2026 ABIM FOUNDATION FORUM

FOOTHOLDS TO ADVANCE TRUST

Professionalism's Path Forward

SUMMARY PAPER

By Timothy Lynch, JD

At this year's ABIM Foundation Forum, health care leaders, practicing clinicians, and scholars examined the forces driving public dissatisfaction with American health care and explored how professionalism can help strengthen trust, restore professional agency, and address the challenges facing medicine today. Participants discussed four categories of "footholds" that can help clinicians and others across health care navigate these pressures and deliver care aligned with their professional values. This paper summarizes the Forum's discussions, insights, and key takeaways.

OPENING THOUGHTS

The opening session framed the Forum around a central question: how can medical professionalism strengthen trust in health care amid declining confidence in institutions, increasing system pressures, and reduced physician autonomy? Fred Cerise, MD, MPH, the president and CEO at Parkland Health and chair of the ABIM Foundation's Forum Planning Committee, began by noting how the Foundation has grappled with the idea that "professionalism wasn't universally accepted as a positive thing." He described the challenge of defining professionalism in a way that captures its complexity while avoiding perceptions that it is merely a tool for judging or controlling clinicians. "When we talk about professionalism," he said, "it's about how individuals and teams can work together to establish trust and equity." In addition to focusing on individuals and teams, he called for addressing "how to hold institutions and systems accountable for those professional values."

Reflecting on last year's Forum, Dr. Cerise highlighted the idea—drawn from closing remarks by David Goldman, JD, the founder and chairman of the Fellowships at Auschwitz for the Study of Professional Ethics—that physicians possess more agency than they realize, despite widespread misinformation and growing frustration within the profession. He also pointed to the successful advocacy of Lilia Cervantes, MD, a nephrologist and director of immigrant health at the University of Colorado, to expand dialysis access for undocumented patients in Colorado as an example of how clinicians can influence systems and policy.

Jessica Perlo, MPH, the executive vice president of the ABIM Foundation, described how this year's Forum agenda and objectives were designed to build on these themes of physician agency. She said "we want to get practical" at the Forum by focusing on concrete trust-building lessons that participants can apply and examples of clinicians overcoming structural barriers, while also exploring the role of professional self-regulation in maintaining public trust and the importance of solidarity within the profession.

"I don't think I need to convince anyone in this room that trust is a problem," Ms. Perlo said. She described a continuing decline in public confidence in institutions and expertise, alongside increases in the numbers of Americans who obtain health information from sources such as social media influencers. She noted that these societal changes have coincided with the significant economic

Jessica Perlo, MPH (left) and Fred Cerise, MD, MPH (right)

transformation of the profession; fewer than 20 percent of physicians now practice independently, leaving many employed physicians feeling they have less autonomy and less time to care for patients. Dr. Cerise, who leads a system in which care is delivered by employed physicians, argued that "if they are going to provide great care and feel engaged, they need to feel ownership, not just feel like employees subject to other people's rules." "Our most effective clinics are those where we have physician leadership," he said, warning that diminished professional agency ultimately weakens patient advocacy and the quality of care.

The speakers concluded by introducing the four "footholds" that would underlie the Forum's discussions. "A foothold is a secure place to put your foot when the terrain seems unscalable," Ms. Perlo said, describing how they were distilled in part from conversations at recent Forums that focused on trust. "These footholds came from you," she said, introducing them as:

- protecting human relationships by preserving meaningful clinician-patient connections;
- strengthening professional agency by enabling clinicians to exercise independent judgment;
- ensuring institutional and organizational accountability for supporting professionalism and justice;
- and cultivating shared responsibility and collaboration across organizations and sectors.

PRESIDENT'S LECTURE

Rachael Bedard, MD, an internist, geriatrician, and palliative care physician who practices at NYC Health + Hospitals and is a contributing writer for the *New York Times*, delivered the annual President's Lecture, using her talk to explore what it means to build trust with people who feel disconnected from or ignored by the medical establishment. She drew from her experience providing medical care for the sickest incarcerated patients at New York City's Rikers Island jail during the COVID-19 pandemic and presented lessons she learned about trust, autonomy, and the role of medicine that apply more broadly, including to adherents of the Make America Healthy Again (MAHA) movement.

