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Interview with Dean Miller

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Interview with Dean Miller

Quill and Scope Staff

Dr. Donald Douglas Miller is the dean of the School of Medicine at New York Medical College. He was named to the post in 2014 after years of experience in medical research, education, and administration. In keeping with the New Frontiers theme of this issue of *Quill and Scope*, we sat down with Dr. Miller to find out more about his past, his vision for the School of Medicine, and what this has to do with Wayne Gretzky. This interview has been lightly edited and condensed.

Quill & Scope: Your career has spanned many different realms. How did you transition from clinical practice and research, where it seems like you were in your earlier career, to focus more on education and administrative work? What got you, or inspired you, to go into medical education?

Dr. Miller: Transition in a career in academic medicine is often hard to predict. It often is just situational. Sometimes it's the person that doesn't step back when they ask you to do something. In my career, I was doing a lot of clinical research and clinical care and working in a limited administrative role [in Saint Louis University]. As good bosses and mentors do, my boss said, "Why don't you take on this role and become our key administrator in this hospital and make sure that our resident training program there is as strong as it can be?" I said, "Sure, I'll do that." In the doing of that, I also suggested that I get support for an MBA that I was going to do at the time, so I did them both at the same time and developed a gene for greater interest in administration. A couple of years later, having done that, he stepped down as the chair, and the Dean asked me if I wanted to be the chair of the department. I thought I was ready and after consulting with some people I trusted, I took that job. That really switched me onto the administrative side.

Q&S: Was the MBA [master's in business administration] sort of a way to buttress your administrative roles and get some skills?

DM: Yes, I think it was a confidence and skill builder. Mostly on the management side, less on the financial side, although I did both. I've used a lot of what I've learned and have developed since then as a basis for administrative style and strategy.

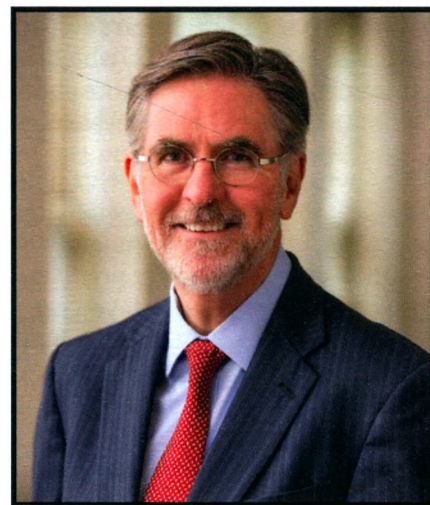
Q&S: Can you speak a little bit about what it's like to be a physician in the business world, where most people who get MBAs do not have any science or medical background?

DM: I was the only physician in my MBA class. The group of people I worked with was actually an international group from all around the world that were doing business training. I brought my experience to it and the people from

Monsanto brought their experience, Boeing brought their experience, people from Budweiser, brought the beer. That was always good.

You don't need an MBA to be a successful small business owner in practice. You can certainly run a practice of a moderate size (as many of our colleagues do) without any formal business training. You do have to learn the skills and acquire the management team that eventually can run it for you, because you have time limits and skill limits that preclude that. So the MBA is not a prerequisite to being a good physician and small business manager. The modern practice of medicine has changed in the 20 years since I've been doing administrative work dramatically. 1996 was when I began my administrative role through now. It's been just complete transformation of healthcare delivery. You know about what's going on and many of the drivers of the business are changing. But at this point in time, nothing about what anybody learned in the past has really prepared them for what's going to happen in the future. It's very much a paradigm shift and a new set of business rewards and risks, so that population health and health management, the new buzzwords are really just a euphemism for health systems becoming more aggregated without any anti-trust concerns to prevent it with Obamacare. Secondly, more risk management is involved in more of a capitated insurance model, so these health systems are actually becoming HMOs [health maintenance organizations]. The third part of what is going on, which most physicians have really struggled with, is data management and large data sets, which your insurer already knows about you.

I just had lunch with the dean of Hofstra Medical School. Northwell [the healthcare system connected to Hofstra] has developed its own insurance company. Their insured clients aren't, as he said, sick now, but when you see the other side of the data that they're able to look at, and you realize how powerful that health insurance data is, it opens up another whole complexity to how we will manage care going forward. I don't know what I would advise a medical student right now, other than to get a good understanding of what the broad levers are of the healthcare business.





Q&S: I remember at the White Coat Ceremony [Aug. 2015], you spoke a lot about how important it is to be educated and knowledgeable about a lot of these big changes. But it seems like the traditional medical curriculum, which we have to follow, and we should follow, has very little on, if anything, about healthcare systems. It's a lot of stuff on basic and clinical sciences, which are very important. How can students really learn more about these larger issues, while also trying to pass physiology?

