "The patient is our foremost responsibility," says David B. Hellmann, M.D., the Aliki Perroti Professor of Medicine. "As stewards of the patient's welfare, we care very much about turning out caring, astute physicians, and properly appreciating the excellent clinicians we already have." After all, this is the issue, raised to Hellmann by a patient, Mrs. Anne Miller, that sparked the existence of the CIM in the first place. And this is the mission, driven by CIM physicians, with major support from Mrs. Miller's daughter and son-in-law, Sarah and Frank Coulson, that has brought about the Miller-Coulson Academy of Clinical Excellence. Launched in 2008, the Academy is already making a difference at Johns Hopkins Bayview – great news for all of us who hope an outstanding doctor will come walking through that exam room door.

As stewards of the patient's welfare, we care very much about turning out caring, astute physicians, and properly appreciating the excellent clinicians we already have.

"Mrs. Miller was concerned that, despite their success in scientific discovery, academic medical centers weren't producing skilled, thoughtful clinicians," particularly of the caliber of her longtime physician, Philip Tumulty, says Hellmann. "This is a universal problem in academic medicine. Even though theoretically, academic medical centers have three parts to their mission – teaching, research, and patient care – and they're all supposed to be equal, only one side ever gets rewarded, with grants and academic promotion: research." (For more on fixing the structure of academic medicine, see Page 6.)

The Miller-Coulson academy combats this "lopsided triangle," Hellmann adds. The initiative began with four Miller-Coulson Scholars – Scott Wright, M.D., Samuel C. Durso, M.D., Colleen Christmas, M.D., and Steven Kravet, M.D. – who applied painstaking science to the subject of clinical excellence. Their first job was to define something whose interpretation tends to be slippery – like great art, most people "know it when they see it" (see side story on Page 24). "It was critical that we were able to build the Miller-Coulson Academy of Clinical Excellence upon a foundation of empiric research and scholarship, rather than assumptions or conjecture," says Wright, who is now the Academy's director. This initial job, of quantifying and laying out the qualities that make an excellent clinician, and then coming up with a reward system, "had never been done before," says Wright. And yet it should have been, adds Kravet. "Most doctors can look back and remember excellent clinicians who inspired us. And all of us can name excellent clinicians who left the hospital, not feeling rewarded for their work."

Next, the Scholars developed the "clinical portfolio," a specific tool designed to measure an academic clinician's performance and contributions. They also established an external review board, made up of top clinicians nationwide, to provide outside validation of a clinician's portfolio. "Rewarding clinical excellence is simply the right thing to do," says Wright. "Academic medical centers risk losing the best clinicians if they are not recognized for their work. If these clinicians are not recognized, academic medical centers will not be able to attract new great clinicians. Then, without these exceptional role models and teachers, the next generation of physicians will not be trained in clinical skills to the same standard."

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On the Academy's Blog, members share their thoughts related to clinical excellence. Here are excerpts from a recent post by Michael Fingerhood, M.D.

It was Monday morning and I was taking over the care of a patient for a colleague who had left on vacation. The patient had been admitted five days ago with a fever and bilateral leg pain preventing her from walking. Her past history was, of course, much too complicated for someone only 44 years old, with a history of lupus, hemodialysis after failed kidney transplant and steroid myopathy. As I usually do when taking over clinical responsibility for a patient, I read all the progress notes since admission and reviewed the orders and medications. I noticed that orders for a variety of tumor markers had been entered. As I was thinking about this, I received a page from the intern caring for the patient. We then conversed and he related that the patient had lost ten pounds since admission and he was worried about cancer. I let him know that I was about to go see the patient and I would find him afterwards so we could go see her together.

I walked in the room to meet her for the first time. She looked rather uncomfortable lying in bed. Her phone, sitting out of reach on the windowsill, was ringing. She appeared frustrated and upset, obviously too weak to walk the few steps to the windowsill to answer the phone. I grabbed the phone and handed it to her without even taking the time to introduce myself. She spoke a few words into the phone, hung up and then looked up at me crying.

