

The background is a complex, low-poly geometric pattern composed of numerous triangles in various shades of green and teal. The triangles vary in size and orientation, creating a three-dimensional, crystalline effect. The colors range from a bright, lime green to a deep, dark teal, with many intermediate shades. The overall impression is one of organic complexity and modern design.

INTERNAL MEDICINE SUMMIT SUMMARY

MAY 21, 2018 | PHILADELPHIA, PA

PRESIDENT'S UPDATE AND WELCOME

Dr. Richard Baron, President and CEO of ABIM, began by speaking about the roots of board certification, which originated at a time when false claims of medical expertise were used as a strategy to attract patients and threatened to sully the reputation of the medical community as a whole. He noted that “doctors get their authority not as individuals, but as members of a community that has collectively validated their credentials.”

Citing [Gallup surveys](#) on trust in American institutions, Dr. Baron noted that over the past 40 years, the medical system has lost more trust than any other type of institution. This erosion of trust serves to underscore that professional self-regulation within the medical community is as important now as it ever was, because both physicians and patients have access to more information than we can process. While initial certification signifies a doctor is ready for independent practice, maintaining that certification demonstrates the physician has kept pace with evolving knowledge and practice.

Dr. Baron went on to explain the community-centered design of ABIM's governance structure and the Board's focus on engaging and gathering feedback from diplomates as we continue developing new assessment methods and program models. He acknowledged the wide spectrum of views in the room – and across the ABMS boards – around summative and formative assessment. In closing, he discussed the new collaborative maintenance pathway [announced](#) by ABIM and the American Society of Clinical Oncology (ASCO). In 2020, oncologists will have the option to take the traditional Maintenance of Certification (MOC) exam or they may take a shorter assessment every two years that will be jointly developed by ABIM and ASCO, reflecting the specialization and expertise of oncologists. Dr. Baron reiterated ABIM's commitment to continue working on focused practice issues in many areas of internal medicine, and urged societies to engage their membership on the topic.



Dr. Richard Baron giving his President's update and welcome message.

Q&A FROM PRESIDENT'S UPDATE

Q: It might not be physicians who are responsible for the loss of trust in the medical profession. I am not sure it's the doctor-patient relationship but more the presence of large institutions, insurance companies and others who are increasingly involved in the profession.

A (Dr. Richard Baron): All kinds of things are out there to make people wonder if they are going to be okay in the health care delivery system. Trust is up for grabs and people who don't have the expertise we have are going to claim it. I don't mean to say any one group is responsible, but when I talk to colleagues in health care who believe they are not at risk in this decline of trust, I think that's naïve. Trust will be the next focus of the ABIM Foundation's work. We believe this is a cross-cutting issue. I do think there is very broad skepticism of authority and expertise. Physicians say to me, "I look stuff up and don't need special knowledge." Well, patients look stuff up too.

Q: Do you believe there is a complete lack of checks and balances in our current system?

A (Dr. Richard Baron): Of course not. The basics are licensure. Very few people don't get through our process. All kinds of factors come into play, and one of the things the credential features is an independent evaluation of knowledge. When I talk to health system leaders, they tell me they are on top of QI and practice improvement, but we need to be there for the knowledge piece.

Q: I am curious where ABIM is going with the maintenance of certification brand. I know that the ABMS is moving toward the idea of continuing certification.

A (Dr. Richard Baron): The overall brand is still ABMS-board certified. Part of what makes the conversation challenging is that family medicine started with time-limited certification. They can say that their certificate is time-limited because they never offered unlimited ones, unlike ABIM

and many other boards. Part of the community conversation is whether continuous certification gets you away from that toxic brand of MOC and the difficult question of lifetime certificate holders.

A (Kathleen Ruff (ABMS): The brand of MOC has become toxic. We have moved our language away from MOC to continuing certification intentionally, and as people have pointed out, that's great but the underlying issues are still there. We have been focusing on what the conversation is and what the credential actually says about the diplomate. Rich has highlighted some of the tension around how we think about assessments. I will say that the community recently was asked about continuing certification as a truly voluntary process, and the challenge still went back to the fact that initial certification is one credential and maintenance is something else. People do not want to go back to lifetime certification and the conversation is ongoing.

Q: What is the vision moving forward, and how can societies collaborate?

A (Dr. Richard Baron): That is the conversation here, and I think we have more common ground than we realize. The maintenance conversation really drove society offerings and resources, and that has gotten lost in some of the arguments. We did an experiment where we offered lifetime certificate holders the opportunity to test their knowledge again, and people did not want to do it, and time-limited certificates came out of that. We believe that for this to work, the summative aspect is vital. The risk and the learning work together, and your ability to communicate why this matters is very important. We know many of you have been positioned by your members to not say positive things about ABIM. But if you are positive about collaboration and it isn't just us saying it, then people will really pay attention.

