

AAMC Chair's Address 2019
"Navigating a New Normal"

Lilly Marks, vice president for health affairs for the University of Colorado Anschutz Medical Campus and chair of the AAMC Board of Directors, delivered the following address at Learn Serve Lead 2019, the association's 130th annual meeting in Phoenix, Ariz., on Nov. 10, 2019.

I am deeply honored to be standing before you today as chair of the Board of Directors of the AAMC. It has been a great privilege to work with the talented staff and a tremendous Board of Directors during such an important transitional year.

There have been many significant accomplishments this year, but I'd like to lead off this morning by highlighting two major Board efforts in particular because of the power each has to dramatically shape the future of academic medicine and the AAMC.

First, of course, is the recruitment of Dr. David Skorton as our new president and CEO. I am confident that David will build on Dr. Darrell Kirch's many notable contributions during his 13 years at the helm.

I am also certain that David will provide his own extraordinary leadership and vision, helping the AAMC further enhance its value to members and hone its voice as the preeminent representative of academic medicine.

Please join me in offering a heartfelt thank you to Darrell and a very warm welcome to David Skorton!

The second hallmark of the board's work this year is the launch of an AAMC-wide initiative to explicitly address the issues of gender equity and gender harassment in academic medicine. It has been our goal to go beyond statements and platitudes and work to find actionable, effective strategies for addressing these decades-old gender inequities.

Our institutions cannot be successful if we marginalize 50% of our talent pool through harassment, structural barriers, and explicit or implicit bias. We are *all* diminished if we keep women's voices from being heard, their talents and contributions from being recognized, and their dreams from being realized.

And the same goes for *all* the diverse and underrepresented members in our community.

Finally, before continuing, I'd like to add two personal thank-you's. First, I must recognize my husband Bob and my daughters Lara and Deborah who are here today. I know the demands of my career have significantly impacted each of you over the years. And it hasn't always been easy for you. I am so grateful for your incredible love and support and am so blessed to have you in my life.

I also offer profound appreciation to my colleagues at the University of Colorado who, throughout my career, have been willing to look beyond the traditional pathways and profiles for leadership. I thank them for recognizing that an unconventional candidate — such as me — might have something valuable to contribute to the leadership of a major academic health center, and for having entrusted me to hold the beating heart of our campus in my hands.

This summer, my husband and I visited the magnificent national parks of Utah — Bryce, Zion, Arches — and marveled at the spectacular landscapes shaped by the powerful forces of wind, water, and erosion.

This morning, I would like to address the changing landscape of academic medicine. It, too, is being reshaped by powerful environmental forces of demographics, economics, politics, and the marketplace, all of which are converging to challenge — and potentially erode — the core missions of academic medicine.

Our institutions are unified by the same missions.

Collectively, we are the major educator of the nation's health care workforce. We are the epicenter of medical research and innovation. And we are recognized for our comprehensive, leading-edge clinical care across all specialties, ages, and economic sectors of society.

The education, research, and patient care that we provide are critical public services. Yet virtually all our institutions now face the enormous challenge of funding and delivering these public goods in an era when society is questioning the value of higher education, the veracity of science, and the cost and value of the health care services we provide.

Academic medicine is being challenged, first and foremost, by strong external forces. Over the past decade, many of our medical schools have had to adapt to significant declines in state and institutional support for education — cuts that cannot realistically be mitigated by further increases in medical school tuition.

Our research mission faces similar funding pressures. To sustain viable and successful research programs requires more than external grant support alone. Multiple cost studies demonstrate that internal cross-subsidies and investments, ranging from 30% to 50%, are also required of our institutions who want to be players in the research arena. Thus, most of our medical schools are engaged in a perpetual search for the revenue sources necessary to cross-subsidize both our critical education and research programs.

And where do we look for those additional funds? For most medical schools, it's the clinical margins that provide the primary source of vital academic subsidy support. The revenue generated by our clinical mission represents 60% or more of the average medical school budget.

The problem is that our clinical enterprises are facing the greatest external challenges of all our missions.

