Creating an Academy of Clinical Excellence at Johns Hopkins Bayview Medical Center: A 3-Year Experience

Scott M. Wright, MD, Steven Kravet, MD, MBA, Colleen Christmas, MD, Kathleen Burkhart, MPA, and Samuel C. Durso, MD, MBA

Abstract

Academic health centers (AHCs) are committed to the tripartite missions of research, education, and patient care. Promotion decisions at many AHCs focus predominantly on research accomplishments, and some members of the community remain concerned about how to reward clinicians who excel in, and spend a majority of their time, caring for patients. Many clinically excellent physicians contribute substantively to all aspects of the mission by collaborating with researchers (either through intellectual discourse or enrolling participants in trials), by serving as role models for trainees with respect to ideal caring and practice, and by attracting patients to the institution. Not giving fair and appreciative recognition to these clinically excellent faculty places AHCs at risk of losing them. The Center for Innovative Medicine at Johns Hopkins set out to address this concern by defining, measuring, and rewarding clinical excellence. Prior to this initiative, little attention was directed toward the "bright spots" of excellence in patient care at Johns Hopkins Bayview. Using a scholarly approach, the authors launched a new academy; this manuscript describes the history, creation, and ongoing activities of the Miller-Coulson Academy of Clinical Excellence at Johns Hopkins University Bayview Medical Center. While membership in the academy is honorific, the members of this working academy are committed to influencing institutional culture as they collaborate on advocacy, scholarship, and educational initiatives.

Academic health centers (AHCs) have tripartite missions focused on research, education, and clinical care. Because the goal of biomedical research is to advance knowledge that may translate into improved health outcomes, and because the objective of medical education is to develop individuals who are skilled professional physicians worthy of public trust, one can argue that excellence in patient care unifies the calling and quest of the AHC. Clinically excellent physicians, therefore, are vital to any AHC's ability to realize its tripartite purpose.[1–4] As such, the leadership and culture of AHCs should value and recognize these individuals in order to enhance the likelihood that they will elect to work, and then remain, at such institutions. Clinically excellent physicians in academia fulfill multiple invaluable functions such as (1) providing outstanding medical care to patients, (2) attracting new patients who become loyal, satisfied clients who speak positively about their experiences at the institution, (3) teaching and serving as role models for the next generation of physicians, (4) interacting with researchers at the interface of clinical care and science, often providing clinical insights that facilitate discovery, and (5) advancing scholarship both by helping to enroll patients in research projects and by translating new research findings into care delivery.

Despite the valuable contributions of faculty members whose predominant activity is caring for patients, particularly those who shine in this undertaking, AHCs are in jeopardy of losing these clinicians to nonacademic entities that more fully recognize and reward excellence in patient care.[4,5] When an AHC's institutional culture fails to appreciate those individuals who deliver the majority of the patient care, low morale among this group of faculty may ensue, and low morale, in turn, has significant consequences.[5,6] If the institutional priorities, values, and reward systems are discordant with those of the clinically excellent physicians, their self-efficacy and motivation to improve care delivery systems may diminish, as might their enthusiasm to serve as role models capable of inspiring trainees to follow in their footsteps. A more dire corollary would be to have clinically talented physicians leave academia. S.W. Yusuf[4] has characterized this dilemma:

> Academic medicine does not only require good scientists and researchers, but good clinicians, who contribute immensely to clinical medicine and the translation of laboratory research into clinical practice. … Unless we recognize those who spend most of their time looking after patients, we will lose them to the private sector and end up with a glut of researchers and no one to teach clinical skills and bedside medicine to the coming generation.

In an effort to address this concern, the Department of Medicine at the Johns

Dr. Wright is director, Miller-Coulson Academy of Clinical Excellence, Johns Hopkins Bayview Medical Center, Johns Hopkins University School of Medicine, Baltimore, Maryland.

Dr. Kravet is president, Johns Hopkins Community Physicians, Johns Hopkins University School of Medicine, Baltimore, Maryland.

Dr. Christmas is internal medicine residency program director, Division of Geriatrics, Johns Hopkins Bayview Medical Center, Johns Hopkins University School of Medicine, Baltimore, Maryland.

Ms. Burkhart is manager, Miller-Coulson Academy of Clinical Excellence, Johns Hopkins Bayview Medical Center, Johns Hopkins University School of Medicine, Baltimore, Maryland.

