

# LEARN PRESIDENTIAL ADDRESSES SERVICES OF THE AAMC PRESIDENTIAL ADDRESSES OF THE AAMC PRESIDENTIAL ADDRESS OF

OF DARRELL G. KIRCH, MD

# LEAD

2006-2018

### Learn, Serve, Lead:

The AAMC Presidential Addresses of Darrell G. Kirch, MD 2006-2018

March 2019







#### INTRODUCTION

For 13 years, Darrell G. Kirch, MD, president and CEO of the Association of American Medical Colleges, inspired the AAMC community through his annual presidential address. Throughout this collection of addresses, Dr. Kirch's vibrant vision for the future of academic medicine, passion for improving medical education and patient care, and warm, collaborative approach shine through.

A distinguished physician, educator, and medical scientist, Dr. Kirch spoke often about the need for transformation in the nation's health care system, the importance of culture and collaboration, and the necessity for academic medicine to lead change across medical education, biomedical research, and patient care.

From framing the mission of academic medicine as a vital public good in his first address in 2006 to sharing his own struggles with burnout as a young medical student in his final address in 2018, Dr. Kirch always reflected thoughtfully about the challenges and achievements of the academic medicine community and inspired its members to action. His words and wisdom will ring true for many years to come.



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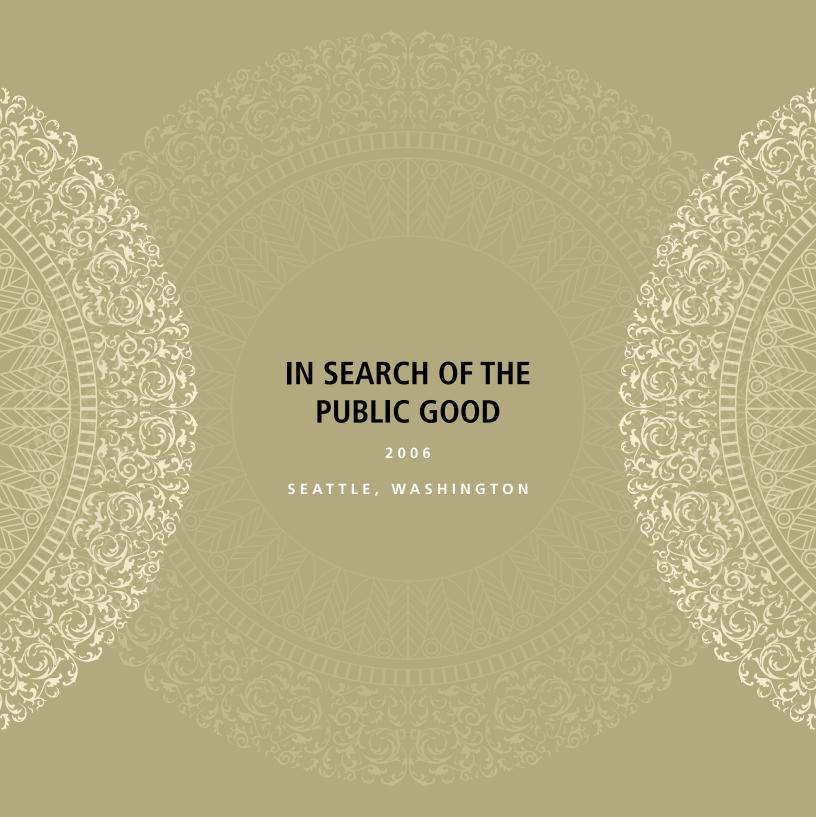
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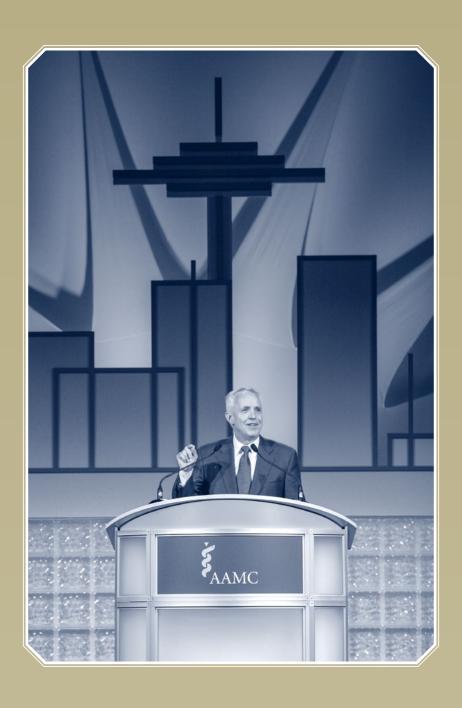
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fter many years of sitting with you on the other side of this podium, it truly is extraordinary—and definitely more than a bit intimidating—to now be on this side, speaking to you for the first time as president of the AAMC. As you might imagine, during my first weeks in Washington I spent considerable time contemplating what my inaugural message should be.

I found myself thinking about the legacy of the three AAMC presidents before me, each of whom made a vital contribution to our value as an association and to the values we hold dear. Our first full-time president, John A.D. Cooper, recognized the value of transforming the AAMC into a strong voice based in the nation's capital. Our esteemed colleague from Seattle, the late Bob Petersdorf, spoke forcefully about our academic values. And of course, it was Jordan Cohen who, in a series of memorable annual meeting addresses, so eloquently affirmed our professional values.

Building on that legacy, it seems that a natural evolution of our great history as an association is to talk about a challenge we face that speaks directly to our social values, and that presents an opportunity to define our shared legacy. My goal today is to argue that our social values demand that we come together to preserve one of our greatest ideals—the principle of "the public good."

#### THE "PUBLIC GOOD"

What is a "public good"? By definition, a public good is any service or good that is provided for the well-being of all the members of our society, or to which every member of our society at least should have access. Public goods are something we all support, either through government funds or, in some cases, by private philanthropy.

Even though our nation was founded on principles of personal rights and individualism (and despite our passion for private enterprise), we nevertheless repeatedly embraced the notion that some things are shared; that they are a "commons" worth preserving for all our citizens. In other words, that they are "public goods."

In education, for example, whether it was the land-grant-university movement of 150 years ago that catalyzed the development of many of

our greatest public research universities, or the Flexnerian revolution of nearly 100 years ago that swept away proprietary medical schools, we established the principle that higher education is a public good worthy of our shared support.

On the research front, our nation declared that improving health through discovery was a public good when we created the National Institutes of Health (NIH), and more recently when we boldly supported mapping the entire human genome.

And in health care, our commitment to the public good began early in our nation's history when we established our first charity hospitals in our oldest cities. Much more recently, that commitment was expressed as a cornerstone of our Great Society with the creation of Medicare and Medicaid in 1965.

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#### THE PUBLIC GOOD TODAY

But despite this great history, it seems that the notion of the public good is missing in action from our national discussions today. Politically, our nation is polarized. If you believe the pundits, we are divided indelibly into "red and blue states." Political gridlock has left many of us feeling disheartened or, even worse, hopelessly cynical. On the fiscal front, our nation's own chief accountant, David M. Walker, the Comptroller General of the United States, has concluded that our nation's current policy is—and I quote—"unsustainable over the long term" with "everlarger deficits and a federal debt burden that ultimately spirals out of control."

What do we find when we examine the fate of the public good in the core missions of academic medicine?

#### **Education**

In education, college tuition levels are so high that higher education in general is in danger of becoming a scarce commodity for a privileged few, rather than a public good available to anyone. The situation in medical education is even more acute. The notion of medical education as a public good is collapsing in a wave of privatization that makes even our public medical schools seem more like private institutions. Tuition and debt are our most important vital signs, and a 2004 AAMC report verified what we all feared. A medical education is far less affordable to students and their families than it was just two decades ago, with a real danger that it will become entirely out of reach for many Americans.

Since 1984, median tuition and fees have increased by 312% in public medical schools. Debt is on the rise, now standing at an average of \$120,300 per student. Not surprisingly, more than 60% of medical students now come from the upper quartile of family income.

Medical education appears to be at serious risk of becoming just one more expensive private commodity, even in our public universities.

At the same time, we see falling public support to help individuals pursue careers in medicine, thereby weakening efforts ranging from pipeline programs to scholarships.

On the federal level, funding for Title VII health professions programs has been cut in half within the last year, and the Health Careers Opportunity Program virtually eliminated. The National Health Service Corps, which provides scholarships and a loan repayment program for physicians who practice in underserved areas, also is struggling. Since 2003, funding for this program has been cut by almost 27%.

#### Research

In the area of research, only a few years after we galvanized as a nation around accelerating the promise of the biomedical revolution by doubling the NIH budget, that budget now is losing ground with inflation. Our schools, which heavily invested their own precious funds in this commitment, now find themselves struggling to support the people and facilities needed to advance science over the long term.

Not surprisingly, researchers now look to the private sector for support, but find that pharmaceutical companies are investing more in clinical trials and less in early, discovery-stage research.

As a nation, we seem to have lost sight of how long the road is from fundamental discovery to finished product and are heading toward a research enterprise that encourages investments in research with the greatest potential immediate return rather than the greatest patient-based need.





#### **Health Care**

Sadly, nowhere is the loss of the core concept of the public good more apparent than in health care. The nation that built some of the greatest hospitals in the world on the core concept of "charity," that had the courage to declare that a Great Society would not leave its oldest, its disabled, or its disadvantaged citizens without health care, now has nearly 47 million Americans who are uninsured, and many millions more who are underinsured.

Every day, our teaching hospitals and faculty physician groups are caught in the depths of a "no margin–no mission" dilemma, struggling with the terrible choices this dilemma forces on them about which services they can afford to maintain.

For an increasing number of Americans, health care looks more and more like a high-priced, hard-to-obtain private commodity. A 2005 survey by the Kaiser Family Foundation found that the top worry of 46% of Americans is paying for health care or health insurance.

The signs are clear. Without any clear national discussion, we seem to be abandoning three things we once affirmed as public goods—higher education, biomedical research, and affordable health care for all. In a de facto manner, we appear to be turning these goods over to the private sector. But do we really want education, research, and health care to be treated like any other commodity, subject to the whims of the marketplace?

#### **The Tipping Point**

In my first months in Washington, I found that people from both inside and outside academic medicine are concerned about the threat to our core concept of the public good. I also found that many of them believe we may be at the tipping point. Across the political spectrum, the people

with whom I spoke believe our nation is on a path that is unsustainable. It makes me believe that we, as the community of academic medicine and as a nation, are ready to make an extraordinary effort to resuscitate one of our most cherished ideals; that is, to reaffirm the public good.

"For an increasing number of Americans, health care looks more and more like a high-priced, hard-to-obtain private commodity."

Clearly, restoring our national commitment to the public good is a daunting task, and I do not come before you today with a blueprint for reversing decades of eroding support. But I do believe I know how we should start a long overdue national conversation.

This conversation involves some very tough questions—questions I challenge each of us to answer:

- Are we ready to declare that some things transcend private commodities and should be preserved as public goods?
- How many of us are still willing to say "yes" if it requires forcing ourselves to have some very difficult conversations with our fellow citizens about our national priorities conversations we clearly have been avoiding?
- What if it means putting our collective social goals ahead of our specific institutional goals as individual schools and teaching hospitals? And even more to the point, are we still willing to say "yes" if it requires personal sacrifices?



I realize that some of you may be thinking this all sounds very abstract and platitudinous, but I would argue that we are facing a very real test—for us as a society, for us as a community of medical schools and teaching hospitals, and above all, for each of us as individuals. Recapturing our collective commitment to the public good will require each of us personally to accept responsibility for the problem, and require us to change some very fundamental beliefs, behaviors, and expectations.

#### "Collectively, we need to declare that education, high-quality health care, and research are public goods."

Here are the steps that I believe we must take, from the national to the personal level:

## As a society, we must take responsibility for the historical legacy we now are constructing.

In order to declare that some things stand as public goods, we need to stop deluding ourselves. We say we support Medicare and Social Security as public goods, but appear to believe that their huge unfunded liabilities are an acceptable legacy for the next generation. Are we willing to stop the charade of claiming we support public goods, while ignoring that our current course is simply to assume that the next generation will pay the massive bill? I would argue that we have a social obligation to fix these problems, instead of dumping them in the laps of our children.

#### On the national level, we must break the political impasse.

Many so-called "hot-button" issues divide us as a nation, and they have become deeply embedded in our politics and in our elections. But I have to believe that collectively we could agree that some priorities are clear and transcend party lines. I would argue that three of these "transpartisan" priorities are public support for medical education, for a high-quality health care system affordable and accessible to all, and for scientific discovery to improve health and save lives.

We must get beyond blaming each other and demand that a much-needed "rhetoric-free zone" be created outside all the partisan posturing. We need a space to have long overdue, reasoned discussions about how we can and should support these public goods.

Collectively, we need to declare that education, high-quality health care, and research are public goods. We then should demand that all candidates, regardless of party, say exactly where they stand on these priorities and tell us how they propose to fund them. With the mid-term elections less than 10 days away—not to mention the start of the 2008 presidential campaign—it is neither too late nor too soon to ask candidates at the national, state, and local levels where they stand on support for these public goods.

## In our medical schools and teaching hospitals, we must get our own houses in order. We cannot exert leadership if we do not show it in our own affairs.

Until a few months ago, I was in the trenches with you. I know the issues with which you struggle daily, and I know how difficult the decisions can be. That being said, we must confront some harsh realities if we seek to lead others in new directions.





One of these harsh realities is that academic medical center governmental advocacy has become increasingly focused on each institution's trying to sustain its school and hospital through so-called legislative earmarks. We need to admit that, in doing so, we increasingly resemble the self-interested lobbying efforts of the private sector and diminish our ability to advocate forcefully on behalf of the public in areas such as health professions scholarships, NIH funding, and coverage for the uninsured. It is a classic confrontation of self-interest versus common interest. To be an effective voice for the greater good, we need to critically reassess our pursuit of institutional self-interest and the way it obscures pursuit of the public good.

Another issue we must confront involves our students. Is it time for each institution to have serious conversations about tuition and debt levels? Does inter-generational fairness demand that we consider some form of caps to limit this burden?

In our research, is it time to rethink our institutional investment strategies to ensure that their focus is as much or more on societal returns as it is on "equity" returns from intellectual property? Are we neglecting important research opportunities simply because they are inherently unprofitable?

And in our clinical programs, do we take care to give "mission" just as much weight as financial "margin" when we make those tough decisions about which programs we can or cannot support?

I know from personal experience how much we all struggle with these questions, but the fact is that academic medical centers can lead by example. I would argue that our social values demand that we do so.

#### At the personal level, each of us must be willing to contribute, and perhaps even sacrifice.

In what may be the hardest pill for us to swallow, we must acknowledge that investing in public goods has a cost, and that a share of these costs will fall to each of us personally. There are only a limited number of ways to provide better governmental support for the public goods of medical education, research, and health care. We can increase our overall tax contributions; we can reorder priorities, trimming some programs and shifting funding to other areas; or we can reduce public benefits for some individuals (especially those who occupy the upper end of the socioeconomic scale) and shift the benefits to those most in need.

"We all come to work every day committed to the highest level of individual accountability. If we intend to recapture the public good, we must bring that same sense of purpose."

Obviously, these strategies are not mutually exclusive, and some combination intuitively seems to make sense. But we cannot get there without a rational discussion of different approaches that goes beyond campaign sound bites. This is not a simplistic debate about whether we should "tax and spend" or should "dismantle government." Any effective society must find a balance of wisely setting priorities and prudently committing limited public funds to support those priorities.

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#### Finally, we simply cannot wait for someone else to go first.

As professionals, we all come to work every day committed to the highest level of individual accountability. If we intend to recapture the public good, we must bring that same sense of purpose, intensity of will, and core values to our shared social accountability. As leaders, we must be willing to be the first to step up to the challenge of reaffirming the public good.

It all comes down to this: sometimes you just have to make a leap of faith. The time is here to take the risk and leap together into a new national discussion—not a partisan debate—but a transpartisan reaffirmation of the public good and a serious rethinking of how we can best support it.

In academic medicine we sit at the intersection of three of the most vital public goods—higher education, scientific discovery, and health care. Is there any other group of people whose lives are so solidly embedded at the epicenter of such important public goods for our country? I would argue that no one is more uniquely positioned than the people in this room to energize this long-overdue national restatement of our priorities.

We all share a commitment to certain goals: ensuring enough caring, skilled, and culturally

competent doctors for the years ahead; providing better support for their practice by advancing science; and giving them a health care system that works equally well for everyone. Energizing support for these public goods is a matter of collective will and shared accountability. It also may be this generation's best opportunity to be "great" and to create a shared legacy actually worth leaving to our children.

I was blessed with wonderful parents. I had a father, who, though not able to attend high school because of the Depression, did his duty in the Battle of the Bulge and then came home and taught his three sons how important a higher education could be to their lives. He was part of that "great generation." As a baby boomer, I find myself wondering when our generation will find a sense of purpose that will make us great. Perhaps this is our time.

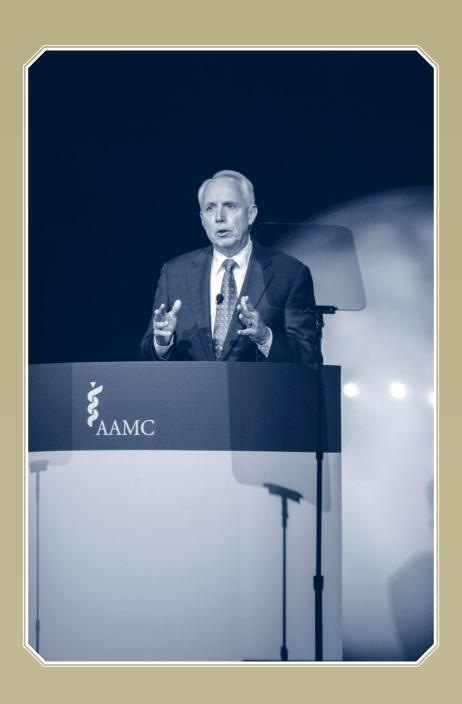
Winston Churchill once said, "You can always count on Americans to do the right thing—after they've tried everything else."

I believe we have tried everything else. Now is the time for us to do the right thing.

I thank you for listening and for giving me the enormous and humbling honor of serving you as president.









ast year, when I had the honor of speaking to this group for the first time as your president, I was only beginning to appreciate the unique privilege it is to occupy this position. I must say this first year has been an extraordinary experience for me. I have had the opportunity to cross the country several times, stopping in over half the states to speak with various groups in our community, and to visit many of our member schools and teaching hospitals. Most important, it has been a valuable opportunity to learn from all of you.

I repeatedly have been impressed by your excellence and your accomplishments. I hope you and your colleagues take great pride in your achievements. Whether it was a graduation ceremony, the opening of a new facility, a faculty seminar on medical education, or an informal lunch with students, I saw signs of progress everywhere and heard many expressions of the passion for medicine that still runs deep and strong.

On my visits, however, I also heard a strong undercurrent of deeply conflicted feelings about our lives in academic medicine. Especially among our front-line faculty colleagues, I frequently encountered expressions of great concern or even deep disillusionment regarding our ability to advance our core missions.

These concerns were sometimes vague and sometimes focused on seemingly insurmountable problems, but at their core, they seemed centered on the ways our professional lives are changing. Frequently, they were accompanied by a sense of great loss about "the way things have changed." Strikingly, when I asked our colleagues why they felt this way, more often than not their answer reflected a perception that there simply is not enough funding—as if more money could bring back "the way it used to be."

There is no doubt about it; we have become tightly focused on strategically increasing the

funding streams for our schools and academic health systems. We develop ambitious strategic plans to expand our grant and contract portfolios. We build targeted clinical programs, often directed toward high-end technology or cutting-edge procedures that have the corollary benefit of being "high margin" in reimbursement. We dramatically expand our fund-raising staff in the hope of filling the widening gap between our aspirations and our fiscal realities.

I point this out not to disparage these strategic activities. These plans certainly are relevant to our missions, and they do generate better financial margins. Everyone in academic medicine understands the principle of "no margin, no mission."

"There is no doubt about it; we have become tightly focused on strategically increasing the funding streams for our schools and academic health systems."

But is money really at the root of our discontent? I am not denying that we face serious challenges on the fiscal side. Whether it is the decreased state support seen by many public schools, the unprecedented flattening in National Institutes of Health (NIH) funding, or all the familiar constraints on clinical reimbursement, our institutions have experienced real downward pressure on their revenues.

These financial pressures have generated the ambitious strategic initiatives I mentioned earlier, and collectively, these initiatives have had



dramatic results. Some key "vital signs" show the tremendous growth that academic medicine has experienced over the last 10 years. Total annual revenues supporting our member U.S. medical schools have increased from \$32 billion to nearly \$71 billion. Annual funding from federal research grants and contracts has grown from almost \$5.8 billion to just over \$15 billion. Support from our teaching hospitals for medical school services and other programs has doubled from \$4.8 billion to over \$9.6 billion. And to advance all these missions, more than 28,000 full-time faculty positions have been added nationally to U.S. medical schools over the last 10 years. To be certain, this growth carries with it substantial additional obligations, and as a result, it should not be interpreted as an indication of margin or greater discretionary resources. However, the point is clear: we are growing. Interest in medicine as a career remains strong as well. This year, a record number of nearly 17,800 students began medical school, and the number of first-time applicants reached an all-time high of 32,000, confirming the findings of a 2005 Gallup poll that the American public views being an MD as the "Most Desirable" profession a young person could pursue.

"I am dismayed by how often faculty members tell me that overall morale in their institutions, and especially their personal morale, is lower than ever."

> But despite these strong vital signs, many of us in academic medicine simply do not seem to feel any better. I am dismayed by how often faculty members tell me that overall morale in their

institutions, and especially their personal morale, is lower than ever. And a recent AAMC-American Medical Association survey of faculty physicians over age 50 validated these conversations by finding that nearly one-third feel less satisfied with their career in medicine than they did three years ago.

I have difficulty believing that the cause of this problem is as simple as "not enough money," especially when you look at the 10-year pattern of strong growth I just described. Clearly, our strategic initiatives are bearing fruit.

Increasingly, it appears to me that the source of our discontent is a fundamental *imbalance* within our institutions—an *imbalance* that stems from a failure to put at least as much energy into improving our *culture* as we put into advancing our *strategy*.

These days I find myself thinking about the frequently quoted saying, "Culture eats strategy for lunch every day." There is a clear implication for us in the concept that culture is every bit as important as strategy. You can have a multivolume, exhaustively prepared strategic plan, but if you fail to attend to the culture of your organization, you may fail to reach any of your goals.

If culture trumps strategy, perhaps we are suffering from how little effort we explicitly devote to the culture of our own institutions. When we add up all the time we spend on developing strategic plans for our curriculum, clinical enterprise, and research programs, how does it compare to the time we spend on explicitly assessing and building the right kind of culture? Is it a brilliant strategic plan that inspires faculty, staff, residents, and students, or is it a culture that makes them feel fulfilled and valued? If you look at our Web sites, you find that virtually every academic medical center has an elegantly detailed strategic plan, but few seem





to devote as much attention to the culture they have or are trying to attain.

