LEADERSHIP
PLENARY ADDRESSES

M. Roy Wilson, MD
Chair, AAMC Board of Directors

Darrell G. Kirch, MD
President and CEO, AAMC
M. Roy Wilson, MD, president of Wayne State University and chair of the AAMC Board of Directors, delivered the following address at Learn Serve Lead 2018, the association’s 129th annual meeting in Austin, Texas, on Nov. 4, 2018.
THE MOST IMPORTANT LESSON I LEARNED IN MEDICAL SCHOOL

AAMC CHAIR'S ADDRESS

2018

The AAMC is an extraordinary organization, and serving as chair of its Board of Directors has been a true privilege. I wish to thank my colleagues on the Board for their dedication and commitment in leading this organization and also the staff of the AAMC, who, individually and as a team, are exceptional.

To have the honor of delivering the chair’s address at this specific time is particularly special, since I am sharing the stage with Darrell Kirch, who will be delivering his final address as president. The AAMC is stronger than ever, due in no small part to the transformative leadership he has provided for 13 years.

I debated for many months on what I would talk about today. The problem was not that I couldn’t think of an important topic; it was that there were too many important topics and too much I wanted to convey.

I finally decided to stop overthinking and just talk about a simple lesson I learned in medical school — something I have thought about repeatedly over the past 38 years.

‘Be good to medicine, and medicine will be good to you.’

A clinical faculty member during my surgery clerkship once said to me, “Be good to medicine, and medicine will be good to you.”

Intuitively, I thought I knew what he was saying, but with the years, I’ve developed a deeper perspective.

“Be good to medicine.” Medicine is a noble profession guided by certain tenets, among which is the Hippocratic oath, which in large measure has remained relevant.
for the past 2,400 years. Practice with humility and with empathy, always put the interest of the patient first, never break confidences.

The faculty member was instructing me to respect medicine.

“Medicine will be good to you.” By respecting medicine, in turn, medicine will provide many rewards — not just financial security and professional standing but deep career satisfaction.

I realize, of course, that many of you may be somewhat skeptical at this point. “Does he not fully realize the physician burnout phenomenon and the increasing suicide rate among physicians and learners?”

As president of a diverse, public, urban research university, I am more aware than ever that my being here today, on this stage, is a statistical anomaly.

I assure you that I do. Just last month, the Physicians Foundation published the results of its 2018 Survey of America’s Physicians: (1) Less than half of doctors reported that they were satisfied with their jobs, (2) three out of four felt some level of burnout, and (3) 62% were pessimistic about the future of medicine. These results are real, and they are startling.

But I am optimistic about medicine. This perspective is fueled by my love of medicine, by my feeling of incredible privilege to be a part of it as a physician, and by my realization that my path was atypical and not at all certain. That I was perhaps lucky.

As president of a diverse, public, urban research university, I am more aware than ever that my being here today, on this stage, is a statistical anomaly.

My younger sister and I basically raised ourselves, as our parents were never around. Our mother was addicted to gambling and our father to alcohol. Left to ourselves, we were subjected to experiences that no child should ever have to endure.

Neither of our parents had the opportunity to go to college. In fact, our mother had to leave school in the eighth grade to work and help support her adoptive family, and our father enlisted in the Navy immediately after high school.

I did not — and still do not — take for granted the opportunity I was provided to go to college and to medical school. At Harvard no less. And yes, I absolutely loved my time in medical school.
To be able to look out into the future and know with certainty that I was going to have a career where I could so positively impact people and also attain financial security was exhilarating.

However, I do understand that the practice of medicine has changed over the years, that there are many challenges to preserving aspects of medicine that we have historically cherished — the meaningful face-to-face interactions with our patients, getting to know them, and perhaps even becoming a part of their lives; the relative autonomy we enjoyed in prioritizing patients’ interests first and foremost, and relegating all other interests as secondary; the trust, even adoration, enjoyed by physicians and by the profession collectively.

But throughout history, medicine has experienced challenges, even disruptions, that have shaken its very foundation. From the time of Hippocrates through the Dark Ages, the Renaissance and the Age of Enlightenment, the Industrial Revolution and the Great Divergence, it has endured, its basic tenets emerging relatively unscathed.

I believe it will do so again.

But this current Technological Age potentially poses the greatest threat medicine has heretofore faced: keystrokes are replacing eye contact; artificial intelligence and robotics are reshaping human-to-human relations of all types and levels in health care; the arts and humanities are under siege, and some undergraduate universities have eliminated them altogether. Compounding these threats is the pervasive and increasing distrust the public has with major societal sectors — including health care.

