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# LEADERSHIP PLENARY ADDRESSES

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The AAMC (Association of American Medical Colleges) is a nonprofit association dedicated to transforming health through medical education, health care, medical research, and community collaborations. Its members are all 155 accredited U.S. and 17 accredited Canadian medical schools; approximately 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and the millions of individuals employed across academic medicine, including more than 186,000 full-time faculty members, 94,000 medical students, 145,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Additional information about the AAMC is available at [aamc.org](https://www.aamc.org).



### AAMC BOARD CHAIR'S ADDRESS 2021

## Leaning Into Change to Fulfill Our Promise



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*J. Larry Jameson, MD, PhD, Executive Vice President of the University of Pennsylvania for the Health System, Dean of the Perelman School of Medicine at the University of Pennsylvania, and Chair of the AAMC Board of Directors, delivered the following address at Learn Serve Lead 2021: The Virtual Experience, the association's 132nd annual meeting, on Nov. 9, 2021.*

Friends and colleagues,

Today, as chair of the Board of the AAMC, I want to use this Learn Serve Lead forum to encourage us to “lean in” and enact change where we know it is needed.

Academic medicine is a complex ecosystem. Like other ecosystems, we must evolve to remain competitive and viable. This audience is uniquely positioned to catalyze this evolution — with your passion for academic medicine, your commitment to improve health for all, and your ability to use evidence-based knowledge.

Our shared experience with COVID-19 provides a poignant case study in adapting to a rapidly changing landscape. Science has never moved more quickly.

Our front-line physicians, nurses, and staff demonstrated remarkable adaptability and resilience — and they are indeed heroes. Our students and faculty pivoted their approach to learning. And, while too many have died, we have also saved countless lives through innovations in care and the rapid deployment of mRNA vaccines.



While I highlight these successes, there are areas in which we could have done better. In my view, our country did not fully harness the power of academic medicine — for test development and widespread, frequent testing; for expedited, nonduplicative clinical trials; and for large-scale pooling of clinical data. Despite determined efforts by many, we failed to communicate effectively to large fractions of the population.



We should be proud of what we accomplished during COVID, but we should also learn from this experience — preserve the elements that worked well — but also acknowledge the challenges and do better.

We should be proud of what we accomplished during COVID, but we should also learn from this experience — preserve the elements that worked well, like telehealth and the strategic use of Zoom interviews, but also acknowledge the challenges and do better in the future.

I cite this well-known example of our shared experience with COVID as a preamble — as a call to action — for us as leaders in academic medicine to adapt continuously, to innovate, to implement, to lean in, to make academic medicine more relevant and effective.

As most of you know, with your input, the AAMC has developed and launched an ambitious [strategic plan](#) that outlines a path to a healthier future through learning, health care, discovery, and community collaborations. Now, it is up to all of us to ensure its implementation.



**There is an understandable reluctance in academic medicine to be nimble and embrace needed changes. We are, indeed, burdened by complexity and steeped in tradition.**

I want to start our journey together by grounding us in our missions.

We have the privilege of serving as physicians — preventing disease when we can, treating patients when disease inevitably occurs, and supporting them when our options are exhausted.

As scientists, we are challenged to unlock the closely held secrets of nature, and when possible, to translate these newly discovered clues into knowledge and treatments.

We are learning to collaborate with our patients and communities to focus on prevention, improve outcomes, and close gaps in health disparities.

We have the privilege of transferring knowledge and experience to eager, stunningly brilliant students, who inherit a future we cannot reliably foresee.

I highlight these classic missions of academic medicine because they reflect the complexity and importance of our professional roles.

Because of that complexity — and the importance of what we do — there is an understandable reluctance in academic medicine to be nimble and embrace needed changes. We are, indeed, burdened by complexity and steeped in tradition.

I want to challenge you — challenge us — to accelerate needed changes in health care and science.

We know the potential of the U.S. health care system. We are the innovators of most new medical advances; we have generous funding from the NIH that fuels our breakthrough basic and translational research discoveries; American biotech and pharma industries pioneer most new therapies. We have some of the finest health care facilities in the world.