Just what is the culture of an organization? Most definitions of culture focus on the shared values, assumptions, norms, behaviors, and rituals developed by a group, as well as all the structures used to preserve these essentials. While culture is an extraordinarily powerful force for a group or organization, it is so pervasive and interwoven with every activity that we may not give it much conscious attention. However, when we directly examine our organizational culture, suddenly we can see clearly the drivers of performance, the reasons for levels of morale, and the root causes of many organizational conflicts and tensions. In turn, this examination presents the opportunity for us to change the culture of our organization to improve performance, resolve conflicts, and, most importantly, help all of us feel genuinely fulfilled by our work.

If culture matters so much, just what is our current culture in academic medicine? The answer cannot be found simply by reciting our vision and mission statements. To understand culture, we have to think about underlying values, assumptions, norms, and rituals that are less apparent. In his provocative book, *The Culture Code*, author Clotaire Rapaille describes how a single code word or phrase often can capture the complex values, assumptions, and behaviors that make up a culture.

As I was thinking about this topic, I asked a number of colleagues which "code words" came to mind when they reflected on the culture of academic medicine. Think about it yourself, and see if you agree with any of the feedback I received. What word would you choose to describe our prevailing culture in academic medicine? The descriptors I heard included words like individualistic, autonomous, scholarly, expert-centered, competitive, focused, high-achieving, and hierarchical.

If those are the words that describe us, we could argue that these culture codes have served us well. There certainly is nothing wrong with generations of medical students, residents, graduate students, and faculty members aspiring to become scholarly experts. The competition of climbing the hierarchy of promotion and tenure may have helped push generations of faculty members to great achievements. And certainly, the intense dedication of an award-winning lecturer, an internationally recognized clinician, or a Nobel-quality scientist is a wonder to behold.

"While culture is an extraordinarily powerful force for a group or organization, it is so pervasive and interwoven with every activity that we may not give it much conscious attention."

But we also need to be honest about how the culture of academic medicine has led to some very specific behaviors and structures that may no longer serve us as well as they did a decade or so ago, especially given the future we face.

In education, generations of medical educators have focused on the individual accumulation of factual knowledge. But is this the best way to create lifelong learners who have the skills to acquire and use dynamically changing and exponentially expanding information?

On the research side, we have a history of training researchers to achieve the status of independent investigators, with the R01 standing as validation of their independence and expertise. But in a world of increasing research complexity, in which



science is more and more interdisciplinary and highly networked, just how well does this model of autonomous investigators work?

In our clinical practices, despite the fact that they have become huge health care delivery systems, we often persist in functioning like solo expert specialists within them. But how can a loose collection of specialized experts ever achieve the clinical and operational coordination needed to create a seamless system delivering patient-centered care?

"The reality is that, increasingly, the world around us is focused less on the achievements of individual experts, and more on collaboration between individuals and groups to solve complex problems."

We have lived in a culture in which our medical schools, laboratories, teaching hospitals, and faculty clinical practice plans often evolved as structures designed first and foremost to support our autonomous pursuits. Perhaps most tellingly, we have held tenaciously to the grand tradition of rewarding the demonstration of combined independence and expertise with that treasured status of tenure, the top rung of our hierarchical professional ladder. And despite whatever struggles we experienced as individual faculty members, we affirmed this culture code by taking enormous pride in our personal status as independent experts.

If this culture of autonomy and individual achievement worked so well for us, just what is causing the negative reactions—ranging from

just under-the-surface unease to downright disillusionment—that I encounter so often when I talk with our faculty colleagues?

My theory is that we find ourselves in the middle of a major culture clash. As we have grown our institutions—despite constraints in state support, NIH funding, and clinical reimbursement we understandably have focused on strategies for generating new revenue while preserving our current structures and culture. But I would argue that, in doing so, we have failed to see how our changing environment is demanding that we adapt to a new, much different culture for academic medicine. The reality is that, increasingly, the world around us is focused less on the achievements of individual experts, and more on collaboration between individuals and groups to solve complex problems. The dilemma for academic medicine may very well be that, while higher education and health care have held fast to their traditional individualistic culture, the world has fundamentally changed.

The evidence for this change is all around. In research, consider the NIH Clinical and Translational Science Awards and other programs with an emphasis on teams of highly networked scientists and the open sharing of information. In clinical care, whether the setting is the intensive care unit or a newly configured "medical home" delivering primary care, the driving concept is that patients want and need their ongoing care provided by a coordinated team, not a series of disconnected consultants. And in our core mission of education, we now understand that attaining competence as a physician requires an integrated learning continuum, not a discontinuous assortment of independent lectures and tests.

The code words of this new culture of academic medicine are very different. When I asked my colleagues to think of single words or phrases capturing what our culture code needs to be, they offered descriptors like *collaborative*,





transparent, outcomes-focused, mutually accountable, team-based, service-oriented, and patient-centered. To put it in simplest terms, when most of us entered academic medicine, it was all about achieving your "personal best." Now it has become the quintessential "team effort."

If culture is made up of the complex web of values, assumptions, norms, behaviors, and rituals pervading an organization, a major change in culture can be wrenching, to say the least. Increasingly, I believe that the root cause of much of the discontent heard in academic medicine is a direct expression of the dislocation we are experiencing in trying to move from a culture focused on autonomy, competition, and individual achievement to one that values collaboration, shared accountability, and team performance.

Imagine the reaction of a faculty member who started his or her career focused intensely on personal achievement and building an impressive curriculum vitae, but who now finds that the emphasis has shifted to being a collaborative component of a research network? What about the teachers who no longer feel that they each have a personal set of lectures that they independently "own"? Imagine being a department chair going from a world in which the individual departments and sections are independent boats expected to float on their own financial bottoms, to a world in which the finances of the entire center are open information and managed as an integrated whole. How does it feel when core organizational values change from competition to collaboration, from autonomy to interdependence, from private focus to transparency and sharing of information and resources, from personal control to trusting one another? For many of our colleagues in academic medicine, it must feel bewildering, like the rules have changed in the middle of the game. In that light, it becomes much easier to understand the distress so many of our colleagues express. They

entered a world of academic medicine built around one culture, and now are asked to embrace a very different culture. No wonder so many of us express a desire to return to the "good old days."

This is where we come to courage. Just as it requires courage to leave one country and emigrate to a new one, it is going to take courage for all of us in academic medicine, as individuals and as institutions, to embrace our new culture.

While any change of this magnitude can be expected to engender a real sense of loss, there are three facts in which we can take great comfort.

"Just as it requires courage to leave one country and emigrate to a new one, it is going to take courage for all of us in academic medicine, as individuals and as institutions, to embrace our new culture."

First, this change in culture is not only possible, it is actually well underway at many of our institutions. Second, we should realize the potential for enormous personal fulfillment in a new kind of culture. Last, and most important, we do not have to abandon every element of the traditional culture of academic medicine. In fact, we should fight to retain our commitment to overall excellence, even as we shift from doing this as individuals to doing so in a new collaborative context. Excellence is excellence, regardless of how we get there.

Culture change is a challenging process, but if we have the courage—some key factors will speed our transition.



To start, as individuals, we need to turn our focus to the future. Time spent longing for the past, which may or may not actually have been as good as we remember, only saps our energy. To quote the great American social commentator Will Rogers, "Things aren't what they used to be, and probably never was."

At the institutional level, we need to be as explicit about our organizational values as we have been about our professional values. This requires us to resolve what I call "the academic paradox." In this paradox, academic medicine is filled with principled individuals we would trust with our lives. Yet in our institutions, there all too often are low levels of group trust. We need to resolve this paradox by doing things to make organizational trust run as strong as individual trust.

To build that trust there will need to be transparency. Do you and your faculty colleagues understand how all the missions are funded in your institution, and do all the complicated cross-subsidies make sense? Is there a shared understanding of how decisions are made? Traditionally, these things have been murky, often leading to low levels of trust rather than group commitment.

In addition to emphasizing values of collaboration, mutual accountability, and group trust, there are tools that can help build a new culture. One important tool is the use of team structures, especially teams that serve as "bridging" mechanisms for building collaboration across departments and creating better connections between the clinical enterprise and the academic enterprise. The new culture demands that different groups be aligned, not autonomous, and teams can help make that happen. There is no

magic in any particular ownership or governance model for these entities. The magic lies in taking the time to build the relationships that establish high levels of communication and trust.

Another important tool to create a new culture is the redesign of our rewards systems so that they emphasize group contributions as much as personal achievements.

This new culture also requires a different kind of leader. Chairs, directors, health system leaders, and deans will need to be selected as much or more for their group skills than for their individual accomplishments. This means search committees will need to look far beyond the weight of a candidate's curriculum vitae, considering factors such as their ability to build alignments, foster trust, and make adaptive changes.

Looking to the future, we need to acknowledge that this new culture also will demand that we rethink whom we select for admission to medical school. What admissions criteria can best attract students who not only are firmly grounded in the scientific foundation of medicine, but also embrace the qualities of the new culture?

While by no means an exhaustive list, these steps are all within our reach, and many already are being pursued by our colleagues around the country.

I urge you, as leaders of your institutions, to support and speed this fundamental culture change for academic medicine. If we have the courage to embrace this change, I am confident that a renewed level of gratification in all our key missions will follow.





As educators, we will experience the excitement of making our teaching truly about integrated lifelong learning.

As scientists, we will realize our true potential through collaborative efforts such as the integrated translational research networks now being built based on our new genomic knowledge.

And our patients, who in many ways stand to gain the most from this change, will benefit by having academic medicine create real "medical homes" for them, from which they can receive true continuity of care. We can finally solve the problem that, despite all our knowledge, too many patients have been left "medically homeless" by our expert-centered system focused on acute episodic care.

In his book *The Courage to Teach*, Parker Palmer talks about the price we pay when we feel a deep internal division between what we know we should do and what we actually do in practice. He talks about the gratification that comes from being what he calls, "divided no more." I think we all have felt distressed by the gap between what we actually have been doing in practice and the patient-centered care we know we should deliver. This is our own opportunity to be "divided no more."

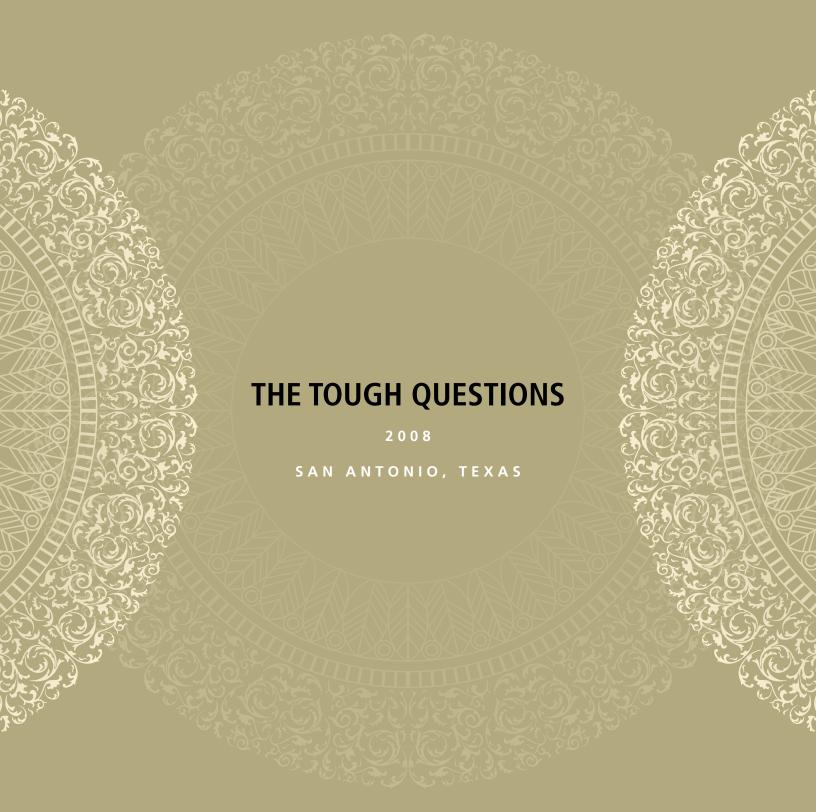
We have the possibility of creating a much more meaningful and gratifying culture for our faculty, staff, and learners, and especially for the patients we have committed to serve. A culture that is grounded in the values of collaboration, trust, and shared accountability. A culture that is reinforced through team-based structures and shared reward

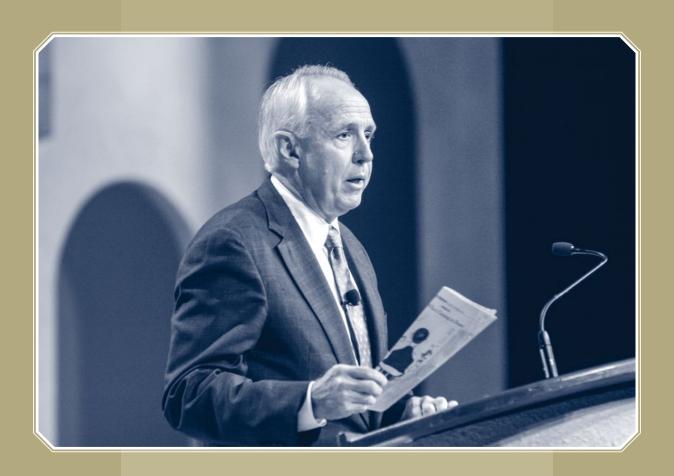
systems. A culture that encourages transparency and inclusivity, rather than exclusivity. A culture that is driven equally by our traditional commitment to excellence, and by service to others. A culture in which all learn and all teach, and all experience great fulfillment in the process.

"We have the possibility of creating a much more meaningful and gratifying culture for our faculty, staff, and learners."

I fundamentally believe that this is an opportunity for us to recapture some of the professional excitement that brought us to academic medicine in the first place. By understanding the positive potential in this new culture, we can regain that sense of optimism so many of us seem to have lost. Understanding our culture and working to change it to better fit the world we now face is a choice we can make. Certainly courage will be required, but we might do well to remember the words of a great man who taught us about "profiles in courage." President John F. Kennedy once said, "Change is the law of life. And those who look only to the past or present are certain to miss the future." Now it is our choice about whether we long for the past, or turn our attention to building the culture of the future for academic medicine.









want to thank Elliot Sussman, MD, for leading our session today and Robert Desnick, MD, for his tremendous leadership as our chair this past year. I also want to thank all of you for giving me the honor of entering my third year of serving as AAMC president and addressing our community at our annual meetings. You are always such a gracious and receptive audience. Two years ago, you were open to thinking with me about reaffirming our commitment to the public good and, last year, many of you gave me valuable feedback when I talked about developing a new culture in academic medicine. Since then—and in many ways—these challenges have become even greater.

Today, I want to link these earlier concepts with an idea we have been hearing constantly this year— "change." With just 48 hours remaining before a momentous national election, it is hard to think about anything other than how our country might change. In fact, we have witnessed a historic primary and presidential campaign in which all the candidates have tried to wrap themselves in the banner of change. As a nation, I think we agree. Every survey shows unprecedented numbers of Americans expressing total dissatisfaction with everything from the unraveling of our economy (unlike anything most of us have ever seen) to an unprecedented low in our international status. Candidates at every level know they need to represent a major change from the status quo to be elected. But, once we move beyond next Tuesday, then what happens?

While we expect those whom we elect this week to lead our nation in change, that idea can be very abstract—just a political platitude. Hopefully, for our next president and the new Congress, that idea will be very real and translated into bold action.

But I do not want to talk about what might happen in government. I want to shift to the conversation we seem to be avoiding. Specifically, how much real change are we each personally prepared to make? In particular, are we finally ready to ask ourselves some very tough questions—questions that we have been putting off for years, if not decades? Increasingly, many of the most important questions we face at the national level are viewed as "third-rail" topics—issues no one (especially candidates for president) wants to touch. Let me give you a few examples.

First, looking at our economy, we have seen in recent weeks what happens when we avoid tough questions such as the following:

- Is the way to current and future economic security for all Americans really based on "free markets," "no regulation," and "no new taxes," or is there some real burden to be shared?
- Are so-called "entitlements," like Social Security and Medicare, guaranteed for all Americans, even those of significant means?

Turning to our infrastructure, and recommitting to the public good:

 Can a nation like ours truly prosper without more public investment in infrastructure, ranging from roads to higher education to medical research?

And, speaking of roads:

 Is the problem really the \$4.00-a-gallon gas we worried about last summer, or clinging now to a belief that we can build a future without investing in the development of alternatives to fossil fuels?

Turning to defense:

 Are we made truly safe by being "the only global military superpower," or does any degree of military strength have its limits in a complicated world filled with fracture lines between its peoples?



And finally, a national question of special relevance to our own community:

 Are we willing to be the only developed nation with such low health indices, such wide health disparities, and so many citizens lacking health insurance of any kind?

While we may not agree on the right answers to these questions, we all know that discussing them is extraordinarily difficult. If we talk about them, we have to examine our national culture, our own values, and especially our personal openness to changing expectations and behaviors.

"Do we need to free ourselves much more aggressively from perceived conflicts of interest with industry, and will that be enough to regain the level of public trust we want?"

Whether change really occurs with a new administration is not up to the next occupant of the White House. It is up to every citizen of this country. After Tuesday, and for years to come, are we prepared to ask and answer these questions, and are we willing to change? Are we ready to take personal action, to give up some of our entitlements, to reduce our national and personal debt, to accept that we cannot unilaterally dominate the world, and to take more responsibility for our own health? Going beyond the partisan rhetoric, each of us will need to search our souls to see if we believe we need to change our own assumptions, choices, and behaviors.

When I think about the challenges facing our nation this year and about what lies ahead for the AAMC, I realize that, in academic medicine,

each of us faces some equally difficult questions. Like our nation as a whole, we have some real strengths. But—to be blunt—we also have been avoiding some very tough questions. Today would seem like a good time to ask a few of them.

Some of these are questions I called upon our community to consider two years ago when I talked about recommitting to the public good and getting our own houses in order so we could better lead the nation in education, research, and patient care. Some of these are questions I raised last year about moving from the old academic culture to a new one. Today, building on these concepts and facing a momentous election, I hope we are ready to answer some of the toughest questions for academic medicine, and talk honestly about taking individual and collective action.

The first question we seem reluctant to confront fully is this: Do we need to free ourselves much more aggressively from perceived conflicts of interest with industry, and will that be enough to regain the level of public trust we want? This question is fundamental to our institutions and our daily work. Speaking at our annual meeting in 2000, former AAMC President Jordan Cohen, MD, observed: "Maintaining public confidence in the integrity of what we do requires more than assuring ourselves that external financial interests have not tainted our scientific and ethical standards." In the eight years since Jordan gave us that challenge, a series of AAMC working groups have issued groundbreaking reports and recommendations about how we should properly manage potential conflicts and ensure integrity in our increasingly complicated, but important, relationships with the for-profit sector. Despite that progress, we continue to be besieged by headlines and negative public reaction about faculty colleagues who appear to have embarrassing entanglements with industry.

What will it take to fully affirm our integrity in the public eye? We may have to go beyond actions





like our current AAMC support for the proposed Physician Payments Sunshine Act that would require public reporting of industry support for doctors. We may have to go beyond banning gifts. We even may need to more strictly limit faculty consulting agreements and end faculty participation in industry speaking bureaus. We also may need to engage in the much tougher task of more rigorously separating our continuing medical education from corporate support. Many of you are already moving in this direction and know how challenging it is.

Earlier I mentioned our national issues of health disparities and the uninsured. There is a similar question for academic medicine. How much economic inequality are we willing to tolerate in our own professional community? Do we really want a world in which some teaching hospitals and medical specialties are "haves," doing very well, while others are conspicuous "have-nots"? While some teaching hospitals have solid margins and endowments, many (especially inner-city and rural safety-net hospitals) struggle to stay alive financially.

Disparities between medical specialties loom just as large. In the United States—more than in any industrialized nation—we see the widest gap between the highest and lowest compensation of different medical specialties. Depending on the data set, some procedural subspecialties currently average an annual income three or four times as much as some primary care disciplines. And then we wonder why our debt-laden students are not choosing primary care. We simply cannot avoid the tough questions that follow. Should the AAMC advocate capping medical school tuition at or below inflation? Should our schools refocus their philanthropic efforts toward student scholarships?

If we truly are willing to step outside our comfort zone, we should ask ourselves another question. If we believe in three balanced missions teaching, research, and service—why have we tolerated misalignment and, all too often, overt conflict between our clinical and academic enterprises? How many academic medical centers are able to boast of a school, health system, and physician practice plan in which all the leaders and the frontline faculty are tightly aligned? In particular, how many of us have truly "opened our books" so that there is broad understanding of the complex finances and solid support for the cross-subsidies that balance all three missions? Even more challenging, if our ability to cross-subsidize medical education and research from clinical earnings is disappearing, is it time for us to develop a new business model for medical schools that does not rely on keeping more and more clinicians on a treadmill?

"Do we really want a world in which some teaching hospitals and medical specialties are 'haves,' doing very well, while others are conspicuous 'have-nots'?"

As we approach the centennial of the Flexner report, we face a very challenging question about medical education. Will we continue to view medical school, residency, and practice mainly as a one-size-fits-all series of fixed, independent compartments, or will we start to design a more flexible system with true continuity that is more accepting of change in premedical requirements and training for new models of practice? Are all students the same and does each require the same time in each "compartment" of medical education, or can we be more flexible about the duration of training? Can we create a system in which some individuals become fully trained, board-certified physicians in less time than others? Can we create a system more welcoming to



nontraditional students and those from disadvantaged backgrounds by acknowledging that the indicators of a good future doctor go far beyond MCAT® and USMLE® scores?

"Do we unrealistically expect the next generation of physicians and scientists to be just like us, or are we willing to accept that they are very different people with different aspirations for their personal and professional lives?"

This brings me to another set of tough guestions about the way we prepare our next generation of doctors. Do we unrealistically expect the next generation of physicians and scientists to be just like us, or are we willing to accept that they are very different people with different aspirations for their personal and professional lives? Our AAMC data show nearly as many women as men entering medical school and, even more strikingly, that both genders have different expectations than my generation had about work-life balance. Can we change to accommodate this different view of professional obligations? How do we support a husband and wife who both graduate from medical school with a combined debt of nearly a half-million dollars, and who want to start a family? Perhaps their specialty choice or their desire to work part-time is not a sign of any deficit in their work ethic, but rather a principled response to challenges my generation never faced.

