breakthrough

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The Rhythm of Healthier Aging

COVID-19 'Long-Haulers'

Addressing Isolation in Older Adults

Empathy in Practice

Medicine is a public trust

THE JOHNS HOPKINS CENTER FOR INNOVATIVE MEDICINE

breakthrough

In this Issue

David B. Hellmann, M.D., M.A.C.P.
Aliki Perroti Professor of Medicine

HOPE IS HERE

As I write this, the tulips outside my window are in full bloom and millions of people across the country and around the world are getting vaccinated against COVID-19. There's a palpable feeling of hope in the air — hope for a post-pandemic future that promises relief from our long months of isolation, sacrifice and grief. And this issue of CIM *Breakthrough* reflects that spirit of hope.

I'm pleased to share, for example, that several of our faculty members are engaged in improving the quality of life of our rapidly aging population. For example, neurologist Alex Pantelyat, the Alafouzos Family CIM Human Aging Project Scholar, is tapping into the healing power of music to help patients with Parkinson's disease improve their gait and speaking capacity — work that has now continued with community-based music programs. Cultivating community support for older adults is crucial for good health, as gerontologist Thomas Cudjoe — the Caryl and George Bernstein CIM Human Aging Project Scholar — has found, through his research and his house calls to aged patients. You'll want to read about his efforts to combat social isolation (p. 8). And looking longer term, I'm exceedingly optimistic about the potential to dramatically reduce the negative health impacts of aging, thanks to the promising bench science of Qinchuan Wang, the Karen and Ethan Leder CIM Human Aging Project Scholar, who is collaborating with Mark Anderson, director of Medicine (p. 13).

Another cause for optimism: This spring, we inducted a new crop of exemplary doctors into our Miller Coulson Academy of Clinical Excellence (p. 16). And I was delighted to welcome Suzanne Koven to the (virtual) podium on May 4 to deliver the 18th Annual Miller Lecture. Dr. Koven spent her formative training years here at Hopkins, and now is the first writer-in-residence at Harvard's Massachusetts General Hospital. Her new book, *Letter to a Young Female Physician*, offers hard-earned wisdom and insights that, I am confident, will help galvanize today's trainees to become tomorrow's great doctors.

Of course, the scourge of COVID-19 is not behind us yet, as Emily Brigham and Ann Parker can attest. They are among the co-directors of the Johns Hopkins Post-Acute COVID-19 Team (p. 2), a group committed to finding answers and treatments for the millions of COVID-19 "long-haulers" who continue to cope with debilitating health effects. The energy and expertise they bring to this daunting task is nothing short of extraordinary.

I am awed by all of these achievements and am most grateful to you, our generous supporters, for making this hope possible.

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.

on the web

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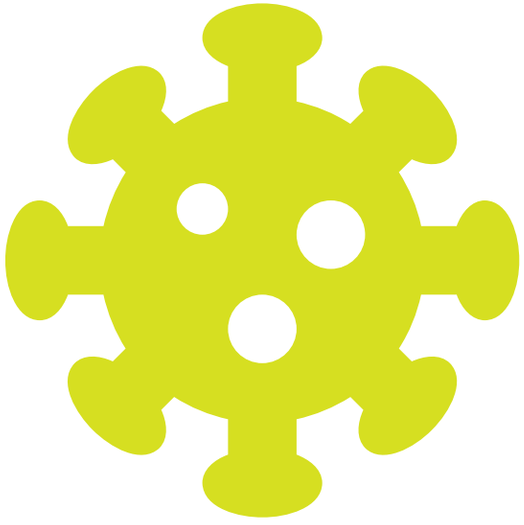
Finding Answers for COVID-19 'Long-Haulers'

"It's heartbreaking."

That's how Johns Hopkins pulmonologist **Emily Brigham** describes her consultations with patients who continue to struggle with debilitating symptoms from COVID-19, months after their initial infection.

"Many of them had only minor COVID-19 symptoms to start, and here they are months later saying, 'I can't return to work. I can't take care of my kids.' They struggle with symptoms like intense fatigue, shortness of breath, heart palpitations and cognitive impairment. Tied to that are anxiety and depression. They are understandably very frustrated," Brigham says.

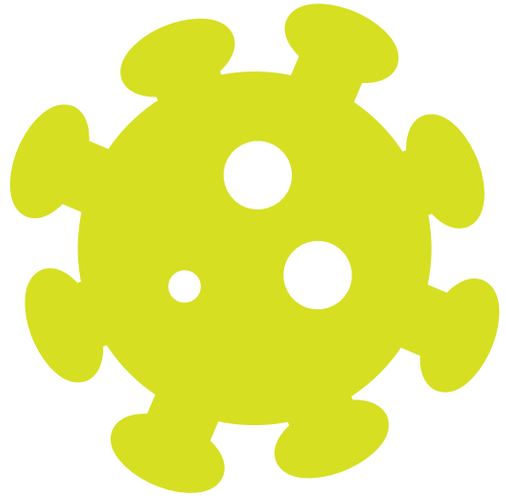


Fortunately for these COVID-19 "long-haulers," as they have come to be known, Brigham and fellow pulmonologist **Ann Parker** can connect them to a broad array of specialists to help support their recovery through JH PACT (Johns Hopkins Post-Acute COVID-19 Team), a service that both doctors launched and now co-direct with Physical Medicine and Rehabilitation colleagues, **Alba Azola** and **Soo Kim**.