For these reasons, the advice I received almost 40 years ago is more relevant now than ever before.

“Be good to medicine, and medicine will be good to you.”

Now, what exactly does this mean in today’s modern-day construct? I have some thoughts:

First, when I was in medical school, the school shield had a motto inscribed on it. It was a single word. It inspired me then, and it inspires me today.

“Veritas.” Truth.
To be good to medicine, we must steadfastly affirm our commitment to better health for our patients and for our community as priority number one. In this time of “fake news,” “alternative facts,” and overall distrust of science among some, there cannot be any daylight between medicine and truth. Truth must be the primary driver for our biomedical research, must form the basis for our patient-doctor relationships, must guide what we teach our learners of medicine.

To be good to medicine means that truth must be our North Star. Truth must inspire us individually and collectively.

Second, medicine must remain mission focused, not profit focused.

I fully understand that sound business practices and decision-making are necessary in the modern-day delivery of medical care. As the saying goes, “no money, no mission.” Without financial margins, the delivery of care to all who require it, as dictated in our Hippocratic oath, would be severely constrained. Current financial margins are thin. To gain access to capital markets, it is likely that we will see increased numbers of for-profit health-delivery systems in the future.

Although I personally wish that were not the case, that in itself is not necessarily bad. In fact, financial reward and profit are compatible with “good medicine.” However, profit for the sake of profit is anathema to medicine and undermines the public’s trust.

Health-delivery systems, especially academic medical centers, have an obligation to serve their communities and invest in the public good. To be good to medicine requires us to take a principled stand against profit as the primary driver of our health-delivery system. This commitment to mission over profit applies to the individual physician also.

To be good to medicine requires us to take a principled stand against profit as the primary motivation for our personal engagement in medicine. To be good to medicine, we must steadfastly affirm our commitment to better health for our patients and for our community as priority number one.

Third, as Hippocrates stated more than 2,400 years ago, medicine is neither science nor art. It is both science and art. Earlier this year, the National Academies of Sciences, Engineering, and Medicine published a Consensus Study Report titled The Integration of the Humanities and Arts With Sciences, Engineering, and Medicine in Higher Education.
A focus on math and sciences has overshadowed the arts and humanities as foundations for the training of physicians. This is understandable, as science is a fundamentally important conceptual underpinning for medicine. But it is only one leg of a three-legged stool.

The opening paragraph of the report reads as follows:

“Albert Einstein once said, ‘All religions, arts, and sciences are branches from the same tree.’ This holistic view of all human knowledge and inquiry as fundamentally connected is reflected in the history of higher education — from the traditions of Socrates and Aristotle, to the era of industrialization, to the present day. This view holds that a broad and interwoven education is essential to the preparation of citizens for life, work, and civic participation. An educated and open mind empowers the individual to separate truth from falsehood, superstition and bias from fact, and logic from illogic.”

I contend that today there is no discipline for which these sentiments are more important than in medicine.

You will likely agree with me that a focus on math and sciences has overshadowed the arts and humanities as foundations for the training of physicians. This is understandable, as science is a fundamentally important conceptual underpinning for medicine.

But it is only one leg of a three-legged stool.

I am so pleased that the AAMC has taken a leadership role in better defining the competencies required in medicine.

In 2009, the AAMC, in partnership with the Howard Hughes Medical Institute, published a report titled Scientific Foundations for Future Physicians.³ It stated that “the desired outcome of the medical education process should be scientifically inquisitive and compassionate physicians who have the motivation, tools, and knowledge to find the necessary information to provide the best and most scientifically sound care for their patients.”

Recognizing that to be too narrow of a focus, the AAMC published another report, Behavioral and Social Science Foundations for Future Physicians, in 2011.⁴

This report stated that “a complete medical education must include, alongside the physical and biological sciences, the perspectives and findings that flow from the behavioral and social sciences.”

Behavioral and social sciences: the second leg of the stool.
Currently, in collaboration with the National Endowment for the Humanities, the AAMC is developing another report that balances the traditional natural and life sciences of the first report with the newer social and behavioral sciences of the second report and adds the arts and humanities as the third dimension that informs the work of the good health care practitioner. This report is anticipated to be published in time for the 2020 Learn Serve Lead meeting of the AAMC.