And here is one more question that becomes vital to each of us when we step out of our professional roles and look at the world through the eyes of patients. If we consider ourselves to be

scientific leaders, why aren't we showing the entire health system how to make quantum leaps in quality of care and patient safety? No longer is it acceptable to presume, because we are academic, that we have an inherent quality advantage. Now we need to rigorously demonstrate that we are better. Even more importantly, we need to be prepared for the possibility that well-constructed measures will show that all too often our patients do not experience the safety, quality, and coordination of care we would expect for ourselves and for our families. If that is the case, then we must have the truly difficult conversation of what we should change in the academic health care systems under our own control, not waiting for any broader health care reform. Does anything really prevent us from coordinating care for each patient across our hospitals and clinics? Many of you measure patient satisfaction. Do you act on the data you receive? Do you change your behavior in response?

We face some very tough questions in academic medicine. Can we achieve freedom from conflicts of interest, fairness in our institutions and specialties, true balance in our missions, flexibility and responsiveness in preparing a new generation of doctors, and leadership in improving health care quality? I realize that many, if not all, of these tough questions may make those of us in academic medicine genuinely uncomfortable. They challenge some of our long-held assumptions about the superiority of our motives and our systems. Answering these questions, and acting on the answers, may cause us to experience some real dislocation and pain.

Perhaps the best example of the challenge we face involves our national financing of health care. As a crushing economic reality has set in over the last month, I have an even harder time visualizing a scenario in which we add significant, national spending to our already globally high per capita health care costs. If any of the economic inequities in our system are going to be corrected, there





likely will be some financial rebalancing between health system components and health care providers. This means there will be some real pain to be shared. If we want to face this tough question, we will need to have extraordinarily difficult conversations nationally and in our institutions. Even more than simply discussing these questions, most likely the answers will involve our being asked to give up something. We likely will be asked to give up cherished assumptions about health care spending, give up a sense of independence and control, and even forego some financial gain. Are we ready to do that?

Let me share with you another tough question with which I have been struggling. Thirty-five years ago this fall, as a first-year medical student, I took an elective course in medical ethics. The course led off with a description of four basic principles of medical ethics: beneficence (helping our patients by doing "good" for them), non-maleficence (doing no harm), autonomy (respecting the individual patient), and justice (always keeping fairness to society in mind). Since then I—and many of you—have taught other medical students these very same ethical principles.

I think many of us are struggling with this issue. We say we remain committed to these four ethical imperatives, but are they in balance? Is each medical school, each teaching hospital, each faculty member considering all four principles in their decision-making? I would argue that, in large part, we have given far too little attention to our shared professional responsibility for the fourth principle, social justice. The reality is that we have been living with far too much injustice in our current health system. As a profession, we have been waiting for someone else to "fix" that system, just as we, as a nation, have been waiting for a new leader to "fix" our country.

As I asked this audience two years ago, do we actually still believe that we have personal responsibility to care for the poor and

disadvantaged? And, in a time of increasing tuition and debt levels that risk making medical school out of reach for all but the wealthiest of applicants, are we selecting affluent students and then failing to inspire them to commit to a social mission? I would argue that the tough questions we face in academic medicine are not questions of political ideology. They actually turn on a personal examination of our medical ethics. If we believe that a core pillar of medical ethics is a commitment to justice, then we have an obligation to answer these questions and act on our answers.

What we should be asking ourselves instead is why we expend so much energy preserving our current world (especially a health care system that over-rewards interventions and "rescue care" while it under-rewards wellness and prevention), rather than taking immediate action in the areas under our control to change the social injustice of our current system. If we are honest with ourselves, our ethics appear to be out of balance. We strive to "do good, avoid harm, and respect autonomy," but we seem to be waiting for someone else to deal with social justice.

"If we consider ourselves to be scientific leaders, why aren't we showing the entire health system how to make quantum leaps in quality of care and patient safety?"

We spend much of our time in academic medicine defending a status quo that fails to inspire us, instead of creating a better future. I am reminded of the cartoon that says, "Change is good—You go first." Are we in academic medicine willing to go first and make both personal and institutional sacrifices, even before someone else fixes all





those things we perceive to be wrong with the larger health care system? I do not see any of our most pressing problems being corrected until we individually and collectively accept the fact that there is a burden we have been avoiding, and there is likely some real pain to be shared. By each of us taking ownership, by personally acknowledging the problem, by preparing to

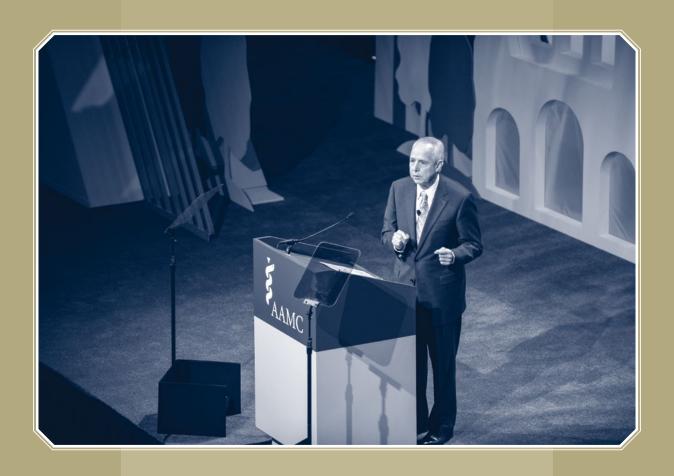
"We spend much of our time in academic medicine defending a status quo that fails to inspire us, instead of creating a better future. ... It truly is up to us."

accept and share some of the pain, and then by taking action (even if it means sacrifice on our part), we will take a major step forward.

Two years ago at our annual meeting in Seattle, I talked about our being at a tipping point for change that would recommit us to the public good. And last year, at our annual meeting in Washington, D.C., I talked about having the courage to change the culture of academic medicine. Maybe we are coming closer to real change. Not just when we will ask ourselves the tough national questions in two days in the voting booth, but when we return to our schools and health systems and take more responsibility for remembering our ethical grounding, and finally answering the tough questions we have been avoiding in academic medicine. It truly is up to us.









ast year, we met in San Antonio on the eve of an extraordinary election with an incredible sense of national hope gaining momentum. While at the time we knew the country faced major challenges, I am not certain any of us could have predicted the highs and lows of the year ahead. We began 2009 with the promise of a new administration, but also with our retirement savings dwindling and millions of Americans out of work. A month later, we saw a massive economic recovery package that brought over \$10 billion in new, two-year funding to the National Institutes of Health (NIH). However, we still face the struggle to ensure sustainable, predictable NIH funding when that stimulus ends. In terms of building our physician workforce, this year many of our member schools expanded their classes and four new medical schools opened their doors, yet we still face an uphill battle to expand the number of federally supported residency positions. Meeting our AAMC mission to "serve and lead the academic medicine community to improve the health of all" seems more challenging than ever.

In one of his early messages to the country, President Obama made it clear that he and his advisers viewed the high cost and long-term financial unsustainability of our health care system as occupying a pivotal role in our financial crisis. There appeared to be growing agreement that American citizens and American businesses could no longer afford the rapidly escalating costs of health care. Even more important, we finally seemed to have a growing sense of national shame that more than 46 million American citizens had no health insurance whatsoever. In the quest to return to economic solid ground and to rescue our fellow citizens left out in the uninsured cold, fixing our health care system became a top national priority. Collectively, we seemed ready to do something that had eluded our country for decades: early this year Congress began to draft bills to make health care reform actually happen!

But by the time August arrived, and I began thinking about my annual meeting address, something was taking place in our country that was truly painful to observe. The usually quiet congressional summer recess, because of town hall meetings nationwide, was marked by some of the most rancorous debate we have ever experienced. It was as if all the fears Americans have had about government since the days when King George III ruled and Bostonians down the street were dumping tea in the harbor suddenly resurfaced.

Just a few months earlier, it appeared as if the majority of Americans believed that, "Yes we can!" and there was a pervasive sense of hope. By late summer, however, it seemed as if too many of our fellow citizens were responding to the health care debate by saying, "No we can't." We saw some of our neighbors slide down the slope of anti-government paranoia, saying, "Stop the death panels—don't euthanize Grandma!" To add an element of absurdity, some government beneficiaries were stridently demanding that Congress "keep the government's hand off my Medicare!"

In early September, President Obama—in an attempt to bring the nation back to some modicum of reasonable discussion—requested a special joint session of Congress to deliver a national primetime speech. I would imagine that many of our members watched that speech, anxiously looking for signs of hope that we could get out of the deeply partisan morass in which we again seemed to be embedded. But even in the hallowed halls of Congress, and on national television, an angry representative shouted an insult directly at our president, showing just how deeply—and sometimes bitterly—divided our nation remained.

But the work continued, and as we meet today, there is every indication that a House and Senate health care reform bill is likely to be forged in the next several weeks and ultimately signed by the president. I know that virtually all of our members



believe that providing health insurance to more people is a good thing; many even see it as a moral imperative. One of academic medicine's greatest champions and a Massachusetts favorite son, the late Senator Ted Kennedy, made it his life's work. Legislation being debated holds the promise of providing health insurance coverage to a clear majority of Americans, bringing us closer to Senator Kennedy's goal.

Therefore, on one hand, the nation may be on the verge of finally addressing a longstanding issue of social justice by legislating greater health insurance coverage. On the other, this news must be tempered with the realization that meaningful change and comprehensive reform of our nation's health care will not occur until we transform how we actually deliver it. The hardest work is still ahead. And so, while we should celebrate the passage of legislation to improve health insurance coverage, we should not think that our larger health system problems have been solved.

"Comprehensive reform of our nation's health care will not occur until we transform how we actually deliver it. The hardest work is still ahead. This is where academic medicine meets the 'innovation imperative.'"

This is where academic medicine meets the "innovation imperative."

A word of warning is in order. Innovation in health care is not for the faint-hearted! The transformational change required to correct the dysfunctions in our health care system will take extraordinary creativity. It also will require the courage to confront our own inertia and powerful vested interests. In addition, we will need research to study our results as well as new approaches to create the physician workforce for the health care system that evolves.

As a nation, we were built on innovation. It is particularly fitting that our 120th annual meeting is in Boston—a city so steeped in history that, everywhere you turn, there are reminders of one of the most remarkable innovations of all: the American system of government. Some of the most impassioned meetings about our political system and speeches by some of our greatest leaders took place not far from the Hynes Convention Center, at Faneuil Hall, where George Washington toasted our nation's first birthday. Despite its flaws, our ongoing "experiment in democracy" is unmatched by that of any other nation in the world.

Throughout our country's history, we have often looked to the states as sources of innovation. Here in Massachusetts, the bold step was taken to bring health insurance to as many citizens as possible. With that step, however, the Commonwealth also demonstrated the complexity of health care innovation, revealing far too few primary care providers to meet the demand of the newly insured. Now, as a result of the Massachusetts experiment, it is very clear that, even when a final health insurance expansion bill passes this Congress, much work remains.

What we call a "health care system" in America is, in most cases, a loose collection of independent facilities and providers. Even worse, all too often each entity is focused on maximizing its own volume of care in line with the powerful incentives of fee-for-service reimbursement. Health care in America today consists of well-trained, well-intentioned providers, virtually all of whom have become dependent upon performing as many visits—and especially on performing as many





tests and procedures—as they can. Volume and interventions are rewarded; few physicians are paid if patients are healthy.

You may be familiar with Clayton Christensen—who spoke at the AAMC annual meeting five years ago—and his growing body of work on "disruptive innovation." According to Christensen, disruptive innovation transforms a given industry from one where its products or services are expensive and complex to one where those products or services become more widely available and, at the same time, improved in quality and/or cost. In his latest book, *The Innovator's Prescription:* A Disruptive Solution for Health Care, Christensen devotes an entire chapter to potential disruptive innovations in medical education.

The fragmentation, quality deficiencies, and high costs within our overall health care system make it a prime candidate for the kind of disruptive innovation Christensen describes. In fact, many policymakers and leaders in academic medicine are advocating for this kind of disruption. They present a strong case for retooling the business model of health care from paying for units of service to paying for outcomes. As compelling as that sounds, these discussions, unfortunately, remain largely at the conceptual stage. As a nation, we are waiting for the real-world innovation that will finally close the gap between the theory of this better system and its actual practice. The question is not whether that disruptive innovation will happen, but rather who will lead it. The AAMC has developed an idea about how academic medicine can accept the innovation imperative and lead this transformation—an idea to which I will return shortly.

As Steve Jobs, co-founder and CEO of Apple, once observed, "Innovation distinguishes between a leader and a follower." I believe the individuals at our member medical schools and teaching hospitals are the true leaders. Since

becoming AAMC president, I continually have been impressed by our members' innovative spirit and willingness to move toward a new health care culture—one that is patient-centered, quality-and outcomes-focused, team-based, and highly collaborative. In fact, the rate of innovation among our institutions often outpaces our ability to document, much less publicize, the degree of transformation underway, and that innovation is taking place in each of our mission areas of patient care, research, and education.

"The rate of innovation among our institutions often outpaces our ability to document, much less publicize, the degree of transformation underway in each of our mission areas of patient care, research, and education."

Some of our critics would say that academic medical centers are the least likely source of the much-needed innovation in health care. They talk about our expert-centrism and traditional departmental "silos." They point to our general resistance to change and slow decision-making processes. But that is the old culture I see so many of our institutions working tirelessly to change. Our members at academic medical centers across the country already are demonstrating remarkable clinical innovation by designing new models of care delivery. They are finding models that not only promote health and wellness, but that also are more affordable—models that give us true value. This gives me real hope!



True to our tripartite mission, that same spirit of innovation our members are showing in clinical care is also taking place in research and education.

In research—as the scientific world becomes increasingly focused on collaboration between individuals and groups to solve complex problems—institutions that are part of the Clinical and Translational Science Award consortium have emerged as powerful role models for the larger academic medicine community. Even while struggling for adequate funding, these institutions have illustrated the power of connecting the laboratory bench to the community in ways that R01 grants—while important to fundamental discovery—were not able to help us do.

"Just as we have a moral imperative to give people basic health insurance, we have an innovation imperative to finally make our health care system work for everyone."

In medical education, we have left a time in which each faculty member owned his or her own lecture—all too often using outdated 35-mm slides—and now operate in a Web-based, interactive world. Today, much of the disruptive innovation in medical education takes the form of cutting-edge technology to teach and assess our learners. We use tools ranging from our own AAMC MedEdPORTAL® to high-tech simulators right outside the operating room, to creating lifelong, Web-based e-Portfolios to assess competence.

Given this, what lies ahead? If we assume that Congress passes and the president signs a bill that gives more Americans health insurance, can academic medicine take the lead in accomplishing the work that remains? Just as we have a moral imperative to give people basic health insurance, we have an innovation imperative to finally make our health care system work for everyone. I would argue that it is the academic medicine community—teachers, researchers, clinicians, as well as students and trainees—who should respond to this imperative and be the standard bearers for innovation in health care delivery. We are the people who should conduct the new science of health care reform to show what truly works and who should create the kind of health professional needed in this new system.

The reason I see our community as a natural leader of this innovation involves the unique nature of our organizations. Most scholars agree that the health care system we need will demand a level of integration of doctors and hospitals that does not widely exist in our nation. However, it does exist in most academic medical centers, and many members work hard to strengthen this internal integration and to improve quality and reduce costs. Among the features of the high-performance, high-value, integrated health systems some of our members already have established are: coordinating care for the chronically ill, more wisely monitoring the use of tests and interventions, and rewarding providers for outcomes rather than volume.

Beyond redesigning care, we will need focused research investments and trained investigators to perform comparative effectiveness studies on these new delivery models to see what does and what does not work to improve the health of the community, as well as how we can finally "bend the curve" of rising costs. Just as important, we will need to determine the right number and mix of health professionals for this new environment. Perhaps an even greater challenge for the academic medical center will be to transform the way students are educated. We will need to go beyond





redesigning our care system to actually teaching medical students, residents, and other health professionals to work as teams and to develop the new skills for such a system.

Combining innovations in health care delivery, critically studying the effectiveness of these innovations, and educating professionals to work in these new models play to the strengths of academic medicine. The innovation imperative will allow academic medical centers to finally attain alignment of all three missions, while truly fulfilling their goal to improve the health of communities.

Thanks to the efforts of both my AAMC colleagues and key leaders from our members, we soon may have a new tool to help us lead this innovation. When it became clear that health care legislation would be focused almost exclusively on expanding health insurance, I was privileged to attend a White House meeting in March in which we introduced the idea of advancing broader health system change by creating federal "Healthcare Innovation Zones," or HIZs. We have devoted the last several months to working with Congress to draft legislation to put academic medical centers in a position to advance further health care transformation.

The proposed legislation would empower academic medical centers and partners in their community to conduct large-scale experiments in innovative approaches to health care delivery for specific patient populations. In our White House meeting, we described how an academic medical center (if it is ready and willing to create an HIZ) would be the place in which its integrated system, together with other willing partnering hospitals and providers, could demonstrate new models of care, closely supported by collaborating researchers and educators. Creating a Healthcare Innovation Zone could facilitate rapid expansion of the kind of pioneering efforts already underway at our institutions. By using special planning grants,

combining varied federal payment waivers, and allowing certain forms of deregulation, the HIZ program would encourage more academic medical centers to embrace factors critical for success, such as promoting the value of teams, incorporating state-of-the-art technology, focusing on quality improvement, and connecting to communities. By responding to the innovation imperative, these academic centers could become the leaders in true health care reform. I feel confident that legislation enabling HIZs will be part of action taken by Congress this year.

A year ago, people asked me whether I believed that academic medicine would have any voice in the health care reform debate. We indeed have had a strong voice in ensuring that the special contributions of our members are recognized in any proposed changes in the current legislation. And now, with the likely creation by Congress of the HIZ program, we have a real opportunity to go beyond having a voice in preserving the value of our institutions to actually leading the process of true, comprehensive health care reform.

"Creating a Healthcare Innovation Zone could facilitate rapid expansion of the kind of pioneering efforts already underway at our institutions."

Over the last few months, it has been gratifying to see members of Congress and the administration viewing us as willing partners—rather than obstacles—to further reform. I am particularly gratified by the work of Rep. Allyson Schwartz (D-Pa.), who championed the HIZ legislation and who, with Rep. Patrick Tiberi (R-Ohio), founded the first-ever academic medicine congressional caucus. But developing the HIZ concept and





finding congressional champions is only a start. As is the case with every disruptive innovation, we will need "early adopters" to diffuse this process of health care transformation more in depth and to a broader audience. This is the challenge, and this is the great opportunity, for academic medical centers. Far too many people inside the Beltway think academic medicine stands in the way of a better health care system. By creating Healthcare Innovation Zones, those academic medical centers that are ready and willing will have the opportunity to prove them wrong.

"As is the case with every disruptive innovation, we will need 'early adopters' to diffuse this process of health care transformation more in depth and to a broader audience. This is the challenge, and this is the great opportunity, for academic medical centers."

But let me repeat my earlier warning. Innovation is not for the faint-hearted. All of us are very conscious of our career aspirations and of what we have been told is the prescribed path to success. That path usually involves sticking to the tried and true: teach your students, do your research, write your papers, and see your

patients. We are not inclined to take risks. But risks, and even potential failure, are inherent in any attempt to innovate.

What gives me hope is the courage I have seen throughout our community. As a profession, academic medicine requires a tremendous degree of personal courage. Our members have shown the courage to posit untested hypotheses and make the unknowable, knowable. They also have shown the courage not only to teach the next generation, but also to be tested and challenged every day by their insistent questions. And they have had the courage to repeatedly highlight the basic injustice in leaving so many Americans without health care insurance. As we finally appear ready as a nation to give more Americans that protection, as a profession we are holding fast to our basic ethical commitment to social justice. Now we need to turn that same courage to tackling our cumbersome and costly "non-system" of fragmented health care.

Next year, when we meet again in Washington, D.C., it will be the centennial year of the Flexner report, the landmark document that, in 1910, led to revolutionary change in medical education. It took courage for Flexner to challenge the blight of proprietary storefront medical schools. And it has taken courage for academic medicine to address the many tough questions it has faced since that time. Now, we have the chance to confront the many ways our health care system fails us and lead the nation toward the kind of health care system we all visualize and deeply desire. Showing the courage to accept the innovation imperative truly is up to us!









thank Dr. Lawley, both for that kind introduction and especially for the dedicated and visionary leadership he, Dr. Powell, and their fellow members of our Board of Directors provide the AAMC. This is not a time to be without strong governance, and we have been fortunate to benefit from the vision of these leaders.

Personally, I have been gratified by the support you have given me, whether I came to your institution to be your commencement speaker or to discuss health care reform with you. You have been incredibly welcoming, and I truly have learned so much from you over the last four years.

In his introduction, Dr. Lawley mentioned that we are in challenging times. And, while true, this may be a bit of an understatement. As I prepared for the annual meeting, I began thinking about the last 24 months and came to the conclusion that we have been suffering from a national case of political whiplash. For those of you who were in San Antonio with us in 2008, we gathered just

two days before the presidential election. The outcome was not certain, but whether you were a Democrat, a Republican, or an Independent, the tone of that election was one of "change." One of the biggest changes being discussed that year was fixing the health care system insuring more people. Last year, in Boston, we gathered the morning after a late-night House of Representatives session in which it passed its version of the health care reform bill. At the time, we were all wondering whether we were at last on the verge of taking a step forward. As for last Tuesday, I am uncertain as to how to describe the events of the midterm elections. I do know, however, that the anger shown in the campaigns is not a viable national strategy.

What all of this has led me to conclude is that we cannot be passive observers watching what the government does or does not do. Now, more than ever, we need to respond; we need to take action. I believe our response is going to define academic medicine for years to come.

### **OUR GREAT SUCCESSES**

I am in no way questioning our past success. In many ways, this year we are stronger and more successful than ever. Dr. Powell mentioned Sir William Osler, who, in 1895 became our eighth AAMC president, and Abraham Flexner, whose report has seen so much attention in this centennial year. I agree with Dr. Powell's observation. If Flexner and Osler could see academic medicine today, both would be amazed. In our lifetimes, the growth and impact of academic medicine has been stunning. Since 1966, when the AAMC began keeping these data, the average total revenue at medical schools has increased 58-fold, from \$11 million to more than \$643 million, and the total number of full-time medical school

faculty members has increased from 16,000 to 133,000. Even more astounding is the \$512 billion impact that AAMC-member medical schools and teaching hospitals have on our national economy, and the 3.3 million full-time jobs directly or indirectly tied to AAMC-member institutions.

But we know the most important impact is the contribution that academic medicine has made to our society—from the innovations in teaching and learning showcased at this meeting, to scientific breakthroughs, to advances in clinical care. Countless lives have been saved by academic medicine's advances, including the lives of some of us in this room. We can be justifiably proud.



# THE PERILS OF "STAYING THE COURSE"

Our growth, and especially these remarkable contributions to society, might seem to make an irrefutable argument that we should "stay the course"—that we should keep doing what we have been doing. Some might think this notion was reinforced by last Tuesday's election results, which seemed to be a call to roll back the clock regarding health care reform. I see two very compelling reasons not to stay the course, but rather to set a bold new direction for our future.

