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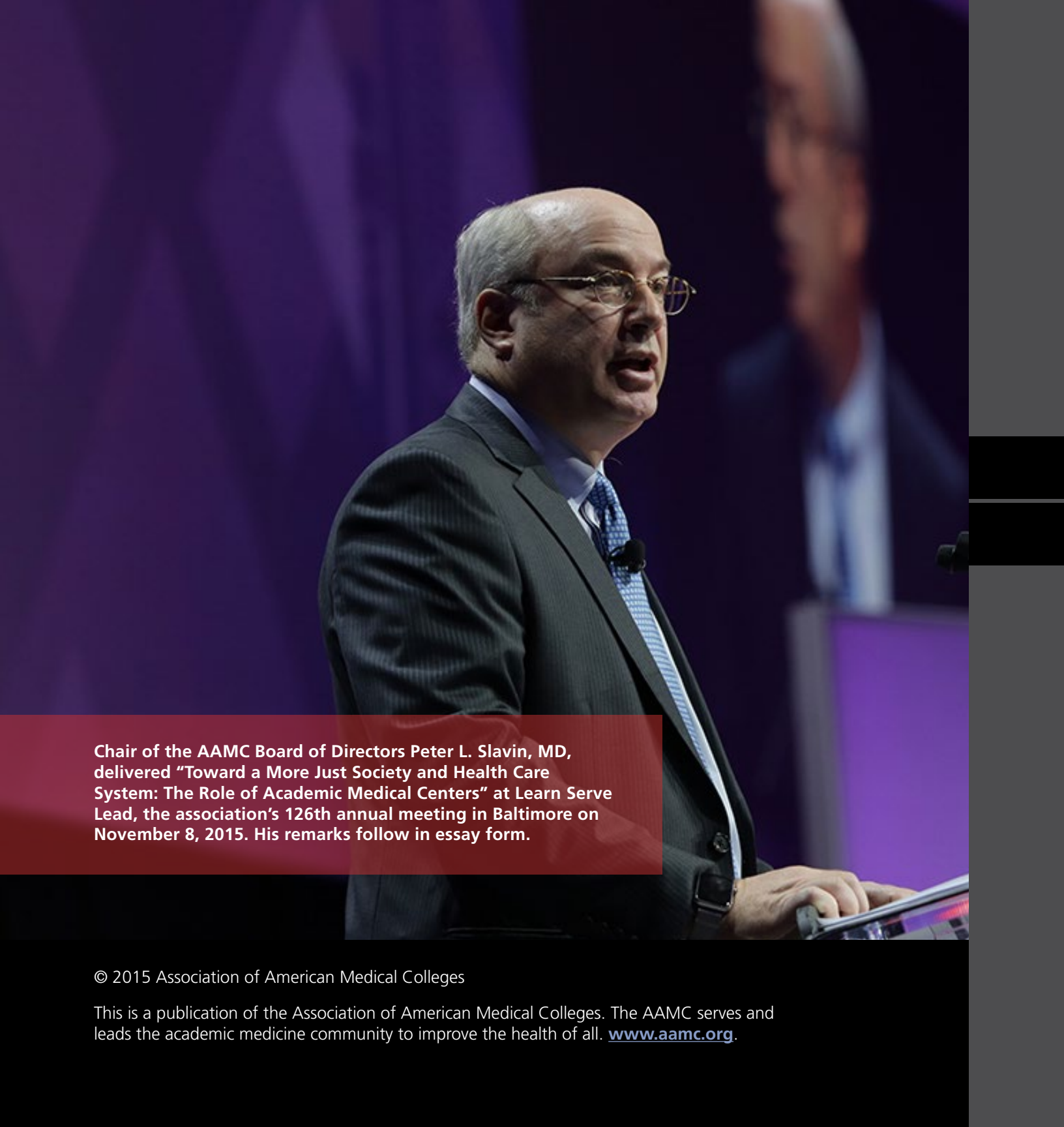
Lead

LEADERSHIP PLENARY ADDRESSES

Peter L. Slavin, MD
Chair, AAMC Board of Directors

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President and CEO, AAMC

Association of
American Medical Colleges

A photograph of Peter L. Slavin, MD, speaking at a podium. He is a middle-aged man with glasses, wearing a dark suit, a light blue shirt, and a patterned tie. He is looking slightly to his right. The background is a blurred purple and blue stage setting. A red rectangular box is overlaid on the lower left of the image, containing white text.

