

breakthrough

NUMBER 11 • SUMMER 2012

Special Issue: Putting the Patient First

Behavior: The Elephant in the Room

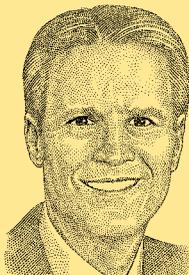
Ask the Patient

Building Healthy Communities

Medicine is a public trust

THE JOHNS HOPKINS CENTER
FOR INNOVATIVE MEDICINE

breakthrough



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PUTTING THE PATIENT FIRST

Our motto here at the Center for Innovative Medicine is, “Medicine is a Public Trust.” How can we take better care of our patients? How can we do a better job of putting the patient first? Well, sometimes the best thing we can do for our patients is to keep them away from the hospital. Jonathan Zenilman (see Page 16) has started a new “house call” program for people who have left the hospital but who are still on IV antibiotics in a nursing home. And Bruce Leff has spent the last two decades creating a “Hospital at Home” program, now implemented in hospitals in several states, for elderly people who are, quite simply, too sick to do well in the hospital (see Page 14).

We also have a new center that addresses the “elephant in the room” for so many people with health problems – issues of behavior that are hurting them. Unhealthy behaviors contribute to so many illnesses that if we don’t address them, we aren’t truly serving our patients (see Page 4).

We have talked about Precision Medicine before, and this new initiative is continuing to grow. The bottom line is that although many people share a diagnosis, everyone’s illness is unique. Is the therapy actually working to fix the things that are bothering the patient? In a pilot study, Clifton Bingham is testing a simple idea (see Page 8): Ask the patient!

I am also very excited to tell you about the Healthy Community Partnership, which takes us outside the hospital and into houses of worship, where Dan Hale, Rick Bennett, and our residents are working with lay leaders to empower their congregations on matters of health (see Page 11). In that story, you’ll see that our residents care deeply about their community, are motivated to educate, and want to give back. We nurture these special qualities with our Aliki Initiative, made possible through the generosity of Mrs. Aliki Perroti, which allows our residents to take care of fewer patients, and spend more time getting to know their patients as people. In a recent issue of the *Journal of General Internal Medicine*, Neda Ratanawongsa and other Aliki faculty reported that this patient-centered curriculum was more satisfactory for residents as well as for their patients. An editorial from doctors at the Northwestern University Feinberg School of Medicine accompanied that article and concluded: “We may find that the ultimate question is not whether we can afford to give every resident focused time to acquire and practice the fundamentals of patient-centered care, but can we afford not to?”

This brings me to another blessing that we are so grateful for, the philanthropy of people who care about helping patients and making medical care better. The Miller and Coulson families (see Page 18) have made possible many wonderful initiatives here, including the Miller Lecture, the Miller-Coulson Academy of Clinical Excellence, and the Frank L. Coulson Jr. Award for Clinical Excellence. Philanthropy has made possible some of our core centers, such as the Courtney Amos Research Fund and the Daniel P. Amos Family Proteomics Center, and our world-class Genomics Center, which exists because of the Lowe Family – partners who share our stewardship of the Public Trust.

Best wishes,

David B. Hellmann, M.D.

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Behavior: The Elephant in the Room

Behavior is how you live your life. It includes a lot more, and has a much greater impact on our health, than most of us realize.

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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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BREAKTHROUGH is published by The Johns Hopkins Medical Institutions, Baltimore, MD 21287-2101.

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Design: Skelton Design

on the web

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

Behavior: The Elephant in the Room



Medically speaking, behavior is the things we do, or don't do; it's what and how much we eat (or don't eat) and drink. It's the countless little choices we make over the years: Such as, "Another beer? Sure!" or "I'm going to go for a walk around the block," or even, "Oops! I forgot to take my blood pressure medicine again." Behavior is how you live your life. And actually, says Michael Smith, Ph.D., director of the new Johns Hopkins Center for Behavior and Health, behavior includes a lot more – and has a much greater impact on our health – than most of us realize.

“Unhealthy behaviors account for as much as 60 percent of all medical care costs in the United States,” says David Hellmann, M.D., Vice Dean of Johns Hopkins Bayview Medical Center and Chairman of the Department of Medicine, whose efforts were instrumental in getting the new Center started. “Even if someday the human genome project can perfectly predict all diseases, it won’t matter if we cannot also get patients to adopt healthy behaviors. The promise of medicine depends on improving behavior.”

In the disease world, there’s a cast of bad behavior thugs, whose mug shots might as well be on “Most Wanted” posters in doctors’ offices. A few of the worst offenders:

- **Poor diet, inactivity, and lack of exercise:** “Being a couch potato paves the way to obesity and may contribute to frailty,” says Hellmann. Obesity itself is a condition that keeps bad company; it opens the door to high blood pressure, heart disease, cholesterol problems, stroke, diabetes, and circulation problems, elevates the risk of some cancers, and even causes knee and back problems.
- **Cigarette smoking:** Not only increases the risk of lung cancer and chronic obstructive pulmonary disease, but of other cancers and heart disease, as well.
- **Drug addiction:** In addition to other health problems, drugs that are injected carry the risk of hepatitis C, HIV, and other blood-borne illnesses.
- **Alcohol addiction:** Too much alcohol poisons the body, and liver problems, including cirrhosis, come from the body’s inability to process it. Even excess use, not at the addiction level, contributes to obesity.

Then, there are some behavioral issues that might not seem nearly as harmful as the ones just mentioned, like “medicine adherence.” Why is this

important? It can be crucial in keeping someone with, say, congestive heart failure, from needing to be readmitted to the hospital.

And then there’s sleep. Sleep? Really? Just ask Frank, age 47. He’s a lousy sleeper. On a good night, he may get five hours. His doctor doesn’t know about Frank’s sleep troubles. It would be nice if he did, because Frank’s glucose level is a bit high. Lack of sleep is known to cause the body to release hormones that increase insulin resistance and glucose intolerance – and often, simply getting at least seven hours of sleep a night is enough to turn this around. Or ask Jenny, age 34, who gets even less sleep than Frank. Although her mother has begged her to get some help, Jenny has refused, because she doesn’t want to become addicted to sleeping pills. Like an estimated 80 percent of people who suffer from insomnia, Jenny has never mentioned the problem to her doctor. She doesn’t know that cognitive behavioral therapy – which does not involve a single pill – could transform her life.

“There are these really intimate connections between very basic behaviors such as eating, sleeping, daily physical activity, and health. We are just scratching the surface.”

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SILENCE IS NOT GOLDEN

With many conditions involving behavior, the silence in the doctor's examining room is often deafening. Important conversations are not taking place. Smith, who also is Director of Behavioral Sleep Medicine, has seen this happen for years. This is why one of the first goals he has set for the new Center for Behavior and Health is to get conversations started – between doctors and patients, and also between doctors and the Center's experts in behavior, who could make a major difference in the course of a patient's illness. "We want to start the conversation within Hopkins Medicine about behavior so that it can become part of routine health care at Hopkins, and that we can be a model for other places."

Hellmann, a rheumatologist, has seen the high price of this kind of silence. "I trained at the University of California-San Francisco" when the AIDS epidemic broke out," he says. "San Francisco was 'Ground Zero' for AIDS. No one knew the cause initially," and patients were sent to the Rheumatology Division. "We had no treatments, and patients died quickly; their first admission was often their last. Academics wanted to focus on cure and vaccine," he adds, "but no one wanted to focus on behavior – the one thing that we knew early on would make a difference. So many people died. I attended so many funerals and felt so badly that the profession and the country did not respond better. I swore that if I ever got to the other side and could marshal resources, I would do something to help improve the promotion of healthy behaviors."

