New Hopkins program trains doctors in urban health issues

Doctors learn to prescribe more than medication, as program seeks to redefine city's health

By Jonathan Pitts
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Devon Blackwell has a history of attention deficit disorder, but things have improved so much that he isn't sure why he even needs to be here at the East Baltimore Medical Center.

The 17-year-old from Baltimore has improved at school, developing a love of physics. He's getting along well with his guardian. He's looking forward to attending trade school next fall.

Yet here he sits, in a paper robe on an exam table near Johns Hopkins Hospital, speaking with his new physician. And Dr. Deanna Wilson wants to talk.

"Do you have friends?" she asks. (Yes.) "How about best friends?" (Not exactly.) "What do you eat on a given day?" (Cereal with O.J., some meat at dinnertime.) She weaves her way through queries on his TV watching habits, household chore schedule, milk consumption, even the tattoo on his forearm.

Clearly, to her, Devon's health involves more than the size of his Adderall dose.

"Health isn't just a biological or medical issue," Wilson says later. She's one of four physicians in a groundbreaking new residency program at Johns Hopkins Medicine that concentrates on urban health care. "Is your goal to heal the population? Well, what ails it? Stress, psychological factors, depression: [many] issues play into biological problems. We need to become conversant in other languages. We're interested in a little paradigm shifting," she says.

A 28-year-old graduate of the Yale School of Medicine, Wilson wants to help redefine medical care in
Baltimore and other American cities. In addition to clinical training in pediatrics and internal medicine, she and her fellow interns (that is, first-year residents) will gain experience in prisons and with police. They'll also earn master's degrees in public health or a related field, clearing the way for policymaking careers.

"We're training people who will end up coordinating health centers, creating more programs like the one we've created, working on Capitol Hill or becoming the future health commissioner," says Dr. Rosalyn Stewart, who helped design the six-year Hopkins residency.

In the clinic, Wilson writes a prescription refill, advising Devon to eat a good breakfast each day and avoid drinking too much soda. That will help him concentrate, she says. Big sister, mentor and scientist, she's becoming the hybrid that Hopkins aims to develop.

The need for doctors

It was two years ago that Myron Weisfeldt, chairman of internal medicine at the Hopkins School of Medicine, took a hard look at health trends in Baltimore. The picture was not encouraging.

Those who live in the city's low-income neighborhoods suffer disproportionately from many ailments, including hypertension, obesity and HIV/AIDS. Residents of relatively affluent Roland Park live an average 20 years longer than their counterparts in the Hollins Market area five miles away, according to the city Health Department. A 2008 RAND Corp. study found that Baltimoreans would have to make 150,000 more visits to medical clinics per year just to attain a moderate level of health.

None of that came as news to Weisfeldt, a man whose job description includes working closely with the university's Urban Health Institute. But to him, things had reached the point of crisis. "We should have been training career [physicians] to serve underserved communities, and we weren't," he says.

There are reasons the U.S. health care system has evolved in a way that shortchanges the urban poor. In the days before researchers discovered such treatment staples as antibiotics and penicillin, the medical world focused on curing maladies that threatened the population.

That emphasis gave rise to a system favoring treatment of acute illness over continuing or general care ("primary care," in modern parlance), and medical training kept the trend in place. As recently as 2005, the Department of Health and Human Services found that nearly two-thirds of new physicians were moving on to careers in subspecialties.

Weisfeldt, a cardiologist, decided to take action. He asked two of his public health experts -- Stewart and fellow pediatrician-internist, Lenny Feldman -- to dream up a program that could change urban medicine. Hopkins, he said, would find a way to fund it.

Feldman became director, Stewart his assistant director. From the start, they looked beyond the usual definitions of health.

Asthma, hypertension, drug abuse, HIV and mental illness -- these were significant urban health
problems, they agreed. But what about the social factors that make them worse: the unsanitary housing that triggers asthma, the scarcity of safe parks that keeps kids and grownups indoors and sedentary? In the standard model, doctors leave such matters to others. Feldman and Stewart included them.