Chair of the AAMC Board of Directors Peter L. Slavin, MD, delivered “Toward a More Just Society and Health Care System: The Role of Academic Medical Centers” at Learn Serve Lead, the association’s 126th annual meeting in Baltimore on November 8, 2015. His remarks follow in essay form.

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AAMC President and CEO Darrell G. Kirch, MD, delivered "Crossing the Inequality Chasm" at Learn Serve Lead, the association's 126th annual meeting in Baltimore on November 8, 2015. His remarks follow in essay form.



TOWARD A MORE JUST SOCIETY AND HEALTH CARE SYSTEM: THE ROLE OF ACADEMIC MEDICAL CENTERS

AAMC CHAIR'S ADDRESS 2015

Welcome to the AAMC annual meeting. It has truly been an honor for me to serve as chair of the AAMC board of directors this past year, and it's a pleasure to be here among so many friends and colleagues.

I'm also glad that this year's meeting is taking place in Baltimore. Baltimore and Boston, where I'm from, have a lot in common. In addition to having great traditions of academic medicine, both cities are avid sports towns. In Boston, we are thrilled that the defending Super Bowl champion New England Patriots are off to a 7-0 start. Our hearts go out to the fans of the 2-6 Baltimore Ravens. Their spirits must be really deflated.

More seriously, Baltimore is a city that pioneered American medical education in so many ways.

Back in the 18th century, Baltimore was threatened by a public health crisis, as poor sanitation around the port led to a devastating outbreak of cholera and typhoid fever.

The average lifespan was 34 years, and there was no real way for a patient to tell the difference between an unskilled charlatan and a doctor who could actually help them.

It was against this backdrop that a group of Baltimore physicians first started teaching students in their homes. In 1807, the University of Maryland, our nation's first public medical school, opened in this city. And in 1876, medical schools from across the country came together to form the AAMC, based on the belief that our profession must hold itself to the highest standards to earn and maintain the trust of the people we serve.

I bring this history up because I believe there has never been a more important time than now to remember our founding obligation to address crises that threaten the health and safety of our communities.

Seven months ago, a 25-year-old Baltimore resident named Freddie Gray suffered a serious spinal cord injury while being arrested. His pleas for medical attention were ignored, and a week later he died. The next month saw the worst riots in Baltimore since Martin Luther King's assassination in 1968.

Over the past year, similar tragedies and unrest from Ferguson, Missouri, to Staten Island, New York, have forced our country to confront profound issues of race, justice, and inequality. We have all seen this drama play out on the streets and on television, among activists, police officers, and politicians. But today, I would like to argue that issues of racial bias and racial disparities should also be discussed and addressed by doctors, and nurses, and medical students, in medical schools and teaching hospitals.

Too often, we don't take the time to consider our relationship to these issues until they are staring us in the face—when someone like Freddie Gray rolls into our emergency department. By then, of course, it's too late.

“ I believe there has never been a more important time than now to remember our founding obligation to address crises that threaten the health and safety of our communities.”

So it's our responsibility to determine what we can do to create a society, and certainly a health care system, that is more equal and more just than what we have today. This is a responsibility that includes everything from addressing health care disparities, to improving medical school admissions and faculty hiring, to beefing up training and advocacy.

Fourteen years ago, the Institute of Medicine Report “Crossing the Quality Chasm” gave our nation a clear blueprint for improving the quality of health care in this country. The report focused on six key pillars: efficiency, effectiveness, safety, timeliness, patient-centeredness, and equity.