Smith knows well that changing behavior is easier said than done. But he also knows that it is not as hard as many people expect. "Often, physicians as well as patients see these changes as insurmountable," he says. "Yet a vast body of research in the science of changing behavior suggests otherwise."

"We had no treatments, and patients died quickly; their first admission was often their last. Academics wanted to focus on cure and vaccine but no one wanted to focus on behavior – the one thing that we knew early on would make a difference."

"JUST SCRATCHING THE SURFACE"

The Center is an interdisciplinary endeavor involving experts from the Departments of Medicine, Pediatrics, and Psychiatry and Behavioral Sciences. "With an issue as complicated and subtle as behavior, collaboration is essential," says Hellmann, who has emphasized communication and teamwork in his Pyramid model for academic medicine. One of the goals of the Center for Innovative Medicine, which he directs, is to tear down the "silos" that compartmentalize specialists and often hinder progress.

Each month, the Center for Behavior and Health brings in visiting scholars to deliver a lecture, talk to faculty and staff, and consult on several pilot projects. Says Smith: "Phase One is really just getting people in different areas of medicine talking. We all have a different language, so we need to find a way to get people all on the same page. What do we mean by health-related behavior, and how do we change it systematically – how do we bring the science of behavior change to the practice of medicine?"

The level of help that people need to deal with behavior issues varies, Smith adds. While some people may need to see a psychologist or a psychiatrist, others may do better with some practical, nuts-and-bolts help from a nurse. Others may be helped by timely encouragement from their physicians. And before any of this can happen, the behavioral problem needs to come to light in the first place.

“Although smoking is now routinely asked about by cardiologists and many primary care physicians, many other behaviors aren’t,” Smith says. “Their doctors really should be asking about these things; patients actually want to talk about it. A lot of doctors never talk to their patients about obesity, for example, but in surveys, patients say that they would like for their doctor to talk to them about it. But doctors often don’t know how to bring it up; they don’t have a language. So that’s what we’re trying to do, get them some help with that very basic problem -- the elephant in the room that has been largely neglected, but that can dramatically impact health and health care.”

Changing behavior is easier said than done. But it’s also not as hard as many people expect.

Smith and colleagues hope that technology can be of help here. They are working with Information Technology experts to develop ways – a patient’s own health website, perhaps, or a specially designed, confidential app that a patient and physician could both use – for patients to identify any particular problems they’d like to talk with their doctor about at the next appointment. “Keeping in mind that physicians are already inundated with information,” Smith says, “we would need to keep

this process simple, perhaps red-flagging a problem that needs attention.”

Behavioral experts know that tracking and monitoring a problem is essential to long-term change. The details are still being worked out, but Smith’s idea is to have something that would not be disruptive for patients to use consistently – Wi-Fi-enabled scales, for instance, for people tracking weight loss; or the ability to input data by text message. “It must be something that patients can do easily, and that they want to do because it will improve their health.”

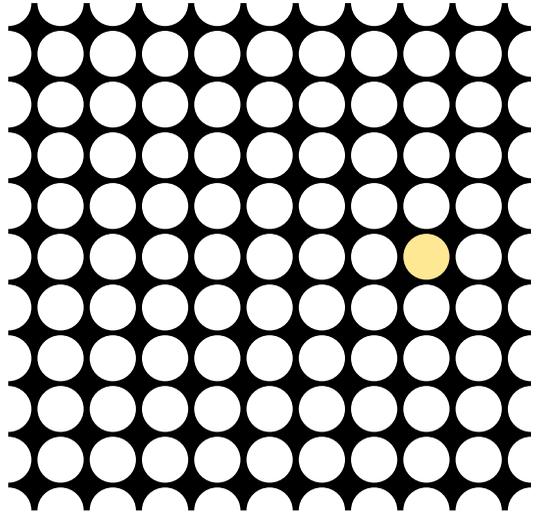
In the long run, changing behavior is going to save money “as patients address the problems that are complicating their medical treatment,” Smith notes. At a recent lecture, one of the Center’s guest speakers, Edward McAuley, Ph.D., from the University of Illinois-Urbana and Champaign, discussed groundbreaking research on physical activity and the risk of dementia. Just walking a few hours a week, he discovered, can prevent shrinking of the hippocampus, the brain’s center responsible for memory, which is affected in dementia.

“There are these really intimate connections between very basic behaviors such as eating, sleeping, daily physical activity, and health,” says Smith. “We are just scratching the surface.” ■

Ask the Patient

This is a story about tailoring treatment to patients' individual needs. But for a minute, let's think about shopping instead. Wouldn't it be nice if you walked into, say, Macy's, and your personal shopper came up to you and said, "I saw some suits that look like the cut and material you like, and I've put the ones in your size in the dressing room along with some accessories that would also work well with the rest of your wardrobe." This salesperson has a finely honed idea of who you are, and isn't just shopping for someone *like* you – your general weight, age, and build – but for you alone.

Now, imagine that you have a chronic disease, like rheumatoid arthritis. A bunch of other people in the world have it, and many of them take the same medications that you do. But their disease is not exactly the same as yours. How could it be? Maybe they are more physically active, maybe less. Maybe they have more pain or fatigue, maybe less. Maybe you and someone else have the exact same swollen joint, but yours isn't bothering you. Should you be treated the same way?



A bunch of other people in the world have the same disease that you do. But their disease is not exactly the same as yours. How could it be?

Most diseases are complicated, with infinite variations and a broad spectrum of severity and response to treatment. If the diseases themselves aren't cookie-cutter, then how can the treatment be?

A new initiative at Johns Hopkins, called "Precision Medicine," is investigating ways to answer this question. "Precision medicine is all about putting the patient first," says Antony Rosen, M.D., Chief of the Division of Rheumatology, who is leading this initiative. "It has the potential to make a profound change in how we monitor and treat chronic diseases." Rosen, whose varied academic titles include being the Hugh and Renna Cosner Scholar in the Cosner Center for Translational Research and the Mary Betty Stevens Professor of Medicine, believes that moving to precision medicine is something in which Hopkins and other academic medical centers must lead the way. But to do so, he adds, means that we need to develop new tools – for measuring not only how patients are responding to treatment,

Neuroradiologist Martin Pomper is used to crossing bridges. An M.D. and Ph.D., he heads a research group that includes chemists, physicists, molecular biologists and clinicians. A professor in the Departments of Radiology, Pharmacology and Molecular Sciences, Oncology, Radiation Oncology, Psychiatry, and Environmental Health Sciences in the School of Public Health, he also directs and co-directs several centers, including one for “Cancer Nanotechnology Excellence” and the soon-to-open Center for Translational Molecular Imaging (CTMI). “Translation” is something he does every day – in working with scientists and clinicians who have their own disparate sets of jargon, and in using technology that didn’t exist a decade ago to study very small aspects of big diseases.

Molecular imaging, he believes, is an essential part of Precision Medicine. “It’s the next phase of imaging,” he says. Current imaging – X-rays, CT scans, MRI – “they’re really just photographs, snapshots in time, and that’s about 95 percent of what we do now. But what we can do with molecular imaging is actually look at the biology or physiology of what’s going on in cells and tissues in real time. We can look at things like gene expression, receptor concentrations, and mitochondrial activity.” Currently, this is mostly done in preclinical animal studies, and is not yet widely available to patients. But it should be, he adds: In cancer, “patients have tumors with different sets of characteristics. With molecular imaging techniques that are very sensitive and specific, we can pick the right patients for a particular form of therapy.” For instance, if one drug targets a certain kind of cancer cell and someone’s particular tumor does not have that target, molecular imaging tests could spare that person from undergoing grueling chemotherapy that is not going to work.