Rachael Bedard, MD

Dr. Bedard described her pre-pandemic work at Rikers as "a period of great alignment" with her values, during which she built a compassionate release program that enabled more than 100 seriously ill incarcerated people to spend their final days outside of jail. When COVID-19 struck, however, it exposed the profound vulnerabilities of incarcerated populations and health care's limits in addressing them.

Once COVID-19 vaccines became available, she and her team aggressively sought to promote vaccination uptake at Rikers. They successfully advocated for early access to the vaccine and financial incentives for inmates who agreed to be vaccinated, in keeping with incentives available to other New York City residents. Rather than building confidence, however, this special access and the incentive program instead reinforced her patients' longstanding distrust of government and institutions. She said: "They said 'Why are you giving it to us first? The government has never paid me to put something in my body before.'" Vaccine uptake among the population foundered, with only 30 percent receiving it by the end of 2021.

Dr. Bedard said that she had shared this story often in the intervening years as "vaccine hesitancy has become a lightning rod topic in political and cultural discourse." Her Rikers experience convinced her that skepticism about vaccines, and medical advice more generally, cannot be understood simply through political labels or demographics. "The vaccine-hesitant people I knew were my patients, who were primarily poor and Black," she said. "The current discourse has barely reflected the people who introduced me to that dynamic."

Rachael Bedard, MD (left) and Dhruv Khullar, MD, MPP (right)

Her Rikers story caused her to think deeply about patient autonomy, how to best meet patient needs, and "the philosophical question about what medicine is for." She concluded that respecting patients' autonomy is essential even when patients employ that autonomy to decline beneficial treatments. "When they tell you what they want, you can probe the beliefs behind it, but you really do have to respect them," she said. "That is a precondition for their feeling that you can be trusted." She reflected on the principles she learned during her fellowship in palliative care, whose practitioners seek to design care based on what patients say is most important to them in handling their pain and suffering. She described this approach as running counter to the "dominant culture of medicine, which is focused on helping people based on what is objectively good rather than subjectively good."

Dr. Bedard identified three lessons she wishes had guided the vaccination campaign at Rikers. First, health care leaders should anticipate mistrust and engage communities before introducing new interventions by actively listening to concerns rather than assuming they understand them. Second, public health recommendations should be presented as choices, with opportunities for patients to delay decisions, seek more information, or decline without feeling coerced. "We need to build policies that give people the chance to exert agency," she said. "And be honest with ourselves about our own priorities and what we can control."

Third, clinicians must possess the humility to recognize that patients often experience crises differently than health care professionals. During the pandemic, incarcerated individuals were suffering not only from the virus itself but also from prolonged isolation, stalled legal proceedings, loss of visitation, and deteriorating jail conditions. By focusing narrowly on ending COVID-19, clinicians sometimes overlooked the broader hardships that mattered most to patients. While health care professionals have an important role in improving health, many of the forces that shape trust and health outcomes—such as housing, poverty, incarceration, and politics—lie beyond medicine's direct control. Rather than attempting to solve every social problem, she argued that clinicians should partner with experts from other disciplines like sociology and anthropology, remain curious instead of judgmental, and focus on building authentic relationships that respect patients' experiences and autonomy.

Dr. Bedard was asked whether and how mistrust in a carceral setting differed from the mistrust of individuals who identify with the MAHA movement, which she has written about extensively. She noted the common theme of trauma, relating how 80 percent of the crowd at an anti-vaccine conference she attended stood when asked if they had a loved one whom they believed was injured by a vaccine. Similarly, she said that patients she interviewed during her

reporting about long COVID wanted to share their stories of trauma. “Trauma is at the heart of people’s mistrust,” she said. “Without addressing that trauma, it’s hard to get past the friction.”

