Comments and Responses

Maintenance of Licensure

TO THE EDITOR: Chaudhry and colleagues' article (1) was written by 5 people with financial relationships with the Federation of State Medical Boards (FSMB) and 1 person who works for the American College of Physicians (1). Both organizations are heavily invested in selling physicians the requisite materials for maintenance of certification (MOC) and maintenance of licensure (MOL). This article is little more than an unpaid advertisement for their corporate programs of board certification (which already consumes more than $400 million in gross receipts annually). Practicing physicians do not want or need these programs, which have yet to be shown to have any proven value to patients.

My concern is that the FSMB, American College of Physicians, American Board of Medical Specialties, and affiliates are nongovernmental agencies without legal authority striving to enforce this lucrative agenda to profit from programs that support MOC and MOL in this difficult economy. The chief executive officers of the boards within the American Board of Medical Specialties that have the longest history of 10-year recertification cycles each earn approximately $1 million annually—well above practicing physicians working in their specialties—and these boards are associated with substantial net worth, as Internal Revenue Service 990 forms show.

These facts document the financial stakes for these programs and their leadership. When I questioned why *Annals* chose to publish this article, Dr. Laine, *Annals*' Editor in Chief, wrote, "*Annals* was specifically interested in having authors involved in developing the MOL process to write on the topic to educate readers about how this would evolve in coming years" (Laine C. Personal communication.).

The common interests and leadership of many state medical boards and the FSMB, as well as many specialty organizations and American Board of Medical Specialties specialty boards, require an opposing and formal presentation of issues here to reveal that this will be a battle in state legislatures, where the law of MOL is seated. In Ohio (the first state in which the FSMB is attempting to pilot MOL), the Ohio State Medical Society and other physician groups have resolved in 2012 to oppose the attempts of Dr. Talmage and the FSMB to implement the MOL program with the force of law. Dr. Talmage, who chairs the FSMB and sits on the State Medical Board of Ohio (SMBO), is in a possibly very effective and possibly conflicted position.

The SMBO's own data for more than 42 000 physicians, accessed through the Freedom of Information Act, disclosed that in 2011, only 5 physicians were subject to disciplinary actions for violation of the minimal standards of care not involving prescribing, with a total of 148 actions—a rather low rate by any measure. Only 1 physician was identified to have been sanctioned specifically related to medical practice issues. Two thirds of all actions resulted from drug or alcohol abuse, pill-mill activities, or other criminal offenses rather than incompetence!

Continuing medical education requirements in Ohio are among the most demanding of all states, whereas some states have no requirements. Ohio also leads states in the number of medical board actions per 1000 licensed physicians (suggesting either overzealousness or high rates of physician misbehavior—but *not* incompetence). Ohio is also a leader in freedom of information and online publication of state medical board activity to allow the extraction of data on the number of actions to which I have referred (www.med.ohio.gov).

Maintenance of licensure has existed for decades in all states and is not new. The FSMB MOL is neither inevitable nor needed. Physicians need to unite, inform, and oppose through their state legislators now. The FSMB attempted implementing pilot projects in 11 states: Ohio, California, Colorado, Delaware, Iowa, Massachusetts, Mississippi, Oklahoma, Oregon, Virginia, and Wisconsin.

In October 2012, this pilot project was rejected in Ohio by vote of the SMBO after 15 medical societies representing more than 15 000 physicians specifically voiced their opposition to FSMB MOL (2). The FSMB board member and executive director of the SMBO was immediately "ousted" the next day from his position on the SMBO (3). Detailed information and references for this and the most important facts can be found at www.youtube.com/watch?v=WRS15Dmsk7E and www.changeboardrecert.com, including the financial data of all boards. Physicians must inform themselves and their colleagues to take action in all states now.

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References

1. Chaudhry HJ, Talmage LA, Alguire PC, Cain FE, Waters S, Rhyne JA. Maintenance of licensure: supporting a physician's commitment to lifelong learning. Ann Intern Med. 2012;157:287-9. [PMID: 22733035]

2. Kumar D, Sechler JL, Perkins J, Talmage L Jr, Cooper CJ, Soin A, et al. Joint Letter From 11 Medical Societies to the SMBO. Accessed at www.itraumaohio.org/aws/OACEP/asset_manager/get_file/54757/2012.10.5_joint_mol_letter_to_medical_board.pdf on 20 December 2012.

3. Johnson A. State medical board ousts chief. Columbus Dispatch.18 October 2012. Accessed at www.dispatch.com/content/stories/local/2012/10/18/state-medical-board-ousts-chief.html on 20 December 2012.

TO THE EDITOR: We read Chaudhry and colleagues' article (1) with great interest. Although MOL sounds acceptable superficially, is it reasonable to implement a costly and highly controversial procedure, such as MOC, that has never been shown to have any value over and above continuing medical education (CME)? Numerous publications point out the real problems with MOC, including cost, time commitment, and that the secure test seems to exist only to provide revenues to the testing organization.

