



Department of Medicine

**State of the Department Address
2006**

**Myron L. Weisfeldt, M.D., Chairman
September 8, 2006**

This summer, my wife and I and one of my daughters went biking in Nova Scotia for a week. We thought this was going to be the usual easy bike trip but we found out that in Nova Scotia there are a lot of hills. After biking 175 miles I wondered if Nova Scotia is like academic medicine with lots of hills that you have to climb? Academic medicine never was like biking on the Eastern Shore of Maryland where it is all flat. It is really more like the North County Trail that has about a 3% consistent uphill grade. And, then the really frightening thing happened when I returned to our hotel room and the Tour De France was on television. I thought it can't possibly be that's where academic medicine is headed. However that said, there are hills and challenges for all of us today.

I believe that the strength of this Department is not only in the depth but also the breadth of our commitment. No matter where in academic medicine there is discovery, advances in healing, new educational adventures, clinical service and delivery or

shaping public policy, this Department by its mission wishes to exert broad leadership. (Figure 1)

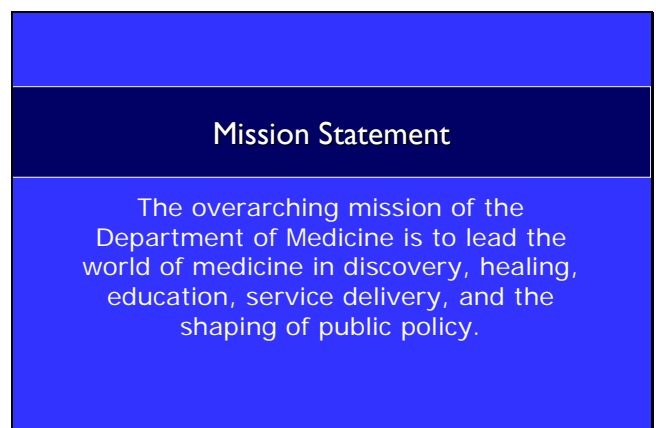


FIGURE 1

The medical school deans and senior faculty, who select the best programs for US News and World Report, have voted this Department the number one Department of Medicine in the country. I am very proud and you should feel recognized for your contribution to this Department. (Figure 2)



FIGURE 2

The breadth of interest as well as excellence of our faculty is reflected in the people who have been promoted to Professor at Johns Hopkins in the past year:

- Dr. Joel Gallant- Internationally recognized for clinical research and education in HIV.
- Dr. Tony Kalloo- Internationally recognized for clinical contributions to interventional gastroenterology.
- Dr. Charles Wiener- Broadly recognized for educational and housestaff leadership. His efforts will lead the integration of basic science and clinical medicine in the new Hopkins medical school curriculum.
- Dr. Roy Ziegelstein- Internationally renown and a real program builder for the Department of Medicine Bayview.

The Blueprint Retreat of the Department is going to be the basis of many of my remarks. The retreat occurred in March, 2006. It was off-campus and 275 of our faculty joined for an entire day. There were four

committees that met before, during and after the retreat and summarized findings with definitive reports. First, I will present highlights of each committee's charge for the past year: Educational, Faculty Development, Research and Clinical Programs. I will then provide some selected quotes from the report: challenging, positive and concerning. Finally I will present the key recommendations from the report and my current response.

I will begin with Education. In the housestaff programs, Bayview has achieved 5 years of certification. The program has a terrific group of recruits this year and a tremendous achievement in terms of fellowship acceptance. I think the second educational highlight is that now we have had 3 years of the Osler program under reasonable duty hours. There was substantial concern about the impact of "duty hours" on the quality of our housestaff education and our trainees. I do not believe that is an issue any longer. Yes, there is a difference in focus, policies and approaches to care and we've learned how to do that while maintaining the strong academic curiosity and forward looking and positive forces of this great housestaff program. Clinical training is superb.