A CASE FOR INDEPENDENT ASSESSMENT

Evolving Challenges and Opportunities in Professional Development – Dr. Graham McMahon
Accreditation Council for Continuing Medical Education (ACCME) and
Why Incompetence Fails to Recognize Itself – Dr. David Dunning-University of Michigan

Dr. Baron concluded his update by welcoming Dr. Graham McMahon, President and CEO of ACCME, and Dr. David Dunning, Professor of Psychology at the University of Michigan, to present about the psychology behind continuing education and self-assessment. Dr. McMahon asked attendees what words they associate with CME and received mostly negative responses including “requirements” and “rules.” He explained how “we have done damage to the community by delivering a system of something that has become compliance education...physicians are an ideal learning community to work with in an imperfect world.”

Dr. McMahon detailed the changing environment clinicians must navigate, using his own endocrinology practice as an example. Patients are more complex than ever before: they take more medications, expect a broader variety of skills from their physicians and exhibit more co-morbidities. On the provider side, physicians are struggling to balance their personal and professional lives; low autonomy and overload lead to burnout, depersonalization and exhaustion, which in turn lead to problems in patient care. The harder physicians push themselves, the greater the negative repercussions for their communities.

Given these factors, is it easier for physicians to learn something new or un-learn something they already know? Dr. McMahon explained that in professional education, “we spend a lot of our time trying to help people learn and practice new things that are different than what they were trained to do. There must be an opportunity for them to see they are not absorbing the new information.” We are better when we take advantage of the diversity of our associations and skills, and leverage others’ experiences.

Dr. McMahon then turned the presentation to Dr. Dunning by asking the physicians in the room to think about their communities, and whether they know clinicians to whom they would not send their family.

Next, Dr. Dunning introduced the audience to his research, which explores how people’s perceptions of themselves don’t align with reality. He summarized significant studies in the field to illustrate that there tends to be no correlation between what we know and what we think we know. The effect of overestimating knowledge and abilities persists even when research subjects are offered money to assess themselves accurately. Dr. Dunning explained the most lauded of his own research findings, which quantifies the ignorance of the lowest performers and is known as the Dunning-Kruger Effect: people believe they are performing in the 50-60th percentile but are in fact hovering around the 12th. In other words, Dr. Dunning continued, “people who are incompetent or poor performers don’t know how badly they are performing; if they did, they would ask for help.”

In medicine, those with experience tend to make the most mistakes, not the beginners. While we can make every effort to be as impartial and honest as we can, Dr. Dunning explained, we simply cannot see how much we do not know, and ego will keep us stuck in the Dunning-Kruger Effect. He concluded by showing data to demonstrate that on top of the low correlation between perception and reality in self-assessment, people have a tendency to seek improvement for their strengths, not their weaknesses.



Dr. Dunning sharing about his work on 'Why Incompetence Fails to Recognize Itself.'

Dr. McMahon built on Dr. Dunning's data discussion by encouraging the audience to think about how continuing education models should be designed in order to spark engagement, improvement and change. He challenged medical society representatives to consider that a physician might be at the annual meeting but not actually

learning; rather, the physician must be engaged with immediately relevant material that is delivered efficiently by a trusted source. He noted that "information is no longer our currency in education; the currency now is skills, problem-solving and performance management, because I can look up the guidelines faster than you can tell them to me."

According to Dr. McMahon, this engagement becomes even more challenging when physicians are burned out, have trouble assessing their own deficits and lack a curriculum for their unique practice type and learning needs. The key issue for medical societies is evolving into an educational home for physicians, creating competency expectations, capitalizing on others' assessments and supporting quality improvement. His model for continuing education moves away from the concept of attending one session to hear information and toward a system where boards and societies share responsibilities for establishing and assessing a competency framework.

Dr. McMahon discussing the 'Evolving Challenges and Opportunities in Professional Development'



Q&A FROM A CASE FOR INDEPENDENT ASSESSMENT

Q: When I see a patient, I might think about that person for days and talk to different colleagues. I look up facts. The test needs to get at my ability to synthesize and evaluate. Do you think our medical education system is setting this up wrong? If you make it through your first two years of medical school, it is very hard to fail out. You will most likely get through the rest and your residency too.

A (Dr. Dunning): Do people know when they need a consult or what they need to look up? People who know what they are doing know when they need to ask for advice. Is it really about social comparison and where you are relative to other people? It is the assessment that truly motivates people. Even when we remove the social comparison, we don't find much correlation between what people know and what they think they know.