Until the MOC procedure has been compared in age-matched physicians with current methods of CME and has been found to positively affect some worthwhile parameter of physician practice and behavior, this faulty mechanism of MOC should be discarded. Unfortunately, that study does not exist.

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Potential Conflicts of Interest: None disclosed.

Reference

1. Chaudhry HJ, Talmage LA, Alguire PC, Cain FE, Waters S, Rhyne JA. Maintenance of licensure: supporting a physician's commitment to lifelong learning. Ann Intern Med. 2012;157:287-9. [PMID: 22733035]

TO THE EDITOR: Chaudhry and colleagues (1) note the considerable similarity between the MOL process and the MOC process, which is required by members of the American Board of Medical Specialties, including the American Board of Internal Medicine (ABIM). I was particularly pleased to learn that the FSMB MOL Implementation Group has recently recommended that physicians actively engaged in the MOC program of the American Board of Medical Specialties or the American Osteopathic Association Bureau of Osteopathic Specialists be recognized as having fulfilled the requirements for MOL in any state. Indeed, if this recommendation is adopted, documentation of participation in an appropriate MOC program will be all that is needed to fulfill MOL requirements.

As a physician continuously enrolled in the ABIM MOC program for the past 12 years, I find the FSMB's recommendation particularly sensible and appealing. Although over the years I have developed an ever-increasing appreciation of the excellent intentions and results of the MOC process (including improved patient care), the process can, at times, be somewhat draining. The proposal of the FSMB, by enhancing recognition and appreciation of the ABIM MOC process and simplifying the MOL process, will probably make the MOC process more satisfying for many physicians already enrolled in the program.

In addition, this proposal may pique the interest of a group of ABIM diplomates who have generally shunned the MOC process: those who obtained their ABIM certification before 1990, the "grandfathers" (2). As such, I would urge the American College of Physicians, the ABIM, and all other members of the American Board of Medical Specialties to support the previously discussed proposal by the FSMB.

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Potential Conflicts of Interest: None disclosed.

References

1. Chaudhry HJ, Talmage LA, Alguire PC, Cain FE, Waters S, Rhyne JA. Maintenance of licensure: supporting a physician's commitment to lifelong learning. Ann Intern Med. 2012;157:287-9. [PMID: 22733035]
2. Glazier JJ. Recertification for grandfathers [Letter]. Am J Med. 2011;124:e11. [PMID: 21962321]

TO THE EDITOR: Chaudhry and colleagues (1) present a thoughtful analysis of the cognitive processes involved in CME. In brief, they identify 3 components—reflective self-assessment, assessment of knowledge and skills, and performance in practice. Their examples include participation in CME, completion of computer-based simulations, and patient or peer surveys. We suggest modifications that should clarify this process.

The first component requires critical self-assessment of clinical skills and knowledge necessary for the physician's current practice. This almost certainly involves more than participation in the usual CME activities and probably requires practice review and relevant testing (in effect, pretests). Based on this self-assessment, the second component involves identification of essential knowledge and skills that need improvement. Next is a structured learning process that focuses on these specific skills. This activity is fundamental to maintenance of clinical skills and is not discussed by Chaudhry and colleagues.

The third component requires assessment of the self-study activities. This should include written tests by using either a secure or a timed case-analysis format. This component also requires direct assessment of clinical practice by using patient or peer surveys, direct observation, or structured medical record review. The fourth component requires a second round of reflective self-assessment, the identification of other areas needing improvement, directed study, and additional assessment.

This 4-step process continues indefinitely to improve decision making, problem solving, and patient care. The MOL process that the authors describe largely restates current requirements for licensure renewal on the basis of required number of CME hours with the addition of a few, possibly 1, practice-assessment activities.

We believe that public schools in Texas have a better grasp of the critical thinking process that drives learning and education. Students are expected to master specific sets of skills and are required to pass a criterion-based examination at the end of each school year. Those who do not pass or who barely pass receive focused accelerated instruction in addition to their regular curriculum. In certain grades, students who do not perform satisfactorily on the state examination must review the necessary skills and retest before they pass to the next grade level.

The process described by Chaudhry and associates is not based on commonly accepted educational methods. In addition, the MOL process that they described will not substantially improve the medical services currently provided in the United States. Finally, unlike Dr. Glazier, we think that MOL is more likely to undermine the ABIM recertification process than to support it, because physicians will choose the easier route. As for the "grandfathers," unless the state MOL requirements become very onerous, they will stick with reporting CME. Our recommendations emphasize continuous practice evaluation and acquisition of medical knowledge and skills.

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Potential Conflicts of Interest: None disclosed.