Once patients' specific needs have been identified and a treatment plan started, some receive care at home, including rehabilitation therapy and nursing visits. Others come to Johns Hopkins for services like physical, occupational and speech therapy.

"As early as March 2020, we recognized that because patients would have complex, multifactorial health needs, we would need to take a multidisciplinary approach."

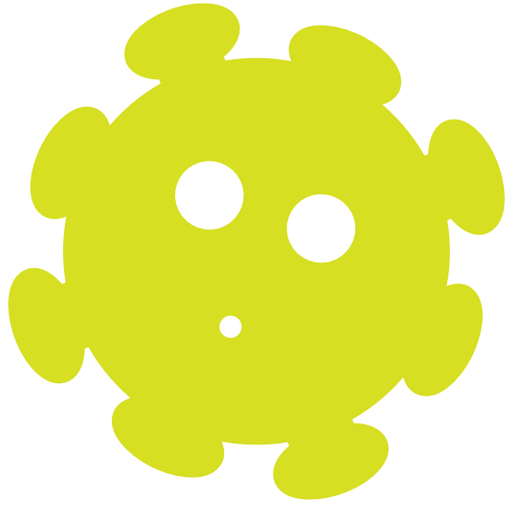
Ann Parker



Rehabilitation psychology, neuropsychology and psychiatry also provide key services to address patients' cognitive and mental health needs. JH PACT also offers medication management in coordination with Johns Hopkins pharmacists, and COVID-19-related radiological imaging.

The idea for JH PACT came early on in the pandemic. "From decades of experience and research involving post-intensive care syndrome (PICS) — a collection of impairments in physical function, mental health and cognition that can persist for months or years after an ICU patient leaves the hospital — we expected there would be patients with COVID-19 who would be at risk for similar impairments," says Parker. "As early as March 2020, we recognized that because patients would have complex, multifactorial health needs, we would need to take a multidisciplinary approach."

Working closely comes easy for Brigham and Parker, who are good friends. They completed their Johns Hopkins fellowship training together and both bring important expertise to JH PACT.



JH PACT came together quickly, Brigham and Parker say, thanks to "amazing collaboration and support" from doctors, nurses and therapists from across Johns Hopkins.

Brigham is an expert in airway diseases like asthma and COPD, and she has done research examining disparate health outcomes among minority populations in an effort to improve health care equality. She also has treated patients with lingering respiratory symptoms post viral illness, and so the respiratory complications that accompany post-acute COVID-19 are not new to her. Parker's research has focused on improving health outcomes for survivors

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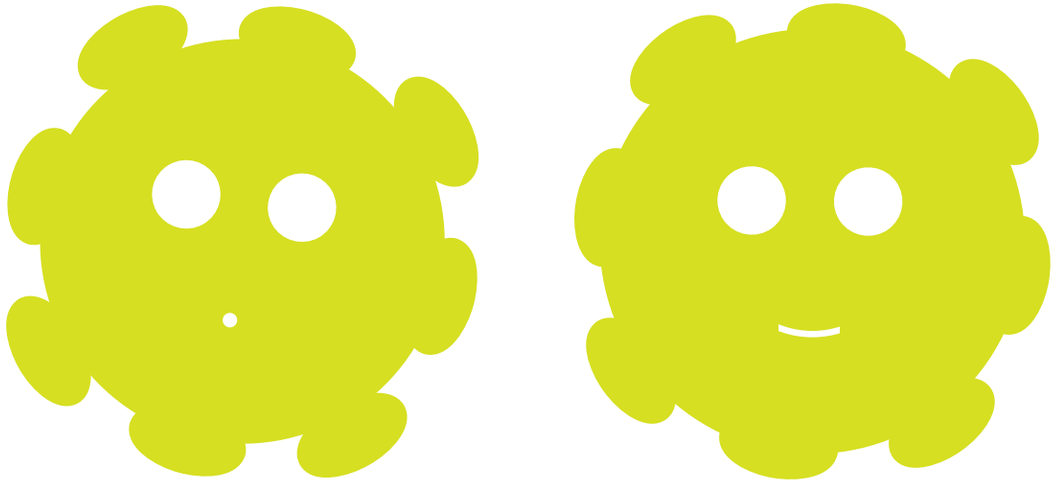


of critical illness coming out of the ICU. In that role, she is well familiar with PICS and has developed strong working relationships with colleagues in Physical Medicine and Rehabilitation at Hopkins — specialists who are key to providing care for those with post-acute COVID-19.

