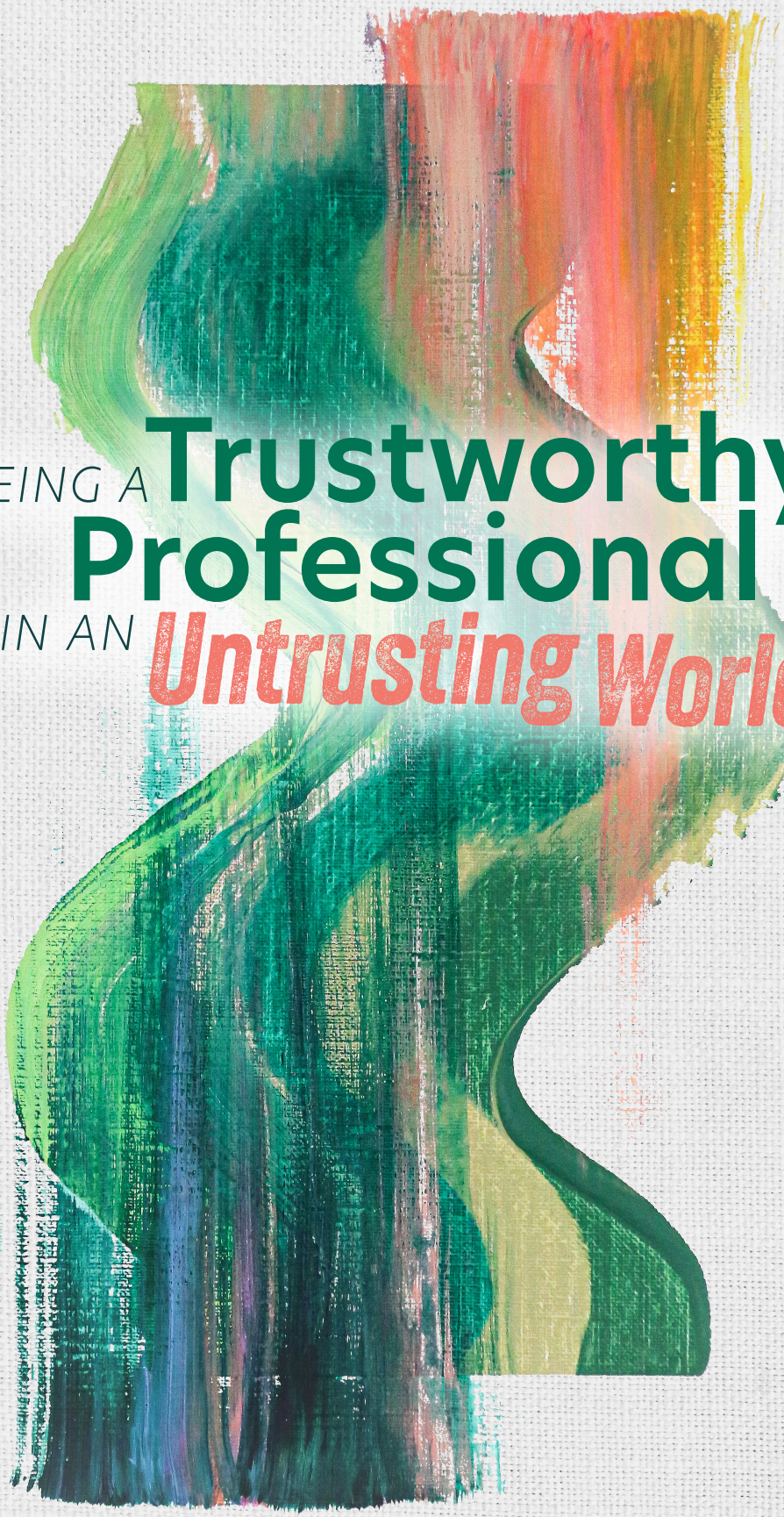

BEING A Trustworthy Professional *IN AN* Untrusting World

ABIM FOUNDATION®

2024 ABIM Foundation Forum

SUMMARY PAPER

By Timothy Lynch, JD

Leaders and experts from across health care gathered in July 2024 for the ABIM Foundation Forum to discuss how the medical and scientific communities can maintain and restore trust in our increasingly polarized society. Participants worked over three days to develop potential approaches to acknowledge past failures and build trust. This paper summarizes the proceedings and learnings from this year's meeting.

