



AAMC President's Address 2022: "What Keeps Me up at Night"

David J. Skorton, MD, AAMC President and CEO, delivered the following address at Learn Serve Lead 2022, the association's 133rd annual meeting, on Nov. 13, 2022.

Thank you, Dr. Woodward. How wonderful it is to be together at Learn Serve Lead. I ask you again: Is it great to be back together in person?

It's been three years, as Dr. Woodward said, since we've gathered like this and in some ways, these years feel like a lifetime. I want to thank you all for staying so effectively in touch and supporting each other and the AAMC throughout the pandemic.

Let's applaud Dr. Calhoun one more time for his outstanding leadership and commitment to academic medicine. Dr. Calhoun's remarks about "Overcoming the Headwinds" remind us that amid the many challenges we face, we can still find strength.

That strength comes from continually learning from each other and focusing on the unmet needs of our patients, families, and their communities. And by "communities," I also mean our own academic medicine community, of which I'm so proud and honored to be a part.

In addition to welcoming all longstanding colleagues and friends back to an in-person Learn Serve Lead, I specifically welcome and recognize our new colleagues who have joined the AAMC community through our recent merger with the Association of Academic Health Centers, now the Alliance for Academic Health Centers and the Alliance for Academic Health Centers – International. Welcome to the AAMC!

In my remarks in 2019, I shared with you my concerns that the status quo was unacceptable across many aspects of our profession and our service to our patients and communities. Since those remarks, together we have faced COVID-19, racial reckonings long overdue, and many other challenges, while maintaining academic medicine's primary mission to serve our learners, patients, their families, and our communities.

And you, learners, faculty, staff, and leaders, have risen to the occasion magnificently, leading the country through one of our most difficult times, albeit with a serious toll on well-being. For that I am grateful; for that I share my admiration with you.

But while what we've accomplished together has been laudable — and even remarkable amid the challenges we've faced — today's status quo is still unacceptable. We find ourselves still in a situation of fragmented communities, often bitterly divided public opinion, and severe difficulties hearing and listening to each other. And the health of people everywhere is not what it should be.

I decided to make today's remarks a set of personal comments, as Dr. Woodward mentioned, to share with you the challenges and problems that I find of highest concern — what you might say keeps me up at night. These challenges are ones that I believe we must face together and with a sense of renewed courage and urgency.

So today, I share four areas of concern regarding which I need your partnership, feedback, and guidance. Across all of these problems, I remain hopeful that somehow together we can transform the status quo. I won't say this work will be easy, but I do believe we can make progress if we all work together collectively and we all work together unrelentingly even — and especially — when the work feels uncomfortable.

This is what leadership looks like.

These were my criteria for choosing the challenges about which I will speak today: First, each challenge represents an unsolved problem affecting the public's health, directly or indirectly. Second, each challenge is related to the specific mission and vision of the AAMC. Third, each challenge is, at least in part, within our power to solve, or at least to improve. Fourth, each challenge specifically affects the community of academic medicine. Fifth and finally, the need to solve each challenge is urgent.

Diversity, equity, and inclusion

Let's start with diversity, equity, inclusion, and anti-racism. I believe this is one of the most critical, overriding problems we face in academic medicine, in our private lives, and throughout society. The health inequities that have long plagued our health system are rooted, in part, in bias, discrimination, and systemic racism.

And it is our responsibility in medicine to address these issues whenever we have the opportunity — not only because we have to in a professional capacity, but because we have to as human beings.

I believe I can speak for all of us when I say that we all strive as individuals to leave the world better and more just than we found it. And in our world of academic medicine related to DEI, this hard-fought but so far unsuccessful journey toward justice has at least two critical components: first, diversifying our student populations, our faculty ranks, our staff, our profession in general, and all aspects of leadership of our great academic health centers. And second, optimizing the culture and climate of our institutions so that all have the chance for success and fulfillment. In my view, both of these are critical components for success.