I cannot overemphasize the importance of this third leg of the stool as a foundation of medicine and health care. In countries with modern medical technology like the United States, health care systems are facing enormous difficulties in meeting demands such as distributing resources equitably and providing quality care to a large number of patients. Overlay these issues with the moral dimension of how much care to provide to those who are terminally ill or those who are unable to pay.

Addressing such challenges requires qualities such as sympathy, empathy, compassion, patience, caring — all implicit in the phrase “humanism in medicine.”

Yet, humanism in medicine embodies much more than a Marcus Welby, MD, persona.

The Institute for Healthcare Improvement introduced the Triple Aim framework in 2007, putting forth a goal to simultaneously (1) improve the patient care experience, (2) improve the health of a population, and (3) reduce per capita health care costs.⁵
Humanism positively impacts all three goals. And apropos my earlier comment regarding physician dissatisfaction and burnout, recent research demonstrates that humanism in medicine supports a fourth aim: It improves the work life of health care providers.

What is sometimes confusing in discussions of this topic is *arts and humanities* and *humanism in medicine* are actually two separate concepts. So what does one have to do with the other?

Rather than providing you with recent data that convincingly link the two — specifically that exposure to the arts and humanities can lead to more humanistic physicians — I defer to Johanna Shapiro, PhD, a professor of family medicine and director of the Program in Medical Humanities and Arts at UC Irvine, who summed it up nicely:

“I have never found a better way of encouraging students to ask questions ... and of stimulating a critical position in regards to the answers that emerge than by having them read a poem or participate in a skit or gaze at a painting.”  

As we are reminded every year in the presentation of the Arnold P. Gold Foundation Humanism in Medicine Award here at Learn Serve Lead, medicine is an intrinsically humanistic construct and has been from its very beginning.

Being good to medicine means — despite the relentless advances of technology and science — embracing the arts and humanities as fundamental to the preparation of physicians and preserving humanism in our profession.

And finally, medicine needs the talents of all segments of our diverse population. I saved this one for last because it is personal.

Earlier I gave you a glimpse of my own situation in life and, as a black male from an incredibly dysfunctional family, how fortunate I feel to be here with you today.

Despite their personal flaws, I love my parents. I would not have been able to share this story if they were still alive. Until now, I did not.

We must do more to ensure that all segments of the public are included in our profession and that biases, even if unintended, do not systematically exclude persons of certain population groups.
We must make sure that underrepresented minorities are represented throughout all the wonderful opportunities afforded by medicine, whether in primary care or specialty care, administrative leadership, or research.

While it is encouraging that the proportion of women in our medical school classes is now about 50%, more must be done to ensure that they have equal access to all the postgraduate training opportunities afforded men. That they are recognized equally with men for awards, including AAMC awards; that their pay is equal to that of their male counterparts; that they are supported for and promoted to the higher academic professorial and administrative ranks. In not doing so, we are not being good to medicine — we cheat medicine.

And whatever their role in medicine, no woman — or anyone for that matter — should ever have to endure sexual harassment or assault.

One of the great strengths of American society has been the diversity of its people, both domestically such as our African-American and Native American populations, and the more recent immigrant populations, including many Latinos, Asians, Middle Easterners, and Africans.

To take full advantage of the talent represented by this incredible and beautiful tapestry, the tent of medicine must be large and inclusive. The goal of equity in medical education and training, particularly for our historically underrepresented populations, has been elusive.

The near future likely will present further challenges in this regard. But better health for all means we must achieve inclusive excellence.

Concerning minorities in the medical workforce, some of us in academic medicine have defined success as their entering primary care and practicing in underserved communities. To do so is laudable.

However, as a minority physician who specialized in the treatment of glaucoma and as someone who has served on academic faculties and had substantial roles leading medical schools, health science centers, and universities, I reject that definition of success.

We must make sure that underrepresented minorities are represented throughout all the wonderful opportunities afforded by medicine, whether in primary care or specialty care, administrative leadership, or research.
Let’s be good to medicine. Let’s recommit to achieving diversity and equity throughout the entire breadth of our profession: gender, racial, ethnic, socioeconomic, religious, and all other forms of diversity that makes America so great.

A final thought:

I recently learned that the word “doctor” is derived from the Latin “docco,” which means “to teach.”

Each year, at medical school commencement, I am reminded that Hippocrates considered the imparting of knowledge to followers as an essential part of the physician oath. It is at the heart of what we do in academic medicine, and it is part of what has made a career in academic medicine so deeply rewarding.