Dr. Bedard also argued that public trust is built primarily through individuals rather than organizations. “I really believe trust is built between people, and trust with institutions is more abstract and confounding,” she said. She highlighted former Maine health official Nirav Shah, MD, saying that his consistent, transparent communication during the pandemic fostered public confidence because he became a recognizable, accountable public face. By contrast, she expressed skepticism about whether most of the public really has an opinion about organizations like the Centers for Disease Control.

HARD TRUTHS ON THE PATH TO REBUILDING TRUST

Participants discussed stories at their table about times when they have seen trust be built, and how those stories fit within the four footholds. This was followed by a panel that featured a discussion among health communicators about how trust in health care can be created or restored. The panel featured Brinda Adhikari, BA, a journalist and host of the Why Should I Trust You? podcast, MacKenzie Isaac, MSc, MA, a Rhodes Scholar and PhD candidate who is the health equity hygienist for Those Nerdy Girls, and Katelyn Jetelina, PhD, MPH, the CEO of Your Local Epidemiologist.

Brinda Adhikari, BA, MacKenzie Isaac, MSc, MA, and Katelyn Jetelina, PhD, MPH (left to right)

Key points from their discussion included:

- **Medicine should acknowledge public concerns about financial conflicts and affordability:** Ms. Adhikari pointed out the salience of the issue of health care costs across ideological and partisan groups. She also noted rampant public distrust in the pharmaceutical industry and the skepticism engendered by the industry’s donations to medical organizations. She called for physician organizations to address these issues directly if they are interested in building trust.
- **Public health should prioritize better understanding human behavior:** The panelists emphasized that scientific evidence alone is insufficient to change behavior. While biomedical science advanced rapidly during the pandemic, comparatively little attention was paid to understanding people’s motivations and decision-making and how social and cultural contexts shape health behaviors. “I wonder whether we are making enough room to study human behavior alongside our study of pathogens,” Ms. Adhikari said. “The study of human behavior—like why someone might choose to take a vaccine—is one of the most important things in modern America.” Participants argued for greater integration of disciplines such as anthropology, sociology, psychology, and behavioral science into public health planning and communication to avoid the unthinking use of alienating terms such as “mass vaccination site.”

- **Scientific communication must extend beyond academic journals:** The panelists criticized the traditional academic incentive structure, noting that peer-reviewed publications reach relatively few people while public-facing communication can influence millions. “There is obvious value in scientists talking to scientists, but we also need to figure out how to translate that for people,” said Dr. Jetelina. The panelists argued that universities and health institutions should value and support scientists who translate research for the public rather than treating these efforts as secondary to academic publishing.
- **Mistrust is rooted in experience and trauma:** Panelists cautioned against overemphasizing the influence of misinformation in declining trust, citing other factors such as everyday negative encounters with the health care system and unaffordability as drivers of skepticism. They also cited historical injustices such as the Untreated Syphilis Study at Tuskegee and generational trauma. “Patients carry their parents’ and grandparents’ history with them,” Ms. Isaac said, relating a story of a teenager who asked her why they should take the COVID-19 vaccine after Tuskegee. “[Clinicians] have to get to know their patient’s history from a generational standpoint, and if you only have 15–20 minutes to talk to a patient that is very challenging,” she said, suggesting this as an area where racial concordance between clinicians and patients is beneficial.
- **Listening is more powerful than correcting misinformation:** Rather than viewing misinformation as the primary enemy, the panel argued that health professionals should try to better understand the kind of information patients are seeking. “People don’t need more data and facts, they need more narrators and storytellers,” Dr. Jetelina said. “They are demanding a far more participatory approach. They truly want to do their own research and we need to help them find ways [to evaluate health information].”
- **Traditional medicine must offer a positive vision of health:** The panelists observed that many people are drawn to wellness movements because they offer an aspirational vision of becoming healthier, not simply treating illness. “The success of the health and wellness industry is a signal that people want to think of health beyond going to the doctor when they are sick,” Ms. Adhikari said. “How can our systems view themselves as providing a positive vision for our lives and not just acute care?”