I think all of us should be proud that this Department has led efforts of Johns Hopkins to increase diversity among the medical students, the housestaff, the fellowship programs and the faculty. We have

increased minority faculty and minority divisional leadership.

We have expanded our specialized fellowship programs in those special skills that make medicine so dramatically beneficial to our patients. We train the best of people in very specialized areas. Also, in education as far as highlights we have individual people who are providing strong, institutional leadership:

- Dr. Pat Thomas- Leads LCME Medical School Review.
- Dr. Charles Wiener- Leads the revision of the Hopkins Medical School Curriculum.
- Dr. Spiro Marinopoulous- Leads the new University Health Program.

The major educational issue this year is the planning and formulation of what will be the basic and advanced clerkships within the new curriculum. I personally believe that we need to teach basic skills, but that we also need to expose our medical students to the excitement of advanced or specialized medicine; so they “realize” as a medical student how exciting medicine is and how exhilarating it is to do medical housestaff training and fellowship training at Hopkins due to what “advanced” medical care offers.

What did the retreat say about education? *“The educational mission faces a crisis imposed by external financial and regulatory pressures- {the hills of Nova Scotia}. Financial concerns must not eclipse our mission.”* This is a very simple and profoundly

important comment. *“Teachers and program leaders must be supported with time, fair remuneration and promotion.” “Bedside and clinically based teaching has eroded.”* (Figure 3)



FIGURE 3

What do they recommend?

1. *“A system to track teaching activities with an evaluation component.”* Dr. Clements has recently appointed Marty Abeloff and Joe Confrancesco to lead a task force to deliberate this issue and to bring forward a proposal and a system. (Figure 4)



FIGURE 4

2. *“Time tied to compensation.”* The system for documentation and assessment is the preamble to discussing financial issues relating to teaching activities. At the end of my talk I will discuss how we

are working towards meeting financial challenges. If we meet our financial challenges, then we will provide support for teaching.

Focusing on recognition of teaching, I am very proud of the role I had in guiding the institutional deliberation with regard to the new Gold Book (the rules for promotion) (Figure 5) and the Silver Book (the guide

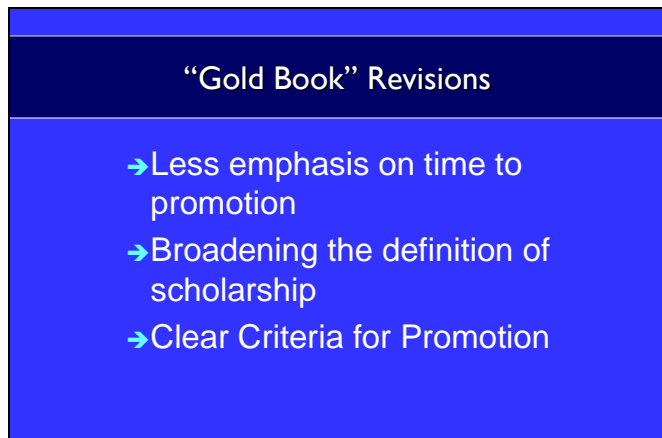


FIGURE 5

for faculty on promotion). One aspect of this revision of Hopkins criteria for promotion, is expansion of the definition of scholarship and means of achieving promotion. The simple changes that are now in place include less emphasis on time for promotion. As long as you are continuing to demonstrate evidence of progress of scholarship, you are welcomed as a member of the faculty of this Department and this Institution. We have broadened the definition of scholarship, particularly to include educational scholarship among the criteria for academic advancement. We have made it clear exactly what the key criteria are. We want our Associate Professors to be recognized nationally for their work and we wish to promote to Professor, faculty who are national leaders.