Dr. Durso is director, Division of Geriatric Medicine and Gerontology, Johns Hopkins Bayview Medical Center, Johns Hopkins University School of Medicine, Baltimore, Maryland.

Correspondence should be addressed to Dr. Wright, Johns Hopkins University School of Medicine, Johns Hopkins Bayview Medical Center, 5200 Eastern Avenue, Suite 2300, Baltimore, MD 21224; telephone: (410) 550-0817; fax: (410) 550-3403; e-mail: swright@jhmi.edu.

Acad Med. 2010;85:1833–1839.
First published online October 25, 2010
doi: 10.1097/ACM.0b013e3181fa416c

Hopkins Bayview Medical Center (JHBMC) established the Miller-Coulson Academy of Clinical Excellence (hereafter, simply "the Academy") in 2009 to recognize and reward physicians who are judged (via a rigorous process, described below) to fulfill the criteria for "clinical excellence in academia." In this article, we describe the three-year experience leading up to the launch of the Academy.

Historical Perspective at One Institution

Like their peers at other AHCs, most physician faculty at the Johns Hopkins University School of Medicine (JHUSOM) attempt to balance patient care with teaching and research. Because academic promotion is largely based on published scholarship and national recognition, incentives exist for physician faculty to increase research efforts and limit their time spent on clinical activities.[7]

The culture and processes related to promotion at JHUSOM are rooted in the school's history. Since the medical school's early days in the late 19th century, specific standards have been used to assess the faculty and to influence advancement decisions, as described by Ayd[8]:

> To be put up for promotion, they [faculty] must publish in recognized journals, hold important research grants to support their [laboratory] work and receive sterling comments about their contributions to medicine in letters solicited from peers outside the institution. All of these criteria must demonstrate incontrovertibly that the faculty member in question is an innovator in his discipline. A national reputation is required to move up from assistant professor to associate professor, and an international one to become a full professor.

Eventually, the faculty at JHUSOM judged these requirements to be too narrow for clinicians and educators to fulfill, and thus the school established a committee in 2004 to clarify and expand on the types of durable, accessible scholarship that would be recognized as achievement (e.g., new curricula for medical learners, practice guidelines, clinical innovations).[9] Unlike some medical schools that allow faculty to move along any one of multiple academic tracks for promotion, including a designation or path for faculty who perform predominantly clinical service (e.g., a "clinical professor" or "professor of clinical medicine" track), JHUSOM has remained committed to a single academic track. One justification for preserving the one-track system may be the conception that a "two-tiered" system diminishes the stature of faculty who achieve rank with the "clinical" designation.[10,11] Hopkins' single-track system promotes a commitment to recognizing excellence of all types. However, evidence of interest and influence beyond the institution (usually in the form of grants and peer-reviewed publications) must lend evidence to that excellence so as to prevent standards from falling, which could potentially damage the integrity of the promotions process.

The concerns about how to demonstrate a genuine appreciation for physician faculty members that led to the Academy's establishment are not new. In 1984, then-chairman of medicine, Dr. Harvey,[12] explained in a letter to the Johns Hopkins' university president how the valuation of research accomplishment, relative to clinical accomplishment, worried him:

> During the past two decades, partly because of the rapid growth of experimental medicine and partly because of certain influences in the full-time system, an undue amount of emphasis has been placed on research in numerous medical schools at the expense of the insistence on mastery as the fundamental requirement of appointment to upper teaching staff as well as promotion to the professorial rank. Research has become a fetish in many universities, and in medicine, hundreds of young men who have had neither the aptitude nor the desire for investigation, have forced themselves (or, in certain instances, have actually been deliberately forced) into investigation work at the expense of their own thorough training, because through investigation (not necessarily important investigation, it must be confessed), lay the more certain way to advancement. It is the opinion of many that various branches of clinical medicine may be suffering a greater loss from the decrease in expert clinicians than they are gaining from the innumerable papers which are being written by the younger generation of opportunists, many of who held real promise of becoming masters of their field.

Origin of the Miller-Coulson Academy

In 2005, the chairman of medicine at JHBMC (who also serves as both the vice dean for the JHBMC and the director of the Center for Innovative Medicine) was asked by a patient, "Why aren't we creating more Dr. Philip Tumulty's?" The patient was referring to her former doctor, a legendary Hopkins physician renowned for his wisdom and humanistic approach to patient care. Her explicit concern was that AHCs, including Johns Hopkins, were no longer producing clinicians of the caliber of Dr. Tumulty—despite (or perhaps even because of) the attention and emphasis placed on research and scientific discovery. To specifically attend to this very question, the patient's family endowed the Johns Hopkins Center for Innovative Medicine with a generous gift.