A (Dr. McMahon): I think medical students graduating today have amazing abilities, and I don't think it is the place where we produce a competent clinician. We have critical issues in continuing practice. A challenge we have is the range of competencies where we have expectations – it isn't just the clinical domain but my EHR, my communication. There are so many essential ingredients and we do not do a good job of assessing our community across these ranges.

Q: It is critical in our time to know what we don't know and to look things up and seek advice. How do we design a system that is both relevant and relatively easy? This is the challenge of mastery in our fields. I study to recertify and then I forget much of what I studied.

A (Dr. McMahon): We have to solve the relevance problem. If the first few minutes of an educational session are not relevant to a clinician, then you have lost them. As a community, the strategy is to move away from any one-and-done approach and look at sustained knowledge and remediation. We need to set the competency framework. It could be some kind of dashboard where ideally you can assess yourself and compare your competency to your peers, then access modules addressing the areas where you are less competent. It would be a global view of competency management. Technically, this is feasible, but it would be a lot of work to build it and determine the framework.

Q: In many training programs, the surgical competency assessment is administered every year. Does this change the self-assessment aspect?

A (Dr. Dunning): In general, there is a lot of inertia for thinking you are skilled even when assessments show you are not.

A (Dr. McMahon): But we know people can learn and change, and they do.

A (Dr. Dunning): When it comes to poor performers, they are the ones that have the most trouble recognizing and changing.

A (Dr. McMahon): It is difficult in society to have a good relationship with a teacher who continually gives you negative feedback. As a medical society, this is part of the relationship you have with your members, and if you become the assessor you are changing the dynamic of you as the educator.



Dr. Art DeCross, American Gastroenterological Association



Dale Singer, Renal Physicians Association

Q: Where do you see high-stakes summative assessment playing a role?

A (Dr. McMahon): I think it has an essential role. I think boards should be able to make competency decisions about their own diplomates, because their responsibility is to the public. I see formative as essential but secondary. There is great disagreement between the boards about this, and boards are wondering if they should be a nurturing community, which is more like a society. Others disagree with me on that. I think boards have the unpleasant task of having to decertify people. What we need to do is connect the standards for assessment and education.

Q: We have so much jargon around assessment, learning and responsiveness. How does this relate to the motivation of learning and is there a sweet spot we can maximize?

A (Dr. Dunning): The distinctions matter and we have to get them right. There are standards as instructors and assessors. American culture is not very good at building skills to give and receive feedback. We have to come up with evidence-based assessment and feedback procedures that have a better shot at helping people learn and motivating them.

Q: It seems there is pressure to deliver learning in smaller and smaller segments that you can do in a moment on a phone. How do you think this will change assessments, for better or worse?

A (Dr. Dunning): Learning is becoming more problem- and teaching-based. It's less about binge and purge, but the problem is that it is hard on self-assessment. You have to build in self-assessment as part of the problem-based learning module. The classroom is a place where people know themselves best. If you make things more like a clinic then people are worse at self-assessment.

A (Dr. McMahon): The key is repeated and continuous engagement in the process of learning, and how to manage this is the problem. Some entities create closed Facebook groups built around presenting and discussing a case. We can encourage clinicians to talk more to each other in clinical systems, which create empowerment. For individual clinicians, email exchanges and closed groups online help build continuity of engagement that reinforces expertise over time.

Q: When I look at people attending our annual meeting, they are coming for education. For mid-career and older providers, who are not in tune with system learning, I see a need for more training. How can CME and other education help with this gap?

A (Dr. McMahon): Look at the rise of chief learning officers. Institutions are realizing that they are responsible for a training infrastructure, quality improvement and performance management work. This is a more recent development in health care. For established clinicians, they have learned to learn a particular way. We need learning that is cross-generational, and the case method is a great way of doing this.

KNOWLEDGE CHECK-IN UPDATE

DR. RICHARD BATTAGLIA

Dr. Richard Battaglia, ABIM's Chief Medical Officer, provided an update on the Maintenance of Certification (MOC) program and the new Knowledge Check-In assessment option, which represents the first time physicians can take an assessment remotely from their home or office. He summarized the resources ABIM created for diplomates in order to explain what the assessment is and how it will look and feel on exam day; these resources include videos, a dedicated phone line for those who have registered and outbound calls to assist physicians with technology requirements for the remote exam. ABIM will continue communicating with these initial exam takers to learn more about their experience.