Their final recommendation is to further *“enhance the doctor-patient relationship at the bedside”*. (Figure 6)

I believe that better and focused Information Technology (IT) are key elements concerning the housestaff work issues. We need to concentrate on core clinical team building and support services related to our clinical care. I would remind everyone that the Division of General Internal Medicine at Bayview has a very strong teaching education component and will aid us in developing new programs to enhance bedside medicine. I take responsibility for focusing our leaders on this particular issue of doctor-patient relations and the quality of our care.

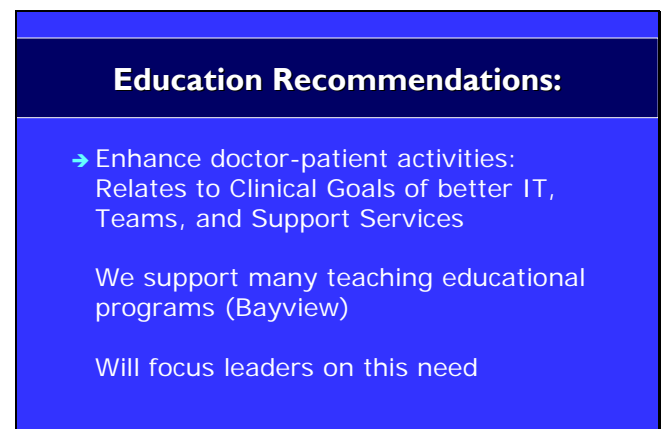


FIGURE 6

Let’s now look at the second retreat committee, Faculty Development. Our faculty has grown from 400 to approximately 475 members over the last 5 years. (Figure 7)

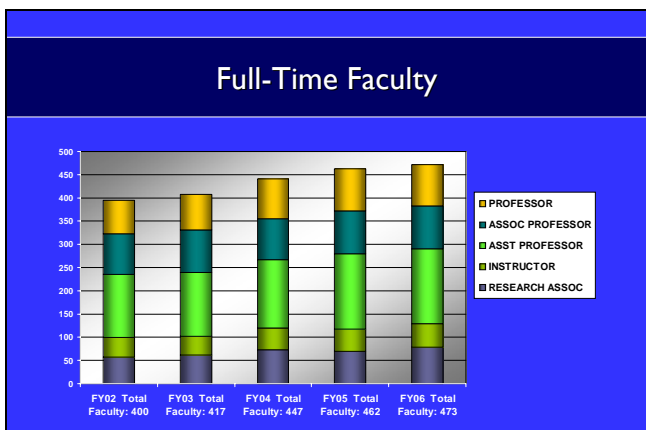


FIGURE 7

It is striking to see the increase of Professors. Associate Professors look stable over time. We are increasing Assistant Professors, Instructors and Research Associates. I think that these data reflect a key issue. There appears to be a major challenge to be promoted from Assistant Professor to Associate Professor in terms of the scholarly requirements.

We must bear in mind that fully one-third of our faculty are on the Bayview campus and that we have, with Dave Hellmann's leadership, increasing strength in academics, clinical programs and education at Bayview. (Figure 8)

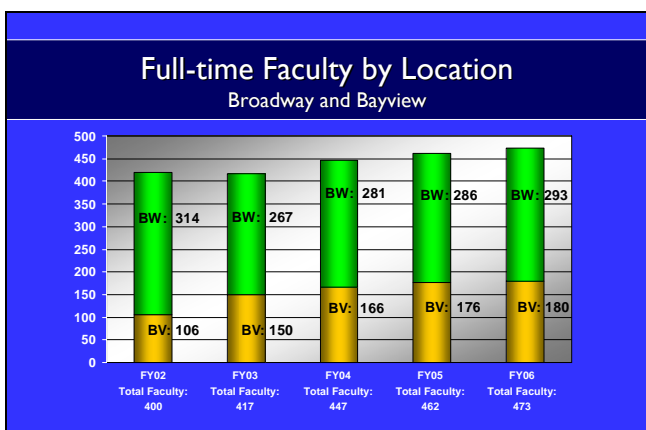


FIGURE 8

The following are the key comments of the report on faculty development:

"All faculty require individual, environmental, and leadership support that fosters and promotes success in our academic culture." (Figure 9) The following is by far the harshest comment to come from the retreat: *"Obstacles to faculty development identified over the past 15 years remain".*

**Key Blueprint Retreat Statements:
Faculty Development**

1. All faculty "require individual, environmental, and leadership... foster and promote success in our academic culture"
2. "Obstacles to faculty development identified over the past 15 years..."

