Three Little Words... and the difference they've made.
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Johns...Hopkins...Medicine

A ten-year report
Dear Friends,

IN THE SPRING OF 1996, I was appointed interim dean of the Johns Hopkins School of Medicine. Because I had come to Hopkins just the year before to head the Department of Anesthesiology and Critical Care Medicine, I had a fresh perspective on the challenges confronting the medical school and the Johns Hopkins Health System.

It didn’t take a rocket scientist to figure out what those were. Virtually all the department directors were nearing retirement age. Education—an endeavor in which Johns Hopkins had once led the nation—was in danger of taking a back seat to the remarkable clinical engine that our health system had become. Researchers were laboring in isolated, outmoded labs. Our clinical buildings had grown cramped and obsolete, yet there was no room and no money to build new facilities. And finally, the medical faculty and senior administration were disproportionately white and male.

The real issue, though, was the lack of an overall strategic vision. Hopkins desperately needed to look forward a decade, but the School of Medicine and the Health System had different boards of trustees, different priorities and increasingly different cultures. The level of conflict between the two organizations was high, and getting higher.

The trustees proposed a way to resolve that conflict: Merge the two organizations into one virtual entity called Johns Hopkins Medicine. Appoint a single chief executive, so they would speak with a single voice and lay out a shared vision. And because research and education have always formed the underpinnings for the Hospital’s clinical excellence, the trustees suggested that the dean of the School of Medicine serve as that executive.

A decade later, I’m happy to report that the new structure has prospered better than any of us could have dreamed. Today, our two medical campuses are in the midst of a rebirth, the biggest hospital expansion of its kind in U.S. history. We remain, year after year, the top-ranked hospital in America; our research program is flourishing, and we’re embarking on a complete restructuring of our medical education program. What’s more, diversity has become a major goal for Johns Hopkins Medicine. Some 120 women on the medical faculty have achieved the role of full professor; women have increasingly moved into leadership roles; and we are engaged in an all-out push to recruit more underrepresented minorities for similar positions.

What made it all happen? Three little words: Johns…Hopkins…Medicine. They’re so simple, but as you read this report, I hope you’ll agree that the collaborations, the unity of vision, mission and purpose they’ve made possible are profound. And well worth commemorating.

Edward D. Miller, M.D.
Dean/CEO, Johns Hopkins Medicine
THE LEVEL OF CONFLICT BETWEEN THE TWO ORGANIZATIONS WAS HIGH, AND GETTING HIGHER.
THEN: A DECADE AGO, as Johns Hopkins’ reputation as a leader in American medicine continued to grow, the picture at home looked more complicated. There was increasing awareness that the University component—the School of Medicine—and the patient care part—the Health System—were often not speaking with one voice. As academic medicine became more complex, that rift could become a chasm. Leaders here realized that medicine at Johns Hopkins needed a better organizational structure.

NOW: IN 1997, University President William Brody and Dean/CEO Edward Miller began blending the clinical and educational strategic missions for medicine. The unifying concept would be called Johns Hopkins Medicine. Miller’s first step, the two agreed, would be to start building a strong alliance with Ronald Peterson, head of The Johns Hopkins Hospital and Health System.

In the decade since then, Miller and Peterson have forged a remarkably collegial partnership—and a common vision. The benefits have been enormous: Today, the once-cramped and aging East Baltimore medical campus is well on its way to being rebuilt—supported by staggering sums in philanthropic contributions. The School of Medicine curriculum is being remodeled to reflect new understandings of the human body. And sitting at the helms of 25 of the School of Medicine’s 28 departments are new directors—some of the most respected names in American medicine—who have taken up the reins from retiring department heads.

How much of this success belongs to the blended governance structure and how much to its leadership won’t really be clear until that leadership changes. Miller plans to stay through the completion of the two new clinical towers. Peterson—consummate team player—says he’d like to stay on a few years longer. But that, he realizes, will be decided by Miller’s successor.
TEN YEARS SINCE THE RESTRUCTURING, TWO THINGS RING DEEPLY TRUE: ED MILLER AND I HAVE A REMARKABLE PARTNERSHIP. AND THIS GOVERNANCE STRUCTURE IS A GOOD ONE FOR JOHNS HOPKINS.
In 1995, I was running Johns Hopkins Bayview Medical Center, finishing up a $150 million modernization, when I was tapped to become executive vice president of the Johns Hopkins Hospital and Health System. At the time, there was a lot of tension between the Health System and the School of Medicine. Gradually the trustees of both institutions decided that maybe structural issues were involved as well as personality differences. The marketplace was changing, getting more complex. The managed care movement was beginning to exert more influence. Perhaps Hopkins needed to change, too.

In a move that showed courage and leadership, the boards of trustees of the Health System and the University entered into a new collaboration that they called Johns Hopkins Medicine. This fresh way of working, they reasoned, would make it easier for medicine's patient care side to coordinate with its educational and research sides. They established a separate board of trustees for Johns Hopkins Medicine and appointed the dean of the School of Medicine as CEO for the collaboration. For Hopkins, all of this made good sense. We're research intensive; we thrive on discovery; it's crucial to our preeminence.

For the past decade, the dean and I have been colleagues, not competitors. When we go to Annapolis to lobby on behalf of Johns Hopkins Medicine, we speak with one voice, and that's helped us get significant state funding for our new clinical buildings. School of Medicine priorities are incorporated into the design of the clinical towers—and gifts to the School of Medicine help support the construction. The trustees think more broadly now, too. We're refocused on the Hopkins mission.

Ten years since the restructuring, two things ring deeply true: Ed Miller and I have a special partnership. And this governance structure—which might not work elsewhere—is a very good one for Johns Hopkins.

If you look at what we’ve accomplished, it’s been a remarkable decade.
He Changed Surgery

Julie Freischlag, M.D.
Director, Department of Surgery

When I interviewed for this job, a lot of factors were not in my favor. First, I was a woman, and female surgery chairs are rare nationwide—only five others in U.S. history. Also, Hopkins had only two other female department chairs of small departments. Second, I was not Hopkins-trained. Worst of all, I was from ucla, not the East Coast.

So it was very noisy when I was hired. Some of the trustees gave Dr. Miller heat, and frankly, the adjustment wasn’t easy. I told the dean of the faculty, Janice Clements, “I don’t fit in; I’m different,” and she said, “That’s why we hired you.” Finally I decided to speak up, tell people my ideas for change. And it worked.

Today, I believe Johns Hopkins is more flexible in its problem solving. Also in its hiring. We now hire from all over the country. We’re more user-friendly, too—more courteous. We act more like Mr. Peterson and Dr. Miller.