PROFESSIONALISM IN PRACTICE

Craig Spencer, MD, MPH

Participants then discussed whether and how physicians can engage on public policy topics without becoming—and/or becoming perceived as—partisan actors. Craig Spencer, MD, MPH, an emergency medicine physician and associate professor at Brown University School of Public Health, moderated this session and began by agreeing with earlier speakers that the MAHA movement is a signal that people are frustrated with American health care. He pointed to survey research suggesting that people who say they support MAHA are primarily concerned about the cost of and access to health care, issues that have been central concerns for Americans over decades.

Dr. Spencer noted that the professionalization of medicine over the past century has been wildly successful. At the same time, he described how this period of professionalization has featured the regular engagement of

physicians in public policy, including disputes over free vaccine clinics, government-provided health insurance, and steps to address social determinants of health. He questioned whether there is concordance between what physician organizations promote and what ordinary physicians believe, and asked meeting participants to select their own priority topics for advocacy. Lowering the cost of care was the most popular choice, followed by improving access.

A few participants offered thoughts after engaging in discussions at their tables. Margaret Levi, PhD, professor emerita and senior fellow at the Center for Democracy, Development and Rule of Law at Stanford University, suggested that physicians frame their advocacy as fighting for their values and accept that their efforts will be branded as partisan. Richard Baron, MD, MACP, the former president and CEO of the American Board of Internal Medicine and the ABIM Foundation, suggested that specialty societies could spend more of their money on attempting to reach the public rather than on influencing politicians. And Helen Burstin, MD, MPH, MACP, the CEO of the Council of Medical Specialty Societies, noted the complex web of conflicts in health care, including for-profit health systems and health plans; she argued that specialty societies are focusing on serving patient interests, including by publicly opposing powerful figures such as HHS Secretary Robert F. Kennedy, Jr. at great risk to them.

INSTITUTIONAL LEGITIMACY AND TRUST

During the afternoon session, the group turned to the role of institutions in bolstering or undermining trust. Dr. Levi offered her thoughts about how we should think about the intersection between professionalism, trust, and trustworthiness at the organizational level.

She focused on the distinction between trust and trustworthiness, arguing that trust can be misplaced, while trustworthiness "is in principle more objective, and can be evaluated against more objective standards." She noted that an institution may be trustworthy even when unpopular or perceived as legitimate despite failing to perform well. For Dr. Levi, trustworthy institutions reliably deliver on their promises, explain their failures, follow appropriate standards of procedural fairness, and demonstrate administrative competence. These qualities shape whether people comply with institutions and consent to their authority or withdraw their participation.

Kirsten Bibbins-Domingo, PhD, MD, MAS (left) and Margaret Levi, PhD (right)

Dr. Levi identified several broad threats to trustworthiness and legitimacy in health care, including misinformation, political attacks on institutional accountability, private equity ownership, consolidation, pharmaceutical influence, and policies that limit clinician-patient time. She noted the paradox that many people continue to trust their individual physicians while expressing growing mistrust of science and health care institutions, suggesting that strong interpersonal relationships can only partially compensate for systemic shortcomings.

She therefore emphasized the need for structural rather than exclusively interpersonal solutions. She encouraged physicians and their professional associations to "stand up when science is being undermined" and build coalitions with the people they serve to advocate for reforms that improve access and accountability. In the current political environment, she viewed relying solely on traditional methods and channels to achieve change as insufficient.

The idea of a “community of fate” was a central concept in Dr. Levi's remarks. This concept recognizes how people's well-being and futures are interconnected. Drawing on examples from progressive labor unions, she described how participatory institutions can motivate people to accept personal risk on behalf of others who may never reciprocate. She suggested that this model could inform efforts to redesign caregiving, elder care, and other health-related systems.