Their proposal had four basic parts. The residency would allow doctors to be certified in both pediatrics and internal medicine. They would get outside the hospital and into community clinics, treating patients and their families and following their progress. They'd do rotations in nontraditional urban settings. And they'd be schooled in the financial end of health care, learning what it takes to change minds on hospital boards, at insurance companies and in government.

Within a year and a half, the team had sold its plan to the top brass at Hopkins Hospital, won accreditation from the required national governing bodies, raised more than $200,000 in startup funds and recruited its first class.

The Johns Hopkins Urban Health Residency Training Program, the first of its kind in the U.S., started July 1. It's working well so far, Feldman says, thanks in no small part to Deanna Wilson and her fellow interns.

The first class

At the East Baltimore clinic, Wilson is perched at a computer, reviewing the records of a patient she's about to see. Her peers Monica Mix and Sara Mixter, meanwhile, search databases for information on Baltimore treatment centers.

"You have to use the moments you get," says Mixter, 28, a graduate of Harvard Medical School.

When a slender young man in a white coat arrives, they realize it's an unusual moment. Paul Doherty, 33, a former Peace Corps volunteer and Hopkins med school graduate, is back from a brief vacation. It's the first time the four have been in the same room since the program began.

Though their 60 hour-a-week schedules usually keep them apart, the members of this inaugural class are driven by a common ideal: that medicine is a path to social justice.

Take Mix, a 26-year-old native of northeastern Ohio. She has always wanted to be a physician, dreaming of practicing primary care among the poor -- overseas. "To people in their 20s, that can seem glamorous," she says, looking up from her research.

She later worked in free health clinics in Akron and New Haven, where she was attending the Yale School of Medicine, and found herself alarmed at the barriers to health among the urban poor. "Why go to Africa? We need you here," she recalls a mentor saying. The Hopkins program felt perfect, and she was among the 160 who applied for the first class.

Mixter grew up in well-to-do Chevy Chase, where her father, a securities lawyer, made sure she was schooled in giving back. When she was 10, he started involving her in church projects that fed the
homeless.

"We'd go out in his station wagon early in the morning, delivering lunches before people had risen," she says. "I remember how surprised people were to see a little girl out there, talking to them without any fear. It surprised me that something that to me seemed so small could mean so much."

After completing undergraduate work at Harvard, Mixter says, she worked for a year with Project Health, a Boston Medical Center program that teamed undergraduates with doctors and legal-aid attorneys to provide health care access to the city's poor.

That background primed her for the Hopkins program, which also offers a chance to become a policymaker. "I'd like to see physicians in a position to tell decision-makers, 'This isn't just about dollars and cents. Think about the impact affordable housing could have on community health,'" Mixter says.

Doherty, too, merges interests in medicine and social concern. A University of Virginia graduate, he worked on sustainable agriculture projects in Kenya, then in legal services at a Washington, D.C., health center that treats the underinsured and offers services to HIV/AIDS patients.

Then he attended Hopkins medical school, aiming to be part of a resurgence in primary care, especially for the underserved. "Yes, I could make more money in a subspecialty than I'm going to make, but what's your threshold of comfort?" he says. "I went into medicine to try and be useful, to go where people are underserved."

Wilson was born in West Grove, an "economically homogeneous" small town near Lancaster, Pa., but the sameness never enveloped her. Her father, Rafael Bautista, a native of the Dominican Republic, believed in showing his children how others lived. Her mother, Helen Wilson, an African-American, impressed her with the size of her heart.

Rafael took the family on regular trips to visit relatives in the Dominican. Even at 6, it angered Deanna to see gated enclaves right down the street from ramshackle huts. "I remember thinking, 'Why do some people have so much and others have almost nothing?'' she says. "Those were striking images of injustice."

Those images -- and similar ones in her own country -- left Wilson with a pervasive sense of outrage. She might have succumbed to bitterness, she says, were it not for her mother's side of the family -- especially her grandfather, James Wilson, who grew up in segregated America and lived through the civil rights era.