As a group, I find our medical students and residents to be remarkable — smart and committed, imbued with a sense of justice and a genuine desire to help people or advance biomedical knowledge. Or both.

I implore academic medicine at all levels — collectively, at the institutional level, clinical department level, specialty level, and individual faculty level — to embrace its responsibility to transmit to all learners a sense of hopefulness, optimism, and empowerment and to project an appropriate sense of gratitude for the incredible rewards that come to those who practice medicine.

Let’s all of us aspire to the ideal of “veritas.” Let’s pursue mission over profit; let’s embrace the arts and humanities; let’s diversify medicine.

And remember: Be good to medicine, and medicine will be good to you.
NOTES


At Learn Serve Lead 2018 in Austin, Texas, Darrell G. Kirch, MD, AAMC president and CEO, delivered the following address on Nov. 4, 2018.
Welcome to Austin! We are delighted to see the more than 4,600 of you who have joined us, including the more than 1,100 of you who are experiencing your first AAMC annual meeting. Thank you so much for being part of this important national conversation for all of us in academic medicine.

Seeing so many dear friends, and meeting so many new colleagues, is bittersweet for me. This is my last annual meeting as AAMC president and CEO. We are on track to hand off responsibilities to my successor on July 1. It is truly humbling, and an incredible honor, to have served this great organization that in just eight years will celebrate its sesquicentennial — 150 years since our founding in 1876. Over its first 90 years, distinguished leaders such as Sir William Osler served the AAMC as annually elected presidents. The full-time position of president and CEO was established in 1969, and I am privileged to serve as only the fourth person in that role.

Given that history, I found myself wondering what my three predecessors said in their farewell addresses to see what has stayed the same and what is new in our world. Drs. John A.D. Cooper, Robert Petersdorf, and Jordan Cohen are the giants on whose shoulders I stand. After carefully reading the powerful valedictory addresses of these visionary AAMC leaders, I was struck by how consistently the AAMC has worked for progress in four key domains over the past half-century. Each of my predecessors spoke passionately about his unwavering commitment to the core missions of clinical care, education, and research, as well as to the imperative of advancing diversity, inclusion, and equity — in both academic medicine and society at large. It is a point of pride that over the last 50 years, we have remained true to these commitments.
But I also saw how much has changed since their speeches. Allow me to use a metaphor from my beloved Rocky Mountain home state to illustrate the point. Colorado has 53 mountain peaks over 14,000 feet tall. Climbing one of these “fourteeners” is, in every sense of the word, truly breathtaking — and I’ve climbed a few. You feel the thinning air as you climb, but each step brings a higher and more expansive view of the same landscape. Academic medicine advances the same way. Over time, our key mission domains remain constant, but as we ascend, we gain clarity when we look back, and with each step higher we are better able to see what lies ahead.

Many of us would mark the climb as having begun in earnest with Abraham Flexner’s landmark 1910 report affirming the model of the modern medical school — built around a rigorous science-based curriculum and with active teaching in closely affiliated hospitals and clinics.2 After World War II, we reached new heights, experiencing what Dr. Cooper, our first president and CEO, called a “golden age” of medicine. It was a time when the National Institutes of Health and other federal agencies were growing in their impact, and fundamental research discoveries were leading to the development of powerful diagnostic and therapeutic tools, all stimulated by growing federal investment in science and health care.

This growing federal role in our work led to the AAMC moving from a small office in Evanston, Illinois, to Washington, D.C., in the late 1960s.3 That decision took us to a new level of national influence as the voice of the rapidly expanding community of academic medicine. And we started to grow accordingly. Teaching hospitals and academic medical societies were added to the AAMC membership; three councils were established; medical students and residents were given a voice; and new AAMC groups were created over the years to recognize and represent key roles in the academic medical center. It was the vision and leadership of Drs. Cooper, Petersdorf, and Cohen that brought us this modern version of the AAMC as the “big tent” where all parts of academic medicine come together. And what we have accomplished together is stunning.

In our mission of clinical care, over the decades my predecessors spoke powerfully about the challenges of having so many Americans without health insurance and how our clinical outcomes lagged, despite constantly rising spending on health care. They defined the problems clearly and called us to action. Nearly 10 years ago we took decisive action, making the AAMC one of the first and most vocal supporters of the Affordable Care Act. And today we are unwavering in our support for expanded health insurance coverage. The evidence tells us that people who have health insurance lead better lives.
Our health systems are making headway in improving the quality of clinical care and health outcomes. A recent study in Health Affairs showed that patients treated in teaching hospitals have up to 20% higher odds of survival than similarly ill patients treated at a nonacademic facility.

