MoS Rapid Response Script – David Skorton

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BOB SAFIAN: That's Dr. David Skorton, CEO of the AAMC, the Association of American Medical Colleges, and a cardiologist by training. David Skorton isn't our typical guest. He's not a founder or an entrepreneur in the typical sense. But for months now, hospitals have been on the frontlines of scale. Hospitals have faced overwhelming challenges they weren't equipped for — and in many cases, they're now innovating their way toward solutions.

David has a bird's-eye view of what health institutions are grappling with, how they need to rethink the way they operate, and what all of us — in any kind of organization — can learn from this moment.

This is Bob Safian, your host for Masters of Scale: Rapid Response. Let's listen in.

[Theme Music]

SAFIAN: I'm Bob Safian and I'm here with Dr. David Skorton, CEO of the Association of American Medical Colleges. The AAMC includes among its members all of the teaching hospitals in the country, from Johns Hopkins, the Mayo Clinic, to UCLA. David is also former Head of the Smithsonian Institution and former President of both Cornell University and the University of Iowa, so he can offer us insight into the evolving challenges around COVID-19 in both healthcare and education, from policy to on the ground actions. He's coming to us today remotely from his home in Washington D.C. as I ask my questions from my home in New York. David, thanks for joining us.

SKORTON: Bob, such a pleasure.

SAFIAN: You have direct access to the under pressure hospital system as well as an overarching perspective. And I want to start by asking you about when the hospital and medical community first began to recognize and prepare for this pandemic. For you personally, when did you realize that, whoa, this COVID-19 thing was something different?

SKORTON: I remember very distinctly in late February, early March, beginning to read about this a little bit in medical alerting services and a little tiny bit in medical journals. And then roughly the first week of March, it dawned on me that this was something serious. The word pandemic hadn't popped into my mind yet, but outbreak was the word that I was using at the time.

And the next week I decided to have all of the employees of the AAMC, 700 strong, work from home in Washington or close by environs. In retrospect, there were things to be known several weeks before that, but that was when I really tumbled, not so much to the fact that there was an outbreak, but that this was going to be something potentially very big and life changing for the world really beyond the country.

SAFIAN: Yeah. I think there are people who look back and say, "Should we have been more prepared?" Or, "What ways could we have been more prepared?" My recollection is first concerns were about sort of lack of personal protective equipment. The phrase “PPE” wasn't something people even knew. Now you can just use that expression and people know what you're talking about. And I'm curious whether as you think back sort of the way our hospital system works, there's kind of a disincentive or had been to have excess equipment, even excess beds, and whether that's something you reflect on now?

SKORTON: It would be a great, great wasted opportunity if we didn't look back on many, many things from the middle of this pandemic. For sure, we could have been better prepared as a country and as a sector. Now, as you said, there's a lot of disincentives to have extra stuff around for whatever set of reasons, but we have something called the strategic national stockpile, so-called SNS, and the point of that stockpile was to have materials that seemed excess at the moment but would be called into play if there was a surge in this or that problem. And we didn't keep that up as well as we might have.

In the hospital healthcare arena in general, one might say that there are some things that have been unsolved problems, not for years, Bob, but for decades, for generations, that I hope we now take more seriously.

One has to do with the financial incentives that we give for the way we do healthcare delivery. Now this is outside the hands of the people who provide medical care, physicians, nurses and so on. It's largely outside the hands of those who are executives at hospitals and health systems, but we largely have worked in a system that's based on

reimbursing people for the amount of volume of the care that they deliver. We're working toward changing it, but we still basically have a lot of areas where we're based on volume. And the other one that I've thought more about than any single factor since the pandemic hit is the plight of vulnerable populations.

And newscasts say, "Well, it's shocking that African Americans are dying in numbers beyond their representation in the population, in certain neighborhoods and certain areas. The same for Hispanic folks." But actually the pandemic didn't cause these inequities, but it sure brings them out in bold relief. And we have for a long time not really dealt with the enormous, enormous inequities in our society, and I'm just talking about health inequities today aside from anything else. And we're paying the price for that now in disproportionate danger for those whose lives had disproportionate risk anyway – and not only ethnic and racial groups, but the homeless, incarcerated, a whole variety of people who are more vulnerable.

SAFIAN: And you're saying that vulnerability is demonstrated by the COVID-19 crisis, but it existed anyway in society with all kinds of health issues.

SKORTON: That's exactly right. I'm a cardiologist, and deaths from heart disease have gone down quite a bit since we're doing a better job controlling hypertension, since smoking has cut down quite a bit. But the biggest factor in health are so-called social determinants of health, what's your zip code is and what your neighborhood is within a zip code. And so not too far from where your apartment is, you can find the extremes of these social determinants of health.

SAFIAN: Hospitals right now are crazy busy, super busy, and yet at the same time some of them are being forced to do layoffs because the kinds of things they're busy with are not the things that pay as well. I'm just curious what best practices are for a business in this kind of environment? In other words, can you exhibit best practices clinically and business-wise at the same time? Or are you making a choice right now as an institution, as a hospital, as a healthcare institution, between those two things?

