



## **AAMC President's Address 2019** **"The Status Quo is Unacceptable"**

*David J. Skorton, MD, AAMC president and CEO, delivered the following address at Learn Serve Lead 2019, the association's 130th annual meeting in Phoenix, Ariz., on Nov. 10, 2019.*

Thank you, Joe, for that introduction — and thanks to Lilly for those inspiring remarks and for all you do leading the AAMC Board of Directors. It is also an honor to be joined today by our two presidents emeritus, Drs. Jordan Cohen and Darrell Kirch.

I'm grateful to be here in Phoenix — a city whose name invites the idea of a new beginning. And new beginnings, as you might expect, are something I've thought about quite a bit lately.

At this time last year, I was leading a very different American institution: the Smithsonian. It was a privilege, an awesome responsibility, and I loved every minute of it.

But I never forgot that I am, first and foremost, a physician. I've dedicated most of my life to patient care, education, and research. And as I observed the debate over health care, education, and biomedical research in America, I couldn't escape the feeling that I had something more to contribute.

So, when I was approached about joining the AAMC, I knew I wanted to be part of that effort again. My extraordinarily positive experience on the AAMC Board of Directors from 2010 to 2013 gave me confidence in my decision.

But, as I stepped into this new role, I was struck by an uncomfortable realization: during my long career in medicine and academia, my colleagues and I had come up short in important ways.

Yes, we had delivered the best possible care to our patients. We had developed and mentored a generation of doctors and medical professionals. And we had made some incredible strides in medical research and the battle against disease.

But we had done it all within — and often despite — an imperfect system. Often, we had failed to consider the perspectives of the patients, families, and communities who were relying on us. And instead of tackling problems head on, we had allowed them to persist and, in many cases, worsen.

The system still fails for so many.

In 2008, in his address to this meeting, my distinguished predecessor Dr. Kirch said: "We spend too much of our time in academic medicine defending a status quo that fails to inspire us, instead of creating a better future."

That was more than a decade ago.

Today, the status quo is not just uninspiring. It is unacceptable.

Just ask the patients contending with exorbitant costs and insufficient access to care. Or the students concerned about the cost of college and medical school, and the debt that burdens their future. Or the trainees feeling exploited as a source of labor and concerned about their work-life balance. Or the doctors frustrated by their loss of autonomy and the demands of documentation and electronic health records. Or the young researchers, uncertain of their future ability to contribute to the corpus of knowledge. Or the learners and physicians struggling with burnout and depression.

If you ask any of them — and I have — they all say the same thing: The status quo isn't working.

Now, I want to be clear. I'm proud to be a U.S. physician. I'm proud to be a product of the American health care education system. And I still believe this is the most exciting place in the world to practice medicine, with by far the greatest potential.

Our mission statement says that the "AAMC serves and leads the academic medicine community to improve the health of all."

In my view, we are committed to serving our membership well, but we need to step up and lead to a greater degree, with courage and determination. The same could be said of academic medicine: We serve our patients well, but we need to step up and lead beyond the boundaries of our institutions to improve the nation's health.

In that spirit, I'd like to discuss with you some of the key issues that I believe will shape our future.

To begin, I want to address three seemingly disparate challenges: first, diversity, equity, and inclusion in health care; second, mental health and substance use disorders; and third, the cost crisis in American health care.

I've chosen these three examples because they stand out in their complexity and in their crying need for change.

## **DIVERSITY, EQUITY, AND INCLUSION**

Let's start with diversity, equity, and inclusion.

It's no secret that, as the country has become much more diverse, the medical community has failed to keep up. This is unacceptable.

The dismal representation of black men in medicine is especially discouraging. In 1980, black men made up 3.4 percent of all matriculants in U.S. medical schools; they remain at 3.4 percent today.

Meanwhile, our Latinx and American Indian or Alaska Native populations are also underrepresented. In 2019, 11.3 percent of first-year enrollees are Latinx students, while there are only 230 American Indian or Alaska Native students enrolled in medical schools across the country.