The chairman initially used part of the gift to support four physicians with backgrounds in clinical care, teaching, research, health systems management, and the promotions process (C.C., S.D., S.K., S.W.), appointing us "Miller-Coulson Scholars." He charged us with the overarching objective of developing a structure that not only formally recognizes academic physicians who are truly exceptional in caring for patients but also rewards them for being clinically excellent. After careful consideration, we concluded that the most viable way to achieve the desired results would be to create an academy of clinical excellence. The objectives of the proposed academy would be (1) to provide the infrastructure for measuring clinical excellence, (2) to identify clinical faculty and programs that were excellent, (3) to call attention to individuals and programs achieving clinical excellence, (4) to bring together the finest clinicians across disciplines around a unified vision of advancing clinical excellence within the institution, and (5) to develop educational curricula to assist all clinical faculty caring for patients to move along the continuum from clinical *competence* toward clinical *excellence*. Ultimately, we hoped that the Academy would advocate for and support clinically excellent physician faculty who spend most of their time in patient care, assisting them and facilitating their promotion through academic ranks.

For the proposed academy to realize the aforementioned goals, we needed first to *define* "clinical excellence" and, then, to develop a metric that would *measure* clinical excellence. Only after defining and measuring clinical excellence could we hope to establish an appropriate vehicle for recognizing and rewarding it.

Defining Clinical Excellence

We, the Miller-Coulson Scholars, used multiple methodological approaches to define clinical excellence in academia. First, we conducted a systematic review of the literature. Although this exercise revealed that most publications addressing measures of clinical performance focus on competence rather than excellence, some of the themes we identified did prove useful to our deliberations. We thought that the attributes captured by the Accreditation Council on Graduate Medical Education competencies[13] represented a reasonable starting point but that true excellence in the delivery of patient care in academia had to include additional details related to elements such as clinical judgment and diagnostic reasoning.[14,15] We also hoped to include the notions, which we discovered in our review, that clinically excellent academic physicians are cognizant of and judicious in their use of finite resources and that they function consistently at a high level with limited variability in their performance. We further realized as we read the published literature that a definition of clinical excellence in academia must acknowledge the special contributions to the other missions of the AHC: education and scholarship.[16–18] We derived the following preliminary definition from our review of the literature:

> The clinically excellent academic physician is one who judiciously and consistently applies the masterful use of knowledge and skills (both technical and communication), broad or specialized, for the benefit of his or her patients, with unfailing humanism and professionalism. Clinically excellent physicians work effectively within health care systems and lead efforts to improve care delivery. They must be committed to continuous lifelong learning through multiple modalities including reflection on their practice. Clinically excellent physicians practicing in the academic medical center must explicitly role model their expertise to medical learners, and promote the advancement of science by sharing clinical insights with research colleagues that facilitate the bidirectional transfer of knowledge from clinical practice to discovery.

After our literature review, we conducted IRB-approved qualitative research. The informants were, according to the estimation of the chairman, the most highly respected and admired clinicians within the top 10 university-affiliated departments of medicine (as judged by *U.S. News and World Report*). Qualitative methods allowed for the emergence of themes that we may not have previously anticipated. The in-depth, one-on-one interviews were transcribed verbatim and were analyzed. Participants' perspectives led to the identification of themes related to clinical excellence in academia (e.g., scholarly approach to clinical practice, passion for clinical medicine). Findings from this published research describe features of clinical excellence in academia[19] and the consequences of AHCs' failure to reward excellence in patient care.[20]

Next, we met with internal organizational leaders (including deans, the university president, promotion committee chairs, and department chairs) to understand leaders' views of excellence in patient care and to attempt to understand the institutional value assigned to this clinical care. We also queried the visiting faculty coming to present medical grand rounds at Hopkins whom we considered to be experts in clinical care about their beliefs regarding defining, measuring, and rewarding clinical excellence in academia.

Finally, as part of the iterative process to arrive at a practical and pragmatic definition, we sought feedback and input from the members of the Hopkins Center for Innovative Medicine.