SKORTON: So just think about, let's have two theoretical hospitals, two hypothetical hospitals. One is in a COVID so-called hot zone or hotspot, maybe not too far from where you are right now. And those hospitals are overwhelmed, with people who are very sick, some of the sickest people healthcare workers have ever seen, no matter their specialty, and yet those same hospitals have for good and understandable reasons, canceled or postponed elective procedures where a lot of their revenue comes in. And so in that setting, they're very, very busy, but they're not doing what they would usually be doing, non-urgent elective procedure, so that's one.

Let's take another hypothetical teaching hospital or non-teaching hospital for that matter in an area of the country that's been only lightly touched so far by the pandemic, well,

they're still very likely to have canceled many elective procedures and they are less busy and also losing revenue. And how much revenue are they losing? Everything I know about this, I know by listening to the members of AAMC, people who are actually on the ground in the front lines. They're telling me that they're losing between two and $10 million a day based on having to pay to keep the place functional and pay to have, not just doctors but nurses, technicians, laboratory professionals and many, many others available, but yet they don't have the revenue from these procedures.

So yes, exactly as you stated it, choices have to be made, and right now those hospitals are all thinking about what is the appropriate careful way to re-enter into a world where non-emergency elective procedures could again be rescheduled, and where they could begin to sort of right the ship, if you will. That's what's happening all across the country. I'm particularly worried about rural areas that even under the best of conditions, rural hospitals have a very hard time staying afloat.

SAFFIAN: From your vantage point as you're hearing from the different member hospitals, are there specific examples of rapid responses that you've seen in hospital settings that you've found inspiring?

SKORTON: Well, this is going to sound like a bold advertisement for these places, but it's coming right from the heart. I've seen nothing but heroism from the C-Suite of the hospital, to the people in the ER, and the intensive care unit. They have done whatever has been necessary to help not just the local situation, but the national situation.

The most profound heroism has been in the front lines of actual patient care. And the emotional stress, the fear, the anxiety, the fear for one's own health, the fear of bringing a very contagious lethal virus home is incredible.

There's been heroism in the research labs. That may sound weird. You tend not to think about people in research labs as heroic frontline workers, but when the day comes that we have a successful and effective antiviral treatment, when the day comes that we have a successful and effective vaccine, it will be because of heroism of those working in a lab, remember, exposing themselves to potentially infectious materials.

And one more heroic frontline person I want to mention is the person who works in the diagnostic lab doing these PCR tests. They're exposed to potentially infectious materials. They too need the PPE that you mentioned before. And so all of these are heroics, and I've seen and heard of case, after case, after case, after case of people dusting themselves off and going back to make sure that they're there when the next life is at stake. So I'm seeing it all over the place.

SAFIAN: It seems like information about COVID is kind of fractured. What we know is uncertain, including in a clinical environment, and I'm curious what's being done between hospitals,

between systems to share the information about how to know how to best try to treat someone with who's presenting in a particular way, because there's no existing protocol to go back to. How is that information flow working? How has the AAMC members sort of trying to share that information across?

> **SKORTON:** So individual member institutions on their own are sharing guidelines and new insights of course with our own staff. They're sharing it with their colleagues who are executives or providers at other hospitals. My colleagues in the AAMC, have set up clinical guidance repositories where one can go and say in a quickly updated dynamic repository, "This is what is known now. This is something you might try in this or that kind of clinical condition."
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> So it's all the things. It's person to person, doc to doc, nurse to nurse. It's within a hospital system or health system. It's within a school of medicine. It's between and among colleagues who are heading up different institutions.
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> We actually have physicians within the association staff, one of whom, for example, is a practicing physician who's in charge of our healthcare affairs area. Her name is Dr. Janis Orlowski, and she's still practicing. She's still on the front lines, and so she's seeing it herself. She's listening to her colleagues around the country and bringing it back. We have the head of our scientific affairs area, Dr. Ross McKinney, who is listening to his colleagues in the research labs, and bringing that back, and getting the word out around the country.
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> We have the person who's the head of our medical education area, Dr. Alison Whelan, very, very distinguished and a longstanding medical education expert who's listening to all the educational innovations that have to be done when you have to empty out classrooms. So whatever you're talking about, we're listening first to our members and others. We're compiling it, trying to make it an organized body of information, and then getting it out there for people to dip into.

SAFIAN: So I want to talk to you about teaching institutions. You brought up medical schools. I'm curious, what will it take for medical schools to reopen? Will it vary by geography? By each institution? By the same way the States are opening up at different paces?

> **SKORTON:** Of course, local conditions are going to decide exactly what happens in the local circumstance, what the amount of coronavirus is, what the availability of PP is at that particular site. And it's a balancing act among various variables. One is public safety in general.
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> Another is the safety of the trainees. Another is the availability of these things that allow you to be safe like PPE and so on and so forth.

We've offered guidelines to suggest that all things being equal, which of course they're not, but all things being equal, we want to make sure that we protect the health of medical students. And so depending on the situation locally, which is always needed to be decided by the leaders of that local institution. We've said if possible, we thought medical students should stay away from a direct exposure to COVID and that's happened in a lot of medical schools, but not all.