Nevertheless, it is a long-standing tragedy that our health outcomes lag most of the developed world. Our business community, government, and fellow Americans are losing patience with the cost of health care delivery and challenges with access.

In this audience, the sources and potential solutions to this paradox are well-known — social determinants of health, persistent health disparities, misallocation of resources, particularly relative to prevention, and a payment system that is overly bureaucratic and not well aligned with incentives to optimize outcomes at lower cost — to name just a few issues that are well known to you.





We own the culture of academic medicine. We should remember that our profession is largely self-regulated. ... We can change these policies and practices.

As physicians and leaders in academic medicine, we cannot wait for others to address these challenges. Change will happen either with us or to us.

While these challenges can seem intractable, I am convinced that we can solve these problems — big and small. Remember, you have power to act locally in your own institution and in your communities. Each step that we take to improve access, reduce disparities, or advance prevention adds up.

We can all implement these changes locally — in our classrooms, clinics, laboratories, and operating rooms. We own the culture of academic medicine. We should remember that our profession is largely self-regulated. We created most of our policies — formal and informal. We establish the curriculum — explicit and hidden.

Therefore, in principle, we can change these policies and practices.

For example, we can decide whether to embrace more holistic criteria for promotion. We can decide whether we value team science as much as, *or more than*, individual accomplishments.



At my institution, Penn, we recently added community-engaged research to our formal categories for scholarship; we set explicit expectations for professionalism and review these for appointment and promotion; we expanded our education categories to embrace teaching and mentoring in practical settings like clinics, ICUs, and laboratories, as well as in the classroom. We overtly state that we are united as an anti-racist organization, setting an expectation for our culture.


I know you have similar examples in your own institutions, but I cite these to remind us of the ability to act locally.

As an academic community, using holistic review criteria for medical school applicants, we can select for characteristics and skills that are likely to predict future clinicians that you would turn to for a consult or to care for a loved one.

Perhaps these characteristics will not be so heavily weighted toward traditional quantitative measures like GPA and MCAT, which granted, provide one indicator of success.

But what about overcoming adversity, demonstrating empathy and resilience? What about curiosity and willingness to learn broadly and take chances on courses that might not earn an A? Within LCME guidelines, we can redesign our curriculum and residency training experiences focused on the future, rather than based on tradition.



We have reached an inflection point in the effort to root out racism and bias in medicine. ... We need to ... ensure that our climate is conducive to learning and positive experiences. 

These are examples of hard problems involving policies and culture, but they can and should be taken on by the people in this audience. After all, we are innovators and healers.

In Walter Isaacson's historical accounts of innovators like Leonardo da Vinci, Benjamin Franklin, Albert Einstein, Steve Jobs, and one of our speakers, Jennifer Doudna, he observes a recurring theme of creative people feeling alienated early in life, but then overcoming adversity, taking chances, and applying discoveries to real-world problems.

There are lessons in these themes.

Yes, there are risks to broadening our selection criteria, but there are also risks to *not* embracing a more diverse group of future physicians. Innovation and diversity are symbiotic partners.

Diversity in medicine is a long-standing priority for the AAMC and, I am confident, in each of your institutions.

I hope — and believe — that we have reached an inflection point in the effort to root out racism and bias in medicine. Last year's widespread outrage over racial injustice has catalyzed an ongoing movement to effect enduring change.

Each of our institutions saw a major uptick in applications during the pandemic. After years of slow progress, this increase was fortunately accompanied by the enrollment of more diverse students into medical school and PhD programs.

We need to build on this momentum and ensure that our climate is conducive to learning and positive experiences, so that the word can spread that medicine and science are receptive to diversity and that exciting professional opportunities await students from a wide range of backgrounds and experiences.

The literature is replete with evidence that diversity strengthens the performance of high-functioning teams. Embracing diversity and inclusion will help us evolve more quickly and successfully.

More diverse caregivers are essential to build trust in our profession, and this trust can accelerate closing health disparities.