The refined working definition for clinical excellence in academia, combining input from all the above-mentioned sources, evolved into the following:

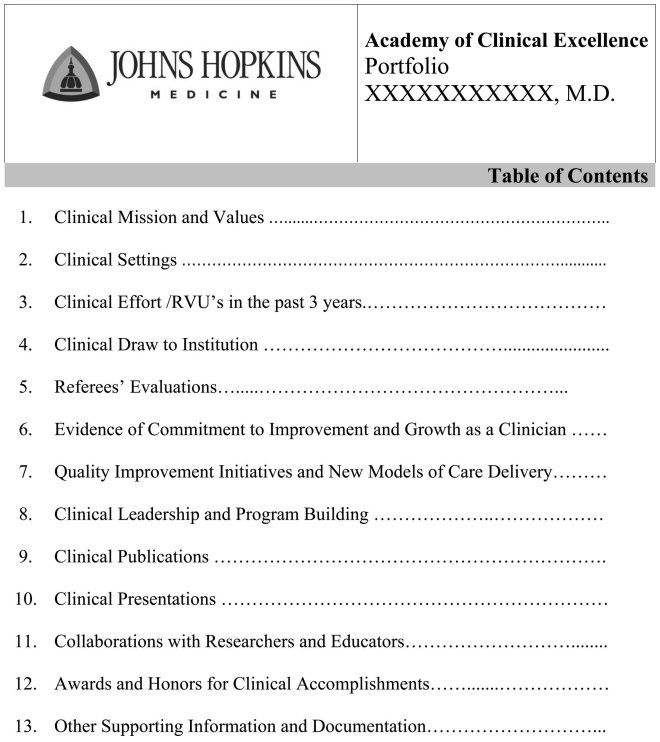
> Achieving a level of mastery in the following six areas as they relate to patient care—(1) communication and interpersonal skills, (2) professionalism and humanism, (3) diagnostic acumen, (4) skillful negotiation of the health care system, (5) knowledge, and (6) scholarly approach to clinical practice—as well as exhibiting a passion for patient care, explicitly modeling this mastery to medical trainees, and collaborating with investigators to advance science and discovery.

Measuring Clinical Excellence

We considered several ways to transform the definition into a metric that could identify the clinically excellent academic physicians. The three mechanisms that received the most consideration for measuring clinical excellence were (1) identification based entirely on reputation (i.e., being named by peers), (2) a 360-degree evaluation process, and (3) a clinical portfolio.

We rejected reputation-based determinations because we felt that these overly rely on subjective opinion and would disadvantage more junior clinicians (who had not yet interacted with as many colleagues) and physicians who do not have referral-based practices. We considered the 360-degree assessment methodology to be less desirable because it is designed for formative (rather than summative) evaluation, it places significant burden on others, and it is vulnerable to gamesmanship if evaluators are assessing multiple candidates and/or if they themselves are undergoing evaluation. Costs associated with executing 360-degree evaluations (using commercial vendors) also represented a significant barrier.

Ultimately, we decided that the clinical portfolio presented the optimal solution because it was the most comprehensive for exemplifying the achievements of clinically excellent physicians with diverse types of clinical practices.[21] We developed the components of the clinical portfolio (Figure 1) with the definition of clinical excellence in mind. In aggregate, subjective materials (e.g., clinical mission and values) balance quantitative sections (e.g., referees' evaluations, number of clinical presentations). These quantitative sections present objective measures including information that the health care system collects (e.g., RVU data) as well as measures that have been conceived and generated by the Academy (e.g., clinical draw to the institution; i.e., the number of unique patients who have a home address either outside of Maryland or beyond a 25-mile radius of JHBMC who come to the medical center specifically to see a particular physician). The clinical portfolio assembles a breadth of measures to create a circumstantiated


JOHNS HOPKINS MEDICINE

Academy of Clinical Excellence
Portfolio
XXXXXXXXXXX, M.D.

Table of Contents

1. Clinical Mission and Values .....
2. Clinical Settings .....
3. Clinical Effort /RVU's in the past 3 years.....
4. Clinical Draw to Institution .....
5. Referees' Evaluations.....
6. Evidence of Commitment to Improvement and Growth as a Clinician .....
7. Quality Improvement Initiatives and New Models of Care Delivery.....
8. Clinical Leadership and Program Building .....
9. Clinical Publications .....
10. Clinical Presentations .....
11. Collaborations with Researchers and Educators.....
12. Awards and Honors for Clinical Accomplishments.....
13. Other Supporting Information and Documentation.....