"We sat down together in March, with pulmonologist **Sarath Raju** and **Christian Merlo** [pulmonary director of outpatient clinical operations], and said, 'We need a service. Let's hit the ground running with streamlined care for patients who will inevitably be coming to us post COVID-19,'" recalls Brigham. JH PACT came together quickly, Brigham and Parker say, thanks to "amazing collaboration and support" from doctors, nurses and therapists from across Johns Hopkins, including trainees like **Jacqueline O'Toole** and **Sandra Zaeh** (senior Pulmonary fellows).

In the midst of it all, Parker gave birth to her third son in May. "From March until he was born, I shifted from working directly with patients in the ICU. Instead, I was able to put systems in place to get JH PACT up and started," she says.

"Ours was one of the first post-COVID-19 services in the nation and we were very proud we were able to do this. It really speaks to the breadth and depth of expertise here at Johns Hopkins."

Emily Brigham

"Ours was one of the first post-COVID-19 services in the nation and we were very proud we were able to do this. It really speaks to the breadth and depth of expertise here at Johns Hopkins," says Brigham.

Because COVID-19 long-haulers come in with such a variety of different symptoms, involving all of the body's major organ systems, she says, it's critical to have access to an array of subspecialists: cardiologists, nephrologists, infectious disease specialists, hematologists, psychiatrists and more.

"With JH PACT, when I see a patient with all of these different systems, I can connect them to the appropriate care in a way that is relatively fast," says Brigham. "And because our specialists are seeing many individuals with similar concerns, they are starting to see patterns, and they feedback to us."

That feedback is an important element of JH PACT, notes Parker. "From the very beginning, we have been completing our clinical assessments in a very deliberate and standardized way, so that we can begin to recognize patterns and compare outcomes — across Johns Hopkins, the United States and internationally — with the ultimate goal of improving care for patients with post-acute sequelae of COVID-19 (PASC)."

Toward that end, there are efforts well-underway to launch a Johns Hopkins-wide data registry that will hold health information from the electronic medical records of patients who have been treated for COVID-19. The registry will offer a treasure trove of data that Johns Hopkins researchers can tap as they investigate new protocols and treatments for COVID-19 and post-acute COVID-19. There are also plans to establish a biorepository, with samples of body fluids and tissue from patients with COVID-19. Brigham and Parker believe such a biobank will prove crucial for future research efforts. "Having the availability of specimens will allow us to recognize patterns, ask questions, and rapidly answer those questions," says Brigham.

These efforts have taken on increased urgency as evidence shows that a notable percentage of COVID-19 survivors (some estimate as high as one-third) continue to be plagued with life-altering symptoms long after they recover from acute illness.

"Sitting down with these patients, seeing their pain and frustration, and not being able to tell them when their symptoms will go away…it only drives us to come up with strategies as quickly as possible," says Brigham. ■

The Zoom Connection

While the stay-at-home orders brought by COVID-19 led to countless canceled events and an end to in-person meetings, there has been one silver lining for members of CIM's International Advisory Board and other CIM affiliates.

"Our CIM seminars, which used to be held in my office and attract at most 25 or 30 participants, moved to a Zoom format and our attendance has skyrocketed," says CIM Director **David Hellmann**. "We routinely draw 50 or 75 people, and attendance at one seminar about COVID-19 surpassed 170 participants."

Among those is board member **Susan Immelt**, a retired nurse, who says she has blocked out Tuesday afternoons at 4 p.m. on her calendar in anticipation of the Zoom seminars, which are scheduled about twice a month. "In this past year with so little structure, the CIM seminars have been a very welcome event to look forward to. They are phenomenally well done," says Immelt, who together with her husband funds pulmonologist **Brian Garibaldi** as the Douglas Carroll, MD, CIM Scholar, in honor of her father.

The format of the seminars is straightforward. At each session, a keynote researcher whose Johns Hopkins work is supported by the Center for Innovative Medicine takes 30 to 40 minutes to share the scope and progress of that work in an accessible way, which some liken to a TED Talk. Subjects range widely: from the latest advances in detection of pancreatic cancer, to housing policy and health equity, to the importance of addressing isolation in the nation's aging population. Then the floor is open for questions, and a lively back-and-forth ensues.

"I've been in a self-imposed lockdown here at my home in Danville, Kentucky, and when the CIM seminars moved to Zoom, I was just elated," says board member **Dana Case**, also a retired nurse. "The presentations really expand my knowledge base and it makes my heart sing to see Johns Hopkins and the Center for Innovative Medicine doing so much good to benefit the world."