Medical education must also adapt to the accelerating, and sometimes overwhelming, amount of information that physicians must learn and digest on an ongoing basis. We will increasingly need highly specialized experts who can digest the information needed to deliver precision medicine.





As leaders, we need to guide students toward fields where they can excel and make a difference.

But we also need to support the most complex and challenging specialty in medicine — primary care — a field requiring extraordinary breadth, depth, and expertise to filter the rare from the common.

As leaders, we need to guide students toward fields where they can excel and make a difference.

An important goal is to minimize financial and lifestyle incentives that do not currently align with a student's skills or interests, nor with the clinical needs of our patient population. Innovation in research has been, and remains, a critical part of our relevance and our future.

I am trained as a physician-scientist. At each stage of my career, I thought we were approaching the pinnacle of biomedical advances.

But we are far from the apex.

Around every corner is a stunning unforeseen breakthrough — the emergence of epigenetics for regulating gene expression, the engineering of CAR-T cells to treat cancer, the use of fetal surgery to treat developmental defects like spina bifida, the development of CRISPR-Cas9 for gene editing, and the use of TAVR as a less invasive way to repair heart valves.





The tools and opportunities for major research advances have never been greater. The remarkable efficacy and safety of the mRNA vaccines ... reinforce the value of biomedical science to society.

The tools and opportunities for major research advances have never been greater. The remarkable efficacy and safety of the mRNA vaccines against the SARS-CoV-2 virus show how much we can accomplish.

These types of advances can rarely be supported by academia alone.

The platform for mRNA vaccines was developed by two scientists at my institution based upon decades of basic research. But it required collaboration with government and industry to bring this technology to patients.

We can seize this moment in history to build support for translational science and quicken its pace by expanding our partnerships with industry, while being transparent and attentive to conflicts of interest, as we collaborate to find and evaluate new treatments.

In addition to the practical benefits of new therapies, these breakthroughs give our patients hope and reinforce the value of biomedical science to society.



I encourage each of you to reflect on the way you lead. We need leaders willing to innovate boldly, but in a manner that preserves our high standards for evidence, safety, and professionalism.

This call to action — to shape the future of academic medicine — cannot happen without your leadership and commitment. You are our current and next generation leaders.

I encourage each of you to reflect on the way you lead in education, in your clinics, in your laboratories, in your communities, or at a system level.

There are literally thousands of books on leadership. While I encourage you to read some of these and participate in leadership courses, there is no substitute for graduated experience, self-reflection, and mentoring.

Academic medicine has myriad leadership niches.

Different institutions and different roles require varied leadership styles and experience. You can find your niche within this spectrum of opportunities. Some of these will likely require stepping out of your comfort zone and taking risks. We need leaders willing to innovate boldly, but in a manner that preserves our high standards for evidence, safety, and professionalism.

Before I finish, I want to return to where I started — the privilege of serving our mission areas.

I have spoken of challenges, innovation, and change management. I also want to speak of gratitude because it will remind us of the excitement and importance of what we do. And it can provide resilience when we navigate the choppy waters that often accompany change.

I have found gratitude and joy in each of my roles in academic medicine.

I never expected to be a doctor or a scientist, much less a department chair or dean. Each of our roles is different. I find that satisfaction comes not from titles but from doing a job well and loving what I do.

I will give some examples from my own experience, mainly to encourage you to think similarly about your own professional lives.

I vividly recall a clinical experience as a newly minted intern during one of my first patient encounters. I admitted an elderly man with metastatic prostate cancer. He had lost weight, was listless, and was bedridden.

He came up from the ER with the common diagnosis of “failure to thrive.” My initial assumption was that he was in the final stages of his disease. However, his K+ was elevated. Somewhere from the memory banks of medical school lectures, adrenal insufficiency surfaced in the differential diagnosis.

An ACTH stimulation test confirmed the diagnosis, and cortisol replacement dramatically restored his vitality. This diagnosis may not have changed his long-term outcome, but it did improve his quality of life, and reinforced for me the power of knowledge to help people.

I know you have similar stories, and I urge you to reflect on your own memories of making a difference in people’s lives.

This is the joy of medicine.