FIGURE 9

This is a serious indictment, but this is not a problem across this department. We have model systems that have been successful. I think the best example (and not the only example) is the Welch Center. (Figure 10) For those of you who do not know about the Welch Center, it is approximately two blocks from the Hospital on Monument Street and comprises a group of faculty that combine the forces of the Department of Epidemiology in the Bloomberg School of Public Health with the Division of Internal Medicine and the Department of Medicine. It began 15 years ago and it trains and mentors fellows and faculty. How good has it been? It produced the Dean of the

Bloomberg School of Public Health, Mike Klag; the



FIGURE 10

Vice Dean for Clinical Research for the Johns Hopkins Medical School, Dan Ford, the leader of the Division of General Internal Medicine, Fred Brancati and the leader of the Division of Geriatrics, Linda Fried. Furthermore it has produced 3 additional professors at Hopkins and an enormous number of faculty for other institutions.

Lisa Cooper gave me a description of the mentoring program of the Welch Center. First of all, she defines mentoring as: *“A mentoring relationship is a relationship in which a person of greater rank and expertise guides and develops a novice or protégé in a profession. The mentor needs useful experience, knowledge, skills, wisdom and offers advice, information, guidance, support and opportunity”.*

How is that accomplished? *“1) Help the trainee identify their area of special interest. 2) Facilitate contacts with Hopkins faculty who have common interests. 3) Meet weekly to set goals and objectives to select research questions and data, develop protocols, track data collection, assist in analysis and*

review drafts of abstracts and manuscripts.” That is an active mentor. Then as time progresses the mentor, *“encourages the mentee to attend the mentor’s team meetings and research seminars. The mentor shares successful grants, papers and presentations and finally introduces the mentee to colleagues at regional and national meetings to afford job opportunities at the end of training”.*

So, how do we improve what we are doing? The recommendations are to expand the role of the Vice Chair for Faculty Development, Adrian Dobs. We will do that but with a major role by Susan MacDonald, our Associate Chair, who has always been concerned about annual reviews and faculty development on both the individual and collective basis. (Figure 11)



FIGURE 11

The committee also recommended that *“the major change in faculty development should take place at the divisional level”.* We believe either the Division Chief themselves or a special designee must be, if you will, the Mentor-In-Chief with adequate time to provide supervision and quality control and be a pivotal person in the mentoring approach. The

documents of the Gold Book and Silver Book are simple and straightforward and I believe will be also an aid in faculty development and understanding of the process of scholarship and promotion. I intend to continue to support the Women's Task Force and Diversity Council and their programs because they are both very concerned about the issues of mentoring, faculty development and all the problem areas.

If faculty development is the biggest hurdle, here is our biggest success: the research agenda. The overall revenue of the Department is now over a quarter of a billion dollars/year. (Figure 12) Every year when I



FIGURE 12

present this, the next year looks as if it's going to be flat, but it never is. The administrative staff of the Department is conservative. Yearly we evaluate revenues from research and clinical funds and support from the Hospital and the Medical School. What is striking is that the ratio of research revenue to clinical revenue has gone from about 2 dollars of research revenue for every dollar of clinical revenue to over 3 dollars of research revenue for every dollar of clinical revenue. Also there is an increase in hospital support.

With the NIH flat in terms of funding there is a challenge. But we are expecting at least \$12 million of new grants, not replacement grants, to be funded over the next year.