I introduced myself and then asked her if she had received bad news. She stated, "No, I'm upset over what is happening here." She wanted to know why after five days, she felt no better and still could not walk. She had told her eleven-year-old son not to visit because she did not want him to see her so sick and unable to walk. She then admitted that she was even ashamed that she could not get the phone lying on the windowsill. When I asked her why it was there, she stated, "Whenever I go for a test or go to dialysis, when I am helped back into bed, that's where it winds up. I ask for it to be placed on my bedside table and the person forgets and then when I use the intercom to ask for it to be moved, I am told the staff are busy and will eventually come, when they have the time, but they never do."

I apologized to her for this and let her know I would speak with the nursing staff. We then discussed her hospital course in more detail and this led to a discussion of her weight loss. She emphatically stated her appetite was absolutely fine and in fact she was hungry at the moment. "How could I not lose weight, when I am only given one or at most two meals a day," she explained. "Whenever I go for a test or to dialysis, which is every day, I miss breakfast or lunch or both. I am told the tray will be held for me, but it's never there and then I just get upset and let it be."

She proceeded to cry, overwhelmed, scared and somewhat hopeless. We wound up talking for over an hour. I learned about a twin brother who had recently died and her parents' bitter divorce, but most of all I learned of her fears related to loss of dependence, frustration over her reliance on others and her difficulty coping with her frailty (especially how it impacted on her being a mom to her son). As she talked, I realized how we had failed her. We had contributed to her demoralization and we had caused her to lose weight. ... After leaving her room, I spoke with the nurse manager for the floor, who assured me that the problems would be corrected and she would not miss any further meals.

As she talked, I realized how we had failed her. We had contributed to her demoralization and we had caused her to lose weight.

Walking back to my office, I realized how powerful our conversation had been. I had discussed with the intern my conversation with the patient and urged him to sit down with her and get to know her as a person, rather than as someone with a fever who had lost weight. … The next day, the patient was in a better mood. She smiled when I entered the room. She had not missed a meal, and the intern had sat and talked with her for quite a while. Our conversation made my day. I have always been unsure as to whether you can teach empathy, but on this day it was apparent that perhaps you can at least encourage it.

The Miller Lectures

The goal is to inspire. To make the audience – mainly physicians, nurses, doctors in training, and scientists, but some laypeople, too – think about academic medicine – what it is, what it should be, and how to make it better.

For six years, thanks to the generosity of the Miller family – Thomas and Anne Miller and their daughters and sons-in-law, Sarah Miller Coulson and Frank L. Coulson, Leslie Anne Miller and Richard Brown Worley – the Johns Hopkins community has gathered for a much-anticipated event. We have shared the cutting-edge ideas and unique perspectives of the Miller lecturers – doctors, authors, historians, even a poet. You may have heard of "policy wonks." At the CIM, we are "idea wonks," always looking for creative solutions and exploring novel ways to make medicine better, to make medicine and science work better together, and to make sure that the patient benefits from our very best efforts. "We owe so much to the Miller family," says David B. Hellmann, M.D., the Aliki Perroti Professor of Medicine. "From the beginning, even before there was a Center for Innovative Medicine, they have been committed to the cause of putting patients first."

Here's a brief look at the Miller Lecturers we have enjoyed so much:

Steven McPhee, M.D., who was a medical student, resident, and fellow at Johns Hopkins, is a pioneer in the field of end-of-life care, palliative treatment and pain management. Professor of medicine at the University of California-San Francisco, McPhee was our first and third Miller Lecturer. "He is the editor of a series on end-of-life care for the *Journal of the American Medical Association*," says Hellmann. "Largely as a result of his stirring Miller Lectures, we created an end-of-life care unit here at Johns Hopkins Bayview." McPhee, who received the Lifetime Achievement in Mentoring Award from UCSF, cited one of his own mentors, Philip Tumulty, who remains beloved at Hopkins – and especially here at the CIM – for his excellence as a teacher and clinician. Tumulty, recalled McPhee, "taught me about the art of medicine. He taught me about listening to the patient's story, letting the patient tell her whole story, hearing the story that is in the other. Phil taught me about patients struggling with difficult-to-diagnose, and even-more-difficult-to-treat multi-system illnesses, about 'managing' patients who could not be cured. He taught me about the importance of the physician's presence. And he taught me, by his example and advice, about the relevance of one's own spiritual life to this work. One day, he offered me one of the best pieces of advice I've ever received – to spend some time each day in complete silence."