A Focus on Trust

David Coleman, MD

David Coleman, MD, interim director at the Yale Center for Clinical Investigation and the chair of the ABIM Foundation's 2024 Forum Planning Committee, kicked off the discussion with the goals of the meeting, calling on participants to "think critically and creatively...about building on ideas generated here to make meaningful impacts on communities across the country."

Richard Baron, MD, the president and CEO of the American Board of Internal Medicine and the ABIM Foundation, described how the 2024 ABIM Foundation Forum would serve as a Season Three of a "trust series" that began with the 2022 meeting. The 2022 ABIM Foundation Forum focused on misinformation and Dr. Baron noted the continuing salience of the topic. He highlighted that keynote speaker Renée DiResta has since attracted hostile attention from the U.S. House Subcommittee on the Weaponization of the Federal Government, and along with researchers doing similar work at other institutions, had seen her work sidelined, with Stanford closing the Internet Observatory where she served as research director. He highlighted her book, *Invisible Rulers*, which had just been published. The 2023 ABIM Foundation Forum was organized around a historical perspective of thinking around science and medicine, and the relationship between science on one side and liberty and freedom on the other.

Richard Baron, MD

To introduce this year's discussion, Dr. Baron pointed to two pieces of data from the 2024 Edelman Trust Barometer Special Report on Trust and Health. First, the public expressed as much concern about the politicization of medical science as about affordability of care or another pandemic. Second, 41% of worldwide respondents aged 18–34 said they would not trust advice from or continue to see a physician who does not share their political beliefs. "A generation that wants to know our political beliefs before taking our advice on managing their diabetes—that's a real challenge to deal with," he said.

Dr. Baron also discussed the Healthcare Trustworthiness Theory of Change co-created with the Institute for Healthcare Improvement (IHI) that would serve as scaffolding for many of the conversations at the meeting. In particular, he discussed its emphasis on acknowledgement and apology, and their roots in centuries-old traditions and practices in Judaism and Christianity.

A Demand for Misinformation

Dannagal G. Young, PhD

Dannagal G. Young, PhD, an associate professor of communications at the University of Delaware, delivered this year's President's Lecture, which focused on the public's appetite for misinformation and the media's complicity in feeding it.

Dr. Young described three fundamental motivations that influence us: comprehension, control, and community (the "three Cs"). She argued that we are driven by a motivation to feel as if we ***comprehend*** our world, as if we have ***control***, agency and power, and to be part of a ***community***, understanding that we cannot survive alone. "These needs for the three Cs," she said, "are often better served by fiction than reality."

Early in her remarks, Dr. Young spoke about her own past embrace of conspiracy theories, during the time while her young and healthy husband was suffering from the disease that would take his life. She searched widely for comprehensible explanations for his condition, questioned the care his clinicians provided, and sought community in online support groups whose members touted alternative solutions. Ultimately, her existing circle of friends persuaded her that her anger and her questioning of her husband's doctors were not helping her husband, thereby disrupting her "emerging identity" as a health conspiracy theorist.

Dr. Young stressed the significance of group identity more broadly – both one's own social identities (e.g., physicians, runners, sports fans) and the "outgroups" that threaten the expertise or identity of your groups. She noted that the defensive and hostile reaction of ingroup members against "outgroups" is exemplified by the extreme polarization of the current political climate. Indeed, as America's two major parties became more ideologically coherent over recent decades, two "mega-identities" developed that encompass many Americans' cultural and ethnic backgrounds, religious faith (or lack thereof), hobbies and social pursuits, and trust in institutions. The growth of these social identities fosters more extreme issue positions and attitudes, leading people to see members of the other group as less human and creating fundamental problems for relating to one another.