Case adds, "As I learn new things I pass them along, and I've found the seminars to be a great way to connect with others." For example, she invited her granddaughter, Kennedy, a law student in Rhode Island, to attend several meetings. "It's given us a lot to discuss and she has taken information we learned during a seminar about COVID-19 to her legal internship in Nashville. She designed a database to help employees throughout the United States discern when they would be eligible to receive a COVID-19 vaccination."

The seminars have also provided an outlet for Case to connect with her sister, fellow CIM International Advisory Board member **Mary Ousley**, also a registered nurse. (Both were integral to the inclusion of nurses in CIM's Good Doctor Initiative, which is part of the Aliki Project.) "We usually text back and forth during the meetings or call once the session is over to talk through the material in more detail," says Case. "It really elevates my thinking."

Immelt concurs. "Most of the talks hit me right at the edge of my knowledge base — I know enough to understand what they're covering but I am also learning something new."

CIM International Advisory Board member **Mark Rubenstein**, who earned both his B.S. and M.S. from the engineering school at Johns Hopkins, says he was particularly struck by a presentation about the new Engineering Aging Alliance, which is part of Hopkins' Human Aging Project, an initiative launched and supported by the CIM.

"I'm an engineer, so I was very interested to learn about what they've got planned," says Rubenstein. The Aging Alliance is bringing together teams of clinicians, trainees and students — in engineering, medicine, nursing and business — in "innovation incubators" to come up with technological solutions to promote healthy aging.

Though he's been officially retired from his career in commercial real estate now for 18 years, Rubenstein has remained very busy with a full schedule of daily business meetings, even during the pandemic. "Fortunately, however, my late afternoons on Tuesday are free, so I log on to the CIM seminars whenever I can," he says. "There's just so much great information." ■

"The presentations really expand my knowledge base and it makes my heart sing to see Johns Hopkins and the Center for Innovative Medicine doing so much good to benefit the world."