In the years since, we have dedicated tremendous attention and resources to the first five of those pillars. But equity has too often been ignored or politicized, instead of being treated as a defining test of whether we're meeting our responsibility to deliver quality care to everyone who needs it. The simple truth is that we cannot achieve quality without addressing inequality.

Now, it's important to note that biases and disparities in health care persist along lines of gender, socioeconomic status, sexual orientation, and so on. But today I'd like to focus on race, because it's still true here in America—half a century after the Civil Rights Act became law—that the strongest predictor of someone's health status is the color of that person's skin.

To offer just a few examples: Minority patients tend to receive less pain medication for the exact same fracture. White women are more likely to have breast cancer, but African American women are 40 percent more likely to die from the disease. And people of color are two to four times more likely than white patients to develop end-stage renal disease.

There are many factors at play here. The root causes of unrest in cities like Baltimore are also the root causes of health inequities. Our country's long legacy of discrimination has led to substandard housing, residential segregation, neighborhoods plagued by drugs and violence, a vast income and wealth gap, and lack of access to good education, health care, and nutrition—all social determinants that negatively affect physical and mental health. In the Baltimore neighborhood where Freddie Gray lived before

his death, one-half the residents are unemployed, one-third of the homes are vacant, and 60 percent of residents don't have a high school diploma.

But even if you control for income, education, and health insurance, patients of color are still not receiving the same care as their white counterparts.

Something else is going on here. The

truth is that health care disparities are exacerbated by the conscious and unconscious biases of health care professionals on the one hand and the fear of bias by patients on the other.

As Mazarin Banaji explained in her superb presentation at last year's AAMC meeting, even when doctors, nurses, and hospital staff have the best intentions, we bring our blind spots to work. In one study, when doctors were shown identical patient histories and asked to make judgments about heart attack symptoms, they were much less likely to recommend cardiac catheterization to black patients.

“ It's still true here in America—half a century after the Civil Rights Act became law—that the strongest predictor of someone's health status is the color of that person's skin. ”

At the same time, patients' awareness of disparities and anticipation of unfair treatment leads to poorer mental and physical health. Studies have shown that just the fear of discrimination is enough to trigger a stress response. When patients come to our hospitals, they bring with them their experiences and expectations. The mistrust that people may have for the police mirrors the mistrust they feel for the health care system. That's a big problem. Providing quality care depends on earning the trust of patients so they tell us the information we need to know to make an accurate diagnosis and follow our treatment recommendations.

The bottom line is that in order to live up to our oath to "do no harm," we must first take a hard look at where we're falling short. A decade ago at Massachusetts General Hospital (MGH), we decided to do just that. We started by assuming a mindset of "guilty until proven innocent." In other words, instead of just saying, "Racial disparities don't exist here," we said, "We're going to assume they exist here. So let's go find them and fix them."

We founded the Disparities Solutions Center in 2004 under the great leadership of Dr. Joe Betancourt. We realized that while a lot of people were talking about disparities and measuring them, there was no systematic effort underway to eliminate them.

Our approach was very straightforward, and involved three overarching steps.

Step one has been to rigorously collect demographic and quality data so that we can identify gaps and be transparent about bias. As we often say, "You can't manage what you don't measure." We were the first institution to collect detailed, self-reported demographic data on all of our patients and publish clinical outcomes stratified by race on our website. We believe this transparency is essential to building trust with disenfranchised communities and holding ourselves publicly accountable. To paraphrase Supreme Court Justice Louis Brandeis, sunlight is the best disinfectant.



Step two has been to act aggressively in closing the gaps we've identified. And here I'll give you just one example. Our first year of evaluating patient data revealed that Latino patients were more likely than white patients to be in poor diabetes control. So we launched a series of interventions that included proactively reaching out to Latino patients with diabetes, offering visits with a bilingual coach and bilingual nurse educator, as well as group classes, support groups, and clinical visits with a nurse practitioner.

One of the most successful things we did was hire a health coach named Eddie, who was from the community we were trying to reach. Eddie would spend time with diabetic patients after they had met with the doctor and talk to them about underlying issues, like diet and exercise, in a practical manner and within their cultural context. When we interviewed patients, many singled out Eddie for helping them turn things around.