Dr. Young explained that media companies have found a way to profit from these "two Americas." Opinion-based programming that highlights the outgroup threats perceived by ideological Americans on both sides enables networks to sell these "homogenized and passionate audiences" to advertisers. Online, content that goes viral tends to be moral and emotional content that is easily tied to social identity and outgroup threat.

As many Americans' identity becomes subsumed into these "mega-identities," embracing falsehoods to stay in good standing within groups becomes more logical. "We cannot survive by ourselves," Dr. Young said. "If believing something empirically true deprives us of group support, why do it?"

Dr. Young suggested that addressing "identity-based wrongness" thus requires moving upstream from the misinformation itself, empathizing with the three C's underlying people's false beliefs and demonstrating humility in seeking ways to address them. She also suggested that reminding people

of their other, less polarizing social identities (e.g., local community member) could help diminish their susceptibility to group-motivated thinking.

"The more I study social psychology, the more I'm convinced that individual human beings aren't really the problem," she concluded. "The economics of media and broken political incentives are transforming our needs into an appetite for identity-driven wrongness. I hope we can work collaboratively to think of creative ways to disrupt some of the processes, empathize with people in need, and recognize that the needs are real."

Dr. Baron asked how her advice could be applied to the physician-patient and public health guidance contexts. In working with patients, she said, humility is a counter to condescension—clinicians can stress that they are always looking at new information and are happy to review things their patients bring to them. She presented intellectual humility as a "wonderful opportunity for the medical community." "People who embrace the possibility they might be wrong are actually much more likely to be empirically accurate," she said. She called for approaching the world with constant curiosity and a willingness to update one's beliefs (an attitude that she noted is punished in the current political and media environments). She also said that "anchoring your identity to the community you're serving and becoming part of the ingroup in that community completely changes how that group will see you."

Following the Lecture session, Forum participants worked on an "Outrage Factory" exercise in small groups. Each group was assigned a "myth" related to health care, such as that the COVID-19 vaccine is 100 percent safe or that ivermectin is an effective COVID-19 treatment. Participants worked together to develop a messaging approach that might persuade people who accepted these myths to change their minds without trying to "fact-check" them out of their beliefs.

Forum participants working on "Outrage Factory" exercise

Wolfson Scholars

Three medical students who had submitted winning entries for the ABIM Foundation's 2024 Building Trust Essay Contest then addressed the group. (These students are known as Wolfson Scholars, in honor of former ABIM Foundation leader Daniel Wolfson.)

Margaret Sorg, APRN, MSN, DNP, a second-year medical student at the University of Kentucky and a former pediatric nurse, talked about how she persuaded her brother-in-law that a tonsillectomy was the best course of action for his son (her nephew). Her brother-in-law held an advanced degree in a scientific field but had many negative experiences with the health care system. She found that listening and responding to his questions and worries with evidence and concern—and helping him develop a set of questions to discuss with his son's ENT physician—alleviated his concerns. "One's lived experiences often take precedence over rationality and knowledge when trust is at stake…We must listen and strive to understand in order to build communication that facilitates trust," she said.

Kaveri Curlin, a medical student at UC Irvine, spoke about her experience with a Chinese-American teenager who had been admitted to the Child and Adolescent Psychiatry unit after threatening to harm himself. She described how Asian Americans are less likely to seek mental health treatment, which is more likely to be stigmatized in Asian American communities. The patient largely resisted engaging in meaningful conversation with clinicians until a fellow asked him if he was scared to participate in family therapy with his parents. The fellow persuaded him that his parents were not upset with him and wanted to help him get better. "Challenging centuries-old behavior and creating space for emotional vulnerability is *scary*," Ms. Curlin said. "But when there is mutual respect and understanding of someone's background, physicians can empower patients to build the confidence necessary to take the first step in the right direction."

