CFAS Connects: A Conversation with David Skorton, MD

March 16, 2022

Opening comments:

Dr. David Skorton, MD, President and CEO of the AAMC, began the session with CFAS reps with comments on diversity, equity, and inclusion; wellness and resilience for faculty and students; and a renewed emphasis on community collaborations.

On the topic of DEI, Dr. Skorton highlighted the importance of approaching these issues with humility, openness, and a willingness to engage in ongoing dialogue. Many medical schools are committed to advancing DEI and the current student class is larger and more diverse than ever, but there is still much work to be done. More than 100 medical schools have agreed to complete the Diversity, Inclusion, Culture, and Equity Inventory (DICE) from the AAMC's Council of Deans (COD). The AAMC will produce a report showing aggregate data and trends across the various schools that participate.

Well-being in academic medicine, and among faculty in particular, remains a major area of concern for Dr. Skorton, who highlighted recent activity from the CFAS Faculty Resilience Committee, including the committee's report, *The Rise of Wellness Initiatives in Health Care: Using National Survey Data to Support Effective Well-Being Champions and Wellness Programs*.

Dr. Skorton described the AAMC's role in the Coalition for Physician Accountability, which is a group of leaders involved in the transition to residency. The Coalition issued recommendations last summer for comprehensive change and improvement for the UME-GME transition. The AAMC supports the concepts and themes in these recommendations and is working with its members to achieve their objectives.

The AAMC is also adding community collaborations as its fourth mission, alongside patient care, research, and education. Community collaborations are truly necessary in today's fragmented political climate. Academic medical centers should focus on learning from their surrounding communities.

Q&A:

Question: How do you see the role of CFAS as we tackle the big topics that health care has to deal with today?

Answer: The best thing CFAS can do with AAMC is to share opinions with David by emailing him directly at AAMCPresident@aamc.org or communicating through Eric Weissman. David is eager to hear from CFAS reps directly and welcomes disagreement and alternate points of view.

Question: A big problem in the UME-GME transition is who actually gets an interview. How do we standardize the interview process to give everyone an equal chance now that virtual interviews are commonplace?

Answer: Most of this will be decided at each institution locally and those decisions should be made by faculty members. The Coalition for Physician Accountability is still evaluating this. The issue is definitely

one of equity, though, because not every applicant can afford the expensive travel costs associated with in-person interviews.

Question: What's the national perspective on how The Match has gone so far?

Answer: Thankfully, no major IT issues have happened this year because of work the AAMC and the NRMP have done. The NRMP has changed the amount of time that unmatched learners have to submit their final bid from 4 hours to 22 hours. This time extension also helps program directors by giving them more time to manage the vast volume of applications.

Question: Could we separate the days that the program directors' rank order lists are due and the candidates' rank order lists are due, since they're both due on the same day? Could we make the program directors submit their lists two weeks before the applicants do and then whoever wishes to come visit the programs can do that, but it has no impact on whether those applicants are put on a rank order list? This way we could keep everyone doing virtual interviews to keep things equitable but applicants still do have the opportunity to come and visit programs without that visit affecting their applications.

Answer: David and AAMC leadership are regularly in touch with NRMP leadership on these questions and are aiming to achieve the most equitable outcomes.

Question: Who are the communities we should be reaching out to and where is the best place to start?

Answer: This is a conversation that would best be decided by faculty members locally in their institutions, but there is a National Academy of Medicine paper titled, *Patients, Families, and Communities COVID-19 Impact Assessment: Lessons Learned and Compelling Needs*, that features a comprehensive set of stories about how to create these community connections. The work of the AAMC's Center for Health Justice, especially its "Principles of Trustworthiness" publication, also addresses these issues directly.

Question: It's becoming increasingly important for medical students to have research experience. When is the best time for medical students to be involved in research and how do we make the requirement to have research experience equitable, since students from lower-income backgrounds can't afford to take time off to do unpaid research?

Answer: This is another case where the solutions should be found at the local level, although it would be nice for there to be a blanket recommendation. The purchasing power parity of the NIH is still at the level of 2004, even after the budget increases, so it's still very challenging to get funded and students can become discouraged when they see their mentors struggling to get funded. There are three issues involved: local resources, the equity issue in general, and then the issue of local faculty governance, so the AAMC isn't in a position to make a broad statement or recommendation with regard to the question. These kinds of issues are perfect for bringing up to CFAS as a whole to learn about potential solutions from other faculty members.

