INTERNAL MEDICINE SUMMIT SUMMARY

MAY 13, 2019 | PHILADELPHIA, PA

INTRODUCTION

On May 13, 2019, leaders from 30 internal medicine specialty and subspecialty societies joined with the American Board of Internal Medicine (ABIM) in Philadelphia for the 2019 Internal Medicine Summit. This year's summit focused on the decline of trust in health care and implications for the physician community.

Patricia Conolly, MD, Chair of ABIM's Board of Directors, started the day by framing the goals of the Summit around such issues as rebuilding trust, developing meaningful relationships, finding common ground, collaborating, and the future of assessment. She encouraged attendees to share their own personal experiences with trust in health care and to explore how it could be rebuilt.

"We want to understand what we, as a profession, might do to influence this issue of trust. All of this is deeply rooted in our obligation to the public and the patients we serve."

– Dr. Conolly, Chair, ABIM Board of Directors

PRESIDENT'S UPDATE AND WELCOME

Richard Baron, MD, President and CEO of ABIM, shared his appreciation with society leaders for gathering to discuss the broader themes surrounding trust that impact health care, the physician community and society at large. Dr. Baron said it was a challenging time to be in leadership anywhere due to the challenges to authority and institutions, the pace of change brought on by advances in technology and the spread of misinformation. He envisioned leadership playing a key role in fostering ongoing learning and helping physicians deliver the best care possible to their patients. He related how ABIM's evolution as an organization stemmed from eroded trust with the physician community, and how the organization has made a concerted effort to adapt to meet the needs of the modern physician.

CME for MOC Program

Dr. Baron then provided an update on some of ABIM's programs, activities and recent developments, including the CME for MOC program in collaboration with the Accreditation Council for Continuing Medical Education (ACCME). He illustrated the many ways physicians reduce redundancy by earning both CME and MOC points, presenting the program as an opportunity for the societies to be leaders in the educational arena. Since the ACCME collaboration began in September 2015, over 26,000 activities have been registered and more than 12.6 million MOC points earned by 151,535 ABIM diplomates. Participating diplomates earned an average of 84 MOC points.

Updates on the Knowledge Check-In

Dr. Baron provided an update on the Knowledge Check-In (KCI), which rolled out in Internal Medicine and Nephrology in 2018, and an additional eight specialties in 2019. He framed the session by reporting some of the feedback ABIM has received and addressing some misconceptions:

- The KCI is a point-in-time assessment and it is pass/fail, but no one will lose their certification because of their performance on a single assessment.
- The KCI lets physicians demonstrate in a lower-stakes way that they are staying current in their fields.

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

Dr. Baron then provided information about physician sentiment related to various aspects of the KCI based on post-assessment survey data.

- In 2015–2016, up to 25% of physicians said the traditional 10-year MOC exam was not a fair assessment of their knowledge in internal medicine. In 2018 that number declined to 14% for the 10-year, and 11% for the KCI, showing that ABIM's efforts to engage diplomates in the exam blueprint review process was helping.
- ABIM predicted that when given the choice of testing location, physicians would overwhelmingly choose to take it at home over a test center. But in reality it has been in fact closer to 50-50 between home and Pearson test center.
- In general, physicians said they appreciated the flexibility that came with choosing a testing location, as well as the shorter testing time, and said they had a positive experience.

The Vision Commission Report

Dr. Baron then turned to **the Vision Initiative**, an effort created by the American Board of Medical Specialties (ABMS) to assess the current state of continuing board certification and envision its framework for the future. The Vision Commission included physicians, professional medical organizations, national specialty and state medical societies, hospitals and health systems, the general public and patients, and the 24 Member Boards of ABMS.