Figure 1 The clinical portfolio's cover page, showing the components that, when amassed, provide sufficient detail to determine whether an academic physician has achieved excellence in patient care.

representation of the physician without significantly disadvantaging one specialty relative to another. Although specific sections may not be applicable to all physician types (e.g., intensive care unit doctors do not attract patients from remote ZIP codes), the clinical portfolio was created to be flexible enough to allow academic clinicians practicing across a wide variety of specialties to express their eminence. Pilot testing the clinical portfolio at "academic research in progress" conferences led to iterative revisions, and physicians practicing across multiple clinical settings and in different departments were comfortable using the template, feeling satisfied that the resultant product adequately captured their accomplishments and contributions.

Rewarding Clinical Excellence

Academic promotion is the ultimate form of recognition at medical schools, and control over such processes is influenced by history and institutional culture (informed by the institution's members, leaders, and mission). Because no one had defined clinical excellence in academia or developed a means to measure this construct comprehensively, one cannot fault promotion committees for not considering clinical accomplishments. However, deliberation about achievements in patient care for academic physician faculty who spend the majority of their time in clinical settings would now be feasible with the clinical portfolio.

With the goal of rewarding clinical excellence in mind, we made plans to establish the Academy at JHBMC.

Planning

Through regular meetings spanning many months, we undertook measures we thought would launch the initiative effectively; these measures comprised refining the mission and vision, developing a strategic plan, formulating a stakeholder map, performing a SWOT (strengths, weaknesses, opportunities, threats) analysis, and developing an action plan. We appointed a director and hired a manager to, respectively, lead planning efforts and handle day-to-day functioning of the Academy. We garnered the support of institutional leaders, specifically the chairman of medicine and vice dean. We presented an overview of the plans to other institutional leaders whose approval and buy-in were critical to the success of the venture. The presentations included a four-minute video montage revealing patients' expectations that the institution recruit, retain, and recognize clinicians committed to excellence in patient care. We also presented the proposal to, among other groups, the Dean's Executive Committee, the Clinical Practice Committee, and the Board of Governors. Chairs of the Professorial Promotion Committee and Associate Professor Promotion Committee were present at some of the meetings.

Although we were unable to find any clinical academies through our literature review, we learned of several academic institutions that have established teaching academies to promote an aspect of academic medicine thought to be undervalued within the institution and/or within the broad culture of academic medicine. Two of these academies, the University of California, San Francisco (UCSF)'s Haile T. Debas Academy of Medical Educators[22] and the Academy at Harvard Medical School, had missions to recognize their institutions' best teachers and to advance educational initiatives. Visiting the academies at UCSF and Harvard was invaluable as we learned about matters such as infrastructure, governance, leadership, membership, application processes, budgets, marketing, growth, and advocacy. Reviewing online materials for these and other teaching academies contributed to the conceptualization of the infrastructure and functioning of the Academy.

The inaugural class

For the sake of efficiency and to increase the likelihood of success, we decided that the Academy's first year would focus exclusively on the Department of Medicine, which has the largest number of clinically active faculty. Two steps allowed us to identify potential candidate members:

1. Using a blinded electronic system, we surveyed all physicians, asking them to name faculty physicians in the department whom they judged to be clinically excellent.
2. Using a blinded electronic system, we surveyed all house officers, asking them to name faculty physicians in the department whom they judged to be excellent role model clinicians (we defined role model as "a physician you

consider to be a standard of excellence to emulate").

We considered the eight physicians whom colleagues and trainees most frequently named to be nominees, and we invited them to apply for membership in the Academy. We told the applicants that in addition to the honor, membership required the donation of 20 hours of service annually to advance the Academy's mission.

The application process involved collating and composing materials for the clinical portfolio (Figure 1). The Academy collected additional information for specific sections of the portfolio, including the following: productivity data, draw to institution, and summative evaluations from four types of referees: (1) physician colleagues, (2) nurses / medical assistants, (3) medical learners / trainees, and (4) patients. We collected data from referees confidentially and assured them that the candidate physician would never see the assessments.