This, too, is unacceptable.

Indeed, every time I look out into rooms like this one, brimming with bright minds and bold ideas, I'm reminded of the people who are not here to contribute to the conversation and make us stronger with diversity.

Their absence is not just unfair — and counterproductive and wrong. It weakens us as a profession. It is also self-perpetuating. It sets in motion — or keeps in motion — a cycle of exclusion and lost opportunity. Because when bright young people of any background or identity look at our profession and don't see role models who resemble themselves, they are less likely to enter the field.

It also undermines the effectiveness of the entire system.

Substantial research shows that racial and ethnic minority patients, LGBTQ patients, and disabled patients have less access to care, and experience worse outcomes, than white, heterosexual, cisgendered, and nondisabled patients.

To bridge the enormous disparities in health within communities, we must first confront the racial gaps in our own community of academic medicine and foster more diverse and inclusive environments in our institutions.

Only when all groups feel they belong and contribute to the fundamental fabric of the academic medical institution will we see durable increases in diversity among our learners, faculty, and leaders. And it's not just the ethical imperative. A growing body of evidence suggests that more diversity in many settings makes us more effective.

For our part, the AAMC is actively working to increase opportunities for underrepresented students in medicine and biomedical research with a range of partners and allies. At the same time, I believe we must begin much earlier in the educational continuum than college — as early as middle school — and to seek new partners in that effort, including historically black colleges, Hispanic-serving institutions, and local school districts.

I will say I'm encouraged by our progress when it comes to gender diversity.

Back when I was a med student nearly 50 years ago, women accounted for barely a fifth of enrollees in U.S. medical schools. Last year, women made up most new students, and in 2019, for the very first time, women constitute the majority of all enrolled medical students.

That's something to celebrate — though we are still a long way from achieving parity among faculty, let alone in leadership positions.

As Lilly mentioned, the AAMC Board has made gender equity one of its top priorities. Ending gender harassment was the theme of our Leadership Forum in June, reflecting the urgency of an issue that affects 40 percent of women medical students and 58 percent of all women faculty.

Soon, we will be seeking your participation in a new nationwide initiative to improve gender equity, including closing the pay gap, promoting more women to positions of leadership, and ending harassment.

These efforts to promote diversity and inclusion in academic medicine are an important start. But there is more that each of us must do.

We need to be intentional in our actions. But we also need to be accountable for our results.

As a first step, I have asked the AAMC Board of Directors to hold me accountable for the diversity and the climate of our association. In turn I've added this to the responsibilities of the entire AAMC Leadership Team.

Today, in that same spirit, I ask each of you — deans, CEOs, faculty, learners, researchers, and staff — to accept this responsibility for yourselves and your organizations and to set a goal with me: that when we are back together each year, we will have improved the diversity of our institutions both in terms of composition and climate.

Let's do this together.

## **MENTAL HEALTH AND SUBSTANCE USE DISORDERS**

Next, I want to discuss two issues that have affected many of us personally and that we see firsthand in our institutions every day: mental illness and substance use disorders.

In 2018, nearly 48 million Americans — one in five adults — experienced some form of mental illness. Nearly 18 million suffered a major depressive episode. More than 20 million had a substance use disorder — and almost 50,000 died of opioid overdoses alone. And let's not forget the immense, ongoing problem of alcoholism.

Meanwhile, the national suicide rate has climbed to its highest point since World War II. According to the American Foundation for Suicide Prevention, there is an average of 129 suicides in the United States every day and about 1.4 million suicide attempts every year.

These trends are exceedingly troubling and demand focused action on all our parts. Some of the causes are out of our control, but many are within reach.

From my perspective, we must address three important factors:

First is the stigma of seeking treatment. Many people still fear that getting the help they need will result in harsh judgment from the people they care about most — their families, friends, coworkers, and employers. All too often, this means they keep their mental health problems hidden.