“The CTMI was developed because it’s not easy to take imaging agents from the laboratory into the clinic,” says Pomper. “We’re really geared toward taking things that have succeeded in preclinical models – discoveries at Johns Hopkins and with our collaborators from elsewhere – and moving them to the patient’s bedside.” With imaging agents, he notes, there are not only numerous government regulations that must be navigated to make sure a product is safe and effective; the product must be synthesized in a dedicated manufacturing facility according to very specific quality-control protocols.

And, after all the strict standards, what is the reward? Why is a revolution needed in imaging? Take prostate cancer: Current imaging, along with blood tests, biopsy results and other tests, can help doctors determine the stage of a man’s disease. But “now we can inject a specifically targeted molecular imaging agent into the patient, and it will light up the tumor wherever it is, and that way we can determine the extent of the disease and even begin to know a bit about its biology, or predict how it may behave in the future.” Molecular imaging can be applied to understand a wide variety of diseases. It can show the activity of drugs or the state of damage in neurological diseases such as Alzheimer’s; in rheumatological disorders; heart disease, and other ailments. It can also enable measurement of degrees of inflammation and infection at the molecular level.

“The potential is unbelievable,” says Pomper, “to use this technology for more informed clinical decision-making and ultimately, a better outcome for patients.”

but their quality of life – and an infrastructure to administer new tests and make sense of the results. “How do your patients feel that they are doing? And how do you incorporate that into your therapy? Is your therapy actually working to fix the things that are bothering the patient?”

This is why the work that rheumatologist Clifton Bingham, M.D., Director of the Johns Hopkins Arthritis Center, is just beginning has the potential to be so important. With a grant from the new, government-funded Patient-Centered Outcomes Research Institute (PCORI, pronounced “picori”) and support from Sibley Memorial Hospital, Bingham is developing an interactive way of incorporating the

perspectives of patients with rheumatoid arthritis into their clinical care. “With a disease such as rheumatoid arthritis, the traditional way of evaluating how well a patient is responding to treatment has been done at a group level,” he explains, with lab tests quantifying certain inflammatory markers in the blood and other signposts, such as the number of swollen and tender joints. “But those may not really indicate how well or poorly the individual patient is doing. We have to start looking at the patient as the center of the disease. And to understand how a patient experiences the disease, we have to evaluate patient-centered outcomes.”

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What does this mean? Well, a doctor might see a drop in a patient's level of an inflammation marker in the blood after a certain treatment, and think, "Aha, an improvement!" But if that medical intervention – a new drug, maybe, or a different dosage – makes no difference in how the patient feels, then "while it's interesting what that biomarker may be telling you about the mechanism of the illness, if it doesn't make a difference in the patient's quality of life and ability to function, it doesn't really help us determine whether something is effective or not."

Traditionally, in treating people with rheumatoid arthritis, doctors have focused on pain and physical function; recently, they have looked at fatigue, as well. Bingham is developing an intricate questionnaire, to be administered on an iPad to patients in the waiting room, that will evaluate many more

"We have to start looking at the patient as the center of the disease. And to understand how a patient experiences the disease, we have to evaluate patient-centered outcomes."

aspects of the disease and create "a spectrum from very bad to very good in multiple domains of quality of life," he says. "Not just how much pain someone is having, which is what we ask now, but how does pain affect your activities? What does pain make you do differently than you would otherwise do?" The detailed questionnaire – which varies with each patient, according to how someone responds to specific questions – asks about things like fatigue, sleep, depression, anxiety, and physical function. It also lets patients describe in detail their ability to do "the things that matter to them – interacting with their family, serving as a care provider, socializing, participating in leisure activities, and work. Are they able to do the tasks at work that they need to do in order to stay employed?"

If the diseases themselves aren't cookie-cutter, then how can the treatment be?

Wouldn't these topics come up in a normal visit to the doctor? Unfortunately, not always, says Bingham, particularly as doctors are seeing more patients, with less time to spend in each visit. His goal is for each "domain" category – a disease-specific problem such as fatigue or pain – to be "essentially a thermometer that tells how a patient is doing in relation to the general population. What we want to study is how what the patients are telling us compares with what physicians are determining the disease activity to be. We also want to see if we can understand what is not responding to treatment, and get a better idea of why." Alternatively, "if a physician sees that there is a swollen joint, but the patient reports that everything is going well, is that necessarily something that we need to treat?"

Bingham anticipates that this questionnaire, which can be taken online, could be valuable between doctor visits, too: "If there is a significant worsening in the degree or extent of one or more of these domains, that could signal that the patient needs to come back in. Instead of the patient saying, 'I'm feeling worse,' it would give us a metric, a means of tracking an improvement or a downturn." He believes this will help patients feel that they are taking charge of their disease as they record what's happening in daily life and how the disease is affecting it. Also, over time, "I truly believe there are going to be patterns of these different pieces of disease experience that will emerge, and we will begin to identify clusters of symptoms that relate to what is happening in the blood with the biomarkers, and in the physical exam. So it really will become true precision in how we treat our patients." ■

Recently, Panagis Galiatsatos, M.D., a resident in internal medicine at Johns Hopkins Bayview, went to church, and an elderly woman he had never met before came up and gave him a big hug and kiss. It turns out that a month earlier, when he had given a talk at the church about cancer screening, she had been in the audience. Based on his advice, “she mounted up the courage to talk to her physician about some symptoms she was having,” Galiatsatos says. “She was diagnosed with early stage colon cancer. The doctor told her that if she had waited any longer, it could have been considerably worse.”

This is exactly the kind of result that the founders of the Healthy Community Partnership at Johns Hopkins Bayview hope for, and have come to expect. The program is new, but it’s based on nearly 20 years of collaboration between clinical psychologist Dan Hale, Ph.D., and geriatrician Rick Bennett, M.D., President of Johns Hopkins Bayview. Their partnership began in the early 1990s; Hale was on the faculty at Stetson University in DeLand, Florida, “where the population was already more than 20 percent age 65 and over – about 60 percent more than the rest of the country,” says Hale. Although his expertise was in mood disorders, Hale also became interested in the general health problems that his patients were facing. In 1992, he won a small grant to see what could

be done to help older adults, especially those with chronic illnesses. “It is remarkable how much responsibility rests on the shoulders of patients with a chronic illness to learn about their condition, to understand how to monitor it and how to treat it,” he says. “What they really need is reliable, easy-to-understand information and support.”

But exactly what did they need, and how to get it to them? Looking for additional medical expertise, Hale became impressed with work being done in the Geriatrics Division at Johns Hopkins. He called up the division’s longtime chairman, John Burton, M.D., who invited him to come and meet with some of his colleagues – particularly, with Bennett. Together, with help from Burton, they came

“We are really seeing these partnerships as a way of building trusting relationships, particularly with communities from underrepresented minority groups in health care.”

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“When you have a chance to talk to people, to understand them and their situation, it’s got to improve what you do.”

up with “a very simple idea,” says Hale: “We had to find a way to reach out into the community. We had to reach people sometimes even when they didn’t know they had a chronic condition like high blood pressure, diabetes, or glaucoma. The only places where older adults gather in large numbers on a regular basis are the houses of worship – so we needed to find a way to develop partnerships between medical centers and faith communities.”

They worked with local clergy in DeLand to identify what they called natural leaders, people who didn’t necessarily have a background in health care but who “had a real heart for this sort of work,” says Hale. Then they developed a curriculum – about 20 hours of training for these leaders that covered conditions including hypertension, heart disease, cancer, diabetes, depression, and dementia, plus issues such as vaccinations (particularly, regular shots to prevent flu and pneumonia), advance directives, managing medications, and preventing accidents and falls in the home. Then, with grants from a medical center in nearby Daytona Beach, Hale and

“We had to reach people sometimes even when they didn’t know they had a chronic condition like high blood pressure, diabetes, or glaucoma.”