Question: Is there a way to identify the best practices that led to this current body of medical students, which is the largest and most diverse ever, and to track this cohort of students as they matriculate so that we can learn about how to replicate this success going forward?

Answer: The AAMC has staff, including Geoffrey Young, PhD, who are dedicated to doing just that by looking at the data. Dr. Young believes that we need to focus on pathway programs starting as early as

the 6th grade to affect more long-term change. My biggest fear is that we regress toward the mean this year, but, anecdotally, I believe there's more of a push on holistic admissions and I think virtual interviews are also helping to increase diversity. The outcome of the Supreme Court case on race-conscious admissions will of course have huge ramifications on this front.

Question: There are still persistent access to care problems, such as those in rural and urban areas, and there are known solutions to those problems. How do we implement these solutions?

Answer: The real solutions are happening on the ground at institutions and the AAMC does its best to promote those initiatives to get wider uptake. More funding opportunities through the National Health Service Corps and HRSA programs would also help. David's previous testimony on the physician shortage addresses some of these solutions. The answers are known: Attract future doctors who are from the areas you want to see more doctors in and have financial resources to make it possible for those people to succeed. The academic medicine community should also spread the word about successful local experiments.

Question: How can we convince institutional leaders to give faculty time to pursue the academic mission, since that's what gives many of them joy and makes them more productive for the clinical enterprise?

Answer: One of the most compelling presentations I've heard on this issue was from a health system CEO, who realized the importance of supporting time for research, no matter what's happening in the world around us, because that's the way medical centers attract patients – because they feel confident when the place where they're getting their care is full of knowledgeable and highly-trained people.

Faculty members must always push to be a part of their institution's governance and I've found that a lot of institutional leaders are willing to talk with faculty about how to make needed changes. Governance must be shared.

Chat:

(Note: the session recording, available on the CFAS resource page, includes a complete chat transcript.)

Please register for the CFAS Spring Meeting: https://cvent.me/anKyM3?RefId=PubListserv

Other links and resources that came up in chat:

https://www.aamchealthjustice.org/resources/trustworthiness-toolkit

https://store.aamc.org/the-rise-of-wellness-initiatives-in-health-care-using-national-survey-data-to-support-effective-well-being-champions-and-wellness-programs.html

https://sites.google.com/oakland.edu/ppbfirstannualconference/home

How did the match go across the country?

I like the notion of community engagement. Q can you elaborate on the community - who's included?

For those who didn't hear, the question focused on equity issues related to in-person vs. virtual interviews in the residence application process.

There is good evidence in primary care that rural and inner-city access to care can be improved if medical students from rural and inner-city areas are accepted into medical school in greater numbers and trained in rural and inner-city areas. Any broad AAMC plans?

My question is with respect to the impact of governance on faculty well-being. Shanafelt tells us all it takes is 10% of faculty time each week spent in things that bring joy to bolster faculty morale and satisfaction. So, I am interested in your thoughts on “best practices” in AHC governance at a time when the clinical enterprise is increasing the dominant force and faculty time devoted to the academic mission is increasingly constrained?

In the area of diversity, equity, and inclusion in academic medicine, how do we systematically address the issues of "implicit bias."

We are talking about the SOAP process. These are individuals who did not March.

This does not totally address the issue. Some students will still have “audition” clerkships even of their interview was virtual.

We (U of Michigan) started a 'second look' day for applicants who want to visit our campus to attend a day-long program where they learn about our school, programs and community. They have NO contact with our training programs or residents/fellows during this time. The names of those visiting are NOT provided to our programs, so there is little (no?) risk of a decision to visit influencing the rank ordering. The response exceeded our capacity.

Great idea. Key is to ensure that there truly is no contact allowed either with program directors or residents/faculty.

I think this issue is only going to get worse as schools move to pass fail and USMLE moves to pass fail. Program directors will look for some other way to distinguish among applicants.

How can AAMC help shed light and communicate best practices on the changing structure and functioning of biomedical science departments at many medical schools around the country and the impact this is having on biomedical science researchers and educators, their relationship with their chairs and with their institutions?

We have placed a great new focus on students’ portfolios in applying for residency. Individuals with more personal resources will appear to have "stronger" credentials in applying for residencies because they can take non funded positions.

We have begun a "Pathway Programs and Bridges" PPB SIG to support all of these programs from K-12, summer, undergrad, post-bac, masters, etc.

The CFAS DE&I committee would love to connect with Dr. Geoff Young of the AAMC to look into potential best practices we can promote at our academic institutions to support increased diversity.