The other chairs Dr. Miller has hired are great. So are the people who run the place. And when the new buildings are finished, we’ll be in nirvana for at least 10 years.

The organizational structure we have here works beautifully for the clinical chairs. Instead of having just one avenue of support, we have two. For example, I’ve just hired a new pancreas surgeon. The hospital’s paying his salary, but the School of Medicine is paying for his research, which is equally important.

Before I came, just 10 percent of our surgery residency applicants were women. Now, 30 percent are. When Dr. Miller hired me, he changed surgery, really liberated it. Not just here—all over the country. He’ll never know what a difference he’s made for women in surgery.
WE NOW HIRE FROM ALL OVER THE COUNTRY. WE’RE MORE USER-FRIENDLY, TOO—MORE COURTEOUS. WE ACT MORE LIKE MR. PETERSON AND DR. MILLER.
THEN: | BY THE MID-1990S, ALL OVER THE NATION, BASIC SCIENCE RESEARCH WAS CHANGING. Besides working in their own laboratories on specialized problems, investigators were turning to larger studies that blended disciplines. At Hopkins, the nine basic science departments—Biological Chemistry, Biomedical Engineering, Biophysics and Biophysical Chemistry, Cell Biology, Molecular Biology and Genetics, Neuroscience, Pharmacology, Physiology and Comparative Pathobiology—operated independently from each other and also from the clinical end of medicine. Collaborations occurred in spite of this organizational structure, not because of it.

Under the Basic Umbrella

Nine departments form the Institute for Basic Biomedical Sciences (see previous page) and also these eight research centers.

High Throughput Biology Center
This core facility develops technologies to examine gene and protein interactions in systems ranging from yeast cells to humans. It used to take years to identify such interactions in single pairs of genes or proteins. Now, this center’s labs identify thousands of functional interactions at one time.

Center for Epigenetics
Researchers here decipher the interactions between genes themselves and with their biochemical neighbors, such as chemical tags attached to DNA, or proteins that bind to DNA. Epigenetics, one of the most exciting fields of exploration, promises to illuminate diseases from cancer to Alzheimer’s.

Center for Sensory Biology
This is the world’s first research center devoted to exploring the molecules and biochemical pathways involved in all five human senses.

Center for Metabolism and Obesity Research
Scientists in this center focus on the cellular, molecular and hormonal mechanisms of two of the most urgent global health problems, obesity and diabetes.

Center for Cell Dynamics
Here, researchers develop technologies like biosensors and software to reveal how most cells divide and differentiate into normal tissues and organs—and how others may change shape and migrate as metastatic cancer cells.

Center on Drug Addiction
Researchers working here probe how brief exposure to drugs can generate lifelong changes in nerve cells, cellular communication and behavior.

Center for Chemoprotection
Research in this center explores toxicity-fighting molecules in edible plants that can counteract inflammation or other cellular stresses that contribute to cancer and degenerative conditions.

Center for Transport Biology and Medicine
This center’s focus is on the movement of water and salts into and out of cells. Researchers explore the role of faulty transport in such conditions as cystic fibrosis, hypertension and diarrhea.

Stephen Desiderio, M.D., Ph.D.
Director, Institute for Basic Biomedical Sciences

We Still Learn by Doing

When the Johns Hopkins University was founded in 1876, the English biologist Thomas Huxley—“Darwin’s bulldog”—spoke at the opening ceremonies. Huxley stressed the importance of posing new problems and finding new solutions, and praised Hopkins’ unusual emphasis on experimental science.

That emphasis hasn’t changed. One hundred and thirty years later, we still learn by doing. The bedrock of Johns Hopkins Medicine, in fact—in the lab and with patients—is doing new things, and doing them with our hands—what physicians call praxis.

Johns Hopkins has an honorable tradition in basic research. We made the Human Genome Project possible, by discovering restriction enzymes, and we created the field of medical genetics through pioneering studies of inherited disease. Those two discoveries reflect profoundly important and powerfully complementary views—one focusing on the chemical nature of the gene itself, the other on the interaction of genes and society.

When the Institute for Basic Biomedical Sciences was formed eight years ago, it was viewed as a research consortium that would achieve economies of scale. It’s done that, but it’s also sparked synergies, exciting research proposals and eight visionary new research centers. It’s allowed scientists from different departments to gather around shared biological and technical problems. It’s the opposite of divide and conquer—and it’s a new experiment.

I always like to make one point about Johns Hopkins Medicine: Yes, we have superb clinicians who are interested in science. And we also have superb scientists who are interested in the human condition. But what we achieve is greater than the sum of our parts.
ONE HUNDRED AND THIRTY YEARS LATER, WE STILL LEARN BY DOING NEW THINGS, AND DOING THEM WITH OUR HANDS—WHAT PHYSICIANS CALL PRAXIS.
Then: A decade ago, the main Johns Hopkins medical campus desperately needed to modernize and expand. But where? Hopkins’ East Baltimore location was landlocked. “Everybody was explaining why we couldn’t grow,” Edward Miller recalls. “I told them to come back when they could tell me how we could.”

There were other problems too—Hopkins lacked an overarching method for solving hidden threats to patient safety. And eroding collaboration between researchers and physicians threatened to limit the bench-to-bedside medicine that had made Hopkins famous.

Now: These days, Johns Hopkins Medicine has a new symbol: the construction crane. The slate of buildings completed or begun during the past decade is breathtaking in cost ($1.2 billion) and in scope. What’s more, Hopkins is now recognized as a national leader in the patient safety movement. And new approaches to treating diseases are moving with speed from our research laboratories to the marketplace and to patients worldwide. >>>
PUTTING THAT HOSPITAL THAT FAR AWAY WOULDN'T HAVE OFFERED THE BRILLIANT COLLABORATIONS THAT MAKE JOHNS HOPKINS MEDICINE THE BEST PEDIATRIC MEDICINE IN THE WORLD.
George Dover, M.D.
Director, Johns Hopkins Children's Center

I'M GLAD I STAYED PUT

A FEW YEARS AGO—as our child specialists wrestled with cramped conditions and a seemingly overwhelming set of obstacles to expansion of the Children's Center—Hopkins was offered a site in north Baltimore. There would be plenty of room to build a fine, free-standing pediatric hospital right away, and to expand in the future.

I turned it down. Why? Because putting that hospital that far away from the rest of our medical campus wouldn't have offered the proximities and brilliant collaborations that make Johns Hopkins Medicine the best pediatric medicine in the world.