"Now, more than ever, we need to take action. I believe our response is going to define academic medicine for years to come."

First and foremost, we have a problem of what I call "mission shortfall." If we are honest, in each of our institutions we struggle to fulfill our own mission statements in some very important areas. For example, we have been talking for decades about the need for medical students to reflect the growing diversity of America. But we have not come close to harnessing the full power of diversity to meet our nation's evolving health needs and resolve health inequities. And, while we have achieved stunning advances in molecular medicine, our national health indices continue to lag behind those of much of the developed world. Clinically, we often find ourselves competing fiercely with our fellow academic medical centers to build the latest, most advanced subspecialty programs while, collectively, we fall short in addressing some fundamental health needs in the neighborhoods outside our front doors.

I have personally felt this conflict between mission success and mission failure. Until a few years ago, I was a health system CEO who woke up in the morning hoping the hospital beds were filled with enough well-insured patients who needed our most specialized treatments because I knew that would keep our financial ship afloat. It was the classic "no margin, no mission" dilemma. Yet, at the same time, I was plagued by the realization that we were falling short in providing comprehensive primary and mental health care to some of our patients. I have also been in an institution that was justifiably proud of its world-class health services research on managing certain chronic diseases, but that did not quickly translate those findings about best practices into its specialty clinics. When I became a dean, I still could vividly remember being a resident who was so sleep-deprived that I knew I wasn't thinking clearly enough to make the best decisions, but felt it was my badge of courage never to admit it. But in our own residency programs, I saw us struggling to find the balance among supervising appropriately, managing fatigue, and maintaining rich learning experiences for our students and residents. And while I would talk to the faculty about creating a true, seamless continuum of education, I, and other deans in this room, can tell stories of refereeing frustrating battles with faculty members lobbying for independent control of more hours in an already overloaded curriculum.

I, painfully, must admit that these are examples of cases in which I failed to fulfill our mission statement. Despite our great successes, in academic medicine we do struggle with this problem of "mission shortfall." The question I would pose today is, what do we do about it? Do we believe that, with all the talent and resources in our institutions, these are problems we cannot solve? Should we excuse ourselves





based on the external challenges we face? I do not think that resigning ourselves to mission shortfall would satisfy any of us. On the contrary, I believe every person in this room truly wants a future in which we unquestionably fulfill our mission, regardless of the challenges we face.

# THE NEW REALITIES

Going beyond our obligation to our mission, there is another compelling reason to rethink our future direction and conclude that we cannot "stay the course." Quite simply, the world around us is demanding change. We ignore the realities of our rapidly changing world at our peril. I believe a convergence of three realities makes 2010 a unique moment in time for academic medicine.

The first reality of 2010 is the one about which Dr. Powell spoke so eloquently. We must recognize the Flexner centennial not as an anniversary event, but rather as an unprecedented call to arms to take on the challenge of creating a true continuum of competence-based learning and assessment.

While some have viewed the Flexner-centric focus of this year as an indictment of our educational programs, I see it as providing new energy for accelerating the collaborative educational innovation being driven by many of the people in this room. You are innovating all the way from rethinking premedical education and our admission processes to creating lifelong, competence-based continuing medical education. The Flexner centennial can be an empowering event for us.

The second reality of 2010 is the historic passage of the Affordable Care Act. Last year at our annual meeting after the House of Representatives passed its health care reform bill, we wondered whether final legislation would make it through Congress. Things looked even less certain after the Massachusetts special Senate election. Final passage of the bill, which the AAMC strongly supported, represents the first time in decades our nation took action on this scale to meet the moral imperative of covering the uninsured. Yet

we all know that while the Affordable Care Act expands health insurance, it does not resolve the larger dysfunctions of our payment and delivery system. In particular, what I would submit to you is that we still have financial incentives that focus our system much more on the total volume of sick care we deliver than on the amount of wellness we can promote. If we are very honest, we know we still face areas of waste, duplication, and unnecessary variation that are extremely difficult to isolate and eliminate.

Last March, when a small group of AAMC constituents and I were privileged to meet with President Obama in the Roosevelt Room of the White House to affirm our support shortly before passage of the final health care bill, everyone at the table (including the president) acknowledged its limitations. Congress and the president were able, however, to take this crucial first step to ensure that most Americans have health coverage. Despite the "repeal and replace" rhetoric of the midterm elections, this step seems to be a firm one. In our heart of hearts, we know there are many problems left to solve. But who does the rest of the work? As I said at our annual meeting in Boston last year, we are the only ones with the ability and the obligation to make the real transformation of health care happen. More than ever, the health care innovation imperative rests with us.

The third reality is by far the most challenging. Currently, we sit in a deep, global economic trough, and economists tell us that we are going to spend years "bouncing along the bottom." This is not a pretty image, but perhaps it is a realistic assessment of where we sit. A key driver of this predicament is the painful fact that our



national debt has become unsustainable, and we cannot right our nation's fiscal ship without an unprecedented period of retrenchment. Most important for us in this room, rising health care costs—for Medicare, for Medicaid, for American businesses, even for our own universities—stand at the epicenter of our economic challenge. A recent and sobering *New York Times* editorial by Peter Orszag, former director of the Office of Management and Budget, said that state governors are making difficult choices between

Medicaid funding and higher education funding. In such a climate, health care spending and the imperative to bend the cost curve are more real today than ever.

In combination, the challenges presented by these realities certainly seem daunting. But that does not mean we are condemned to struggling to maintain the status quo while being buffeted by the events surrounding us. How we respond—the future we create—is our choice.

### **TAKING ACTION**

I am convinced that most of us agree on our goal for academic medical centers. We envision a future health care system that finally maximizes both affordability and quality, an educational continuum that produces the right workforce for it, and science that constantly improves it. Our task now is to create a specific action agenda to get us there. Let me be clear that I am not talking about hiring a consultant to write a new strategic plan or to implement the latest management

"We need a very different way of working on our campuses, an action agenda of coordinated change unlike anything we ever have experienced in academic medicine."

"fad du jour" on our campuses. I am talking about leaders from all levels of the academic medical center (deans, CEOs, chairs, practice plan directors, faculty leaders, and others) jointly committing, with a real sense of purpose, to a set of specific actions that harnesses our incredible intellectual

power to innovate, mobilize our massive resources, and leverage the special role we play in our communities. We need a very different way of working on our campuses, an action agenda of coordinated change unlike anything we ever have experienced in academic medicine. I believe that collectively declaring our intent to create this new future, and doing it now, can inspire us in ways many of us haven't felt in some time.

Does our future happen to us, or do we create it? I firmly believe we create it through our action agenda. My time as a clinician, researcher, dean, and CEO, and all the things you have taught me as AAMC president, give me a strong sense of some elements that are essential in this action agenda. These are things we must demand from ourselves, and from our colleagues. Let me describe five key elements that I believe we all need in our action agenda.

Action Step One is to build a new approach to leadership development at all levels of our organizations. For far too long, we have assumed that acquiring an MD or other doctoral degree, followed by a series of impressive individual academic accomplishments, qualified one to lead. I do not believe that spending a few days in a course focused on how to be a chair or a dean is sufficient to prepare a leader for academic medicine





today. The new demands on our campuses require both the AAMC and our members to develop much deeper and broader leadership development programs. We need to train our future leaders as well as retool those of us currently in leadership roles to master a complex new skill set. These new skills include leading by values, organizing high-performance teams, leveraging technology, creating financial transparency, communicating effectively in the face of ambiguity, and managing change. At the same time, the search and selection process for our future leaders must go far beyond assessing the weight of a traditional curriculum vitae. And perhaps our biggest challenge is the need to redesign our leadership programs to focus on developing teams as much as developing individuals.

**Action Step Two** is to pull back the curtain, honestly and openly analyze our resources (our finances, our facilities, our time and attention), and critically assess how we allocate them.

This is our new economic reality. More than ever, we need to be wise stewards of the hundreds of millions of dollars that flow through our institutions each year. The level of stewardship required today is unprecedented. We need to be more focused and live within our means. This is what we have all been struggling to do in our personal lives. Now it is time to do it in our institutions. We have become so accustomed to creating new revenue streams that it raises the question of whether we have become addicted to growth. But those who fund our education, research, and health care face unprecedented constraints. Our students are at their limit, with tuition increases on a course to make physician debt unmanageable. I do not think we can count on more resources coming our way, and I strongly echo Dr. Powell's challenge that we commit to ensuring the affordability of medical education. In the research arena, does anyone here believe that another doubling of the National Institutes of Health budget lies just around the corner? And

as health insurers look at their new constraints, does anyone expect they will be increasing fee-for-service payments to us? Many of us have conducted funds flow studies or established some elements of mission-based budgeting. These definitely are steps in the right direction, but only first steps. The successful academic medical center of the future must demonstrate levels of rigor, transparency, and coordinated mission-based allocation of financial and human resources far beyond anything that exists on our campuses today.

**Action Step Three** is to break down the artificial barriers in the so-called continuum of medical education, both within our institutions and at the national level. The AAMC should push forward in its work to rethink its tools for assessing medical school applicants. Our schools should be organized to support a seamless integration of learning and assessment from admissions to continuing education. We must ask ourselves whether we are really thinking about this in a unified, competence-based framework. We have done good things; we have done our regulatory jobs—and now it is time to do our integrative jobs. It is time for us and other accrediting and certifying bodies to work together with a higher level of policy and programmatic integration in support of this continuum of learning and assessment. Nothing is stopping us from creating this future, and Dr. Powell just gave us a detailed roadmap for action.

Action Step Four is to use our extraordinary research capacity in a broader, more powerful manner to improve our health system. Let me be clear: I do not want to lose the momentum and power we have in basic and clinical research. But, it is time to complete the cycle. Even Francis Collins, MD, PhD, director of the National Institutes of Health, alludes to this in saying that it is time to bring the same scientific prowess that allowed us to explore molecular frontiers to bear on the problems of health care delivery. The research agenda of



the future involves studying how we can create a health care system that works for everyone, focuses as much on prevention and wellness as on sickness, and remains affordable. Whether we use terms like "comparative effectiveness studies" or "implementation science," they all point in the same direction. We need a full cycle of research that does not go from the bench to the bedside and stop, but rather continues on to our community, our nation, and the very real dimensions of global health.

Action Step Five relates to the ancient dictum "Physician, heal thyself." In my view, this means that the first group of patients for which we should redesign health care is our own faculty, staff, and families. Despite our knowledge and experience, our own faculty and staff members do not necessarily choose or receive the best heath care. We are capable of cutting-edge medical interventions, but data show we often do not receive basic preventive services or good continuity of care, and too often we overuse tests

and procedures despite the best medical evidence. Because many medical schools and teaching hospitals self-insure, they carry all the financial risk for their employees' health status and health care. That presents an unprecedented opportunity. Rather than being one more employer lamenting rising health care costs, academic medical centers are major employers who, in many cases, are in the best position to improve the health of their own faculty and staff. Some of you have successful pilot urban and rural health care initiatives that approach health care with a population focus. It is time to take what we have learned from these programs and apply it more broadly to other populations we serve. We should start with our own faculty and staff. A wonderful story in the Washington Post that serendipitously appeared today described Dr. Lloyd Michener's outreach program in Durham, N.C. The initiative connects Duke University School of Medicine with the region's poorest neighborhoods. If we can do that, can we not connect with our own faculty and staff in a similar way?

### A TIME FOR COURAGE

I know from personal experience that it is all too easy to say we should do these things, but then feel stymied. We see reasons all around us for not taking bold action: falling state funding; responding to the next LCME or ACGME site visit; meeting the deadline for that CTSA application; dealing with general faculty discontent. For too long the "tyranny of the urgent" has preempted our taking bold action. My response is that the realities we face create a golden opportunity for bold action. This is a time when we need to show real courage.

It does not require courage to write a mission statement and post it on our walls and Web sites. It does not require courage to "imagine" an integrated continuum of medical education, a more balanced portfolio of research, or a population-based health care system of the future. Most of us actually have a clear picture of how these things should look—"in theory." But it does require courage to take the action steps I listed. I have talked in the past with many of you about our historically individualistic culture. In the culture of academic medicine, taking actions like these challenges our traditional autonomy and independence. It challenges our individual control of decisions, programs, and revenues. Actions like these will require us to deal with dynamic tension, even outright conflict, on many fronts. But they will lay a solid foundation for a better future—a future in which each institution fulfills its mission statement with much greater success and integrity and closes the mission-shortfall gap.





My colleagues and I at the AAMC need to show that same courage. While the AAMC has done many things well over the years, it is all too easy to sit in Washington and observe the issues with which you struggle. The time has come, however, to rethink AAMC involvement and become a more active and accountable association. We need to engage with our members more deeply in their efforts—not only giving you our reports and recommendations, but also providing the tools you need and working more directly with you to carry out your action agenda. If you need to show courage, if you need to deal with conflict, we should help you.

Let me give some examples. This means strengthening our leadership development programs in ways that help you build teams among leaders at all levels of your organization. It means making faculty satisfaction measurement and improvement efforts a national learning process, as we are doing with our Faculty Forward program. It means helping you conduct the "Readiness for Reform" assessments of your health systems, as we have been doing with dozens of academic health systems and their medical school partners in recent weeks. It means a much more engaged AAMC.

Since June, with our Board of Directors' enthusiastic support, the AAMC has been formulating a series of strategies to accelerate change in academic medicine—not only to observe, but to be on the ground with you—strategies to help you meet the challenges ahead as well as take a leadership role in reshaping our nation's health care system. We have been exploring ways in which we could significantly expand the AAMC's capacity to provide more direct support to our members. You will be hearing more about these efforts, both in this meeting and in the weeks and months to come.

There is no question about our remarkable past successes. But our future remains to be created.

As responsible leaders at all levels, it would be our failure to wait passively for an externally imposed future to happen to us. I firmly believe we can actively create an extraordinary future on each of our campuses, and nationally for academic medicine. The key ingredients will be a focused action agenda combined with personal and professional courage. If we do this, we have the ability to create what our keynote speaker, Malcolm Gladwell, calls a "tipping point" for the entire health care system in our nation. I commit to you that a much more engaged AAMC stands ready to work with you to create that tipping point.

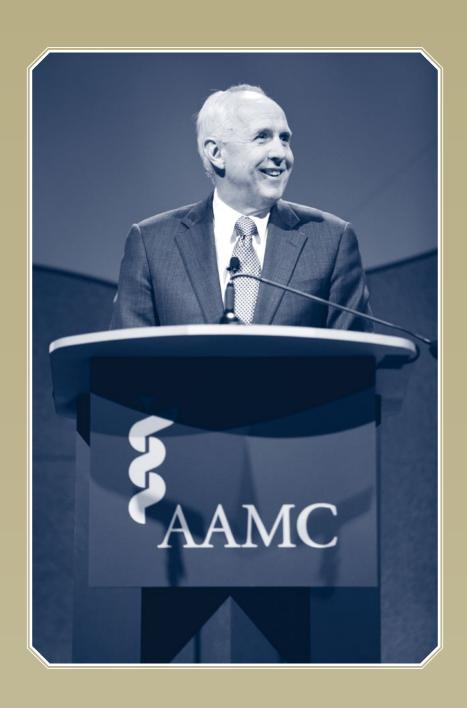
"The realities we face create a golden opportunity for bold action. This is a time when we need to show real courage."

I know that the people in this room are like me. Each of us here today came to academic medicine because we were inspired by something. But in my travels, I meet far too many of us who fear we have lost that inspiration. I firmly believe it can be recaptured. I hope each of us leaves this meeting ready to find our courage, supporting an action agenda for our campuses and knowing that a more engaged AAMC stands ready to work with you to create a future that again inspires us. Alan Kay was a computer scientist who foresaw the world of personal computing we now take for granted. I think he captured this sentiment well when he said: "The best way to predict the future is to invent it."

My AAMC colleagues and I look forward to working with you to invent a future that truly inspires! Thank you!









y thanks to Mark Laret for the kind introduction, and my special thanks to all of you—not only for the honor of allowing me to serve as your AAMC president, but also for joining me in my hometown. Being in Denver calls up many memories, not only memories of growing up at the foot of the majestic Rockies, but also memories of how I came to pursue the career in medicine that led me here today. I am privileged that the path I ultimately pursued has allowed me to see the excellence that my colleagues on the AAMC staff, and especially that all of you, demonstrate every day. My experiences as AAMC president also have shown me that excellence can take many forms, and that there are many paths to achieve a "new excellence" in academic medicine, a realization that is especially important when so many of our colleagues feel that "the sky is falling," as Dr. Lawley just observed in his address. We will return to this new excellence shortly.

My own path to medicine was far from certain. Four decades ago as an undergraduate in my junior year at the University of Colorado in Boulder, I definitely was not headed toward being a physician. I was a philosophy major who finally noticed the poor job market for philosophers. Like many uncertain college students, I thought law school might be a good default option.

The following summer, always in need of tuition money, I found a dream job. I discovered I had the key qualification to be a land surveyor for the Colorado Department of Highways, specifically that I actually passed high school geometry. The work involved surveying the construction of Interstate 70 west of Denver as it was being built through the Eisenhower Tunnel at the Continental Divide. It went so well that, instead of returning for the fall semester, I agreed to work until the mountain snow would close down the job.

One beautiful fall afternoon, with the aspen trees in their full golden color, my surveying crew was

on the gravel roadbed at an altitude of nearly 11,000 feet just below the tunnel. In the midst of the glorious fall foliage, clear blue sky, and brilliant sunshine, a passenger plane came into view flying low up the canyon. Within another minute, the pilot realized too late that he could not clear the ridge tops of the Continental Divide ahead of him. The plane crashed into the trees on the mountainside a few hundred feet above us, quickly followed by an explosion. Amazingly, after scrambling uphill toward the billowing flames and acrid smoke, we found that some on the plane had survived, living at least long enough for us to carry them awkwardly down the steep mountainside to the road below. In all too many cases, they died from their burns and injuries. Altogether, 31 football players and fans from Wichita State University lost their lives that day, and in the midst of a perfect fall afternoon I came to a deep realization that—no matter how beautiful and ideal a particular time or setting might appear—life can be very serious, even deeply dark and tragic.

> "Excellence can take many forms, and there are many paths to achieve a 'new excellence' in academic medicine."

The tragedy I saw that afternoon pointed me in a new direction, and shortly after the accident, I returned to college as a premedical student. While doing construction work in Denver during the day, in the evenings I started taking those daunting premed courses two blocks from here in a renovated city bus garage that served as the classroom building for what was called an "extension" of the University of Colorado, Boulder campus. But despite the fact that it was



not large, well endowed, or famous, I found excellence in that "commuter college." Some of the best teachers I ever encountered were so-called adjunct faculty, teaching evening courses to make ends meet while inspiring students like me. Now, the University of Colorado at Denver is a full-fledged university, demonstrating excellence here downtown as an urban-serving institution, and at the University of Colorado medical school and teaching hospital, located at the new Anschutz campus a few miles from here.

"At times, we seem caught in an 'old excellence,' defined by boosting our rankings numbers compared to our peers on metrics arbitrarily defined by others."

Just as I found excellence in an unlikely place four decades ago, I now see that there are multiple paths to excellence for academic medicine. Yet, in America today, we often judge excellence simplistically with top-10 lists and "best of" issues. We see rankings for medical schools and teaching hospitals based on how many faculty members have a full-time appointment, not whether they actually educate and motivate students, and we see rankings utilizing the mean MCAT® exam score of matriculating students, not the degree to which they have the core personal attributes of a good physician or whether they actually reflect the diversity of those they will serve. We see rankings related to the total research dollars flowing to faculty members, which may be as much a function of faculty size

as of scientific excellence, and we see rankings based on hospital patient volumes and patient satisfaction scores, which of course tell us nothing about our success in keeping patients well and out of the hospital.

I fear we have a view of excellence that all too often leaves our medical schools and teaching hospitals trying to achieve a national ideal focused on size and other easy-to-measure aspects, as well as that exceptionally nebulous concept of reputation, distracting us from our true mission and the real communities at our front doors. How many of us (including me) have been at institutions with strategic goals based on national ranking systems, even touting our own rankings in our public relations while, at the same time, privately believing the ranking system itself is seriously flawed? At times, we seem caught in an "old excellence," defined by boosting our numbers compared to our peers on metrics arbitrarily defined by others.

But five years of visits to dozens of our schools and teaching hospitals have given me great encouragement that we may be breaking free from this trap. I see our longest-established and best-known institutions redefining their excellence—and I see our newest members creating their own excellence in new ways, focused on their specific missions and the direct benefits to those they serve. Today, I want to share with you examples of the "new excellence" emerging at our medical schools and teaching hospitals, and relate how the AAMC is working to be an engaged partner in your innovation efforts. Even though I cite efforts I have seen while visiting our schools and hospitals, I am certain many of you will think immediately of even better examples of the new excellence at your own institutions.





# **MEDICAL EDUCATION**

In our educational mission, the way you are redesigning the medical school admissions process is an especially exciting development. In the past, we often said that our schools were proud of accepting only the "best and brightest" from our ever-expanding applicant pool. Yet, all too often, our evidence of this was to point toward, even to rank ourselves by, the MCAT exam scores of our matriculants. The MCAT exam is certainly a reliable tool to measure cognitive ability (that is, "brightness") in certain areas, but we all know how little it tells us about the attitudes, values, and experiences that may make an applicant truly among the best. Our own AAMC public opinion surveys show this dichotomy. While the people we serve have a high level of confidence in the medical knowledge of our graduates, a significant percentage of them express real concern about the bedside manner of the doctors we produce. In essence, the public is more confident in our ability to bring the "brightest" to medicine than in our ability to find and educate the "best."

Across the country, you are showing that the "new excellence" in selecting future doctors lies not in simply moving up the scale in matriculant MCAT exam scores. Rather, you are developing better ways to identify the "best." One example is the use of new interview approaches, such as the "Multiple Mini-Interview" developed at our Canadian AAMC member, the McMaster School of Medicine, and now being used by over two dozen of our member schools across the United States and Canada. As many of you know from personal experience, these interview scenarios allow us to probe dimensions ranging from applicants' responses to novel situations to their reactions to an ethical conflict. I have seen the positive results from this new tool at institutions ranging from Stanford University School of Medicine to our new member, Virginia Tech Carilion School of Medicine.

To support this broadened assessment, the AAMC is developing tools such as a restructured AMCAS® application and a new format for letters of recommendation, focusing them more specifically on the pre-professional attributes most important in our future physicians, such as integrity, compassion, and respect. To further support this new approach to assessing our future doctors, an AAMC committee has worked hard for three years to create the next version of the MCAT exam itself, focusing in new ways on the scientific and analytic competencies needed by future physicians in areas ranging from molecular biology to the social and behavioral sciences. The committee's recommendations have been finalized and are open for discussion at this meeting before they go to the AAMC Board of Directors for final consideration in February. Your approaches to rethinking medical school admissions, and the supportive tools being developed by the AAMC, are bringing us much closer to a truly holistic approach to admissions decisions that will more accurately identify both the brightest and the best to be the doctors you and I will rely upon for decades to come.

