AAMC President’s Address 2011:
“THE NEW EXCELLENCE”

AAMC President and CEO Darrell G. Kirch, M.D., delivered the following address at the association’s 122nd annual meeting in Denver, Colo., on November 6, 2011:

My 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 do feel that “the sky is falling.” 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.
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 here in Denver. 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.

Just as I found excellence in an unlikely place, 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” measures, 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 seemed 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.

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 percent 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.

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.

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, over 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.

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 15 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.

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 not only 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.

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 their innovative use of outcomes research to assess the effectiveness of each community outreach program. This work is guided 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.

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. Thank you!