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COURAGE

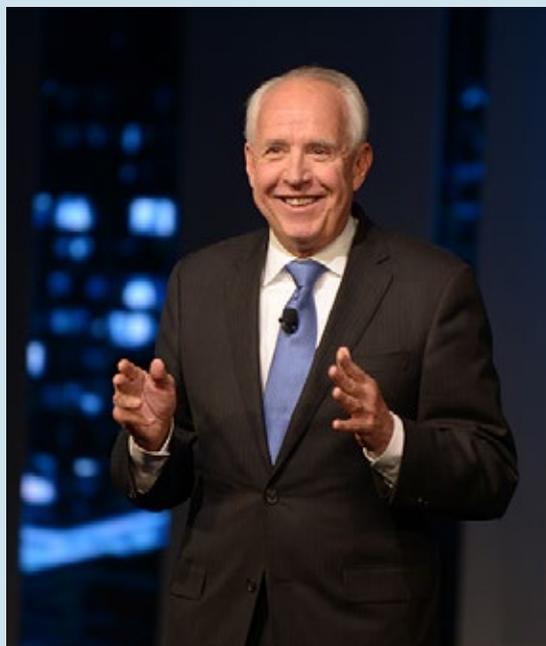
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RESILIENCE

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Chair of the AAMC Board of Directors A. Lorrin Betz, M.D., Ph.D., delivered "Courage" at Learn Serve Lead 2014, the association's 125th annual meeting in Chicago. His remarks follow in essay form.



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This is a publication of the Association of American Medical Colleges. The AAMC serves and leads the academic medicine community to improve the health of all. www.aamc.org.

Courage

A. Lorris Betz, M.D., Ph.D.

Rude, disruptive behavior can be funny when it happens to someone else on TV. In real life? Not so much. Let me tell you three real-life, not-so-funny stories.

A third-year medical student begins her surgery clerkship. She's heard how "difficult" some of the attending surgeons and residents are, but she thinks she's prepared. When she enthusiastically expresses her interest in family medicine, one of the surgery attendings sharply replies, *"Family medicine isn't real medicine. If you end up doing that, you won't be a real doctor."*

A hospital administrator received a letter from a patient who had been in the hospital for just two days. He wrote: *"The health care professionals as a whole, are impersonal. The doctors barely talked to us. The residents are ill prepared and do not collaborate enough with the attending physician. Many nurses and other professionals freely share patient information in the hallways . . . If things continue as they are then we will probably never use your hospital for anything again."*

A faculty member interviewed medical students, residents, anesthesiologists, and surgical nurses to collect data for a study of disruptive behavior by surgeons.¹ Here's one interviewee's description of a disturbing incident: *"He was very angry, yelling at the nurse across the desk, and then he came around the desk and actually pinned her up against the wall and had his hand on her throat while saying, 'You can't take my room away.' People had to pull him off."*

Another interviewee said: *"The institution gives them the signal that they bring in a lot of money and they can do whatever they like. And so they do. The institution turns its head, because to fire a surgeon . . . well, you're probably talking tens of millions of dollars."*

I'm sad to say that these stories are from my institution. But I'm certain that you all have your own stories. Most of you have seen demeaning, disrespectful, and disruptive behavior in your institution. Many of you have experienced it. And some of you have been responsible for it.

You may argue that the offenders are a small minority. Individually, we are good doctors, nurses, physician assistants, residents, and . . . people. After all, we are health care professionals. It's just a few bad actors who give us all a bad name.

But when you look at the numbers, another story unfolds. The American College of Physician Executives recently conducted a survey to quantify disruptive physician behavior.ⁱⁱ A total of 840 physicians responded. Of those, 70 percent said they observe disruptive physician behavior every month and 11 percent said they see their colleagues behaving badly every single day. And when the survey asked if they themselves had exhibited disruptive behavior sometime in their career, about 25 percent admitted they had. And you've got to wonder whether there might be some underreporting on a question like that.