Have we made progress? In some areas, yes. In others, absolutely not. While we have seen historic increases in underrepresented applicants to medical school in the last several years, there is much more work to be done to diversify the classes.ⁱ

To share just a few of many examples we could cite: The number of Black men in medicine has not changed substantially from the 1970s, when I was a medical student.ⁱⁱ That is unacceptable. First-generation students account for only about 11 percent of matriculants.ⁱⁱⁱ American Indian

and Alaska Native people account for less than one percent of physicians.^{iv} This is not representative of this population's overall presence in the United States. And, as is the case for many groups, when compared with their populations across the U.S., those who identify as Hispanic or Latinx are very underrepresented in medicine.

Certainly, as Dr. Calhoun so poignantly demonstrated with his own personal story, "you cannot be what you cannot see."

What is the way forward in diversity, equity, and inclusion? Like so many other social issues, we must start with humility and the willingness to listen, and to recognize that much of the greatest wisdom regarding any group and its struggles and challenges comes from within that group. And, while listening to voices from our communities, we must be willing to commit to two principles regarding how we approach any recruitment, whether it's to medical school or an employment pool.

First, we cannot and must not accept candidate pools that are not diverse. No matter the hurdles we may face in areas like race-conscious admissions, we must insist on diverse pools of applicants to medical school and to employment openings. If the candidate pools are not sufficiently diverse, then the outcome will regress toward our insufficiently diverse status quo.

And second, in making every individual decision, we must teach ourselves to imagine a candidate from a background different than the current norm being successful and eventually a leader in whatever area we are focusing on, and someone we can learn from.

We must face our biases that cause us not to see that potential in every individual. I work on this intensively regarding my own biases that may affect recruitment efforts, and for me, it requires constant vigilance.

And after successfully recruiting a more diverse student population or employee pool, is our work over? Far from it. We are then just getting started.

For, if the recruitment is successful but the climate, the culture, the milieu of each organization is not conducive to individual perceptions of belonging, of the likelihood of success, then the game is lost. How frequently we have all learned that lesson.

Do I have all the answers here? Absolutely not. Is the AAMC itself the exemplary organization you deserve? We are making progress, but we have a long distance to go.

Let's raise the level of the conversation from "if" to "how" we can and must succeed in recruiting and supporting a diverse workforce and a diverse student body. Let's refuse to accept anything less.

And along our way, let's become more devoted to looking at everything we can through the lens of equity: for individuals, for organizations, for communities. If we do this, we will have a fighting chance to succeed.

Will we face headwinds? We already are facing pushback. For example, you may have noted pushback from some quarters when the AAMC released our diversity, equity, and inclusion competencies several weeks ago and it may very well get worse — but that doesn't mean we should change course.

For only one example, the Supreme Court of the United States recently heard arguments in two cases related to race-conscious admissions in higher education, one at a public university, one at a private university. I was in university-wide administration during the Grutter vs. Bollinger case and the Court is now considering whether to overrule that decision.

Our superb AAMC legal team filed a powerful amicus curiae brief on the cases; a brief on which 45 other organizations signed. If the Court's decision rules out any consideration of race in admissions, we will likely see precipitous drops in the diversification of our student populations going forward. And our patients and our communities will pay the price.

If so, we in higher education will need to adopt some other approaches based on our collective thinking. And this may need to be done very quickly. In that context, leadership will matter. Under no conditions will the AAMC retreat from our journey. We will stay the course. Under no conditions can any of us back down.

This is what leadership looks like.

Learner well-being

Now, to move onto the second challenge about which I am so deeply concerned: the well-being of our learners. And this includes both graduate and undergraduate medical education, graduate school, and the postdoctoral experience.

The pressure on our learners is enormous and becoming ever greater throughout their educational journey. The pressure to achieve a college degree is strong because of its many advantages — real and perceived. We in academic medicine — surrounded by colleagues with professional and graduate degrees — may forget that, although the proportion of bachelor's degrees has grown steadily, as of 2021 it was still less than 40 percent of those 25 years or older in the U.S. This statistic should remind us that a college degree is a privilege not shared by most adults in our country, let alone a medical degree.

In so many families, the goal of a college degree is one that is strongly desired but so many obstacles can get in the way, from finances to the pressures of student life, that it may seem unobtainable. Although we may think about, for example, undergraduate education as a time of making friendships and enjoying new adventures, the pressures of college — on top of the tumult of adolescence in general — can be fearsome.