Second is a lack of access to trained mental health professionals. Last year, a study in the *American Journal of Preventive Medicine* found that 65 percent of non-metropolitan counties in the U.S. did not have a single psychiatrist and nearly half lacked a psychologist.

And according to the National Council for Behavioral Health, the 38 percent of people who *do* have access to mental health services face wait times of more than a week — far too long for a patient in crisis. I am particularly concerned about our neighbors in inner cities and in rural or frontier areas, where social determinants of health, which remain unaddressed, make access to care particularly important.

Third is the lack of adequate coverage for mental health care. More than a decade after Congress passed the Mental Health Parity and Addiction Equity Act, true equity remains elusive. Some insurers continue to restrict or deny coverage for mental health services. And patients are finding it harder to locate a provider who takes their insurance.

Here, again, the status quo is unacceptable.

We in the medical community need to do more to help address America's struggles with mental illness and substance use disorders, starting with our own institutions.

We know that suicide is a major problem on the campuses where we work. We also know that burnout and depression constitute a growing crisis in the medical field, particularly among learners and their mentors. We can start, as I mentioned, by helping to reduce the stigma of asking for help.

That begins with sharing our own stories.

When I was president of Cornell University our campus was badly shaken by the loss of multiple students who took their own lives in a single year. I felt it was important to address our grieving community and encourage anyone who was suffering to seek help.

So, I recorded a message to students in which, among other things, I talked about a tough time in my education when my father was sick, and my grades suffered. I got counseling that, to this day, I credit with saving my life and career.

I hope other leaders in academic medicine will join me in sharing your experiences. It's essential for people in our community to hear that, by seeking help, many of us who once suffered were able to survive and thrive.

If you have had such experiences, please be open about them. Show others that seeking help is not a weakness, but rather a form of life-sustaining strength.

We also need even better teaching strategies — and I am encouraged by the work happening at medical schools across the country and at the AAMC to educate students about substance use disorders in general and, more specifically, about opioid addiction and pain treatment.

I am also proud of the work that the National Academy of Medicine Action Collaborative on Clinician Well-Being and Resilience is leading on these issues. These are all positive steps, but there is more we need to do.

We need to integrate mental health education across all the health professions.

We need to add more doctors trained in addiction medicine and ensure that all physicians get ongoing education and training.

We need to think more broadly, beyond the strengths of cognitive behavioral therapy, and consider the lessons of other interventions such as 12-step and peer-counseling programs, which are among the most successful approaches but are still not, in my view, sufficiently discussed in our medical curricula.

We must continue to increase our emphasis on more recent innovations, such as medication-assisted treatment, to ensure that students and clinicians are equipped with the latest and most effective tools to combat these crises.

We must work with our public health colleagues and local partners to identify unlikely opportunities for intervention — such as the Oregon county that reduced suicides by 40 percent by identifying recurring patterns in the behavior of individuals who took their own lives like checking into motels or leaving pets at animal shelters — and training workers at these locations to recognize signs of distress.

And finally, we need to keep advocating and working with insurers and pharmaceutical companies to eliminate structural barriers to access and coverage — barriers that prevent people with mental illness and substance use disorders from getting the care they need.

Let's do this together.

## **RISING COSTS**

That brings me to the third challenge I want to discuss — an issue that we've heard about at every presidential debate, not just this year, in the run-up to 2020, but in every election as far back as I can remember.

I am referring to the rising cost of health care in the United States.

You've all heard the numbers: Last year, the U.S. spent an estimated \$3.65 trillion on health care, which translates to about \$11,000 a person – higher than any other developed nation. And it's projected to grow at an annual rate of 5.5 percent over the next decade.

This level of spending might be tolerable if Americans were receiving more and better care than people in other countries and had better outcomes. But the opposite is often true. American patients have fewer hospital discharges, shorter hospital stays, and less access to a doctor's care than their European counterparts. They also, in many cases, experience worse outcomes.

There are a variety of reasons for this, including that waste accounts for up to a quarter of all health care spending, with the highest burden coming from administrative costs, according to a new study in *JAMA*.