DM: There are certain elements of the curriculum that standard required elements. Then there are some electives and selectives. I think many students work naturally during the required elements--you're pretty much just keeping up with the work. You're a student, you get ready to pass the test based on that work. I think the judicious use of research time, selective time, and elective time, which currently is largely directed towards getting a better residency, could be used in a more altruistic way to get a better view of the world and of what the future of medicine will be. I don't want to sound cynical—but I think you can certainly get a leg up by doing an elective or selective in orthopedics if you want to be an orthopedic surgeon. It's almost a mantra that you need to do—you've got to do research. All these things that we have traditionally adopted and advocated for are probably still in play. But if you want to get ahead of the game, that would be a game changer. One suggestion that Dr. Smith [of Hofstra] had was, why don't you send one of your students over to work in our insurance company on an elective for a week or two? They'll learn more about how healthcare works than they could ever learn in any class and it will be maybe an eye-opener or a career-changer. Maybe they'll develop a whole new area of interest. We need to make more of that available. We need to make it more relevant to the students that still want to compete for their residencies, but maybe also want to have a longer view, sort of like selling short, selling long, you get a couple of different views to your career.

Q&S: You were quoted [in the Chironian] as saying something along the lines of, one of the advantages you have as coming as having never having been at NYMC before is that you bring a fresh perspective. I think talking about people's education and population health can be one of them. Are there other things you're trying to implement or work on now that come from this place of bringing in a fresh pair of eyes to your position?

DM: Yes, I hope so. I try not to be, you know, "Mr. Know-it-all." The experience I've had in other systems of care, in other health systems, and in other parts of the country, I hope, has informed what I think works generally, and what might be uniquely helpful here. If you spend long enough in a sector, you develop a certain playbook of things that generally speaking, work. Other things might be a little

riskier, but probably are necessary to take the risk. And so, from experience over the course of time, building research programs, that we've been recently developing a strategy in, and we vetted it with our strategic plan, to be more translational. Bench to bedside scientists... think about not just what goes on in a basic lab, but how get it applied.

Q&S: And using current researchers at NYMC to reach that goal?

DM: Yes, trying to reinvent and rejuvenate their career because, to be fair, and we agree on this—that's where the NIH funding is going. It's leaving the basic sciences, to their chagrin, though not completely. But the new money is going to precision medicine and cancer, and to more translational programs. So we're trying to build very trans-

“...we're trying to build very translational research programs.”

lational research programs. If we can't do that, then we probably won't be as competitive. Capabilities plus partnerships equals competitiveness, is our philosophy.

That's true when you're building educational programs, so we talk about the new educational approach with other medical schools or nationally, trying to bring in those ideas. Faculty development, student programming in new areas of concentration, and stuff like that, that we've been working on. This, I think, works someplace else that I've heard about it. People are quite receptive to that approach.

Q&S: That's good that they're receptive, because you might imagine at an old institution like NYMC, there might be some resistance to the new guy coming in and with all these fresh ideas.

DM: Yes, I think you've got to "build a village" around all these issues. There are a lot of people with very good ideas and that have done very good work. What I always try to do is take time to listen and understand what the platform is, talk about it with the stakeholders and the advocates for that approach and see if there's something we can graft onto. That's an enhancement that doesn't require complete disruptive change.

Q&S: I think this sort of relates to a role, that I don't think most students know that you have, is that you're the chief scientific officer at BioInc, which is something that we have on campus, but I don't think most students interact with. I was wondering if you could speak about your role, and what is BioInc, and if it really should matter to students at all.

DM: "BioInc at New York Medical College" is descriptive of our bioincubator, which is a new company startup environment. It's in the BioInc facilities on Dana Road, where the simulation and clinical skills are; on the other side of the building there are seven companies. [It hosts] Philips Healthcare, big companies, small companies, that are doing a combination of biotechnology and high-technology

research towards new products. That's commercialization - you're creating jobs, you're creating new products. In recent weeks, we hosted an event we called the "Pitch Contest." Angel investors came and decided whether they wanted to put money into these ideas, to fund them, to the level of being commercially viable products. The idea is to foster opportunity for both university scientists and investigators, outside clients, and strategic partnerships with big companies. This allows us to help the Philips Healthcare research group that was going to otherwise be moved to Massachusetts to be retained in New York. Eleven extremely well-trained colleagues and scientists, instead of having to move to Cambridge, Massachusetts, were able to stay in New York and work with our NYMC colleagues on their projects. My role is just to help to make sure the science is as robust as it can be and that we don't miss opportunities to grow in different sectors. We're in new drugs, biosensors, high-technology, computational genomics, we're kind of taking advantage of our available options. We like to imagine that we're the fastest growing, soon-to-be best, incubator between Downtown Manhattan and Kendall Square, Cambridge. That's the big goal.

Q&S: That would really be something. How do you think this should relate to students?

DM: Just like students might like to embed into a health insurance company to kind of learn how that part of the world might work going forward, we have opportunities to place students in companies at BioInc and give them some experience as to what it's like to start up a company, to talk with these owners of these companies. Some of them might be faculty-operated, some of them will be corporately-operated, but we'd like to imagine that students who want to be innovative and might have ideas that they would want to commercialize. Students I've worked with in the past have developed apps for education purposes, and we can help to create intellectual property and protect that for students if they want. We hope students that have research ideas that come out of their projects and they actually develop companies—I've always been amazed at how they have time to actually do that, but it's kind of like working on your 64-Mustang in the garage and you just make time on the weekends.

