JOHNS HOPKINS MEDICINE

Aequanimitas

A twice yearly newsletter for current and former Johns Hopkins Medicine housestaff and friends

Fall 2011

My Turn

Looking at the fellowship choices among this year's senior residents, I'm reminded that the Osler program continues to produce physicians sought by the best training programs in the country. Among the class of 36, 10 are staying at Hopkins, while others have scheduled fellowships at Stanford, Harvard and Brigham and Women's Hospital, the Cleveland Clinic, the University of Michigan, Duke and the Mayo Clinic. Ten are pursuing training in cardiology, eight in hematology/oncology, six in gastroenterology and four in pulmonary and critical care medicine.

This is the bread and butter of sophisticated academic medicine. Through our program they meet role models, get involved in exciting projects and become amazing fellows and leaders.

Still it's concerning that only a few residents in each class express interest in geriatrics, general internal medicine and community-based medicine. The new branch of the Osler residency, the Urban Health Residency, finds medical students with these interests and commitments; we train four internal medicine residents and four med-peds residents per year in this pioneering program.

We anticipate that these young physicians will similarly become future leaders—of urban primary care on a local, state and national level.

Mike Weisfeldt, Director
Department of Medicine

An early dispatch from the duty-hour trenches

Interns, residents and faculty alike are stepping up to meet the challenges of new time rules.

Assistant chiefs of service, from left, Joanna Peloquin, Kavita Sharma, Deepa Rangachari and Lorrel Brown

Being an assistant chief of service in the Osler Medical Training Program is difficult any year. This summer brought an entirely new set of challenges. New rules from the Accreditation Council for Graduate Medical Education that took effect July 1 reduced maximum duty periods for first-year residents from 30 hours to 16 hours and established several changes regarding supervision of residents and transitions of patient care.

While many programs adopted a night float schedule to meet these requirements, the Osler program in the spring piloted two versions of alternate schedules—developed by housestaff—named for the popular television series *Knight Rider* and *Hawaii Five-O*. Each team included an ACS, two third-year residents, a junior resident and five interns. In Hawaii Five-O, interns worked a five-day rotation, spending every fifth day overnight. In Knight Rider, the five interns alternated spending six days in a row covering nights, then switched to daytime duty for the remaining three weeks of the rotation.

Within the first month, says Deepa Rangachari, ACS for the Longcope firm, Hawaii Five-O emerged as the clear winner and was implemented starting July 1. But most housestaff directly involved with the pilots had moved on, leaving almost everyone to start fresh.

"It's a major paradigm shift in day-to day-activity," she says. "It's been a challenge, having trained and grown up in a different system, how to provide the highest quality compassionate and comprehensive patient care" in the face of the duty-hour restrictions.

Interns, striving to achieve their goals and sign out in time, have a level of pressure never experienced before, adds Thayer ACS Kavita Sharma.

The ACSs say their main goal was to preserve the training program's foundations, including "the principles of ownership, excellence and the intern being the primary caregiver," says Lorrel Brown, Janeway ACS, who was heavily involved in developing work schedules.

(Continued on page 2)

Sanjay's Section

On moving parts and clock-watching

The challenges of the new ACGME requirements have been substantial. The 16-hour duty-hour limitation for interns has posed the greatest challenge. We changed our model based on two overarching priorities: preserving core values and adhering to regulation. Yet, in such an utterly complex system with nearly limitless moving parts, goals and constraints, the "ripples" of change spread far and fast.

We learned quickly that our solutions were not perfect and iteratively modified them since July. Although we are closer to the right solution, more change is likely required. Through these changes, one constant remained—the resolution of everyone in our program to do this right, and while predictability is desired in residency training, we will not compromise on our mission to achieve it.

The housestaff have, as always, stepped up each time they were asked to do more. Moreover, they have driven much of the problem-solving, even introducing solutions that make their own roles more challenging. Their leadership has impressed even the most senior leaders in our institution. Their goal and our obligation is always to create the best clinical training experience possible.