THE CASE

After Dr. Levi’s remarks, Mr. Goldman introduced an exercise that required participants to “navigate between concepts of compromise and complicity.” Each table of participants took on the roles of decision-makers at a medical school seeking to respond to political pressure to expand offerings on nutrition (and de-emphasize equity issues). Collectively, they had to decide whether to comply with the pressure, refuse to comply, or take another course. About three-quarters of the groups chose to take another course, such as by arguing that their existing curriculum already complied with the desired vision of nutrition.

David Goldman, JD

Mr. Goldman noted that “being a professional means that you have a particular expertise” and called upon physicians to rely on their own expertise and values in determining whether any particular compromise is worthy. He also argued that it is essential to consider the long-term consequences of potential compromises, and to consider how any compromise would affect “your constituencies’ willingness to trust you.”

REFLECTIONS ON DAY ONE

Troyen Brennan, MD, MPH, JD, an adjunct professor at the Harvard T.H. Chan School of Public Health and former executive vice president and chief medical officer of CVS Health, emphasized the tension between compromise and being compromised, framing the day's discussion as a broader examination of trust, legitimacy, and professionalism in medicine. Dr. Brennan, one of the authors of Medical Professionalism in the New Millennium: A Physician Charter, highlighted its principles, such as a commitment to the good of your patients and the pursuit of equitable, affordable access to care, as a framework for understanding today's challenges. He expressed concern that current attacks on scientific expertise, coupled with the influence of social media and institutional retreats in the face of political pressure, are eroding public trust and the moral authority of the medical profession.

He also stressed the importance of affordability and access, noting how Irving Washington, Foundation Trustee and senior vice president and executive director of the Health Information and Trust Initiative at KFF, had pointed to the fundamental problem that the system we have created does not provide the care people need at a price they can afford. “We have to take responsibility for the financial aspects of what we do in health care as part of our responsibility to patients,” he said. He described a recent history of progress in this area, from the creation of a Medicare drug benefit to the dramatic reduction in the uninsured population as a result of the passage of the Affordable Care Act. But he questioned whether that progress is sustainable. “That might not have been a tectonic plate moving toward universal access and a better system,” he said. “It might have been a blip during a stronger long-term trend toward the concentration of wealth and a system that doesn’t promote access or demonstrate concern about costs.” Dr. Brennan closed by saying he looked forward to a discussion about solutions that could address this sobering moment for American health care.

DAY TWO

Margaret Flinter, APRN, PhD, FAAN, FAANP, the senior vice president and clinical director of the Moses Weitzman Health System and its Community Health Center, Inc. and Secretary-Treasurer of the ABIM Foundation Board of Trustees, began the Forum's second day by summarizing some of the previous day's proceedings and providing an overview of what lay ahead. She noted how a shared desire to protect patients and uphold quality care unites Forum participants and encouraged them to draw strength from one another.

AI AND TRUST

Robert Wachter, MD, professor and chair of the UCSF Department of Medicine, then discussed the impact of AI on physician agency and trust. He expressed "guarded optimism" about AI's impact, which he said was partly the result of how poorly many aspects of today's health system work. He contrasted its potential favorably with earlier technological leaps, such as the development of electronic health records. But he cautioned that realizing its promise will require redesigning clinical work, education, governance, and the physician's role, rather than simply adding AI to existing workflows.

Robert Wachter, MD (left) and Heather Comer Yun, MD, MACP, FIDSA (right)

He discussed how medicine will have to redefine the physician's value in response to AI's capabilities. "We've never had to prove our value before," he said. While physicians historically have possessed expertise that patients did not, patients can now carry a tool that may "know" more than an individual physician and may even be perceived as more empathetic. Dr. Wachter argued that medicine will therefore have to demonstrate more explicitly what physicians uniquely contribute—judgment, contextualization, communication, responsibility, and knowing which information matters.