Beyond insurance, many academic health systems are working to replace what Jordan Cohen referred to in his 2005 address as the “obsolete” fee-for-service payment system we inherited. At the same time, our health systems are making headway in improving the quality of clinical care and health outcomes. A recent study in Health Affairs showed that patients treated in teaching hospitals have up to 20% higher odds of survival than similarly ill patients treated at a nonacademic facility. We are reaching a level where true “value-based” care is coming into sight. Not only that, you are going beyond the direct care you provide.

When I visit your institutions, I am excited by how committed you are to leaving the ivory tower and becoming deeply engaged with the communities beyond your walls. More medical schools and teaching hospitals have become important anchor institutions — proactively listening to and partnering with their communities. Your work to revitalize neighborhoods is helping the homeless leave the streets and bringing grocery stores to food deserts. Our AAMC member institutions are hiring and training new employees and supporting 6.3 million jobs nationwide. That is a real community commitment.

Turning to medical education, my predecessors focused on improving the curriculum and experimenting with new modes of teaching and learning. Today, the educators in this room have taken us to a whole new level. We no longer view students as empty vessels to be filled with facts. Collectively we are seeing a profound transformation — a paradigm shift — to learning and assessment based on competencies. Those assessments are defining entrustable activities and milestones of advancement. They no longer rely solely on a time-based progression and traditional fact-based exams. And we have “flipped” the classroom. Lecture halls are giving way to flexible spaces as we engage in more interactive, problem-based learning. And after four decades of talking about it, we are finally taking interprofessional education seriously.

In addition, technologies ranging from simulation labs to virtual reality tools are already enhancing learning. As artificial intelligence progresses, the use of an interactive voice-activated “digital assistant” at the side of every physician is within sight. These
advances will free the physician from being a clerk at the computer, offloading routine tasks and allowing the clinician to focus on the relationship with the patient. But I agree about the threat of technology. I see it at work in the clinical setting as it disrupts the doctor-patient relationship. Let’s put our hearts and minds into making sure technology helps us restore the humanism and empathy at the core of medicine. If anyone is going to make technology work for us, it’s the people in this room.

Speaking about our third core mission of science and research in his farewell address, Dr. Cohen celebrated the completion of the human genome project. That science now is yielding astounding advances, such as CRISPR gene editing, immunotherapy, and massive data networks that combine and analyze staggering amounts of clinical data and research information in the service of improving care. These fundamental discoveries of our scientists are translating into real-world solutions. Cancer death rates continue to decline thanks to breakthroughs in research, early detection, and more targeted treatments developed in academic centers. And a recent analysis showed that every new drug approved in the United States between 2010 and 2016 can be traced back to NIH-funded research — many on our campuses.8 Supporting all this, advocacy by the AAMC and out partners over the past three years has put research funding back on a path of meaningful, sustainable growth.

When you take the long view, our progress in all three missions to care, educate, and discover has been steady and remarkably strong.

Turning to our fourth imperative of diversity, inclusion, and equity, my predecessors were equally passionate in their aspirations, but they were honest about the challenges we face. Despite the latter, we’ve made some real gains. We’re diversifying our profession by embracing holistic review in admissions, with positive results on some key fronts. In 2017, women surpassed men as medical school matriculants for the first time, and again this year, more women than men enrolled in medical school.9 Black women have boosted their numbers in medicine.10 But we must redouble our efforts to bring more black males, American Indians, and Alaska Natives into medicine.11,12

Our academic medical centers exhibit a living commitment to diversity and a degree of inclusiveness that, sadly, is not seen in many other segments of our polarized society.
We must be relentless in surmounting the obstacles still in our path, from overt discrimination and harassment, to unconscious bias, to gender and race-based gaps in salary equity.

Our learners, faculty, staff, and patients reflect the full range of Americans, including veterans, people with disabilities, immigrants, rich and poor — people of all races and sexual orientations. They all come together to accomplish great things. We saw this play out poignantly last Saturday, when teaching hospital physicians and staff (some of whom were Jewish) gave attentive care to the alleged gunman in the Pittsburgh synagogue shooting. In the face of hatred and terrorism, they showed true grace.

We now may face the toughest part of our diversity climb. But please be certain about three things: (1) the AAMC will strongly advocate — both in the courtroom and in the court of public opinion — for the ability of medical schools to recognize diversity when selecting future physicians; (2) the AAMC will remain a clear voice about the important role of immigrants, who contribute so much to medicine and science; (3) the AAMC will continue to fight for the Dreamers and their aspirations.