Ella Eisinger, a medical student at the University of Pennsylvania, described an encounter during her sub-internship with a patient with a history of alcohol use disorder who was admitted after a fall. She watched her attending lower herself to the patient's eye level, talk to him about his drinking (which he said was related to the recent death of his son), and gently persuade him to remain in the hospital for placement in rehab. After suffering a seizure, the patient decided to instead return home before entering rehab on his own. Although she had concerns about how returning home might impact the trajectory of his recovery, Ms. Eisinger ultimately accepted his decision. "Trust is neither a thing to be 'won' or an active 'winning' of patient compliance," she said. "Trust is to meet a patient halfway, to walk alongside them, and to encourage them forward while never abandoning them should the journey grow circuitous."

In a discussion following their remarks, moderator Nakela Cook, MD, MPH, the executive director of the Patient-Centered Outcomes Research Institute, asked each panelist for one thing they'd want physicians to embrace. They mentioned intellectual humility, engaging in dialogue and careful listening, and finding ways to honor and acknowledge one's patients. "There is so much value in understanding the legacy of mistrust in health care, as uncomfortable as it can be to confront it," Ms. Eisinger said. "Leaning into that is the first step in trying to improve and dismantle the legacy of mistrust."

Reflections on the Day

Rajeev Jain, MD, a practicing gastroenterologist and the Chair of the ABIM Board of Directors, and Heather Yun, MD, an infectious disease physician who recently retired from active military service and is a member of the ABIM Foundation Board of Trustees, brought the first day to a close with a dialogue. Dr. Jain said it was important to have a framework like the "three Cs" to apply in day-to-day clinical practice or managing a health system. He also stressed the importance of humility – "If you just say 'Do X,' it's not going to fly," he said. His other takeaways from the day included the importance of active listening and addressing patients' cultural needs, and the idea that patient trust is not manifested by and cannot be measured by adherence to medication.

Rajeev Jain, MD, and Heather Yun, MD

Dr. Yun said that she appreciated the framing in Dr. Young's lecture. "We all make decisions about what we believe about our identities, reinforced by what we hear," she said. "Ultimately, even if we're acting on what we believe to be the best evidence, we're still believing in authorities telling us something." She said that the basic building block of trust is the 1:1 relationship between individuals and clinicians, and that she believes it is up to her as a physician to retain trust as an "act of hope."

New Perspectives on Trust

The first plenary session on the Forum's second day featured two new perspectives on trust. Tony Mills, PhD, MA, senior fellow and director of the Center for Technology, Science and Energy at the American Enterprise Institute, provided a philosophical perspective on trust and medicine. Dr. Mills discussed the sources of legitimacy for medical experts, noting that there is no inherent reason to assume that members of a society would trust in expert authority.

He said the first source of legitimacy is competency: the skills to perform tasks competently and efficiently. Competency alone, however, is not enough to ensure legitimacy. Character is also a necessary source. He said that character in this context means "the capacity to pursue a scientific or medical practice in accordance with standards that are enforced by institutions and respected by society." It encompasses disinterestedness (not being driven by personal motives) and organized skepticism (having one's work subject to scrutiny by peers).

Tony Mills, PhD, and Sara Gorman, PhD

He noted the importance not only of empowering experts but also restraining them. Restraint is essential, he said, because experts have power, institutionally if not individually. Indeed, modern societies depend on expert systems, with experts who represent powerful abstract systems, whether or not they understand themselves that way.

Dr. Mills argued that one way to understand today's problem of distrust is as popular alienation from these abstract systems. He noted that individual clinicians are more trusted to tell the truth than medical authority figures. The decline in trust intensified during the COVID-19 pandemic, when he argued that experts were perceived as going beyond their competence and restraining others without restraining themselves.