For most of my career as a physician-scientist, my work has felt more like a hobby than a job. Why else would one awake at 2 a.m. with a novel idea, get out of bed, and head into the lab to get started on the next experiment?

It is thrilling when new data turns over a missing piece of an unsolved mechanistic puzzle, ultimately revealing a full picture that is beautiful to behold.

Some of these experiences feel like epiphanies and are shared with graduate students or postdocs in the relative isolation of the laboratory. Others occur during a plenary talk when a large group shares the experience of a new insight as they see the final slide with the “big reveal.”

Research can be arduous with many failures, so we must recognize, celebrate, and remember these dopamine-rich moments of euphoria. This, too, is the joy of medicine.







Teaching is amplification leading to impact. The spirit of joy touches every aspect of our work — patient care, research, teaching, and engaging with our communities. 

Our devotion to teaching and mentoring is arguably the greatest wellspring of joy.

I am often surprised when one of my former trainees mentions something I said to them of which I have no clear recollection but seemingly provided a memorable pearl or changed their career plans.

As you teach students, residents, or colleagues, they will, in turn, use this knowledge to manage untold numbers of patients. For me, this is like a PCR reaction.

Teaching is amplification leading to impact. The spirit of joy touches every aspect of our work — patient care, research, teaching, and engaging with our communities. It can also be found in leadership roles and in implementing the changes in the culture, traditions, and practices of academic medicine that are essential to our future and to improving the health of our nation.


Our field needs your leadership at this time, and you can find joy and satisfaction in leadership, as well as in our traditional missions.

I am deeply grateful for our community's collegiality and sense of purpose. We can meet the challenges of these extraordinary times.

We can lean into change — to improve patient access and outcomes, to create a stimulating educational environment for a broader group of learners, and to translate new scientific insights into novel therapies and cures for our patients.

I call on each of you to join in this journey to a healthier, more equitable future — to enact the change that we know is needed to fulfill the promise of academic medicine.



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## AAMC PRESIDENT'S ADDRESS 2021

### Momentum



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*David J. Skorton, MD, AAMC President and CEO, delivered the following address at Learn Serve Lead 2021: The Virtual Experience, the association's 132nd annual meeting, on Nov. 9, 2021.*

Thank you, Dr. Calhoun, and what a powerful message from Dr. Jameson about the spirit of joy that draws us to academic medicine. I'm honored to join you and our colleagues for the third time and at such a critical point in academic medicine's journey.

A moment ago, we heard Dr. Jameson's eloquent call to lean into change. I'd like to share some thoughts about what kind of change is needed, as well as how much change *is possible* — in other words, how far can our momentum take us? I speak from two perspectives: the monumental advances I've witnessed throughout the four decades of my academic career, as well as the accelerating change over the last two years.

But before continuing with the remarks I had prepared for this plenary talk, I want to stop and acknowledge the concerns expressed during the Meeting of the Minds panel this morning.

The original intent of that session was to encourage us to stretch ourselves to learn from others' perspectives, including those who hold divergent viewpoints.

As I mentioned in introducing the panel, I have received feedback from members and AAMC staff over the past year about how the AAMC must do better in welcoming a broader range of points of view on political and social issues. The panel was an attempt to move toward that broader dialogue in a respectful and mutually reinforcing manner.

I take responsibility for the fact that the panel did not in many respects realize my aspiration in organizing it. I watched carefully the comments from many of you in the chat and shared many of those concerns. There are many lessons to take from this panel, and I hope that in our town hall tomorrow, we can further discuss the underlying issues and the panel, as you wish. I look forward very much to that conversation.

Now, I want to return to my prepared remarks and acknowledge the remarkable progress academic medicine has made over the course of my career.

If I had been born with a congenital heart defect, like so many patients I've treated in my practice, I likely would not have lived to become a physician.

Back then, over 80% of babies born with congenital heart disease died before reaching adulthood. And today, it's the reverse: 90% survive into adulthood.