“Bad behavior is the symptom. A culture of disrespect is the disease.”

In another study using a meta-analysis of the literature, Fnais et al. found that nearly 60 percent of medical trainees had experienced at least one form of harassment or discrimination during their training.ⁱⁱⁱ 60 percent!

These numbers corroborate what I believe to be true: that disrespect is more systemic than it is isolated. Unfortunately, it's part of the very culture of medicine, a culture that has existed for many decades if not centuries. Disrespect doesn't just manifest as egregious behavior like angry outbursts and verbal threats. It's embedded in how we practice medicine. It can be as subtle as referring to patients by their disease, e.g. “the herniated disk in room 214.” As self-centered as scheduling all patients to show up for clinic at the same time and then making them wait. And as blatant as a surgeon refusing to take a mandated time out in the operating room.

For years we've tolerated or ignored the problem, perhaps using a “that's just the way things are” attitude. Now, finally, there is growing recognition of disrespectful and disruptive behavior by physicians and efforts to deal with it.

The AAMC deserves much of the credit for creating awareness and bringing the issue to the forefront. Last June, the Board of Directors unanimously endorsed a statement concerning mistreatment in the learning environment. A portion of the statement reads: *“We affirm our commitment to shaping a culture of teaching and learning that is rooted in respect for all. Fostering resilience, excellence, compassion and integrity allows us to create patient care, research and learning environments that are built upon collaboration, mutual respect, and human dignity.”*

I think all of us would agree with that statement, and we would all aspire to have those kinds of collaborative and supportive environments. Unfortunately, despite our best intentions and admirable efforts at many institutions, bad behaviors persist. And they seem to resist our best efforts to change them.

Take for example, the David Geffen School of Medicine at UCLA, which in 1995, long before the issue was on many schools' radar, did four things:

1. They instituted policies.
2. They created reporting mechanisms.
3. They provided resources.
4. They began educating faculty and residents about student mistreatment.

In addition, they surveyed the students every year to determine the frequency of mistreatment.

As recently reported by Fried and colleagues, the overall incidence of mistreatment during clinical clerkships did fall by about 25 percent during the first 2 years of the program.

But then, for the next 8 years, the incidence remained unchanged at about 57 percent.^{iv}

Similarly unimpressive is the progress we've made across the country. Mavis et al. studied responses to the Graduation Questionnaire between 2000 and 2012 and found there was essentially no change in the percentage of students reporting incidents of personal mistreatment.^v

Regrettably, only one-third of students who experienced mistreatment even reported the incidents, also a number that did not change.

So why is it so hard to eliminate these behaviors? I believe it's because programs that are focused on student mistreatment or the disruptive physician are directed at treating the symptom and not the disease. Bad behavior is the symptom. A culture of disrespect is the disease.

And culture is very hard to change, especially a "dysfunctional culture that resists change," as Leape et al. concluded. In their words: "Central to this culture is a physician ethos that favors individual privilege and autonomy – values that can lead to disrespectful behavior."^{vi}

Well, that privilege and autonomy are among the very reasons that many generations of physicians went into medicine in the first place. Is it any wonder, then, that it's so hard to change?

“Recognizing and addressing this culture of disrespect is not simply “the least of our worries.” It is, in fact, foundational to our survival.”

I know we all have a lot on our plates. These are certainly challenging times in academic medicine. Change is happening at a relentless pace whether we like it or not and it seems almost impossible to keep up. Just glancing at the agenda of this meeting is a quick outline of the things we need to fix. While we worry about new payment models, constrained NIH funding, ensuring the competence of learners across the continuum, and our very survival, the treatment of medical students or dealing with a tightly wound physician can sometimes seem like the least of our worries.

But I agree with Lucien Leape and others who argue that it's our dysfunctional culture, not a lack of know-how or resources, that leads to under performance in every corner of our organization.