Bennett recruited their first cadre of volunteers. “We aimed for 24 to 25 volunteers to go through this 20-hour training program, because we had heard that we would probably experience about 50 percent attrition,” says Hale. They recruited 22 people, then three more wanted to join. No one dropped out. “The hospital was so impressed, we were asked to do a second and third cohort. So here we had started hoping to train 12, and we ended up with 59 people. It has taken off from there.” The program expanded to other Florida hospitals and resulted in a book, written by Hale and Bennett, called *Building Healthy Communities Through Medical-Religious Partnerships*, published in 2000 by the Johns Hopkins University Press.

Hale learned that “often, the people who caught onto this last were the clergy” – not because they didn’t think it was worthy, but because “they already felt burdened with trying to keep so many things going – the music program, the youth program, Vacation Bible School, Sunday School, and you start talking about one more program and they would think, ‘Oh, we just don’t have time for it.’” With this group in mind, Hale and Harold Koenig, M.D., an expert in the field of spirituality and health at Duke University, wrote another book, aimed at clergy and loaded with case studies, called *Healing Bodies and Souls: A Practical Guide for Congregations* (Fortress Press).

The second edition of *Building Healthy Communities* was published in 2009; a symposium was held at the Johns Hopkins Asthma and Allergy Center in its honor, and local community leaders began asking Bennett and Hale, “Why aren’t we doing something like that here?” Hale left Stetson University to team up with Bennett in Baltimore, and the Healthy Community Partnership program was born. Initially, as before, the program focused on health care issues for older adults. “But as we’ve begun expanding our work here in Baltimore, we have begun to look at other needs,” including childhood asthma and adolescent obesity, says Bennett. “I think as we move forward over the next five to 10 years, we’ll have new ideas that maybe we’ll incorporate into our third edition of the book.”

YOUNG DOCTORS AS TEACHERS

One new idea that everyone involved seems to agree is a great success: “We have really relied upon our own house staff (interns and residents) at Bayview to be the instructors for the course,” says Bennett. “It’s been a nice way for the house officers to learn how partnerships can be built with community and religious leaders. It also gives them an opportunity to improve their own teaching skills and to come up with new ways that we might work with these congregations.”

Colleen Christmas, M.D., who directs the residency program, recalls: “When Dan Hale approached me to see if I thought there might be any interest in having the residents participate in community outreach medical education, I was so excited. I said, ‘Yes, definitely, we would love to do it!’ The type

of residents we attract to the Bayview program are totally passionate about doing this type of work." Ten residents worked with the program this year. "The residents found it deeply meaningful," says Christmas. "It was an opportunity to give back, to provide health education to a group of really motivated community representatives. They just loved that. It's such a win-win, the opportunity to share

"We don't just roll it out and try to impose it. First we have to build relationships, listen to what people want and what works for them."

what you know with people who really want to hear it. It's nice to reach beyond what we do every day and feel like we're making a difference on a bigger scale." Hale adds: "Once they dip their toe in the water a bit, they find it invigorating."

The first Baltimore cohort of lay health educators, 17 strong, represents a diverse group of religious congregations. A second cohort is planned for next year. Better yet, says Bennett: The program has "already morphed" to inspire other Bayview-community partnerships including the Heart Failure Community Advocates program, which is training lay leaders to help people with congestive heart failure. "We are really seeing these partnerships as a way of building trusting relationships, particularly with communities from underrepresented minority groups in health care, where that trust may not have existed in past decades. We are actively seeking out partnerships with African American churches and looking for ways to partner with our Hispanic community in Baltimore."

This work, adds David Hellmann, M.D., Vice Dean of Johns Hopkins Bayview and head of the Center for Innovative Medicine, "fits beautifully with our Pyramid," a new model of academic medicine, "in which the patient, family, and community are at the top. We are here to make their lives better." ■

Dan Hale and Rick Bennett learned years ago in Florida not to go in like gangbusters and tell people what they ought to be doing. "We got some very good advice right from the beginning," says Hale. "Wherever we start a program, we don't just roll it out and try to impose it on a congregation or a community. First we have to build relationships, listen to what people want and what works for them."

Although the basic curriculum might be the same, the approach can differ considerably. "Some congregations are very comfortable actually taking time right during the service to provide information and resources," says Hale, who thinks this works better because there's a captive audience. "If they say, 'Come at a totally different time to hear about diabetes,' and you don't know you've got diabetes, then why are you going to come?" At one synagogue in Florida, he adds, "One program on depression, in the middle of the Shabbat service, took about 15 to 20 minutes, and some people in the congregation grumbled about that. The next time they did a program, the rabbi said, 'We'll hold it immediately afterwards.' But he added, 'I don't want anyone to leave!'"

The first step is to listen, say Hale and Bennett. In Florida, three African American congregations "really wanted one white cardiologist to speak," says Hale, "because he was the son of a Baptist preacher," and a great speaker. Making the program work has so many good benefits for both patient and doctor, he notes: "If you have patients who come in already knowledgeable about their condition, and who know how to be engaged in their own care, that makes our work easier and better. I think we would all agree that the best medical care occurs when you have patients who are informed and engaged, along with a physician who's informed and engaged." This year, one of the churches was in Turner Station, a largely African American community in southern Dundalk. The young doctors who spoke there "got to see what that community is like. When you have a chance to talk to people, to understand them and their situation, it's got to improve what you do."

Balancing Act: Sick Enough for the Hospital, Too Frail to Go

Think of an eggshell, and imagine that this is all that stands between you and a major change in your health. That's about how tenuous the margin is for some, particularly the elderly and frail. For these people, the line between being independent and having to live in a nursing home – between still being able to walk and becoming bedridden, between understanding what's happening and becoming confused or delirious – can be very thin indeed.

“For some older patients, the hospital can be an extremely dangerous environment,” says Bruce Leff, M.D. “As a geriatrician, usually the hardest decision I’ll have to make is whether to put a frail older person who’s acutely ill in the hospital. Will they go into the hospital and then have a fall and break their hip? Will they have a severe episode of delirium in the hospital, which may affect their long-term cognitive function? Will they get put to bed for a week and lose muscle function – and then not be able to go home again because they can’t get up out of bed as easily, can’t get dressed or take care of their activities of daily living?”

Who says the hospital is the only option if you’re very sick?

“For some older patients, the hospital can be an extremely dangerous environment.”

For the better part of two decades, Leff, leading a team of researchers at the Johns Hopkins Schools of Medicine and Public Health, has been developing an innovative alternative: Hospital at Home. Based on an idea by pioneering Johns Hopkins geriatrician John Burton, M.D., Hospital at Home is a full substitute for acute hospital care – the only difference is, it's in the patient's home. It's not for everybody (see side story), but those who meet the entry criteria tend to do better and recover more quickly. In studies, “we demonstrated that patients like it and that they have much better clinical outcomes,” says Leff. “There was a huge reduction in delirium; less sedative medication was used, satisfaction was better, and costs were about 30- to 40-percent lower.” In analyses summarizing the results of multiple studies in the international literature, at-home patients were 38 percent more likely to be alive six months later. Much of the work in developing and disseminating this program has been supported by the John A. Hartford Foundation.

What is it that makes going to the hospital so hard on someone who is elderly and frail? For one thing, being laid up takes a hit on everybody, whether you're a strapping professional athlete in your prime, an energetic teenager, or an ailing senior. When it comes to muscles, “use it or lose it” is an unyielding rule. “Most people, if you put them to bed, will lose about 1 percent of their muscle mass per day,” explains Leff. “Older people, by the end of a week, may have lost 7, 8, 9 percent of their muscle mass, and that alone might be enough to make them incapable of doing the things they used to do.”