And throughout my career, astounding new diagnostic and treatment options were developed, ultimately extending lives. Well, cardiology is obviously not the only field in which academic medicine has revolutionized care. Many of you have seen revolutionary changes in your own fields, whether immunotherapies or accurate and sensitive new approaches to diagnosis — and not just witnessed them, but *delivered* them.

And the last two years of the COVID-19 pandemic have seen further dramatic developments. And to name just two — and there are too many to list — we've introduced some of the first groundbreaking mRNA vaccines after decades of fundamental research, unleashing great potential for the future. And we've embraced the widespread adoption of telehealth.

The brave new ideas you've pioneered — and your boundless resilience in the face of immeasurable stress and pain — fill me with hope, and optimism, and confidence for our future.



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I know the last two years have cost you. In our conversations, I have heard and felt deeply the immense strain you bear.


Crushing burnout, fatigue, and anguish are nearly universal, and not just among front-line physicians. Premed and medical students, other health professionals, and others in a variety of roles suffer, too.

Beyond COVID and the world of medicine, we're reeling from the impacts of systemic racism, economic uncertainty, the way science has been politicized, and financial and operational challenges within our own institutions.

And I am relieved that many of you have sought help, which is not a sign of weakness but of strength. I salute you for seeking help and for coming together to support each other.

Two years ago, when I first had the privilege to speak with you in this forum about the unacceptability of the status quo, none of us could have imagined the extent of change that has occurred since then. This, indeed, has been our time to act — and you have acted.



Community collaborations are blossoming across academic medicine and beginning to make a real difference toward improving population health and health equity. 



Community collaborations are blossoming across academic medicine and beginning to make a real difference toward improving population health and health equity. As you recall, last year the AAMC added community collaborations to our traditional tripartite [missions](#) of research, education, and clinical care, aligning with longstanding consensus on the vital role of communities.

At the University of Texas at Tyler, for example, the Health Science Center is working with organizations in criminal justice, law enforcement, school districts, and more. They're co-creating ways to address substance use disorders in the rural communities of East Texas through shared decision-making and long-term relationships built on trust.

Boston Medical Center is working with community organizations and government agencies to invest in programs that create stable housing, reduce hunger-related illnesses and malnutrition, prevent violence and help victims, and care for people with substance use disorders. Working with communities to assess their needs is a crucial component of the program.

Well, these are just two examples of many across your institutions. And it's wonderful to see these types of programs increasingly central to the work of academic medicine.

And medical education is also transforming as access to virtual learning and competency-based education expands, and faculty have advanced more meaningful competency assessments.

And I am especially gratified to see redoubled commitment to diversifying the medical profession, although we have such a long way to go. Efforts like Morehouse School of Medicine's holistic admissions process and innovative K-12 outreach



are encouraging students from underrepresented backgrounds to enter careers in science and medicine. These programs provide mentoring and introduction to medical careers and specialties.

Additionally, our institutions are developing the commitment to becoming anti-racist organizations. They are working to address structural racism and are fostering diversity, equity, and inclusion. Initiatives like diverse search, promotion, and tenure committees, as well as diverse search pools for faculty hiring, among others, are underway.

And to achieve gender equity, institutions are working to increase the number of women in leadership positions and supporting them once they are in those roles.

A wonderful example is the Medical College of Wisconsin's IWill program, in which faculty, staff, and students pledge to support gender and other types of equity, with an element of personal accountability.

Dr. Francis Collins, who has led the National Institutes of Health with remarkable distinction for more than 12 years, set another superb example by declining to speak on panels comprised only of men. Today, I pledge a similar commitment to participate only in public panels with a diversity of panelists. I call on each of you — as leaders at your institutions — to please join me.



Today, I pledge ... to participate only in public panels with a diversity of panelists. I call on each of you — as leaders at your institutions — to please join me.





The inequities and gaping holes in our health care system from systemic racism that have long plagued us have only intensified in the last two years. ... We must make a long-term commitment to change – to sustaining it and advancing it.

In research, clinical trials are expanding demographic participation to groups that have historically been excluded.