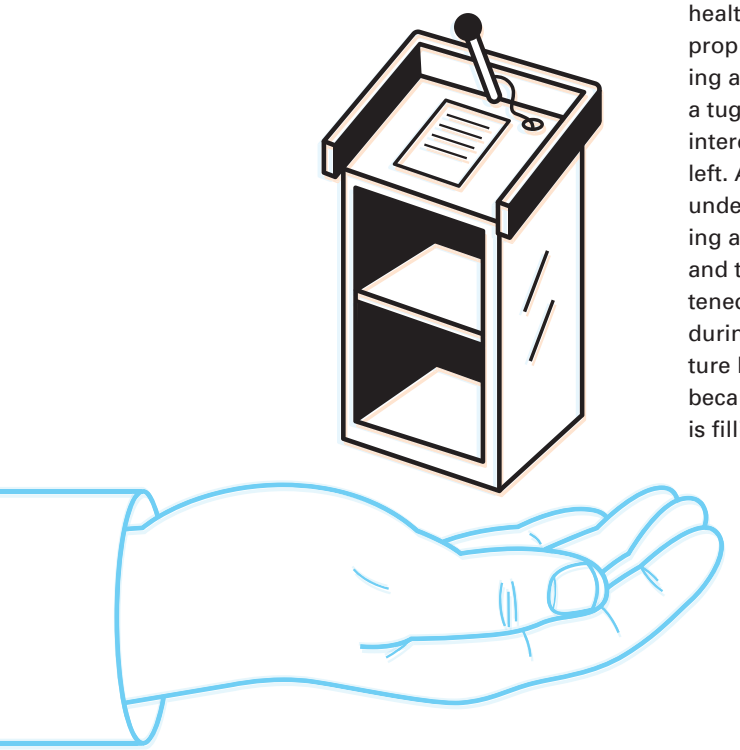
The second Miller Lecturer was the late John H. Stone, M.D., professor of medicine at Emory University, a cardiologist, and a noted essayist and poet, who created one of the first medical school courses combining literature and medicine. A colleague remembering him after his death from cancer in 2008 wrote, "he focused his entire career, in medicine and as an author, on matters of the heart." Much of Stone's writing focused on the doctor-patient relationship.

David Bottoms, Georgia's poet laureate, once said that exposure to the poems of John Stone "is like getting a house call from an eminent physician of the spirit." Another colleague, Sylvia Wroebel, writing about his death, said "John's poems most often sang of life, of catching a bass with his then-young son, of a lusty interpretation of Mona Lisa's smile. But as a physician, he also often wrote of patient encounters, of literal as well as metaphorical pains of the heart, and of loss. A line from one of his poems, in which death sometimes comes as 'slowly as rust' and sometimes as unexpectedly as 'finding the doorknob come loose in his hand,' could have described his own sudden illness and his death. He would have liked that he caught the essence, and we all wish he were still here to share it with us."

Our fourth Miller Lecturer was William R. Brody, M.D., Ph.D., then President of The Johns Hopkins University. "It is fitting that Dr. Brody gave this lecture,

"We owe so much to the Miller family, From the beginning, even before there was a Center for Innovative Medicine, they have been committed to the cause of putting patients first."

because we often refer to him as the 'father' of the Center for Innovative Medicine," says Hellmann. Brody, widely known as a successful leader, is one of the best at making collaboration possible, bringing disparate groups together for a greater good. When Brody stepped down in 2008 as President, Michael R. Bloomberg, the New York City mayor who was chair of the board of trustees for nearly six of Brody's 12 years, said: "Bill Brody hasn't just been the greatest president that Johns Hopkins has ever had; I think that he has been the greatest president that any university has ever had. I've worked with a lot of schools in New York City and around the world, and I would be hard-pressed to find anybody who has had a greater impact and made more improvements than Bill has at Hopkins."