It would be nice to believe that what we are experiencing is temporary. That the storm will pass,

and we will return to normal.

Unfortunately, that is simply not true.

We cannot escape the realities that are conspiring to create what we need to recognize as a “new normal” in health care.

This new normal is defined, first, by the inexorable rise in health care costs brought on by the mounting pressures of an aging society; the impact of the nation’s unaddressed social determinants of health; and the enormous power, profits, and leverage of a market-driven and rapidly consolidating health care industry.

America has created the most expensive health care system in the world. A system that we, the richest country in the world, can no longer afford.

For economic context, consider this slide.

These five cars, and many more just like them, have something very important in common: you can buy any of them for about \$27,000 or less.

Compare that to the findings of national studies reporting the total cost of health care insurance and out-of-pocket costs for a family of four is now more than \$28,000 annually. That’s more than the cost of any one of these cars. Think about that!

That’s the equivalent of buying a new car for virtually every family in America — every year. Is that sustainable?

The rising cost of health care is nothing short of a national crisis. And it’s a crisis that many of us, in all honesty, have contributed to.

These environmental and economic realities ensure that health care — how it is organized, delivered, reimbursed, and governed — will remain a central focus of the public debate well into the future.

Regardless of which side of the political spectrum prevails in the 2020 elections, the outcome of this national debate will have profound implications for the patients we serve. It will also have significant financial and programmatic implications for academic medical centers and our continued ability to deliver on the promise of our missions.

Yet these external forces are not the only challenges we face. The internal strategies our institutions adopt in response to these environmental imperatives are also changing, and potentially eroding, the landscape of academic medicine.

Let me explain.

To remain successful in a rapidly changing health care environment, many of our institutions are

restructuring and rebalancing both our clinical and academic enterprises. From a clinical and economic perspective, these decisions make absolute sense.

But we must also consider the serious implications our actions may have for our schools, faculty, students, and missions. The external threats to our clinical revenue and margins have led many academic medical centers to reorganize their structure, governance, physician employment, and cash flow models.

Many of us have built or expanded our own health care systems by merging, acquiring, or partnering with community hospitals, and in some cases, with for-profit systems or even private equity firms. Strong market imperatives have driven these strategies, and many of them have been very successful in achieving the goal of protecting our clinical revenues.

Yet, as I'm sure some of you have experienced, these actions have also created some unintended consequences. We now face significant new internal challenges that come with merging different corporate and financial structures, governing boards, and the different cultures and DNA that characterize our new blended families.

What concerns me most of all is the impact of another emerging trend. And that's what I'd really like to talk with you about.

For a growing number of schools, the intensified focus and priority of protecting and growing the clinical enterprise is shifting the center of gravity and the locus of power away from the academic institution and toward the clinical enterprise, disrupting more equitable and collaborative partnerships.

While that may not have been our intention, I believe we must all ask ourselves some fundamental questions:

- What does this shifting power equation mean for the role of deans and chairs and other academic leaders?
- Are their voices and critical perspectives being muted or excluded from important enterprise-level discussions and decisions?
- What does it mean for our faculty who, in some cases, are already feeling marginalized, commoditized, undervalued, and burned out?
- What does it mean for our learners who may face some uncertainty about the stability of their training opportunities?
- What does it mean for our faculty practice organizations, some of which are being sold or transferred from the school to the hospital system, thus separating the stewards of the mission from the stewards of the money?

In those cases, who prioritizes the use of the physician clinical revenue streams that medical

schools have historically controlled — and relied upon — to provide critical subsidies to the academic missions that define and enhance both our schools and hospitals? Can academic medicine survive if we seek margin, not as support for our missions, but as our mission?

There are, of course, no easy answers. There is, similarly, no grand solution to the challenges we face. But there *are* steps we can take as a community to promote the success of the clinical enterprise while protecting academic medicine's unique and differentiated role at the epicenter of American health care.

It will require us to adopt a new mindset and a more holistic approach to change.