Dr. Battaglia also shared confidential program updates pertaining to the Knowledge Check-In:

- A physician may switch from the Knowledge Check-In pathway back to the traditional 10-year pathway after failing the Knowledge Check-In. They can do this and still keep their original exam due date, as long as it has been less than 10 years since they last passed the 10-year exam.
- A physician could fail the Knowledge Check-In multiple times without being obligated to take the 10-year exam, as long as it has been less than 10 years since the diplomate last passed the 10-year exam.
- Diplomates may take both a Knowledge Check-In and a 10-year exam in the same year.

- Beginning in 2019, non-certified physicians or physicians who let a certificate lapse can recertify by successfully passing two consecutive Knowledge Check-In exams. This pathway will be communicated to diplomates in fall 2018, and in an effort to ensure that transparency does not breed more confusion, Dr. Battaglia asked attendees to refrain from sharing this news with their membership.

The final Knowledge Check-In update concerned the ABIM task force with Endocrine Society and the American Association of Clinical Endocrinology (AACE) that is reviewing data on practice patterns in the discipline and providing recommendations around potential specialization topic areas. The task force has recommended thus far that all assessments include core content plus specialized areas such as diabetes, thyroid or general endocrinology. Work on feasibility, operations and timeline is ongoing, as is the number of takers for a given module which will impact the validity of the assessment. "If you believe your specialty should follow this path, we want to talk to you about it," said Dr. Battaglia. "This is another way for societies to have significant impact on the program without requiring major financial or infrastructure investments."

In conclusion, he took a few minutes to list the most common misconceptions about MOC that ABIM hears from diplomates. [Click here to learn more about common Mythbusters.](#)

Dr. Richard Battaglia giving his Knowledge Check-In Update.



Q&A FROM MOC/KNOWLEDGE CHECK-IN UPDATE

Q: How long is the Knowledge Check-In?

A (Dr. Rebecca Lipner, ABIM): It will be about 90 questions over 3.5 hours, though the exact number of questions will vary by discipline. We respect that you have a resource to use and a limited amount of time.

Q: What does the security look like and why is there a webcam?

A (Dr. Richard Battaglia): Physicians on staff have all tested this process. You'll need to use the webcam to show no one else is there as well as show your ID to the greeter. Your camera stays on to film and a small number will be audited, or will be audited if any red flags come up in exam scoring.

A (Dr. Richard Baron): We know there is a lot of confusion, and one of our resources is a video. We modeled it after something Microsoft put together for their certification credential, because they use video proctoring technology. So we are following industry standard, and we know doctors like to multitask. We are trying to get the information out there that you cannot do this exam while remaining on call with your phone next to you.



Veronica Jones (ABIM) answers question about the Knowledge Check-In update.

Q: How many people have signed up for Knowledge Check-In versus the 10-year exam?

A: There are more people than we anticipated signing up for the 10-year exam, even though we see a good amount of interest in the Knowledge Check-In.

A (Veronica Jones, ABIM): A greater number of diplomates signed up for the spring 10-year exam but looking at fall numbers, they are about the same for each exam format, with the vast majority being Internal Medicine.

Q: What is the feedback component?

A (Dr. Richard Battaglia): We will offer immediate feedback for many diplomates for the first time. Some takers will receive a pending result if they are in a gray area for scoring, and will need to wait for their score report.



Jin Soo Kim, American Society of Nephrology

EXPLORING ADDITIONAL ONLINE RESOURCES FOR ASSESSMENT – DR. BRYN HERRSCHAFT-ECKMAN

The meeting continued with a presentation on open-book resources for assessments led by Bryn Herrschaft-Eckman, PhD, a Senior Research and Innovations Specialist on ABIM's Research and Innovations Team. She opened by reiterating ABIM's commitment to adding reliable resources to exams as a reflection of current medical practice and sharing preliminary results from an ongoing survey intended to identify additional resources used by the physician community. ABIM has reached out to society partners, specialty boards and exam committees asking them to share the three most common resources used in their respective disciplines.

Initial results indicate that UpToDate® remains the most popular resource, with approximately 60% of respondents ranking it as their top resource and the vast majority accessing it via their institution. Clinical guidelines issued by societies and other organizations were the second most popular resource. Survey respondents also listed specialty-specific journals and textbooks, board review materials and subscription products.

From a technical standpoint, ABIM continues to collaborate with Pearson VUE to identify feasible strategies for supporting multiple resource formats within the exam interface. Dr. Herrschaft-Eckman explained that resources will likely vary by discipline, with some exams including subscription services and others PDF documents or free websites. She noted that test-takers will ultimately be responsible for managing their time, as the 10-year exam already meets the seat limit at Pearson VUE and cannot be made any longer. ABIM must also consider which content could be contradictory in different resources and develop items accordingly.