Our fifth Miller Lecturer was Holly J. Humphrey, M.D., Dean for Medical Education at the University of Chicago, and a nationally renowned leader in internal medicine. "She is remarkable because she managed to accomplish the unthinkable," says Hellmann. "She persuaded the University of Chicago's medical school to reduce class size from 112 to 88. This was a bold move – particularly coming, as it did, when the American Association of Medical Colleges had just asked each medical school to increase class size by 30 percent. Instead, Humphrey believes, as we do here at Johns Hopkins Bayview, that to become excellent physicians, medical students need two things very much: Extra time, and extraordinary teaching and supervision."

Most recently, our Sixth Annual Miller Lecturer was David Wessel, the Economics Editor of the *Wall Street Journal*, who twice has shared the Pulitzer Prize for his writing. His most recent book, *In Fed We Trust*, is an account of the internal decision-making at the Federal Reserve and Treasury through the course of the financial crisis. Recently, he wrote: "The current health-care debate focuses, for good reason, on the unsustainable pace at which costs are rising, the reasons the U.S. gets less for each health-care dollar than other countries, and the appropriate role for government in financing, overseeing and providing health care. That is when it isn't a tug of war between competing health-business interests or ugly name-calling between right and left. Amid all this, it is easy to lose sight of one big, underlying issue: the enormous value of broadening access to quality health care, both to individuals and the entire society." Says Hellmann: "As I listened to his astute analysis of medical care reform during his Miller Lecture, it struck me that this lecture has become a major event at Johns Hopkins, because we are hungry for such messages. The CIM is filling a powerful need." ■

CONTINUED FROM PAGE 20

The scholars identified potential Academy members, through a survey of faculty members and residents, and elected their first six, who were inducted during a special symposium in May. They are: Nisha Chandra-Strobos, M.D., Michael Fingerhood, M.D., William Greenough III, M.D., Jonathan Sevransky, M.D., Leah Wolfe, M.D., and Roy Ziegelstein, M.D. The Academy members not only practice clinical excellence, they share their thoughts about good medicine on a newly established blog. You can read their reflections at: http://clinical-excellence.blogspot.com. (A recent post from Fingerhood, an expert on treating people with chemical dependency, appears on Page 21.)

Academic medical centers risk losing the best clinicians if they are not recognized for their work. If these clinicians are not recognized, academic medical centers will not be able to attract new great clinicians. Then, without these exceptional role models and teachers, the next generation of physicians will not be trained in clinical skills to the same standard.

Over the last few months, the Academy has expanded beyond the Department of Medicine at Johns Hopkins Bayview, to include all clinical departments. It will be holding its second annual Excellence in Patient Care Symposium in May 2010, and also is conducting Medical Grand Rounds three times this year. Wright and the Academy members, with the help of the Academy's manager, Katie Burkhart, are developing a curriculum to help all faculty move along the spectrum from clinical competence toward clinical excellence. They also are planning further empiric research projects to learn more about clinical excellence in academic medicine. "It's an exciting time to be a clinician at Johns Hopkins Bayview," says Wright. ■

What is Clinical Excellence?

You know it when you see it, and you know it's missing when you don't see it. Clinical excellence is an ideal; everybody's got a personal definition of what makes a great doctor. The first task at the Miller-Coulson Academy was coming up with an actual, concrete definition for this concept – not unlike the dilemma, expressed by Rogers and Hammerstein in The Sound of Music: "How do you catch a cloud and pin it down?" Well, the Academy has done it, and published the findings in an article in the September 2008 issue of Mayo Clinic Proceedings. The clinically excellent physician, the article notes, exhibits and imparts a passion for patient care, and a level of mastery in these areas relating to patient care:

- **Communication and interpersonal skills;**
- **Professionalism and humanism;**
- **Diagnostic acumen;**
- **Skillful negotiation of the health care system;**
- **Knowledge; and**
- **A scholarly approach to a clinical practice.**

CONTINUED FROM PAGE 13

need to go to the hospital. Unfortunately, many of these people have trouble maintaining the treatment plan when they get home." One big problem is simply that it's hard for many people to obey the laundry list of instructions they get sent home with; these include following a regimen of medications (and knowing which other medications, even over-the-counter painkillers, they are supposed to avoid); keeping to a low-salt diet and limiting fluids; and weighing themselves every day. It makes sense, then, that when doctors spend more time with patients – making sure they understand what they need to do when they get home, and why it's important – and they check on them, and help with any unforeseen problems that may have cropped up, these people are likely to do better.

