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Culture and the Courage to Change

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**AAMC President's Address
2007 Annual Meeting
Washington, D.C.**

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Darrell G. Kirch, M.D.,

AAMC president and CEO, delivered his address, “Culture and the Courage to Change,” at the AAMC annual meeting in Washington D.C., November 4, 2007. His remarks follow in essay form.

Last 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.”

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.

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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

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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 M.D. as the “Most Desirable” profession a young person could pursue.

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.

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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.

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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.

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.

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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?

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.

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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.

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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

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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.

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.”

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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.

As leaders of your institutions, I urge you 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.

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.

Thank you for the opportunity to share my thoughts with you today.



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