We made a parallel commitment to study the impact of the new regulations. We did this across many outcome domains and uncovered the complicated implications of pulling on one or two levers of a complicated system. For example, although operational and safety outcomes were not different with the new hours, education and satisfaction deteriorated. In addition, while the interns in the new system had 14 additional hours out of the hospital across the 48-hour "call" window, they only used three of those hours for more sleep. Moreover, the number of handoffs that were required increased by 100 percent to 175 percent.

These outcomes, and large population-based studies of the 2003 duty-hour restrictions, give pause, particularly when considering the enormity of risk involved—patient safety and clinical excellence for the next generations of physicians.

Currently, however, we do not have the luxury to pause in our accommodation of the rules. Because of this, a new variable has crept into housestaff training—a focus on time. The current paradigm places at odds variables that should be aligned. Physicians in training may have to choose between building knowledge and adhering to policy. Attendings and senior residents may often become enforcers rather than educators. Furthermore, the prescriptive rules erode originality in training models. Each iteration we have made brings us asymptotically closer to other programs' solutions—solutions that do not prioritize the unique strengths of our Firm system and intern ownership. Again, given the risks, this is a time for policy to prioritize innovation over restriction.

Thankfully, the success of this program has always been determined by internal forces, not external forces. We are confident the Osler Program will always thrive—and we can't wait to return all of our energy to that mission. ■

Sanjay Desai, Director
Osler Medical Training Program

An early dispatch from the duty-hour trenches (*from page 1*)

"But it's really challenging when the hours they are allowed to be in the hospital are limited and the continuity of care is disrupted. We want them to see the evolution of disease and the implementation of their therapies, and to have an overnight experience where they are responsible, while keeping an environment in which everyone is healthy and safe."

ACSs have been learning at what point in the year interns should be taught certain skills, Brown says: "The current interns are better at signing in and out of the service and cross-covering patients than we were at that point, because of necessity."

Barker ACS Joanna Peloquin says faculty and housestaff worked to preserve the tradition of ACS rounds and prioritized the two hours of daily bedside teaching in how they structured the schedule. Now multiple interns present new patients, though some need to sign out directly after.

It's been a dynamic process, say the ACSs, who have been meeting with program director Sanjay Desai and others daily, weekly and monthly to fine-tune the scheduling, teaching and patient care responsibilities. A couple of months in, they say, everything seems to be finally falling into place.

"What I've learned is that there's no one model or schedule that's perfect," Sharma says. "I'm very proud of our department for trying different models. It shows that our housestaff and interns not only can provide great care but in a state of flux."

Interns have stepped up to the challenges, the ACSs note. "They're keen to figure out what works and just do it," Brown says. "Their level of commitment has been very inspiring to me."

"The interns' job itself, their experience in the O, the patient care and the medicine has not changed," adds Peloquin. "The O lives on, even without 30- or indefinite-hour calls." ■

Beyond the Dome

Aimee Zaas: Osler alum; Director, Internal Medicine Residency Program, Duke University Medical Center

David Zaas: Osler alum; Medical Director, Lung and Heart-Lung Transplant Program; Vice-Chair for Clinical Practice, Department of Medicine Duke University Medical Center

Aimee and David Zaas, who met during medical school at Northwestern University and married before their 1998 graduation, had the unenviable task of looking for residency programs they could do together.

"We were pretty fortunate," says David, "since we were interested in similar specialties."

Adds Aimee, "We were both looking for programs that had outstanding clinical training and the philosophy that interns were the primary doctor for patients," with upper-level residents responsible for teaching and managing.

They came to Johns Hopkins that summer as internal medicine residents, and after spending a year at Duke doing postdoctoral fellowships, returned in 2002 to become assistant chiefs of service, with Aimee heading the Thayer firm and David directing Janeway. The Zaases were the first married ACSs to head the Osler Medical Service at the same time, and Aimee became the first pregnant ACS.