Sara Gorman, PhD, MPH, the CEO and co-founder of Critica, then talked about why Americans feel betrayed by the health care system, based on more than 70 interviews she conducted in researching her new book, *The Anatomy of Deception*. She told the story of a retired Massachusetts woman who threw out her back and sought treatment from a chiropractor after being unable to find a physician. Although she had previously had relatively high trust in the system, she started to shun medical care and died after refusing to go to the emergency room after having terrible abdominal pain. Dr. Gorman said this was emblematic of a common theme across her interviews: a lack of trust in health care has dire consequences and immediate health impacts.

Dr. Gorman also noted a connection between health care trust issues and people's faith in the government, noting that her interview subjects felt abandoned by the government and that this abandonment fed a sense of increasing alienation.

She argued that two key drivers of mistrust were access and inequity. People who could not access the system – or perceived that they could not access it – questioned why they would trust a system that felt unavailable to them. And inequity damages relationships and undermines trust. "Equity issues are no sideshow—they are fundamentally trust issues," Dr. Gorman said.

Dr. Gorman proposed conducting longitudinal studies of trust that measure how trust varies over time for patients; she suggested that this could inform targeted interventions that seek to capitalize on times when trust is higher. She also recommended that health care institutions "double down" on reducing disparities and building community and that physicians not shy away from talking with patients about political and social issues, which she said can shape patients' experience and how they use information.

Jackie Judd and Tony Mills, PhD

Moderator Jackie Judd, a former reporter and communications consultant, noted a tension in our conversations; many of the suggested ideas for improvement require relying on inter-personal relationships, but those relationships often occur within large and impersonal institutions like health systems. She asked if our system is "too big to fail" or "too big to fix." Dr. Gorman said that she was encouraged by the finding that trust does ebb and flow, as it suggests that there are ways to pull people out of their distrustful feelings, and that we need to work harder to figure out how to do so.

During the next session, Uché Blackstock, MD, discussed her experiences as a Black physician and how they affected her own trust in the health care system, a story she tells in her book Legacy. Dr. Blackstock described how her mother was raised by a single mother in Brooklyn who received public assistance but went on to graduate from Harvard Medical School (HMS). Her mother returned to Brooklyn to practice, and Dr. Blackstock and her sister both attended HMS, making them the first Black mother-daughter group to do so.

Dr. Blackstock practiced in academic medicine, an experience that sharply affected her.

She said that she wanted to follow her mother into academic medicine – "that was going to be my future." Once she was there, however, she struggled to find mentoring, which she partly attributed to a lack of Black physicians at her institution.

When she took on an equity role, she said she felt silenced and limited in her ability to make changes, and found that everything she posted on social media was being scrutinized by her institution. "I found myself in misalignment, in an environment where I couldn't speak truth to power," she said. "I felt like I was suffocating." Ultimately, Dr. Blackstock left medicine entirely to start an equity consulting business. "It wasn't bravery," she said. "It was survival."

Dr. Baron asked what she has seen white male system leaders do that has been helpful. "I would love for white colleagues to think about ways they can elevate the work of Black colleagues, such as sponsoring someone for an important role," she said. She stressed that mentorship should not and cannot happen only along racial lines. She said her own mentor at NYU was an older white woman who was fully invested in her – "it's impractical to say it should just be Black faculty mentoring Black students."

Workgroups

During the next section of the meeting, participants divided into self-selected groups devoted to repairing trust in areas such as bias and inequity, medical debt, and COVID-19 care. Before joining their groups, participants heard from Kedar Mate, MD, president and CEO of IHI, about the Healthcare Trustworthiness Theory of Change that Dr. Baron referenced during his opening remarks.

Aim: *Improved trust between health care organizations, their workforce, and the communities they serve.*

I. ACKNOWLEDGE	II. REDRESS & CLOSE	III. BUILD SYSTEM
past breaches of trust	trust gaps in the present	to strengthen trust for the future

Dr. Mate said that the IHI team had devoted much thought to how to apply to institutions what we know about how individuals can build trust. Team members explored the individual trust-building theories of Frances Frei, which highlight the importance of authenticity, empathy, and logic, and the population-level trust theory of Darity and Mullins, which focuses on acknowledgment, restitution and closure.