But one other undeniable factor stands out. As the late, great health economist Uwe Reinhardt famously put it, "It's the prices, stupid."

As you know, patients in the U.S. pay much more than patients in other countries for the same health care services. One example: the price of an appendectomy is around \$2,000 in Spain or \$3,800 in Australia. Here, the average sticker price approaches \$16,000. And that's not to mention the price differences from state to state and even from plan to plan within the same hospital.

The status quo is clearly not acceptable to our patients. It shouldn't be to us, either.

There are meaningful steps that we can take to address this challenge.

I'll give you one.

As many have observed, our current health care system still has too many incentives for volume and not enough for quality. These incentives drive up costs, clearly; they also create potential conflicts of interest.

Now, I speak from experience. As a cardiologist, I used to evaluate patients and perform echocardiograms. I would see a patient for, say, 20 minutes and bill a certain amount. But then, if needed, I could refer the patient for an echocardiogram, often to myself, and, in an hour, bill multiple times the cost of the office visit.

This wasn't out of the ordinary. It was simply how the system worked.

Often, these were important and necessary procedures. But while we have made strides in focusing on value, today there are still tremendous incentives to focus on volume. It's easy to see how volume incentives might change behavior, even at the margins.

There are a number of possible remedies, some of which are being explored at our member institutions, that I believe merit serious consideration by us all.

First, we need to focus on decreasing the cost of care for each admission or episode. Do we really need to perform that extra echo, lab work, or other test, particularly when it may have been done recently?

I also believe it is time to consider working faster toward replacing the fee-for-service model with physician salaries. The Mayo Clinic and the Cleveland Clinic, among others, have successfully made the transition, proving that it's possible — at some of the greatest medical institutions in the world, no less.

And recent data suggest that many physicians would be comfortable with — and even prefer — a salaried arrangement, along with limiting bonuses based on volume incentives. Given the scope of the problem, I think the approach deserves wider consideration. While we exist in a payment world that rewards clinicians and institutions largely on volume, can we lead the way toward a system that rewards us differently?

In addition, we must incorporate population health approaches such as accountable care organizations and bundled payments into our care models and do a better job of providing preventive care.

Finally, we need to make better use of interprofessional teams for patient care. By expanding opportunities for coordination with our colleagues in the nurse practitioner and physician assistant communities, we can accelerate progress in both access and cost-effective care.

One sensitive issue that is, nonetheless, important to discuss more fully is the extent to which increases in the scopes for other members of the health care team might help to ameliorate our current and predicted physician shortages. This must, of course, be done carefully and must be based on evidence and not emotion, but I believe it's an option that should be actively pursued.

Again, these are just a few ideas. But I believe they could make a real difference.

Let's do this together.

## **LESSONS AND CALLS TO ACTION**

Of course, these are just three of the many ways in which the status quo is unacceptable at a national level.

Yet I hope we won't lose sight of what we can do closer to home — and the role that we in academic medicine can play in solving challenges within our own institutions.

I believe that we have the best chance to make progress if the change is planned and carried out by members of our community, and not dictated by those outside the health professions who lack our knowledge of the system's nuances — and its possibilities.



Who better to challenge the status quo and create the change we urgently need than the people in this room and our colleagues in academic medicine? Who better than our learners?

Together, we — all of us — wrote the book. Now let's rewrite it and add some chapters.

For example, leaders in education must evaluate whether curricula are adequately attuned to both the needs of the moment and the challenges of the future.

I believe there are two keys to optimizing our evolving curricula:

First, we need to lead a serious national conversation about what it truly takes to become, and remain, an excellent physician in these rapidly changing times. Only when we've answered this question can we be confident that medical schools and postgraduate training programs are preparing the next generation of physicians to thrive in new learning and workplace environments.

Once we have identified these factors, we need to focus more directly on assessing learning outcomes and collaborating as appropriate not only with other medical organizations, but also with colleagues in schools and departments of education at our own and other institutions.