The Commission's work included testimony and public comment from stakeholders across the spectrum of health care professionals, and culminated in its recently published report. Dr. Baron remarked that he saw the Vision Initiative as an opportunity for the community to align its work around a set of shared values and purpose. Among the Commission's recommendations was the concept of creating lower stakes assessments and remediation opportunities for physicians to retain their certification. Dr. Baron pointed to the KCI as one way ABIM is currently approaching this recommendation in that it provides diplomates multiple opportunities to pass, and that no diplomates will ever lose their certification due to failing a KCI.

"It's very inspiring to me to see this gathering of voices from the internal medicine community. We are convinced that having a reputable credential is critical for trust with patients and that this is a very important issue in health care today."

– Dr. Richard Baron

Dr. Baron reflected on the Vision Commission's recommendation that Boards and Societies work together in their shared responsibility to enable doctors to stay current—and be recognized for having done so. He cited ABIM's Collaborative Maintenance Pathways with the American College of Cardiology (ACC) and American Society of Clinical Oncology (ASCO) as two examples of how these partnerships are providing board certified physicians with more options for maintaining their certification.

DECLINING TRUST IN MEDICINE TODAY AND WHAT WE CAN DO ABOUT IT

Dhruv Khullar, MD, a physician at NewYork-Presbyterian Hospital, researcher at Weill Cornell Medicine, and a contributor to the *New York Times* delivered a **keynote address on the decline of trust** in American institutions, including health care, in recent decades. He offered detailed evidence of this disturbing trend and discussed how we can work together to collectively rebuild it, citing common instances of shared experiences where trust comes into play.


Dr. Khullar presenting on the declining trust in medicine today.

Where Trust Has Declined

Dr. Khullar began by highlighting that trust has declined in nearly every sector. He reported survey data that showed trust in the media declined from 75% in 1976 to 32% today and trust in government declined from a high of 75% in the 1960s to a low of 15% today. Confidence in medical leaders has fallen from 75% in 1966 to 34% today —and only 25% express confidence in the health care system. He showed that the US ranked 24th among industrialized countries in terms of how many patients say doctors in their country can be trusted at 58%. Switzerland ranked first at 83% and Great Britain second at 76%.

Dr. Khullar spoke about how trust is a pervasive element in society and that it is particularly important in medicine because the care of patients is highly personal and unique in nature. He quoted Nobel Prize-winning economist Kenneth Arrow who said, "Virtually every commercial transaction has within itself an element of trust…much of the economic backwardness in the world can be explained by the lack of mutual confidence."

The Benefits of Trust

Reflecting on the importance of trust and whether it actually matters, Dr. Khullar cited several real-world consequences resulting from a lack of trust. For example, trust makes people more likely to adhere to treatment and engage with health care innovation. The level of trust in a doctor was seen as a significant factor in patients participating in clinical trials and equal to their trust that the medication would help them. He stressed how trust can play a key role in how we respond to public health crises such as in the case of the Ebola epidemic where distrust made it more difficult to contain the epidemic and save lives. In terms of promoting healthful behavior, Dr. Khullar said patients with high levels of trust are more likely to take their medications, adhere to treatment, follow their physician's advice and keep coming back.

In closing, Dr. Khullar made the case that trust can be rebuilt by promoting transparency, communicating clearly and establishing long-term relationships built around shared interests and goals. He gave some examples of initiatives on trust, such as:

- Comprehensive Care Physician Program in Chicago: advocates having patients see the same doctor in the clinic that they see at the hospital.
- The Open Notes initiative: An international movement committed to making open visit notes available. It's believed that providing ready access to notes can empower patients, families, and caregivers to feel more in control of their health care decisions, and improve the quality and safety of care.
- Geisinger's Refund Promise: A money-back guarantee that dissatisfied patients can claim in full for all expenditures, no questions asked.

In closing, Dr. Khullar emphasized that trust plays a central role in health care, and that dedicated attention to building trust can have important downstream health benefits.

HIGHLIGHTS FROM THE Q&A ON TRUST

A Q&A session followed Dr. Khullar's presentation, and attendees asked about specific issues pertaining to trust. One attendee asked what could be done when the patient trusts the physician, but not the health care system, to which Dr. Khullar provided an example of a health insurance company that tried to arrange it so that every time a patient calls they spoke to the same person.