Once the clinical portfolios were submitted and finalized, we sent them to an external review board made up of six individuals chosen for their reputation for clinical excellence in medicine. All were professor-level faculty with clinical leadership roles; they hailed from the following institutions: Harvard University, McGill University, University of California, Los Angeles, The University of Chicago, University of Washington, Yale University, and the American Board of Internal Medicine. Each external reviewer reviewed four of the portfolios. We supplied the reviewers with rating forms, so they could assess all 13 components of the clinical portfolio and give an overall summative score out of 100. We also asked them to judge whether the materials in the clinical portfolios supported the premise that the applicant had achieved clinical excellence and whether the applicant deserved to be honored with membership in the Academy. We requested that the reviewers write specific comments and feedback so that the applicants would understand how to strengthen their portfolios for promotion purposes or, if appropriate, how to improve their application for a future year.

Launch

The first annual "Hopkins Symposium for Excellence in Patient Care," which occurred on May 8, 2009, marked the official launch of the Academy. The Academy sponsored and coordinated the event, which we designed to feature and celebrate excellence in patient care. Select highlights of the symposium included the following:

- Each of the six inaugural Academy members shared their perspectives about clinical excellence.
- Department chairs explained the need for the Academy and the value it would add to the institution's eminence.
- Students recounted how clinician role models had influenced and inspired them.
- A physician who had performed quality improvement research presented results from a study illustrating how a new initiative reduced both ambulance diversion and emergency department holding times (i.e., "boarding") by facilitating more efficient admission to the hospital's beds.[23]
- A patient, one of the first HIV-positive liver transplant recipients, told her story, which included details of how one of the new Academy inductees had masterfully cared for her.

Administration and governance

We have delegated the Academy's management to a full-time manager and the director (supported with protected time). Together with the members, they have been working to implement the high-priority programs. The members, the four Miller-Coulson Scholars (C.C., S.D., S.K., S.W.), the manager, and the director have been meeting regularly to work through issues related to length of terms and to strategic issues in order to ensure that the Academy will grow successfully in accordance with its mission of serving the public trust.

Current activities

The mission of the Academy is succinct: "Recognizing and promoting excellence in patient care." The Academy's ongoing activities and offerings reflect and further its mission. We briefly describe some of these here.

Each year, the Academy hosts three Department of Medicine Grand Rounds. The director of the Academy presents challenging cases to a panel of three physician faculty (almost exclusively Academy members) who demonstrate and explain their approach, clinical thinking, diagnostic acumen, knowledge, and other domains of clinical excellence (including both resource utilization and communicating uncertainty). The Academy also manages a blog called "Reflections in Clinical Excellence," wherein Academy members post insights and stories about excellence in patient care. Further, members of the Academy are developing rigorous curriculum methods[24] for an optional course that will help clinical faculty move along the continuum from clinical competence to excellence.

Also, in an effort to better understand physicians' perspectives of the JHUSOM climate and culture, the Academy has conducted focus groups with stakeholders and surveyed more than 400 Hopkins physician faculty who spend more than 50% of their effort on patient care. The results of the focus group and survey will inform advocacy efforts: The Academy hopes that promotion committees will be open to reviewing the clinical portfolios of faculty members who spend the majority of their time in patient care.

Recently, the Academy inducted nine new members (of 22 nominees from eight clinical departments). In association with the induction, the Academy held the second annual Excellence in Patient Care Symposium on May 11, 2010. The event was successful as measured by a full auditorium and guests overflowing into a secondary space outfitted with audio and video feed. Family members (parents, significant others, and children) attended the event, watching with great pride as their loved ones were inducted. A patient and his wife who live in North Carolina drove many hours to attend the event and witness his doctor's induction.

The Academy is also disseminating details about its mission and programs to garner support from within and beyond JHUSOM; the support, in turn, will allow the Academy to realize its midrange and long-term goals.

Finally, the Academy is conducting and planning to publish the results of empiric studies in an ongoing manner to create new understandings about excellence in patient care in academia.

Start-up and maintenance-associated costs

We, the four Miller-Coulson Scholars, were supported at 10% effort for 2.5 years prior to the launch of the Academy. We directed our efforts toward projects (including research) related to defining and measuring excellence in patient care (much of which has been described above). Beginning approximately six months prior to the launch of the Academy with the induction of the first class of members, a full-time manager was hired whose experiences include earning a master's in public administration and working in nonprofit administration. The director of the Academy receives 20% salary support. The total expenses for the Academy during the 2009–2010 academic year were approximately $160,000. Costs beyond the salary support of the manager and director included expenses for meetings, the symposium, visiting professors, honoraria to external reviewers, and marketing materials. Operating expenses may increase when additional programs begin.