The framework they developed—which the workgroups would employ in their discussions—included three components: acknowledging past breaches of trust; redressing and closing trust gaps in the present; and building systems to strengthen trust for the future. Determining how health systems could implement this framework in an iterative and continuous fashion—with a focus on both clinicians and the community—presented challenges.

Six health systems sought to implement the framework, with interventions as varied as adding trust as a measure, starting a local hiring program, and prioritizing procuring food locally. All six project teams reported a perceived increase in trust, and qualitative data showing that listening to and addressing employee and community concerns had increased trust or at least an openness to trusting their organizations in the future. Notably, however, none of the six projects tested interventions in the specific area under acknowledgment focused on recognizing past harms and offering an apology if appropriate. Many of the project teams said they were interested in the area but that senior leaders and/or risk management personnel at their institutions prevented it.

Dr. Mate described a process of acknowledgment at his own institution, in which IHI created an equity and culture team and explored how its past work had affected disparities. (IHI found that in most cases it did not know whether disparities had increased; in occasional circumstances where the data were available, there was some indication that a QI initiative had potentially worsened them.) These steps, however, did not solve staff members' concerns; only an acknowledgment and apology about the

organization's past behavior built trust among staff. Dr. Mate pointed to a few lessons from this and other experiences: that solutions are not enough and may sometimes not even be what is desired, that mistakes are inevitable, and that acknowledgment (which does not necessarily have to include apology) creates psychological safety. He also disputed the idea that admitting a mistake increases liability risk, pointing to health systems that have trained personnel in apologizing and seen a decrease in liability costs.

Finally, he noted the challenge many individuals feel about apologizing for actions that occurred before their time at an institution. "We all enjoy privileges on some level that we didn't earn," he said. "To understand that and say you can see it and apologize for it is an important step. And not everything demands an apology—simply saying 'I see you and understand what you say' is important."

The workgroups then met and continued their discussions on the last day of the meeting; takeaways are described below.

Reflections on the Day

Fred Cerise, MD, MPH, the president and CEO of Parkland Health and Chair of the ABIM Foundation Board of Trustees, offered closing remarks. He began by noting a few learnings from the opening session. He recognized the challenge of balancing Dr. Mills' concept of physicians needing to serve as 'access points' between citizens and abstract expert systems and a health care system that is trending away from 1:1 interactions. He noted Dr. Gorman's caution not to emphasize individual historical events (like the USPHS Untreated Syphilis Study in Black men) over an overarching history of inequity, which he illustrated with an example of segregated care in New York City in the 18th century.

Dr. Cerise turned to Dr. Blackstock's remarks about the history of racism in medicine, discussing the history of 'redlining' in Dallas and showing how the same neighborhoods where banks once refused to lend suffered the most during the COVID-19 pandemic. He said that health leaders need "to buy into [DEI] work and recognize the years of structural racism leading to the disparities we see today."

He suggested a number of principles that system leaders should follow, including:

- Look beyond your institution to engage your community and address its needs
- Listen to your physicians and other providers, pulling them into helping solve problems with you
- Trust your patients – avoid tendency to think they can't do things that they can do, such as a home dialysis program that Parkland has launched
- Commit to an equity agenda as an anchor institution with broad impact on your community
- Examine your practices related to medical debt
- Partner with public health, sharing data, case reporting, etc.

At the same time, he recognized the challenge that nonprofit hospital CEOs continue to be compensated based on market share, operating margin and revenue, not providing uncompensated care or appropriate community benefit spending.

Building Trust at Scale

Sreekanth Chaguturu, MD, the executive vice president and chief medical officer at CVS Health, described how the company prioritized and built consumer trust. He said that their "analytics have clearly shown that trust and performance are linked" and that the company follows the philosophy that "trust + engagement = outcomes." According to Morning Consult data he shared, CVS Health is the most trusted brand in health care and the fifth-most trusted brand in America.