Another attendee asked what actions could be taken to address the amount of misinformation and alternative facts about health issues. Dr. Khullar spoke about the need to develop a health and media "literacy" such as directing patients to websites your organization recommends in order to learn more about a particular condition or health concern.

Other questions pertained to perceptions patients may have regarding profit motives or conflicts of interest and the disparity between patients' trust and their expectations. Dr. Khullar advocated being as transparent as possible with patients regarding costs, outcomes and treatment options.

PANEL TO FURTHER EXPLORE TRUST

Moderator:

Dr. Dhruv Khullar

Panelists:

Austin Chiang, MD, MPH – Chief Medical Social Media Officer at Thomas Jefferson University Hospitals

Robert W. Lash, MD – Chief Professional and Clinical Affairs Officer at the Endocrine Society

Ana Pujols McKee, MD – Executive Vice President and Chief Medical Officer at The Joint Commission

Kristin Schleiter, JD, LLM – Vice President of Policy, Government Affairs & Strategic Engagement at American Board of Medical Specialties

Following his keynote address, Dr. Khullar moderated a panel discussion on trust. The session began with each panelist sharing their perspectives on the topic.

Ms. Schleiter: *My work in legislative advocacy is all about trust; legislators are not physicians and need to trust where we come from. With the Vision Commission, there is a tremendous amount of trust being placed in the ABMS so this permeates all of my work.*

Dr. Chiang: *I am a gastroenterologist and chief medical social media officer at Jefferson. My focus is on helping more trained professionals engage online but doing so in a responsible manner.*

Dr. Pujols McKee: *The focus of my work is patient safety. Although for years many did not recognize the Joint Commission as a patient safety and quality improvement organization, it is exactly that. Unfortunately, the experience for many physicians mostly due to misinformation has been one of frustration and disempowerment building on their loss of trust.*

Dr. Lash: *I am an endocrinologist and a former chief of staff, and now that I represent a medical society, I am a voice for our members. I believe trust is earned by what we do on a regular basis for all of our constituencies.*

Trust panel answering audience questions.

Dr. Khullar then led the panel – and attendees – in an engaging dialogue that delved deeper into issues of trust among physicians, patients, organizations and the system at large. Highlights of the conversation included:

Dr. Khullar: *We've talked a lot about making the case for self-regulation and autonomy for clinicians. How do you work in this landscape of oversight?*

Dr. Pujols McKee: *Many times physicians do not have a seat at the table when decisions are made. The crafters of policy may not be clinicians or individuals who do the actual work in the area the policy applies. Being at the table gives them the opportunity to design processes and make policies that support the clinical practice without undo burden.*

Dr. Khullar: *What strategies have you used?*

Dr. Pujols McKee: *Taking actions that help physicians feel empowered. Encouraging physicians to engage in performance improvement and policy and planning activites can improve the clinical environment in which they practice, which should have a positive impact on building trust.*

Dr. Khullar: *How does this translate to trust in legislation?*

Ms. Schleiter: *A lack of trust can certainly result in legislation, or in breaking down the institutions we've all taken for granted. We see this in questions about licensure, and who needs to be licensed. Words matter. You can't take titles for granted. Titles like doctor and physician are increasingly being taken over by non-physicians, such as naturopathic physicians and doctors, pharmacy and physical therapy. Titles that used to be in the purview of specialty medicine are under attack, and now in my world, everyone is board certified no matter who you are. There used to be a gentlemen's agreement that certain words belonged to physicians, however that can no longer be taken for granted.*

Dr. Khullar: *For certain groups, trust has always been an issue, and then we have the rise of social media.*