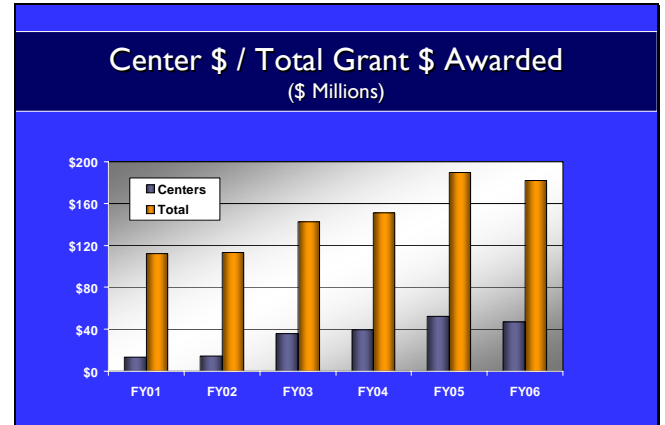


FIGURE 13

Our total research funding to medicine faculty including funds spent in other Departments and funding of multi-investigator grants is greater than \$180,000,000. (Figure 13) This figure of research funding per square foot continues to be well above the national average. (Figure 14) We certainly are appreciative of the space that has come to us and there is more space that will be available on the Bayview campus and in the new Rangos Building. We will again see more space for this Department. If

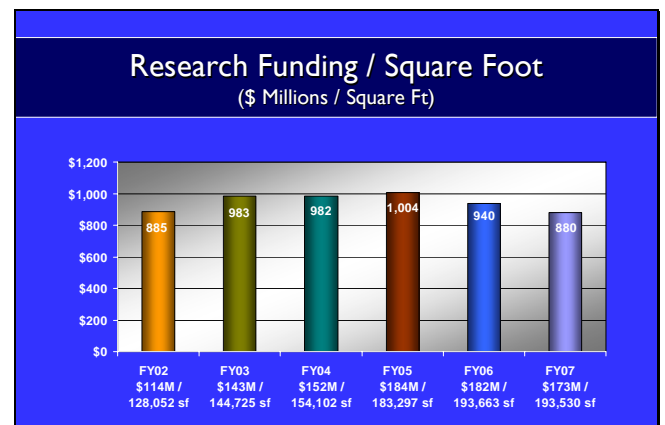


FIGURE 14

we look at the \$180,000,000 of total research revenue there are 257 of those faculty who are responsible for writing major research grants. Research Associates and Instructors are not really expected to write major grants and we have about 140 clinician educators who do not intend to do peer reviewed research. So if you take the 180,000,000 and divide it by 257, that means the average research contributory faculty person in this department brings in nearly \$775,000 per year per person of outside research revenue.

Therefore it is not surprising that the retreat committee on research said that *"the Department of Medicine is a world leader in research. The NIH is changing its research portfolio, multi-investigator and cross disciplinary grants that are increasing in their importance and their funding"*. (Figure 15)



FIGURE 15

The first recommendation is that *"there is a major need in new computational approaches"*. The second recommendation is to *"expand research centers in obesity, aging and inflammation"*. Those are all expanding as we speak. *"Finally, we need new and expanding research cores, particular to support the*

clinical research mission." We need the major grant



FIGURE 16

that we are making every effort to obtain. That grant will support many of the costs in the infrastructure elements that we need for clinical research. (Figure 16)

Finally, I want to turn to clinical care and our clinical programs and that committee's report. The increase in inpatient care is truly remarkable. With respect to patient discharges, in the last 4 years we have gone from about 24,000 to 28,000 discharges per year. (Figure 17) This has come on both campuses in large part by improving the efficiency and the way we take care of patients.

