



AAMC Board Chair’s Address 2020
“Learners and Justice: Our Present and Future”

Joseph E. Kerschner, MD, dean of the Medical College of Wisconsin School of Medicine and chair of the AAMC Board of Directors, delivered the following address at Learn Serve Lead 2020: The Virtual Experience, the association’s 131st annual meeting, on Nov. 17, 2020.

Good afternoon. It is an enormous privilege to address you, my colleagues, during this leadership plenary.

As I began to consider what I might say, I was struck that whatever I might impart would fall short of the amazing words of wisdom delivered with such eloquence and passion in many of the past Learn Serve Lead addresses by those who preceded me as Board chair.

Certainly, the address by Lilly Marks last year highlighting the need to emphasize the “academic” in academic medical systems was a call to action.

“When facing a challenge,” she said, “what defines you is how you respond.”

This advice could not possibly be better during our current circumstances in academic medicine — and throughout our country — as we face challenges related to economics, health, and justice.

And only two years ago, Dr. Roy Wilson delivered his address — one that moved me to the depth of my soul — imploring the audience to do more to bring equity to academic medicine, health care, and our greater society.

Again, these words have an added meaning and emphasis today.

Before proceeding with some of my own words, which I hope will provide some modicum of inspiration or reflection, I wish to acknowledge that it has been a great privilege to serve as chair of the AAMC Board of Directors.

The AAMC is a unique organization with a unique position to influence medical education — a primary emphasis of my address today — research, and our nation’s health.

I have learned a great deal from the outstanding members of the Board with whom I have served, and I am grateful for their wisdom and tireless efforts in support of the AAMC’s mission.

I truly have enjoyed every minute of working with the AAMC’s CEO and President, Dr. David Skorton, and his tremendously talented leadership team. They and the AAMC Board have moved

this organization a great distance forward over the past year. I hope that this has been apparent to all of you as well.

One major accomplishment is the AAMC's new strategic plan, which will position not only the AAMC, but all of academic medicine, on an enormously positive and impactful trajectory.

The engagement of the AAMC in the most important national conversations on medicine, health, and medical education has never been more crucial.

The world has changed in so many ways since I first began thinking about this address, but the place to which my heart, mind, and passion was initially drawn — in both my leadership tenure of the AAMC Board and in this address — has not changed.

Although our current landscape contains a broad range of issues that need solutions, I have always tried during my leadership year on the AAMC Board to put learner topics front and center, because at the very core of the AAMC, our organization needs to be about our medical students and residents — who, after all, represent our future.

Not only are they our future, they are our present. And, when given a voice, they provide important insights and identify solutions to our current challenges.

I have experienced this numerous times when listening to learners who engage with the AAMC through our Board, through the Organization of Student Representatives, through the Organization of Resident Representatives, through students at my own medical school, and through other venues as well.

My first point to you today is that if you don't have a good understanding of the issues facing our learners at present, then you have some work to do!

And, if you think you know the issues faced by our learners, but you haven't specifically taken the time to talk and listen to learners, then you have some work to do!

Finally, if you know what the issues are and have discussed these issues with learners but haven't actively engaged with them in forming solutions, then you really must ask yourself, "Why not?"

I present these scenarios because I personally would have been in each of these categories during my development as a leader.

Of course, I cared about our learners — particularly those who were following in my chosen career path of otolaryngology — and especially those learners who were interested in academic medicine. However, more globally, I had distance I needed to travel to effectively mobilize my influence that might bring about needed change.

I am grateful to Dr. Marie Walters, an MD-PhD student at Wright State University, who has served as the medical student learner on the AAMC Board during my tenure.

In that role, she has consistently helped elevate the “voice” of students everywhere and facilitated my listening to the voices of medical students.

Dr. Walters, after consulting with numerous student colleagues across many institutions, also discussed with me the topics students identified as the most important areas for emphasis by our medical schools, academic health systems, and the AAMC.

The first is **learner well-being**.

This is at the top of my list — and at the top of the list for the medical students at your institutions as well. We simply cannot be satisfied with the state of our overall learner well-being.