Dr. Chiang: *I think social media can help restore some of this autonomy. We can talk about health in our own way and I think this is more and more important, especially with the rise of influencers. Now this is coming to health care, and it brings pitfalls because other industries are tapping into medical students and using impressionable faces to promote products. My underlying philosophy is we need more trained professionals on social media talking about their health credentials and health knowledge. People try to justify bad information they see online, so we have an opportunity to get trained clinicians online and talk about what they actually do. We need the future generations to join the ranks.*

Dr. Khullar: *Robert, how does this look in the clinical setting?*

Dr. Lash: *I talk about insulin pricing—this is a huge issue you've all read about. What most people don't know is you can get the older insulin—e.g., NPH insulin—for $25 at Walmart. And you don't even need a prescription. But when you try to get that message out to patients you're immediately pilloried that you're trying to give people second-class care. And we can push back and say – no, we believe if the alternative is dying because you can't get the 'good stuff' vs being alive because you get the older stuff, this isn't even a question. But because there's so much bad will about drug prices and forcing people to take therapy that their insurance company [covers] we face an uphill battle even doing little things that we think will make a difference for a large number of people.*

TRUST PANEL Q&A:

In the question and answer session following the panel discussion on trust, attendees raised questions about efforts by the societies and ABIM in terms of social media. Dr. Baron gave his view about how ABIM has increased its involvement in social media to parallel the organization's transformation. Dr. Pujols McKee pointed out that societies can take advantage of their list-servs and other information to help identify misconceptions regarding accreditation and regulation. Providing physicians with accurate information through list-servs and social media might be a useful tool.

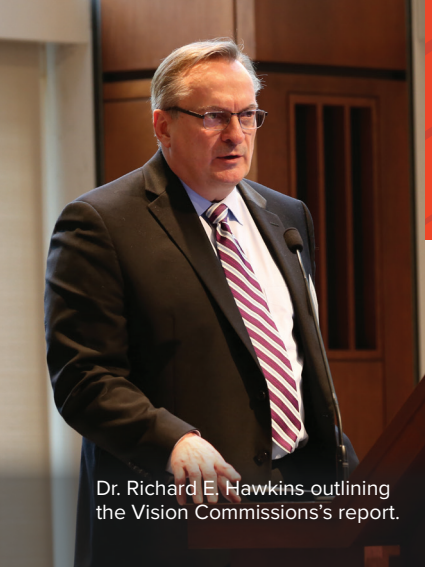
Other questions centered on trust in organizations and the impact of diversity on that trust. Dr. Pujols McKee stated: "The evidence is out there, and we know that organizations with metrics about this are making a difference. We are less than 100 years from Tuskegee and this is always going to be with us. There is no change management strategy when an organization does this, and we need to talk about the need for competency there. From my perspective, I see embattled organizations that start going down this path and end up fighting over these issues because it isn't handled well with the physician community, which is unfortunate."

TAKEAWAYS FROM THE SMALL GROUP DISCUSSIONS ON TRUST

Daniel Wolfson, MHSA, Executive Vice President and Chief Operating Officer of the ABIM Foundation, led participants in tabletop conversations on how trust is eroded and can be rebuilt. Topics ranged from how easy it is to lose trust to the difficulty of building trust, the need for acting with consistency and for being accountable for your actions.

A number of themes emerged from the discussions:

- Trust is easy to lose and hard to rebuild.
- The loss of trust is often seen as a significant betrayal.
- Relationships rebuilt due to challenges with trust can become stronger than relationships that never went through such issues.
- Not all eroded trust is bad; it's how you handle it that matters.
- Misinformation in patient charts is a difficult issue that can lead to mistrust. Turnover on teams makes it difficult to achieve treatment continuity for patients.
- Respect the person you are communicating with and to keep an open mind.
- Diversity is an asset to forming and maintaining trust.


Dr. Richard E. Hawkins outlining the Vision Commissions's report.