Sreekanth Chaguturu, MD

He began by talking about CVS Health's role in vaccine distribution, noting that it provides about one-third of seasonal respiratory vaccines in America. He pointed to CVS survey data showing the importance of convenience and cost to customers and noted a link between patient satisfaction and flu vaccine rates. He also discussed CVS Health's emphasis on building trust with women, whom he said drive 80 percent of family health care decisions. This trust-building effort included both policy advocacy (e.g., calling for elimination of sales tax on menstrual products) and store policies (providing access to over-the-counter contraception).

Finally, he discussed seniors, a major target audience for CVS. "If you want to build trust, you have to engage at the moment people are making decisions," he said. For seniors, he said these key moments include when people are retiring and transitioning to Medicare and when they lose friends and family members.

Dr. Chaguturu said CVS' research shows that patient trust is partially driven by clinical efficiency, such as avoiding unnecessary tests and visits that could be perceived as being done to serve providers' financial interests. He also said that trust is essential to the success of CVS Health's Aetna insurance business, noting the importance of the onboarding process for new customers and the fact that customers who trust Aetna are 3.5 times less likely to leave than those who distrust it.

Trust and the Online Environment

The next panel featured individuals working to promote trustworthy care in online environments. Lisa Fitzpatrick, MD, MPH, MPA, the CEO of Grapevine Health, is an infectious disease physician who leads a company focused on promoting health literacy as a path to build trust and engagement. She collects qualitative data about how to provide health information effectively and has concluded that we need "to approach health communication with a lot of humility." "A lot of the distrust around health information and even engagement with providers is because we're not speaking to them in the language we need to be communicating," she said.

Dr. Fitzpatrick pointed to a number of false narratives about online communication that need to be addressed. She said the primary false narrative is that the digital divide prevents us from innovating in low-income communities. In reality, she said, cell phone ownership is nearly universal and text messaging is the most popular form of communication in those communities. She said that even seniors are interested in using technology, and the key is helping them figure out how to use it to optimize their health.

She shared a story that illustrated the need and the opportunity to build trust in communities. While conducting outreach in a neighborhood, a woman approached with two bananas. The woman ate one and gave the other to Dr. Fitzpatrick, who thanked her but did not immediately eat it. The woman persisted, saying that she wanted Dr. Fitzpatrick to eat the banana to demonstrate her trust in the community. "That was a powerful moment for me," she said. "I realized the bidirectionality of trust."

(left to right) Irving Washington, Phoebe Yang, JD, Neel Shah, MD, and Lisa Fitzpatrick, MD

Neel Shah, MD, MPP, is an obstetrician who works as the chief medical officer at Maven Health, which provides fully virtual fertility care. He noted how in the recent past physicians often bemoaned patients' tendency to seek out information on Google and WebMD, but now express nostalgia for those days as TikTok has become a dominant source of information. His views of TikTok, however, were less negative than many of his peers. He discussed how the idea of taking Mucinex to help with conception went viral during the pandemic. After researching and finding no solid evidence for or against Mucinex, Maven decided not to direct patients away from using it. "It may not have helped conception rates but it did help with engagement," he said. Dr. Shah pointed to other virtues of technology and the online environment. For example, people have been more willing to report potentially stigmatizing sexual or reproductive information to Maven digitally.

Phoebe Yang, JD, shared insights from a career spent at companies inside and outside the health sector, including time she spent as General Manager of Amazon Web Services, Healthcare. She suggested that although artificial intelligence remained in its embryonic stages, its ability to offer insights into patient care was accelerating quickly. At the same time, companies offering telemedicine were largely struggling unless their products were integrated into physicians' existing workflow. She noted that the House of Medicine and physicians already have a foundation of generations of trust with patients and health care consumers that is the envy of companies seeking to work at the intersection of technology and health care. She said this foundation can and should be the basis for expanding into new arenas of engagement, knowledge and deeper trust.

