

**AAMC President's Address 2008:
"The Tough Questions"**

AAMC President and CEO Darrell G. Kirch, M.D., delivered the following address at the association's 119th annual meeting in San Antonio, Texas, on November 2, 2008:

"I want to thank Dr. Sussman for leading our session today and for that very kind introduction. I also want to thank you for giving me the honor of entering my third year of serving you as AAMC president and addressing our community at our annual meetings. I am especially grateful for your being open to thinking with me in 2006 about reaffirming our commitment to the public good, and last year to considering the need to develop a new culture in academic medicine. These areas remain significant challenges for us, and I greatly appreciate your support and insights.

Today, I want to link these earlier concepts with an idea we have been hearing constantly this year: 'change.' With just two days remaining before a momentous national election, it is hard to think about anything other than how our country might change. In fact, we have witnessed historic primary and presidential campaigns in which all the candidates have tried to wrap themselves in a banner of change, and, as a nation, we have seemed to agree. We are totally dissatisfied with everything from an unraveling of our economy unlike anything most of us have ever seen to an unprecedented low in our international status. All the candidates know they need to represent a major change from that status quo to be elected. But what happens once we move beyond next Tuesday?

While we expect those whom we elect this week to lead our nation in change, that idea can be very abstract – just a political platitude. But hopefully, for our 44th president and the 111th Congress, that idea will be very real and translated into bold action.

Today, I want to talk about the conversation we seem to be avoiding. Specifically, how much real change are we each personally prepared to make? In particular, are we finally ready to ask ourselves some very tough questions; questions that we have been putting off for years, if not decades? Increasingly, many of the most important questions we face at the national level are viewed as 'third-rail' topics; that is, issues no one (especially candidates for president) wants to touch. Let me give you a few examples.

First, look at our economy. In recent weeks, we have seen in our financial markets what happens when we avoid tough questions such as the following:

- Is the way to current and future economic security for all Americans really based on 'free markets,' 'no regulation,' and 'no new taxes,' or is there some real burden to be shared?

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- Are so-called ‘entitlements’ guaranteed for all Americans, even those of significant means?

Turning to our infrastructure:

- Can a nation like ours truly prosper without government spending on public infrastructure, ranging from roads to higher education to medical research?

And speaking of roads:

- Is the problem really the \$4.00-a-gallon gas we worried about last summer, or clinging now to a belief that we can build a future without investing in the development of alternatives to fossil fuels?

Turning to defense:

- Are we made truly safe by being ‘the only global superpower,’ or does any degree of military strength have its limits in a complicated world filled with fracture lines between its peoples?

And finally, a national question of special relevance to our own community:

- Are we willing to be the only developed nation with such low health indices, such wide health disparities, and so many citizens lacking health insurance?

I think you will agree that these are extraordinarily tough questions. The reason they are tough is that they speak to our own personal values, to our national culture, and especially to our openness to change our own expectations and behaviors. Whether change really occurs with a new administration is not up to the next occupant of the White House. It is up to us, as citizens of this country. After Tuesday, and for years to come, are we prepared to ask and answer these questions about our own willingness to change? Are we ready to take personal action, to give up some of our entitlements, to reduce our national and personal debt, to accept that we cannot unilaterally dominate the world, and to take more responsibility for our own healthy behaviors? Each of us will need to search our soul to see if we are ready to accept these burdens.

As I thought about the challenges facing our nation this year and about what lies ahead for the AAMC, I realized that academic medicine faces a similar challenge. Like our nation as a whole, we have some real strengths, but—to be blunt—we also have been avoiding some very tough questions. Today would seem like a good time to ask a few of them. Some are questions I called upon our community to begin to consider two years ago when I talked about recommitting to the public good and getting our own houses in order so we can better lead the nation in education, research, and patient care. Some are issues I raised last year about moving from the old academic culture to a new one. Today, building on these concepts and facing a momentous election I hope we stand ready to face some of the toughest questions for academic medicine and move closer to individual and collective answers and action.