I'm glad I stayed put, because in June 2006, Johns Hopkins Medicine began building a remarkable new pediatric hospital. The Johns Hopkins Children's Tower will be joined at the hip—floors one through five—to the Cardiovascular and Critical Care Tower; the two buildings will also share a common core of surgical and imaging suites and critical care facilities that will increase efficiency and also promote collaboration between pediatric specialists and adult specialists.

I'm convinced the new Johns Hopkins Children's Tower will be the outstanding children's hospital in America, bar none. Because it will be so closely linked to both the adult tower and to our research facilities, it will be more comprehensive and more innovative than any free-standing children's hospital is now, or ever could be.

A Building Overview

In 2000, Hopkins swapped land elsewhere for eight city-owned acres directly adjoining the campus. The new real estate offered room for two 12-story clinical towers. When these facilities are completed in 2009, they'll transform the skyline of Baltimore ... and reshape American medicine. But the towers are only part of the picture. Take a look at the whole scenario:

The Cardiovascular and Critical Care Tower will take collaboration and synergy to new heights. Its operating rooms will adjoin imaging suites, cardiac cath labs and recovery rooms. Whatever diagnostics, intervention or acute care a patient requires will be close at hand. Cath labs and ORs can swap functions as needed. That flexibility will be crucial as technologies change.

The Children's Tower will adjoin the CCT for the first five floors, sharing a core of ORs, imaging suites and emergency facilities. Labor and delivery rooms will adjoin the neonatal intensive care unit. Patient rooms will be large, private and family friendly. A 40-bed pediatric intensive care unit will nearly double today's capacity to care for critically ill children.

Two cancer research buildings—the Bunting-Blaustein Cancer Research Building and the David Koch Cancer Research Building—which house nearly 900 investigators

The Broadway Research Building, a 10-story tower of basic-science labs and faculty offices

The Harry and Jeanette Weinberg Building, a $100 million clinical facility that houses the Sidney Kimmel Comprehensive Cancer Center

The Armstrong Medical Education Building (see "Training Tomorrow's Doctors," page 29), a $100 million facility scheduled for construction in 2007–2008

John Shaw Billings—intellectual architect of the original Johns Hopkins Hospital—once said, "A hospital is a living organism .... The stream of life which runs through it is incessantly changing .... Its work is never done; its equipment is never complete." If Billings could see the current growth spurt of his organism now, he would surely smile and nod approval.
To Do No Harm

Take a look at some of the programs nurses and doctors have put to work here. They are helping our hospitals protect patients from harm better than ever before.

The Josie King Patient Safety Program Launched with a contribution from Josie’s parents by critical care specialist Peter Pronovost, this program is led by patient safety expert Marlene Miller. Two Josie King patient safety teams have spent the past four years attacking safety issues throughout the Children’s Center.

The Comprehensive Unit-based Safety Program (CUSP) Developed by the Center for Innovation in Quality Patient Care, CUSP is measuring and improving the culture of safety by responding quickly to issues. With a feature called Executive Rounds, for instance, CUSP ensures that senior leaders hear safety concerns directly from caregivers who staff the unit. Recently, this program was selected by the World Health Organization as a global model.

Patient safety dashboards These tools quantify and summarize safety-related data.

RASMAS The computer-based Risk and Safety Management Alert System safeguards patients against defective supplies, drugs, blood and even computer hardware or software by checking alerts and other data sources for product recalls. It’s been adopted by some 100 other U.S. health care organizations.

A $20 million computerized prescription system This investment now protects against medication errors and warns of potentially dangerous side effects and interactions.

A catheter safety checklist Modeled after aviation preflight checklists, this routine has sharply reduced bloodborne infections from cardiac catheters.

Peter Pronovost, M.D.
Director, Quality and Safety Research Group

Josie King Affected My Life

In 1990 I was a fourth-year medical student at Johns Hopkins. That August, my father died because his cancer, lymphoma, had been misdiagnosed and incorrectly treated.

My father’s needless death changed everything. It steered me into critical care medicine, it shaped my research interests, it made patient safety my passion.

Medical errors are a huge problem. In America alone, 7 percent of patients in academic medical centers experience medication mistakes, and nearly 100,000 of those patients die every year. A 2004 study at Hopkins estimated that in 2000 alone, some 4,000 U.S. children died from hospital errors.

In the past six years we’ve had three visible, preventable and tragic deaths here at Hopkins as a result of errors: One of those, Josie King’s, has affected my life and work profoundly. Josie was about the same age as my own daughter, Emma. When I saw Josie’s picture, it hit me: that could have been Emma. I met with Josie’s parents, I cried with them, and I redoubled my efforts.

The right way, the redemptive way, to respond to preventable deaths is not to point fingers or assign blame; redemption lies in detecting the weak safety links in our systems, and strengthening them.

At Hopkins, we place a huge premium on discovering new ways to cure our patients. My goal is for our culture to place just as much emphasis on keeping patients safe.

It’s too late to save my father, too late to save Josie. But by making their deaths matter, by making them catalysts for change, we’re saving others. Thousands and thousands of others.
IT'S TOO LATE TO SAVE MY FATHER, TOO LATE TO SAVE JOSIE. BUT BY MAKING THEIR DEATHS MATTER, BY MAKING THEM CATALYSTS FOR CHANGE, WE'RE SAVING OTHERS. THOUSANDS AND THOUSANDS OF OTHERS.
AT FIRST I THOUGHT IT WAS A DREAM; WHEN I REALIZED THE SOUND WAS REAL, I BEGAN TO WEEP. FOUR MONTHS LATER, I WAS ABLE TO HEAR JOHN CRYING IN THE BACKYARD, EVEN THOUGH THE DOOR WAS CLOSED.
Heather Whitestone McCallum
Miss America 1995

THE SOUND OF TWO HANDS CLAPPING—AND ONE CHILD CRYING

When I was 18 months old, meningitis and a high fever almost killed me. My doctors gave me two strong antibiotics, which saved my life—but I lost my hearing.

As I grew up, my mother and Helen Keller became my role models, inspiring me to pursue big dreams. Ballet and a competitive sport called orienteering that involves cross-country running gave me the confidence I needed to enter pageants.

I was relatively content with minimal hearing until my older son, John, started walking. One day he fell down in the backyard, and I saw my husband go to comfort him. He had heard John crying; I had not. Right then, I decided to have a cochlear implant in my right ear. I came to Dr. John Niparko at Hopkins.