Drs. Fitzpatrick and Shah both sympathized with residents and younger physicians who want to engage with the public on social media and face restrictions from their institutions. "Leaders in health care need to more introspective and less risk-averse," Dr. Fitzpatrick said. While recognizing that some regulatory limitations apply to things such as texting patients, she said, "We have to be creative to find ways to reach people however they're engaging." Ms. Yang acknowledged the legitimacy of privacy concerns that health care organizations must address but said there are proven ways to protect data that larger organizations can afford to implement.

Workgroup Results

After discussions over two days, the workgroups that were applying the Healthcare Trustworthiness Theory of Change to trust problems in health care reported about their recommendations:

- **COVID-19:** Groups working on this topic recommended that members of the House of Medicine come together to write an open letter that acknowledges mistakes during the pandemic and proposes creating an interdisciplinary risk management taskforce that would include community voices and would make recommendations for future pandemic preparedness. The letter could be presented as a paper in NEJM or another peer-reviewed journal.
- **Professionalism and Culture:** This group called for reimagining professionalism through a process that would include conversations across stakeholders, including health systems and plans. The process would explore where and why professionalism has eroded and propose concrete actions that could rebuild it. A parallel effort to establish an Organizational Charter outlining the principles of organizational professionalism could also be valuable.
- **Bias and Inequity:** One group focused on bias and inequity recommended building organizational competency in community engagement, developing and providing organizations with tools to understand community contexts and engage community members in ways that make sense for them. Another group called for systems to acknowledge their failures in providing care to publicly-insured patients and propose solutions to improve access, including executive compensation.
- **Medical Debt:** This group called for the House of Medicine to endorse a set of best practices for hospitals, recognizing physicians' roles in addressing medical debt.
- **Erosion of Workforce Control and Professional Autonomy/Workforce:** This group recommended emphasizing transparency in institutional decision-making and finances to clinicians and staff.
- **Inadequate Management of Conflicts of Interest:** This group proposed seeking payment reform through a focus on facilitating conversations with professional organizations in medicine about inequities in the current system and the role of physician payment.
- **Medical Education:** This group proposed an effort to hold institutions accountable for whether federal funding for teaching hospitals that is intended for education is actually used for that purpose.

Concluding Remarks

For the final session, Dr. Baron was joined by Dr. Mills and Dr. Young, whom he asked to reflect on themes of the meeting. Dr. Young noted that intellectual humility and acknowledging the possibility of being incorrect were persistent themes. She said she was also pleased to hear people recognize the need to expand their own circles and social identities.

(left to right) Richard Baron, MD, Dannagal G. Young, PhD, and Tony Mills, PhD

Dr. Mills said he was also struck by the humility theme. He described the concept of "competence-competence" from the Continental legal tradition, in which courts decide what kinds of cases they are competent to decide. He called for something similar for the realm of expertise, with experts acknowledging limits to their areas of authority—an area where he believes experts fell short during the pandemic.

Dr. Baron then asked how experts can simultaneously demonstrate humility and expertise. Dr. Young proposed that experts speak more plainly: 'I'm a person drawing on my experience in the world, which is studying this a lot, and I've been overwhelmed by the data on one side.' Dr. Mills said there are conflicting ideas about an expert's role (to point to data? To offer policy recommendations?) and proposed that experts embrace humility by reframing their statements as their best judgments rather than as irrefutable conclusions.

Dr. Baron raised the difference between authority and power. Dr. Mills said the two cannot be decoupled, but that it becomes tricky when institutions trade on their authority to assert power in other domains.

Finally, Dr. Baron asked the panelists what advice they would give to professionals seeking to be trustworthy. Dr. Young called for honoring the dignity and autonomy of all the individuals they treat, honoring their perspectives and seeking common ground without judgment. She stressed the importance of authenticity, an integral part of humility. "Leaning into one's authentic self could go a long way," she said. Dr. Mills said that professionals should reflect on the obligations and accountability they have, and how their roles can contribute to creating a more trustworthy system.