The first question we seem reluctant to confront fully is this: ‘Do we need to free ourselves much more aggressively from perceived conflicts of interest with industry, and will that be enough to preserve the public trust in medicine?’ This question is fundamental to our institutions and our daily work. Speaking at our annual meeting in 2000, former AAMC President Jordan

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Cohen, M.D., observed: ‘Maintaining public confidence in the integrity of what we do requires more than assuring ourselves that external financial interests have not tainted our scientific and ethical standards.’ In the eight years since Jordan gave us that challenge, a series of AAMC working groups have issued groundbreaking reports and recommendations about how we should properly manage potential conflicts and ensure integrity in our increasingly complicated and important relationships with the for-profit sector. Despite that work, we continue to be besieged by headlines and negative public reaction about faculty colleagues who appear to have embarrassing entanglements with industry.

What will it take to affirm our integrity in the public eye? We may have to go beyond actions such as endorsing legislation, including the proposed Physician Payments Sunshine Act that would require public reporting of industry support for doctors. We may need to go beyond our own institutions banning gifts, to more strictly limit faculty consulting agreements, as well as end faculty participation in industry speaking bureaus. We may even need to engage in the much tougher task of more rigorously separating our continuing medical education from corporate support. Many of you are already moving in this direction and know how challenging it is.

Earlier I mentioned our national issues of health disparities and the uninsured. But there is a similar question for academic medicine. ‘How much economic inequality are we willing to tolerate in our own professional community?’ Do we really want a world in which some teaching hospitals and medical specialties are ‘haves,’ doing very well, while others are conspicuous ‘have-nots?’ While some teaching hospitals have solid margins and endowments, many (especially inner-city and rural safety-net hospitals) struggle to stay alive financially. Disparities between medical specialties loom just as large. In the United States—more than in any industrialized nation—we see the widest gap between the highest and lowest compensation of different medical specialties. Depending on the data set, some procedural subspecialties currently average an annual income three or even four times as much as some primary care disciplines. And then we wonder why our debt-laden students are not choosing primary care. We simply cannot avoid the tough questions that follow from this situation, such as whether medical school tuition should be capped at or below inflation, and whether we should redouble our philanthropic efforts toward student scholarships.

If we really are willing to step outside our comfort zone, we should ask ourselves another question: ‘If we truly believe in three balanced missions – teaching, research, and service – why have we tolerated misalignment, and all too often overt conflict, between our clinical and academic enterprises?’ How many academic medical centers are able to boast of a school, health system, and physician practice plan in which all the leaders and the frontline faculty are tightly aligned? In particular, how many of us have truly ‘opened our books’ so that there is broad understanding of the complex finances and solid support for the cross-subsidies that balance all three missions? Even more challenging, if our ability to cross-subsidize medical education and research from clinical earnings is disappearing, is it time for us to develop a new business model for medical schools that does not rely on keeping more and more clinicians on a treadmill?

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As we approach the centennial of the Flexner report, we face a very challenging question about medical education: ‘Will we continue to view medical school, residency, and practice mainly as a one-size-fits-all series of fixed, independent compartments, or will we start to design a more flexible system with true continuity that is more accepting of change in pre-medical requirements and training for new models of practice?’ Are all students the same and does each require the same time in each ‘compartment’ of medical education, or can we be more flexible about the duration of training? Can we create a system in which some individuals become fully trained, board-certified physicians in less time than others? Can we create a system that is more welcoming to nontraditional students and those from disadvantaged backgrounds by acknowledging that the MCAT® may not be the only indicator of a good future doctor?

Which brings me to another set of tough questions about the way we prepare our next generation of doctors: ‘Do we unrealistically expect the next generation of physicians and scientists to be just like us, or are we willing to accept that they are very different people with different aspirations for their personal and professional lives?’ Our AAMC data show nearly as many women as men entering medical school and, even more strikingly, that both genders have different expectations than my generation about work-life balance. Can we change to accommodate this different view of professional obligations? How do we support a husband and wife who both graduate from medical school with a combined debt of nearly a half-million dollars, and who want to start a family? Perhaps their specialty choice or their desire to work part time is not a sign of any deficit in their work ethic, but rather a principled response to challenges my generation never faced.

And there is one more question near and dear to all of us when we view the world as current or future patients: ‘If we consider ourselves to be scientific leaders, when will we show the entire health system how to make quantum leaps in quality of care and patient safety?’ No longer is it acceptable to presume that we have a quality advantage because we are academic institutions. We must *demonstrate* that we are better. Even more important, we need to be prepared for the possibility that well-constructed measures will show that all too often our patients do not experience the safety, quality, and coordination of care we expect for ourselves and our families. If that is the case, then we must have the truly difficult conversation about what we should change *now* in the academic health care systems under our own control, rather than wait for broader health care reform to occur. Does anything really prevent us from coordinating care in our hospitals and clinics? And, if we measure patient satisfaction, are we acting on the results?