And although research laboratories in areas unrelated to the pandemic faced setbacks from COVID shut-downs, remarkable breakthroughs continue to propel science and medicine forward. The first successful pig-to-human kidney transplant by a surgical team at NYU Langone Health is just one example.

And lastly, on the clinical front, greater use of telehealth and drive-up care — two innovations that finally became more widespread during the pandemic — promise to increase access to care. Each of these examples, and many others I did not list, are worth celebrating.

Yet we're far from successful across the board on all the issues that deserve academic medicine's attention. The inequities and gaping holes in our health care system from systemic racism that have long plagued us have only intensified in the last two years. We still have quite far to go in addressing the paradox Dr. Jameson spoke about: our lagging health outcomes despite our best efforts.

The issues we face also include barriers to medical education, including questions about the length and financial burden of medical training, and a lack of role models.

And so, we must make a *long-term commitment to change* — to sustaining it and advancing it.

And this will not be easy. The issues involved are deeply complex. And they're further complicated by fundamental issues of mistrust, the politicization of nearly everything in our country, including science, and the heightened level of discord in our national dialogue on so many issues. But I have confidence we can together achieve lasting impact: learning from each other and forming meaningful partnerships with our communities, beyond the formal bounds of health care.

Our communities, and the patients and families we serve, deserve nothing less than our most concerted efforts. What does that kind of leadership look like, both at the AAMC and within your institutions?



I have confidence we can together achieve lasting impact: learning from each other and forming meaningful partnerships with our communities, beyond the formal bounds of health care.



When we actively and intentionally listen to and collaborate with communities, we can successfully co-create ways to address the social determinants of health that prevent too many people from being as healthy as they could be.

I'd like to offer three ideas, drawn from my conversations within and beyond the academic medicine community.

First, our communities deserve an environment in which academic medicine takes direct responsibility for the longstanding, seemingly intractable problems I mentioned in my previous speeches — and Dr. Jameson touched on as well — regarding health inequities and more. They are even more urgent than two years ago.

We can improve our communities' well-being by being intentional and holding ourselves accountable, as I spoke about last year — and by practicing humility. That means instead of working in isolation, we must partner with our patients, our families, and our communities to better identify solutions through such conversations. When we actively and intentionally listen to and collaborate with communities, we can successfully co-create ways to address the social determinants of health that prevent too many people from being as healthy as they could be.

That's what the University of Arkansas for Medical Sciences is doing to address food insecurity and nutrition. Community members in that region, home to the largest concentration of Marshallese in the United States, have helped develop culturally adapted programs such as a Diabetes Self-Management Education and Support effort, which leads to better and more personalized care.

It also means improving access to quality care. One way we are doing this at the AAMC is by working with your institutions to study the transition to value-based care and explore ways to improve quality without increasing costs. The AAMC's work with the Center for Medicare and Medicaid Innovation on enhancing new models of care is one example of how we are moving this important work forward.

But to be effective, efforts must also address underlying factors that affect the social determinants of health, factors such as poverty and systemic racism. Last year, the AAMC developed a [framework](#) to address and eliminate racism, recognizing that organized medicine must come together to collectively address racism in medicine. Working together is the best way to dismantle the exclusionary policies, and practices, and norms that perpetuate systemic racism.



The academic medicine community holds tremendous power and privilege. And those we serve should benefit from all the resources with which we've been entrusted.

Our goal is to disrupt the status quo and move academic medicine and health care toward health equity and racial justice.

Let me now turn to the second idea I propose for the type of leadership our communities deserve from us. The academic medicine community holds tremendous power and privilege. And those we serve should benefit from *all* the resources with which we've been entrusted — which means academic medicine must focus on what we can do internally to maximize our external impact.

Let's start with our assets. In few other settings can we find such robust ideas from the next generation of learners, such unparalleled inspiration from faculty in the research, and patient care, and education missions.

This brainpower is reflected in the AAMC [strategic plan](#). Most ideas that formed the basis of the plan and our bold, new initiatives have actually come from you and others in academic medicine, and for that I am most grateful. I will share more about the AAMC's strategic plan in a moment.

