Editorials

Our Winter of Discontent

In 30 years of experience in our profession, I sense there has never been a time that my colleagues have expressed so much discontent. The source of the malady is generally believed to be the obfuscation of the ability to practice according to one's own conscience, without excessive interference from external agencies. We perceive unnecessary control by others masked as a need for "accountability." Clinical decisions, and thus expressions of the "art" of our profession, are being categorized, systemized, constricted, and otherwise distorted. We, as physicians, are enjoying less and less respect from our patients, and so we are losing our self-respect.

At times we seem to be increasingly confused by DRGs, RBRVS, and hundreds of other demonic acronyms. We seem to be subject to a myriad of external forces, all of which seem to be preventing us from doing what we are trained and committed to do. We may feel like we are being herded along by bureaucratic enforcers wielding stinging prods to keep us in line. Our social and professional environment is changing—being remolded by often unseen sculptors of destiny.

Is it too late to modify the metamorphosis of our profession into a highly regulated trade? Are we now witnessing the destruction of a noble profession? Perhaps these changes are only transient tribulations—perhaps these threats are more apparent than real—and perhaps we are fools if we think so. Perhaps we have fallen prey to the seductive power of greed and hubris.

It seems that as a profession, we are obligated to continue to struggle in the arena of political engagement even though some of the battles seem futile. While doing so, however, it would seem prudent to try to reestablish a set of fundamental principles for which we have in the past earned respect. The medical profession is, after all, an important and basic support to our society. Physicians do possess special skills and knowledge necessary for a social system to progress.

Each of us can contribute to societal progress by practicing our profession to the best of our ability. We must avoid temptations to compromise the quality of the care we provide. To earn and maintain a respected place in society is likely to require some sacrifices. In the short run, it may be necessary that we exert increased effort and vigilance, and we may have to give up some comfort and possibly some security. The rewards will be immediate in terms of gratitude and respect from our patients. The long-range rewards will be a legacy of increased freedom for future physicians and, best of all, a healthier society.

These admonitions are much more easily pronounced than followed. Worthy goals are often difficult to attain. We can, however, resurrect a proud and noble profession through patience, perspicacity, some pain, and a large dose of perspiration.

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Certificates of Added Qualifications

"Totus in toto, et totus in qualibet parte"

There has been some gross misunderstanding about certificates of added qualifications (CAQs). In the interest of all concerned, we wish to clarify in detail what CAQs are and what they mean to the American Board of Family Practice and to family practice as a specialty.

CAQs are just what they say: "Added Qualifications." This means that the generalist may pursue further studies and activities in an area of personal interest in the practice of medicine. It is important for all to know that CAQs are NOT divisive as has been charged by some. CAQs are merely an acknowledgment of some extra knowledge in areas that are not currently recognized as a primary specialty or a subspecialty of another primary board. This acknowledgment can be obtained by examination in the area of interest (much like a "minor" field of study in a college curriculum). In the case of family practice, you *must retain* certification in the primary specialty of family practice. However, should you decide to limit your practice to your "CAQ area of interest" (e.g., *full-time* geriatrics), then you would jeopardize your primary certification, which could result in the loss of the primary certificate and *concomitant loss of the CAQ*. In such cases, physicians who choose to limit their practices could wind up not being certified at all. In

other words, CAQs are *contingent on maintaining Diplomate status*: lose your Diplomate status, you lose your CAQ automatically. Hence, a CAQ when granted by the American Board of Family Practice virtually *demands* that you maintain a generalist function *in addition* to pursuit of an area of special interest.

Further, in family practice the CAQ is a formal recognition of those Diplomates who enjoy spending extra time, study, and professional effort in an area in which they have special interests in *addition to their generalist function*.

We are all mindful that medical students are not choosing the generalist specialties (family practice, general internal medicine, and general pediatrics) as much as all of us in organized medicine would like; however, in talking with medical students, we find that there are many who are undecided as to specialty choice but seem to be intrigued by the CAQ, which permits them to practice general (family) practice yet still ply their special interests. CAQs may, in fact, help reverse the trend to subspecialism.

Subspecialism, indeed, does fragment care and seems to be growing; whereas, if the generalist is allowed (nay, recognized for) special interests while maintaining the holistic approach to the practice of medicine, we may pick up more "undecided" students.

It must be borne in mind, that the ABFP clearly delineates a subspecialty from a CAQ. A subspecialist (which the ABFP, I hope, never will have) is one who usually restricts practice to a distinct subspecialty (e.g., cardiology). That person need not be recertified in the primary specialty, whereas a CAQ of a Diplomate of the American Board of Family Practice MUST continue active certification (recertification) in the primary general specialty of family practice. This may seem to be a fine difference, but to us, it is an especially *marked* difference regardless of any interpretation by other specialties. Hence, CAQs are NOT to be equated with subspecialties. There is no intention whatsoever by the Board to allow subspecialties in family practice, and we are opposed to any effort to splinter our hard-earned specialty.

Even though it is the prerogative of the Board to grant CAQs, we want it understood that we all (ABFP and AAFP) desire what we think is best for medicine and family practice in particular. The Board considers *certain* CAQs in the best interest of family practice and believe it will fortify family practice. We are continuing to fight for family practice, for we believe that it is necessary for the common good of our patients. We believe that family practice is the keystone specialty in American medicine, and we will do everything in our power to preserve, enhance, and improve it; after all, we started the specialty.

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