JOHNS HOPKINS
MEDICINE

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Dean of the Medical Faculty
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Dear Colleagues:

As the new school year starts, we've been joined by some remarkable young people: a total of 282 new degree candidates and 206 new house staff – the best and the brightest of the next generation of physicians and scientists.

A recent biography of Sir William Osler maintains that from the earliest days of Hopkins Medicine, the institution's greatness could be attributed in large part to its ability to draw such students, attracted and stimulated by the energetic and productive faculty. I believe that's still true.

In the past year, our faculty has done a magnificent job. Your work has been recognized with a Nobel Prize, amazing *U.S.News & World Report* rankings for both the Hospital and School of Medicine, a Presidential Medal of Freedom, the top NIH research award ranking, an American Hospital Association Quest for Quality Award for patient safety. And your efforts have given our Clinical Practice Association its best year ever.

You've delivered and deserve as much from us.

You have more than delivered for Johns Hopkins Medicine, and you deserve as much from us. Indeed, that's why so much of my effort during the past year was devoted to the challenge of addressing what you need to conduct research, care for your patients, teach your students.

Some tangible results are immediately obvious. For those of you whose focus is bench research, we've provided a magnificent new research building, with another well on its way and more on the drawing board. Add to them new core facilities, a "mouse house," and vastly bolstered staffing to support animal research.

In clinical care, I'm absolutely delighted to tell you that we have been able to negotiate much better physician reimbursement rates from major insurers, who finally seem to recognize the superior quality of your work. Our enormous investment in IT resulted in the rollout of POE -- the Provider Order Entry system -- of ORMIS to support the surgical specialties, and of PAC to end the time-consuming scrambling to retrieve images that bedeviled us all. In response to your pleas for relief from some of the paperwork burden, IT enhancements also have simplified the process of applications for grants and for IRB approval.

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Our students and trainees are benefiting from a quadrupling of resources devoted to education over the past few years. A few examples include expansion of the Professional Development Office, which provides instruction in grant-writing and other professional skills for graduate students, and broader use of simulation in medical education, ranging from actors to high-tech mannequins and robots that provide medical students and residents exposure to a clinical scenario before they have to treat real patients. This will culminate in a new simulation center slated to open in July 2006.
Tangible results are one thing. I know you well enough, however, to guess what you're thinking: If the faculty is our most important asset, how do we promote your careers and make you feel encouraged and wanted, so that you, in turn, want to stay with us? How can we reward you for teaching in the face of new NIH effort-reporting guidelines? How can we do a better job at technology transfer?

We're exquisitely attuned to your dilemmas.

Last fall, members of the Advisory Board of the Medical Faculty and others spent an entire weekend tackling such tough questions. Midway through the retreat, the Medical School Council president commented: "The faculty would be surprised to hear today's discussion. They don't think there's any appreciation of their problems at the School's highest levels."

The group was exquisitely attuned to your dilemmas: If you're in a basic science department, in this age of Big Science vs. Little Science, how will you establish yourself and be rewarded if you work under the umbrella of a large research group? If you're in a clinical department, how can you juggle the pressures of patient care and research? How can faculty in any department advance while devoting significant time to teaching or to administrative responsibilities? Or succeed at a time of stultifying regulatory paperwork in an infrastructure-thin environment?

Part of the solution for young investigators lies in our inherent strengths: For a research-intensive institution, we're very clinical. Before interdisciplinary, translational research became a popular term embedded in the new NIH roadmap, that approach characterized some of our most successful programs, such as oncology and the neurosciences. My challenge now is to encourage large departments to aggregate across department lines, to develop different models for deploying Ph.D.'s in clinical areas, to build bridges between departments and other Hopkins divisions -- the schools of Engineering, Public Health, Nursing, the Applied Physics Laboratory, for instance.

Room for both collaboration and individual creativity.

While collaboration exists between self-selected individuals, we're seeking ways to shed barriers between departments in order to give junior faculty more opportunities. The diabetes/obesity symposium organized by Chi Dang, for example, demonstrated that we have the makings of a major center if we pool talent and interactions. Within the umbrella of a large program, young investigators have a chance to do risky research, with access to our core facilities. Remember, innovative science often comes from collisions between unrelated fields.

Retreat participants recognized that young investigators need funding to get off the ground, as well as to tide them over dry spells. We've established various funds, such as the Ross Clinician Scientist Award, the Fund for Medical Discovery, and Institutional Research Grants, to address this need. Department and division directors and other mentors (including the Dean's office) can help you access them. But they can do more, such as occurred when an assistant professor in hematology was brought together with a geneticist to identify the cause of a patient's clotting problem. One retreat proposal we're exploring would establish a new fund emphasizing collaborative ventures, not just individual investigation. Yet while we promote opportunities for collaboration, the respect for the individual investigator's creativity is an ingrained part of Hopkins' culture and success and continues as a core value.