Reference

1. Chaudhry HJ, Talmage LA, Alguire PC, Cain FE, Waters S, Rhyne JA. Maintenance of licensure: supporting a physician's commitment to lifelong learning. Ann Intern Med. 2012;157:287-9. [PMID: 22733035]

IN RESPONSE: We respectfully disagree with Dr. Kempen's assertion that MOL is not needed. More than 7 years of thoughtful discussion and study persuaded the FSMB's House of Delegates in 2010 that a physician's commitment to lifelong learning should be supported, and nearly a dozen state medical boards are beginning to survey physicians to determine how to implement MOL over time. The

FSMB's guiding principles are that MOL should neither be onerous nor compromise patient care.

As medicine continues to evolve and grows more complex, the need for lifelong learning and maintenance of skills has increased. Research suggests that some physicians develop deficits in medical knowledge and skills the further that they are from their training. Just this year, in a major national report, the Institute of Medicine called for better systems of continuous professional development to address this need (1). Through MOL, all physicians will be able to reassure patients of the enduring value of their hard-earned license to practice medicine.

Dr. Frager's comments are aimed primarily at specialty recertification (for example, MOC), which we believe should not be required of all licensed physicians. However, as an FSMB advisory committee recommended, participation by physicians in such activities should enable "substantial compliance" with a state's MOL requirements (2). We are also not mandating completion of a high-stakes examination to meet MOL requirements. However, targeted continuous professional development has been shown to improve patient care and MOL would be an effective mechanism to encourage such activities.

Ms. Connie Nugent and Dr. Kenneth M. Nugent's suggestions for improving our MOL construct are welcome and will be considered as MOL continues to evolve. The framework for MOL already includes assessment measures, but these will be further analyzed in upcoming studies. It is vital that all such measures be balanced and reasonable for physicians.

Finally, we agree with Dr. Glazier's observation that carefully integrating MOL and MOC is "sensible and appealing." We also believe that the overwhelming majority of physicians are already engaged in a range of ongoing professional development activities that include CME or specialty recertification activities; they should have little difficulty in fulfilling a state's future requirements. If crafted diligently, MOL should improve health care quality and enhance patient safety—aspirations that benefit everyone.

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Potential Conflicts of Interest: Disclosures can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M12-0364.

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Effect of Nonpayment for Hospital-Acquired, Catheter-Associated Urinary Tract Infection

TO THE EDITOR: Although we do not take issue with Meddings and colleagues' (1) premise that coding data may not accurately reflect clinical outcomes, we do have an issue with a frequently cited article that is fundamental to the argument that catheter-associated urinary tract infections (CAUTIs) are frequently underreported. Klevens and associates' paper (2) cited in Meddings and coworkers' article is widely referenced as being the epidemiologic study showing excessively high CAUTIs and core to the premise that UTIs are underreported.

Klevens and colleagues used 2002 data from various sources. To calculate the total number of hospital-acquired UTIs, the National Nosocomial Infections Surveillance System rates for hospital-acquired UTIs in the intensive care unit (ICU) of participating facilities were multiplied by the total number of ICU days in the United States to get an estimate of 102 200 hospital-acquired UTIs in the ICU. The methodology for patients outside of the ICU was based on unsubstantiated assumptions.

Their model presumed that the rate of surgical site infection to the UTI rate outside the ICU would be identical to the rate inside the ICU. Because they knew the infection rates for surgical site infections both outside and inside the ICU, they multiplied the outside-ICU surgical site infection rate by the same proportion to obtain a hospital-acquired UTI rate outside the ICU. By these calculations, they suggested that 424 060 CAUTIs occurred outside of the ICU, or more than 500 000 CAUTIs in hospitals. Their estimate of 32% of the total 9.3 hospital-acquired infections per 1000 patient-days translates to an infection rate of 3.1 per 1000 patient-days (or 1.5 per 100 admissions).

Banner Health, a nonprofit health care system with 22 hospitals and 4330 beds, has been monitoring CAUTIs since 2011 in most of its facilities. Infection-control specialists using National Healthcare Safety Network criteria monitor for any catheter- and hospital-acquired UTIs. In 2011, we had 0.29 CAUTIs per 1000 patient-days, and so far in 2012, 0.20 CAUTIs per 1000 patient-days—one tenth of Klevens and associates' reported rate.

We believe that it is improper to continue to reference Klevens and coauthors' results because they are estimates based on 2002 data with questionable assumptions in proportionality of infection rates and, when used, overstate the infection rate by a factor of 10. In addition, of the 6 references that Meddings and colleagues cited for epidemiologic rates, 3 were published between 1981 and 1983. We use a lot fewer urinary catheters than we did back then.

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Potential Conflicts of Interest: None disclosed.

References

1. Meddings JA, Reichert H, Rogers MA, Saint S, Stephansky J, McMahon LF. Effect of nonpayment for hospital-acquired, catheter-associated urinary tract infection: a statewide analysis. Ann Intern Med. 2012;157:305-12. [PMID: 22944872]