



AAMC President’s Address 2006: “In Search of the Public Good”

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AAMC President Darrell G. Kirch, M.D., delivered the following address at the association’s 117th annual meeting in Seattle, Washington, on October 29, 2006:

“After 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.

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 "ever-larger 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 percent in public medical schools. Debt is on the rise, now standing at an average of \$120,300 per student. Not surprisingly, more than 60 percent 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 percent.

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 percent 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.

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 this is 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 also require us to change some very fundamental beliefs, behaviors, and expectations.

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 trying to sustain its school and hospital through so-called legislative earmarks (what some label “pork-barrel” projects). 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.

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.

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. 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.

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.

Thank you.”

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