“ Targeting inequality actually raises the quality of care for everyone. Quality and equality go hand-in-hand.”

This program has reached many patients. The disparities in poor diabetes control have been reduced substantially, while overall rates of good control have improved for both whites and Latinos. I really want to stress that point because this lesson is so important: targeting inequality actually raises the quality of care for everyone. Quality and equality go hand-in-hand. There can't be true quality without equality.

I'll give you another example of the progress we've made, this time in the area of patient satisfaction. Since the early 2000s, we've surveyed our patients about their experiences and stratified the results by race and ethnicity. Initially, one in five African-American patients felt as though the white patient next to them was receiving better care. One in four Latinos felt the same way.

When we dug deeper, it turned out that a big part of our patients' experiences were shaped by how they were greeted and engaged by our frontline staff when they first walked into the hospital or an outpatient practice. It turns out that while patients of color didn't wait any longer than white patients, many assumed that they did. So we trained our frontline staff about how to greet and welcome patients in a culturally competent way, so that everyone felt valued and respected. And ever since making that change, our patient satisfaction gap has dropped dramatically.

The work of the Disparities Solutions Center has had a profound effect on the culture and care of our entire institution. Since 2007, we've issued an annual report that monitors our performance, so we can say with a high degree of certainty that if you were admitted last year to Massachusetts General Hospital with chest pain, you were given the same kind of care, regardless of skin color. Putting equity front and center has made all of us more conscious of these issues as we go about our daily work.

Now, the good news is, MGH is far from the only hospital that is finding new ways to close gaps in care. The Henry Ford Health System in Detroit now collects demographic data from more than 90 percent of its patients and embeds that data into equity dashboards that are part of its overall quality and service metrics. Robert Wood Johnson Hospital in New Jersey, by using data to identify inequities, has reduced its overall 30-day hospital readmission rate from 13 percent to 5.2 percent in just one year. And here in Baltimore, the University of Maryland and Johns Hopkins are working with the state of Maryland to create health enterprise zones that bring providers and the community together to address major public health issues. And the AAMC itself has been a leader in promoting health care equity. It has developed a number of tools, resources, and programs that are readily available to our institutions. Please check them out on the AAMC website.

So there is a lot of great work being done in a number of places with regard to disparities. But there's also a third step we're taking to achieve a more just and equal health care system—using what we've learned to create a more diverse and inclusive work environment. At MGH, we've developed hospital-wide cultural competency standards, as well as specific education and training programs for physicians, nurses, and caregivers.

But I'll be honest: we're far from perfect and still have a lot of work to do. In fact, one of the reasons I wanted to speak about this topic today is because of a very humbling experience I had in the wake of the protests in Ferguson and Baltimore. I had an opportunity to meet with MGH medical house staff from underrepresented backgrounds.



These staff members shared how they were deeply affected by what was happening around the country, but didn't feel they had a safe place at the hospital to discuss these important issues. It was a reminder of how much we can learn from our trainees and also a punch in the gut. It proved that despite all the work we've done, and all the progress we've made, we can't rest until every employee and every patient feels that our hospital is an open, inclusive, and understanding environment.

This requires better communication, but it also requires building a workforce that reflects the varied backgrounds and experiences of the people we serve. A more just health care system depends upon us building a more diverse talent pipeline through our medical schools and training our students to think more broadly about these issues.

As some of you know, I've been involved at Massachusetts General Hospital in one capacity or another for more than 30 years. But my connection to MGH actually goes back a couple generations to my great-grandfather, who was a Jewish immigrant from Lithuania. In the 1920s, he received exceptional care at MGH over a 10-year period. But if he or one of his children had wanted to go into medicine, they wouldn't have been allowed to train there. In those days, MGH and many other hospitals across the country wouldn't train Jewish physicians.

Today, bias in medical school admissions isn't nearly as obvious or intentional. But the truth is, we still don't have a system that encourages the best talent from every background. Even as our country grows more diverse, our hospital staffs and medical schools have not.

