AAMC Chair's Address 2017
"The Most Important Question We Can Ask"

Marsha D. Rappley, MD, chair of the AAMC Board of Directors, delivered the following address at Learn Serve Lead 2017, the association's 128th annual meeting in Boston, Mass., on Nov. 5, 2017.

Good morning and welcome. I want to thank all of you for taking time away from your day jobs and spending your limited resources to be among us here today. How does it feel to be among 4,000 people who understand the value of medical education, research, and service?

I want to thank my family for joining me here today. Everything I have to give in my work with patients and my students and my colleagues comes from my family.

Last night, I learned about many of you who are establishing clinics in remote parts of Puerto Rico. Thank you to those of you for your courage in doing this work and for refusing to be daunted by this catastrophe.

I have had so many opportunities to experience education, research, and service leadership through the AAMC, the pediatric organizations, and all of my colleagues at Virginia Commonwealth University and Michigan State University. You always remind me and inspire me to put our patients and our students first.

This morning I would like to ask you to think with me about some very important questions:

- What are the essential experiences that can only be achieved in medical school?

- What experiences are both necessary and sufficient to demonstrate competency and readiness to step to the next level of training?

- How do the experiences of residency extend seamlessly from medical school and then again seamlessly into the practice of medicine?

I believe that these are the most important questions we can ask ourselves, because answering them will provide us with a path to reduce the cost of what we do. And I believe that the cost of what we do in education and in service is undermining our ability to improve the health of the nation.

Our cost is compromising our ability to prepare a diverse and inclusive physician workforce. This is something we believe is absolutely necessary to attain a truly healthy nation. And our cost is impinging on our ability to sustain the world's leading research enterprise, which is essential to the discoveries that save lives.

I want to start with my perspective. I began as a nurse's aide, scrubbing bathrooms through the night and setting up trays for breakfast in the morning. I was then a licensed practical nurse, an associate degree nurse, and a BSN for about 12 years, before I graduated from medical school. I worked at Children's Hospital of Michigan, where I learned what I had to contribute to others. I worked in child psychiatry inpatient services, where I experienced the depths of despair and the heights of human resiliency.

And I was an inpatient clinical research nurse, where the advancement of science had an intensely personal face. I moved through medical school and residency with a laser focus on my own competency. I then stood like a deer in the headlights when I took my first job in academic medicine, moving with great trepidation through levels of responsibility—as division chief, interim chair, associate dean, dean of a medical school, and now as vice president for five health professional schools and CEO of an anchor academic medical center.

I am also a patient.

I survived an unusual lung cancer, I lost my mother to pancreatic cancer, and I am continually seeking to find a new normal with chronic disease in my immediate family. So my perspective is deeply rooted in the trust that our patients and our learners place in us at the most vulnerable times in their lives. The reality is that our cost is hampering our ability to deliver on this trust.

And when I ask us to think about cost, I am not talking about ways to "cover the cost." We have faced this problem for a long time. We have been successful in garnering support from health systems and payers, from universities and donors, within medical schools and across departments. We have charged students more in order to provide more scholarships. We have created high-volume master's programs to generate revenue to support the higher cost of medical education.

But this is moving the chairs on the deck. And in the end, our cost is carried by the very people we want to help—our students and, ultimately, our patients. Today, I will build the case that our cost poses a serious threat to a healthy nation. And then I will describe the assumptions we make that feed this cost, assumptions that we can change.

Three trends are converging on what we do. The first trend is a growing lack of confidence in the value of higher education in general and the cost of education to the individual student. On Sept. 7, the *Wall Street Journal* published an article by Josh Mitchell and Douglas Belkin, "Americans Losing Faith in College Degrees." Only 49% of the population surveyed believed that a college degree will lead to a good job and higher lifetime earnings.

For people ages 18–35, among those who go to college, 57% did not think college is a good deal. And this is a significant change in how our society views education.

So what does this mean for the young people we hope to educate as physicians? Many pieces of information, often cited, falsely reassure us. For example, we can cite application to acceptance ratios: on average, medical schools received 39 applications for every available position in 2017.

Only 11 of our 149 U.S. medical schools received fewer than 1,000 applications, and one school received more than 14,000 applications for 175 positions.

How many times have you heard a university president, or others, say, "We have thousands of people wanting a place in our medical school? We should be charging more!" We can also cite incomes after entering practice compared with what other professional students face in the tuition/future income value proposition. Medical students are better off than law students.

We can also illustrate that tuition is a relatively small portion of the total support of medical education. So why be worried about this? I want to give you another illustration.

I sat at a dinner a few years ago where a young graduate—the first generation in her family to go to college—stood on stage with her 11-year-old son and thanked many people for making her career in medicine possible. We were all so proud of her. And then her faculty mentor whispered to me, "And you know she has $450,000 in debt."

With the reversal of loan forgiveness for the kind of institution in which she trains, she will enter the practice of medicine with monthly loan repayments similar in size to a home mortgage. This young woman does great work to help others have a better life. But it comes at a personal cost to her that none of us intended.

I think about my own decision to apply to medical school. The odds were against me in every direction. My age, sex, background, my path to my bachelor's degree, and my financial status. I worked throughout medical school, an option that is virtually impossible today. I benefitted from deferments through my residency—deferments that are no longer available to our residents today.