Our culture of disrespect creates obstacles to patient safety and to working effectively in teams.

“Change is not only vital.
It is possible.”

It produces hostile work environments, dissatisfied patients and an increase in malpractice claims. For medical students, what they see and experience in our organizations can cause humiliation, shame, self-doubt and low self-esteem. Worst of all, students often emulate the bad behavior of their faculty role models. And thus the cycle goes on and on.

My point is, that recognizing and addressing this culture of disrespect is not simply “the least of our worries.” It is, in fact, foundational to our survival. It can't be on the back burner. It is the burning platform.

We need to take on, and fix, our culture so we can successfully deal with all of our other challenges. Let's stop treating just the symptoms. Let's find a cure for the disease. Let's stop being defeatist about changing a deeply entrenched culture and begin to believe that change is not only vital. It is possible.

Let me tell you a story of my own. In 2008, as senior vice president for Health Sciences at the University of Utah, I learned from patient letters and surveys that we were providing a health care experience that was well below our patients' expectations. We ranked in the low 20th percentile for patient satisfaction when compared nationally with our peers. This issue became particularly urgent for me when I saw firsthand the less-than-perfect experiences my wife, Ann, had in my own health system. I was embarrassed. I was frustrated. And that became the perfect storm that created the urgency to change.

Throughout my 12-year tenure leading the University of Utah Health Sciences, I issued very few mandates, but this was one of them: We need to provide an exceptional experience for every patient, every time, and at every point within our system.

The goal was clear, but we left its execution to the individual departments and divisions. Patients navigating the health care system touch too many different pieces of the puzzle for a one-size-fits-all approach. And we certainly didn't want it to feel like another program of the month. We wanted a foundational culture shift.

We called the initiative the Exceptional Patient Experience. As you might expect, projects took off quickly among the hospital and clinic staff. But the physicians, at least initially, were reluctant to change. So we decided to make it personal and competitive for the faculty. We gave every physician and their chairs a scorecard outlining their performance and how they compared with their departmental peers. As patient feedback poured in, the physicians finally took note. We had broken through. We began sharing these data with the entire system and that transparency led to further improvement.

“I've learned that changing the culture of our organizations is not for the faint of heart. It takes courage.”

In two years, the system moved from the 27th percentile to the 66th percentile on the question “Would you recommend this hospital?” More importantly, patients were happier, clinic sessions ran more smoothly, and people began learning from, and respecting, one another. And all of a sudden, the number of positive letters from patients greatly exceeded the negative ones.

When I stepped down in 2011, my successor, Dr. Vivian Lee, enthusiastically embraced the initiative, and our scores continued to climb. In late 2012, she pushed the system to give patients a greater voice and to embrace an unprecedented level of transparency. The University of Utah became the first academic medical center to publish its patient satisfaction scores online, complete with patient comments and a familiar five-star ranking system, just like Amazon. What I couldn't have even imagined a decade ago was now happening. The culture had shifted organically. And the results are remarkable.

Of the nearly 650 physicians with 30 or more returned surveys, one out of two rank in the top 10 percent nationally. Perhaps more impressively, one out of four rank in the top one percent.

And for those who think this isn't good for business, our quality and safety measures were improving at the same time. Over a two-year period, we jumped from 50th place to number one in the University HealthSystem Consortium quality and accountability rankings of academic medical centers. And we've stayed in the top 10 for the past five years.

Additionally, our malpractice premiums have decreased, employee satisfaction has increased, and over the past four years our costs have increased at a rate that is less than half of the national health care inflation index. And in the past year, we have finally seen a reduction in student mistreatment in most of the areas reported in the Graduation Questionnaire, a change that we certainly hope will continue.

While the data are encouraging, our exceptional patient experience initiative was never just about achieving numbers. The scores are only the metric. The real goal of our efforts was to create a culture of respect around the patient and among one another. And in this, we have succeeded.