What this means is that if you are an older person and your ability to function is just over the threshold – if you are able to do the things you need to do, but just barely – and you are put to bed for seven days, you might not be able to go back to being independent. “Even if you don't want to be in your bed, in the hospital it's hard to get out of bed,” says Leff. “It's not like you have a living room you

can walk to; people are usually just kind of stuck in their bed.” Plus, they’re sick: Being inactive is one problem, and the toll of illness is another. “Older people who are acutely ill really are at substantial risk of losing the ability to function, and that, in turn, is highly associated with mortality a year after hospitalization. The loss of function is very predictive of bad outcome.”

Unfortunately, the body isn’t the only casualty here. There is often a mental toll, and it’s the stuff of nightmares for family members helplessly watching it happen. “Seeing someone you love become delirious is an awful experience,” says Leff. “It’s very frightening; it’s like a horror movie.” In the mid-1990s, when the team was developing Hospital at Home, scientists at Yale and elsewhere were developing interventions to prevent delirium in the hospital. “What those interventions do is actually very much what happens naturally in Hospital at Home: We try to keep people oriented, try to keep them up and functional, we make sure that they’re not getting dehydrated. We make sure that they’re actually eating; that if they wear glasses, their glasses are on, and if they have hearing problems, that they’re wearing their hearing aids. We make sure they’re not using sleeping pills to help them get to bed, because those very much provoke delirium.”

Hospital at Home is a full substitute for acute hospital care – the only difference is, it’s in the patient’s home.

In the Hospital at Home, “what we’ve found using very careful measurements is that the risk of getting delirious was 75 percent less, which is a very nice outcome.” ■

First, geriatricians Bruce Leff, John Burton, and colleagues at the Johns Hopkins Schools of Medicine and Public Health spent years laying it all out – not only *how* to provide hospital-level care in someone’s home, but who would be most likely to benefit from it. “We did a lot of good science trying to figure out ways to choose the right patients,” says Leff. Their research, published in the *Journal of the American Geriatric Society*, found that Hospital at Home is right for about 30 percent of older patients with conditions including pneumonia; congestive heart failure; emphysema; cellulitis; dehydration; urinary tract infection; urosepsis; deep venous thrombosis; and pulmonary embolism.

Then they tested the program, first in a 17-patient pilot trial in the late-1990s, next in a national study involving 455 patients in three Medicare managed-care organizations and one Veterans Affairs medical center in New York, Massachusetts, and Oregon; their findings were published in the *Annals of Internal Medicine*. The results were impressive: The average length of stay was shorter, overall costs were about a third cheaper than an inpatient stay, patients were less likely to become delirious, need sedatives or chemical restraints. Compared to those treated in the hospital, the at-home patients and their families were more satisfied with care; family members reported feeling less stress; and patients seemed to bounce back – return to their usual daily tasks – more quickly.

“What we’re really doing is delivering hospital care at home,” says Leff. “So doctors go to the home, nurses go to the home, patients get IV medicines, IV fluids, oxygen, breathing treatments, ultrasound, and x-ray.” For some tests like endoscopy or CT scans that can’t be done at home, “we bring the patients to the hospital, they get the test, and then go back home.”

Currently, Hospital at Home is being used or developed at centers throughout the country, including Presbyterian Health Services in Albuquerque, New Mexico; and at Veterans Affairs Medical Centers in Idaho; Hawaii, Louisiana, Pennsylvania, and Oregon. Also, a modified version of the program, called Clinically Home, offers home-based care provided by nurses, with physicians always available via telemedicine. This high-tech form of long-distance monitoring allows a physician to see the patient, hear the heartbeat through a digital stethoscope, and keep track of all vital signs in real time.

For more information, Hospital at Home has a website: www.hospitalathome.org.

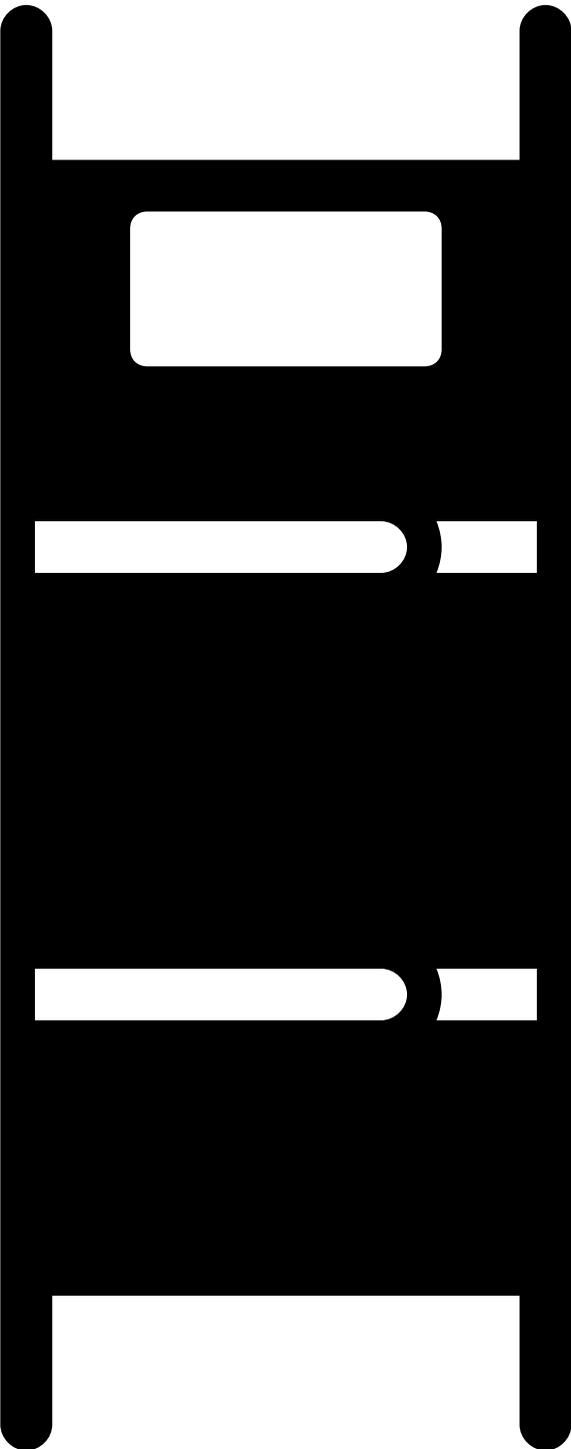
Sparing Mom that Extra Trip in the Ambulance

Imagine that your elderly mother spent the last week in the hospital, and now has moved to a rehab facility. She's still got a PICC line (peripherally inserted central catheter, a port that allows IV access for weeks or months), and is getting a high-powered IV antibiotic, Vancomycin. She's worn out, not only from being sick but also just from being in the hospital, and her ordeal isn't over. Today, some muscular strangers will come, along with an aide she doesn't know. They will put her in an ambulance and take her back to the hospital so she can get her IV line and blood levels checked. She's already stressed out about it. The whole ordeal will take half a day, and she may need to do it again next week.

Wouldn't it be nice if the doctors would come to her instead?