“ There is so much that we, as a medical community, can do to help create a more just and equal health care system. But let's also remember that as major employers, corporate citizens, and leaders of our communities, we also have the ability to help create a more just and equal society.

In fact, the demographics of medical school classes have barely changed in 20 years. Not only are black and Hispanic physicians underrepresented among medical school faculty, they are less likely to be promoted and less likely to hold senior faculty and administrative positions. This isn't right, and from a purely business perspective, it isn't smart. Patients will be less likely to choose a hospital that doesn't have caregivers who share their varied backgrounds and experiences. There's also plenty of evidence that organizations with more diverse teams make better decisions and outperform organizations that are less diverse.

We have to examine the barriers to entry that are often “baked into” the process by an emphasis on GPA, the MCAT exam, and board scores, which can discourage many qualified candidates of color from even applying. And while we pay lip service to qualities like resilience in the admissions process, it’s time to be more concrete about how we assess and factor that into our decisions. If one student has a slightly lower MCAT score but worked two jobs to put herself through college despite growing up in a poor, violent neighborhood, I want her in my medical school and residency program.

There is so much that we, as a medical community, can do to help create a more just and equal health care system. But let’s also remember that as major employers, corporate citizens, and leaders of our communities, we also have the ability to help create a more just and equal society. We can and should be advocates on all those issues that ultimately effect the health of the men, women, and children we serve, from criminal justice reform and gun safety to education and poverty.

The next time your emergency department treats a gunshot victim, someone with a heroin overdose, or a poor child whose diabetes was never diagnosed, ask yourself, “Is there something we all could have done to help before this person came through the doors of our hospital?” Like those 18th-century Baltimore physicians before us who took responsibility to solve a public health crisis in their midst, our full obligations as medical professionals and institutions extend well beyond the walls of our medical schools and hospitals.

A grayscale portrait of a middle-aged man with glasses, wearing a suit and tie, speaking into a microphone. The image is partially obscured by a purple overlay on the right side.

“ If we can discover these biologic miracles of modern medicine, then surely we can uncover the biases that exist in the care we deliver and learn to treat each other with the dignity and equality that every human being deserves.

Our job is to heal.

Our job is to save lives, regardless of what our patients look like, where they come from, what they believe, or who they love.

Issues of equality and justice are not separate from the practice of medicine. They are central to the practice of medicine, and they must be central to the training and education of every bright young person who enters the profession.

I know that progress on these issues is difficult, but I also know that it's possible. I know it because I've seen it at MGH, where tackling disparities has improved the care we deliver to all our patients. I know it because I've seen it in a growing number of medical schools and teaching hospitals across America. And I know it because I've seen the dedication and compassion in the eyes of so many students and professionals who want to do better.

In just the past century, we have seen doctors and scientists in our institutions sequence the human genome, stem the HIV epidemic, and nearly eradicate polio from the face of the Earth.

If we can discover these biologic miracles of modern medicine, then surely we can uncover the biases that exist in the care we deliver and learn to treat each other with the dignity and equality that every human being deserves.

Thank you so much and enjoy the rest of the meeting.



CROSSING THE INEQUALITY CHASM

AAMC PRESIDENT'S ADDRESS 2015

Thank you all for joining us this morning. As I listened backstage, I heard Dr. Slavin demonstrate the honest conviction and courage he has brought to his leadership roles at the AAMC and at Massachusetts General Hospital. He leads a great hospital that could easily rest on its laurels, but he was willing to look at where it fell short. He made a powerful statement by speaking so frankly about the issue of race—an issue our nation has grappled with since our founding. So rather than turn to another topic, I want to build on his powerful message by looking at other inequities in our society, their impact on health, and what we in academic medicine should do to address them.

I have a colleague (probably in the audience this morning) who introduced me to the technique of helping a group enter a more reflective and thoughtful discussion by beginning a meeting with a poem. While initially skeptical, I have found his strategy does indeed help a group focus on the issue at hand. So with your indulgence, let me share a poem by William Stafford, titled “The Way It Is.”

