AAMC Chair’s Address 2015:
TOWARD A MORE JUST SOCIETY AND HEALTH CARE SYSTEM: THE ROLE OF ACADEMIC MEDICAL CENTERS

Chair of the AAMC Board of Directors Peter L. Slavin, MD, delivered the following address at the association’s 126th annual meeting in Baltimore, Md., on November 8, 2015:

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

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

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

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

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

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

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

Seven months ago, a 25-year-old Baltimore resident named Freddie Gray suffered a serious spinal cord injury while being arrested. His pleas for medical attention were ignored, and a week later he died. The next month saw the worst riots in Baltimore since Martin Luther King’s assassination in 1968.
Over the past year, similar tragedies and unrest from Ferguson, Missouri, to Staten Island, New York, have forced our country to confront profound issues of race, justice, and inequality. We have all seen this drama play out on the streets and on television, among activists, police officers, and politicians. But today, I would like to argue that issues of racial bias and racial disparities should also be discussed and addressed by doctors, and nurses, and medical students, in medical schools and teaching hospitals.

Too often, we don’t take the time to consider our relationship to these issues until they are staring us in the face—when someone like Freddie Gray rolls into our emergency department. By then, of course, it’s too late. So it’s our responsibility to determine what we can do to create a society, and certainly a health care system, that is more equal and more just than what we have today. This is a responsibility that includes everything from addressing health care disparities, to improving medical school admissions and faculty hiring, to beefing up training and advocacy.

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

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

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

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

There are many factors at play here. The root causes of unrest in cities like Baltimore are also the root causes of health inequities. Our country’s long legacy of discrimination has led to substandard housing, residential segregation, neighborhoods plagued by drugs and violence, a vast income and wealth gap, and lack of access to good education, health care, and nutrition—all social determinants that negatively affect physical and mental health. In the Baltimore neighborhood where Freddie Gray lived before his death, one-half the residents are unemployed,
one-third of the homes are vacant, and 60 percent of residents don't have a high school diploma.

But even if you control for income, education, and health insurance, patients of color are still not receiving the same care as their white counterparts. Something else is going on here. The truth is that health care disparities are exacerbated by the conscious and unconscious biases of health care professionals on the one hand and the fear of bias by patients on the other.

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

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

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

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

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

Step one has been to rigorously collect demographic and quality data so that we can identify gaps and be transparent about bias. As we often say, “You can’t manage what you don’t measure.” We were the first institution to collect detailed, self-reported demographic data on all of our patients and publish clinical outcomes stratified by race on our website. We believe this transparency is essential to building trust with disenfranchised communities and holding ourselves publicly accountable. To paraphrase Supreme Court Justice Louis Brandeis, sunlight is the best disinfectant.
Step two has been to act aggressively in closing the gaps we’ve identified. And here I’ll give you just one example. Our first year of evaluating patient data revealed that Latino patients were more likely than white patients to be in poor diabetes control. So we launched a series of interventions that included proactively reaching out to Latino patients with diabetes, offering visits with a bilingual coach and bilingual nurse educator, as well as group classes, support groups, and clinical visits with a nurse practitioner.

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

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

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

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

The work of the Disparities Solutions Center has had a profound effect on the culture and care of our entire institution. Since 2007, we’ve issued an annual report that monitors our performance, so we can say with a high degree of certainty that if you were admitted last year to Massachusetts General Hospital with chest pain, you were given the same kind of care, regardless of skin color. Putting equity front and center has made all of us more conscious of these issues as we go about our daily work.
Now, the good news is, MGH is far from the only hospital that is finding new ways to close gaps in care. The Henry Ford Health System in Detroit now collects demographic data from more than 90 percent of its patients and embeds that data into equity dashboards that are part of its overall quality and service metrics. Robert Wood Johnson Hospital in New Jersey, by using data to identify inequities, has reduced its overall 30-day hospital readmission rate from 13 percent to 5.2 percent in just one year. And here in Baltimore, the University of Maryland and Johns Hopkins are working with the state of Maryland to create health enterprise zones that bring providers and the community together to address major public health issues. And the AAMC itself has been a leader in promoting health care equity. It has developed a number of tools, resources, and programs that are readily available to our institutions. Please check them out on the AAMC website.

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

But I’ll be honest: we’re far from perfect and still have a lot of work to do. In fact, one of the reasons I wanted to speak about this topic today is because of a very humbling experience I had in the wake of the protests in Ferguson and Baltimore. I had an opportunity to meet with MGH medical house staff from underrepresented backgrounds. These staff members shared how they were deeply affected by what was happening around the country, but didn’t feel they had a safe place at the hospital to discuss these important issues. It was a reminder of how much we can learn from our trainees and also a punch in the gut. It proved that despite all the work we’ve done, and all the progress we’ve made, we can’t rest until every employee and every patient feels that our hospital is an open, inclusive, and understanding environment.

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

As some of you know, I’ve been involved at Massachusetts General Hospital in one capacity or another for more than 30 years. But my connection to MGH actually goes back a couple generations to my great-grandfather, who was a Jewish immigrant from Lithuania. In the 1920s, he received exceptional care at MGH over a 10-year period. But if he or one of his children had wanted to go into medicine, they wouldn’t have been allowed to train there. In those days, MGH and many other hospitals across the country wouldn’t train Jewish physicians.
Today, bias in medical school admissions isn’t nearly as obvious or intentional. But the truth is, we still don’t have a system that encourages the best talent from every background. Even as our country grows more diverse, our hospital staffs and medical schools have not. In fact, the demographics of medical school classes have barely changed in 20 years. Not only are black and Hispanic physicians underrepresented among medical school faculty, they are less likely to be promoted and less likely to hold senior faculty and administrative positions. This isn’t right, and from a purely business perspective, it isn’t smart. Patients will be less likely to choose a hospital that doesn’t have caregivers who share their varied backgrounds and experiences. There’s also plenty of evidence that organizations with more diverse teams make better decisions and outperform organizations that are less diverse.

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

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

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

Our job is to heal.

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

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

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

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

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

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