Equally important, the students you now are selecting in this holistic approach are encountering the new excellence in teaching and learning. We all know, despite the metrics used by some, that quality of instruction cannot be measured simply by a faculty-to-student ratio. A key factor now is how well we use emerging technology in the education of our students. One example is the power of medical simulation technology and clinical skills centers in enhancing learning and assessing competence. A recent survey of our member medical schools and teaching hospitals shows that 100% of responding institutions use simulation at some point during the four years of undergraduate medical education. In my visits to long-established institutions such as Emory University School of Medicine, to a medical school



that opened its doors a few months ago at Oakland University William Beaumont School of Medicine, to community-based schools such as the University of North Dakota School of Medicine and Health Sciences, I repeatedly have been impressed by the ways you are embedding simulation at all levels of the educational continuum, from standardized patients to the most advanced simulated trauma rooms and operating suites.

"In the world of the new excellence, both our research and education increasingly will be judged by their ultimate relevance to the overall improvement of health."

For our part, the AAMC is embracing technology as we continue to expand MedEdPORTAL® as a Web-based repository of high-quality educational material to support our members and other health professions. I heard a wonderful slogan in a recent visit to the new school at the University of Central Florida College of Medicine that captures this new era of technology-enhanced education. Instead of building a library that

will be judged by the number of books on its shelves, their motto is: "Information Anywhere, Anytime, on Any Device."

Which brings me to another emerging area of the new excellence—interprofessional education. Only recently have we honestly acknowledged that we cannot aspire to team-based care in the clinical setting while educating different health professions in isolated silos. While practicing doctors, nurses, and other health professionals fight political battles in their state legislatures over "scope-of-practice" regulations, academic medicine has an obligation to focus on building true clinical teams. We can be proud that the AAMC partnered actively over the last year with osteopathic medicine, nursing, pharmacy, dentistry, and public health to develop a set of core competencies that should be the focus of interprofessional education in all our schools. This coalition is moving forward on multiple fronts, but many of you are leading the way. In schools ranging from the University of California, Davis, School of Medicine, to the Medical University of South Carolina College of Medicine, to Jefferson Medical College, I have seen creative interprofessional activities focused on understanding different professional roles and enhancing team functioning. You are demonstrating that the real interprofessional issue is not who has control or power, but whether the team works together to provide optimal clinical care.

# **PATIENT CARE**

Turning from education to our patient care mission, the quality of clinical care is one of the areas in which I see us most actively redefining excellence. Even if our faculty, residents, and students truly are the best and the brightest, and our education employs the most advanced technology, there is no guarantee the quality of care in our teaching hospitals and clinics is the best. Nor is a ranking

based on reputation a quality guarantee. Clinical quality cannot be presumed. It has to be demonstrated. To do just that, more than 250 AAMC-member schools and hospitals have come together in the initiative "Best Practices for Better Care." Unlike other clinical quality and safety initiatives, Best Practices for Better Care not only includes a clear commitment to improve





performance on a number of core quality and safety measures, it involves an equal commitment to align our research and educational enterprises with those efforts. Only academic medical centers have the ability to work simultaneously on improving clinical quality, scientifically studying our efforts, and teaching evidence-based best practices to the next generation of physicians so they can take this new knowledge with them wherever they practice.

# **RESEARCH**

Turning to another of our missions, I want to be certain to talk about one of our most valued and unique forms of excellence in academic medicine—the discovery of new knowledge. With the dramatic growth of the National Institutes of Health (NIH) after World War II, all too often, excellence in medical schools has been defined in terms of the total amount of NIH funding coming to a given campus. One might question, however, whether our assessment of the quality of a medical school should be based on the size of the related research enterprise operating under the same institutional name.

To be clear, I spent a significant portion of my career at NIH, and no one is more committed to, or supportive of, its role as a catalyst of historic scientific advances. That being said, I would argue that educational institutions should be measured on the outcome of their educational efforts, and research institutions should be measured on the outcome of their scientific efforts. Stated another way, while medical education certainly requires sound scientific foundations and a milieu that embraces the value of research, excellence in medical education is not a direct function of the total size of the research institute next door. Similarly, the excellence of a research institution is not primarily a function of its size, but rather of its quality, as reflected in the success of specific individuals and teams in the peer review process and the impact of their work.

Perhaps most important, in the world of the new excellence, both our research and education increasingly will be judged by their ultimate

relevance to the overall improvement of health. While we currently lack metrics that assess how well excellent outcomes in medical education or research do or do not synergize better outcomes in patient care, I am excited to see new collaborations emerging that explicitly seek to achieve this goal.

An example is the HOMERUN initiative in which hospitalists from 13 health care systems, including several AAMC members, are working together to form an implementation research network capable of measuring what works for whom and in what settings, and then mounting and evaluating interventions to improve hospital care. One HOMERUN institution—Northwestern Memorial Hospital—has led the way in implementation science by teaming systems engineers with clinicians from a wide variety of specialties. Their efforts have improved perinatal outcomes, reduced medical errors of several types, lowered costs, and enhanced patient satisfaction. In fact, we see many of our hospital members and medical schools reorganizing so that they can focus their research expertise on improving care for the patients they serve. As an example, the Carolinas Health Care System in Charlotte annually brings more than 150 of its researchers and quality-improvement staff together to align their research, quality, and safety goals. Across the country, medical schools and their clinical partners are focusing on a new form of discovery—the science of how best to ensure that the care we deliver actually enhances health, mitigates disparities, and reduces costs.

Learn, Serve, Lead: The AAMC Presidential Addresses of Darrell G. Kirch, MD, 2006-2018



# **DIVERSITY**

Beyond our core missions of education, clinical care, and research, I want to mention two final areas in which I see our members demonstrating the new excellence. One is diversity. The issues of access and under-representation in academic medicine remain vitally important, and we stand on the shoulders of people who devoted their lives to achieving them. Increasingly, however, we understand that diversity extends beyond quantitative representation. It is a core driver of excellence. We now see that the incredible richness of diversity in our community and our nation offers medical schools and teaching hospitals a

unique opportunity to achieve levels of excellence in each and every mission in a manner no single group can attain. This broader view of diversity as a key to improving health for all continues to be led by institutions with rich traditions of diversity, our historically black medical schools, Howard, Meharry, and Morehouse, and schools such as the University of Hawaii John A. Burns School of Medicine. It also is being championed by traditionally majority-serving institutions, ranging from Vanderbilt University School of Medicine to the University of California Program in Medical Education, also known as PRIME.

### **COMMUNITY SERVICE**

A final area in which I see the new excellence involves serving the communities around us, some of which are privileged, but most of which face serious economic and social challenges. To see the commitment of our members to demonstrate excellence around meeting the needs of their own communities, look no further than the institutions receiving our Spencer Foreman Award for Outstanding Community Service over the last two years, the Massachusetts General Hospital (MGH) this year and Tulane University School of Medicine in 2010. The MGH is one of our oldest and justifiably most highly regarded hospitals, but it is far from an ivory tower. Its award this year recognizes the innovative use of outcomes research to assess the effectiveness of each community outreach program. This work is guided

"Commitment to community is the new excellence in its purest form."

by a community assessment conducted every three years to ensure its neighbors' needs are being met. Last year's awardee, Tulane, is an institution that experienced the full force of Hurricane Katrina followed by the trauma of the Deepwater Horizon disaster. Many wondered if the school itself would survive. Instead, it overcame massive challenges to become a model for broad and deep engagement in a badly battered community, essentially rebuilding the city's primary care infrastructure and bringing much-needed social services, such as case managers and translators, to its many clinics for New Orleans' residents. In my mind, this commitment to community is the new excellence in its purest form.

As you can see, the new excellence is not about size, growth, or public relations. It is about locally defined commitments to fulfilling an institution's specific mission and to demonstrating real outcomes from those commitments. Please understand that my focus on the new excellence today is not intended to negate the accomplishments of the best known (and highly ranked) medical schools and teaching





hospitals represented in this room. The fact is, however, even our most venerated institutions now find themselves approaching excellence in a new way. This was illustrated for me two weeks ago, when I was invited to participate in a retreat with several dozen leaders from Johns Hopkins Medicine. Hopkins was identified as a benchmark of excellence by Abraham Flexner 101 years ago, but its leaders now recognize that we face a dramatically changed world. They are doing exciting, creative thinking about how they can transform themselves to be a benchmark of the new excellence in the coming century.

Change is the only constant, and that discussion convinced me that even our most established and successful institutions understand the need to face our challenges squarely and to embrace the opportunities that change presents.

For academic medicine, the new excellence will not be defined by someone else's arbitrary standards, but rather by meeting our own stated missions. It means admitting increasingly diverse applicants who are both the brightest and the best, and who no longer are educated in silos, but in interprofessional teams that work together to provide optimal care. It means that new technologies will greatly enhance their learning and our ability to assess their competence. And it means that our teaching hospitals will achieve a new level of clinical excellence, not only by improving the quality and safety of clinical care, but also by aligning our research and educational enterprises with those efforts. And we will judge our success, not by rankings, but by how well our research and education efforts lead to the overall improvement of health, and how well we serve and meet the needs of the communities at our front doors.

"Let us judge our success not by rankings, but by how well our research and education efforts lead to the overall improvement of health, and how well we serve and meet the needs of the communities at our front doors."

It is very difficult for me to comprehend that the shaken and uncertain 21-year-old who left behind the depressing crash scene on that mountain ridge to take evening classes on a commuter campus now has the honor of serving you as AAMC president. I know that, today, many of us in academic medicine feel as if we are standing in the midst of a depressing crash scene of economic and political trouble unlike anything we have ever witnessed. When I visit your campuses, I hear the concerns about the stark national challenges we face. But I agree with Tom Lawley, and believe we have the tools to rise above those challenges and "hold up the sky." I have seen your intellect, creativity, and core values creating the new excellence in medical schools and teaching hospitals large and small, old and new, famous and relatively unknown. It leaves me certain that we can create a much better future for academic medicine, for our communities in need, and for this nation as a whole.



# FROM MOSES TO MULTIPLIERS— THE NEW LEADERS FOR ACADEMIC MEDICINE 2012

SAN FRANCISCO, CALIFORNIA





n 48 hours, we elect a president. For months, we have faced a deluge of campaign advertisements and cable channel talking heads. We have been told repeatedly that our future depends on the person we choose. We have been waiting—in what seems like suspended animation—to make this choice. And during this time, despite the urgent problems facing our nation, virtually nothing of substance has occurred in Washington. It is as if the prospect of any progress rests on the shoulders of this single individual we will choose as president.

Sound familiar? How many of us have seen this same dynamic play out in our own organizations? One of our leaders announces his or her retirement, someone steps down—perhaps voluntarily, perhaps not—and the search for a new dean, the next hospital or health system CEO, the new department chair, is announced. Virtually everything is put on hold while we wait for that wiser, more knowing individual—more often than not, a new person from another institution—who will arrive with all the answers to lead us into the future, solving all the challenges we face.

This process of waiting for the great leader seems hardwired into our culture. In his book *The Culture Code*, author Clotaire Rapaille talks about how a single code word can capture the beliefs and feelings we have about a person or process. His analysis is that, in America, the culture code we attach to the presidents we elect, and to our leaders in general, is "Moses." This is not meant to be a religious reference. Rather, it describes an archetype, a mental image we hold. Moses represents the special figure on whom we pin all our hopes, who single-handedly ascends the mountain, and returns with the definitive commandments that will lead us into the Promised Land.

In academic medicine, we often long for that one leader with special knowledge, maybe even special powers, to be our Moses, or "the sage at the top." You and I have seen this play out in search committees, faculty meetings, even in hallway conversations. Whether we acknowledge it or not, there often seems to be a deeply shared belief that, if we search hard enough, we will find that person with that special knowledge and those special powers.

"In academic medicine, we often long for that one leader with special knowledge, maybe even special powers, to be our Moses, or 'the sage at the top."

But today, I want to offer an alternate view. Perhaps we serve our nation and our institutions poorly by seeking a Moses figure to lead us. I would argue that, today, we need a new kind of leadership. What we need now is not a Moses, but the kind of leaders that author Liz Wiseman and her co-author Greg McKeown call "multipliers" in their best-selling book of the same title.

Wiseman describes multipliers as leaders who do not pretend to have all the answers or stifle the creativity of those with whom they work. Instead, multipliers consistently strive to make everyone around them smarter by unleashing others' full potential and empowering the broader problemsolving abilities of the entire organization. In short, multipliers are not necessarily the geniuses. They are the genius-makers. As she describes, "They invoke each person's unique intelligence and create an atmosphere of genius—innovation, productive effort, and collective intelligence." A multiplier believes that most people in organizations are underutilized, and that their capabilities can be leveraged with the right kind of leadership.



In a few minutes, we will be privileged to hear our keynote speaker, Walter Isaacson, the acclaimed biographer of figures ranging from Benjamin Franklin to Albert Einstein to, most recently, Steve Jobs. While his biography of Jobs showed us a man who was, to say the least, complex, there is no question that he was a creative genius. He was a visionary—a commanding presence who foresaw a new technological future.

Since we are here in San Francisco, not far from the birthplace of Apple, let us think about how the creative genius of Steve Jobs was implemented. In their book, Wiseman and McKeown identify another leader who, by being a multiplier, has been central to driving the ultimate performance of Apple over the past 15 years. His name is Tim Cook, now Apple CEO.

"The more time I spend visiting campuses of medical schools and teaching hospitals, the more encouraged I feel. I find multipliers emerging at all levels."

Fellow employees view Cook as approachable, easy-going, and cheerful. He is quiet, yet demanding, and consistently displays thoughtful and ethical behavior. He even is known for showing up in the Apple cafeteria to sit with fellow employees. At the beginning of this year, Cook shocked Apple merely by listening. One day, when a group of investors visited Apple on a tour led by a banking research analyst, the session started with a 45-minute presentation by Apple's chief financial officer. The investors were surprised when CEO Tim Cook came into the

room, quietly sat in the back, and listened. This was unusual for an Apple CEO. He did not check his iPhone once, and he did not interrupt.

Steve Jobs was no doubt a creative genius, much like the Nobel-quality scientists, master clinicians, and uniquely inspiring teachers we have in our academic medical centers. But we cannot fulfill our missions simply with a collection of individual geniuses. We also need multipliers like Tim Cook. Yet, it does seem that, historically, we have selected organizational leaders based on their individual accomplishments. These colleagues may be viewed justifiably as the sage at the top of their field. The problem is that we often select them for an organizational leadership position, expecting them to step in, answer our complex questions, and singlehandedly lead us to some higher state. Worse yet, these leaders may believe they truly have all the answers. When that happens, at a time when we really need collective creativity and problem solving, it becomes difficult, if not impossible, to leverage the capability of others.

Given the complex challenges we face today, I think even Moses would have a very difficult time being a medical school department chair or dean, or teaching hospital CEO. In fact, in a recent conversation with Liz Wiseman, I learned that the full story of Moses confirms this. After leading his people out of captivity, Moses lamented to his father-in-law, Jethro, that people continually were lined up waiting for him to adjudicate their disputes and solve their problems. Jethro's response, liberally translated, was that Moses needed to stop micromanaging. Jethro said Moses needed to develop a team of colleagues around him and entrust them with the accountability to resolve disputes and create solutions. Moses needed to bring out the best in those around him. I would venture to say that the experience of Moses, and his need to become a multiplier, runs parallel to that of many leaders in academic medical centers today. If you think about it, this makes Moses





the first prototype of a new dean or chair who is trying to handle everything personally, and it makes Jethro the first effective executive coach in recorded history.

You might think that while all of this sounds interesting, we are academics and being multipliers just is not in our DNA. The more time I spend visiting your campuses, however, the more encouraged I feel. I find multipliers emerging at all levels. I see medical students bringing their peers together to run clinics and outreach programs for the homeless, for immigrants, for the underserved that live in the shadows of our campuses. I see junior faculty leaders stimulating their colleagues, even some more senior colleagues, to create new educational tools to promote learning and assess competence, or new research models to support team-based, interdisciplinary science across the full spectrum. When I visit your hospitals and clinics, I see residents and fellows engaging entire care teams in safety and quality efforts on the frontlines of patient care. I see faculty and health system leaders creating innovative clinical care and payment models that move us away from fragmented, fee-for-service care.

Across your institutions, I see groups of department chairs working together across disciplinary lines, creating teams to bring down costs, improve quality, and share resources, rather than fiercely trying to amass individual departmental reserves at the expense of other departments. Perhaps most important, I see medical school deans and teaching hospital CEOs who know it is not about them—it is about maximizing the team around them.

I think we finally are acknowledging that leadership no longer represents a special gift or power held by a select few. Instead, it is a relationship established among committed people. It becomes a shared opportunity for all of us at any level. Think about this: Our medical schools, teaching hospitals, and health systems

now employ nearly two million exceptionally talented and committed individuals, including faculty members, medical students, residents, graduate and postdoctoral students, and staff members. Imagine what we could accomplish if more of us began to work as multipliers. What creativity and innovation could we unleash? What problems could we solve? Most important, what progress could we make toward improving the health of those we are privileged to serve? In our traditionally hierarchical world of medicine, moving from the "Moses" to the "multiplier" model of leadership could indeed be the real game changer.

"I think we finally are acknowledging that leadership no longer represents a special gift or power held by a select few. Instead, it is a relationship established among committed people."

Today, I would like to suggest that there is an urgent challenge facing us that calls out for the multiplier approach to leadership: How to create a more sustainable future for academic medicine. Whether or not our nation marches off the fiscal cliff at the beginning of next year, the hard truth is that we must all prepare for a future in which we do more with less. I acknowledge that, as a community, we have to do everything possible to fight vigorously against unwise, short-range governmental decisions that would destabilize our missions. As I wrote in my recent column in the AAMC *Reporter*, the worst thing we could do is passively wait for legislators and policymakers to impose the path forward upon us. Rather, as





the people who know our missions and our institutions best, we must lead this transformation from within by harnessing the intelligence, creativity, and commitment of our faculty, students, residents, and institutional leaders.

"Across academic medicine, I see tens of thousands of individuals are ready and willing to assume greater leadership responsibilities. There never will be a better time to unleash their potential."

We have the opportunity to bend the cost curve in medical education, research, and patient care ourselves and reinvest any savings back into our missions, rather than depend on increasing levels of government support. This will take the collective talent, capabilities, and commitment of everyone working as multipliers. I know of no group more able to meet this challenge than the leaders at medical schools and teaching hospitals.

So, how do we get there? For many years, the AAMC has been committed to helping individuals in academic medicine develop

professionally. Many of you have attended our leadership programs, from the early- and mid-career programs for women in medicine and science, to the program for new chairs and other leaders coming into their roles, to the executive development seminars for new deans. I admit I was certainly far from prepared when I left the National Institutes of Health to become dean of the Medical College of Georgia at Georgia Health Sciences University nearly 20 years ago. The AAMC program for new deans was a godsend because of the insight it gave me into the work of a dean, and especially for the advice and networking opportunities the program fostered. More recently, AAMC staff advisors, many of whom worked on the frontlines of academic medicine, have begun visiting your campuses to provide information and training about emerging best practices in leadership development.

To meet the daunting challenges facing academic medicine, the AAMC is expanding our leadership development strategy. Instead of conducting programs only focused on individuals already selected for leadership roles, we have added programs to prepare individuals aspiring to become leaders. Our new Executive Development Seminar for Interim and Aspiring Leaders and our restructuring of the programs for both early- and mid-career women in medicine and science are two examples of this more forward-looking view of leadership development in academic medicine.





Turning to frontline faculty, our Faculty Forward program has helped more than 30 of your organizations create a learning community to engage faculty more broadly at all levels. Our goal in all these efforts is to partner with you and your own institutional leadership development programs to develop more multipliers for academic medicine, whether they are already nationally recognized leaders or just starting their careers. And we plan on more to come.

First, we plan to offer you more online options using technology to give you true, just-in-time learning with no constraints on time or travel. Instead of our leadership programs reaching hundreds each year, as they do now, our goal is to reach thousands. Second, we are bringing our programming to your institution so that leaders from your medical school, teaching hospital, and clinical practice can learn together as a team on your own campus, with a focus on your most pressing strategic challenges. Third, and perhaps most important, our leadership development offerings will be more inclusive. Whether you are a student, resident, faculty or staff member, dean, or an executive, our goal is to provide opportunities for colleagues at any level who wish to develop their leadership capabilities.

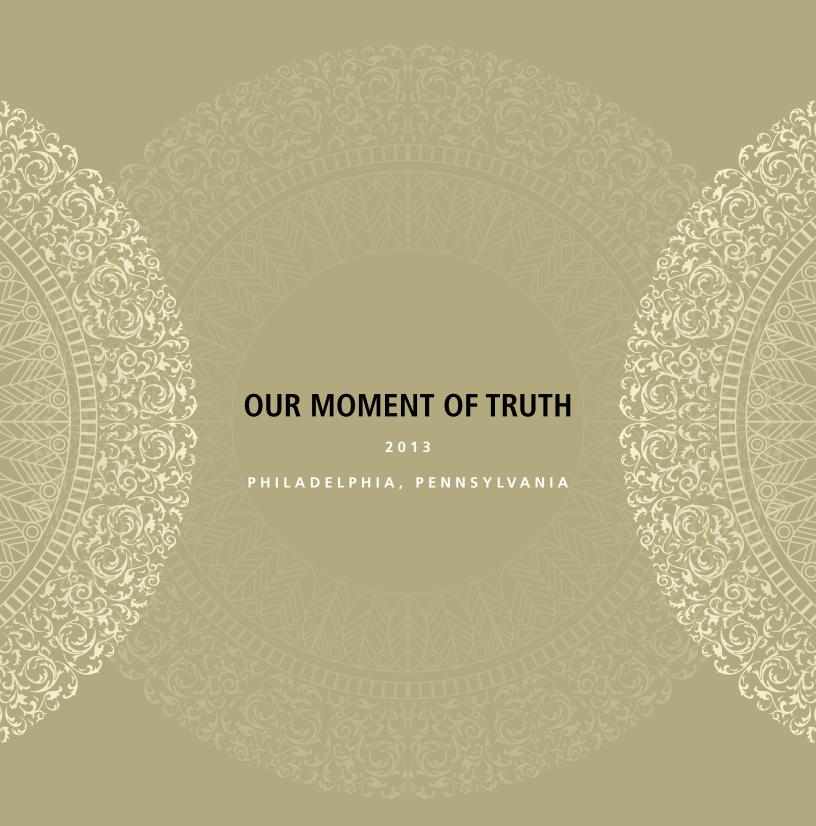
All these efforts have been an expression of a values-based and future-oriented approach that helps leaders "be and act" in ways that multiply

the leadership potential of the talented and committed people within their organizations. Our guiding belief is that leadership depends less on hierarchical organizational charts and more on building relationships based on shared values and purpose. The AAMC is committed to being an active and engaged part of your leadership journey because we need good leadership now more than ever.