Dana Case

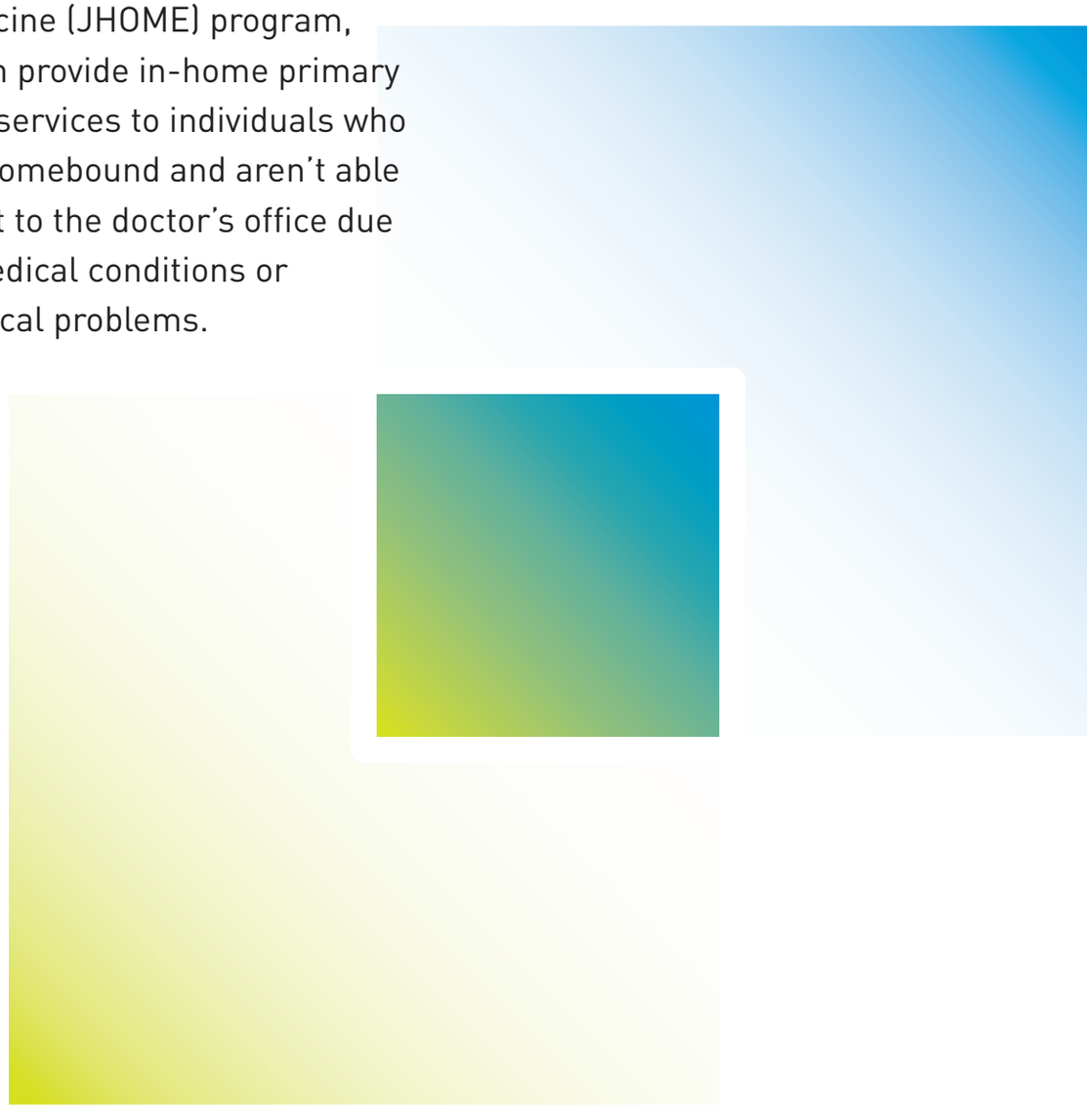
CIM Seminars

If you'd like to receive an invitation for future CIM Seminars, please email Tambra Noethen at: tnoethe1@jhmi.edu

Addressing Isolation in Older Adults

For Hopkins geriatrician **Thomas Cudjoe**, making house calls to older patients throughout Baltimore City is a critical part of his day's work, thanks to the Johns Hopkins Home-Based Medicine (JHOME) program, which provide in-home primary care services to individuals who are homebound and aren't able to get to the doctor's office due to medical conditions or physical problems.

"Home-based care is a great investment that our institution has made, and out of this experience I have seen firsthand the toll that social isolation has on older patients, particularly those with complex health needs who live in subsidized housing," says Cudjoe, the Caryl and George Bernstein CIM Human Aging Project Scholar. "That's why I've dedicated my professional life to understanding social isolation as an important health issue — and working toward solutions."



Even before the COVID-19 pandemic, social isolation was a significant issue, impacting one in four older adults in the United States. And more than 40 percent of older adults reported experiencing loneliness. The impact on health is sobering, particularly among the homebound who are frail, depressed or cognitively impaired, Cudjoe notes.

"We know from multiple studies that social isolation is associated with higher levels of mortality," he says.

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Thomas Cudjoe

In one avenue of his research, Cudjoe is looking to advance the science of social isolation, or as he puts it, "the way that social isolation 'gets under our skin' through biological pathways." In early work that he presented recently at the Gerontological Society of America Meeting, which drew on data from the National Health and Aging Trend Study, he reported an association between social isolation and two key biomarkers for inflammation.

"These findings are important," Cudjoe says, "because they indicate that social isolation is an important factor that has biological influences… which may potentially lead to poor health outcomes."

Given the health implications for older adults, says Cudjoe, it's important for geriatricians and other primary care providers who treat older patients to routinely assess social connectedness. Questions like "Do you feel left out?" or "How many people do you feel you can depend on or feel close to?" should become a routine part of each health visit, he believes, in much the same way that geriatricians regularly monitor blood pressure and weight. "On a public policy level," he says, "advancing regular assessments for social connectedness is critically important."

Once social isolation has been identified, what strategies can be employed to help connect older adults who are and feel isolated?

Leveraging technology is one possible solution, Cudjoe notes. During COVID-19, the almost overnight switch to telemedicine — prompted by shelter-at-home orders — showed that smartphones and video-enabled technologies could be effective platforms for offering counseling and for connecting older adults to family and friends through virtual interactions.

But access to technology remains an important barrier, particularly among older adults of limited income or who are Black and Latino — populations particularly hard hit by COVID-19 — as well as those struggling with vision or hearing loss or cognitive decline.

To reach a broader swath of the homebound, Cudjoe sees an opportunity to "harness volunteerism" and provide more support for organizations (such as Meals on Wheels) to provide regular in-person check-ins with older adults in the community. He points as an example to the "Call & Check Visits" in Jersey, British Channel Islands, where postal workers monitor and support older adults on their delivery routes with a knock on the door and a hello. Closer to home, programs like the AARP's "Connect2Affect" provide a way to connect people with programs and technologies to increase their engagement.

"When thinking about solutions, it's also important to remember that there are two sides of the coin and to acknowledge that there is heterogeneity among older adults," says Cudjoe.

"Just as some older adults are isolated, there are others who are resilient and well integrated within their communities and contributing in so many different ways. What can we learn from those who are thriving?" ■

The Rhythm of Healthier Aging

Johns Hopkins neurologist **Alex Pantelyat** is developing promising treatments for his aging patients with Parkinson's disease and other neurodegenerative diseases that involve no costly drugs or unpleasant side effects. These treatments are easy to pursue at home, or together with friends and family. And they appear to improve the health of patients with debilitating chronic illness while also unlocking feelings of joy and well-being.

What is this seeming miracle drug? In a word, it's music.

Pantelyat, a talented violinist and co-director of the Johns Hopkins Center for Music and Medicine, is passionate in his belief that music could hold a key to better aging. And he has embarked on a range of music-related studies that back up that optimism.