After graduation, they returned to Duke, where Aimee works with the Division of Infectious Diseases and International Health, and David for the Division of Pulmonary, Allergy and Critical Care Medicine. David was just appointed chief medical officer for the Duke Private Diagnostic Clinic Physician Practice.

***Aequanimitas:* How did you balance work and family life as ACSs? Was it difficult?**

Aimee: We definitely spent a lot of time at work, but most of our friends were there, too. Not having children, it was a perfect time for a job requiring so many hours. Sometimes it confused the patients by having two Dr. Zaases. I would hear, "I thought Dr. Zaas was a man."

David: It was easier to spend so much time at work because we did it together. We shared many dinners over Subway in the hospital cafeteria. We were close friends with the two other ACSs as well. It was maybe easier than having a spouse who was not in medicine and who did not understand the job demands.

***Aequanimitas:* What do you remember most about your residencies?**

David: We both really enjoyed the history and the traditions, in addition to the culture, and recognizing the importance of those who went before you. I remember climbing the dome with Victor McKusick, as well as people like Dave Hellmann, the residency director when we started, who is a master clinician, and Charlie Wiener, the residency director during our ACS year, who is a master educator. It motivates your career to have people like them as role models.

Aimee: The training philosophy at Hopkins. Being a good doctor is taking responsibility and ownership for patient care, and learning what you need to know to best manage the patient. The aequanimitas "keep it together, be calm under pressure" philosophy really resonates throughout the workplace. For both of us, it's how we approach our careers.

***Aequanimitas:* What is your advice to current residents?**

Aimee: First of all, enjoy the opportunity. Recognize how much fun you can have taking care of patients and being around others who are really motivated to be the best.

David: Appreciate the culture that makes Hopkins special. The role models, the mentors and the opportunities opened up by training at a place like this—it sets you up for a successful career path that others don't have. ■

The Osler Fund

Give today for tomorrow's leaders

Every day, the Department of Medicine receives requests from residents who want to attend meetings where new clinical techniques will be presented or experts will share new knowledge in a particular field. Funding those trips becomes expensive, yet they're a vital part of the Osler training program.

Contributions to the Osler Fund for Scholarship help support these activities and also a multitude of other enriching experiences, including housestaff-initiated research projects and national poster presentations.

By investing in the future of our young doctors, we are continuing the legacy of Osler and we are preparing and inspiring the next generation of leaders.

If you are interested in supporting our housestaff, please send your tax-deductable contribution in the enclosed envelope or donate online http://hopkinsmedicine.org/Medicine/hstrainingprogram/philanthropy.html ■

Interested in learning more? Contact: Anne Kennan in the Department of Medicine, 410-550-9890 or akennan1@jhmi.edu.

Osler Scrapbook: Biennial Reunion 2011

Osler alums and others enjoyed the festivities in June. Among those attending were:

Philip Seo, Holly Dahlman, Ashwin Dharmadhikan, Traci Thompson Ferguson, Rhadi Ferguson

Osler latchkey recipient Jack Stobo and Mike Weisfeldt

Back, from left: Ken Silverman, Michael Silverman, Polina Teslyar, Steven Hsu; front, from left: David Heller, Julie Rosenthal, Michael Grunwald

Back, from left: Jack Stobo, Mike Weisfeldt, Linda Weisfeldt, Thomas Hendrix, Richard Johns, Evan Calkins; front, from left: Mary Ann Stobo, Deborah Chambliss, Richard Ross

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The Johns Hopkins University School of Medicine
Department of Medicine
600 North Wolfe Street
Baltimore, MD 21287-1720

Edward D. Miller, M.D., *dean/CEO*
Myron Weisfeldt, M.D., *chairman, Department of Medicine*
Sanjay Desai, M.D., *director, Osler Medical Training Program*
Patrick Gilbert, *director of editorial services*
Mary Ann Ayd, *managing editor*
Karen Blum, *writer*
Maxwell Boam, *designer*

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