The number of students requesting to participate in the Aliki Initiative is far greater than the number of positions available.

Preliminary reports also suggest that Aliki patients believe their physicians are more concerned, friendlier, and skilled. They also believe their physicians spend more time with them, and answer their questions better. In turn, interns and residents have reported that they feel the Aliki Initiative was a professionally valuable experience, and that it has made an important difference in their medical training. Even future doctors in training – medical students – want to be part of the Aliki team. "The number of students requesting to participate in the Aliki Initiative is far greater than the number of positions available," says Rand. Teaching faculty say they love being on the Aliki service, because it gives them extra time to share what they know about the practice of medicine. One physician commented: "The Aliki service provided me the opportunity to give every single patient 100-percent effort, 100 percent of the time. I relished the teaching on Aliki." ■

Note: The Aliki Team, residents, and faculty have developed new tools to help residents ask the right questions, to help them teach their patients, and also to help patients feel closer to their doctors. We'll be taking a closer look at these teaching tools in the next issue of Breakthrough.

Now Part of U.S. History

These comments on the Aliki Initiative were recently added to the* Congressional Record *by Maryland Congressman John Sarbanes:

As Congress works to extend health insurance coverage and improve the quality of care for all Americans, I would like to commend the Johns Hopkins Center for Innovative Medicine and their Aliki Initiative, an effort to restructure medical education with an emphasis on patient-centered care, for creating an innovative program that puts patients first. The Center for Innovative Medicine, launched five years ago by Dr. David Hellmann and Mr. Richard Paisner, has three goals: getting doctors to know their patients as people, members of families and communities; encouraging collaboration among all members of the Johns Hopkins Bayview campus; and creating a culture where everyone on the Bayview campus feels like a part of something special.

The Center's Aliki Initiative focuses on the first goal and has been called the most important innovation in graduate medical education in a generation by the renowned historian Dr. Kenneth Ludmerer. As described in *Pharos*, the journal of Alpha Omega Alpha, the honor society of medical schools, the Aliki Initiative seeks to train young doctors to get to know their patients as people. Through the generosity of Mrs. Aliki Perroti, internal medicine residents care for patients hospitalized at Johns Hopkins Bayview Medical Center under the direction of Dr. Roy Ziegelstein and Dr. Cynthia Rand. This initiative emphasizes that optimal medical care can only be delivered if medical treatments are tailored to the individual patient, and this can only be done if doctors get to know patients better as people, which sometimes involves visiting them at home after hospital discharge. Dr. Charles B. Green, Surgeon General of the Air Force, circulated the *Pharos* article to all Air Force Medical Service personnel and said, "It [the article] emphasizes the necessity for all of us to understand that health care must be patient-centric. We must know our patients and ensure schedules provide time for care teams to spend with patients. We must focus on the patients to help them achieve new levels of health."

Madame Speaker, I commend the hardworking people at Johns Hopkins Bayview Medical Center, the Center for Innovative Medicine and the Center's Aliki Initiative. Their work should be seen as a model for improving the quality of care for all Americans. I'd like to enter the full text of the *Pharos* article into the record.

Medicine is a public trust

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"As Congress works to extend health insurance coverage and improve the quality of care for all Americans, I would like to commend the hard-working people at Johns Hopkins Bayview Medical Center, the Johns Hopkins Center for Innovative Medicine and their Aliki Initiative, an effort to restructure medical education with an emphasis on patient-centered care, for creating an innovative program that puts patients first. Their work should be seen as a model for improving the quality of care for all Americans."

Congressman. John Sarbanes. *Congressional Record*, October 14, 2009

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