What does it mean to be excellent in education?

Reward for teaching was recognized by retreat participants as a continuing problem. As one person put it, "The faculty are frustrated; they can't be excellent in all things, and they don't know what it means to be excellent in education." As a result of these discussions, I have appointed a subcommittee of the Advisory Board on the "Status of the Clinician-Educator." While holding fast to the standard that academic promotion depends on recognition of excellence by one's peers nationally and internationally, this subcommittee is well along in examining ways for faculty to demonstrate excellence and ways for the School to expand opportunities for clinician-educators through enhanced mentorship, small innovation grants and collaborative networks ("academies").

Another interesting concept from the retreat: Give junior faculty the time, by granting renewable contracts, to immerse themselves in different aspects of our tripartite mission sequentially, rather than expecting them to be triple threats in a short period of time. Peter Agre, who came to Hopkins as a clinician and then moved to the lab, exemplifies this approach. The reality is that the School already is prolonging the period allowed to reach full professor, mainly through rolling, renewable five-year contract extensions. Without instituting a two-track system, we seem to be accepting the reality that some valuable faculty are never going to reach full professor -- and may value security more than promotion. On one thing, however, I will insist: There needs to be a standard system for annual reviews to ensure that junior faculty receive the career mentoring they need. As of this September, there will be no "automatic" salary increases. Written annual reviews, which have been discussed with the subject, must be submitted along with the increase request.

Bringing mature research to market – more swiftly.

We've also taken steps to address concerns of those of you who have mature research projects that you wish to bring to market – and hence to patients – more swiftly. Leadership in the LTD office has changed and should be more user-friendly. With the help of Dick Johns, the Technology Opportunities Group – an alliance of successful business people from the pharmaceutical and technology world -- has been recruited as advisors to help steer your research to market. The Life Sciences and Technology Park soon to be our neighbor offers opportunities for entrepreneurial faculty who wish to start their own companies. As retreat participants pointed out, however, first we need to

clarify – and perhaps relax – what we mean by conflict of interest and conflict of commitment. There's no question, however, that technology transfer offers a potential, welcome source of unrestricted funds.

I'm fortunate to have a terrific team to help me deal with all of these challenges on a day-to-day basis. If you see less of me on campus this year, that's because I'm out raising money for the clinical towers, teaching facility and other components of the campus master plan. In late fall we'll launch an unusual campaign in New York City designed to help convince wealthy individuals that they can make a difference in medicine by investing in Johns Hopkins. Why NYC? It holds our nation's largest concentration of wealth. With the departure of yet another corporate headquarters from the Baltimore area, we must reach beyond our region to attain our philanthropic goal. As the Osler biographer pointed out, new facilities and a sufficient endowment also played a role in attracting gifted faculty and trainees from our earliest days.

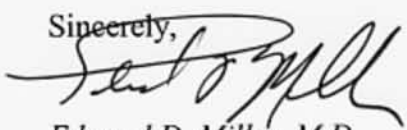
***Patient safety* must *take top priority*.**

Only one thing takes greater priority for me than the challenges of raising money to rebuild our campus and to meet your needs: Patient Safety. And if you are involved in any way with clinical care, it *must* take top priority for you, too. Patient safety will be a major focus of the Joint Commission on Accreditation of Health Care Organizations (JCAHO) triennial site visit in November; if we don't receive accreditation, we won't receive payment from insurers and might as well shut our doors. But the importance of patient safety goes far beyond JCAHO. Hopkins may be considered a national leader in patient safety, but we're not yet doing well enough for me – or for our patients. I'm asking each department, each clinical unit to set measurable goals for improving their patient safety record. That's how we drove down our rate of bloodstream infections after bypass surgery, for instance. Take seriously hand-washing between patients, elimination of confusing abbreviations when ordering medications, marking a surgical site, taking a time-out -- as a team -- to review all identifiers before starting surgery or an IV or a blood transfusion. Record any misses or near-misses in our new Patient Safety Net database. Then help us learn from your mistakes, and try to learn from those of others.

My challenge to you: Make medical errors ancient history.

I realize there are many issues that we all deal with on a daily basis. I also understand how hard you work. But for me, our efforts are so incredibly important because we can make a difference in another person's life. Whatever the challenges, members of this academic community have always faced them and conquered them – to the benefit of an individual patient and society as a whole. Together we will continue to fulfill that mission.

Sincerely,



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