As part of a pilot project between Johns Hopkins Bayview and a local nursing home in Baltimore, this is just what is happening. Developed by Jonathan Zenilman, M.D., Chief of the Division of Infectious Diseases, the program is proving better for patients and also for the doctors treating them. This is not only because it spares the logistical roadshow – involving an ambulance and the help of three or four people just to get patients back to the hospital. It's also because, when patients come back, often the visit is not ideal. "From our side, it can be very hard, and medically frustrating," Zenilman says: "Typically, there are two burly guys with a patient on a stretcher who is kind of disoriented, and an aide who has no idea what's going on, and you try calling up the nursing home to get some information and they say, 'The nurse taking care of this patient is on break.'" Even worse, this recurring situation has made Zenilman think, "we're providing lousy care," and that there had to be a better way.

The project is still pretty new – just a few weeks old – but Zenilman believes the potential is huge. When he makes a "house call" to the nursing home, he and a nurse practitioner, Karen Daniels, usually see three or four patients, people with infectious diseases or those taking IV antibiotics. Over the next few months, he hopes to implement an antibiotic management program – reviewing antibiotic prescriptions and following the guidelines of "antibiotic stewardship" that Zenilman and colleagues have developed and used to reduce infection and unnecessary antibiotic use in the hospital. "There's been a lot of focus on antibiotic stewardship in acute care hospitals, but really not much in long-term care or rehab facilities," he notes. And yet: These are the same patients who were just in the acute hospital setting. Surely the need for management does not go away as soon as the patient leaves the building.



Worldwide, recurring infection “is an enormous problem,” Zenilman says. “Actually, most of the intervention we do in the hospital is in taking people off of antibiotics.” He sees great potential for study and medical improvement with this hospital-nursing home partnership and with others he hopes to develop. Many long-term care facilities are parts of local or national chains and have extensive data systems, which might prove helpful in documenting the results of antibiotic management programs, he says. “This is a huge untapped area.”

“Typically, there are two burly guys with a patient on a stretcher who is kind of disoriented, and an aide who has no idea what’s going on, and you try calling up the nursing home to get some information and they say, ‘The nurse taking care of this patient is on break.’”

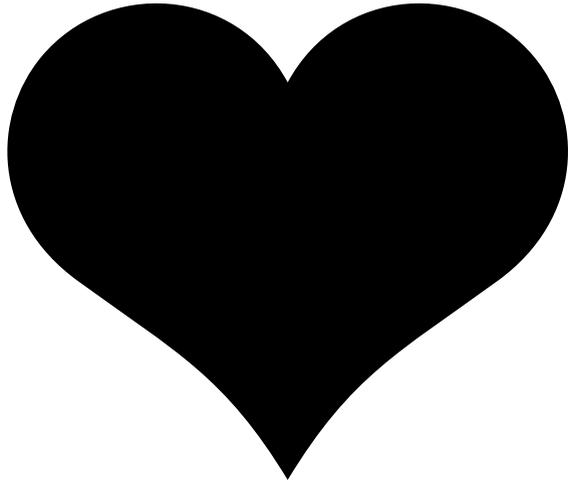
Part of antibiotic stewardship is changing a mindset of “treating to the cultures” – giving antibiotics to people who have bacteria in their urinary tract but no symptoms of an infection. The danger is that the more antibiotics are used, the greater the risk that resistant or hard-to-treat strains of bacteria will develop. “This is the population, especially, where heavy antibiotic use is going to increase the *c.diff* rates enormously.” In recent years, *c.diff* (*clostridium difficile* bacteria, which normally live in the intestines) infections have become increasingly severe and tough to treat. “*C. diff* rates grow exponentially once you’re over 70.” ■

Celebrating Clinical Excellence

Generosity

It's amazing what a difference one family can make. The Miller-Coulson family – Mrs. Anne G. Miller, G. Thomas Miller, Richard B. Worley, Leslie Anne Miller, Sarah Miller Coulson, and the late Frank L. Coulson, Jr. – has made possible some of our finest initiatives. It started nine years ago, with the Miller Lecture. Actually, it started before that, when Mrs. Anne G. Miller asked Vice Dean David Hellmann, M.D., why there weren't more clinically gifted, compassionate physicians like the great Johns Hopkins internist, Phil Tumulty.

That led to many discussions about what makes an outstanding clinician – which, in turn, led in 2004 to the first annual Miller Lecture, an important event throughout Johns Hopkins that focuses on clinical excellence and how treating the whole person can improve the lives of our patients (for a list of the distinguished speakers who have graced this podium over the years, see side story). This year's Miller Lecturer was Edward D. Miller, M.D., The Frances Watt Baker, M.D., and Lenox D. Baker, Jr., M.D., Dean of the Medical Faculty at the Johns Hopkins University School of Medicine, and Chief Executive Officer of Johns Hopkins Medicine (see side story).



But the family's contribution didn't stop there: There's an endowed professorship, The Sarah Miller Coulson and Frank L. Coulson, Jr., Professorship, which helps support the work of one of our outstanding clinicians and teachers, Roy Ziegelstein, M.D., a cardiologist who is also the Miller Scholar. There are four Miller Coulson Scholars: Colleen Christmas, M.D., Steven Kravet, M.D., S. Chris Durso, M.D., and Scott Wright, M.D., – a team whose diligent work in defining what comprises clinical mastery laid the groundwork for The Miller-Coulson Academy of Clinical Excellence, an initiative sponsored by the Center for Innovative Medicine.

The Academy's mission is to recognize master clinicians. Academic medicine traditionally has tended to reward its scientific researchers, those whose contributions are measured by publications and grants. But great teaching? Being a caring, astute physician? It's often a case of "we know it when we see it," but hard to define and measure objectively. This was the task that the Miller Coulson Scholars accomplished with such success: Based on their efforts, the Academy developed a rigorous process to identify exceptional clinicians, a clinical portfolio that assesses clinical accomplishment. The portfolio of each candidate nominated for membership in the Academy is reviewed and scored by an external committee of respected physicians at top academic medical centers, and then by an internal selection committee. "Through the acknowledgment of our most clinically excellent physicians, the Academy hopes to celebrate the significance and accomplishment of these individuals and provide inspiration to all clinicians," says Wright, the Academy's director.

For four years now, the Academy has sponsored an annual symposium devoted to excellence in patient care. This year, it inducted four new members (see page 22). Members in the Academy contribute to a blog, "Reflections on Clinical Excellence," which draws readers from around the world into discussions and sharing of perspectives on being a better doctor and taking care of the whole patient. The Academy offers a curriculum to help physicians move toward clinical excellence; an elective for Johns Hopkins medical students; an "oath development program" to help medical residents crystallize their commitment to humanism in medicine (see side story); Academy-hosted Medical Ground Rounds; and journal articles related to medical excellence.

"Your friendship and generosity have been of extraordinary importance, and I will never be able to adequately thank you."

This year, the Miller-Coulson family and the Academy have created a new annual award for young doctors who have shown clinical excellence. Frank Coulson died last year after a battle with cancer, and The Frank L. Coulson, Jr. Award for Clinical Excellence honors his life, his personal commitment to professional excellence, and his great interest in clinically excellent physicians. (For a list of the winners, see side story.)

In early May, the Miller-Coulson family was present at the program marking the 4th Annual Miller-Coulson Academy Excellence in Patient Care Symposium and the 9th Annual Miller Lecture. In his opening remarks, David Hellmann said to them: "Your exceptional and sustained generosity have given us the opportunity to try to be a better Public Trust, and many of the things that you have helped support are the things that we most care about. Your questions have guided us, your friendship and generosity have been of extraordinary importance, and I will never be able to adequately thank you." ■

Ed Miller, M.D., has led Johns Hopkins Medicine since 1997. Under his tenure, working with Ron Peterson, M.D., President of the Johns Hopkins Hospital, both the Hospital and the School of Medicine have been ranked among the very best in the nation by *U.S. News & World Report*, and the school continues to rank at the top in NIH research funding. Johns Hopkins Medicine has developed a regional, integrated health care delivery system, incorporating several hospitals in the area and All Children's Hospital in St. Petersburg, Florida. It has also broadened its international presence to include relationships with medical centers in the Americas, Europe, the Middle East and Asia, including a partnership to help Malaysia develop its first fully integrated, private four-year graduate medical school and teaching hospital. Miller has also led a massive rebuilding and renovation effort that has transformed both the Broadway campus and Johns Hopkins Bayview.