CONVERSATION ABOUT THE VISION COMMISSION REPORT

Richard E. Hawkins, MD, President and CEO of ABMS, began the session with a presentation outlining the Vision Commission's report and providing insights into what the recommendations mean for many stakeholders associated with ABMS' 24 member boards, stressing that the purpose of the Commission was to bring together multiple stakeholders to envision the future of continuing board certification. Dr. Hawkins said there was a need to bring value to physicians to support their learning and improvement needs, as well as to bring value to the profession and other stakeholders by offering a meaningful credential, and that the two value propositions aren't mutually exclusive. He stressed that meaningful self-regulation required a system of engaged stakeholders asserting that advancing continuing certification must be accomplished within the profession.

Dr. Baron followed Dr. Hawkins' presentation by relaying how ABIM has worked—or is working toward—many of the recommendations from the Vision Commission. For example, he cited ABIM's efforts to engage with the diplomate community to obtain feedback to make changes to its programs. Specific to the Vision Commission recommendation that Boards offer clearly defined remediation pathways, Dr. Baron spoke about ABIM policies that allow physicians to take the Knowledge Check-In without fear of losing their certification due to failure, and how they could utilize this option to reinstate a lapsed certificate. He also reflected on how ABIM is already aligned with other recommendations, such as expanding opportunities for gaining CME and MOC points and collaborating with other organizations to create alternative pathways. He closed by noting while much progress has been made, there is still much work to be done, and that ABIM continues to iterate its MOC program so that it can better meet the needs of physicians and the profession.

Dr. Richard Battaglia, Chief Medical Officer of ABIM, then moderated a panel conversation on the Commission Report.

Moderator:

Richard G. Battaglia, MD – Chief Medical Officer of ABIM

Panelists:

Richard J. Baron, MD – President and CEO of ABIM

Patricia M. Conolly, MD – Chair of the ABIM Board of Directors

Marianne M. Green, MD – Chair-elect of the ABIM Board of Directors; Member of the ABIM Council

Richard E. Hawkins, MD – President and CEO of the American Board of Medical Specialties

As the panel discussion got under way, Dr. Hawkins clarified a point raised in the previous presentation: "We have boards that have data showing that some of their diplomates prefer point-in-time assessment, and ABMS does not interpret the commission's report as indicating this should be eliminated, only that diplomates must have alternatives to it," he said.

One attendee asked the panel, "I was struck by the discussion and recommendation about assessments and framework—particularly if any of the Boards are trying to move to integrate what we've seen as silos in the past of the MOC program. Is this something the boards are doing?"

Dr. Hawkins: *There have been some discussions about the need to move away from the 4-part framework to a more integrated one – something along the lines of, 'we deliver programs where assessments support learning and improvement and that program is integrated into practice. I'm not aware of any Boards doing pilots in that area. It's going to be a significant change for the Boards community and require changes in infrastructure and business models for implementing continuing certification.*

Dr. Baron: *There is a certain amount of clarity in expectations. The 4-part framework allowed us to communicate clearly what diplomates need to do to stay current. What do Boards base a certification decision on? What do diplomates need to do to remain certified?*

Dr. Hawkins: *I don't think the 4-part framework ever really embraced the core competencies, so we can probably develop something that improves our coverage of the competencies.*

Q: *When I hear about everything that has gone into the KCI, and then the report opens more questions, I have to ask how societies move forward. What do you see us doing in the next couple years in terms of positioning ourselves?*

Dr. Baron: *We still see ourselves as having an assessment role, and we want to work with you to integrate education into that process, but this is all going to happen in a world where we have assessment options too. We think we will have options in each discipline, maybe that is longitudinal or maybe it is a society partnership model. We'll need to co-create that.*

Dr. Hawkins: *I agree. We have to think creatively as we work together in identifying our respective roles, so we can prioritize our efforts and share the data we need to fulfill our responsibilities.*

Dr. Green: *I think we can leverage innovation, data and technology to speak to each other and target material based on an individual's performance. This is already happening with Artificial Intelligence in education.*