How clearly I remember the year at Cornell University when six students died by suicide. That shocking year opened more broadly for me a window into student life and its attendant pressures.

So fast-forward to graduate school and the postdoctoral experience, as well as medical school and graduate medical education: the pressures can be much, much more profound. Preparing for high-stakes national examinations and interacting with patients for the first time can all add up to just the ingredients for mental health stress, as can forging new research directions and applying for grants.

And while being a physician can be stressful at all stages of one's career journey, the stresses are especially acute when one is encountering this type of pressure for the very first time. At Cornell, partly in response to the suicides, I spoke publicly about my own history of mental health counseling, as did others. The point was to reduce the stigma of asking for help, and I said to the students: "If you learn one thing at Cornell, learn to ask for help."

And help is needed by so many of us in the medical profession, and far beyond. Stress and anxiety are common among multiple subgroups of master's and doctoral students outside the field of medicine, as well. Depression and therefore the risk of suicide is more common among medical students than their age-matched peers,^v and this trend has worsened in the last few years.^{vi}

The way forward on many issues affecting learner well-being starts as with so many human dilemmas: ask those most affected to share their experiences and the places they see barriers to their success.

At the September AAMC Board of Directors meeting, Jennifer Hayashi, our student member of the Board of Directors, and from the Organization of Student Representatives, two colleagues Amal Cheema and Samuel Borer, made a powerful presentation on some of the major challenges faced by our learners. Some of these challenges, of course, are related to COVID, but most preceded it and are ongoing issues of great concern. These students will be addressing a meeting of the Council of Deans at this meeting.

Their generosity in offering their thoughts was a good step in educating all of us about what it's like to be a learner today. Listening to other learners, I am hearing from those who are in counseling and others seeking behavioral health care, and from those whose friends died by suicide and those who themselves have considered suicide. And I am learning more about the roadblocks in the way of receiving behavioral health care: the stigma, the expense, the time commitment, the lack of availability of behavioral health providers.

I believe we can group our responses to the issues into two major categories: First, we must look to address and ameliorate the individual, identifiable problems themselves, whether curricular or financial, whether related to the competitive environment or the complex transition to residency, or so many other issues. Second, we must better support the accessibility of behavioral health care for all of those who could benefit.

While the AAMC is committed to supporting institutions at the national level, each institution needs to develop its own solutions where it can, since local faculty are — appropriately — in charge of local curricula and the overall local experience of learners. And each institution also

needs to ensure that appropriate and affordable behavioral health services are available and that students are encouraged and supported to push through any stigma to seek care.

Our colleague and friend, emeritus president Dr. Darrell Kirch, wrote a moving exploration of his own history of mental illness, that published in our journal *Academic Medicine* in 2021. I hope that those of you with such histories will follow Darrell's example and that of others willing to come forward and share personal stories.

But all of the pressures on our learners cannot be solved at the level of individual medical schools or teaching hospitals. Some, of course, are national issues that must be approached nationally, and we in the AAMC are in a good position in that regard to work collectively with all of you.

The National Academy of Medicine's Action Collaborative on Clinician Well-Being and Resilience, co-chaired by Dr. Kirch, recently released a "National Plan for Health Workforce Well-being," a plan to take collective action to address systemic issues around burnout and well-being. I encourage you to learn about this national plan and see how each of you and your institutions might get involved.

And as many of you are likely aware, in 2020, the Coalition for Physician Accountability, a collaboration of 15 national organizations, formed a committee to examine the transition from undergraduate medical education to graduate medical education.

Their report suggested 34 recommendations to improve the transition to residency across the impacted individuals and groups, many of them supporting learners through this process. These recommendations validated the work that AAMC has had underway for several years, focused on reducing the number of applications that learners submit.

These efforts include providing better data insights; partnering with medical specialties to help learners differentiate themselves through highlighting their experiences and signaling their program preferences; and supporting increased emphasis on holistic review through training and tool development. The AAMC will continue to collaborate across the transition-to-residency ecosystem to tackle this complex, multifactorial challenge.

All of this is a partnership. We must work together at every step and, if we do so, we can make progress in support of our learners. Anything else is unacceptable.

This is what leadership looks like.