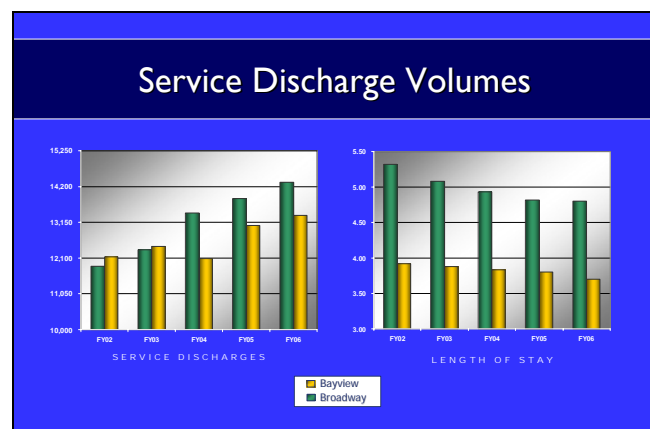


FIGURE 17

We have shortened the length of stay, not through perverse means, but through improving our timeliness of consultations and procedures, planning for discharge or doing what is right to see that care has improved. In fact, that is why the Hospital has contributed more financial support to this Department. We promise growth and improvement in the economics that will be based upon thoughtful, improvement and programs of patient care with each new program that the Hospital supports. Subsequently we improve and that is clearly a benefit mostly to our patients, but also of course to the Hospital and to the Department.

We also think about safety. We have demonstrated a remarkable level of achievement in terms of reduced bloodstream infections as an example of one of the many safety issues. One of the most important factors on which we are going to be judged is our consistency of performance by national parameters in common elements of care in acute myocardial infarction, heart failure and pneumonia. These will be concentrated areas of attention throughout the next

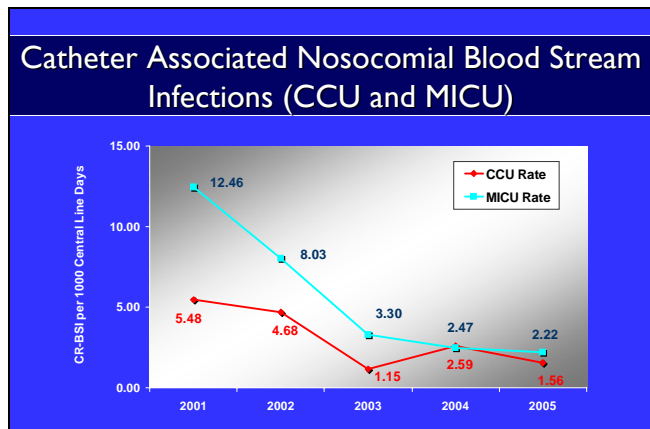


FIGURE 18

several months. (Figure 18)

Hospitalism is growing remarkably on both campuses and that is a way we have been able to preserve the intensity of work at a reasonable level for the housestaff, while increasing our patient volumes. Hospitalism, I believe, is here to stay. Hospitalists will soon have teaching and education for future Hospitalists. American medicine is changing to value the clinical care, teaching and a systems approach of physicians who concentrate attention on the complicated, in-hospital patient care environment. (Figure 19)

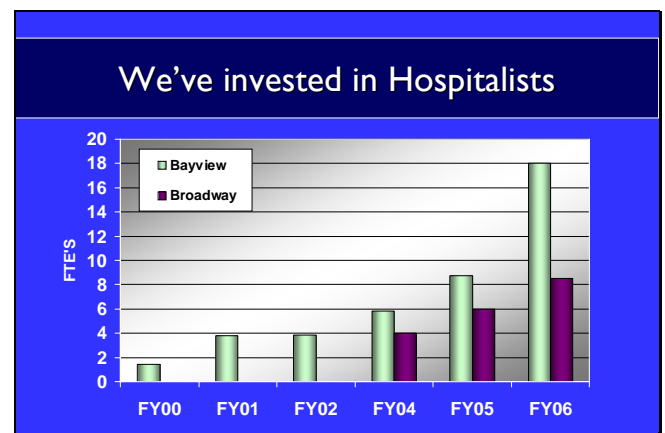


FIGURE 19

We also need to salute our nursing colleagues. Nurses are working harder and more efficiently everyday. This is evidenced by the increase in patient discharges while the number of nurses and support staff have not increased significantly. We pride ourselves in the fact that we are not shifting to a less skilled nursing staff. (Figure 20)