“If we expect our providers to respect their support staffs, students, and patients, we need to design systems that fundamentally respect them.”

So what have I learned from this experience? Well, I've learned that changing the culture of our organizations is not for the faint of heart. It takes courage. It takes the courage of leaders who must be persistent and consistent in pushing toward the goal. It takes the courage of faculty and staff to work together to find solutions to seemingly insolvable problems. It takes the courage of students and staff to identify people who are not on board with the program, and the courage to move them out. And it takes courage to speak up. Because as the philosopher Plato said, “I shall assume that your silence gives consent.”

Along with courage, we also must create systems and establish policies to engage and motivate change in our organizations. These include a zero tolerance policy for both mistreatment and for not reporting failures, a safe and non-judgmental reporting environment, and an expectation of personal accountability. We need to identify or

create meaningful metrics to monitor our progress and transparency to celebrate our successes and to challenge the laggards. And if we expect our providers to respect their support staffs, students and patients, we need to design systems that fundamentally respect them. A tall order, but I believe it can be done.

Learn. Serve. Lead. That is the theme of this year's meeting. So I ask you: How many of you can learn while being bullied? Who wants to serve their patients in a hostile and disrespectful system? And who among you has the courage to take the lead in changing this culture? I believe there are many who are not only willing, but who can make a difference.

So I call on you to begin the work of breaking up this age-old and useless cycle. Individually and collectively, we need to act now. It's a good business decision. It's a good people decision. Moreover, it's what our patients expect and deserve. It's what our learners expect and deserve. And it creates the kind of environment that we all want to work in. Working together, I believe we can achieve it.

ⁱ Cochran A, Elder WB. A Model of Disruptive Surgeon Behavior in the Perioperative Environment. *Journal of the American College of Surgeons*. 2014;219(3):290-398.

ⁱⁱ MacDonald O. Disruptive Physician Behavior. May 15, 2011. http://www.quantiamd.com/q-qcp/Disruptive_Physician_Behavior.pdf. Accessed October 30, 2014.

ⁱⁱⁱ Fnais N, Soobiah C, Chen MH, et al. Harassment and Discrimination in Medical Training: A Systematic Review and Meta-Analysis. *Academic Medicine*. 2014;89(5):817-827.

^{iv} Fried JM, Vermillion M, Parker NH, Uijtdehaage S. Eradicating Medical Student Mistreatment: A Longitudinal Study of One Institution's Efforts. *Academic Medicine*. 2012;87(9):1191-1198.

^v Mavis B, Sousa A, Lipscomb W, Rappley MD. Learning About Medical Student Mistreatment From Responses to the Medical School Graduation Questionnaire. *Academic Medicine*. 2014;89(5):705-711.

^{vi} Leape LL, Shore MF, Dienstag JL, et al. A Culture of Respect, Part 1: The Nature and Causes of Disrespectful Behavior by Physicians. *Academic Medicine*. 2012;87(7):1-8.

Resilience

Darrell G. Kirch, M.D.

One 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 percent—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 percent for emergency medicine. Even more concerning is that more than 40 percent of the physicians who responded screened positive for symptoms of depression, and seven percent reported having suicidal ideation in the last year.ⁱ

“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.ⁱⁱ 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.”

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.ⁱⁱⁱ

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.

“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.”

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.”^{iv} 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.

RESILIENCE

AAMC PRESIDENT'S ADDRESS



“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.”

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 Balsler, 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.

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.”^v

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. Thank you!

ⁱ 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.

ⁱⁱ Sinha P. Why Do Doctors Commit Suicide? *The New York Times.* September 5, 2014:A27.

ⁱⁱⁱ Coggeshall L. *Planning for Medical Progress Through Education.* Washington, DC: Association of American Medical Colleges; 1965.

^{iv} 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/>

^v Seligman M. *Flourish.* New York, NY: Free Press; 2011.