Several members of the Commission were present and offered their perspectives on the process and ensuing report:

Dr. Leff (Chair of ABIM's Geriatric Medicine Board): *It was often brought up that the line between boards and societies could be completely disrupted in terms of function and business model. I think we sink or swim together, and if we can create trust we can do great things for diplomates and enhance the field.*

Dr. Russo (President, Heart Rhythm Society): *We can learn from each other. There are great models and innovations that have been created. We still need data to prove it.*

Dr. Green: *One of the challenges is about an individual's performance or ability. That is part of the issues around assessment and the consequences of erosion of knowledge over time and if self-assessment alone is enough. This is where ABIM has had a position of maintaining some form of measuring ability. Creativity around how we do that and integration with adult learning is key and no question we need to partner to be able to do that. I think for me, it would help me to understand more about ABMS's position on measuring the ability of diplomates.*

Dr. Hawkins: *I think we can reliably measure performance with knowledge assessments, though we are not there with other competencies, such as procedural and communications skills, so we can't defend performance standards there. We realize that not every assessment question is answerable now, and this is where the task forces will help us move forward as a community.*

Q: *As a cross-cutting subspecialty, I am looking for a word of hope about consistency among the boards and how we can support the value of the credential.*

Dr. Hawkins: *We know there's a problem. There is significant inconsistency across the Boards, and different boards apply our policies in different ways. There may be rationale behind why a Board has certain methods, guidelines or policies in place – but we need to think more about those guidelines as we seek to evolve our programs to be more consistent.*

Q: *Do you believe that hospice and palliative medicine (HPM) and sleep medicine need to be at the table?*

Dr. Baron: *Rich [Hawkins] has been in his position for a little over a year, and he has really driven a conversation around shared purpose. There wasn't a lot of clarity about that. We are also just beginning to grapple with the multi-specialty sponsored certificates like HPM or sleep, and what we didn't do as an ABMS community was really ask the question of who should be controlling the long-term expectations. The administrative board is offering the exam as a matter of convenience, but the certifying board sets other expectations. We need to have a conversation where we agree on how to differentiate disciplines, and it is bigger than exam sponsorship.*

Q: *I'm wondering about milestones and timelines. Are you considering when some of these decisions will be laid out?*

Dr. Hawkins: *We're committed to all of the boards considering alternatives to point-in-time assessments. We are discussing this in terms of piloting other models and having to plan for their implementation by the end of 2019*

Q: *ABIM got it right on part 4, and in an era of epic burnout it would be tone-deaf to insist on these projects. They listened well, and recognized that others are monitoring quality. We are interested in what anesthesia is doing, especially because of the remedial component and algorithm measuring what people got wrong, then retesting them on that content. There is a point where you bounce out of that program and have to take a summative exam. Can you comment on that program?*

Dr. Hawkins: *I can't comment on measurement decision theory, which provides the psychometric basis form MOCA-Minute. However, I believe longitudinal assessment in general has a lot of value because it supports learning and improvement, and can ensure gaps are filled. However, overall we need the right balance between formative approaches supporting learning and improvement and summative decisions that ensure the value of certification to the public.*

Dr. Baron: *They are doing what we are with the KCI, where people who are not progressing successfully will have to demonstrate that they have stayed current with a summative exam. We can emphasize that it's about learning, but we think a lot about our purpose as an assessment organization. We believe in the transparency of what we do, and we want to be clear that we are using assessments to determine whether someone may keep the credential.*

Q: *What was the report's recommendation regarding professionalism?*

Dr. Hawkins: *In the future, we would like to assess professionalism as part of Continuing Certification but we know we are not at the point we can accomplish this in a reliable and valid manner. Also, we currently are inconsistent among the boards in our response to disciplinary action regarding professional standing, based on information we receive from state licensing boards. Both the future of assessment of professionalism and the need for more consistency in judgments regarding professional standing are included in this recommendation.*

Q: *I maintain my internal medicine credential, hematology and oncology credentials. A MOCA minute-type system for all of those credentials would be a huge volume of questions per quarter. Shouldn't we talk about what this really means for people and what that might really look like?*

There is no question that the KCI is a positive step, and a MOCA minute is not going to work for every area. The problem with KCI is people saying that they have to prepare like they are taking a 10-year exam but it only gets them 2 years, so why should they take it?