Miller credits several reasons why Johns Hopkins Medicine has enjoyed such success:

- Excellence. "If you don't like excellence, you shouldn't be here."
- Integrity.
- Respect for the individual. "How we treat the people we work with on an everyday basis is critical."
- Diversity, "which strengthens us."
- A culture of innovation.
- The belief (and motto of the Center for Innovative Medicine) that "Medicine is a Public Trust."
- Balance, of research, education, and clinical care.
- Centers of Excellence, in Aging, Sleep, Wound Healing, Memory, Bariatric Surgery, Addiction, the Alike Initiative, Arthritis, the Miller-Coulson Academy, Vasculitis.

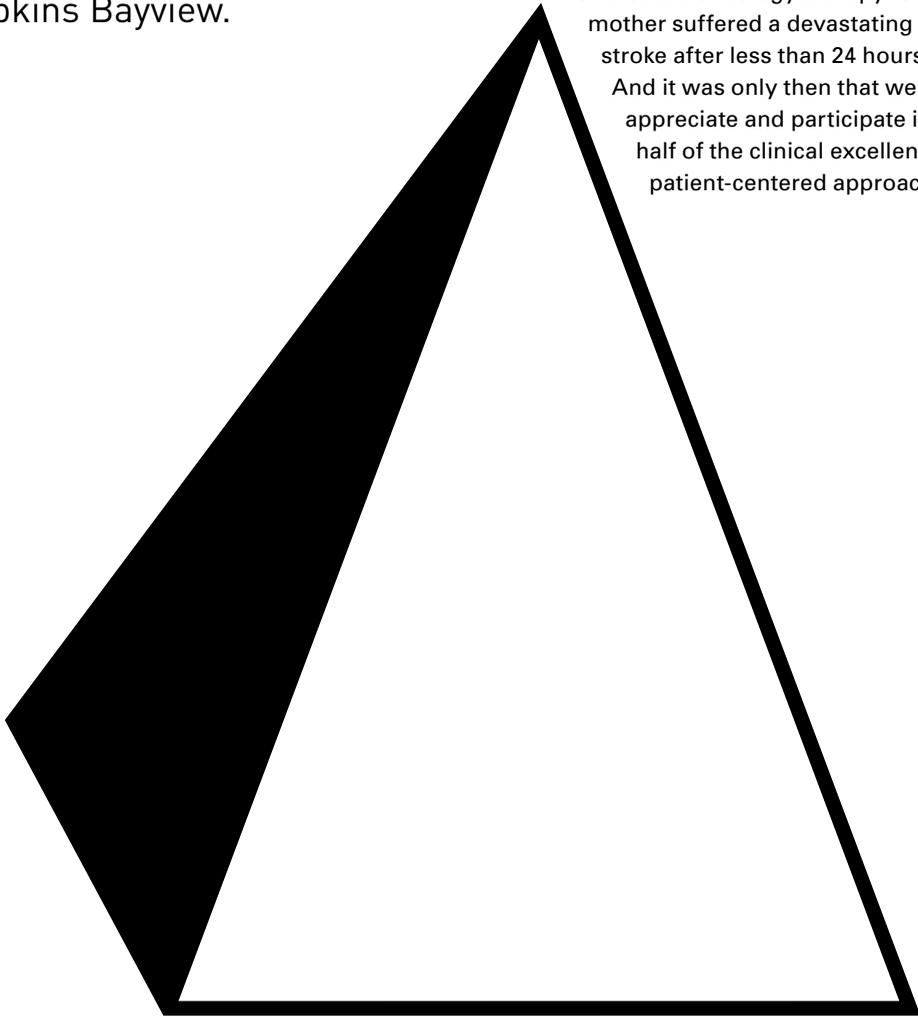
"Clinical excellence will occur if there is a rich infrastructure that supports the research and educational mission of the institution," Miller says. "Clinical excellence will only occur if the patient is the center of our attention."

Celebrating Clinical Excellence

Perspective

Every year, the symposium includes someone who represents the patient's perspective. Dr. Martin Rusinowitz, is a neurologist. Recently, his mother was hospitalized in New Jersey, and Rusinowitz arranged for her to be transferred to Johns Hopkins Bayview.

"As a physician, my primary motivation...was to get her the knowledge and scientific breakthroughs for which Hopkins is legendary," he told the audience. "In retrospect, I've come to understand that my motivation was not the lack of medical expertise in New Jersey, where she was – one-half of what I now realize is truly a part of medical excellence – but rather the other half, which is empathy, humanism, and wisdom... We came to Hopkins seeking the former, but an unexpected turn of events showed us that we desperately needed and received the latter. When we arrived, I felt secure because we had now entered the Mecca for scientific-based oncology therapy. Unfortunately, my mother suffered a devastating hemorrhagic stroke after less than 24 hours at Bayview. And it was only then that we were able to appreciate and participate in the other half of the clinical excellence balance, the patient-centered approach to care.



"I knew instantly as a neurologist, upon seeing my mother's CT scan of the brain, that she had suffered an irreversible neurologic deficit, for which death was not the enemy, but rather the most reasonable sequel to a horrible event." Although he had faced this situation hundreds of times as a doctor, "it was very different when my mother was the patient," he says. The Neuroscience Critical Care Unit fellow was a blessing for Rusinowitz. "His ability to provide a patient-centered approach to a dying patient's family was handled so well that those last few hours of my mother's life will always be positively remembered... We also felt supported by the doctor and nurses, and knew that we were being held tightly in their arms, and that they were going to be there with us until and after my mother's last breath.

"...When my mother got sick and died, I thanked God for the wonderful, humanistic, patient- and family-centered approach to her care, and thought, 'Thank God, this is Hopkins.'"

"When my mother was first transferred and tucked into her surgical oncology bed, I breathed a sigh of relief, and thanked God that we would now receive the latest high-tech treatment because this was Hopkins. When my mother got sick and died, I thanked God for the wonderful, humanistic, patient- and family-centered approach to her care, and thought, 'Thank God, this is Hopkins.'" ■

The Arnold P. Gold Foundation, which supports humanism in medicine, recently named the Academy as a pilot site to create an oath and an image – an opportunity for residents "to think about the kind of doctor that they're striving to become," says Academy director Scott Wright. At the symposium, two second-year medical residents shared what their class created: A poster with the words, "We Heal."

"It's a simple oath," says Panagis Galiatsatos, M.D., "but it embraces our outlook of what a physician should be – a healer – and our promise to our patients." To show the universal goal of their oath, the class translated it into some of the world's languages they have encountered within the walls of Johns Hopkins Bayview.

"The image hangs where our residents can see it and be reminded of the pledge daily," adds Erin Reeves, M.D. In the background is the labyrinth (a meditation labyrinth is located outside the hospital). "It's a symbol of transformation seen throughout history for many cultures in the world. During our residency training, we are working diligently to undergo a transformation ourselves, from brand new doctors to clinically excellent healers like the role models in the Miller-Coulson Academy."

Celebrating Clinical Excellence

Academy Inductees

Michele F. Bellantoni, M.D., associate professor and Clinical Director in the Division of Geriatric Medicine and Gerontology, and Medical Director of the Johns Hopkins Bayview Care Center.