The current median debt for our students at graduation is $192,000. Today the cost and the length of time in training would discourage me from the career that has given me so much joy and satisfaction. I ask you to think about what sociodemographic of people will even imagine for themselves a career in medicine, given this cost. We are making this hardest for the people we are trying to include.

The second trend is the increasing cost of health care borne to the individual patient. Between 2004 and 2014, the cost of health care for the individual has increased by 72%. Looking to the year 2018, adding copays for visits, prescriptions, and deductibles, my 90-year-old father could pay $1,000 per month and my 28-year-old son could pay $700 per month for health care. This individual expense will change the way individuals seek care. Again, think about what sociodemographic of people will be able to afford the kind of care that we provide in academic medical centers?

The third trend is the falling margins in health care systems. The impact may fall most heavily on research and medical education. Our medical schools are vulnerable because 61% of the revenue that flows into our medical schools across the nation comes from health care delivery systems. Currently, my health system is in the process of reducing costs, with a target of about 10% of our revenue, or $350 million, over three years. Systems across the country have done

this or are doing this as we all face declines in all lines of support for patient care, including Medicare, Medicaid, commercial insurance, support of education, and support for care of the uninsured.

Over many years, our health systems have partnered to support large start-up packages and heavy investments needed to support laboratories, technology-driven equipment, and basic, translational, and clinical science initiatives. It is not uncommon for the health system to provide half or a third of the cost of the research that leads to cures. With falling margins, there is less money available to provide financial support for research.

I am careful about my choice of words. I have experienced "research leading to cures." This is not a sound bite.

In the early 1970s, as a nurse, I cared for children who were dying of Wilms tumor, renal disease, cardiac anomalies, leukemia, cystic fibrosis, prematurity … just to name a few. I helped these children and their families at the most difficult times of their lives. And now we regularly graduate medical students who survived these conditions because of our science.

Over time, millions of people who would have died at the time when I entered my career now have full, productive lives and children of their own. This is what science is doing for us.

Our ability to support this science is being eroded by lack of faith in education, prohibitive cost of attaining an advanced degree or even a first degree, protracted training and career advancement, and the decreasing margins of health care delivery. We have the tools to improve the value proposition of preparing the physicians of the future and to support the research that leads to cures—but we are not using them.

We have evidence that students can enter practice successfully with three years spent in medical school. So why do most systems still require four years? We have evidence that some students can enter practice successfully without a four-year undergraduate degree plus four-year medical school path. So why are most systems still built on the longer, more expensive model?

We place confidence in the competency of our graduates, and our ability to assess that competency. So where are the systems that allow students to enter and leave our programs according to their levels of competency?

We believe that our students must be competent in critical thinking developed through understanding research and competent in the social systems in which our patients and their families live. Then why are these experiences add-ons to the formal training? Why are these experiences not the vehicle to the gaining of competency in a shorter and more focused period of time?

We struggle to provide care in places and to people who do not benefit from our large health care systems, especially in our rural and urban areas. So why are the building blocks to the practice of medicine not happening among these people who need us? Why are we not integrating in rural and urban settings the science and technology that promises to improve lives?

There are many people who do not benefit from our science and technology, and some of them clearly understand that what is available to others is not accessible for them. And that is not okay. We can change that through education and research, but we must all agree that this is not okay.

I know that many of you are sitting here thinking that we are doing that, we are doing exactly what you describe. And thank you to all of you who are giving us the evidence to support significant change, to increase our value and efficiency in preparing the physicians of the future.

But why are these kinds of opportunities still the pilot programs, the experiment, the exception?

No one set out to design a system that requires most of our learners to spend four years to get a bachelor's degree, four years in medical school, three to five years in residency, another three or five years for subspecialty training, with entry to practice in their mid- to late 30s. This is assuming no time off was taken for a year to better prepare for medical school, to work abroad, for a child being born, or someone sick to care for.

We did not intend that many of our young people would enter academic careers in their mid- to late 30s and would receive their first RO1—still a common requirement for promotion—at the average age of 45.

I believe that we are stuck, often protecting our turf without realizing it. And I believe we can change this value proposition if we focus on what is essential to preparing the physicians of the future. Each of you in this room has the creativity, the drive, the values, and the dedication to move beyond the status quo to create significant change.

I want to convey a sense of urgency, from the vantage point of more than 40 years in health care. If we do not reduce our cost and the time in training, people who do not share our values will fill this vacuum that we leave.

It is still a privilege, and the best job in the world, to care for people when they need us and to bring that enormity of science to bear on the problems of a single person or hundreds of thousands of people. I want to pass this baton by clearing the path for all those who can come up behind us.

Today, we contribute to the deepening cleft that exists between those who can become physicians and those who cannot. Between those who receive health care and those who cannot. Our awesome science has not yet had the chance to lead our nation to the health status that many other nations enjoy.

My own story tells me what is possible. And for that I am deeply grateful.

As we leave the room today, let us remember that *we* are the stewards of our nation's health care, and addressing our costs, shedding our assumptions, is critical to achieving our mission to improve the health of all.