Although there are encouraging trends, and progress is being made, the overall levels of depression and distress for physicians (and other health care professionals) remains enormously high, and the evidence is clear that these difficulties begin early in one’s journey to becoming a physician.

Changes to curricula and how we assess students are making a difference. I personally believe that the recent change to pass/fail for the Step 1 exam also will have a positive impact.

But we must do more to explore access to mental health resources, financial support, and milestone-based curricula that will provide more flexibility to our learners as they progress in their development.

I believe we must provide the ability for a student to finish medical school and residency in less time, or more time, than the “standard number of years,” depending upon her or his previous experiences and aptitude in various parts of their training.

We need to find a way to allow students to begin residency at multiple intervals during the calendar year. This will not only facilitate flexibility and process moving forward but also will provide the additional benefit of having our newest physicians enter our health systems as residents during multiple points of time — rather than essentially all of them on July 1st.

We must improve overall learning environments and continue to assess how we provide instruction and evaluation.

As it relates to mental health, there is not a single one of us who does not have a personal responsibility to actively reduce barriers to mental health access and to remove the stigma for those in our profession and others who seek healing when they are struggling with difficulties in mental health, addiction, and other related concerns.

How many of us, as leaders, have created a culture in which we engage in annual conversations with those who report to us about their mental well-being in the same manner and frequency as

we question the RVUs or NIH grants brought in by their faculty or balanced scorecard of their unit?

We can change our cultures, in part, simply by bringing the conversations forward and highlighting the importance of engaging in this manner. The currency of leadership is time — and, as leaders, if we do not spend time on this issue, we will devalue the importance of well-being.

How many of us, as educators, have stressed to our learners the importance of taking time for oneself and one's loved ones with the same passion that we have stressed completion of the latest research project or preparation for the next presentation on rounds?

How many of us have been concerned that one of our students or colleagues is struggling and have “cleared the deck” to really talk to her or him to provide guidance, resources, and support?

How many of us, after that conversation, have decided, “This person needs time away to heal,” and have enabled a process for an individual — including a highly compensated leader or a resident learner that we simply cannot do without — to take time off with pay and support and with a guarantee that her or his position, standing, and esteem would be protected and intact upon their return?

Well-being and mental health are broad topics, and much of the literature emphasizes the need for system approaches to these difficulties. While I agree with this conclusion, I believe that the most critical systems change we need — throughout medicine and education — is a change in our culture.

Until we enable our culture to truly see those who are suffering and remove negative connotations attached to this suffering and what is needed to support our colleagues, we will continue to risk our own and our colleagues' mental health and wellness.

A favorite saying of mine is, “Our attitudes influence our perceptions, which in turn create our realities.”

The message of hope embodied here is that we all can help in changing our culture to change attitudes and perceptions so that our reality for the health and well-being of our learners — and, really, all who pursue health and science careers — will improve!

The second area I wish to emphasize is **student debt and transition to residency**.

Often linked to well-being for our learners is overall debt and residency opportunities — or competitiveness.

I will focus here mostly on the overall debt of our learners.

But first, I will say that I do believe that great progress is being made on the residency competitiveness issue. I am extremely excited for the continued focus in the AAMC strategic plan on improving the transition from medical school to residency.

Related to student indebtedness, I believe it is time for a national strategy.

The U.S. is an anomaly in the world, in which those who have chosen to dedicate their lives to the practice of medicine are often asked to take on an enormous debt burden before they even begin to see patients.

We have resisted solutions to this problem in the U.S., in part because it has been said that physicians will be well compensated and can afford to pay back loans — or that many who attend medical school already come from privileged backgrounds and can afford to pay their own way. Certainly, there is some truth in these assertions.

However, in relation to the need to encourage diversity in our medical profession, how many students from less advantaged socioeconomic backgrounds are discouraged from even considering the field of medicine because, early on, they learn of the overwhelming cost and debt that is required?

I believe that if medical school debt could be limited through means-based support of those with fewer economic advantages, our medical profession would quickly demonstrate progress in well-being and would make further strides toward a more diverse workforce.