The Way It Is William Stafford

There's a thread you follow. It goes among
things that change. But it doesn't change.
People wonder about what you are pursuing.
You have to explain about the thread.
But it is hard for others to see.
While you hold it you can't get lost.
Tragedies happen; people get hurt
or die; and you suffer and get old.
Nothing you can do can stop time's unfolding.
You don't ever let go of the thread.

From Stafford's Ask Me: 100 Essential Poems. ©1998. Reprinted with permission.

A faint, grayscale background image of a man with glasses, wearing a suit and tie, is visible on the left side of the page. He appears to be speaking or gesturing with his hands.

As physicians, the thread we follow is our ethical commitments. These commitments guide us through the transformations of our health system and our society. They never change. Whatever our personal politics may be, whatever issues swirl around us, our ethical commitments require physicians to do just four things: provide benefit, do no harm, respect the autonomy of our patients, and work for social justice. This final commitment, to social justice, is the reason we work so hard to bridge the inequalities that create deep health care disparities between those who live in communities that promote health and those who do not.

Peter mentioned the landmark Institute of Medicine report on “Crossing the Quality Chasm,” which recognized equity as a central tenant of quality care. Nearly 15 years after that report was released, where do we stand on crossing the “inequality” chasm? Over the last year, many issues relating to racial, social, and economic inequality have come to the forefront of our national conversation. We have seen protests, and deep frustration has even spilled over into violence. But we have also seen Pope Francis come to our country and go out of his way to reach out to the poor, the homeless, immigrants, and prisoners. And now we are hearing presidential candidates talking about everything from immigration, to the widening wealth gap, to women’s health and gender inequality.

“ Whatever our personal politics may be, whatever issues swirl around us, our ethical commitments require physicians to do just four things: provide benefit, do no harm, respect the autonomy of our patients, and work for social justice.

While the issue of inequality has entered national politics, I want to be clear that as health professionals, our obligation is not to view it through the lens of any political ideology. Our obligation is to view it through the lens of our ethical commitments.

Countless research studies have proven that social and economic inequality contribute to disease. Confronted with the scientific evidence that social inequities lead to poorer health outcomes, we have a clear ethical obligation, as health professionals, to address this issue.

Unfortunately, we have seen the inequality chasm deepen in recent years. Though the Great Recession is behind us, for many Americans, personal income and wealth have not recovered. At the same time, college tuition is rising and higher education has become out of reach for many low-income students.

“ Income inequality, educational inequality, and decreased social mobility converge to affect health in countless ways.

These forces contribute to a growing public health problem. Income inequality, educational inequality, and decreased social mobility converge to affect health in countless ways. Most of us in this room are among the fortunate—we have college degrees, good jobs, and health insurance. But I know many of you have seen firsthand how your emergency room is too often the only care available for the poor, the uninsured, and the undocumented in your communities. Our teaching hospitals represent only 5% of all U.S. hospitals, but they provide nearly 40% of the charity care in our nation. Our hospitals are a safety net for those who fall through the gaps in our nation's health care system. But when patients cannot receive care until they end up in the emergency room, they already have missed opportunities for prevention, early intervention, and promotion of good health. It is often too late.

With that in mind, consider the Affordable Care Act in light of the facts, not the politics. The ACA has helped narrow the gap in health care access by making health insurance available to millions of previously uninsured or underinsured Americans. Today, the percentage of our population without health insurance is less than 12%—the lowest rate ever. But insurance does not guarantee access, and access does not guarantee proper care. People might have insurance, but may not have the specialist they need nearby, they may not have transportation, or they may not know how to navigate a complex health system. As our physician shortage deepens, the most vulnerable among us—even those who have insurance—will face longer wait times to see a doctor.