Future Plans

The Academy has created a definition of clinical excellence, has developed a metric to appraise academic physicians with respect to clinical excellence, has built an administrative structure, and has elected into the Academy 15 members whose clinical portfolios have undergone rigorous internal and external review. In addition, the Academy has embarked on a variety of activities to increase the recognition of clinically excellent physicians.

However, the Academy's larger goal is to enhance clinical excellence at Johns Hopkins broadly. In addition to recognizing and rewarding clinically excellent faculty throughout JHUSOM, we hope to encourage all clinicians to collect data that can be assembled into their clinical portfolios so that they can have the ability to review and reflect on their clinical performance. We also hope to study the impact of the Academy over time, in terms of the impact on institutional culture, the morale of clinicians, and whether the clinical portfolio or Academy membership is valued with respect to promotion decisions. To accomplish these goals, the Academy will need the support of the dean of JHUSOM, the department chairs, the promotions committees, and other institutional leaders. The progress of earning this support is promising, and a commitment to the cause, at least philosophically if not financially at this time, is evident in the institution's establishment of the Committee on the Promotion of the Academic Clinician.

To continue with current activities and to develop new initiatives (such as pilot grants for quality improvement projects that are focused on realizing excellence in patient care), the Academy must secure adequate funding. This financial support will allow the Academy to flourish into a successful entity that will boost Johns Hopkins' reputation for excellence in patient care.

The generous philanthropic support of a family committed to supporting excellence in patient care made the Academy possible. Although a substantive portion of the initial gift was used to support the individuals who were engaged in the groundwork and planning leading up to the establishment of the Academy, the annual expenses are not exorbitant. If the Academy succeeds in boosting the morale of academic clinicians, resulting in improved faculty retention, then clinical revenues resulting from high patient loyalty and the savings from not having to recruit new physicians (of indeterminate quality) may exceed the operating costs of the Academy.

By recognizing clinically excellent physicians, the Academy will strengthen the health care system by focusing on a fundamental goal: to create an environment that optimally supports the highest-quality patient care. Honoring and celebrating the physicians who are excelling in caring for patients, and holding them up as role models that should be emulated, is simply the right thing to do.

Acknowledgments: The authors wish to thank the Miller-Coulson family, Dr. Hellmann, and members of the Johns Hopkins Center for Innovative Medicine for their support and feedback with this project.

Funding/Support: Dr. Wright, Dr. Kravet, Dr. Christmas, and Dr. Durso were supported with protected time as Miller-Coulson Scholars during the period when this work was conducted.

Other disclosures: None.

Ethical approval: Not applicable.

References

1 Levinson W, Rubenstein A. Mission critical—Integrating clinician–educators into academic medical centers. N Engl J Med. 1999;341:840–843.
2 Passo MH. The role of the clinician–educator in rheumatology. Curr Rheum Rep. 2006;8:469–473.
3 Wright SM, Kern DE, Kolodner KB, Howard DM, Brancati FL. Attributes of excellent attending-physician role models. N Engl J Med. 1998;339:1986–1993.
4 Yusuf SW. The decline of academic medicine. Lancet. 2006;368:284.
5 Buckley LM, Sanders K, Shih M, Hampton CL. Attitudes of clinical faculty about career progress, career success, and recognition, and commitment to academic medicine. Arch Intern Med. 2000;160:2625–2629.
6 Lowenstein SR, Fernandez G, Crane LA. Medical school faculty discontent: Prevalence and predictors of intent to leave academic medicine. BMC Med Educ. 2007;7:37.
7 Johns Hopkins University School of Medicine Committee on Clinician Educators. Johns Hopkins Faculty Gold Book. Available at: http://www.hopkinsmedicine.org/som/faculty/policies/goldbook/index.html. Accessed August 20, 2010.
8 Ayd MA. One-track mind. Hopkins Medical News. Fall 2003. Available at: http://www.hopkinsmedicine.org/hmn/F03/top.cfm. Accessed August 20, 2010.
9 Johns Hopkins University School of Medicine Committee on Clinician Educators. Professional Development Guide for the faculty of the Johns Hopkins University School of Medicine. Available at: http://www.hopkinsmedicine.org/bin/i/z/SilverBook2006.pdf. Accessed August 20, 2010.
10 Jones RF, Gold JS. Faculty appointment and tenure policies in medical schools. Acad Med. 1998;73:212–219.
11 Taylor RB. Academic Medicine: A Guide For Clinicians. New York, NY: Springer; 2006.
12 Harvey AM. Letter to Johns Hopkins University President Stephen Miller, M.D. June 19, 1984. Unpublished.
13 Accredition Council on Graduate Medical Education. ACGME Outcome Project. Available at: http://www.acgme.org/outcome/comp/compMin.asp. Accessed August 20, 2010.
14 Epstein RM, Hundert EM. Defining and assessing professional competence. JAMA. 2002;287:226–235.
15 Whitcomb ME. Redirecting the assessment of clinical competence. Acad Med. 2007;82:527–528.
16 Muller JH, Irby DM. Developing educational leaders: The teaching scholars program at the University of California, San Francisco School of Medicine. Acad Med. 2006;81:959–964.
17 Kevorkian CG, Rintala DH, Hart KA. Evaluation and promotion of the clinician–educator: The faculty viewpoint. Am J Phys Med Rehabil. 2001;80:47–55.