Dr. Herrschaft-Eckman concluded by sharing that ABIM will proceed by surveying diplomates by specialty on their preferred resources. Next, ABIM will select a set of resources for each exam, which will vary by specialty, and continue planning and development work for each individual exam. Diplomate surveys will take place later in the summer, and societies can expect to hear more from ABIM about technical specifications for resources at the end of 2018.



Dr. Bryn Herrschaft-Eckman giving her presentation exploring additional online resources for assessment.

Q&A FROM EXPLORING ADDITIONAL ONLINE RESOURCES



Dr. Kirk Garratt, Society for Cardiac Angiography and Interventions

Q: Will there be an attempt to catalog resources that societies have?

A: (Dr. Bryn Herrschaft-Eckman): Yes, this was part of the survey to society partners.

Q: Has ABIM explored a licensing agreement with UpToDate that would obviate some of the other concerns?

A (Dr. Richard Baron): This is about expanding the options of what is available.

Q: The selection of these sources implies they have accurate information. Do you know how you are going to adjudicate if the information contradicts what the exam writers intended?

A (Dr. Rebecca Lipner, ABIM): This is the challenge with trying to be true to practice. We have a committee that will adjudicate beforehand what the right answer is, and that is taking into account conflicting information of which they are already aware.

Q: Is there effort to make sure there is no overlap between people writing content for UpToDate and those developing the exams?

A (Dr. Richard Baron): This is part of our conflict of interest policy. Currently writing for UpToDate is not a prohibited activity. Exam committees spend a lot of time arguing over what the answer choices should be. If we determine there is a question that we might have gotten wrong, we put it in front of the exam committee. And if we did get it wrong, we will throw that question out and rescore the exam without it.



Dr. Richard Baron



Dr. Bruce Johnson, American Society of Clinical Oncology

PANEL – LEGISLATIVE DISCUSSION

Moderator: Dr. Richard Battaglia, ABIM Chief Medical Officer

Panelists (physician representatives): Dr. Suzanne M. Norby – American Society of Nephrology (ASN), Dr. Daniel J. Pambianco – American College of Gastroenterology (ACG), Dr. J. Patrick Walker – American College of Surgeons (ACS)

Dr. Battaglia moderated the following session, a panel discussion addressing the legislative landscape around certification and how societies have engaged with their membership on the topic. He reiterated the ABMS policy on MOC and licensure, which states that licensure is required for board certification. You cannot be board certified without having a medical license and therefore states cannot require board certification to maintain licensure. Furthermore, specialty or subspecialty certification should not be the sole determinant in granting and delineating a physician's clinical privileges.

Dr. Battaglia asked the panelists to comment on professional self-regulation and their own roles as society representatives. Dr. Norby shared that ASN surveyed members a few years ago and compiled a task force to issue recommendations; the society believes first and foremost that each nephrologist has a choice in how to maintain knowledge, and is neither for nor against legislation, because it impacts the choice of each individual physician.

She elaborated that nephrologists are in a unique position, because dialysis is highly regulated, and they have seen the adverse impact of strict measurement on ratings and patient care. Dr. Pambianco explained that ACG issues surveys and frequently collects feedback as part of its commitment to representing its membership; building off of members' concerns, ACG supports legislation that members want and assists them with drafting legislation on the state level. Finally, Dr. Walker relayed his experience representing physicians who strongly supported MOC legislation through his position with the Texas Medical Association. "The legislation in Texas passed in the last hour of the legislative session last year. It was an ugly fight and has pitted physicians against each other, which doesn't look good," he shared.

Dr. Battaglia followed up by asking Dr. Pambianco to comment further on how ACG balances facilitating grassroots efforts without having an official position.

Legislative Discussion Panel



Dr. Pambianco explained that the majority of ACG members are private practice physicians who feel changing requirements for recertification make the process unstable and onerous, whereas academicians have more representation at ABIM and have different opinions on testing and learning. “The majority are not objecting to an ongoing method of learning,” he said. “It has to do with concern about credentialing at institutions and reimbursements. There is momentum given the concern of our members.” In response, Dr. Walker noted that each hospital may make its own determination and the process might not be any more transparent. He shared that despite the new legislation in Texas, many hospitals have shown little inclination to have physicians who are not certified on staff.