AI's ubiquity and growing sophistication have raised questions about whether and how medical education and training should change. Dr. Wachter suggested that medical education needs to distinguish "useful deskilling" from dangerous "neverskilling." While some memorization and routine work can appropriately migrate to AI, Dr. Wachter suggested that trainees would still benefit from a "foundational stage" where they develop their clinical reasoning skills and ability to glean the most important information from patient charts and encounters. He suggested that AI could be used in educational settings to coach learners rather than do their work for them.

Dr. Wachter also discussed the concept of "human in the loop"—the idea that an individual clinician should be involved in any significant clinical decision. He noted that AI, at least for now, "is right often enough to be useful and wrong enough not to be entirely trusted." But humans are poor at remaining vigilant when a system has repeatedly performed correctly, and increasing reliance on technology could lead physicians' skills to atrophy. And if AI eventually outperforms clinicians on some functions, requiring human oversight could actually worsen care. Dr. Wachter therefore characterized today's human-AI oversight model as potentially providing "false security."

What does professionalism require in response to the rise of AI? “Our goal is to keep people healthy and do it at the lowest cost, not employment,” Dr. Wachter said, arguing that physicians’ professional responsibility may ultimately require embracing AI for some or many functions. In the near term, however, he suggested that there is ample space for AI and the physician workforce to coexist, citing the overbearing workloads that primary care physicians currently face as an example of how AI can benefit clinicians by taking on easily automated tasks.

Alongside his general optimism, Dr. Wachter did offer cautions. He noted that AI recommendations can reflect bias, outdated evidence, commercial incentives or other influences hidden “under the hood.” He also said that patients may become too deferential to AI. He emphasized the need for empirical evidence showing that systems actually perform as promised.

“The answer to what distinguishes a doctor is going to have to be negotiated as we go forward,” Dr. Wachter said. His remarks suggest that medicine will increasingly need physicians who can frame the right problem, recognize clinically meaningful signals, supervise AI intelligently, exercise judgment, communicate consequential information, and take responsibility for care. Knowing what information to give an AI may itself become a sophisticated clinical competency.

PRACTICAL PATHS TO IMPROVE CARE

Participants then engaged in an activity designed to explore how clinicians might better work with one another and with other interested groups to promote policy and societal change that would benefit patients. Alice Chen, MD, an internal medicine physician and former executive director of Doctors for America, and Ali Kahn, MD, MPP, the chief medical officer – Medicare at Aetna/CVS Health and a Foundation Trustee, led a session in which participants considered how much influence clinicians have and how they could best use that influence. First, participants offered their answers to “How much influence does the medical profession have today?” Slightly more than half said it has more influence than it recognizes and about one in 10 said it has “a great deal” of influence; about two-fifths suggested its influence was diminished or limited. Participants then voted for the issues where they felt they could make the greatest difference through concerted action—increasing access and addressing cost received the most support. Following the votes, table discussions centered on potential partners, with patients and families, nurses, health systems and communities the most popular choices.

This session was followed by a panel that featured three individuals who have worked to improve care in service of patients:

Natalie Davis, MA, founder and CEO at United States of Care, shared findings based on her organization’s engagement with roughly 30,000 people across the United States, highlighting deep and increasingly visceral frustration with the health care system and a growing perception that financial interests and profits influence decisions about care. While affordability remains a dominant concern, people also want a system that feels centered on their needs rather than on money—a dynamic illustrated by negative reactions to terms such as “value-based care,” even when people strongly support its underlying goals. The organization’s research identified four values that consistently resonate across demographic and political differences:

Natalie Davis, MA

1. People have the certainty that they can afford their health care.
2. People have the security and freedom that dependable health care coverage provides as life changes.
3. People can get the personalized care they need, when and how they need it.
4. People experience a health care system that is understandable and easy to navigate.

"We don't have to agree on every detail, but the status quo isn't working and we need a new vision of where we need to go," Ms. Davis said, presenting these shared priorities as a potential foundation for a new narrative and vision for health care.