18 Glick TH. How best to evaluate clinician–educators and teachers for promotion? Acad Med. 2002;77:392–397.

19 Christmas C, Kravet SJ, Durso SC, Wright SM. Clinical excellence in academia: Perspectives from masterful academic clinicians. Mayo Clin Proc. 2008;83:989–994.

20 Durso SC, Christmas C, Kravet SJ, Parsons G, Wright SM. Implications of academic medicine's failure to recognize clinical excellence. Clin Med Res. 2009;7:127–133.

21 Boyer EL. Scholarship Reconsidered: Priorities of the Professoriate. Princeton, NJ: The Carnegie Foundation for the Advancement of Teaching; 1990.

22 Irby DM, Cooke M, Lowenstein D, Richards B. The academy movement: A structural approach to reinvigorating the educational mission. Acad Med. 2004;79:729–736.

23 Howell E, Bessman E, Kravet S, Kolodner K, Marshall R, Wright SM. Active bed management by hospitalists and emergency department throughput. Ann Intern Med. 2008;149:804–810.

24 Kern DE, Thomas PA, Hughes MT. Curriculum Development for Medical Education: A Six-Step Approach. 2nd ed. Baltimore, Md: Johns Hopkins University Press; 2009.

Teaching and Learning Moments

Perspectives

It was an exceptionally busy day at our family medicine training site. With the place a hum and at maximum capacity, I found myself working from exam rooms not part of my usual routine. In the middle of a physical on a young man, I lowered the back of the exam table. Being in an unfamiliar room, I searched to find the appropriate lever. Unaware that the table was an older model than the ones in my 'regular' rooms, I depressed the lever, anticipating the need to push the back into position. To my surprise, the full force of the upright table suddenly slammed down, smashing my thumb in its path! Following the initial shock and pain, I realized I was bleeding and awkwardly explained to my patient (while grabbing a handful of tissues, compressing, and elevating my thumb) that I needed to step out of the room and would be back as soon as possible. While fleeing into the hallway and feeling rather vagal, I bumped into a nurse who took one look at me and demanded that I go lie down.

Luckily, I found an open exam room, and, as I lay on the table, a sea of thoughts immediately flooded my mind: How embarrassing! What's happening to the patient? Is my thumb broken? How will I finish the rest of my schedule? Continuing to hold my throbbing thumb above my head while lying on my back, I could not but notice what a boring ceiling we had in our office. In all the years that I had worked here, I never saw it from this angle.

Soon a nurse appeared with an icepack, and we both cautiously examined my thumb, determining that an emergency room visit was a good idea. She exited to make the arrangements, and again I was left in the room staring at the ceiling. "We really should have something interesting up there," I thought. Nice art work or pictures of nature would be much more comforting than those blank white tiles accented by the bright fluorescent lights.

Fortunately, after careful inspection and cleansing in the ER, my thumb only required a bit of special glue, and I was good to go. I returned to the office the next day armed with pictures from old wilderness calendars, cleanly cut out and ready for posting. The staff was delighted, and the patients loved them. I realized that my exam table mishap had afforded me a poignant perspective. Although we often are advised to see a situation from a different perspective, we do not always put it into practice. I now smile when I look up at the pictures, reminded that becoming a patient in my own office yielded valuable insights that I could only have imagined.

Mary P. Guerrera, MD

Dr. Guerrera is professor, Department of Family Medicine, University of Connecticut School of Medicine, Farmington, Connecticut.