This requires a national solution and a realization that our medical students are a national treasure who deserve our support.

However, absent a national solution, MCW and many of your institutions are placing greater emphasis on allocating resources through scholarships, endowments, and overall tuition forgiveness to those with fewer financial advantages to level the playing field.

I am hopeful that as we engage in conversations at a national level about the need to increase access to health care and the diversity of our work force, support for the education of our medical students will be brought into alignment with these conversations — and those who are driving policy improvements will understand the necessity of linking these issues.

The third area I wish to emphasize is **student diversity**.

Moving specifically to the topic of diversity, our students view this as a critical area in which medical schools must make improvements to enhance education, health outcomes, and bring much needed racial and social justice to our society.

Student leaders associated with the AAMC consider this issue as a most critical issue of our time.

While every LCME[®]-accredited medical school has a plan for enhancing diversity, and most have long-standing pipeline programs, we simply have not made enough progress in this regard.

We know, for example, that the matriculation rate for Black and African American men has not made any appreciable progress in 50 years! We must improve this metric significantly to ensure that our medical school classes resemble the population of patients that they will care for.

And we know that racial concordance between patients and providers can contribute to better patient communication, satisfaction, and trust — and that these attributes and others can provide at least a part of the solution to the lack of equity in health outcomes.

However, we have not yet constructed our admissions processes, pipeline programs, or support systems to enable this reality. Is it because our institutions and processes harbor implicit and unconscious — and, at times, even explicit — biases that impede this progress?

I believe that our medical schools and institutions must pledge to become anti-racist institutions and make additional progress to establish institutionwide practices related to unconscious bias training for all faculty, staff, and learners.

How many medical school admissions committees ensure that those entrusted with making the decisions about incoming medical school classes emphasize enhancing diversity and require unconscious bias training for committee members?

For those of you in positions of influence, what have you done today, this week, or this month to ensure greater diversity in your medical school's student body?

Will you, today, ask the question, “What is your institution's anti-racist plan?” Will you, tomorrow, ask about how your school's admissions committee is formed and what training is required? Will you, going forward, take an active interest in the pipeline programs for your school?

As you listen today, my ask of you is threefold:

One: If you are in a position of decision-making at your institution, when you make a decision that has a potential impact on learners, please ask, “How will this impact our learners?” But before you answer that question, I would suggest that you actually listen to the opinion of some students to ensure that you have it right.

Second: If you are a learner, and you believe that your voice is not being heard, find allies — they do exist at every institution, I assure you — to ensure that your voice is heard. It might be hard, it might seem “risky,” it definitely won't help you pass your Step exams, but it is important.

Third: If you are neither a learner nor a major decision-maker, ask how you can be a better ally for our learners. Ask yourself frequently how you might improve their environment and their support, how you might help elevate their voices and ideas — because they do matter.

How we listen and provide this support has the potential to change everything in medicine.

I am certain that there is not a single institution represented at Learn Serve Lead, or a single person listening today, who has not participated in some critical soul-searching about what, as individuals and organizations, we are doing — and will do — to enhance social and racial justice.

Many organizations, including the Medical College of Wisconsin, have committed to the process of being anti-racist institutions. We still have a long way to go, and we have made far too little progress, but it is critical that we seize the moment now — and we do not lose this momentum.

I would like to provide a personal story that I hope will illuminate my own progress toward better understanding.

When I was fortunate to enter the dean's office at MCW nearly a decade ago, there were many willing thinkers and doers who were already accomplishing much — and who were willing to do more through initiatives such as developing institutionwide goals that included equity, diversity, and inclusion; enhanced structures to measure pay equity; changes in policies influencing the manner in which inequities were handled; and institutionwide unconscious bias training that started with every leader and progressed to include all students, all staff, and all faculty.

As these efforts unfolded, I saw a tangible difference at MCW.

In our medical school, we had doubled the number of underrepresented in medicine matriculants. We were enhancing our pipeline programs, and students of color specifically shared with me their heightened feelings of inclusion at MCW.

Greater diversity in the leadership teams at MCW was noticeable, resulting from a rigorous process for ensuring greater diversity in faculty hiring and leadership searches.