On September 19, 2002, Dr. Niparko awakened my right ear from a 28-year sleep. My family was in the room when I heard my first sound—the clapping hands of my audiologist, Jennifer Yeagle. At first I thought it was a dream; when I realized the sound was real, I began to weep. Four months later, I was able to hear John crying in the backyard, even though the door was closed.

Over the next four years, I lost the last of my hearing in my left ear. So in August 2006, Dr. Niparko installed a second implant.

Understanding a world of new sounds hasn’t been easy, but it’s been worthwhile. I feel blessed today.

New Approaches to Disease

This sampling of recent news stories hints at the remarkable “translational medicine” taking place here as researchers and clinicians blend their knowledge.

Triple swap kidney transplants Surgeons at the Johns Hopkins Comprehensive Transplant Center have pioneered “triple swap” transplants, in which three pairs of kidney patients and incompatible family donors are rearranged. That means each patient “trades up” to a more compatible donor. Nationwide adoption of the round-robin technique could allow hundreds or even thousands more kidney transplants every year.

A new way of attacking severe aplastic anemia
This approach to treating patients with the rare and deadly autoimmune disease was developed by hematologist Robert Brodsky. He discovered how to use high doses of a powerful immune-system suppressant to temporarily shut down both the haywire immune system and the failing bone marrow. The immune system then reboots and the bone marrow gradually revives. The treatment is saving lives and also proving effective against other autoimmune disorders.

A vaccine for women with cervical cancer
Developed here by basic scientists Drew Pardoll and T.C. Wu, the new vaccine boosts the immune system’s ability to destroy cells infected with the human papilloma virus that causes cervical cancer—a disease that kills some 300,000 women each year. Human trials are now under way.

Much-cited researchers
Science Watch’s summary of frequently cited cancer researchers between 1995 and 2005 placed five researchers from Johns Hopkins at the top of its list. Scientific articles by Bert Vogelstein, Kenneth Kinzler, James Herman, Stephen Baylin and David Sidranski were referenced more than 90,000 times by their peers.

Halting a death threat
When pediatric cardiologist Hal Dietz and his colleagues demonstrated in mice that a common blood pressure medicine, losartan, could prevent the most deadly problem associated with Marfan syndrome—a potentially fatal rupture of the aorta—it became one of the most exciting news stories of 2006.
THEN: Medicine was about to enter a period of amazing change as Johns Hopkins Medicine got off the ground in 1997. Within two years, a Hopkins researcher named John Gearhart would become famous throughout the scientific world for isolating human stem cells, the fundamental building blocks of the human body. At the same time, new understandings of the long-obscured microworld of DNA strands coiled within our cells would open possibilities for a modern kind of “genetic medicine.” With these new fields of knowledge would come the promise of combating diseases once thought incurable.

NOW: Today—with Vice Dean for research Chi Dang at the helm of the School of Medicine’s world-renowned research engine—Johns Hopkins Medicine is emerging as a leader in both genetic medicine and stem cell research. By bringing together scientists with similar interests and providing them with sophisticated labs and vital core equipment, collaborations and exchanges are sparking unusual insights. >>>
Ted Dawson, PH.D.
Co-Director, Neuroregeneration and Repair Program
Institute for Cell Engineering

It would be a shame for this country

If you had asked me three years ago if it would be possible to turn an adult neuronal stem cell back into an embryonic stem cell, I’d have said no. But it’s clear now that it is possible. And by learning more about how to turn cells back—how to undifferentiate them—we’ll learn a lot more about how to turn them forward, how to differentiate them into whatever cells we need.

Creating neurons from stem cells—the focus of research that the Neuroregeneration and Repair Program conducts—represents a remarkable opportunity: a chance to cure neurodegenerative diseases like Parkinson’s and Lou Gehrig’s. But it’s also a huge challenge because neurons have to connect in very complex ways. The big focus of the Institute for Cell Engineering is on getting cells to the point where they can be put in the body and work. That’s the Holy Grail.

The future is coming so fast, it’s hard to envision. Ten years from now, I may be able to go to a physician and say, “I’d like some new knee cartilage, please.”

The real obstacles to stem cell therapies aren’t scientific, they’re political and financial. We may lose a whole generation of scientists to other countries if political restrictions and funding constraints don’t ease soon. People like me will stay here and continue to make contributions, but young researchers are already looking overseas.

It would be a shame to lose them—a shame for Hopkins and a shame for this country. Think of all the people with diabetes and Parkinson’s and heart disease who could be helped by breakthroughs in stem cell research.
THE FUTURE IS COMING SO FAST, IT’S HARD TO ENVISION. TEN YEARS FROM NOW, I MAY BE ABLE TO GO TO A PHYSICIAN AND SAY, "I’D LIKE SOME NEW KNEE CARTILAGE, PLEASE."
The Team at the Table
Johns Hopkins Medicine senior management

Chi V. Dang, M.D., Ph.D.
Administrative Title: Vice Dean for Research
Job Description: Oversees research activities for the School of Medicine, including conflict-of-interest issues and technology-transfer initiatives; directs the Institute for Cell Engineering.
Years at Hopkins: 20
Other Titles: Professor, Medicine, Oncology, Cell Biology and Pathology; The Johns Hopkins Family Professor

David B. Hellmann, M.D.
Administrative Title: Vice Dean, Johns Hopkins Bayview Medical Center
Job Description: Works with Johns Hopkins Medicine’s top leadership to coordinate and manage clinical, research and teaching programs at Johns Hopkins Bayview.
Years at Hopkins: 21
Other Titles: Chairman, Department of Medicine, Johns Hopkins Bayview; Aliki Perotti Professor

Ronald R. Peterson
Administrative Title: President, The Johns Hopkins Hospital and Health System; Executive Vice President, Johns Hopkins Medicine
Job Description: Provides executive oversight of the Johns Hopkins health care delivery system; partners with Edward Miller in solidifying the alliance between the Johns Hopkins Health System and the Johns Hopkins School of Medicine
Years at Hopkins: 34
Other Titles: Professor of Anesthesiology and Critical Care Medicine and Pediatrics; Mary Wallace Stanton Professor of Education

William A. Baumgartner, M.D.
Administrative Titles: Vice Dean for Clinical Affairs
Job Description: Plans, manages and coordinates activities for a group practice of 1,700 Hopkins faculty physicians.
Years at Hopkins: 25
Other Titles: Cardiac Surgeon in Charge; President, The Johns Hopkins University Clinical Practice Association; The Vincent L. Gott Professor