"Music has been an integral part of the human experience as long as humanity has been around," says Pantelyat, the Alafouzos Family CIM Human Aging Project Scholar. "It's been intuitively felt to have healing properties, but now we are in a position to study the mechanisms and optimize music-based interventions."

Quality of life improved over six weeks of drumming and worsened when participants were assessed six weeks later, suggesting that continued drumming is necessary to sustain improvements.

Perhaps his longest-ranging project involves singing and patients with Parkinson's disease. In a pilot study several years ago, Pantelyat found that those who participated in group singing saw improved quality of life, and voice strength and clarity. And when spouses or caregivers were invited to participate, their quality of life also improved. He has continued the project with ParkinSonics, a choir for patients with Parkinson's disease and their caregivers. The choir met weekly at Govans Presbyterian Church in north Baltimore before COVID-19 and it continues to meet virtually.

"That's such an important part of our work. If a study is deemed valuable, we make every effort to roll out the intervention as a community program," Pantelyat says. "The results are inspiring: People who had never sung before are now singing in four-part harmony. The ParkinZoomSonics choir continues to grow, even during the pandemic. Just last week we had several more people sign up."

Pantelyat's work involving West African drumming followed a similar trajectory. In this project, patients with Parkinson's disease sat in a circle, each straddling a traditional goblet-shaped djembe drum, and they followed the lead of the instructor, who set the rhythm. In a pilot study of patients who participated in the drumming twice a week over six weeks, Pantelyat reported that participants experienced a reduction in their symptoms: Some walked more easily; for others, tremors subsided and they were in a better overall mood. Quality of life improved over six weeks of drumming and worsened when participants were assessed six weeks later, suggesting that continued drumming is necessary to sustain improvements.

To Pantelyat, this points to the importance of establishing sustainable community-based programs. "We have to continue activating these parts of the brain to continue to see results. So, it's important for programs like group drumming to be continued long term," he says.

Fortunately, through the Center for Music and Medicine, in February he was able to establish a virtual drumming group for individuals with Parkinson's disease and their care partners, led by

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drum therapist and instructor Jason Armstrong Baker. The goal is to add another virtual drumming group for people with Huntington's disease and their care partners soon.

"There's evidence that being involved in music may improve your life, and it may even prolong your life."

Alex Pantelyat

"The big idea behind all of these community-based programs is this concept of 'social prescribing,' which originated in the U.K. over 10 years ago," says Pantelyat. "The idea is to give a patient a 'prescription' to enroll in a community-based arts program, or for tickets to museums or concerts, which would be covered by health insurance." To his mind, the cost-benefit analysis of social prescribing clearly comes down on the side of music. "There's evidence that being involved in music may improve your life," he says. "And it may even prolong your life."

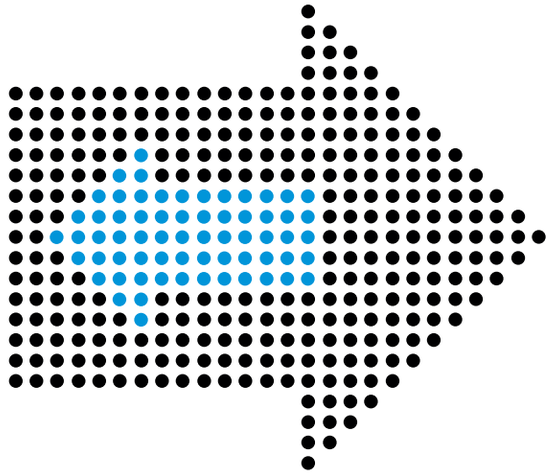
In his recent work, Pantelyat is turning to technology to create individualized solutions for his patients with atypical parkinsonism, which encompasses a range of movement and neurological symptoms and can make walking particularly difficult. Pantelyat undertook a pilot study, in which a patient is asked to walk for two minutes, during which time the velocity of his or her gait is measured. Then the patient walks for two minutes again, but this time to a metronome beat of music that is 10% faster than the baseline gait. "So, if a patient took 90 steps per minute the first time, he's now aiming to take 99 steps per minute, trying to synch each step to a beat on the metronome," Pantelyat explains. After a 10-minute break, the person is asked to walk the same path again for two minutes, but without the metronome beat.

Many patients in the pilot study showed improved gait with the metronome, and for some the improvement was sustained without the metronome. This is proof of concept for the idea "that you can get people with atypical parkinsonism to walk faster and with more confidence after a very short-term intervention," says Pantelyat.

He is working now with a Boston-based tech firm to develop an adaptable device that would make it possible for patients to pursue this "treatment" at home. The idea is to use a playlist of songs that the user enjoys (whether Bach or Jimi Hendrix) while they walk. Then, through a sensor attached to the shoe, the tempo of each song continually adjusts to the walker's gait, encouraging the person to walk at a more regular pace.