In the Division of Geriatric medicine, she says, “we are like a family. We share the burden of chronic disease. But to us it is not a disease, it is an opportunity. Our skills as clinicians are needed for every patient we serve,” patients who often have multiple conditions, and whom they treat in the clinic, the hospital, and in the patients’ homes. “With our care of these multiply complex older adults comes a great deal of optimism and hope.” The bottom line for the Care Center, she adds, “is, we care. And that’s our real family secret for clinical excellence.”

Giorgio Galetto, M.D., assistant professor of Emergency Medicine at the Johns Hopkins University School of Medicine and attending physician in the Emergency Department at Johns Hopkins Bayview.

Two decades ago, when Galetto decided to specialize in emergency medicine, a friend told him that he would be “sacrificing the all-important patient-doctor relationship for a succession of one-night stands.” Although it’s true that “we tend to treat people episodically,” he notes, what he and his colleagues see instead is an opportunity to reach out to people who are often “marginalized, poor, neglected, those in greatest need, for whom the Emergency Department at times is the only salvation, the only way they will get the therapy they need. How we talk to our patients, how we communicate – in essence, how we connect with the souls behind – is one of our most important missions. And it is the weaving of practice, teaching and public service with which we are shaped day after day that keeps my mind alive and keeps me here.”

Stephen Milner, M.D., F.A.C.S., professor of plastic surgery at the Johns Hopkins University School of Medicine and Director of the Johns Hopkins Burn Center, Surgical Director of the Johns Hopkins Wound Healing Center, Director of the Michael D. Hendrix Burn Research Center, and Honorary Civilian Consultant Advisor to the British Army in Plastic Surgery and Burns.

“Patient care should embrace three things,” Milner says: “Comfort, compassion, and collaboration. Our prime goal in the unit has always been to prevent premature death and alleviate unnecessary suffering, bearing in mind that many of our patients have to undergo protracted, painful therapies and repetitive surgeries, often for months on end. So the ultimate decision to continue treatment is based on whether the quality of life is acceptable. And this is as judged by the personal values of the patients themselves. Now, we hear a lot about compassion and we teach compassion. But compassion alone without a sound medical knowledge will never be appreciated by any patient.” Milner is grateful for his daily opportunities to collaborate with outstanding people: “If you want to return a patient to the quality that they enjoyed before they sustained their trauma, you need as many ideas as you can get.”

E. James Wright, M.D., associate professor of urology and Director of Urology at Johns Hopkins Bayview. He is a co-developer of the Johns Hopkins Center for Women’s Pelvic Health.

Wright believes that we are the summation of all that we touch, interconnected at all levels, and “each of our interactions shapes who we are and how we practice.” Clinical excellence, he adds, “requires a willingness to be part of and to contribute to something bigger than one’s self, and I see it here every day. We build on an incredible legacy of science and discovery. We pass what we know to the next generation of doctors. And we are witness at times to incredible joy, stunning fear, and crushing sadness, and we are able to make a difference for others where no one else can. How great is that?” There remain many things “that defy explanation. We may eventually understand everything there is to understand, but for now, there is plenty of room for uncertainty. Why do outcomes still vary when all things are allegedly equal? Science is a powerful tool, but so is human interaction. We have the benefit of large data sets and unending statistics. But medicine still happens one patient at a time. How you have the conversation matters.” ■

The Frank L. Coulson, Jr. Award for Clinical Excellence

Frank Coulson, says David Hellmann, M.D., “was extraordinarily talented, extremely funny, and my dear friend. The outpouring of memorial gifts in Frank’s name allowed us to create another important award in clinical excellence to recognize outstanding residents at all of the programs at Johns Hopkins Hospital and Johns Hopkins Bayview.” Adds Scott Wright: “The nominating letters were all wonderful, and they all spoke to the incredible humanism, professionalism, and the fact that these doctors are wise beyond their years and rising stars in clinical excellence.”

At the symposium, Roy Ziegelstein, the Sarah Miller Coulson and Frank L. Coulson, Jr., Professor, told the recipients: “An award to people like you who are early in their career is an absolutely fitting tribute to Mr. Coulson. Frank was the leading bond salesman for Goldman Sachs for four decades. But I think the part of his work that he enjoyed the most was mentoring young people. He really would have loved to have met each of you. He would have

greeted you with warm enthusiasm, a broad smile, and he probably would have told you a joke. He then would have given you a pat on the back as you accepted this award. For all of you, please feel Mr. Coulson’s presence with a pat on your back as you accept the award.”

Modupe Agueh, M.D.
Gynecology and Obstetrics

Hans Bjornsson, M.D.
Genetics

Phillippines Cabahug, M.D.
Physical Medicine & Rehabilitation

Jason Chan, M.D.
Otolaryngology-Head & Neck Surgery

Linda Chu, M.D.
Radiology

Mary Cutler, M.D.
Child Psychiatry

Amena DeLuca, M.D.
Dermatology

Latonya Hendricks, M.D.
Emergency Medicine

Marc Larochelle, M.D.
Medicine- JHBMC

Bonnie Lonze, M.D.
Surgery

Matthew Naylor, M.D.
Medicine- JHH

Phillip Pierorazio, M.D.
Urology

John Probasco, M.D.
Neurology

Owen Thomas, M.D.
Radiation Oncology

Matthew Tilson, M.D.
Pathology

Lia Tron, M.D.
*Anesthesiology and
Critical Care Medicine*

The Miller Lecture

It’s where the rubber meets the road – where the art and science of medicine come together, in a holistic, humanistic approach. This is clinical excellence, and you don’t have to be a physician to have something important to say about it. In fact, past Miller Lecturers have included a poet, an economist, noted authors – and a few doctors, too. Here’s the list of previous speakers, which is a veritable “Who’s Who” of influential thinkers:

2004 – Stephen J. McPhee, M.D.
Professor of Medicine; University of California, San Francisco

2005 – John H. Stone, M.D. (deceased)
*Professor of Medicine, Emory University
Author, On Doctoring: Stories,
Poems, Essays*

2006 – Stephen J. McPhee, M.D.
Professor of Medicine; University of California, San Francisco

2007 – William R. Brody, M.D., Ph.D.
President: Salk Institute for Biological Studies former President, The Johns Hopkins University

2008 – Holly J. Humphrey, M.D., F.A.C.P.
Professor of Medicine, Dean for Medical Education Founding Dean, Academy of Distinguished Medical Educators

The University of Chicago Pritzker School of Medicine

2009 – Mr. David Wessel
*Pulitzer Prize winning Economics Editor,
The Wall Street Journal
Author, In FED We Trust and Prosperity*

2010 – Abraham Verghese, M.D., M.A.C.P.
Professor and Senior Associate Chair for the Theory and Practice of Medicine; Stanford University School of Medicine Award-winning Author, Cutting for Stone and The Tennis Partner

2011 – Peter J. Pronovost, M.D., Ph.D., F.C.C.M.
Professor, Departments of: Anesthesiology, Surgery, Health Policy and Management, and Nursing; Johns Hopkins University

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“We may find that the ultimate question is not whether we can afford to give every resident focused time to acquire and practice the fundamentals of patient-centered care, but can we afford not to?”

Muriel Jean-Jacques, M.D., M.A.P.P. and Matthew K. Wynia, M.D., M.P.H., Northwestern University Feinberg School of Medicine, in an editorial in the *Journal of General Internal Medicine*, published Feb. 11, 2012. This accompanied an article written by Neda Ratanawongsa and other faculty in our Alike Initiative, reporting on how this focused, patient-centered curriculum has affected the experiences of our residents and their patients.

Mr. & Mrs. William Gooch
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