Next, the panelists discussed the meaning of certification credentials and maintaining procedural competencies in their respective fields. Dr. Norby, a program director, strongly supports initial certification and reiterated how an array of metrics in nephrology further regulates the discipline. For the American Board of Surgery (ABS), Dr. Walker said while many quality measurements exist in surgery, these pertain to results as opposed to the procedural expertise of each surgeon. Dr. Pambianco explained the importance of analyzing complication rates, which generally occurs at the local level, and that an outcome registry for gastroenterologists is part of self-regulation in the field. He added that legislation should not prevent institutions from forming their own processes, and another iteration of legislation could be forthcoming.

Dr. Battaglia concluded by thanking the panelists, inviting comments from other attendees whose societies have not issued a public position on MOC legislation, and opening the discussion to questions.

Q: Once MOC changes in a way that is palatable, you can’t go back and re-legislate everything. We know that particularly in gastroenterology, some physicians work out of their private office with zero hospital privileges and no boss. There is a need to demonstrate leadership on these issues and not simply give assistance to the most vocal segment of membership.

A (Dr. Daniel Pambianco): Are we going to pass regulatory legislation that actually affects the best physicians? I am an optimist and I am driven by my responsibility to my patients, as opposed to my hospital system. I want to be up-to-date so I can do the best for the patient. I think if we create a system that makes it less onerous, physicians will rise to that. I do not think we need to be punitive.

Q: Most people will not break into others’ homes, but some will, therefore we have laws against it.

A (Dr. Daniel Pambianco): I don’t think the job of the ABIM or societies is to be the policeman. I think the system is fairly successful at policing itself.

A (Dr. Richard Battaglia): If we finally do agree on the how, we may have unintended consequences because we have now involved state legislators in the issue.

A (Dr. Graham McMahon): The issue of the government taking over is on a path. Our community started it, and it will be very hard to unwind. There is legislation in front of the Senate and House around pain management, and regardless of what we as a community think about MOC, we are allowing the government to encroach on our ability to self-regulate, and I think this is dangerous precedent.

A (Dr. Patrick Walker): The founding argument in the beginning was to create our own system to keep the government out, and here we are with our own colleagues driving the issue right to their state legislators.

A (Kathleen Ruff, ABMS): What we find effective is physicians standing up for this. Last year, what happened in Texas was awful for physicians. We need advocates in states. The state legislature doesn't want to hear from us at ABMS, they want to hear from physicians in their state. This is seen as a physician civil war, which makes it even harder to involve patients and consumers. In the pediatrics community, we have some parents who have been willing to advocate and speak up, and then physicians are attacking them on social media. This makes people hesitant to be involved. ABMS is launching a major consumer campaign about board certification. There is public interest – they assume someone is making sure their physicians are up-to-date. When they understand that this is what is going on, they are upset.

A (Dr. Mira Irons, ABMS): The committees in the states care about physicians practicing there. When I testified in Massachusetts for ABMS, lactation consultants and athletic trainers were testifying about how they maintain their credentials and how they want to be recognized as professionals. Then, for the MOC bill, physicians came in and were advocating that they not have to do this continuing certification. It was striking for the committee to hear these disparate views.

Q: What about the vision commission? There are patient representatives as well as physicians. How is ABIM going to respond to the recommendations of that commission?

A (Dr. Richard Baron): We know there are a lot of different views there, and it would be premature for us to take a position since we don't know what recommendations will result. Of course, we know that irreconcilable positions are being put in front of that commission.

Q: It's not always good to stick with one thing, but I think ABIM could benefit by sticking to one plan for more than a couple years. Members call, and I have to explain the ins and outs because they are confused, and I wonder if this leads to the frustration that has gotten us to the National Board of Physicians and Surgeons (NBPAS) and all this legislation and now the commission. I hope you have contingency plans for communicating to diplomates. It seems like it could be a repeat of "we made a mistake, we're sorry."

A (Dr. Richard Baron): I hope you don't think we have no plans; we just have no reaction prepared for the commission since it is ongoing. There is much articulation in this room of shared purpose, and we have announced where we are with collaboration. We are clearly committed to standards.

A (Dr. Bruce Johnson, President of ASCO): We are working closely with ABIM and are fully behind it, and so are our members.

A (Dr. Richard Baron): With this topic we believe everyone has skin in the game. Yes, the program is transforming and it is hard to change in a way everyone feels comfortable with, and collaborating more is a big piece of that. But we do not take too lightly the landscape of legislation, because then we will be facing a regulatory environment.