No one sees social inequities and health disparities more clearly than we do. We must be relentless in surmounting the obstacles still in our path, from overt discrimination and harassment, to unconscious bias, to gender and race-based gaps in salary equity. I believe that seeking equity in the health professions — and equity in health care — is a climb worth making.

While we can be proud of progress in clinical care, education, research, and diversity, inclusion, and equity, there is a threat that could stop us in our tracks. We cannot climb mountains if we are not strong, if we have lost our resilience. I am talking about the threat to our personal well-being.

Despite our advanced degrees, the rigors of training and caring for others can take a toll on us. Today, more than half the physicians in this country are experiencing symptoms of burnout — an increase of 9% over a four-year period. It is sad when the joy of practicing medicine fades for a physician. It is tragic when as many as 400 physicians, including some of our learners, die from suicide each year.

Becoming a physician does not make one immune to workplace burnout or the closely related problems of anxiety, depression, substance abuse, and other disorders that often follow burnout. If anything, the high stress levels of the academic and clinical environment may put us more at risk. This problem has been with us for years, but we have been in denial. Two years ago, the AAMC was proud to be a founding sponsor of the National Academy of Medicine Action Collaborative on Clinician Well-Being and Resilience, and we are finally making progress in finding solutions that can make the environment of care and learning more supportive of our well-being.
We need to acknowledge that burnout, depression, and suicide among physicians are not the failures of those individuals. Twenty years ago, the report entitled *To Err Is Human* helped us see quality and safety issues not as causes for blame but as systems problems.² Sixteen Twenty years later, I say, “To Care Is Human.” And humans working in complex, high-pressure environments shouldn’t be blamed for their burnout. We need to change the systems that wear them down.

In my first year of medical school, during a brutal winter quarter of gross anatomy and never seeing the sun, I — like too many students — became burned out. Then I hit the wall. I regret that only now, in my last annual meeting speech, am I telling you about my own struggles. My anxiety and depression were on the verge of derailing my career aspirations. My fear of being judged negatively and the dark shadow of stigma nearly kept me from seeking help. But an extraordinarily empathic student affairs dean steered me to the treatment I needed. As a result, I am blessed to stand here today.

Today, I want to make a personal plea. I know that many of you have a story like mine. We need to tell our stories and beat back the stigma that causes so many of our learners and colleagues to suffer in silence. Speaking out and erasing the stigma around seeking help is a most worthy mountaintop to reach.

Before I close, there is one more part of our journey that I want to mention. Throughout my tenure, many of you have heard me talk about the importance of culture. In every campus I visit, I see the many ways you are changing our culture at all levels of your organizations. It has been incredibly gratifying to see how our community is moving from its culture of independent silos to cross-cutting collaborations. How much of our work is now the result of high-performing teams instead of independent individuals. How we are moving from academic medicine being perceived as the problem in our health care system to being innovative leaders in developing solutions. How we are shifting the paradigm for choosing the next generation of physicians to one that values humanistic qualities as much as academic competencies.

Perhaps nothing has the power to shape culture more than a leader. Each of my predecessors was an exceptional leader. During difficult times, effective leaders who set a positive tone are critical in guiding success. The leaders we need not only will seek excellence in our core missions but also will remain true to our core
ethical principles. As a nation, we are clearly struggling to define the culture we seek. Is it a culture that values hierarchy, exclusion, privilege, and power? Or is it one of compassion, inclusion, community, and accountability? Academic medical centers are shining examples of those latter qualities, and we need leaders at all levels striving to strengthen and extend that culture. It isn’t just important to the future of health care that depends on that leadership; it’s important to the health of our democracy.

Dr. Cooper closed his final speech at the AAMC annual meeting in 1985 with a wish that in 30 years, a young medical scholar or educator, perhaps someone in the audience that day, would be standing on the same podium and once again say, “We have lived through one of the golden ages of medicine.”17 When I look out from the new heights we have reached in our missions, I certainly can say that today. And now, my wish is that when one of my successors stands here 30 years from now, she or he will be able to say the same thing.

There is no way I can adequately express how grateful I am for having had the opportunity to work for and represent you for 13 years. I deeply appreciate the unwavering support you have given me, and more important, your abiding commitment to advancing the health of all. Please know that I will always remain fully committed to doing my part. Together, we will continue climbing mountains, however high they prove to be.