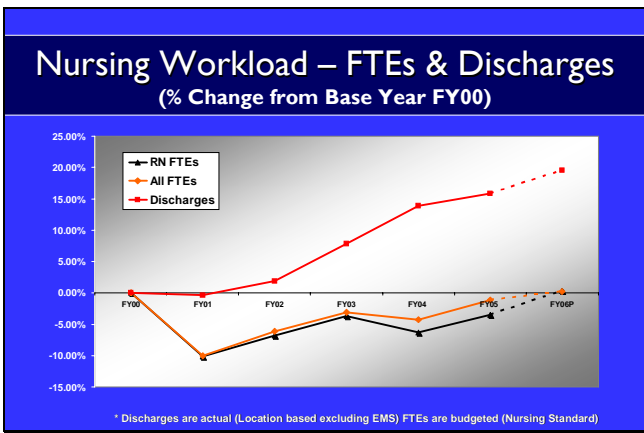


FIGURE 20

Comments from the clinical care retreat committee include: *“the fragmented nature of our IT systems with multiple unlinked systems collecting required redundant information and the lack of clinical decision support is problematic. Well coordinated Care Teams are increasingly important. The Department of Medicine should serve as a model to systematically study the work processes that make our optimal patient care and financial outcomes”.* (Figure 21)

**Key Blueprint Retreat Statements:
Clinical Care**

1. IT: *“the fragmented nature of our systems with multiple unlinked systems collecting and requiring redundant information... and the lack of clinical decision support is problematic”*
2. *“Well coordinated care teams are increasingly important”*
3. *“The Department of Medicine should serve as a model to systematically study the work processes that make for optimal patient care and financial outcomes”*

FIGURE 21

Medicine should be a voice to advocate IT solutions, not work around them. We have done this and this effort is led by Redonda Miller, Stuart Ray, Roy Brower, Steve Schulman and Dave Thiemann. We have emphasized the IT issues that deal with patient

safety and order entry in the last year. Because progress has been made, we now intend to shift our focus from that agenda to improving the IT solutions for documentation and problem solving. We must improve the efficiency and effectiveness of the IT systems that serve the needs of the medical housestaff. I think this is an important and key element to going forward in our clinical programs.

Blueprint Recommendations

- *“Medicine voice to advocate IT solutions” not work arounds:
First Patient Safety and Now housestaff efficiency...
Miller, Ray, Brower, Schulman and Thiemann*
- *Study clinical work processes and teams:
Academic hospitalist program
Housestaff initiatives
Improve procedural facility administration*
- *Define, measure and reward clinical excellence: Look to the new Gold and Silver Book*

FIGURE 22

We continue to study the clinical teams. I believe this should be a major focus of our academic hospitalist program. We have always looked to the housestaff to come to us with ideas about how we can improve the clinical theater. This year we intend to put considerable emphasis on improving our procedural areas: administration and operations in the catheterization laboratory and the GI and pulmonary endoscopy facilities. The final recommendation is to find, measure and reward clinical excellence and again this is really embodied in the new Gold and Silver Books. (Figure 22)

How are we going to meet our financial challenges? I do not believe that Medicare will in fact increase

physician compensation substantially. I hope and certainly all of us should communicate to the government that a 10-20% increase in Medicare payments after 5 years of flat Medicare payments is really important to cognitive medicine. However, I believe we will continue to be dependent on our cleverness and our hard work in other areas for improving our financial position.