And we're telling the med students, "Well, maybe you can't do that right now because there isn't enough PPE to go around and we want to make sure that PPE is used by frontline physicians and nurses. So the med students had themselves been pitching in, in a variety of ways. They're doing things with telehealth. Telehealth has turned out to be an amazing, amazing thing. The big question that I'm thinking about as a former college president and as a former very active teacher in medical curricula. How do we reopen places of instruction? What kind of rules do we follow? What kind of precautions do we put in place? What kind of yard sticks do we know that it's time to move from one phase to the next phase, to the next phase?

That conversation is going on all across the country at educational institutions, whether they're schools of medicine or whether they're colleges of engineering, or whether they're research universities in general.

SAFIAN: Brown University's president recently wrote an op-ed piece that I'm sure you saw that sort of argued that universities have to open in September in part for business model reasons to get revenue, to get money coming in so they can stay solvent.

And I'm curious if medical schools are similarly vulnerable. What's at stake if we can't open up by the fall? Does that mean that medical colleges or teaching hospitals are going to start dropping away?

SKORTON: Well, it's a microcosm of what's happening throughout the country. By our own volition, we decided to shut down the economy. By our own volition, we decided to cancel procedures of an elective nature in hospitals. By our own volition, we decided to close classrooms, whatever kind of educational institution they are.

So one could argue all day long about what the right time to go back in especially what would be the indicators that it's safe to go back. Whether it's a barbershop or a school of medicine. The only plea I would have to everyone is that we go slow. We agree in advance on what those criteria are and we don't change in midstream what we think the criteria are, just because we are worried about economic issues. And when I say just because we are worried, I'm not in any way belittling the crushing effect of this economic downturn.

But I believe very, very strongly that if it wasn't for vigor social distancing and other mitigation procedures that we'd be seeing even a higher death rate. And here we are with I believe a staggering, staggering death rate in our country.

One of the beautiful things about America is that we love to just jump in a car and go somewhere. Jump on a train and go to another city, take a plane somewhere. And the virus to state an obvious fact knows no boundaries and can travel anywhere that a human with that virus on board can travel. So the risks are still high. I think we have to agree on criteria and stick to those criteria.

SAFIAN: Are there any medical schools that have been particularly proactive in embracing a new kind of model? Even if it's just for now, but that is saying, "Hey, we're going to change the way we do our curriculum. We're going to change our engagement for this new world." Is there something specific that comes to mind that you say, "I love this program that they've done here. I love the way this is happening over in this place?"

SKORTON: I always tend to think about things in terms of principles by which we lead and manage. Number one is first to think about the people more than the institution per se. Think about the people themselves. What can be done to protect jobs? What can be done if furloughs have to occur to protect those who are going to be really up against it?

The second is how to deal with the service that we're giving healthcare to those who are vulnerable, how to make sure that those who already are behind the eight ball so to speak, will have a chance to survive with odds more closely akin to those with the best access to and coverage for medical care? So, that's been an important principle.

A third one is communicate, communicate, communicate, it can't be said enough. And a fourth one that I think is incredibly, incredibly important is not to be rigid about a certain course of action, but to continue to gather data. Depending on what we're talking about, it could be every day, could be every week, could be every month, but keep gathering data and, like one would do in a research lab, comparing one's idea about what might be done. Call it up a hypothesis to the data coming in and, you know, if a data and hypothesis don't match up, you don't throw away the data, you throw away the hypothesis.

SAFIAN: I want to ask you, these are stressful times and I'm curious how you handle your own stress and whether you have any advice for our listeners, for other leaders about how to manage the stress in a time like this?

SKORTON: I'm first turning to my family and getting a wonderful support and love for my family. That's big for me. Secondly, I meditate a little bit. I pray a little bit. I'm also a failed musician and I'm doing this recording in my modest electronic recording studio. That's very, very relaxing. I'm a voracious reader and that helps, but most importantly when I

feel that I'm very stressed and all of these levers that I'm talking about pulling are not getting the job done, I reach out for help wherever I need to reach out for it.

And if there's one thing that stops us rough, tough, individualistic Americans from getting the help we need, it's the self-imposed stigma of asking for help when we need it. One year when I was president of Cornell University, we had a series of suicides on campus and I, with some other students, made a little video recording aimed at what to do in stressful times. And I shared with them an experience I had, and I'm glad to share with you and your listeners, that when I was a med student my dad became quite ill suddenly. It was very stressful and I had some bumps in the road both academically and emotionally and I got some help from a faculty member who actually cared and said, "A little counseling wouldn't hurt you."

I got some counseling. It really turned things around for me and I told that to the students at Cornell and I said to them at the time, "If you learn one thing at Cornell, learn to ask for help." And that's what I tell people right now. If you learn anything about life, learn that it's okay to ask for help, that it's a sign of great strength, not a sign of weakness to ask for help. And if I had one wish about handling stressful situations, it's that people would be less loathed to reach out and ask for help wherever that help might come from.

SAFIAN: Well David, I want to thank you for sharing and helping us in putting this together and giving us help in trying to understand the situation. I really appreciate it and thank you for your time.

SKORTON: Thanks a lot for asking me to do this.