While medical school is foundational, it is of course a small fraction of a physician's career. As health care evolves, the continuing medical education domain will require the same level of attention to competencies — the same rigor to assessing learning outcomes — that we see, or must see, in medical schools.

Those in academic leadership positions might also reassess the wisdom of expecting professors to be so-called triple threats who are outstanding caregivers, teachers, and researchers all at once. This is certainly possible in some cases. But it's essential that faculty members are empowered to excel in their greatest areas of strength and expertise. That is what will make the system more effective overall.

On the research front, we must strive to strike an appropriate balance between supporting established investigators and accommodating first-time grantees and early-career scientists. Dr. Francis Collins and his colleagues at the National Institutes of Health are leading the way on this critical issue.

It's extremely hard to predict the long-term significance of an isolated research finding. For that reason, we must do everything we can to provide consistent funding for investigator-initiated, curiosity-driven, peer-reviewed research by scientists at all stages of their careers. And we must incentivize collaboration across our great institutions to address our most difficult and persistent challenges.

Finally, in the realm of patient care, we must find a way to contain costs. I've already discussed a few ideas.

But tackling this problem will also require system-wide collaboration. I believe that academic medicine can play a central role by acting as a convener — bringing together insurers, pharmaceutical companies, and leaders from the broader medical community, as well as patients, families, and community members, to devise the solutions that patients clearly need. And I intend to convene those conversations.

Whether we are focused on the entire country or a single medical school department, there are some important principles that we can apply to the challenges we face.

So, before I close, I would like to share just a few of the most important lessons I've learned over the years. These are lessons that I believe are equally applicable whether you are a dean, a clinician, or a hospital CEO — a professor, student, resident, or colleague of any kind — and that I hope to bring to our work together at the AAMC.

First: Collective wisdom is infinitely more valuable than an individual perspective. In my experience, bringing a wider range of perspectives into the decision-making process consistently leads to more robust solutions.

Second: Grand solutions are enticing, but also elusive. The best way to solve enormous challenges is often to break them down into their constituent parts and tackle them one by one. The bigger the challenge, the more this tends to be true.

Third: Effective leaders strike a balance between confidence and humility. No matter how much expertise we have, it's important to maintain our desire to learn from others. We can all benefit from the Zen concept of the beginner's mind, which is to be open to new observations and, therefore, new ideas. As the aphorism goes: "In the beginner's mind there are many possibilities, but in the expert's mind, there are few."

Fourth: We should never be afraid to experiment with new ideas. Progress — in medicine, in science, and in society — requires taking risks and trying new things. The key to this approach is establishing clear measures of success, and then being willing to walk away from experiments that do not succeed.

And finally: Leadership accountability matters. In fact, it is essential to change the status quo. The forces of inertia and resistance to change are simply too great. Leaders, like everyone in this room, must stand up and say: Enough. The status quo is unacceptable.

These lessons guide my thinking every day. I share them with you now because everyone in this room has a role to play in challenging the status quo.

Many people across our academic medical community have asked: What are my plans for the immediate future of the AAMC?

For my first year, one of my primary aims is to listen to you and your colleagues throughout the AAMC family. Thanks to your willingness, I am already learning an enormous amount about your concerns, aspirations, and hopes for our professions.

Another key goal is to complete a bold and thoughtful strategic plan for the AAMC that will help us focus not only on the areas of greatest concern, but on other important areas where we have the capability to supply new and effective ideas to improve the health of all through education, discovery, and clinical care.

At the AAMC, we are well along in the process of developing a shared understanding of the environment in which we are working, and the themes of our strategic plan will follow soon.

Last of all, I want us to speak out more boldly and effectively on the myriad issues of the day related to our callings. I will do my part to add the voice of academic medicine to the national dialogue. You have the knowledge, you have the ideas, and you have the standing to add your voices as well.

I hope you will join me in this great endeavor. Together, we will break through to find durable solutions to our thorniest challenges. I know we can do this. In that effort, I ask for your partnership, today and far into the future.

Let's do this together.