"This is an example of moving toward precision medicine, or 'precision music,' that would benefit a patient population that is prone to falls and reduced mobility," says Pantelyat. "If we could get this rhythm-based auditory stimulation approach out into the broader population of patients with parkinsonism, it would be an important step forward." ■

Reversing a 'Terrible Trade-Off'



It's a Faustian bargain in the world of basic biology. And, crucially, it could have important implications for advancing our understanding of the mechanisms behind human aging.

Cardiologist **Mark Anderson**, director of the Department of Medicine, explains it this way: An enzyme known as CaMKII developed an oxygen-sensing capability 500 million years ago, at the dawn of vertebrate evolution, that was preserved through all subsequent speciation into humans — an exquisite chain of evolutionary preservation documented recently by molecular biologist **Qinchuan Wang**, a research associate in Anderson's lab who is the Karen and Ethan Leder CIM Human Aging Project Scholar.

But *why* has oxidated CaMKII — prompted by a pair of amino acids known as methionines — been preserved through all these millions of years? And what impact does that have on human aging?

That's where the Faustian deal comes in. Using fruit flies and genetically engineered mice, the Hopkins scientists have shown, through painstaking work conducted over many years, that CaMKII activation improves physiologic (fight-or-flight) performance by actions in skeletal muscle. That quick burst of movement is a good thing early in life, allowing us to outrun predators and to live to reproduce. But as animals like humans age, CaMKII activation damages many tissues in the heart, brain and skeletal muscle, making us more susceptible to diseases linked to too much oxidation, such as heart disease, cancer and cognitive decline.

It's quite a trade-off, notes Anderson. "Evolution doesn't care if you die of heart failure at 60, or get Alzheimer's in your 50s, because you've already done your thing: You've reproduced," he says. "The mutation [oxidized CaMKII] that enabled you to be faster and more fit earlier in life will remain fixated in the species and will prosper."

"Evolution doesn't care if you die of heart failure at 60, or get Alzheimer's in your 50s, because you've already done your thing: You've reproduced."

Mark Anderson

Now, using new molecular tools and genetically engineered animal models, Wang and others in Anderson's lab are focused on finding ways to reverse this terrible trade-off.

"The goal is to find ways to preserve the benefits of oxidized CaMKII and to minimize its damage," says Anderson, who serves on the executive committee of the Johns Hopkins Human Aging Project. "This could have dramatic implications in the quest to prevent frailty, reduce the burden of diseases related to aging, and to extend our life span." ■

Empathy in Practice

Physician and author **Suzanne Koven**, who completed medical school and residency at Johns Hopkins before moving on to a career in primary care at Harvard and Massachusetts General Hospital, is Mass General's first writer-in-residence and a frequent contributor to publications ranging from *The Boston Globe* to *The New England Journal of Medicine*. Her new book, *Letter to a Young Female Physician: Notes from a Medical Life*, came out on May 4.

Notably, that is the very day that Koven gave CIM's 18th Annual Miller Lecture. In the Q&A that follows, Koven talks about the influences that have shaped her career and explains how art and literature can hold a key to better doctoring.

You arrived at Johns Hopkins in July 1980 and left for Harvard almost exactly 10 years later. What memories stand out during your time here?

I started by working in a lab while I took post-baccalaureate coursework so that I could apply for medical school, which I started at Johns Hopkins in 1982. The first two years of medical school, I struggled because I hadn't been a science major in college and the coursework was so difficult. Then we moved to clinical work the second two years and I discovered that my Yale College background in English — all those novels that I read — served me a lot better than the organic chemistry that I crammed and promptly forgot.

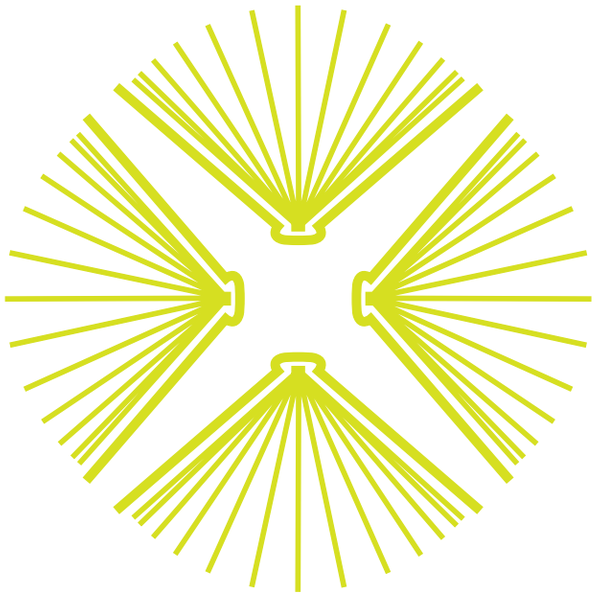
Reading is like empathy in practice. When you're reading a novel, you're being asked to care about a character whose experience and suffering you can only imagine. That imaginative leap is something that we do in clinical medicine every day. I've never had a heart attack and I don't know what chest pain feels like or the fear that comes with it. Reading is very good practice for developing that kind of imagination.