But first, one critically important way we're harnessing our resources at the AAMC is by pushing forward important initiatives like our collective effort with other organizations and learners to improve the challenging transition from medical school to residency, which has long needed rethinking. The AAMC has developed a variety of resources, data, and tools to assist students, advisors, and institutions with this important transition.

And our work with the Coalition for Physician Accountability, a group of leaders involved in the transition to residency process, is making some early headway on issues that negatively affect the transition from undergraduate to graduate medical education.

Making these types of changes will not be easy — and we may not all agree on suggested solutions. But we must continue the dialogue, strengthen the communication, push harder the effort.

Turning back to the AAMC's strategic plan, we have launched specific efforts that we hope will help shape academic medicine's future to enable an even better use of resources. Well, let me comment on two:



To diversify tomorrow's physician workforce ☒ our approach ☒ centers on leveraging data for change, widening the path to medicine and other health professions, and addressing the culture and climate for equity in medical education. ☒



One is an effort to create a climate of inclusivity and equity within medical schools, teaching hospitals, health systems, and scientific labs so that *everyone* can contribute to the best of their promise. And the second is to increase the number of diverse medical school applicants and matriculants. These efforts aim to empower and diversify academic medicine's talented and passionate people so we can make greater impact in — and better relate to — our communities.

The first of these, our effort to help academic medical institutions become more inclusive, equitable organizations, addresses two areas that require urgency and attention: promoting gender and racial equity within academic medicine. One component of this plan is to provide foundational educational resources and assessment tools for institutions. Another is to conduct formative research to swiftly support all of you as you examine and eliminate policies and practices that perpetuate inequities. Together we can — and indeed we must — improve the culture and climate of our institutions so *all* of our people are positioned to make lasting impacts.

The second effort is our imperative to diversify tomorrow's physician workforce. Despite a number of approaches, Black, American Indian, or Alaska Native people, among other historically excluded groups, are not well represented in medical schools and the physician workforce.

And so, our approach within our strategic plan centers on leveraging data for change, widening the path to medicine and other health professions, and addressing the culture and climate for equity in medical education.



Through the plan, we will also listen carefully to students, families, educators, and clinicians, partner with subject matter experts in K-12 education, and build on existing efforts to catalyze change.

We hope you'll join us by taking an evidence-based, longitudinal approach within your institution and work with us to facilitate bolder structural interventions. We have a long road ahead, but together I believe we can make significant inroads.

I have a third and final suggestion. In this age of divisive politics, truly listening to each other seems to be a lost art. In fact, we seem to retreat to our own echo chambers, where the possibilities of helpful communication, growth, and problem-solving are increasingly limited.

Our communities deserve safe, productive channels for civil discussion, and I believe academic medicine can provide one place for that. But it will require us to move decisively out of our comfort zones in many cases.

As scientists and physicians, we must *invite* conversations on topics like gun violence and abortion — problems that may have seemed “too controversial” to touch. Well, we can no longer ignore those issues that have been deadlocked by hostile emotions, disagreement, or apathy in our communities.

I urge you: Walk toward these issues and go out into your communities to address them. Take off your white coats. Step outside your offices, head down the block, initiate crucial conversations, and listen with more than your stethoscopes.



Our communities deserve safe, productive channels for civil discussion — and I believe academic medicine can provide one place for that.





**We must invite conversations on topics like gun violence and abortion because they are health issues, even if the conversations challenge us. Even if they show us we could do better. And even if we don't have all the answers.**

Why now? Why us? Because prejudice, hate, politics, and other nonscience factors have taken over public discourse in harmful ways. Dr. Anthony Fauci has called disinformation one of the enemies of public health.

Well, that's our cue. We must create open dialogues on these topics because they are health issues, even if the conversations challenge us. Even if they show us we could do better. And even if we don't have all the answers.

One example is climate change. More than 200 medical journals have identified its effects, including air pollution and extreme heat, as the world's biggest public health threats.

You're already working with your communities to begin to address the social determinants of health. Let's not forget that climate change is relevant to those determinants, limiting access to resources like clean water and air.