Let us return to matters at hand. Regardless of who each of us would like to see win the presidential election, I hope that all of us, from members of Congress to the newest 18-year-old voter, realize that neither Mitt Romney nor Barack Obama can be a Moses. The person we elect will need to lead as multiplier, drawing on the creativity of a wide range of talents, including all of us in academic medicine, to resolve the national problems we have been avoiding. I encourage each of us to view the leadership of our medical school dean, our health system CEO, our department chair, our section chief, our chief resident in a new way. We need to see leadership not through a one-way lens of hierarchy, but rather as a dynamic relationship among equally committed individuals.

Across academic medicine, I see tens of thousands of individuals are ready and willing to assume greater leadership responsibilities. There never will be a better time to unleash their potential.









want to thank Dr. Williams for her inspiring words, for her gracious invitation to join "The Dance of Change," and especially for her leadership during an exceptionally challenging year. I also deeply appreciate your coming to this meeting to engage in important discussions about how we confront these challenges. Each day, the decisions facing us seem to become more difficult. Some are large (even dramatic) decisions. Some are small. But I believe they all are moments of truth that ultimately define each one of us. What we do in these moments shapes not only our personal futures and the future of our organizations, but even the future of our nation.

Think, for a moment, about your own personal moments of truth. Two years ago at this meeting, I described what was perhaps my own most dramatic moment of truth. I was a 21-year-old doing road construction and adrift regarding my future. The moment of witnessing dozens of people die in a plane crash on a golden autumn afternoon high in the Rocky Mountains drove my decision to pursue medicine.

The challenging moments kept coming. Not too many years later, I experienced how agonizing clinical moments of truth could be. All too often as a psychiatry resident, I had to decide whether I would honor the passionate request of a depressed or psychotic patient to leave the emergency room, or I would deny their personal freedom and involuntarily hospitalize them. Decades later, as a health system CEO, it was equally agonizing to decide whether to close psychiatry beds and open operating rooms, not because there were fewer psychiatric patients in need, but because we needed to overcome a budget deficit, and in America, surgery is reimbursed at a much higher level than mental health care. And I vividly remember the struggle when, as a dean, I faced the difficult decision of approving the dismissal of a student unable to overcome academic or personal issues, knowing they would be losing their lifelong dream—but not their debt.

Sometimes our moments of truth involve a choice in which we decide to take a path that in hindsight we regret. When I was that resident making those difficult decisions, there certainly were times I was at my physical and mental limit and knew my judgment was not as sharp as it needed to be. But whether because of pride or a misplaced sense of duty, I did not seek help from my chief resident or attending. Later in my career, I know there were times as a dean I avoided confronting a problematic faculty member, or even a department chair. I looked past their questionable actions or disruptive behavior, avoiding the battle that might occur around their tenure status or the clinical revenue or grants that might be lost.

"What we do in these moments [of truth] shapes not only our personal futures and the future of our organizations, but even the future of our nation."

Many of you have generously shared with me similar experiences in confronting challenging decisions. These moments have tested and shaped each of us as individuals. But today, I want to look forward and talk about the shared moments of truth we face as a nation, as the academic medicine community, and as a profession—a profession that has taken an oath to be true to our values.

There is no denying that the United States faces a national moment of truth when it comes to our health care system. We spend nearly \$3 trillion on health care each year, far more than other comparable nations, yet our health outcomes in vital areas lag far behind many of them. All too often, when I travel internationally on behalf of the AAMC, a conversation occurs that I always



dread. Often it comes over dinner, when our international colleagues ask me, "How can you reconcile spending so much on health care, but falling short on so many health outcomes?" They know about our infant mortality rate, our obesity epidemic, and the other ways we lag behind them. I imagine that every physician in this room struggles as much as I do in answering that question.

"There is no denying that the United States faces a national moment of truth when it comes to our health care system."

Yet our national leaders seem bent on avoiding decisive action on this moment of truth. Just consider what has happened in Washington recently. The Affordable Care Act has become the law of the land, withstood a Supreme Court challenge, and hopefully will bring millions of Americans in from the uninsured cold and help them achieve better health outcomes. But in recent weeks, the nation watched in disbelief as the entire federal government was shut down in yet another effort to defund or delay the law from taking effect. Although Congress fought back successfully against attempts to unravel the law, it once again has "kicked the can down the road" and avoided its moment of truth on our nation's budget and the devastating sequestration cuts that threaten to disrupt decades of progress in medical research that one day will lead to better health for all.

As Washington avoids its national moment of truth, we face equally daunting challenges in academic medicine. In visiting your campuses, I often meet with medical students. Every time, without fail, students challenge me by describing

their debt burden and asking me why we cannot just keep tuition increases closer to inflation. Just as passionately, the scientists on your campuses tell me how frustrated they are to have groundbreaking research slowed or even halted by the federal fiscal stalemate. They ask why I cannot simply explain the enormous human benefits of their science to fund their work. And in your hospitals, I hear anxious questions about how we ever will care for all the newly insured patients coming into the health care system over the next few years, when we face serious shortages of physicians and now are perilously close to not having enough federally supported residency slots to even train the students graduating from our own schools.

Faced with problems like this, it is all too tempting to look to others to somehow fix them. But now we know how unrealistic it is to believe that Congress will solve these problems. In the face of that, I firmly believe that you and I bear the responsibility to take decisive action. This is our profession's moment of truth.

But unfortunately, as physicians we seem inclined to point a finger at everyone but ourselves. In fact, Dr. Jon Tilburt and his colleagues conducted a fascinating survey of physicians that appears to prove just that point. Published in JAMA this past July, they reported the results of a survey that asked nearly 3,000 physicians this question, "Who bears major responsibility for health care costs?" Guess who they pointed toward? Sixty percent said that major responsibility for our nation's health care costs belongs to the trial lawyers, followed by health insurance companies, pharmaceutical and device companies, and hospitals. Closely following all these groups, 52% of the physicians surveyed assigned major responsibility for costs to patients! Only 36% thought that they, as practicing physicians, had a major responsibility to reduce health care costs. Not surprisingly, that study also revealed that our profession is





reluctant to abandon the pay structure that has rewarded us so well. An overwhelming majority, 70% of responding physicians, said that as a way to reduce health costs they were "not enthusiastic" about eliminating fee-for-service payments that reward volume, not health outcomes. This is an undeniable moment of truth for medicine as a profession. But how can we be part of the solution, if we do not believe we are major contributors to the problem?

Please know how much I appreciate the many moments of truth when our community of medical schools and hospitals is at its very best as physicians and caregivers. We have recent examples in the way you responded to tragedies and disasters: tornadoes in the Midwest and South; devastating hurricanes like Sandy; the all-too-common, horrific shootings at shopping malls, federal office buildings, movie theaters, military bases, and even elementary schools; as well as acts of terrorism like the Boston Marathon bombing. In each of these instances, phenomenally dedicated faculty, residents, and students at our nation's medical schools and teaching hospitals gave everything they had. I am never more proud to be a part of this community than in these moments when our remarkable colleagues provide spectacular care to patients in desperate need.

Yet even when we do not face a disaster, I see bold, positive decisions occurring in the face of more routine moments of truth. Our community is dramatically changing how we select physicians for a transformed future—using the new MCAT<sup>2015®</sup> exam, improved application and reference letter formats, innovative applicant interview techniques, and more holistic admissions processes. We are changing how we prepare tomorrow's doctors through more interprofessional education, shifting the focus from the individual to the team. We are leading the development of new models for providing and reimbursing care that will improve both the health of our patients and, potentially,

the health of our economy. We are improving the quality and safety of medical care by identifying and researching best practices and teaching them to the next generation. And despite the funding obstacles scientists face, every day we are discovering new treatments, sometimes even a cure, that provide hope for our patients. Change is not just possible. It is happening now—driven by all of you in this room. These are the moments of truth when you choose to move forward, and that gives me hope and optimism that we can lead change.

"But how can we be part of the solution, if we do not believe we are major contributors to the problem?"

The theme of this year's meeting is "The Change Imperative." As we participate in sessions over the next few days, I hope each of us will take time to reflect upon how the topics being discussed often lead to moments of truth that we personally face on a daily basis. These are our opportunities to act positively, courageously, and decisively. From medical students to frontline staff members to deans and CEOs, use your time here to ask yourself what decisions you will make in your personal moments of truth:

- As a medical student, am I obsessing about grades and pushing for higher USMLE scores, or focusing on developing empathic and patient-centered communication skills?
- As a resident or faculty physician, do I view the imperative to reduce health care costs as someone else's problem, or as a challenge for me to take leadership?

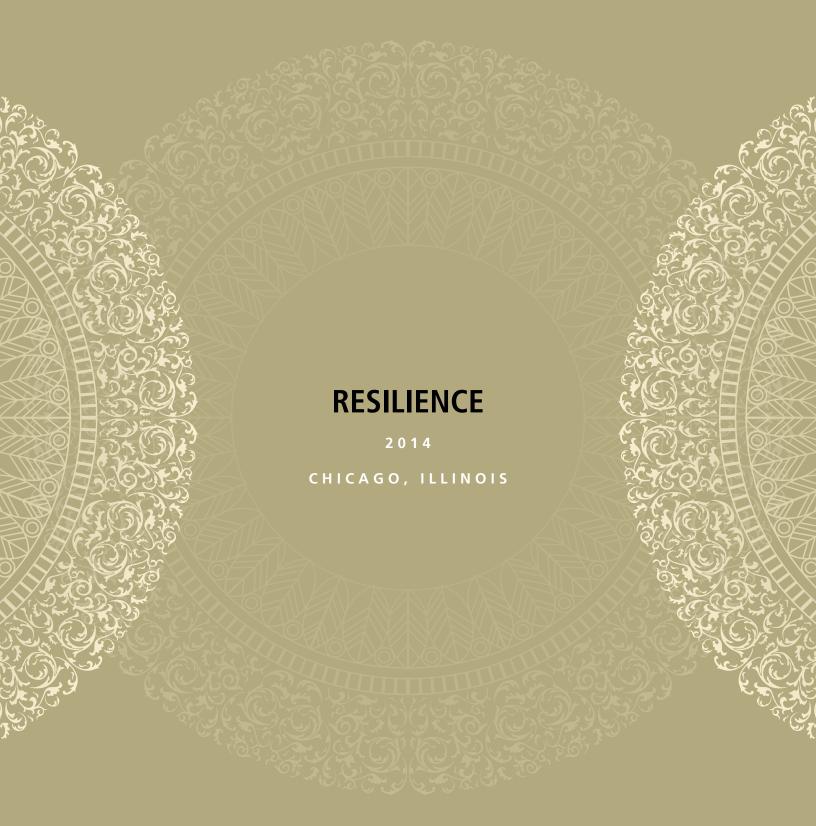
## Learn, Serve, Lead: The AAMC Presidential Addresses of Darrell G. Kirch, MD, 2006-2018



- As a researcher responsible for a graduate program, is the number of graduate students and postdoctoral fellows I recruit based only on the work needs of my laboratory, or with a clear mentor's eye toward how many future career opportunities are truly open to these trainees?
- As a teacher, do my comments and actions perpetuate the turf battles that plague physicians, nurses, and other health professions, or am I living the values of interprofessional respect and collaboration in front of my learners?
- As a chair, a dean, a CEO, am I just hoping the status quo holds until I retire, or pushing myself and my colleagues to take on the transformational change our institutions and health care system desperately need?
- As a citizen, am I gritting my teeth and privately lamenting political gridlock, or using my voice and my ballot to demand better from the people we elect?

We all have choices in these moments of truth. We can sit on the sidelines, or we can embrace responsibility for transforming our health care system. Valerie alluded to our nation's recent celebration of the 50th anniversary of Martin Luther King Jr.'s "I Have a Dream" speech. Dr. King was fond of quoting an early-19th-century social thinker, Theodore Parker, who said, "The arc of the moral universe is long, but it bends toward justice." Each of us confronts moments of truth in which we can actually affect that arc, moments in which we can bend the arc toward justice in health care. We are in a unique position to demonstrate leadership in academic medicine. This is a moment of truth our nation desperately needs us to seize!









ne of the great honors I have as AAMC president is visiting your campuses, speaking at meetings of our member societies, and personally seeing all the great work you are doing. Since our annual meeting last year in Philadelphia, I have had the privilege of making more than 60 of these visits. I am heartened and inspired by your progress on so many fronts. But I also hear your concerns—loud and clear!

The pointed questions you and your colleagues ask reflect deep concern about the current and future state of academic medicine. You pose questions like:

- NIH funding is stagnant. Are we about to lose a whole generation of new scientists?
- Beyond NIH, all our funding streams are threatened. Is our basic "business model" still viable?
- Speaking of business, we seem to be forming new clinical partnerships every day. Are we abandoning our core academic mission?
   And as we partner with community doctors and hospitals, what does it even mean to be a "faculty member"?
- And between Supreme Court decisions and state ballot initiatives rolling back affirmative action, how can we continue to make progress on our commitment to diversity?

Our students ask tough questions, too:

- With tuition so high, will I ever be able to pay off my debt? Can anything be done to reduce the cost of medical education?
- Competition for residency training slots is more intense than ever. What will I do if I do not get a residency position? What can we do to convince Congress to lift the cap on funding for residencies?
- Is a career as an academic physician even a viable option for me?

As a psychiatrist, I find myself wondering how these deep concerns and daunting challenges are affecting our overall well-being. More and more, in my conversations with our colleagues, issues of stress and burnout come up. A 2012 paper published in JAMA documents this distress. Surveying 7,000 physicians, Dr. Tait Shanafelt and colleagues found that nearly half—46%—reported at least one symptom of burnout, a significantly higher rate than in the general population. Burnout rates were highest for clinicians on the front line, topping 60% for emergency medicine. Even more concerning is that more than 40% of the physicians who responded screened positive for symptoms of depression, and 7% reported having suicidal ideation in the last year.1

> "While most of us would say that medicine is the most gratifying, stimulating, and noble career a person can pursue, many of our colleagues are in genuine distress."

Earlier this fall, like many of you, I was moved by a *New York Times* opinion piece written by first-year resident Pranay Sinha, titled "Why Do Doctors Commit Suicide?" The article describes not only burnout and depression, but also the burden of isolation and the pressure for perfection many doctors feel.<sup>2</sup> While most of us would say that medicine is the most gratifying, stimulating, and noble career a person can pursue, many of our colleagues are in genuine distress.

When we allow ourselves to acknowledge this and talk about what is causing this distress, we almost always point to all the changes occurring in health care. Recently, I have been reading an



AAMC report that describes academic medicine's struggles to keep pace with this change. Consider a few sentences from the report:

- "The future will see more health care demanded and provided than ever before. More physicians must be trained, and as quickly as possible."
- "A clear trend of recent decades—
   and a virtually certain trend in the future—
   is the continuous rise in costs. All components
   of health care costs have risen. The cost
   of educating physicians has grown."
- "The rise of specialization has resulted in the increasing trend toward team practice involving the contribution of a spectrum of specialists."
- "Scientific advances have made vital the development of new skills to apply new knowledge."

"It is our resilience—
as individuals, as institutions,
and as a community of academic
medicine—that decade after
decade has allowed us to
accomplish more than we could
imagine in the face of seemingly
overwhelming challenges."

Doesn't that sound familiar? It is what I hear when I visit your campuses and attend meetings. Actually, these sentences are from an AAMC report published nearly 50 years ago, in 1965. The primary author was Dr. Lowell Coggeshall, a physician leader at the University of Chicago, and

his "Coggeshall Report" was highly influential in reshaping both academic medicine and the AAMC as an association in the years that followed.<sup>3</sup>

Some cynics might ask why, 50 years later, we are still fighting the same battles. I do not see it that way. I see the amazing progress academic medicine has made—and continues to make—in improving health over the last 50 years. The challenges evolved, and committed generations of academic physicians made steady progress addressing them. In fact, just about every time our nation has faced a new health challenge, academic medicine has stepped up. Today, I know we all are inspired by the extraordinary efforts of our colleagues at Emory University, the University of Nebraska Medical Center, and Bellevue Hospital Center on the front lines of caring for patients with the Ebola virus. And I am proud of how our broader community is stepping up to help care for additional patients, if necessary.

What drives us forward? What inspires us to take on the most difficult challenges and to keep trying in the face of doubt and even failure? I attribute our progress to an essential quality shared by many physicians and others who choose careers in health care—a quality that makes it possible for us to work on problems that often require decades of effort to solve. That quality is resilience.

Professor Rosabeth Kanter at Harvard describes resilience this way: "Resilience draws from strength of character, from a core set of values that motivate efforts to overcome the setback and resume walking the path to success. Resilience also thrives on a sense of community—the desire to pick oneself up because of an obligation to others and because of support from others who want the same thing." It is very simple. Resilient people share a sense of mission and work together to achieve it. Think about it. Resilience is a quality we look for in applicants to medical school and residency programs. Resilience is also a quality we greatly admire in our colleagues. Even





outside times of traumatic stress, we demonstrate resilience as optimism, self-confidence, and a willingness to embrace change.

We all have setbacks in our work—the unmatched student, the failed experiment, the death of a patient. Failure is part of our daily lives. But so is our resilience. Each of us in this room has experienced great disappointment. Yet at our best, we return to our work with vigor, propelled by our mission and our colleagues. It is our resilience—as individuals, as institutions, and as a community of academic medicine—that decade after decade has allowed us to accomplish more than we could imagine in the face of seemingly overwhelming challenges. Resilience is why we can look at a report from 50 years ago that listed the deep concerns of our predecessors and see the clear progress they made in the face of those challenges.

Today, I see signs of our resilience at work when I visit your institutions and speak to your leadership, your faculty, and your students and residents.

On the individual level. I see scores of scientists demonstrating resilience through their continued perseverance in spite of historically low NIH acceptance rates. Take the example of physician scientist Dr. Talene Yacoubian, an assistant professor at the University of Alabama at Birmingham. She studies Parkinson's disease, a neurodegenerative disorder projected to double in prevalence by 2040. Despite the critical need to develop effective neurotherapies, Dr. Yacoubian was denied R01 funding three times. When I asked her why she continued to apply, she described a consistently supportive chair, a department that encouraged her to persevere, and a personal motivation a mission as it were—to help her patients. Dr. Yacoubian crafted a fourth proposal, which was funded this spring. That is resilience.

On the institutional level, academic medical centers are not retreating in the face of all the changes around them. They are seizing the opportunity to

reinvent themselves and create a sustainable model for the future. For example, when Dr. Jeff Balser, the leader of the Vanderbilt University Medical Center, learned his institution faced a projected deficit of \$250 million by the end of fiscal year 2015, he knew that long-term sustainability would require tough choices. So while he and his colleagues reduced operating costs, they simultaneously forged new partnerships to strengthen their system, as well as their ties to their community. Because of these efforts, today Vanderbilt is in a much stronger financial position and is hitting its financial targets in a very competitive market. Perhaps even more important, Jeff tells me that the shared experience brought many people in his institution closer together because they communicated repeatedly and broadly in a way that built a sense of shared purpose that renewed Vanderbilt's commitment to its patients, faculty, staff, and the region. That is resilience.

"Academic medical centers are not retreating in the face of all the changes around them. They are seizing the opportunity to reinvent themselves and create a sustainable model for the future."

As a community of academic medicine, I do not think there is any better sign of our resilience than the strong commitment so many of you have made to create a more positive environment for our learners and the patients they will serve. When you do that, you show the courage to change culture that Dr. Betz described earlier. I also see resilience in our collective efforts to transform



education and to improve clinical quality and safety. Over the last few days at the AAMC Medical Education Meeting, I have had the privilege of learning more about the innovative work you and your colleagues are doing across the continuum because of your commitment to prepare our learners to enhance the health of patients.

"I am more convinced than ever we will continue to thrive if we rise together to meet the challenges ahead."

So let us circle back. Why are the rates of burnout and signs of depression so high among physicians? I do not believe it is because we have lost our resilience. I think it is because some of us have lost sight of our shared commitment to our mission, and that many of us have become isolated and are not reaching out to each other to create networks of support. AAMC data from our Faculty Forward initiative show that two of the most significant drivers of faculty satisfaction are connection to institutional mission and interaction with colleagues. Unfortunately, it seems to be a short path to burnout and depression if we allow ourselves to lose these connections.

I know many people in this room feel very, very challenged these days. That is why it is so important to come together as a community this week and throughout the year. Together, we draw renewed strength from one another and use that strength to face the challenges we share and the obstacles we must overcome. Collectively, we are able to see how, time after time, over many decades, we have risen above these obstacles as we strive to fulfill our shared commitment to educate tomorrow's

doctors, discover tomorrow's cures, and provide our patients today with the best medical care possible. That is our resilience at work.

Dr. Marty Seligman, in his book *Flourish*, describes resilience as "the glue that holds groups together, provides a purpose larger than the solitary self, and allows entire groups to rise in challenges." <sup>5</sup>

As a community, now is the time to draw on our resilience by remembering our shared purpose and committing to support one another more strongly than ever.

So as you leave here today, ask yourself:

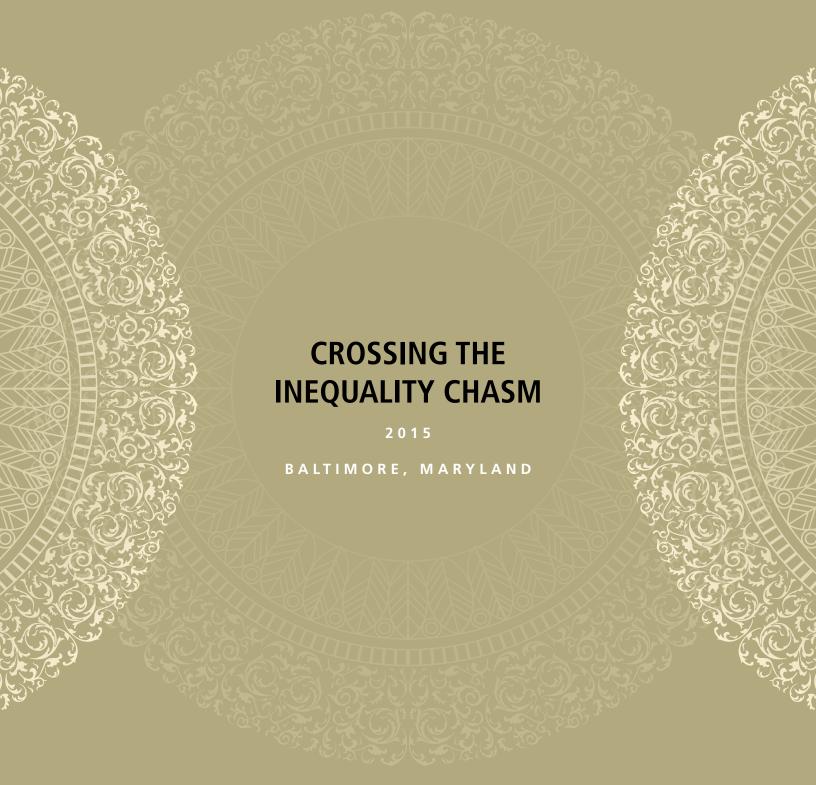
- Do we still feel connected to our mission?
   Does it still inspire us, or are we focused mostly on advancing our individual objectives?
- Are my colleagues and I taking the time to talk honestly about our work and the stress we feel and give each other support?
   Or does the fog of daily demands isolate us?
- If we have lost that connection to our mission, or if we feel isolated, what steps can we take to energize our commitment to our shared purpose and to each other?