For example, I believe our institutions should expand our due diligence efforts when creating new clinical structures, systems, and relationships. We currently conduct extensive and sophisticated analysis of the risks and rewards of these new ventures to the clinical enterprise.

As we should! Yet we often fail to perform the same level of due diligence on the potential impacts — positive or negative — on our academic enterprise.

It's time for that to change.

If we are entering a new normal in health care, I believe we have a duty to ensure that the integration of the clinical enterprise does not lead to the disintegration of the academic enterprise. We must devote the time and political capital necessary to ensure that our new structures, agreements, funds flow, and employment models provide the critical commitments and protections necessary for the survival of our academic missions.

We must build these fundamental protections directly into the basic architecture of our new clinical enterprises.

That's hard work we sometimes avoid, relying instead on statements of good faith and good will. Statements alone won't withstand the tests of time, memory, or subsequent changes in leadership.

We must all remember — and reinforce — what makes our institutions special in the first place.

Our ability to fuse the latest learning and medical discovery with the clinical care we provide is the defining characteristic of academic medicine. It is the secret sauce that differentiates us from other clinical providers in the community.

All of us must commit to the critical task of ensuring that the survival and integration of our three missions will continue to blaze the way to better treatments, outcomes, and cures.

The power of our integrated missions is at the heart of our public narrative when we seek preferential consideration from legislators, payers, donors, and patients. We must ensure that it remains at the heart of our internal narrative as well.

And for academic medicine to retain our position of national trust and leadership, we must also continue to ask ourselves other hard, uncomfortable questions. For example, is bigger better or is *better* better? They need not be mutually exclusive, but neither are they automatically the same.

In our quest to grow our health systems, will the billions of dollars of debt and real estate we've added to our balance sheets become an anchor? An anchor chaining us to preservation of the status quo rather than motivating us to be leaders in creating innovative delivery and reimbursement models crucial to success in a health care world poised for disruption?

Given the critical need for clinical revenue and margins, how do we balance our necessary pursuit of "principal" with the protection of our core values and "principles"?

Let me be very clear. I fully recognize the financial and market imperatives that require our institutions to better align ourselves with the evolving consolidation and challenges of the health care landscape.

As chair of the board of University of Colorado Hospital, I played a large part in our own efforts to develop our UCHHealth system in 2012, and it has been incredibly successful both financially and competitively. Yet my experience also informs the very real concerns that I am raising today.

Having spent most of my four-decade career at the intersection of our academic and clinical enterprises — and having served in multiple leadership roles across our medical school, faculty practice organization, university hospital, and health campus — I have learned that virtually anything we do to promote one of our missions significantly impacts the other two, either for good or for bad.

I have seen it firsthand.

We must ensure that our necessary efforts to evolve do not inadvertently compromise the essence of who we are and the unique role we play in American medicine.

Tomorrow, we will hear Jon Meacham talk about the soul of America. What I'm talking about today is how do we preserve the soul of academic medicine.

We are all stewards of academic medicine in this country. We cannot avoid the challenges and risks of traversing new landscapes. But we have an obligation, as leaders and faculty, to work collaboratively to sustain all three of our essential missions, lest we be judged like the witch in this Gary Larson cartoon.

"What! We hired you to babysit the kids and instead you cooked and ate them both!"

It has not been my intent to focus only on the litany of problems. I truly believe there are achievable solutions.

And, as I look at the immensely talented people in this room, I am confident that, together, we can address our challenges and emerge even stronger. My hope is that both the AAMC and our member institutions will focus our attention on improving not only our institutional interests, but also America's health care system.

Ours is a power fueled by our intellect, honed by our experience, and inspired by the heroic and transformational work that takes place within our walls every day. Let us harness that incredible power for the good of all Americans.

With that, I want to conclude our discussion by addressing two critically important issues in these challenging times: resilience and survival.

On an individual level, we know that resilience and burnout are growing concerns in the medical community. Meanwhile, on an institutional level, basic survival has recently been called into question as we witnessed the unfortunate demise of Hahnemann, the major teaching hospital affiliated with Drexel University College of Medicine.

