VIEWPOINT

As ABIM Creates Division, Geriatricians and General Internists Should Unite

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Geriatricians and general internists can agree that our American Board of Internal Medicine (ABIM) certification was a rite of passage — the culmination of grueling medical training followed by a common stressful testing experience that bound us together. To "pass" the ABIM exam, we studied, practiced questions, debated which whether "A" or "C" was the most common answer, and laughed at the thought that a patient would present with a "multiple-choice" disease. We shared strategies for maintaining mental focus for 8 h of cognitive testing. Passing the exam granted us our specialty.

In a recent publication[1], ABIM-affiliated authors present an analysis that compares general internists and geriatricians on the measure of "potentially inappropriate medication (PIM) prescribing." In this study, the authors matched characteristics of geriatrics and general internal medicine physicians who "passed" the ABIM certifying exam. The ABIM-affiliated authors assembled and linked decades of data from sources including ABIM board exam performance, ABIM-mandated physician data, ABIM Maintenance of Certification (MOC), Universal Provider Identification Numbers, and Medicare data on encounters (part B) and prescriptions (part D). The study found that geriatricians prescribe statistically fewer PIM than general internists. The clinical outcomes of PIM prescribing are not addressed.

The results of ABIM's study are unsurprising. One would expect to find differences in prescribing practice along the lines of our specialty training. If ABIM desired, the assembled and linked data could demonstrate that gastroenterologists (an ABIM specialty) have higher colon cancer screening rates, cardiologists (an ABIM specialty) have higher referrals to cardiac rehabilitation, and endocrinologists (an ABIM specialty) achieve better diabetes control. Similarly, training in geriatrics includes a focus on polypharmacy and avoiding or deprescribing potentially inappropriate medications.

The conclusions of ABIM's study should give all ABIM diplomates concern, because ABIM is using our data to establish the "safety" and "value" of one specialty at the expense of another. The authors' concluding paragraph states, "We found evidence that physicians trained and certified in geriatric medicine prescribed more safely to older adults than similar physicians only trained in general internal medicine."[1] The ABIM authors also conclude, "these findings demonstrate the value geriatricians provide with regards to care quality for older adults."[1] General internists and geriatricians can agree that ABIM should not establish "value" of one specialty at the expense of another.

Additionally, geriatricians and general internists can agree that our ABIM exam performance and the ABIM-required personal information (necessary to register for the exam) were used without our voluntary, informed consent. To take the ABIM exam, physicians must agree to ABIM's confidentiality policy which states that ABIM information can be used "for research or related purposes."[2] Amidst the ABIM privacy policy is an email for opting out of future research (research@abim.org). Such an "opt-out" policy does not meet the standards of informed consent[3] because ABIM could practically obtain voluntary informed consent for its research purposes. ABIM has a secure online portal that every certified candidate or diplomat must use to qualify, register, perform MOC, view results, and agree annually to the ABIM Code of Conduct.[4] Adding a voluntary informed consent for research to the secure ABIM portal is a programming step. If this research demonstrates the "value" of geriatricians, I would argue this research study directly affects the rights and wellbeing of geriatricians and general internists and, thus, is not minimal risk — a necessary criteria for waiving informed consent. Geriatricians and general internists can agree that voluntary informed consent should not be waived for research using ABIM exam performance, including MOC and longitudinal assessments.

As the certifying body for both geriatricians and general internist, ABIM's motivation behind the data linkage and analysis reasonably raises additional concerns. ABIM historically has driven revenue streams potentially to the detriment of candidates and diplomats. Since 1990, ABIM has required physicians in all specialties to recertify for their specialty and qualify through its MOC program. The ABIM MOC program was substantially modified in 2014 and the physician backlash caused substantial revision in 2015. For this study, ABIM invested heavily in this analysis with Medicare data purchase, integration, and coding. In addition, all authors have financial interests with ABIM. Whether ABIM expects a return on investment for this study is unclear, but

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geriatricians and general internists can agree that historically, ABIM's motivations do not consistently benefit its mission of "excellent patient care."[5]

General internists and geriatricians can agree that training influences care, not performance on a standardized test. There is increasing understanding that standardized testing "success" may be skewed to those with the time, resources, and access to practice materials.[6] ABIM certification exams are high-stakes, high-stress standardized tests and performance is related to my testing ability and access to test-training resources. General internists and geriatricians can agree that ABIM exam performance decades prior has limited influence on practice, unless the patient presents with a multiple-choice disease.

Unsurprisingly, my geriatrics colleagues and specialty society will endorse that these findings match their experience. I urge caution with this interpretation. First, many of us consider ourselves as both internists and geriatricians. ABIM should be working to unite specialties, not divide us. Second, irrespective of the authors' conclusion, ABIM certification does not dictate my "value" as an internist or geriatrician, the quality of care I deliver, or my stewardship to our profession. As ABIM moves forward on conducting analyses between internal medicine specialties and includes ABIM exam performance, general internists and geriatricians can agree that ABIM has, again, overlooked the rights and wellbeing of its diplomats and candidates.

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