

CERTIFICATES OF ADDED QUALIFICATIONS – POSITION PAPER

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1. The CORNEA Society opposes the creation of CAQ's in Ophthalmology through the ABO/ABMS/ACGME pathway.
2. This position was adopted by the Board of Directors of the CORNEA Society at their last meeting in April, 2003. The vote was 14 against the ABO created a new CAQ, 1 in favor and 1 abstention.
3. The above position was taken by a vote of the Board of Directors. The topic was discussed at the general membership meeting, but the vote was taken at the board meeting.
4. The Cornea Society believes that subspecialty certification through the ABO/ABMS under ACGME regulations would have a detrimental effect of our profession. Potential benefits to the training of fellows can be obtained through other channels.

The CORNEA Society and a number of other societies have been working with the AUPO and have formed a task force on subspecialty accreditation or sponsorship. We feel we can insure quality education while respecting the unique fellow/mentor relationship traditional in ophthalmic fellowships. This type of unique approach within our field is not new. Ophthalmology had taken different paths in the past. We are one of only 5 residencies' that do not use the NRMP. Our match, the SF matching program, was established by the AUPO in 1977. This "different path" has served our needs very well. It continues to function effectively and coordinates with the NRMP. We (the CORNEA Society) feel a similar approach to fellowship approvals can be formulated to insure quality training without the negatives associated with ABO/ABMS/ACGME certification.

Potential negatives include:

1 – ACGME accredited fellows would fall under the same regulations as residents. A fellow would become a PGY-5. There is currently, however, no funding for these positions. This also has the potential for significant negative impact on the number of available resident positions. Moreover, as "housestaff," fellows would no longer be able to bill for services or take call. The impact of this is outlined below.

2 – By nature of the accreditation process, we would relinquish control over the content of our fellowship programs. We would rather see control stay with the sub-specialty societies.

3 – All fellowships would be required to affiliate with Residency programs and be placed under the control of the department Chairman. For most fellowships this would not represent a significant change, but there are some highly respected fellowships for which this would represent a major and possibly detrimental change.

4 – Fellow's salaries are currently augmented by assistant fees, call, etc. Under ACGME guidelines, this would not be allowed.

5 – Current ACGME fellowship guidelines do not support nor allow for fellow research.

6 – While ABO/ABMS/ACGME fellowship certification process can offer assurances on the quality of the fellowship training experience, this can also be achieved through other channels that would not adversely affect the current fellow/mentor relationship or put additional strains on the sponsoring practices.

7 – We have concerns about the impact on the ability of the comprehensive Ophthalmologist to perform general ophthalmic plastic surgery (and other procedures in the future should other subspecialties seek CAQ certification). In the ASOPRS position paper Dr. Shore states "It is in the interest of the oculoplastic community and ophthalmology to define the large number of procedures that are performed by both groups as within the realm of ophthalmology." This seems to be at odds with their motivation for obtaining a CAQ. If some oculoplastic surgeons are having difficulty in obtaining hospital privileges, than it would appear that the addition of a specific CAQ in Oculofacial Plastic Surgery may make it more difficult for the comprehensive ophthalmologist to obtain and/or maintain their privileges for general oculoplastic surgery.

Finally, the problem (hospital credentialing) is not going to be solved by ASOPRS getting a CAQ. The problem stems from Ophthalmology's lack of departmental presence in some hospitals and/or ASCs. If Board Certification for Ophthalmology has not been adequate in these hospitals for Ophthalmology to achieve departmental status, why would we think that an OphthalmicPlastic CAQ would have any better result? I think that we could do more for our profession by putting our effort into strengthening Ophthalmology's presence as a whole as opposed to attacking the problem piecemeal.

The CORNEA Society strongly believes in ensuring quality fellowship education. We feel it is in the best interest of the trainee, the profession and the public. We feel that fellowship training oversight can be accomplished via other channels without incurring some of the negative ramifications associated with CAQ certification.