Edward D. Miller, M.D.
Administrative Title: Dean of the Medical Faculty of The Johns Hopkins University School of Medicine and CEO of Johns Hopkins Medicine
Job Description: Leadership responsibility for all matters affecting Johns Hopkins Medicine and The Johns Hopkins University School of Medicine
Years at Hopkins: 13
Other Titles: Professor of Anesthesiology and Critical Care Medicine; Frances Watt Baker, M.D., and Lenox D. Baker, Jr., M.D. Dean of the Medical Faculty

Chi Dang
David Hellmann
Ron Peterson
Bill Baumgartner
Ed Miller
Steve Thompson

**Administrative Title:** Senior Vice President, Johns Hopkins Medicine  
**Job Description:** Guides development of Johns Hopkins Medicine through oversight of strategic planning, marketing and the development of ambulatory clinical activities.  
**Years at Hopkins:** 23  
**Other Titles:** CEO, Johns Hopkins Medicine International

Steve Rum

**Administrative Title:** Senior Associate Vice President for Development and Alumni Relations  
**Job Description:** Oversight of all philanthropic activities for the Fund for Johns Hopkins Medicine; communicating and engaging with Johns Hopkins medical alumni.  
**Years at Hopkins:** 2

Joanne Pollak

**Administrative Title:** Vice President and General Counsel, The Johns Hopkins Health System and Johns Hopkins Medicine  
**Job Description:** Leadership responsibility for all legal matters affecting the Health System and Johns Hopkins Medicine. These include business, personnel, governance, professional liability, patient care, institutional review boards and other matters.  
**Years at Hopkins:** 13

Rich Grossi

**Administrative Title:** Vice President and Chief Financial Officer, Johns Hopkins Medicine  
**Job Description:** Assures the financial viability of Johns Hopkins Medicine and each of its entities. Leads a team charged with helping execute new business development and external business relationships.  
**Years at Hopkins:** 28  
**Other Titles:** Senior Associate Dean, Finance and Administration, School of Medicine

Janice Clements

**Administrative Title:** Vice Dean for Faculty  
**Job Description:** Ensures that the leadership and culture of the School of Medicine support the promotion and development of the Johns Hopkins medical faculty, its greatest resource.  
**Other Titles:** Professor, Molecular and Comparative Pathobiology, Neurology, Pathology, Molecular Biology and Genetics; Mary Wallace Stanton Professor for Faculty Affairs; Director, Retrovirus Laboratory  
**Years at Hopkins:** 27

Janice Clements, Ph.D.

**Administrative Title:** Vice Dean for Faculty  
**Job Description:** Ensures that the leadership and culture of the School of Medicine support the promotion and development of the Johns Hopkins medical faculty, its greatest resource.  
**Other Titles:** Professor, Molecular and Comparative Pathobiology, Neurology, Pathology, Molecular Biology and Genetics; Mary Wallace Stanton Professor for Faculty Affairs; Director, Retrovirus Laboratory  
**Years at Hopkins:** 27

Daniel E. Ford, M.D., M.P.H.

**Administrative Title:** Vice Dean for Clinical Investigation  
**Job Description:** Institutional responsibility for protection of human research subjects; monitoring and maximizing the efficiency and effectiveness of clinical research; supporting clinical and translational researchers.  
**Years at Hopkins:** 19  
**Other Titles:** David M. Levine Professor of Medicine
by 1997, Hopkins’ famous medical school curriculum was losing ground. The accelerating pace of genetic medicine and the advent of new classroom technology made clear that our program needed to change to remain current. Sadly, our education building was hampered by limited computing resources, outmoded instructional technology and cramped group-study space.

HISTORY COULD BE ABOUT to repeat itself. A century ago, the Flexner Report—a nationwide study of hospitals and medical schools—named Hopkins as the gold standard in American medical education. Other medical schools began modeling their programs after ours. Now, our School of Medicine is once more about to refashion its approach to educating tomorrow’s doctors. This time, the building where this new curriculum unfolds will feature every bell and whistle available for teaching—in surroundings meant for learning.

At the start of the 20th century, Johns Hopkins was America’s undisputed model for medical education. Early in the 21st century, we’re committed to maintaining that distinction.
TODAY’S MEDICAL STUDENTS WILL BE PRACTICING INTO THE MIDDLE OF THIS CENTURY; WE NEED TO GIVE THEM A WAY TO ASSIMILATE NEW INFORMATION AS MORE GENES ARE LINKED TO DISEASES. OUR NEW CURRICULUM, GENES TO SOCIETY, DOES JUST THAT.
David Nichols, M.D.

Vice Dean for Education

POWERFUL NEW WAYS OF TEACHING

Seven years ago, as I was leading rounds on the pediatric intensive care unit, Ed Miller tiptoed up behind me—no small feat for such a big guy—and asked me to come see him. An hour later, he asked me to serve as vice dean for education.

I thought it would be a huge challenge, but I was wrong: It’s been multiple huge challenges.

One has been the complete revamping of our medical curriculum, a process we began five years ago. Another has been the design of a new education building—an undertaking we began in 2004. Only now, are we completing both these projects. Each of them is a heavy weight. Together, they’re a once-in-a-lifetime opportunity.

Today’s medical students will be practicing into the middle of this century; we need to give them a way to assimilate new information as more genes are linked to diseases. Our new curriculum, Genes to Society, does that.

Genes to Society also relies on powerful new ways of teaching and sophisticated technologies. We plan for instance, to take whole-body CT scans of every cadaver before it’s dissected in Anatomy, so lab teams can refer to the scans before, during and after dissection. We’re also reinvesting in the human touch—committing more faculty time to advising and mentoring than ever before. Mentors have played a crucial role in my career; I want all our students to have the same advantages I’ve had.

Preparing Tomorrow’s Doctors

The convergence of these opportunities could reshape medical education, here—and elsewhere.

Our new curriculum, Genes to Society, reflects the revolutionary advances of the Human Genome Project, genetic medicine and systems biology. It incorporates not just new content but a new way of organizing biomedical knowledge into levels of increasing sophistication, just as genes are organized into cells, tissues, organs, systems and organisms. Genes to Society is designed to serve as a framework for lifelong learning.

A new medical education building, launched by a $20 million gift from Anne and Michael Armstrong, is being designed from the ground up to support the new curriculum. It will harness multimedia technologies, CT scans and MRIs from Hopkins’ clinical facilities, 3D virtual-reality teaching tools, and abundant resources for online research, small-group study and other innovative learning techniques. The Armstrong Medical Education Building will also serve as a new “front door” and intellectual crossroads for the entire School of Medicine.