These then, are the tough questions we face in academic medicine: can we achieve freedom from conflicts of interest; fairness in our institutions and specialties; true balance in our missions; flexibility and responsiveness in preparing a new generation of doctors; and leadership in improving health care quality? I realize that many, if not all, of these tough questions may make those of us in academic medicine genuinely uncomfortable. They challenge some of our long-held assumptions about the superiority of our motives and our systems. Answering these questions, and acting on the answers, may cause us to experience some real dislocation and pain.

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For example, I do not see any prospect for significantly increasing total national health care spending beyond our already globally high levels. Given that fact, if any of the economic inequities in our system are going to be corrected, it means there likely will be some financial redistribution between health system components and health care providers. It means we will need to have extraordinarily difficult conversations nationally and in our institutions. It means that more than simply discussing these questions, the answers will likely involve our being asked to give up something. And it means there will be real pain to be shared, as we likely will be asked to give up cherished assumptions, our sense of autonomy and control, and even to forego some financial gain. Are we ready to do that?

Let me share with you another tough question with which I have been struggling. Thirty-five years ago this fall, as a first-year medical student, I took a course in medical ethics. The course led off with a description of four basic principles of medical ethics: beneficence (helping our patients by doing good for them); nonmaleficence (doing no harm); autonomy (respecting the individual patient); and justice (always keeping fairness to society in mind). Since then I – and many of you in this room – have taught other medical students these very same ethical principles.

The question with which I struggle is this: We say we remain committed to these ethical imperatives, but are they in balance? Is each medical school, each teaching hospital, each faculty member considering all four principles in their decision making? I would argue that, in large part, we have given far too little attention to our shared professional responsibility for the fourth principle, social justice. The reality is that we have been living with far too much *injustice* in our current health system. As a profession, we have been waiting for someone else to ‘fix’ that system, just as we, as a nation, have been waiting for a new leader to ‘fix’ our country.

What we should be asking ourselves instead is why we expend so much energy toward preserving the status quo (especially a health care system that over-rewards interventions and ‘rescue care’ while it under-rewards wellness and prevention), rather than taking immediate action in the areas under our control to change the social injustice of our current system. If we are honest with ourselves, our ethics appear to be out of balance. While, in keeping with these four principles, we strive to do the right thing for our individual patients and to avoid harming them, and while increasingly, we respect patient autonomy, we seem to be waiting for someone else to deal with social justice.

As I asked this audience two years ago, do we still believe that we have a personal responsibility to care for the poor and disadvantaged? In a time when increasing tuition and debt levels may put medical school out of reach for all but the wealthiest of applicants, are we selecting increasingly affluent students and then failing to inspire them to commit to a social mission?

It seems that we spend much of our time in academic medicine preserving a status quo that fails to inspire us, instead of creating a better one. I am reminded of the cartoon that says,

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‘Change is good – You go first.’ How prepared are we in academic medicine to go first and make both personal and institutional sacrifices – even before someone else fixes all those things we perceive to be wrong with the larger health care system? I do not see any of our most pressing problems being corrected until we individually and collectively accept the fact that there is a burden we have been avoiding. By each of us taking ownership, by personally acknowledging the problem, by preparing to accept and share some of the pain, and then by taking action (even if it means sacrifice on our part), we will take a major step forward.

Two years ago at our annual meeting in Seattle, I talked about our being at a tipping point for change. And last year, at our annual meeting in Washington, D.C., I talked about the culture clash in which we find ourselves between the old academic world and the new. Maybe this is the time it all changes. Not just when we will ask ourselves the tough national questions in two days in the voting booth, but when we return to our institutions and take responsibility for answering the tough questions we have been avoiding in academic medicine. Maybe—after this long presidential campaign in which the word ‘change’ has so clearly resonated at campaign rallies—it also will be the focus of our discussions and our actions in our own schools and health systems. It truly is up to us.

Thank you so much for the opportunity to share these thoughts with you.”

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