After medical school, you remained at Hopkins for your residency training. How was that experience for you?

I adored my residency! I loved wearing my Osler scarf and running around the hospital and the overwork of it and the excitement of it and the brilliance of the Attendings and being a part of a team that was so defined by excellence. And yet, looking back, there were some darker aspects of medical training in that era, which I get into in my book. One was sexism.

As a junior resident, I had my first baby. (There was so little precedent that I was invited by Human Resources to write a formal policy for maternity leave.) Looking back, why, as a pregnant woman, was I standing on my feet for hours, a factor that led to my developing preeclampsia? It didn't occur to me or anyone else at the time to provide accommodations. In retrospect, the hours that we worked were punishing but the feeling was that you can't be a "real" doctor unless you follow a patient through the first 36 hours of their crisis, for example. But that came at a price, particularly if you were pregnant.

The other dark side, and this was invisible to me at the time, was the inherent racism of health care then. Hopkins Hospital was formally segregated until the 1950s, and it was de facto segregated when I was there in the 1980s. The poor Black patients were on the Osler service by the house staff, while the well-off white patients had private rooms and were treated by the attending physicians.



"The whole idea of narrative medicine is that by reading literature closely, you become better able to elicit and interpret and respond to patient stories."

Suzanne Koven

Years later, I reconnected with one of my few Black residency mates, and he shared stories of white patients refusing to be seen by him, and of micro- and macro-aggressions he endured. Sadly, all of this was invisible to me at the time.

You left for Harvard in 1990 and have practiced primary care there for the last 30 years. At what point did your interest in narrative medicine and storytelling take root?

For a very long time, I just assumed that once I chose medicine, I would read novels at night and it would be a hobby. I continued to believe that until about 15 years ago. After I earned a master's degree in nonfiction writing, my division chief — in an example of how good mentoring can be life-altering — suggested I run a monthly reading group at Mass General. That evolved into running writing workshops and hosting events in narrative medicine, and then I became the writer-in-residence, first for my division and then for Mass General. Now that work is a bigger part of my professional life than my medical practice. I've become more and more emboldened by the idea that if you get members of the hospital health care team seated around a conference table and talking about literature, something magical happens.

How does that magic play out?

The whole idea of narrative medicine, started at Columbia University 20 years ago by Rita Charon, is that by reading literature closely, you become better able to elicit and interpret and respond to patient stories, which is so foundational to providing excellent clinical care. This isn't some "squishy" feel-good stuff: Being able to appropriately listen and respond to a patient's story really affects diagnosis and treatment. And sitting around a table with colleagues allows us to talk about our work and our patients in a much deeper and less guarded way.

As doctors, we are often so worried about whether we're going to make a mistake in the care we provide. But patients aren't worried about our competence. They are worried about whether we are listening to them, and caring about them. Patients I've talked to about narrative medicine totally get it. When I say to patients that I find that sitting around a conference table talking about a Shakespeare play makes us better at listening to patients and their experiences, my patients light up. ■

The 18th Annual Miller Lecture, which Koven offered virtually on May 4, is made possible by the generosity of Mrs. Anne G. Miller and her daughters, Sarah Miller Coulson and Leslie Anne Miller, and her husband, Richard Worley.

CLINICAL EXCELLENCE

Miller Coulson Academy Inducts New Members

This spring, the Miller Coulson Academy of Clinical Excellence at Johns Hopkins inducted nine new clinicians — doctors who are the "best of the best" when it comes to providing patient care. The new class of Academy members joins 80-plus clinician members, from departments across Johns Hopkins Hospital and Bayview Medical Center, who are all committed to establishing initiatives and programs to advance excellence in clinical care.

The 2021 Miller Coulson Academy inductees are:

Gail Berkinblit, M.D./Ph.D.,
Department of Medicine, General Internal Medicine

Ed Bessman, M.D., M.B.A., F.A.A.E.M., F.A.C.E.P.,
Department of Emergency Medicine

Brian Garibaldi, M.D., M.E.H.P., F.A.C.P., F.R.C.P.(E.),
Department of Medicine, Pulmonary and Critical Care Medicine

Neda Gould, Ph.D.,
Department of Psychiatry and Behavioral Sciences

Elisabeth Marsh, M.D., F.A.H.A.,
Department of Neurology, Neurovascular

Leslie Miller, M.D.,
Department of Psychiatry and Behavioral Sciences

Heather Sateia, M.D.,
Department of Medicine, General Internal Medicine

B. Douglas Smith, M.D.,
Department of Oncology, Hematologic Malignancies

Sumeska Thavarajah, M.D.,
Department of Medicine, Nephrology

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