Q&S: Three-year medical programs are getting a lot more attention. Can you talk more about whether the college here would develop one?

DM: We've talked about it hypothetically. One of the other schools in Alberta, in Calgary, was a three-year medical school. We could compare ourselves to them in many ways in quite a detailed manner. Their students completed the three-year curriculum, were well-trained and seemed to be

happy. It was all continuous three-year curriculum, there were no breaks. They were slightly more mature students. They wanted an accelerated program and were willing to put up with the limited quality of life that goes on with three years of continuous work. They wanted to get it done. I think there is value to the fourth year if the fourth year is part of a well-thought out curriculum that gives all sorts of opportunities for enrichment in the four years. If you look at the curriculum and said, "Really we could teach this curriculum in three years," get people an MD degree, and get them into the workforce or their residency programs earlier, it would be nice to offer that to people. But it's very hard to do that as a track. You've got to really commit one way or the other. It would have to work for everybody. I would say, knowing the students and talking the students, I think as students, you generally value the work-life balance that allows you to move through the work. And sure, you can do it quicker, but you wouldn't have the relationship development time, you wouldn't have the breaks, you wouldn't see your families as much.

Q&S: Such as taking advantage of opportunities like Bio-Inc...

DM: Yes, exactly. The enrichment opportunities would be limited by that. You can master the curriculum and go through it—I think there are very bright students who can

handle the work in three years—but it would probably change the whole experience. The average student that I've met with really values those extra things. It's my feeling that most medical schools stay with a four year MD program because they

also believe that that's in the best interests of the students' well-being, maturation as individuals, as well as their ability to have work-life balance.

So probably we won't do that. We'd like to create more value-added opportunities. We have committed to the idea that our medical school will have a more progressive curriculum. In the last ten years, that's meant more integration, earlier clinical experience. I'm not convinced of the value of [early clinical exposure] even though it's a widely adopted concept that we integrate more clinical work in the early years.

Q&S: From my perspective as a student, there seems to be some tension from the LCME visit, where there were a lot of things that we had to change to be reaccredited. On the other hand, there are a lot of things that we would like to do independently because we think they're good ideas. How do you balance those things? Now that the LCME visit is over, what are some things that are still being worked on?

DM: First of all, we want to be well-accredited by the

LCME. The LCME does require curriculum management and curriculum enhancement. For example, one of their premises is less big classroom didactic, and more small-group interactive. We've tried to produce a relatively heavy classroom content of the past into a kind of 50/50 proposition. We're not quite there yet. We're working in that direction. I think that's a good trend.

The other big trend is more clinical experience early, because generally speaking, students feel connected to why they're working so hard on the core work in the basic sciences if they can sort of see some clinical relevance. So we do that with patients and/or simulation in clinical skills, so that's been another trend that I think we're a part of. We've caught up, if you will, to those two trends by having our own more integrated curriculum and our own better clinical skills and simulation capability.

Having done that, then what do you do to really make the curriculum more valuable? The new idea, which is extra-curricular, is areas of concentration, where every student will have the opportunity to pursue an area of interest or passion for them, whether it's in biomedical ethics or healthcare safety or biomedical research or other areas that will be developed. So when you leave, you'll have committed to completing the curriculum and it will continue to evolve in a related area. You'll also have this sense that you developed a higher understanding of an area that thematically will always be part of your career. You could argue that if you did biomedical ethics, you're always going to be thinking about that in a way that's probably a little bit better informed by what you've learned than maybe your average doctor. That is how we'll drive the curriculum going forward.

I think we will also look at novel approaches to expose our students to clinical clerkships. The traditional clerkship

model is to embed in a hospital on a clerkship rotation. You do the surgical clerkship and in the old days, when I was in medical school, patients stayed in the hospital for a week, two weeks, around surgery. Now they're in and out. The entire surgery experience involves a tremendous amount of pre-work. Patients drop in, maybe for a day surgery or a two-day admission, and then go home for post-op care right out of the hospital. If we're just dropping people into a rotation that says, "Hi Mr. Smith, your operation is in three hours. Did you eat anything after midnight?" And then they have their procedure and they're leaving by eight o'clock that night—that's not what surgery's all about anymore. We have to explore and look at those current dogmas of medical education that reflect the clerkship experience. I'd like to see us put more students into multidisciplinary clinic settings. I'd like to see students embedded into large practice groups. I've visited with the Caremount Medical Group, which has multiple primary and specialty care capabilities. I think they would be wonderful partners for a longitudinal integrated clerkship.

Q&S: So essentially, you want students to be integrated in settings where healthcare as a whole is moving.

DM: Yes, you're right, exactly. We want to make sure that what we do in medical education is relevant to where healthcare is going.

Q&S: And not necessarily just the way it was done in past years.

DM: Yes, that's what we're trying to be. That would be in a nutshell, as you said, where we're trying to be. We're trying to - I'll paraphrase the Gretzky saying - we're trying to skate to where the puck is going, not to where it isn't.