On the financial side, data was now available around compensation, which provided an annual process to rectify gender-based and other inequities.

And we were in the early stages of developing a Center for the Advancement of Women in Science and Medicine, which would soon become a reality.

During this time of positive momentum, six years ago, a group of MCW medical students raised their concerns about police brutality, the Black Lives Matter movement, and racial injustice.

They requested support from my office for a “White Coat Die-in” — a national initiative in 2014 that many listening today will remember. My office was supportive and helped arrange for the most prominent location at MCW's Milwaukee campus for this to occur — the entrance to our Medical Education building.

The event took place and received some local media coverage.

Although I was well aware that MCW still had a great distance to travel, I remember specifically contemplating that this student-led “die-in” was yet another example of MCW’s progress on its journey to becoming an anti-racist institution — as well as a beacon in Milwaukee and Wisconsin related to racial and social equity and justice.

Fast-forward to 2020: ongoing police brutality; George Floyd’s senseless, horrific, and tragic death; and a Town Hall meeting shortly thereafter with MCW students to discuss these topics.

The meeting included panelists who provided expert opinions related to racial justice and steps to move forward. The conversation was honest and, at times, raw, but action-oriented — qualities that I believe embody a maturing, questioning, and vibrant organization.

One of the panelists, a person of color who had been a student at MCW during the 2014 “die-in,” provided her impressions of the event. She stated that she felt the event was an enormous disappointment. And why? Because of low turnout; the overall lack of dialogue about the event by leaders and the broader MCW community; and a general sense that this issue was not important at MCW.

And she was right.

Hers was the true story — not the one I had told to myself six years previously. It was not the “comfortable” narrative which I had constructed at the time of the die-in that rewarded a need I had to see progress.

I logged off the Town Hall meeting and reflected upon the “uncomfortable” place I now was in — and what I should have done differently.

I knew that I needed to acknowledge her story — part of which is telling it to you today — and I knew I needed to engage in additional dialogue. But more importantly, I needed to take concrete and meaningful steps forward to make MCW an anti-racist institution through changes in communication, policies, behaviors, and organizational structure.

One concrete step has been declaring and publishing MCW’s commitment to being an anti-racist institution, which has enabled a cascade of positive momentum around communication and organizational structure.

Additionally, to lead on a national level and enable progress across institutions, the AAMC last month released a framework to address racism in academic medicine; I sincerely hope you will read, comment on, and join the effort.

I would like to share several final comments:

One: I can’t say it any better than Bryan Stevenson did last year at Learn Serve Lead, when he suggested that we have an obligation to get proximate to the issues at hand.

Clearly, my own misinterpretations of student reactions following the “die-in” in 2014 were partly a result of my lack of proximity. In the current climate and dialogue around racial justice, the number of people I see who are seeking proximity suggests a hope that this time, things are going to proceed differently.

Second: I would encourage us all to work to elevate the voices of others.

This can be achieved via platforms large or small. But through these efforts, if we are going to participate in meaningful change, we need to take the time to listen and to reflect.

In my weekly Monday morning communiqué to the students, staff, and faculty at MCW, I have added the opportunity for other voices to be heard as guest columnists. This has resulted in a dialogue at MCW which has increased a richness of diverse experiences that many individuals, including me, could not have brought with authenticity.

Finally, if we hope to more rapidly “bend the arc of the moral universe toward justice,” as the Rev. Martin Luther King Jr. so eloquently told us, we must all continue to engage in dialogue, thought, and action.

We must increasingly see how the judgments we impart, the ways we consciously or unconsciously behave, and the decisions we make impact progress toward an inclusive, equitable and healthy environment for all.

I know that those of you listening today are often the driving changes within your respective institutions and communities — and that you are making a difference. And I know that you join me in acknowledging how much more change is needed.

As I step away from my leadership role on the AAMC Board, I pledge to continue this work with all of you. I pledge to continue with this dialogue, thought, and action, and I look forward to gathering with you — hopefully in person — at next year’s Learn Serve Lead!

Thank you.