Dr. Anand Lal, ABIM Board of Directors

ASK ABIM GOVERNANCE PANEL

Moderator: Eric McKeeby, ABIM Director of Community Engagement

Panelists (ABIM Governance): Dr. Richard J. Baron – President and CEO of ABIM, Dr. Patricia M. Conolly – Chair of the ABIM Board of Directors, Dr. Roger W. Bush – Member of the ABIM Board of Directors, Dr. Robert D. Siegel – Member of both the ABIM Board of Directors and the ABIM Council, Dr. Jeffrey S. Berns – Chair, Nephrology Board; Chair-Elect, ABIM Council, Dr. C. Seth Landefeld – Member of the ABIM Board of Directors

Eric McKeeby, ABIM Director of Community Engagement, moderated the final session of the day, a panel discussion with six members of ABIM governance. By way of introduction, he asked the panelists to explain their role and the unique characteristics they bring to their service. Dr. Siegel explained that he began with the Oncology Exam Committee and brought the perspective of a community oncologist who could identify which questions did not apply outside the academic environment. Dr. Conolly and Dr. Berns also started their service with exam committees, while Dr. Bush detailed his variety of experience as a program director and as a community-based generalist with a background in rural practice. Dr. Landefeld, an academic department chair, noted that over time the board has grown more balanced between academic, private and community practice physicians.

When asked about the learning challenges of generalists as opposed to specialists, and how to integrate this distinction into learning and assessment, Dr. Conolly explained that “there is recognition on the board that specialization is

increasing, and over the course of their careers, physicians carve out different areas. The big question is what core knowledge people need to have. We want to mimic real practice more, and we’ll continue to grow into that as we develop these programs.” In response, both Dr. Bush and Dr. Siegel reiterated the importance of ABIM’s partnership with ASCO as a major step in supporting focused practice. “Without them being involved, it is very difficult for the ABIM to know how to slice and dice what an oncologist does. ASCO will be working with our Oncology Specialty Board to sort out what is core knowledge and what would be better content for a specialized module,” said Dr. Siegel.

Dr. Bush continued by highlighting how practice setting impacts the practice of “internal medicine,” sharing that “sometimes you are everything to your patients, and in other settings you are essentially making a series of referrals. The duality is between customization to the context of practice, which is very important, and a certificate that says you are a generalist, and your patients can be confident that you as their doctor can handle their needs.”



Q&A FROM GOVERNANCE PANEL:



Dr. Andrea Russo, Heart Rhythm Society

Q: Physicians respond very well to data, and you have shown a lot of data today. There is also data on physicians who don't perform well on MOC. Is there a plan to disseminate it more widely?

A (Dr. Richard Baron): On our website we have an annotated bibliography with literature, and recently we have tried to do a better job making this information available with infographics as well as sharing on social media.

A (Pamela Browner White, ABIM): We know that many visitors to our website are looking for information about what they need to do, but we also share information about research. We also want to work with your communications teams to help this information move outward.

A (Dr. Seth Landefeld): We hear you. As someone who is new to the board, I can tell you I am just a doctor and not a communications person. But we definitely need to tell the whole story more broadly.

Q: Can you describe how the board and council make decisions in light of conflicting viewpoints?

A (Dr. Jeffrey Berns): I have seen a lot of things move to council from the specialty boards, and then that moves up to the board. The interaction between the council and the specialty boards is an opportunity to move information and discuss. Previously the specialty boards only wrote exams, but now they serve a unique and important purpose.

A (Dr. Patricia Conolly): It was a deliberate decision to create more diversity across ABIM governance, and as a result there are different opinions and a lot of robust discussions. Sometimes it takes longer to make a decision, or issues move back and forth as we learn more about each other's perspectives, but I think it benefits the work.

Dr. Roger Bush, ABIM Board of Directors



Q: What are other ways societies can partner?

A (Dr. Jeffrey Berns): *In nephrology there is a lot of discussion about scope of practice. Much of that is outside the realm of MOC but it has helped society members think seriously about what we are responsible for as subspecialists.*

A (Dr. Robert Siegel): *We also have representatives from subspecialty societies at some of our meetings. This makes the conversation bi-directional because it brings the society's concerns to the specialty board. Part of the role of the specialty board is to maintain those relationships.*

A (Dr. Seth Landefeld): *There is probably more that board members would be open to, whether it's writing a piece or meeting with a society council, or being available at a national meeting.*

Q: What do you want attendees to take away from today?

A (Dr. Roger Bush): *The morning session rocked my world. It created a different kind of moral case for what we do together. We learned that people have blind spots and those with the least ability have the biggest blind spots, which to me is a call to action.*



Dr. Richard Simons, American College of Physicians



Dr. Seth Landefeld, ABIM Board of Directors

Q: Hearing some of this from you all is still a little suspect, but to hear this from a different source makes the message resonate in a very different way and I think we can partner with you on sharing it.