Keegan D. Warren, JD, LLM

Keegan Warren, JD, LLM, executive director of the Institute for Healthcare Access at Texas A&M University, focused on the delivery of care and the power of collaboration. She said that trust in health care delivery is built—or depleted—through every interaction, with positive interactions serving as "deposits" in a patient's "trust account." She cited the health care system's tendency toward professional and organizational silos as a major obstacle to trust. "We train separately, measure success separately, and collaborate only at the margins," she said. This fragmentation becomes particularly problematic when addressing social determinants of health, such as unsafe housing and family insecurity, which require broader interprofessional responsibility. She noted that stronger collaboration can benefit both patients and the workforce by reducing the moral friction clinicians experience when they can identify problems but lack the ability to address them. "If we want more deposits than withdrawals, patients need to experience us as one team," she said, noting the importance of warm handoffs, visible follow-up, and responsibility that is genuinely shared.

Panagis Galiatsatos, MD, MHS, associate professor of medicine and oncology at the Johns Hopkins University School of Medicine, emphasized that building medicine as a public trust begins with a simple but powerful commitment: showing up consistently in the communities health systems serve. He described how his Medicine for the Greater Good initiative earned trust not only by providing clinical care but also by attending community events from marching band practices to union meetings, engaging families and faith leaders, and developing initiatives with community members. "If you want medicine to be a public trust, you have to go into the spaces that the public trusts," he said. His approach includes developing community member liaisons who are meaningfully engaged and activated as partners in improving health. Dr. Galiatsatos noted the challenge of aligning the economics of health care with the ethics of community engagement so that this work can become a true standard of care, but also emphasized the value of this kind of work in promoting physicians' engagement with their work and reducing burnout.


Panagis Galiatsatos, MD, MHS

FLESHING OUT THE FOOTHOLDS

The Forum's final exercise gave participants the opportunity to develop concrete ideas to improve care and enhance physician agency within the four foothold domains: protecting human relationships, strengthening professional agency, ensuring institutional accountability, and cultivating shared responsibility. Bruce Leff, MD, Chair of the ABIM Foundation Board of Trustees and professor of medicine and director of the Center for Transformative Geriatric Research at the Johns Hopkins University School of Medicine, introduced the exercise by describing the current state of health care as marked by "diminished trust and constrained agency, fragmentation and institutional pressures" that presented profound challenges for professionalism. He said the ABIM Foundation was motivated to enable professionalism to be exercised visibly and consistently and be more highly valued, and that he hoped that the participants' ideas could help provide a pathway to guide the Foundation's activities.

Concepts developed in the small groups included:

Protecting Human Relationships

- Promote clinicians' communication skills by encouraging training programs (UME/GME), professional organizations, and certifying bodies to train and/or test clinicians' communication and relationship-building competencies
- Support efforts to develop and implement AI in ways that support rather than undermine human relationships
- Promote creation and implementation of reforms to protect/expand clinician-patient visit time
- Support regular discussions between system staff and community members about what matters to them and how to better protect human relationships

Strengthening Professional Agency

- Persuade the House of Medicine to advocate for meaningful clinical representation on institutions' governance bodies that make decisions affecting patient care
- Support the creation and dissemination of leadership development curricula and programs for physicians in training and practice
- Support efforts by physicians to organize and collectively bargain
- Develop a process for credentialing/certifying medical AI

Institutional and Organizational Accountability

- Create a hospital recognition program to recognize organizations that enable the conditions for medical professionalism to thrive
- Strengthen patient advisory boards, such as by investing them with approval power for community spending decisions
- Advocate for health systems to stop harmful billing and debt collection practices and address affordability concerns
- Support conditioning payor reimbursement to system action in addressing community health needs assessment

Cultivating Shared Responsibility

- Persuade health systems to commit to a to-be-defined "Gold Standard" of affordability
- Enhance system engagement with community organizations through town halls, focus groups, etc.