First on the list is philanthropy and second is being business smart. We have seen significant success particularly in philanthropy. We need to pursue entrepreneurialism and patents and licensing for our ideas that have a practical value. We can gain financial support in return for our clinical expertise and leadership. We need to continue to improve care. The financial support of the Hospital for more effective programs is key. I would say that in the top of the list for better programs are substance abuse, nutrition and sickle cell anemia care.

We need to augment our sponsored clinical research portfolio. The Medical School is working hard to improve the infrastructure and the way in which clinical research grants are handled.

This was a record year in terms of philanthropy. We now have more than 16 million dollars per year from endowment and gifts to support our programs. Roughly 20% of that money is invested in the Hopkins building programs. (Figure 23)

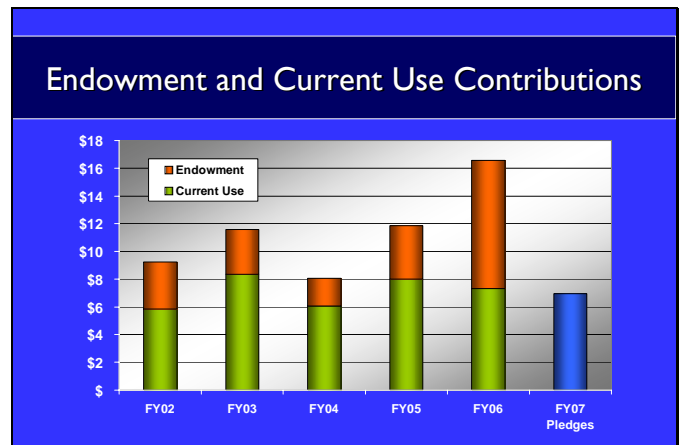


FIGURE 23

A major success story in this arena is Dave Hellmann's Center for Innovative Medicine. I am personally very proud that the endowment of this Department is growing substantially. I project that in that next year will be able to tell you that we have a 100 million dollar endowment. (Figure 24)

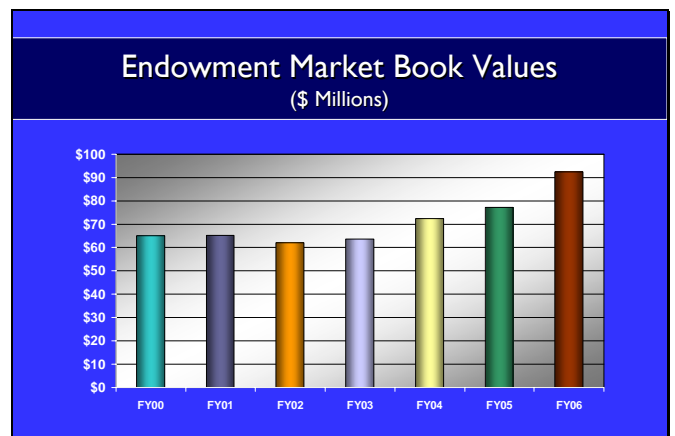


FIGURE 24

That certainly is one of the insurances against adversity in terms of research grants particularly for younger people. We have through licensing and technology, seen \$2.3 million this year come to cardiology and gastroenterology based upon licensing by the leaders of those two divisions.

Thanks Retreat Leaders!

- **Chair: Adrian Dobs**
- Consultants: Emma Stokes and JHH / JHU Staff
- Administration: JoEllen Stinchcomb

- **Committee Chairs:**
- Jeanne Clark and Joe Cofrancesco – Education
- Lowell Maughan and Jonathan Orens – Clinical Care
- Suzanne Jan de Beur and Elizabeth Wagner – Faculty Development
- Charles Lowenstein and Jerry Krishnan – Research

FIGURE 25

Finally, I want to thank the leadership of the retreat, Adrian Dobs, who led the overall efforts. Our consultant, Emma Stokes, administrative staff and particularly the co-chairs of each of the four committees with their long, hard and important work for this department (Figure 25). And additionally, I would like to thank you for your support and I want to tell you how proud I am to lead this great Department.