It's good that you're angry, James told her, but why do you think things are the way they are? What do you think can be done about it? "I knew lots of people who saw injustices and believed they were set in stone," she remembers him saying. "But organizing people who fought those things led to change. Verbalize and localize your outrage. You can make change happen."

Wilson took that conviction to Swarthmore College, where she studied anthropology. But a fellowship
with the Congressional Hunger Center in Washington and another that focused on growth patterns in children convinced her that the world's most powerful social inequities were related to health care.

She followed her love of science to the Yale School of Medicine, and her first week there included a formative experience. James Wilson was present when she received her white coat in a university ceremony. "He was bursting with pride," she recalls, tears coming to her eyes. Her grandfather died a month later.

Like her classmates, Wilson considers access to medical care as fundamental as the right to vote. The Hopkins program, she says, is helping her learn to secure it for others.

"People always debate what you should do with everything you've been given," she says. "I believe I have a responsibility to give back to my community and other communities in need. It's part of being human."

The program's reach

Eighty "med-peds" residency programs -- blending internal medicine and pediatrics -- exist in the United States, and several residency programs focus on urban medical issues. Feldman's is the first to blend the ideas and take aim at the complexity of urban health.

"Dr. Feldman's approach is to [develop] primary care physicians who have significant backgrounds in treating the underserved in urban settings, who will stay in the field, and who will become leaders in urban health," says Dr. Alexander M. Djuricich of Indiana University, president of the National Med-Peds Program Directors Association. "That's unique."

The interns are spending about 80 percent of their first year learning the basics of clinical care. They also work several hours a week at the East Baltimore clinic, a primary care facility overseen by two Hopkins physicians that doubles as a living laboratory in the new urban medicine.

There they not only treat acute illness, but also collaborate with experienced nurse practitioners and social workers on larger issues. They're also discovering Baltimore's network of social services, learning to "prescribe" them as deftly as medications.

"Saying, 'It would be great if you followed up [at this substance abuse treatment center] is a lot different than saying, 'Here's the phone number; your appointment is at 4:00 on Tuesday,'" adds Dr. Chris Gibbons, associate director of the Johns Hopkins Urban Health Institute, who works closely with the program. "It's one of the ways we're redefining the word 'physician.'"

As they progress into years two, three and four, the residents will see the urban health component expand. They'll plan projects within the Health Department, do rotations at HIV outpatient clinics and join the Baltimore police at domestic-violence conferences. They'll train in cross-cultural communications and study the health care systems of prisons from the inside.

The last stage of the marks a key Weisfeldt innovation: grooming residents to be leaders. During the
final two years, each will work as a primary care doctor in an urban practice while pursuing an advanced degree in business, public health, education or another field that has a significant impact on medicine.

"Five years beyond graduation from medical school, these trainees will be highly desired by insurance companies, by foundations and by the government," Weisfeldt predicts.

At a time when President Obama's signature health care reform legislation will extend insurance to millions of Americans, the program has already drawn notice in Washington. A division of the U.S. Department of Health and Human Services announced last month that it will award Hopkins $3.8 million to expand the program. Next year's class will have 12 interns, a number Feldman says will grow to 28 by 2015.

A new prescription

At the East Baltimore clinic, Wilson already is embracing her new role. Devon squirms in his paper robe -- the checkup has lasted 30 minutes -- as she continues her questioning. His great-aunt and guardian, Waynette Flintall, is in the room, too, listening closely.

Point by point, Wilson is evoking a portrait: friendly kid, decent sense of humor, generally doing well.

Then she ferrets out a fact. Since grade school, Devon's ADD diagnosis has qualified him under federal law for an individualized instruction program. He's no longer receiving one; his new school claims he isn't on their list.

"Not all of them are happy about it, but every school has to help all kids," Wilson says, as she takes out a pre-printed document that requests a new evaluation within 60 days. "I'll sign this as pediatrician. A letter helps cut through the bureaucracy."

Flintall thanks the doctor and tucks this new kind of prescription into her purse. That's just what we needed, she says. Devon gets dressed and they bid farewell, a Baltimore family on its way to better health.

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