A (Dr. Robert Siegel): *I have found myself involved in an ABIM microsite that has attracted some of the most verbal, anti-MOC people. I have waded in and found myself concerned about how many of my peers view medicine and where they want to take it.*

A (Dr. Seth Landefeld): *I am delighted that so many of you will spend a day here talking with us. To hear David and Graham tell a story with data is remarkable, because it isn't just about medicine. We have the opportunity to work together to secure a better experience for our patients.*

A (Dr. Jeffrey Berns): *I try to think of myself as both a physician and a patient. I still grapple with how entities reach out to patients.*

A (Dr. Roger Bush): *As a profession, no, we can't get out of MOC. Some measure that people are staying current is really important. Self-assessment is unreliable. What I also learned is we live in such a complex, clinical world, and we can't sit here in Philadelphia and just make rules. You all are here to represent your members who are the experts, and you can deliver an educational process to close the gaps that we and others find. This is real co-creation that needs to be all of us working together and thinking about how well we serve the public.*

CLOSING COMMENTS – DR. PATRICIA CONOLLY

“Thank you for a wonderful day. I am struck by how we exist to serve our patients. All of us share that. Dr. Baron started out by reminding us of the duty we have to do the best we can. Underneath is the reality that no one is very good at self-assessment, which won’t serve our patients in the way they should be served. As medicine changes and we adapt, unlearning the old is very much a part of keeping up, and that needs to be rolled into how we stay current. Our duty is to ensure that physicians who know how to deliver care are leading the way in determining what it means to do that well.”

IM SUMMIT ATTENDEES

Ms. Nicole Augustyn

American College of Chest Physicians

Dr. Richard Baron

American Board of Internal Medicine

Mr. Robert Bartel

Society for Cardiac Angiography and Interventions

Dr. Eric Bass

Society of General Internal Medicine

Dr. Richard Battaglia

American Board of Internal Medicine

Dr. Keith Bellovich

Renal Physicians Association

Dr. Jeffrey Berns

ABIM Council

Dr. Emily Blumberg

American Society of Transplantation

Ms. Marcie Bonilla

American Board of Internal Medicine

Mr. Mike Boudreau

American Society of Transplantation

Dr. Craig Brater

Alliance for Academic Internal Medicine

Ms. Helene Brooks

American Board of Internal Medicine

Ms. Pamela Browner White

American Board of Internal Medicine

Ms. Julie Bruno

American Academy of Hospice and Palliative Medicine

Ms. Michelle Bruns

American Heart Association

Mr. David Buckman

American Board of Internal Medicine

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Dr. Davoren Chick

American College of Physicians

Mr. Charles Clayton

American Society of Hematology

Dr. Patricia Conolly

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Alliance for Academic Internal Medicine

Dr. Ann Danoff

Endocrine Society

Ms. Francesca Dea

Society for Cardiac Angiography and Interventions

Dr. Art DeCross

American Gastroenterological Association

Dr. Thomas Deering

Heart Rhythm Society

Mr. Ed Dellert

American Society for Gastrointestinal Endoscopy

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Society for Healthcare Epidemiology of America

Ms. Katie Duggan

American Association for the Study of Liver Diseases

Dr. Jeremy Dugosh

American Board of Internal Medicine

Dr. David Dunning

University of Michigan

Dr. David Ellison

American Society of Nephrology

Dr. Kirk Garratt

Society for Cardiac Angiography and Interventions

Ms. Anamika Gavhane

American Board of Internal Medicine

Mr. Tim Gregory

Heart Rhythm Society

Mr. Louis Grosso

American Board of Internal Medicine

Mr. John Held

American Board of Internal Medicine

Dr. Bryn Herrschaft-Eckman

American Board of Internal Medicine

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Dr. Mira Irons

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American Society of Clinical Oncology

Dr. Bruce Johnson

American Society of Clinical Oncology

Ms. Jessica Johnson

Society for Healthcare Epidemiology of America

Ms. Wanda Johnson

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American Geriatrics Society

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ABIM Foundation

Save the date for the Liaison Committee on Certification and Recertification (LCCR)

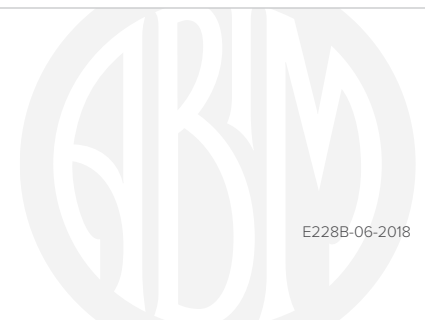
NOVEMBER 5, 2018

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