REFLECTIONS ON PROFESSIONALISM

Paul Starr, PhD, professor of sociology and public affairs at Princeton University, offered a historical perspective on professionalism and its challenges in the Forum's final address. He described how the United States has transformed "from a high-trust society to a low-trust society" over recent decades, during which time "science and medicine [have] remained among the most trusted, authoritative institutions in our society." But that authority has weakened and has become increasingly contested across political, racial, and educational lines. He suggested that this makes for a critical moment for the medical profession. "The profession has a great deal of agency and has the capacity to fight for professional values," he said. "This becomes especially urgent at a moment when institutions are under threat."

Dr. Starr said that today's greater suspicion is not unprecedented, citing strong currents of medical libertarianism in the 19th century that led to the repeal of licensing laws and progressive challenges to the profession in the 1960s and 1970s. "The development of professionalism has not been a linear and untroubled process," he said. What is new, however, is that distrust itself has become a source of political power, reflected in the rise of the MAHA movement and Robert F. Kennedy Jr.'s influence over national health policy. Dr. Starr described how this was fueled by three major "trust shocks" in the 2020s—COVID-19, the political empowerment of health-related mistrust, and artificial intelligence.

Dr. Starr described how the period after World War II illustrated both the strength and limitations of shared trust. The extraordinarily broad participation in the Salk polio vaccine trial demonstrated Americans' faith in medicine and science, while contemporaneous battles over water fluoridation showed that even strong scientific and bipartisan political endorsement could be defeated by organized skepticism. Over subsequent decades, trust in science became increasingly polarized along partisan lines. He attributed that divergence to several structural changes: the political realignment of Americans by educational attainment, industry-led efforts to discredit science in debates over tobacco,

Paul Starr, PhD

environmental regulation, and climate change, and the fragmentation of a common information environment as partisan cable news, talk radio, and other media created increasingly separate understandings of facts, beginning in the 1990s.

Trust in medicine did not show the same political polarization, with modest declines among both Democrats and Republicans. Dr. Starr described frustration across partisan lines about the cost of care, the difficulty of dealing with the health system, and with pharmaceutical and insurance companies. “The commercialization of the whole system has undercut the authority and trust that physicians used to enjoy,” he said, noting patient suspicions about physicians’ motives in ordering tests.

COVID-19 then became “a watershed moment” that intensified distrust, particularly among Republicans, but also among some Black and Hispanic Democrats. He noted the impact of President Trump’s questioning of mainstream science during the pandemic in undermining trust in science, alongside the historical concerns of Black and Hispanic Democrats that caused them to be suspicious of public health guidance.

Dr. Starr identified artificial intelligence as the next major challenge to professional authority and trust. He recalled the first sentence of his 1983 book The Social Transformation of American Medicine: “The dream of reason did not take power into account.” “AI is the latest example of the dream of reason,” he said. “We can’t fully anticipate what the consequences of AI will be without taking power into account.” He argued that AI’s impact will depend on questions of power—"Who will be the final arbiters of the assumptions built into the systems?” He noted the danger of power shifting from the profession to the tech industry and drew an analogy to the decline of traditional media—with its commitment, however imperfect, to concepts of journalistic integrity—and the rise of new media organs that lacked such commitments. He described his attitude toward AI as one of “guarded pessimism,” particularly given the enormous financial interests involved. At the same time, he stressed that physicians and professional institutions retain the capacity—and responsibility—to defend their values, shape emerging systems, and work toward a more just outcome.

CONCLUSION

The Forum underscored that strengthening trust in health care will require more than individual acts of professionalism. It will require protecting the human relationships at the heart of care, strengthening clinicians’ ability to act on their professional values, holding institutions accountable for creating the conditions in which professionalism can thrive, and building greater shared responsibility across health care and communities.

Together, these footholds offer a framework for moving from concern about declining trust to action. The challenge now is to translate them into practical changes that strengthen professionalism and improve care. The ABIM Foundation will carry forward the Forum’s most promising ideas through its convening, grantmaking, thought leadership, and partnerships.