Advocating for patients and families

Now I turn to our interactions with and actions on behalf of our patients and their families and communities. At the AAMC, although our devotion to learners is our top priority, and why we exist, our mission touches on all aspects of academic medicine. We must go far beyond the direct clinical care that we deliver and strive ever to improve.

Our Center for Health Justice and other parts of the AAMC are striving to ensure that all communities have equitable access to the things we all need to thrive: health-promoting social determinants like humane housing; nutritious, affordable food; meaningful work; and freedom from racism and discrimination; as well as easy access to high quality medical care.

Again, I am reminded by my colleagues at the Center for Health Justice and elsewhere that those experiencing injustices are in the best position to participate in finding solutions.

Community collaboration is, therefore, the fourth major mission of academic medicine — alongside education, research, and clinical care — because collectively we make a difference that we cannot individually. The wisdom of the community will guide us toward the solutions we need, together.

But today, I want to focus on a particular aspect of advocating for our patients and their families and communities. One of the basic and critical foundations of medicine is the relationship between physician and patient — a relationship that must not be ruptured or invaded by anyone or anything, including legislation or judicial opinions.

As a case in point, let's consider the *Dobbs vs. Jackson Women's Health Organization* decision by the Supreme Court of the United States. I am not here at this moment to argue the merits of access to abortion. I am here to argue that legislation or judicial opinions that interfere with the relationship between physician and patient, especially if they go as far as intimidating the clinician in the exercise of good clinical judgement, are unacceptable. We must stand firm. We must protect this relationship.

Standing up for what we believe is right may take many forms, from polite discussion, to speaking out in the public square, to formal advocacy. You may have read a recent Perspective in *The New England Journal of Medicine* by Dr. Matthew Wynia from the University of Colorado, where he calls for serious consideration of ways to show support for physicians who find themselves in impossible situations.

What I am advocating for today is that we oppose actions that interfere with our relationships with our patients, the exercise of good professional clinical judgement, and that exacerbate existing health inequities. By advocating for each other as physicians to be able to do our jobs effectively, we're ultimately advocating for our patients.

Here are some things the AAMC is doing to speak out and advocate for our patients and the academic medicine community:

This past August, we joined with the American Hospital Association in an *amicus curiae* brief supporting the federal government's successful challenge to a state abortion ban that would have criminalized the provision of emergency medical care.

And in several cases filed this year, we joined the American Academy of Pediatrics, the American Medical Association, and a host of other leading medical organizations in filing *amicus curiae* briefs opposing the criminalization of gender-affirming care for adolescents. This

treatment addresses troubling rates of suicidality and other mental distress among transgender adolescents and follows widely accepted guidelines of the professional medical community.

And the AAMC has taken steps to support both patients and our broader community in other areas. As just one more example, and relevant to some of the sessions tomorrow, we have committed to the Department of Health and Human Services pledge to reduce carbon emissions from the AAMC's own operations by 50 percent by 2030 and to reach net zero by 2050.

Why would we do that? Because we know that sadly, the climate crisis is linked to health. And the health care sector is itself a substantial contributor to greenhouse gas emissions. We cannot remain silent; we cannot ignore our own role in this crisis.

This is, like so many others, a collective effort.

You can help both individually and by fostering conversations with your colleagues at your institutions and with us at the AAMC through our Virtual Communities. These communities are a private, online forum, a home for academic medicine and other interested community members. You can go — not during my speech but later — to communities.aamc.org to register, and there is no charge.

We need your help. We need your wisdom on how to take effective action and to find the right balance. No matter what actions we take, we must persevere and we must put the welfare of our patients, families, and communities first.

This is what leadership looks like.

Free speech

The fourth and final issue I'm going to discuss today that keeps me up at night is free speech. I have long believed that speaking out in the public square is an important duty of leaders, especially those of nonprofit organizations like the AAMC, that are created for the public good.

AAMC leaders have long spoken out on issues relevant to academic medicine. And in the last few years we have spoken out more broadly as we have recognized the critical importance of nonmedical issues to the public's health. In so doing, and in welcoming feedback, two kinds of comments from our colleagues have come that I want to share with you today under the overall rubric of free speech.