Dr. Baron: *Cycle-length is definitely one of those things we're talking about, and that was included in the Commission report as well. I would point out that your initial score might predict how you'd do if you were still focused in your specialty over career. But what if you got interested in other things, such as someone who buys a tractor dealership or becomes a film director or takes a totally different trajectory? Those people are different, and they may not pass the exam if they didn't keep up clinically. In the same way we need to be distinguishing the way people have been trained by assessing and attesting to the real knowledge they have acquired, I think there's a real collective interest in demonstrating that people have stayed current in a field that changes so rapidly.*

Julie Bruno of the American Academy of Hospice and Palliative Medicine asking the panel a question.

COLLABORATIVE MAINTENANCE PATHWAY (CMP) UPDATE AND PANEL DISCUSSION

Dr. Richard Battaglia provided an update on the details of Collaborative Maintenance Pathways (CMP) and elaborated on ABIM's commitment to work with professional societies to transform and evolve the MOC program. William Oetgen, MD, Executive Vice President of Science & Quality, Education and Publications of the American College of Cardiology, and Jamie Von Roenn, MD, Vice President of Education, Science, and Professional Development of the American Society of Clinical Oncology, each delivered remarks reflecting on their society's maintenance pathway and the process and experience of collaborating with ABIM. A CMP, utilizing ACC's ACCSAP will be available in 2019 in Cardiovascular Disease, and in 2020 in Medical Oncology through the co-created ABIM/ASCO Medical Oncology Learning & Assessment.

Dr. Battaglia then moderated a discussion with Drs. Oetgen and Von Roenn about their goals for collaborating with ABIM, how they navigated the discussions in terms of varying member perspectives, and lessons learned throughout the process.

Dr. Richard Battaglia giving an update on the Collaborative Maintenance Pathways.

Panel Discussion on CMP

Q (Dr. Battaglia): *How do you work with critics of ABIM from within your membership as you work on these programs?*

Dr. Oetgen: *We had fairly easy buy-in from our board of trustees. Our chapter leaders do more grassroots work, and many of them had heard negative things from their members, and we had more conversations with them. Our thinking was we had to have something for everyone, but we weren't going to limit the college's work or impact the options other cardiologists had for what to do.*

Dr. Von Roenn: *Our Board of Directors has been supportive of our collaboration with ABIM and supported the premise of continuous certification early on. Our membership was, by-in-large supportive of our goal to improve the continuous certification process by working for the changes most important to them. We have worked with our member/ non-member critics by seeking their input and responding honestly to their issues.*

Dr. Oetgen: *It also helped to talk with our colleagues from the subspecialty societies, because they have such knowledge.*

Q: *You talk about your stakeholder groups as being your members, which is different from ABIM. How have you engaged others, namely patients and health care organizations?*

Dr. Von Roenn: *We are a member led society and see our members as the primary stakeholder group.*

Dr. Oetgen: *We have not engaged patients, and we might look at that in the future. We defined members as those interested in working with our educational products.*

Dr. Battaglia: *Our goal at the end of the day was providing physicians with what they need to serve patients better. The fact that ASCO and ACC, along with ABIM, believe in that principle was important.*

Q: *Historically the ABIM has been an assessment organization and the societies do education. For societies that are thinking about this, who is taking on what role if a certification needs to be taken away?*

Dr. Von Roenn: *Assessment is part of education, not certification. ASCO is not taking responsibility for the decision about taking away a physician's certification..*

Dr. Jamie Von Roenn answering questions during the Collaborative Maintenance Pathway Panel Discussion.