As a psychiatrist, I feel compelled to talk about another vulnerable population burdened by inequality—the mentally ill. When I was a resident, I spent a year working at a state psychiatric hospital. Though significantly under-resourced, a caring staff did the best they could to stabilize and support some very ill individuals. Both the patients and staff also gave me a powerful lesson in empathy and humanism. Unfortunately, programs like the one I trained in have less funding now than ever, and more than half of U.S. counties have no mental health professionals at all. For many who suffer from mental illness, finding a physician is increasingly difficult.

For this and many other reasons, our health, legal, and social systems are failing people with mental illness. At the same time, our national conversation around mental illness has taken an alarming turn. Over the last two decades, we have seen too many instances of mass violence across our country—shootings at schools, churches, and other community settings where people should feel safe. Following these tragedies, some public figures try to deflect a politically charged issue by pointing a finger at mental illness. But then they do not take action to improve care for the mentally ill. In my own opinion, they focus on mental illness to avoid a more difficult discussion about our culture of violence.

The evidence shows that people with mental illness are at higher risk of becoming victims of violence than of being its perpetrators. They also face greater risk of physical illness, such as obesity, heart disease, and chronic viral infections. But because of our country's failure to provide adequate support for this population, the criminal justice system has become a crude tool for managing people with serious mental disorders. If you want to visit the institution caring for the largest number of mentally ill people in America today, you would need to go to Cook County Jail in Chicago.

“ In many cases, inmates come from underserved communities with significant health disparities, and many return to those communities when they are released, continuing a cycle of disease and disparity.

The Los Angeles County Jail comes in at a close second. Across the country, the National Alliance on Mental Illness estimates that nearly 20% of inmates nationwide suffer from some type of mental illness.

The population of inmates is growing at an astounding rate. From 1980 to 2008, the number of people incarcerated in America has more than quadrupled, from approximately 500,000 to 2.3 million. Incarceration rates vary across racial and economic lines. Since 2001, one in six black men has been incarcerated. With limited access to quality care, correctional populations are among the sickest in our country. In many cases, inmates come from underserved communities with significant health disparities, and many return to those communities when they are released, continuing a cycle of disease and disparity.

Fortunately, there is one area of historic inequity where we made real progress this year. Just one day after upholding the Affordable Care Act, the Supreme Court made another landmark decision by extending marriage equality to all 50 states. From a health perspective alone, this decision was a

step toward greater equity for the LGBT community. With marriage rights comes access to spousal insurance, social security survivor benefits, and hospital visitation rights. Moreover, research has shown that marriage itself is associated with health benefits, including improved cardiovascular, immune, and mental health. While the LGBT community still faces conscious and unconscious bias, including within our health care system, I hope the Supreme Court's decision will be a turning point in closing this part of the inequality chasm.

Lastly, given that this Wednesday is Veterans Day, I would be remiss if I failed to acknowledge the health disparities facing our military and veterans. Whether they participated in the Battle of the Bulge like my father, Vietnam like my brother, or the conflicts in Afghanistan or Iraq like some of our newest medical students, we owe it to our servicemen and women to ensure they have access to high-quality health care. Active-duty military and veterans face specific and complex health challenges, including traumatic brain injury, limb loss, and post-traumatic stress disorder. The VA has long been a leader in patient care, and the VA Office of Health Equity works to ensure equitable care for veterans. But physician staffing challenges in recent years have made it difficult for some veterans to access care when they need it.

So how do we respond? Everywhere we look, it seems we face the inequality chasm. But with every opportunity I have to be on one of our campuses, I see examples how you are rising to meet this challenge. You maintain free clinics, often run by our students, and you have innovative patient outreach programs in our poorest communities. You study genetic and environmental influences on mental health. You are leaders in educating physicians about the unique health needs of LGBT patients. And through our unparalleled 70-year partnership with the VA and our participation in the White House Joining Forces Initiative, you are giving hope to those injured and traumatized by war.



As discouraging as the problems can seem, I am heartened by everything you are doing to solve them. Take the University of New Mexico School of Medicine, for example, which has implemented a four-year curriculum called “Educating for Health Equity.” Every student in the School of Medicine participates in the curriculum, which teaches the social determinants of health and prepares students to become doctors who advocate for their patients and for systemic change. The program now serves as a model for other medical schools around the country.