Will there be other high-profile losses ahead?

None of us can guarantee what the future holds, but I'd like to share a lesson I've learned over the years about resilience and survival because both are critical in shaping our future.

In his wonderful book *Good to Great*, management expert Jim Collins sought to identify the defining characteristics of great organizations and leaders. Among those he interviewed was Admiral James Stockdale, the highest-ranking prisoner of war held by North Vietnam. A POW for eight years, Stockdale's leadership was widely credited with saving many of his fellow prisoners.

Collins asked Stockdale to reflect on any differences between the prisoners who survived their captivity and those who did not. Most of the survivors, Stockdale said, exhibited a powerful psychological duality. They confronted the brutal reality of their circumstance, yet they still maintained a deep faith that they would prevail in the end.

By contrast, he observed that it was often the *optimists* who perished — those who told themselves that they would be saved by Christmas, or Easter, or their birthday, and they just needed to hold on until then. But year after year, those milestones came and went, and nothing changed.

The optimists, said Stockdale, ultimately died of a broken heart.

I've often thought about the subtle difference between optimism and faith underlying what Collins labeled the Stockdale Paradox.

Optimism is a passive hope. It relies on the belief that your circumstances will improve, irrespective of your actions. A belief that the cavalry will ride in and save you.

Faith, however, is something far more substantial. Those with faith believe they will prevail, but also understand the need to actively confront their circumstances in ways that might contribute to saving themselves.

The Stockdale Paradox resonates deeply with me because it echoes the most important lesson that I ever learned from my father.

Few people know that I was born in a refugee camp in Germany following World War II. Both of my parents were Holocaust survivors. My father survived Auschwitz, my mother, Bergen-Belsen.

When I was growing up, my parents rarely talked about their experiences except in the most general terms. But as I grew older, I became interested in whether there were unique characteristics intrinsic to survival, and I had many profound conversations with my father.

He repeatedly told me, “Lilly, to survive life’s difficult challenges, you can never think of yourself as a victim.”

You don’t have to experience something as horrific as war or a holocaust. Too often, people see themselves as victims of all types of environmental and human challenges.

He cautioned that, if you believe you are a victim, it diminishes your resiliency. If you believe your fate is in someone else’s hands, it inevitably weakens your response.

Over time, it makes you feel powerless, thinking your actions don’t matter or affect the outcome. In life, you may actually encounter people who count on exploiting your anger, victimhood, helplessness, and hopelessness.

The key to resilience and survival, he explained, is confronting your challenges every day with the courage, tenacity, and the faith that what you do, and how you do it, makes a difference.

What defines you are not the challenges that befall you. What defines you is how you respond.

So, with that piece of wisdom from my father, I want to end with this magnificent quote by another Holocaust survivor, the noted psychiatrist Victor Frankl. In his book *Man’s Search for Meaning*, Frankl wrote: “Between stimulus and response, there is a space. In that space is our power to choose our response. In our response lies our growth and our freedom.”

All of us here today, and the institutions we represent, are now in that space between stimulus and response that will determine our future. Just as individuals can take on a victim mentality in difficult times, institutional cultures can also develop a victim mentality.

These are clearly difficult times as the missions of academic medicine are being threatened. Some schools and health systems will succeed while others may falter. We are in that space and can choose to see ourselves as the victims of change and circumstances beyond our control.

Or we can choose to be the architects of change, responding boldly, resolute in the belief that our actions *will* make a difference.

Today, it is my hope that we will choose to meet this moment with leadership, creativity, collaboration, and courage. To redouble our commitment to the indispensable and integrated missions at the heart of academic medicine. And to become the architects of change who will lead America's health care system into the future.

My career has many, many more yesterdays than tomorrows. But *you* are the future of academic medicine. Whether you are at the beginning of your careers, or hold leadership roles at this pivotal time, what you do now and how you respond in that space will define academic medicine and health care in America for many years to come.

Thank you very much for the great honor of serving as chair of the Board of the AAMC.