I am on a steep learning curve regarding climate change and health as well as academic medicine's role and how we can address it. But I'm involved and eager to learn.

The National Academy of Medicine (NAM) is leading a new [Action Collaborative on Decarbonizing the U.S. Health Sector](#). I serve on the steering committee for this NAM effort and co-lead its Health Professional Education and Communication Working Group, with partnership from Dr. Alison Whelan, the AAMC’s chief academic officer. We look forward to sharing what we learn.

Of course, climate change is another one of the issues that is fragmenting our nation. Yet we must find ways to come together and take collective action. While this may seem daunting, there’s an old Yiddish proverb that I like: “Two mountains can’t come together, but two people can.” We must start, at the local level, to chip away at the divisions between us.



Academic medical centers can – and should – be vital community partners. That means first proving that our institutions are worthy of their communities’ trust. You may find useful our [Principles of Trustworthiness](#) through the recently launched [AAMC Center for Health Justice](#).



As part of this, academic medical centers can — and should — be vital community partners. That means first proving that our institutions are worthy of their communities’ trust. You may find useful our [Principles of Trustworthiness](#), a product of another part of our strategic plan through the recently launched [AAMC Center for Health Justice](#). The Principles and related toolkit provide specific ways you can demonstrate your institution is worthy of your community’s trust. These resources were co-created by the new center — one of two new entities established as part of our strategic plan — along with its health equity collaborative, known as “CHARGE,” and more than 30 community members from nine cities and towns across the country.

This is just one way that the Center for Health Justice aims to spark practice and policy changes that shift entire communities toward health equity. The center leadership believes in leading through partnership with communities and those working in relevant sectors beyond health care.

As we move forward, let's also continue to ground conversations in scientific evidence that's meant to be shared broadly.

The [AAMC Research and Action Institute](#), another new entity created through our strategic plan, recently released a report on lessons from COVID-19, as one example.

Instead of discussing problems in academic terms, or reducing challenges to cost-cutting solutions, the institute is taking a new approach. It's applying real-world knowledge, a strong academic foundation, and an understanding of policy and political realities to complex and long-standing health policy challenges. It is guided by an external advisory committee and will also be seeking your help. Please stay tuned.

Controversial issues cannot be resolved overnight. But I'm confident we can do this together.

So today, I'm asking you personally to pursue change in multiple ways. Consider hosting your own local "Meeting of the Minds" sessions to offer opportunities for civil dialogue. Listen to and understand your community's concerns.



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Come together with others across academic medicine to learn and share ideas and to support the AAMC’s national efforts that resonate with you. I encourage you to learn about all 10 action plans that comprise the AAMC’s strategic plan, as well as the efforts we’ve launched through them.

When you believe it makes sense, align your corresponding work with our strategic plan, just as the AAMC is adjusting our own activities to meet the needs of our members. At the end of my talk, there will be some links and email addresses in the chat box, and I encourage you to share your input. We within the AAMC want to hear from you, through correspondence, affinity group meetings and town halls — including tomorrow’s, which I hope you’ll join.

I am especially grateful that you continue to share directly with me ways the AAMC could do better, and I commit to continue taking your suggestions seriously.

I’d like to leave you with this thought on where we are as an academic medicine community. While the status quo of health in this country is still unacceptable, we’ve begun to gain momentum in tackling what previously seemed like insurmountable problems.

It’s been wonderful to see your institutions collaborating on everything from curricula and patient care protocols to research collaborations and beyond. I am confident that the talented, innovative, resilient academic community has what it takes to build on the successes of today to create even more tomorrow.



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**We can do this together. Let's build on our momentum!**

Academic medicine, as you know, is always changing. For context, this year marks the 200th anniversary of the birth of Dr. Elizabeth Blackwell, the first woman in the U.S. to graduate from medical school. Wouldn't she like to know that today just about half of medical school graduates are women.

In her day, she commented that "It is not easy to be a pioneer, but oh, it is fascinating!"

She's right. You're doing fascinating work, and I'm thrilled to continue to work with and learn from you as true pioneers on this important mission. We can do this together. Let's build on our momentum!

Thank you.





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