Or look at the University of Massachusetts Medical School, which over the last 20 years has built a national reputation for improving the health outcomes of correctional populations. Through research, education, and patient care, faculty, students, and staff are helping inmates take control of the social and environmental factors that lead to both incarceration and poor health. Their faculty produced the first comprehensive textbook of inmate mental health, published this year.

In clinical care, the Children’s Hospital of Philadelphia helps vulnerable kids become healthy adults through evidence-based community health programs in Philadelphia’s underserved neighborhoods. In partnership with the city, the Children’s Hospital will open a Community Health and Literacy Center in South Philadelphia next year. By incorporating a library and recreation center alongside a health clinic, they will tackle systemic inequities related to poverty and education, while promoting good health.

“As discouraging as the problems can seem, I am heartened by everything you are doing to solve them.”

Or consider an example from right here in Baltimore, where the Hopkins Center to Eliminate Cardiovascular Health Disparities has been working with the community for more than 20 years to study health inequity and potential interventions. Led by last year’s AAMC Herbert W. Nickens Award winner, Dr. Lisa Cooper, the center has conducted groundbreaking research into the effects of race and ethnicity on the patient-physician relationship. The center’s work highlights the importance of training providers in intercultural communication. It also demonstrates the compelling reason why we must admit medical school classes that reflect the diversity of our communities.

While I highlighted only a few initiatives, I see efforts to engage your communities and reduce inequities at every medical school and teaching hospital I visit. The AAMC is committed to supporting you. We work to facilitate collaboration and disseminate exemplary research, innovative care solutions, and best practices for teaching the social determinants of health. The AAMC has awarded grants to evaluate care models, like medical-legal partnerships, and their potential for positive intervention in vulnerable populations. Through our Research on Care Community, dozens of our member institutions are creating a national evidence base for effective, patient-centered methods to collect information on the social determinants of health in electronic medical records. Our goal is to support and enhance your work on the front lines.

While we strive to disseminate your work, we also are using this body of research to address inequity on a national level. We advocate for NIH funding, because research translates into medical practices that reduce health disparities. We advocate for increased funding for residency positions, because failure to address the physician shortage will affect vulnerable populations first. We promote fair and equitable clinical reimbursement so that teaching hospitals can continue to care for those who live on the margins. We work with our colleagues across the health professions to address the social determinants of health from every angle. We file briefs in every Supreme Court case that threatens to undermine holistic admissions. And we take every opportunity to educate policymakers and opinion leaders about the countless ways you serve those who have

been marginalized by the color of their skin, gender, sexual orientation, poverty, mental illness, or wounds of war. For generations you have kept your promise to them, and the AAMC promises to be your most vocal advocate.

“ Each of us is called to reduce health inequity because of our commitment to social justice and our mission to provide quality care.

I see the great things you are doing. But I worry that they are too often done in relative isolation, by individual champions. As Peter so clearly and succinctly said, “Quality and equality go hand in hand.” Each of us is called to reduce health inequity because of our commitment to social justice and our mission to provide quality care. And every one of us can contribute to health equity and community health. If you are an educator teaching the cardiovascular system, could you show your students data that highlight

cardiovascular disparities in your community? If you are a CEO, could you ask for quality improvement reports that identify inequities within your system? If you are a scientist, could you attend a local community board meeting and offer a report on how your research could address community health concerns? By looking at each of our individual roles in academic medicine through a health equity lens, every one of us can help reduce disparities and support our colleagues in doing the same. Just imagine how much more effective all of our efforts would be if they were conducted in mutually reinforcing ways. Think about the benefits that would accrue to our learners, our patients, and our communities.

The inequality chasm looms large, and the health of too many people hangs in the balance. Over the coming year, as political battles and partisan spin escalate, more than ever we will need to ignore the noise and maintain focus on bridging the inequality chasm. Just remember the lines from William Stafford's poem:

**People wonder about what you are pursuing.
You have to explain about the thread...
You don't ever let go of the thread.**

Thank you!