The Colleges Advisory System, a new organizational structure that assigns every medical student to one of four “colleges,” will create strong student bonds within each class—and across all four years of medical school. The colleges will also link students to faculty mentors, who are dedicating an unprecedented 20 percent of their time to teaching and advising. These colleges will share an entire floor of the Armstrong building.

A new simulation center opening this year will teach clinical procedures and communication skills faster and better. Equipped with highly instrumented teaching manikins and virtual-reality systems, the SimCenter will allow students to practice and master skills as simple as inserting a line in a vein, as complex as performing a Whipple procedure.
THEN: A DECADE AGO, BEYOND ITS “MOTHERSHIP” campus, Hopkins had scarcely capitalized locally on its national preeminence. Johns Hopkins Bayview Medical Center was just beginning to take shape as a second Hopkins health care facility. And only one suburban outpatient center met the public demand for Hopkins care outside East Baltimore.

NOW: OVER THE PAST DECADE, Johns Hopkins Medicine has burgeoned as it seized opportunities and created alliances. The groundwork for this broader Hopkins became a $150 million program that transformed the Bayview Medical Center into a modern, 331-bed hospital and outpatient center. Today, under the leadership of its determined president Greg Schaffer, Bayview excels in burn treatment, geriatrics, gastroenterology, and asthma and allergy medicine. Its campus also serves as home to the largest NIH clinical research facility outside Bethesda.

And this is just the beginning. Johns Hopkins Medicine outposts now dot the Maryland map. >>>
Victor Broccolino
President, Howard County General Hospital

OUT OF THE SHADOW, INTO THE FOLD

In 1992, the chairman of the board of trustees at Howard County General Hospital asked me to tell the trustees what I thought the future held for us. I said, “I think we’ll need a partner within this decade. We’re too small to compete. The community is growing. It’s that simple.”

In 1996, I said it again with some urgency. We had a dominant market position, we were profitable, and I knew we’d never be in a better position to choose our partner. We sent out an RFP and received 16 proposals. After several rounds of interviews and discussions, we narrowed the field to three—a religious hospital, a for-profit chain and Hopkins. Then we asked our professional staff and our community for input.

The two groups made their feelings crystal clear: Hopkins wasn’t just the gold standard in medicine; Hopkins was the platinum standard. When the time came to take a vote, I asked my board, “Who do you think will still be around and supportive 50 years from now?” The vote for Hopkins was unanimous.

The day our decision was reported in the newspaper—long before we formalized the affiliation—I got on a hospital elevator with two visitors. One elderly lady turned to the other and said, “You can certainly see the improvements around here since they joined Hopkins!” I knew then we’d made the right choice. I’m even more certain today. Hopkins’ resources—medical, human and financial—have driven a remarkable expansion of our facilities and services.

I grew up on Monument Street, in the shadow of Hopkins. My mother—an Italian immigrant seamstress—always hoped I’d become a Johns Hopkins doctor. I didn’t achieve that goal, but I’m very proud to be a part of the Hopkins system.

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A Network of Possibilities

Here are a few of Johns Hopkins Medicine’s other major presences in Maryland:

**Johns Hopkins at Green Spring Station**
Created as a hedge against the shrinking dollars of managed care, the first Hopkins pavilion at Green Spring Station opened in 1994 to enthusiastic response by suburban patients. A second pavilion opened in 1998, and a third is now on the drawing boards. With some 250 physicians and 16 specialties on site, Green Spring Station is a $100 million-a-year Hopkins venture.

**Johns Hopkins at White Marsh**
Following the success of Green Spring Station, a 50,000-square-foot outpatient center in White Marsh opened in July 2003, offering primary care as well as specialty care in nine disciplines.

**Johns Hopkins at Odenton**
This third ambulatory hub was established to reach the growing suburban Washington, D.C., market. The 40,000-square-foot facility offers a range of primary and specialty services provided by Johns Hopkins Medicine.

**Johns Hopkins Community Physicians**
Hopkins outpatient services are now offered through affiliated clinicians at 15 sites. Several of these communities are slated for rapid growth because of military base relocations. Others in central Maryland have witnessed continued growth.

**Howard County General Hospital**
Since its acquisition by Hopkins in 1998, Howard County General—the largest hospital between Baltimore and Washington—has grown steadily. Its latest expansion will be a five-story, 90-bed addition slated to open in 2010.
ONE ELDERLY LADY TURNED TO THE OTHER AND SAID, “YOU CAN CERTAINLY SEE THE IMPROVEMENTS AROUND HERE SINCE THEY JOINED HOPKINS!”
**THEN:** Split between the School of Medicine and the Hospital, the 13,000 employees on the East Baltimore campus had two different sets of benefits. Equally troublesome, the separate organizations had no coordinated strategy for moving employees ahead. Morale and retention were dropping among nurses, technicians, administrative staff and other employees.

**NOW:** A unified vision, consistent benefits and an array of employee-development programs have boosted retention and job satisfaction among employees. “It’s like the difference between patient care and patient-centered care,” says Pamela Paulk, Hospital vice-president for human resources. “We practice employee-centered management.” Hopkins’ employee- and family-friendly initiatives, Paulk says, result directly from the sea change that took place when Johns Hopkins Medicine came into being.

“It’s the leadership—it’s those two guys, Miller and Peterson. Both of them firmly believe that our employees are what make us great.”
FOR ME, THE LUCKY PART WAS COMING TO WORK AT JOHNS HOPKINS. THIS PLACE HAS STOOD BY ME EVERY STEP OF THE WAY, AND I KNOW IT WILL BE THERE FOR ME AS I KEEP GOING, TOO.
All for Employees

What the workforce shortage in health care means, says Pamela Paulk, Johns Hopkins Hospital vice president for human resources, “is that we have to value our employees and grow our own by making retention and development a priority.”

Among the ways Johns Hopkins Medicine has gotten serious about this mandate are:

Beefed-up education benefits
Hopkins now boasts one of the most generous tuition-reimbursement programs in any industry. At any given time, more than 1,000 employees are receiving education benefits, including roughly 200 in nursing school. Other education benefits range from flexible hours, which allow employees to take classes part time, to intensive, skills-development programs with motivational names like REACH and STEP.

Child care centers
The Johns Hopkins Child Care and Early Learning Center, which opened in East Baltimore in 2001, does more than just babysit its 112 kids; it also offers language, math and science programs. The child care center at Johns Hopkins Bayview, which now serves 40 children, will more than double in size in 2007.

Backup elder care and child care
This program arranges for prescreened, bonded elder-care and child-care workers on a short-term basis. Costs are shared by employees and Hopkins.