The first kind of feedback has been gratitude for speaking out. Not all institutional leaders can speak out publicly, for fear of local political backlash or even funding cuts, and they often look to the AAMC to do so instead.

There is nothing new about limitations of those working in public institutions to speak on behalf of their institutions, but we are certainly encountering those issues more and more today. For this reason — among so many others — it is imperative that the AAMC be a strong voice of academic medicine.

But the second kind of feedback has been criticism of what some in our community see as an excessively progressive ideological lean to the AAMC and my own statements and what some have told me is moving too far in that direction.

As you know, based on this second kind of feedback — which has come from some constituents, AAMC staff, and Board members — we have tried experiments in bringing diverse perspectives to AAMC conversations, including yesterday’s opening plenary with professors Robert George and Cornel West. We heard from them, and in my opinion, they demonstrated and shared their perspectives on the importance of dialogue, including across difference.

In recent months, I have continued to read and learn more about what others have studied and concluded related to free speech in our country and beyond, now and over centuries. During my tenure as a university president of a public and then of a private university, I came to the conclusion that, as a general principle, the more free speech, the better.

But are there limits to free speech? I make no claim to serious expertise in this area, but I do believe there are limits to free speech. Those limits, of course, must be carefully established and not based on anything but the public good.

For example, we cannot promote or tolerate intentional and inflammatory disinformation. And the AAMC has made clear in our public statements that we cannot support hate speech, racist speech, or speech that incites violence, including against health professionals.

In his groundbreaking book, “Free Speech: A History from Socrates to Social Media,” published this year, Jacob Mchangama, founder and executive director of the Danish think tank, Justitia, shares some conclusions from his sprawling review of this topic starting with the time of the Greeks. I want to share three quotes from this book.

First, and I quote: “As an abstract principle, American faith in free speech remains strong. But the unity collapses along unforgiving tribalist and identarian lines once each side’s sacred taboos are violated by the other side.” End of quote.

The second quote speaks to our role in academia, and I quote: “Educational and cultural institutions do not become more diverse, tolerant, and equal by banishing ideas, publications, and speakers that do not conform to the prevailing orthodoxy.” End of quote.

And the final quote I’ll share speaks to what all of us can do, and I quote: “It is up to each of us to defend a culture tolerant of heretical ideas, use our system of ‘open vigilance’ to limit the reach of disinformation, agree to disagree without resorting to harassment or hate, and treat free speech as a principle to be upheld universally rather than a prop to be selectively invoked for narrow tribalist point scoring.” End of quote.

Thought-provoking words, and a powerful reminder that gives me one view to the way forward. Each of us in this room today can set the example and expectation to listen to and to hear each other. That means being willing to have uncomfortable conversations and hear some things we

might not want to hear. Let's challenge ourselves across ideologies to be humble, to be kind, to be empathetic, to be respectful, and to actively listen and truly be open to other opinions, even if they are different from our own.

And yet, the AAMC's mission calls us to speak out, to take a stand when the issues are too urgent and too relevant to our work to ignore, as I mentioned earlier around the Dobbs case for example, since access to abortion is critical to optimally caring for our patients and protecting the physician-patient relationship.

Taking a stand on that is one way we are leading, today. Let us all lead with compassion, empathy, and reverence for the role of free speech in our ongoing dialogues.

As in all of the other issues that keep me up at night, the issue of free speech requires our collective action now. The health and mental well-being of our communities and our colleagues is at stake. Through meaningful, open, and honest dialogue, partnership, and collective action, we can and will tackle these problems in service of the greater public good.

It won't be easy, but we're in this together. This is what leadership looks like! You are what leadership looks like. Let's lead together, in service to the public good.

Thank you.

ⁱ <https://www.aamc.org/news-insights/press-releases/medical-school-enrollment-more-diverse-2021>

ⁱⁱ <https://www.aamc.org/news-insights/black-men-make-less-3-physicians-requires-immediate-action-say-leaders-academic-medicine>

ⁱⁱⁱ <https://www.aamc.org/news-insights/first-generation-medical-students-and-match>

^{iv} <https://www.aamc.org/news-insights/attracting-more-native-american-students-medicine>

^v <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9016109/>

^{vi} <https://pubmed.ncbi.nlm.nih.gov/33644399/>