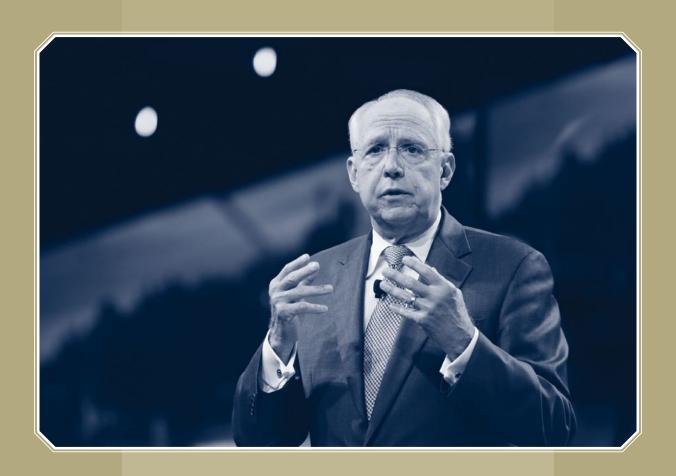
Over the years, academic medicine has epitomized resilience, and I am more convinced than ever we will continue to thrive if we rise together to meet the challenges ahead.

## **Notes**

- 1. Shanafelt TD, Boone S, Tan L, et al. Burnout and Satisfaction With Work-Life Balance Among US Physicians Relative to the General US Population. *Arch Intern Med.* 2012;172(18):1377–1385.
- 2. Sinha P. Why Do Doctors Commit Suicide? *The New York Times*. September 5, 2014;A27.
- 3. Coggeshall L. *Planning for Medical Progress Through Education*. Washington, DC: Association of American Medical Colleges; 1965.
- 4. Kanter R. Surprises Are the New Normal; Resilience Is the New Skill. *Harvard Business Review.* July 17, 2013. https://hbr.org/2013/07/surprises-are-the-new-normal-r/
- 5. Seligman M. Flourish. New York, NY: Free Press; 2011.









hank 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.

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 "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.

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.

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.

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

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. 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.

"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."

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 of 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.

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

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.

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.

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?

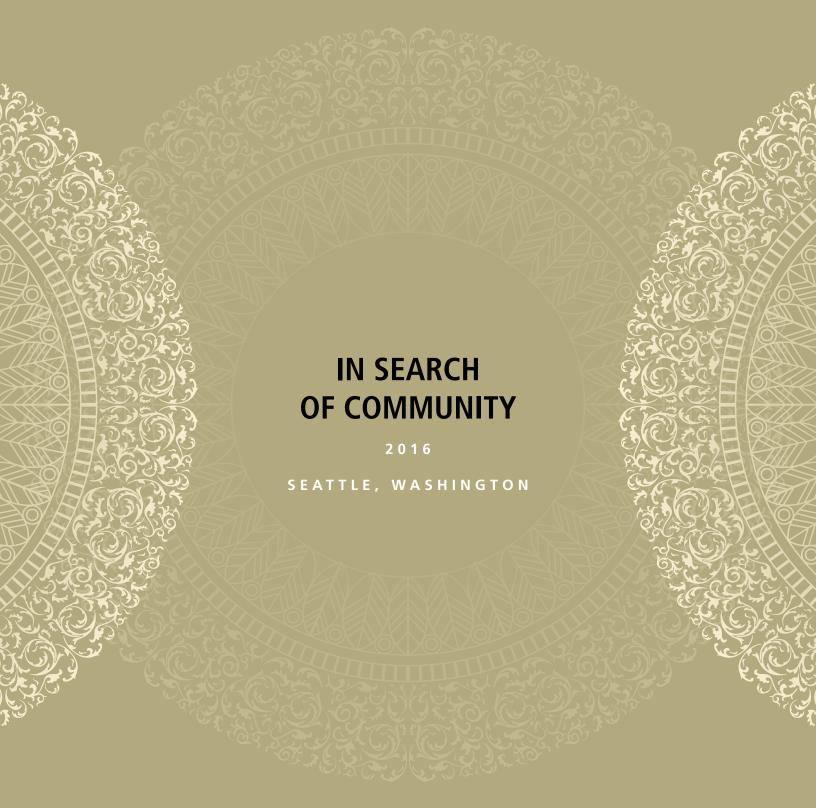
If you are a CEO, could you ask for quality improvement reports that identify inequities within your system? If you are a scientist, could you attend a local community board meeting and offer a report on how your research could address community health concerns? By looking at each of our individual roles 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.

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

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 Dr. Rappley for her kind introduction.
And my thanks also to Dr. Laskowski for his heartfelt reminder of the commitment to teaching and learning we all share. Most of all, I thank all of you for being here in Seattle. I realize how privileged we are, in the midst of an incredibly stressful time for our nation, to be part this passionate, caring, diverse community we call academic medicine.

Being in this room has special meaning for me. Some of you may have been here when we met in Seattle 10 years ago. It is hard for me to believe it was that long ago because I remember it so vividly. That was my first opportunity to speak to this group as AAMC president. I was beyond nervous, but you welcomed me with openness and warmth. My talk was titled "In Search of the Public Good," and I think it reflected what many of us felt at the time. We all know that academic medicine is central to three public goods that determine the well-being of our society: educating the health care workforce, leading scientific discovery, and caring for our patients. My goal 10 years ago was to reinforce how important it is for these public goods to receive strong support from the federal government, from states, and from our donors. That was not just a speech for me. Our economy was doing well, and I had great hope that we might be on the verge of a major national recommitment to the public good.

I did not know—as I am certain most of you did not know—what would happen in the 10 years that followed our last Seattle meeting. Less than two years later, our country plunged into the Great Recession. In some dramatic ways, the public good went on "life support." You saw it firsthand. Each medical school and teaching hospital was forced to fight its own battles—with falling state appropriations, donors pulling back, stagnant NIH funding, and constant downward pressure on clinical reimbursement. For the first time in my professional life, I heard speculation

about whether some of our medical schools and teaching hospitals might even fail. Instead of achieving a shared national recommitment to the public good, it felt as if we were each on our own.

And 10 years later, we still seem to be "in search of the public good." We made clear progress with the passage of the Affordable Care Act in 2010, which brought millions of Americans in from the uninsured cold. But today, the future of the ACA is uncertain. On the research front, once we adjust for inflation, support for NIH remains at the same level as in 2001. And our medical students remain burdened with unprecedented levels of debt. This spring, that debt rose to a median of \$190,000 for each graduating student borrower.

"Ten years later, we still seem to be 'in search of the public good.' ... At a time when our challenges require unity and resolve, our nation descended into acrimony and divisiveness."

Then, on top of all this, there was this year's election. I have spent much of the last 18 months struggling to make sense of what has been going on in our country. At a time when our challenges require unity and resolve, our nation descended into acrimony and divisiveness that left many of us emotionally exhausted. Even worse, it left many of us wounded and frightened. It was deeply disheartening to hear words and witness actions that tore at our social fabric. Our aspiration to be a national community—a melting pot that transcends race, religion immigration, class, and political party—seemed to be under siege.



Today, many of us are asking the same question. After months of stunning rancor and division, how in the world do we come back together?

During the heat of the election, *New York Times* columnist David Brooks wrote a piece titled "One Neighborhood at a Time." He offered an example of how we could go about healing our deep divisions, a process he called "social repair." He said, "The nation may be too large. The individual is too small. The community is the right level."

"Your cities and states may be divided in many ways, but medical schools and teaching hospitals are transcending those divisions to tackle tough problems and build real, vibrant communities centered on our institutions."

Why is community the right level? When you think about it, communities are the building blocks of our society. They are the places where we work, where our children attend school, where we gather with friends and neighbors in churches, libraries, and parks. In a strong community, we can depend on each other. We share the school carpool. We celebrate milestones together. We drop off dinner for a neighbor in a time of need. Citizens bonded in these ways are more likely to vote, to volunteer, to perform good deeds for one another.

But today, our communities are under threat. Some of you may have read Robert Putnam's book *Bowling Alone*. He paints a vivid portrait of civic engagement in decline. Americans are

spending more time isolated in a personal bubble on the Internet and watching TV and less time participating in community events. The passing of the World War II generation only exacerbates this trend. Just think about our parents and grandparents who were so exceptionally engaged in civic life. We simply do not engage with our communities the way we once did.

Academic medicine certainly is not immune to the powerful forces transforming society. But despite all that, AAMC public opinion research shows a broad base of support for our missions to educate physicians, deliver the highest levels of care, and lead discovery. That research also shows that our local communities want us to use our power to drive better health outcomes and improvements in community well-being.

Every time I visit one of your campuses, I see evidence of you tending to the social repair that David Brooks called for. I see how, day after day, you rise above the noise of governmental budget fights, the paralysis of partisan gridlock, the corrosive effects of prejudice. Your cities and states may be divided in many ways, but medical schools and teaching hospitals are transcending those divisions to tackle tough problems and build real, vibrant communities centered on our institutions.

There is no better example than this year's recipient of the AAMC Spencer Foreman Award for Outstanding Community Service, Michigan State University College of Human Medicine. Yesterday morning, Mona Hanna-Attisha, MD, MPH, joined us to discuss the contaminated water crisis in Flint, Michigan. The college has a longstanding partnership with the community of Flint, and in 2014 established its Public Health Research program in downtown Flint. That partnership was critical to exposing and addressing the crisis. On the heels of a report that identified dangerous amounts of lead in





the Flint water supply and with city officials still insisting the water was safe, Dr. Hanna-Attisha and her colleagues presented results of a study showing that the number of Flint children with elevated levels of lead in their blood had doubled, even tripled, in some areas of the city. But they did not stop at shining a spotlight on this public health crisis. Earlier this year, Michigan State University College of Human Medicine and Hurley Children's Hospital launched the Pediatric Public Health Initiative in partnership with the community to optimize children's health and to serve as a national resource for best practices.

Institutions around the country are taking on other issues that do not necessarily make national headlines but that deeply affect the health of our communities. In 2014, Rush University Medical Center in Chicago launched the Road Home Program to support service members returning to civilian life. The Road Home Program provides care and counseling for a range of veterans' issues, including post-traumatic stress disorder and traumatic brain injury, and serves as a hub for services offered through the local VA medical center and other partners. Just as important, Rush also provides overall support with the difficult transition from military to civilian life, including connecting veterans to job-training programs and community events and extending counseling services to the children and families of veterans. In the last 12 months alone, more than 370 veterans and their families received free care at Rush through this program.

I see efforts to build community every time I visit one of your campuses. Last spring, I was honored to be the commencement speaker for the first class to graduate from the University of South Carolina School of Medicine in Greenville. The school was created in partnership with the Greenville Health System to help address community health needs, and it already shows great promise in doing so. It is one of a handful of our medical

schools that trains every first-year student to become an emergency medical technician. These students certainly gain early clinical experience working regular shifts as EMTs as part of an interprofessional team. But the best part of the experience is their immersion in the community. I met with a group of students, many of whom, like many of us, have led relatively privileged lives. They spoke movingly about riding in the ambulance to the homes of people who have been marginalized and whose every day is a struggle. They told me what they saw and learned in those homes. And I saw the understanding and empathy—the bonds of community—they developed through that educational experience.

Later in the summer, I traveled to Texas to speak at the White Coat Ceremony for the inaugural class admitted to the new University of Texas Rio Grande Valley School of Medicine. Despite its location in one of the most economically challenged regions in the country, this first class drew more than a third of its members from the Rio Grande Valley itself. And underrepresented minorities make up a majority of the class. But the school's community commitment goes far beyond the composition of the student body. Its mobile clinic goes to nearby areas where many community members speak no English and many live in homes that lack even basic plumbing. Clinicians and learners work with promotoras de salud—community-based health workers who do health education in these often neglected neighborhoods. They are engaging people where they live.

Across the country I have seen other examples: the ongoing calls to action made by White Coats for Black Lives, the development of health promotion strategies for LGBTQ persons, workshops addressing the unique needs of students with disabilities, and outreach to students with Deferred Action for Childhood Arrivals—students often called "Dreamers." You are showing that the strongest communities are inclusive communities.





Let me share just one more example with you. In June, our country was deeply shaken by the violence at the Pulse nightclub in Orlando. Forty-nine people were killed. Fifty-three were wounded. The shooting rocked our nation—especially our LGBTQ and our Latino communities. In the aftermath of that violence, two teaching hospitals—Florida Hospital Orlando and Orlando Regional Medical Center—cared for badly wounded victims of the mass shooting. These two teaching hospitals then went on to make all that care free.

They donated more than \$5.5 million of services. The head of Florida Hospital simply described this as a "gesture" to "add to the heart and good will that defines Orlando."

"We will always seek to be a uniting force in our nation—to heal and repair our communities and to call on the government to fortify its commitment to the public good."

And in the aftermath of that tragedy, I was proud to see the AAMC Board of Directors affirm its support for treating gun-related injuries and deaths as the major public health issues they are for our communities. The AAMC Board called for an end to the ban on federal funding for research on gun violence. Enough is enough!

I know we are all feeling the stress. Everyone who works in a medical school or teaching hospital is subject to the same forces of change as our communities. We face the same pressures that lead to disengagement and social isolation. We need to be certain we are caring for our own community. Two years ago, at our annual meeting in Chicago, I spoke about the crisis of burnout, depression, and suicide in academic medicine. In the last two years, I have seen more and more of you working to strengthen the community inside your institution, as well as the community outside your walls.

There is no easy fix for these problems. But the AAMC is committed to working with you to bolster resilience and build cultures of wellness for our learners and colleagues. Last June, the leaders of AAMC councils, organizations, and groups gathered at our headquarters in Washington to discuss this challenge and learn from each other about possible solutions. We are sharing your ideas and programs on our website at aamc.org/wellbeing. And now, with support from the AAMC and other organizations, the National Academy of Medicine is launching a collaborative of organizations to promote resilience and well-being for all clinicians across the entire continuum of their careers. We simply cannot afford to let our own colleagues suffer in isolation. More than ever, we need to be a community for each other.

I have mentioned only a few examples, but I have seen hundreds. Please forgive me for not speaking about the work each and every one of you is doing. You are building stronger, more resilient, and healthier communities for all those





who work and learn on your campuses and for all those outside your walls who you serve so well.

Despite what has happened in the 10 years since I stood in this room and called for a strong national recommitment to the public good, please know that I have more hope than ever. We should never abandon our focus on the public good. To paraphrase something I once heard a wise woman say, "When others go low, academic medicine goes high." We will always seek to be a uniting force in our nation—to heal and repair our communities and to call on the government to fortify its commitment to the public good. The AAMC is already working to educate the new presidential administration and the new Congress. We promise to push them to strengthen our national investment in education, research, and care and to help us achieve the social repair our nation so desperately needs.

And despite all the bitterness of this election, I see clear, encouraging signs. A few weeks ago, on a glorious fall weekend in late September, in a dramatic building sitting in the shadow of the Washington Monument, the new National Museum of African American History and Culture opened. Presidents Barack Obama and George W. Bush came together to preside over the event. To signify the opening, a church bell rang over the crowd—a bell from one of the first black churches in America, established in 1776 by free and enslaved black people. The bell was rung by Ruth Odom Bonner. Ruth is the 99-year-old daughter of Elijah Odom, a man born into slavery in Mississippi but who escaped to freedom as a child. The beautiful grace note on this story is that Elijah Odom then went

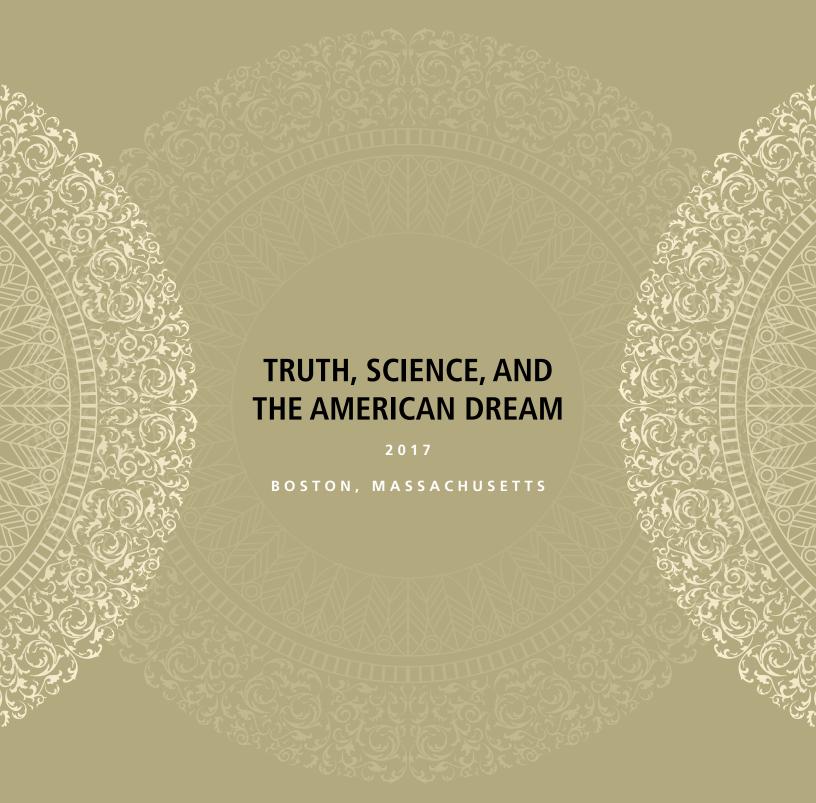
on to graduate from Meharry Medical College. He became the physician for—and an anchor of—his own community in Biscoe, Arkansas.

"At each and every medical school and teaching hospital I visit, I see the better angels of our nature at work— strengthening community bonds with learners, with colleagues, with patients, and most of all, with the people living just beyond your doorstep."

In his remarks that day, President Obama reminded us that our national history frequently has been one of struggle. At times that struggle has torn us apart. But President Obama also quoted President Lincoln, who called on "the better angels of our nature" to come together and transcend that struggle. This election has been a struggle. But at each and every medical school and teaching hospital I visit, I see the better angels of our nature at work—strengthening community bonds with learners, with colleagues, with patients, and most of all, with the people living just beyond your doorstep.

I thank you so much for being here in Seattle to move this national discussion forward. And most of all, thank you for being there for your communities.









hank you, Dr. Wilson, for that kind introduction. And my thanks to Dr. Rappley for her compelling call to focus on the essentials in our missions and our obligation to ensure access to learning, science, and care for all, not just the privileged. In America, everyone should have equal opportunity to achieve their dreams. Most of all, my thanks to each of you for joining us here in Boston for this year's Learn Serve Lead.

It seems to me that the more challenges our nation faces, the more we feel a need to come together as a community at this meeting. This year, one issue in particular has been weighing heavily on my mind. That issue is the threat to truth. The kind of threat that comes from opinion masquerading as fact, especially on the web and in social media. The threat of confusing "fake news" with real news. The threat that exists when bias and fear distract and distort a debate. For us, this threat to truth represents a fundamental challenge to science—the science that we depend on to reveal truth in medicine. Our patients depend on that science.

Each time I visit one of our member institutions, I witness the power of science in action. A few months ago, I spent a day at the Joslin Diabetes Center here in Boston. Diabetes is a disease that likely has been with us throughout human history. And for most of history, the disease meant an early death. But a century ago, medicine found the scientific basis for the disease, leading to the discovery of therapeutic insulin in the early 1920s. Dr. Elliott Joslin, a Boston physician with a deep ethical commitment to patients with diabetes, was a pioneer in the use of insulin and in care models that finally allowed patients to manage their diabetes effectively. He also was a pioneer of interprofessional team-based care. During my visit I learned that as survival rates for diabetes improved, the center established the Joslin Medalist Program to recognize those rare patients who successfully managed diabetes for 25 yearssomething that once seemed impossible. Then, as science progressed, the Joslin Medalist Program expanded, giving 50-year medals and 75-year medals. In 2013, Joslin recognized the first 80-year Medalist—Mr. Spencer Wallace, a man first diagnosed when he was eight years old. I was struck by the medals as a wonderful way to celebrate the courage and victories of our patients. In just a few decades, the truth revealed by science enabled people with diabetes to live their lifelong dreams.

"The threat to truth represents a fundamental challenge to science—the science that we depend on to reveal truth in medicine."

Hearing about the Joslin Medalists reminded me of my own patients from early in my career. Some of you may know that when I finished my residency in psychiatry, I entered a fellowship at the National Institute of Mental Health (NIMH) in a laboratory devoted to studying schizophrenia. Historically, the diagnosis of schizophrenia was every bit as devastating as juvenile-onset diabetes but with a different course. Typically, the symptoms of schizophrenia would appear in late adolescence or early adult life. Rather than an early death, most patients would live a normal lifespan in number of years, but that life was far from normal. All too often, schizophrenia would rob those patients of their grasp of reality. It would burden them with painful delusions and disturbing hallucinations. It even disrupted their ability for organized thought and speech.

I vividly remember the patients and their families who volunteered for our studies. One patient, in particular, still stands out for me. He was about my age at the time. At one point, he looked at me





and said, "You know, I was once you." My first thought was that this was one of the delusional ideas he experienced. But when I asked him to explain, he had a rare moment of clear thought. With deep sadness and total clarity, he told me he had gone to college filled with hopes and dreams, just like he imagined I had. But he never finished, because his dreams were shattered by the onset of his schizophrenia. My patients and their families knew they might never directly benefit from our research. But, like us, they believed that someday research could finally reveal the truth behind the mysterious, devastating illness that had taken such a toll on them.

"We need to match our science with an ethical commitment to ensure that all patients benefit from research."

Their hope in research was well placed. Think of all those centuries during which people who suffered from schizophrenia were thought to be possessed by demons. With no scientific understanding, people with the illness were not cared for. They were shunned. They were mocked. They were shackled. They had no hope.