Mentoring and outreach programs
Designed to interest students in medicine—and in Hopkins—school-based programs in Baltimore City schools have reached thousands of young people, all the way down to elementary school. When you’re growing your own, it’s never too early to start sowing seeds.

Elliott Ward
Pharmacy Technician, Johns Hopkins Medicine

RX FOR SUCCESS

I’d worked as a guard before I started here. But I always wanted to come to Hopkins because I’d heard about the benefits, especially education. My son was a baby then, and I wanted to be able to give him good opportunities. Then, in 1998, Hopkins hired me to work in security.

Pretty soon, I started taking college courses through Baltimore City Community College. My tuition was paid through my benefits. After that, I applied for step—the Skills Training and Enhancement Program—a special Hopkins program that’s designed to create better career opportunities for working parents. In January 2003 I started training as a pharmacy technician. I was in school two full days a week, but Hopkins paid me for my regular 40 hours. The program only took four months, and I passed the national certification exam even before finishing the class. We had a graduation ceremony at the end, and Dr. Miller, the head of Johns Hopkins Medicine, and Pamela Paulk, the head of HR for the Hospital, came.

I’m still taking classes at bccc—chemistry, precalculus and history this semester—and doing pretty well. At one point, I thought about giving up, but Dr. Miller and Mr. Peterson, the head of the Hospital, and my church pastor encouraged me to keep on. By next summer, I’ll have enough credits to apply to pharmacy school. I know it’ll be hard financially once I’m in school full time. But sometimes you have to sacrifice to succeed.

For me, the lucky part was coming to work at Johns Hopkins. This place has stood by me every step of the way. And I know it will be there for me as I keep going, too.
A Community Reborn—East Baltimore Comes Back

THEN: Efforts to renew the blighted East Baltimore communities north of the medical campus—block by block, house by house—were going nowhere fast. Efforts to rehab houses had floundered. Drugs, crime and troubled schools were the norm for our neighborhood.

NOW: Today, East Baltimore is undergoing a remarkable renaissance, marked by gleaming biomedical buildings and inviting townhouses, apartments and outdoor cafés. The rising Hopkins tide—roughly $2 billion worth of construction projects—offers unprecedented opportunities for revitalizing the surrounding neighborhoods through jobs and housing developments. >>>
Mammoth Endeavors of East Baltimore

The public-private venture EBDI—East Baltimore Development Inc.—is orchestrating an 80-acre, $1.2 billion redevelopment program whose linchpin is the new Life Sciences and Technology Park. Before Katrina devastated New Orleans, the EBDI venture ranked as the nation’s biggest urban revitalization program. Plus this; a larger development—called New EastSide—will include a community school, shops, green-space and 1,200 new or renovated homes for mixed-income buyers and renters. The redevelopment project is expected to create up to 6,000 new jobs.

Some Hopkins contributions to East Baltimore are more personal:

In December 2003, Vice Dean David Nichols saw two young brothers die in the pediatric intensive care unit—burned in a house fire started by candles after their electricity was cut off. Horrified by the needless deaths, Nichols organized a task force to work with utility companies, legislators and residents to prevent similar tragedies.

Hopkins medical students are a powerful source of outreach, individually and through groups such as the InterAction Council. InterAction coordinates programs ranging from tutoring and mentoring to social-justice advocacy and volunteer service in community health clinics.

The Dunbar-Hopkins Health Partnership has provided internships, lectures, tours, projects and other learning opportunities during the past decade for hundreds of students at East Baltimore’s Dunbar High School. Some of the program’s “alumni” are now Hopkins students and employees. Others are enrolled in medical school—proof that living near Hopkins can launch great careers.

Deidra Bishop
Director, East Baltimore Community Affairs

CYCLING THROUGH EAST BALTIMORE, JOHNS HOPKINS—AND LIFE

The summer I was 14, I worked as a Candy Striper at Hopkins. I was too young for a real job, so volunteering was a way to do something positive. I took great pride in that peppermint-stick uniform and those white shoes.

After work I’d go to my grandparents’ house in the 700 block of East Lafayette, just blocks away from the Hospital. That was a wonderful area then—nice houses, lots of trees, middle-class families—back before Bethlehem Steel closed and things began to decline. I remember what it was like when I was a child, and I hope to see that same vibrancy return.

You know, people talk about East Baltimore as if it were a single, homogeneous community, but it’s not; it’s many communities—McElderry Square, Oliver, Collington Square, Middle East and others—each with its own character and challenges. Once you understand the differences, the challenges look even bigger. But until you understand those differences—until we at Hopkins understand the differences—we can’t tackle the problems realistically. If we’re in the neighborhood, it’s important to be a partner.

I believe in cycles. Communities have cycles; so do people. My own cycle has brought me back here, back to the neighborhood where my grandparents lived, back to where I first played a part in what is now Johns Hopkins Medicine. I didn’t plan this, and I could never have imagined it. But here I am. And it’s the right place to be.
I BELIEVE IN CYCLES. **COMMUNITIES HAVE CYCLES;** SO DO PEOPLE. MY OWN CYCLE HAS BROUGHT ME BACK HERE, BACK TO THE NEIGHBORHOOD WHERE MY GRANDPARENTS LIVED.
THEN:  In 1997, Hopkins’ international “outreach” consisted of recruiting patients from overseas in order to bring in more revenue. Those fees boosted the bottom line—but did nothing to advance the Hopkins mission or raise the standard of care in other countries.

NOW:  Thousands of international patients still come to Baltimore to see Hopkins physicians, but today Johns Hopkins Medicine is taking its models for patient care, teaching and research to the world. >>>
TODAY **HOPKINS IS AT WORK IN COUNTRIES AROUND THE WORLD**—WHICH I DOUBT WOULD BE POSSIBLE IF WE STILL HAD DIVIDED LEADERSHIP.
Charles W. Cummings
Director of Medical Services,
Johns Hopkins Medicine International

Learning Flows Both Ways

I’ve been involved in international outreach ever since I arrived at Hopkins in 1991 to chair the Department of Otolaryngology–Head and Neck Surgery. For much of that time, though, we were simply recruiting patients to bring in more money from the overseas market. It was no different from what other American medical centers were doing. Then, about eight years ago—not long after the creation of Johns Hopkins Medicine and the change to unified leadership—we realized that wasn’t enough. We needed to expand our vision. We needed to support high-level care, research and knowledge transfer around the world.