Dr. Oetgen: *We had members who wanted to break away entirely and do our own assessment and be our own board, which our trustees rejected. It is walking a tightrope but we are providing an educational component and a way to demonstrate your knowledge to the ABIM. We'll see. In all honesty, some people may be upset.*

Q: *Can you describe how the cardiovascular subspecialties will work?*

Dr. Oetgen: *These separate subject categories will be divided into chunks to be taken over a 5-year period.*

Q: *Can you say more about the cost investment of the society? Cost is one of the big concerns for our members as well.*

Dr. Oetgen: *The College has put a substantial investment in the creation of the SAPs (Self-Assessment Programs) and we have brought the overall price down.*

Dr. Baron: *When there are studies about the cost of MOC, the ABIM piece was a small fraction and the rest was educational. Staying current is expensive. And it's not all MOC, it takes time and resources to generate these materials and physicians are absorbing many of those costs.*

Q: *How did you decide on a passing component?*

Dr. Oetgen: *This is what we are psychometrically testing right now.*

Dr. Battaglia: *We are following our usual process to determine the passing score for the ABIM/ ASCO Medical Oncology Learning & Assessment.*

Dr. Oetgen: *It is conceivable that everyone can pass and we would love to see everyone who uses this option pass.*

CLOSING COMMENTS – DR. PATRICIA CONOLLY

As the meeting drew to a close, Dr. Baron paid tribute Dr. Conolly, who is completing her term as chair of the ABIM Board of Directors this year.

"Pat's been a part of ABIM's leadership for many years, and as a thought partner for me and the entire ABIM organization. I can't say enough about her groundedness and calm demeanor, and I really appreciate everything she's done on behalf of the entire discipline," said Dr. Baron.

In her closing comments, Dr. Conolly reflected on the Summit and what it achieved:

"The tenor, culture and engagement here is dramatically different and better than ever, and I am so pleased and honored to work with all of you. It's critical that people have the space to speak their minds and to disagree with each other, and I think the small groups got everyone thinking about how this issue (trust) will impact us. Our world of expertise is challenged, and I have received a lot of feedback about our community engagement. I hope each of you felt you had an opportunity to speak because your voices are so important."

Dr. Patricia Conolly listening to Dr. Baron paying tribute to her before she gave her closing comments.

IM SUMMIT ATTENDEES

Timothy Attebery
American College of Cardiology

Safwan Badr, MD
ABIM Board of Directors

John Barnes
Heart Failure Society of America

Richard Baron, MD
American Board of Internal Medicine

Eric Bass, MD
Society of General Internal Medicine

Richard Battaglia, MD
American Board of Internal Medicine

Amy Beckrich
Renal Physicians Association

Jeffrey Berns, MD
ABIM Council

Craig Brater, MD
Alliance for Academic Internal Medicine

Margaret Breida
Alliance for Academic Internal Medicine

Helene Brooks
American Board of Internal Medicine

Pamela Browner White
American Board of Internal Medicine

Julie Bruno
American Academy of Hospice and Palliative Medicine

Michelle Bruns
American Heart Association

David Buckman
American Board of Internal Medicine

Roger Bush, MD
ABIM Board of Directors

Alison Carey
American Board of Internal Medicine

Judi Cassel
American Board of Internal Medicine

Austin Chiang, MD
Thomas Jefferson University Hospitals

Davoren Chick, MD
American College of Physicians

Charles Clayton
American Society of Hematology

Karen Collishaw
American Thoracic Society

Patricia Conolly, MD
ABIM Board of Directors

Bergitta Cotroneo
Alliance for Academic Internal Medicine

Ann Danoff, MD
Endocrine Society

Art DeCross, MD
American Gastroenterological Association

Ed Dellert
American Society for Gastrointestinal Endoscopy

Doug DeLong, MD
American College of Physicians

Katie Duggan
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