Then, in the early 1800s, Philippe Pinel in France pioneered "moral treatment," a more humane approach to care for psychiatric patients. In the United States, Dorothea Dix led the battle to create safe asylums. Together with that more ethical attitude, science advanced. By the late 1800s, European psychiatrists like Emil Kraepelin and Alois Alzheimer were focusing on schizophrenia as a brain disease. In the early 1950s, researchers studying anesthetic agents serendipitously discovered that chlorpromazine

calmed and cleared the thoughts of some psychotic patients and eliminated their delusions. This discovery opened the door to the advances in psychopharmacology of the last six decades. Today, slowly but surely, the brain regions and neurotransmitter systems involved in schizophrenia are being clarified, complex genetic and environmental factors in the illness are being studied, and more targeted psychopharmacologic agents are being developed. Schizophrenia, a disease that like diabetes was once considered hopeless, now is a treatable illness for many patients.

But building scientific evidence is not enough. We need to match our science with an ethical commitment to ensure that all patients benefit from that research. Sadly, the treatment of patients with schizophrenia shows what the failure by society to fulfill that ethical commitment looks like. The dramatic discovery of drugs in the 1950s and 1960s allowed many patients who had spent much of their adult lives in psychiatric hospitals to be discharged. But these patients still required care. Unfortunately, the "deinstitutionalization" of these patients coincided with repeated funding cuts to services for the mentally ill, and a growing shortage of mental health providers left many patients without any treatment or support for reintegration into society. Discrimination against the mentally ill in housing and employment exacerbated their challenges, and, today, many Americans with serious mental illness are chronically homeless. Recent estimates indicate that 20% of the homeless suffer from severe mental illness, including high rates of schizophrenia.1 Too often, these untreated patients end up in a revolving door between prison and the street, with no treatment to stop the cycle. When we fail to translate our science—when society reacts with neglect, or with bias and fear-we lose the power of science to help our patients.





This is not just an issue for the mentally ill. Bias and fear affect patients with so many serious diseases, from HIV and AIDS to lung cancer. Bias and fear are the enemies of the truth revealed by science. And worse, they make it difficult, if not impossible, for patients to achieve their dreams. We know bias leads to significant disparities in care for minority populations. Research shows that physicians' conscious and unconscious biases affect how they treat patients of different races. For example, physicians undertreat black patients for their pain while overtreating white patients for their pain. For minority patients, these biases result in worse health outcomes.<sup>2</sup> The message here is clear. We need to match our growing base of scientific evidence with an equally compelling ethical commitment to apply that evidence fairly and equally to all our patients. More than ever, we need to resist and fight back. Medicine is finally working through our long history of overt and unconscious discrimination. Now, more than ever, we need to combine our science with an ethical obligation to fight back against bias and fear.

I am concerned that today we face a growing threat to science, to truth, and to our ethics. In 2016, the Oxford English Dictionary selected "post-truth" as its word of the year, defining the term as "relating to or denoting circumstances in which objective facts are less influential in shaping public opinion than appeals to emotion and personal belief." Do you find that concept as chilling as I do? When we fail to embrace the truth of science and we let bias influence patient care, we contribute to an environment in which important decisions are based on emotion and personal belief rather than on evidence and facts. When this becomes widespread in our culture, across our media landscape, and in our policy discussions, our patients suffer.

In the name of those hopeful patients and their families who so courageously participate in our research studies, I refuse to live in a post-truth world. I believe in truth. I believe science reveals the truth in medicine. I believe our ethical foundation gives us the compass to apply that truth wisely for the good of our patients.

We must not allow emotion and bias to supersede science. We have seen the damage that a post-truth attitude causes. The Centers for Disease Control and Prevention (CDC) has been barred from researching the public health effects of firearms since 1996. The anti-vaccine movement has been putting lives at risk since 1998, when our community let down its guard and allowed junk science to pass through our peer-review system and be published in a highly respected journal. And more recently, this year's divisive showdown over the Affordable Care Act was based more on the emotion-laden, partisan politics of "repeal and replace" than on evidence about ways to improve the health of the American people.

"I refuse to live in a post-truth world. I believe in truth.
I believe science reveals the truth in medicine. I believe our ethical foundation gives us the compass to apply that truth wisely for the good of our patients."

To see our national conversation descend to a place where facts are in question and "fake news" creates a fog concerns me for another reason. For us as individuals and for our nation, our American dream—and the dreams of countries around the globe—were realized through science and innovation. Science has propelled us to incredible achievements—from walking on the moon to



being on the cusp of eliminating polio from the planet. We will always have political differences in our nation. But America's finest moments have been driven not by politics, but by relying on science to reveal the truth.

Our scientific understanding of disease desperately needs to push forward. Which is why we should all be concerned when we see proposals to cut investment in scientific and medical research. And why it is so important that we consistently push Congress to block those cuts and build our investment.

"I see clear and encouraging signs that collectively we are reasserting the authority of science in our national debates."

But it's not all about Congress or politics or the media. Within medicine, we need to be constantly vigilant to balance our science and ethics. Sometimes we will struggle. Consider the current opioid epidemic ravaging so much of America, including here in Massachusetts. As a profession, we need to admit that, despite good intentions, we contributed to this problem. But now, we are responding—guided by our commitment to "do no harm." In that spirit, the leadership of the four medical schools in

this state jointly developed targeted educational initiatives to help improve everything from prescribing habits to addiction treatment models to overdose responses. With every epidemic—whether the pathogenic agent has been HIV or Ebola or opioids—an abiding commitment to evidence and ethics has been our best defense.

For the AAMC, this critical balance of evidence and ethics guides each policy position we take. We have supported and continue to support:

- Expanding access to health insurance, because the evidence shows improved access leads to better health status and longer life—having insurance saves lives;
- Improving access to health care for everyone, regardless of their background, beliefs, race, sexual orientation, gender identity, or geography;
- Preserving a clear immigration pathway for learners, physicians, and researchers from around the world, because the evidence shows that they are vital contributors to our innovation and our national health security; and
- Continuing the Deferred Action for Childhood Arrivals (DACA) program, because the evidence shows that a diverse health care workforce, including these "Dreamers," can improve America's health care and help narrow health disparities.





For every policy position we take, the evidence and ethical principles are our guide.

The challenge to truth has been building for some time. It transcends political party affiliation and our current political leadership. But it is an issue that undermines what we as a community believe and the role we in academic medicine can and should play in society.

I see clear and encouraging signs that collectively we are reasserting the authority of science in our national debates. Last April, more than one million people in 600 cities around the world marched for science. In September, hundreds of you walked the halls of the Capitol in Washington as part of the "Rally for Medical Research Hill Day" to support National Institutes of Health (NIH) funding. And 60,000 of our students and residents have spoken out on key health care policy issues through our AAMC Action grassroots network. It is that kind of passionate defense of science and evidence that will carry the day. Whatever your role in academic medicine, please take a stand for science and truth wherever you encounter misinformation and misunderstanding.

Think of how far we have come in medicine. Think of how much farther we can go. Someday soon, someone with diabetes could receive their 100-year Joslin Medal. Someday soon, schizophrenia might not only be treatable, "Whatever your role in academic medicine, please take a stand for science and truth wherever you encounter misinformation and misunderstanding."

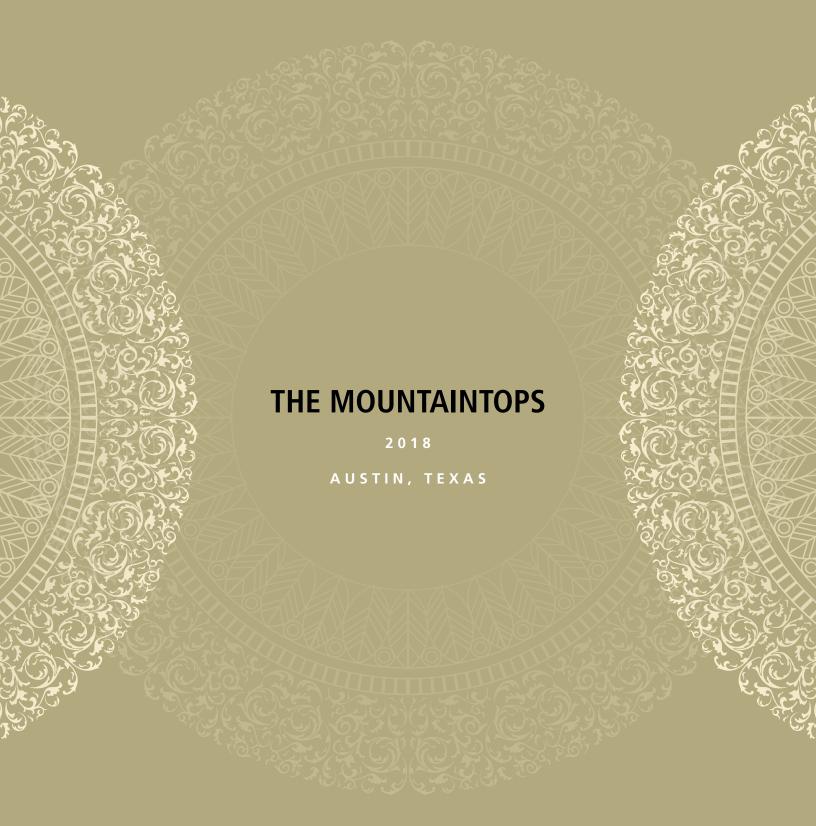
it might be preventable. It all depends on how relentless we are in our commitment to science and truth.

The late Senator Daniel Patrick Moynihan once said, "Everyone is entitled to his own opinion, but not his own facts." We are flooded daily with opinions masquerading as facts. We need to rise above that and occupy the high ground of evidence and ethics. That is when truth prevails. And that is how each of us—and each of our patients—can realize our dreams.

#### **Notes**

- 1. U.S. Department of Housing and Urban Development. HUD 2016 continuum of care homeless assistance programs homeless populations and subpopulations. https://www.hudexchange.info/resource/reportmanagement/published/CoC\_PopSub\_NatlTerrDC\_2016.pdf. Published March 15, 2017.
- 2. van Ryn M, et al. Physicians' perceptions of patients and behavioral characteristics and race disparities in treatment recommendations for men with coronary artery disease. *Am J Public Health*. 2006;96(2):351.









elcome to Austin! We are delighted to see the more than 4,600 of you who have joined us, including the more than 1,100 of you who are experiencing your first AAMC annual meeting. Thank you so much for being part of this important national conversation for all of us in academic medicine.

Seeing so many dear friends, and meeting so many new colleagues, is bittersweet for me. This is my last annual meeting as AAMC president and CEO. We are on track to hand off responsibilities to my successor on July 1. It is truly humbling, and an incredible honor, to have served this great organization that in just eight years will celebrate its sesquicentennial—150 years since our founding in 1876. Over its first 90 years, distinguished leaders such as Sir William Osler served the AAMC as annually elected presidents. The full-time position of president and CEO was established in 1969, and I am privileged to serve as only the fourth person in that role.1

Given that history, I found myself wondering what my three predecessors said in their farewell addresses to see what has stayed the same and what is new in our world. Drs. John A.D. Cooper, Robert Petersdorf, and Jordan Cohen are the giants on whose shoulders I stand. After carefully reading the powerful valedictory addresses of these visionary AAMC leaders, I was struck by how consistently the AAMC has worked for progress in four key domains over the past half-century. Each of my predecessors spoke passionately about his unwavering commitment to the core missions of clinical care, education, and research, as well as to the imperative of advancing diversity, inclusion, and equity in both academic medicine and society at large. It is a point of pride that over the last 50 years, we have remained true to these commitments.

But I also saw how much has changed since their speeches. Allow me to use a metaphor from my beloved Rocky Mountain home state to illustrate the point. Colorado has 53 mountain peaks over 14,000 feet tall. Climbing one of these "fourteeners" is, in every sense of the word, truly breathtaking—and I've climbed a few. You feel the thinning air as you climb, but each step brings a higher and more expansive view of the same landscape. Academic medicine advances the same way. Over time, our key mission domains remain constant, but as we ascend, we gain clarity when we look back, and with each step higher we are better able to see what lies ahead.

Many of us would mark the climb as having begun in earnest with Abraham Flexner's landmark 1910 report affirming the model of the modern medical school—built around a rigorous science-based curriculum and with active teaching in closely affiliated hospitals and clinics.2 After World War II, we reached new heights, experiencing what Dr. Cooper, our first president and CEO, called a "golden age" of medicine. It was a time when the National Institutes of Health and other federal agencies were growing in their impact, and fundamental research discoveries were leading to the development of powerful diagnostic and therapeutic tools, all stimulated by growing federal investment in science and health care.

This growing federal role in our work led to the AAMC moving from a small office in Evanston, Illinois, to Washington, D.C., in the late 1960s.<sup>3</sup> That decision took us to a new level of national influence as the voice of the rapidly expanding community of academic medicine. And we started to grow accordingly. Teaching hospitals and academic medical societies were added to the AAMC membership; three councils were established; medical students and residents were given a voice; and new AAMC groups were



created over the years to recognize and represent key roles in the academic medical center. It was the vision and leadership of Drs. Cooper, Petersdorf, and Cohen that brought us this modern version of the AAMC as the "big tent" where all parts of academic medicine come together. And what we have accomplished together is stunning.

In our mission of clinical care, over the decades my predecessors spoke powerfully about the challenges of having so many Americans without health insurance and how our clinical outcomes lagged, despite constantly rising spending on health care. They defined the problems clearly and called us to action. Nearly 10 years ago we took decisive action, making the AAMC one of the first and most vocal supporters of the Affordable Care Act (ACA).<sup>4</sup> And today we are unwavering in our support for expanded health insurance coverage. The evidence tells us that people who have health insurance lead better lives.

"Our health systems are making headway in improving the quality of clinical care and health outcomes. A recent study in *Health Affairs* showed that patients treated in teaching hospitals have up to 20% higher odds of survival than similarly ill patients treated at a nonacademic facility."

Beyond insurance, many academic health systems are working to replace what Jordan Cohen referred to in his 2005 address as the "obsolete" fee-for-service payment system we inherited.<sup>5</sup> At the same time, our health systems are making headway in

improving the quality of clinical care and health outcomes. A recent study in *Health Affairs* showed that patients treated in teaching hospitals have up to 20% higher odds of survival than similarly ill patients treated at a nonacademic facility. We are reaching a level where true "value-based" care is coming into sight. Not only that, you are going beyond the direct care you provide.

When I visit your institutions, I am excited by how committed you are to leaving the ivory tower and becoming deeply engaged with the communities beyond your walls. More medical schools and teaching hospitals have become important anchor institutions—proactively listening to and partnering with their communities. Your work to revitalize neighborhoods is helping the homeless leave the streets and bringing grocery stores to food deserts. Our AAMC-member institutions are hiring and training new employees and supporting 6.3 million jobs nationwide.<sup>7</sup> That is a real community commitment.

Turning to medical education, my predecessors focused on improving the curriculum and experimenting with new modes of teaching and learning. Today, the educators in this room have taken us to a whole new level. We no longer view students as empty vessels to be filled with facts. Collectively we are seeing a profound transformation—a paradigm shift—to learning and assessment based on competencies. Those assessments are defining entrustable activities and milestones of advancement. They no longer rely solely on a time-based progression and traditional fact-based exams. And we have "flipped" the classroom. Lecture halls are giving way to flexible spaces as we engage in more interactive, problem-based learning. And after four decades of talking about it, we are finally taking interprofessional education seriously.

In addition, technologies ranging from simulation labs to virtual reality tools are already enhancing learning. As artificial intelligence progresses,





the use of an interactive voice-activated "digital assistant" at the side of every physician is within sight. These advances will free the physician from being a clerk at the computer, offloading routine tasks and allowing the clinician to focus on the relationship with the patient. But I agree about the threat of technology. I see it at work in the clinical setting as it disrupts the doctor-patient relationship. Let's put our hearts and minds into making sure technology helps us restore the humanism and empathy at the core of medicine. If anyone is going to make technology work for us, it's the people in this room.

Speaking about our third core mission of science and research in his farewell address, Dr. Cohen celebrated the completion of the Human Genome Project. That science now is yielding astounding advances, such as CRISPR gene editing, immunotherapy, and massive data networks that combine and analyze staggering amounts of clinical data and research information in the service of improving care. These fundamental discoveries of our scientists are translating into real-world solutions. Cancer death rates continue to decline thanks to breakthroughs in research, early detection, and more targeted treatments developed in academic centers. And a recent analysis showed that every new drug approved in the United States between 2010 and 2016 can be traced back to NIH-funded research—many on our campuses.8 Supporting all this, advocacy by the AAMC and our partners over the past three years has put research funding back on a path of meaningful, sustainable growth.

When you take the long view, our progress in all three missions to care, educate, and discover has been steady and remarkably strong.

Turning to our fourth imperative of diversity, inclusion, and equity, my predecessors were equally passionate in their aspirations, but they were honest about the challenges we face. Despite the latter, we've made some real gains.

We're diversifying our profession by embracing holistic review in admissions, with positive results on some key fronts. In 2017, women surpassed men as medical school matriculants for the first time, and again this year, more women than men enrolled in medical school.<sup>9</sup> Black women have boosted their numbers in medicine.<sup>10</sup> But we must redouble our efforts to bring more black males, American Indians, and Alaska Natives into medicine.<sup>11,12</sup>

"A recent analysis showed that every new drug approved in the United States between 2010 and 2016 can be traced back to NIH-funded research—many on our campuses."

Our academic medical centers exhibit a living commitment to diversity and a degree of inclusiveness that, sadly, is not seen in many other segments of our polarized society.

Our learners, faculty, staff, and patients reflect the full range of Americans, including veterans, people with disabilities, immigrants, rich and poor—people of all races and sexual orientations. They all come together to accomplish great things. We saw this play out poignantly last Saturday, when teaching hospital physicians and staff (some of whom were Jewish) gave attentive care to the alleged gunman in the Pittsburgh synagogue shooting. In the face of hatred and terrorism, they showed true grace.

We now may face the toughest part of our diversity climb. But please be certain about three things: (1) the AAMC will strongly advocate—both in the courtroom and in the court of public opinion—for the ability of medical schools





to recognize diversity when selecting future physicians; (2) the AAMC will remain a clear voice about the important role of immigrants, who contribute so much to medicine and science; (3) the AAMC will continue to fight for the Dreamers and their aspirations.

"We must be relentless in surmounting the obstacles still in our path, from overt discrimination and harassment to unconscious bias, to gender and race-based gaps in salary equity."

No one sees social inequities and health disparities more clearly than we do. We must be relentless in surmounting the obstacles still in our path, from overt discrimination and harassment to unconscious bias, to gender and race-based gaps in salary equity. I believe that seeking equity in the health professions—and equity in health care—is a climb worth making.

While we can be proud of progress in clinical care, education, research, and diversity, inclusion, and equity, there is one threat that could stop us in our tracks. We cannot climb mountains if we are not strong, if we have lost our resilience. I am talking about the threat to our personal well-being.

Despite our advanced degrees, the rigors of training and caring for others can take a toll on us. Today, more than half the physicians in this country are experiencing symptoms of burnout—an increase of 9% over a four-year period.<sup>13</sup> It is sad when the joy of practicing medicine fades

for a physician. It is tragic when as many as 400 physicians, including some of our learners, die from suicide each year.<sup>14</sup>

Becoming a physician does not make one immune to workplace burnout or the closely related problems of anxiety, depression, substance abuse, and other disorders that often follow burnout. If anything, the high stress levels of the academic and clinical environment may put us more at risk. This problem has been with us for years, but we have been in denial. Two years ago, the AAMC was proud to be a founding sponsor of the National Academy of Medicine Action Collaborative on Clinician Well-Being and Resilience, and we are finally making progress in finding solutions that can make the environment of care and learning more supportive of our well-being.<sup>15</sup>

We need to acknowledge that burnout, depression, and suicide among physicians are not the failures of those individuals. Twenty years ago, the report titled *To Err Is Human* helped us see quality and safety issues not as causes for blame but as systems problems. <sup>16</sup> Twenty years later, I say, "To Care Is Human." And humans working in complex, high-pressure environments shouldn't be blamed for their burnout. We need to change the systems that wear them down.

In my first year of medical school, during a brutal winter quarter of gross anatomy and never seeing the sun, I—like too many students—became burned out. Then I hit the wall. I regret that only now, in my last annual meeting speech, am I telling you about my own struggles. My anxiety and depression were on the verge of derailing my career aspirations. My fear of being judged negatively and the dark shadow of stigma nearly kept me from seeking help. But an extraordinarily empathic student affairs dean steered me to the treatment I needed. As a result, I am blessed to stand here today.





Today, I want to make a personal plea. I know that many of you have a story like mine. We need to tell our stories and beat back the stigma that causes so many of our learners and colleagues to suffer in silence. Speaking out and erasing the stigma around seeking help is a most worthy mountaintop to reach.

Before I close, there is one more part of our journey that I want to mention. Throughout my tenure, many of you have heard me talk about the importance of culture. In every campus I visit, I see the many ways you are changing our culture at all levels of your organizations. It has been incredibly gratifying to see how our community is moving from its culture of independent silos to cross-cutting collaborations. How much of our work is now the result of high-performing teams instead of independent individuals. How we are moving from academic medicine being perceived as the problem in our health care system to being innovative leaders in developing solutions. How we are shifting the paradigm for choosing the next generation of physicians to one that values humanistic qualities as much as academic competencies.

Perhaps nothing has the power to shape culture more than a leader. Each of my predecessors was an exceptional leader. During difficult times, effective leaders who set a positive tone are critical in guiding success. The leaders we need not only will seek excellence in our core missions but also will remain true to our core ethical principles. As a nation, we are clearly struggling to define the culture we seek. Is it a culture that values hierarchy, exclusion, privilege, and power? Or is it one of compassion, inclusion, community, and accountability? Academic medical centers are shining examples of those latter qualities, and we need leaders at all levels striving to strengthen and extend that culture. It isn't just

important to the future of health care that depends on that leadership; it's important to the health of our democracy.

Dr. Cooper closed his final speech at the AAMC annual meeting in 1985 with a wish that in 30 years, a young medical scholar or educator, perhaps someone in the audience that day, would be standing on the same podium and once again say, "We have lived through one of the golden ages of medicine." <sup>17</sup> When I look out from the new heights we have reached in our missions, I certainly can say that today. And now, my wish is that when one of my successors stands here 30 years from now, she or he will be able to say the same thing.

"We need to tell our stories and beat back the stigma that causes so many of our learners and colleagues to suffer in silence. Speaking out and erasing the stigma around seeking help is a most worthy mountaintop to reach."

There is no way I can adequately express how grateful I am for having had the opportunity to work for and represent you for 13 years. I deeply appreciate the unwavering support you have given me and, more important, your abiding commitment to advancing the health of all. Please know that I will always remain fully committed to doing my part. Together, we will continue climbing mountains, however high they prove to be.

# Learn, Serve, Lead:

The AAMC Presidential Addresses of Darrell G. Kirch, MD, 2006-2018



## **NOTES**

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