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THE AAMC ANNUAL MEETING

LEADERSHIP PLENARY ADDRESSES

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Chair, AAMC Board of Directors

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President and CEO, AAMC



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, Arizona, on Nov. 10, 2019

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NAVIGATING A NEW NORMAL

AAMC CHAIR'S ADDRESS 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.

A woman with short brown hair, wearing a patterned yellow and grey jacket, is shown in profile from the waist up, speaking. The background is a soft, out-of-focus light blue.

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.

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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 with, 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.



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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.

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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 us to better align our institutions 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 UCHealth 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 who says, "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 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.

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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.



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, Arizona, on Nov. 10, 2019.



A photograph of the AAMC President, a man with glasses and a suit, speaking at a podium. The background is a large screen displaying the AAMC logo in white on a blue background.

THE STATUS QUO IS UNACCEPTABLE

AAMC PRESIDENT'S ADDRESS 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.”

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We need to step up and lead beyond the boundaries of our institutions to improve the nation's health.”

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.

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% of all matriculants in U.S. medical schools; they remain at 3.4% today.

Meanwhile, our Latinx and American Indian or Alaska Native populations are also underrepresented. In 2019, 11.3% 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 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

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in June, reflecting the urgency of an issue that affects 40% of women medical students and 58% 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.

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% 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% 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.



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We [...] need to do more to help address America's struggles with mental illness and substance use disorders, starting with our own institutions.”

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 their 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% 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.

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% 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 and \$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.

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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 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.

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.

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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 in 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 systemwide 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 for changing 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?

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I want us to speak out more boldly and effectively on the myriad issues of the day related to our callings.”

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| Let's do this together.”

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.



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