Today Hopkins is at work in countries around the world—which I doubt would be possible if we still had divided leadership. In India, we’re researching and treating a rare genetic cardiac disorder. In the United Arab Emirates, for the first time, we’re managing a substantial hospital operation. Through face-to-face consultations, teleconferencing and even Web-based curricula, we’re providing education in Africa, the Far East and Latin America. We have dozens of projects in dozens of countries—some big, some small, but each unique—because the cultures and needs are all so different. But what’s so meaningful is that the learning always flows both ways. We learn something new from every experience.

Still, there is one resounding theme that unites all our projects: We’re raising the standard of care around the world. ■

International Bootstrapping

In 1998, when Dean/CEO Edward Miller tapped his “right hand,” administrator Steve Thompson to become CEO of a new organization called Johns Hopkins Medicine International, he charged him to think strategically about its role and mission. Thompson began reinvesting patient revenues in broader outreach—“a classic case of internal bootstrapping,” he says. He also began creating collaborations in research, clinical care and education around the world.

The Sept. 11, 2001, terrorist attacks drastically reduced the flow of foreign—especially Middle Eastern—patients to Baltimore. Revenues plummeted, but today, they are up 80 percent from their post-9/11 low point. Meanwhile, Hopkins’ mission is taking root around the world. By the end of 2006, JHI had forged links with governments, health care consortia, physician groups and academic institutions in more than 40 countries. Among them:

Singapore Hopkins faculty are staffing and directing Johns Hopkins Singapore International Medical Centre. Specializing in cancer treatment and cancer research, the program there includes an oncology unit at Tan Tock Seng Hospital and an outpatient chemotherapy clinic. And with nearly 4,700 inpatient days and more than 8,000 outpatient visits in FY 2005, it is going strong.

India In a new research and clinical collaboration with Apollo Health Systems—“the Hopkins of India,” Thompson says—Hopkins faculty will provide cardiac care and conduct research in four Apollo hospitals. The program’s main focus will be on a genetic cardiac disease that strikes an unusually high percentage of Indian males.


Trinidad Hopkins Medicine International has recently been engaged to redesign Trinidad’s entire health system—a unique “soup to nuts” opportunity.
Fortified for the Future

**THEN:** A DECADE AGO, raising money here was pretty much an exercise in alumni relations. The Fund for Johns Hopkins Medicine—created in the early 1990s—had a staff of 40 development professionals, pulling in some $50 million a year. It was enough to get by on, certainly not enough to grow on.

**NOW:** UNIFIED GOVERNANCE gave a huge boost to medical center development work by ending squabbling over priorities. Speaking with one voice is particularly important, it seems, when asking for vast sums of money.

By the end of the 2006 calendar year, the Fund had 110 development professionals who were raising more than $250 million a year. This amazing growth in philanthropy made it possible for Hopkins to plan for the new facilities it was crying out for. >>>
Fundraising, Step by Step

World-class medicine doesn’t come cheap. Groundbreaking discoveries require multi-million-dollar labs, expensive equipment and multidisciplinary research teams. Building two new clinical buildings—the Children’s Tower and the Cardiovascular and Critical Care Tower—will take half a billion dollars. Such staggering sums required major shifts in how Hopkins raised money, and from whom.

John Zeller—appointed head of the Fund for Johns Hopkins Medicine in 1995—quickly realized that half the Fund’s dollars came from alumni, corporations, foundations and other organizations: a source of support that was important, but limited. Zeller spent 10 years increasing the stream of funds from a bigger pool of potential supporters: “grateful patients.” The strategy paid off.

When Zeller passed the fund-raising reins to Steve Rum in September 2005, the pavement was laid to go after the millions still needed for funding the new clinical buildings. Rum, who came to Hopkins from Duke Medical Center, had already led a seven-year campaign that raised more than $700 million. He couldn’t wait to take on the Hopkins challenge.

Still, the commitment to build new clinical and research buildings stretched the Fund to the limit, putting plans for a new medical education facility on the back burner. Then, in an unexpected late-night phone call from Mike Armstrong—the retired chairman of Comcast, AT&T and Hughes Electronics—in 2005, Ed Miller got the $20 million commitment he needed to move forward with a new med-ed building.

Michael Armstrong
Chairman, Board of Trustees, Johns Hopkins Medicine

Anne and I thought long and hard

Ten years ago, I couldn’t have imagined committing $20 million to launch a new medical education building. I guess this just proves how strong our development program has grown under the leadership of Johns Hopkins president Bill Brody, Ed Miller and Ron Peterson.

Anne and I thought long and hard before making the largest financial commitment of our lives. In the end, our decision hinged on three fundamentals: the revolution in medical science, Hopkins’ outmoded med-ed building and Dave Nichols’ commitment to a visionary new curriculum.

The past decade has brought revolutionary changes to medicine. The Human Genome Project, genetic medicine and stem cell research promise to unlock the secrets of disease—and create new ways to prevent and cure it. But you can’t teach 21st-century medicine in a 20th-century building. We’ve made remarkable strides in our facilities for research and clinical care, but facilities for the third side of the Hopkins triangle—education—weren’t keeping up. Ed Miller knew that; he also knew we’d already bitten off as much of a building program as we could chew.

When we learned about the new curriculum, Anne and I realized that the School of Medicine had to have a facility designed to support Genes to Society. Turning that curriculum’s vision into reality would require a new kind of structure, built from the ground up to incorporate medical imaging, virtual-reality simulation, stronger mentoring and collaborative learning.

Our decision had a fourth, emotional side, too. Johns Hopkins Medicine has given so much—to us, to Baltimore, to the entire world. Anne and I wanted to give back something that could help train an entire generation of Hopkins physicians in amazing new ways.
WHEN WE LEARNED ABOUT THE NEW CURRICULUM, ANNE AND I REALIZED THAT THE SCHOOL OF MEDICINE HAD TO HAVE A NEW FACILITY, ONE DESIGNED SPECIFICALLY TO SUPPORT GENES TO SOCIETY.
Family Ties

They’ve been thrilling, these 10 years, but we could never say they’ve been easy. It’s taken meticulous planning to shape Johns Hopkins Medicine. It’s taken enormous resources, clear vision and tremendous energy by thousands of people—our institutional family. Only a tiny fraction of that family is represented in this booklet.

If you’ve found yourself glancing through these pages, you, in fact, may also belong to the Johns Hopkins Medicine family. This special group extends today throughout Maryland, into the nation and onward to the world beyond. It includes our patients and those who care for them, our employees, our alumni, our scientists and educators, our community and our benefactors.

As medicine moves forward, it is this powerful network of supporters that will allow Johns Hopkins to remain a pacesetter. We’ll be counting on all of you. And we thank you for being there.