Views on recertification

The *CMAJ* editorial on mandatory recertification[1] expresses a positive opinion on the desirability of such a move. However, nothing approaching good evidence is quoted to support this view, which raises the question of whether our licensing practice should be as evidence-based as our medical practice.

Another question is, What are we trying to solve through recertification? If we are trying to prevent mistakes, we need to look much deeper than basic competence, given that many, if not most, errors are due to systemic problems such as overwork and inadequate resources. A medical school truism is that it takes a genius to make an original mistake. It would make more sense to address the systemic causes of error rather than compounding them by increasing physician workload and stress.

Of course we need to embrace quality and maintain competence. But that doesn't mean sending practising professionals back to grade school. Let's define the problems and test the solutions before embarking on a course that may have counterintuitive results.

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Reference

1. College certification and recertification [editorial]. *CMAJ* 2004;171(4):301.

DOI:10.1503/cmaj.1041649

It seems to me that the only real reason licensing bodies are going ahead with mandatory certification, as described in a *CMAJ* editorial,[1] is the sense that "we should do this ourselves before someone does it to us" and the hope that we can create a better public perception without necessarily providing better care. I reject these as very poor reasons for increasing physician stress and expense and effectively reducing physician human resources (through time taken for studying and examinations).

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Reference

1. College certification and recertification [editorial]. *CMAJ* 2004;171(4):301.

DOI:10.1503/cmaj.1041648

The Aug. 17 issue of *CMAJ* contains 2 articles illustrating contradictory approaches to continuing medical education: one emphasizing independent thinking, the other arguing for more conformity.

Alexandra Barratt and associates,[1] in their series on teaching tips for evidence-based medicine, encourage us to be professionals and think things out for ourselves; the first article in the series presents the foundation for calculating risk in a meaningful way.

A news article in the same issue[2] quotes Dr. Sunil Patel (then president of the CMA) as saying that "It makes sense that in a rapidly evolving world, … standards have to be maintained ... ." The logical extension of this thinking is that individualized decision-making is to be discouraged and a standardized approach to problems encouraged.

Rather than running with the pack, our medical associations must remind the public, government and the legal profession that the practice of medicine, even in 2004, is not a manufacturing enterprise. It is highly individualized with very few absolutes, despite the impression that might be given by the proliferation of guidelines.

Having an educated and well-informed public and medical profession entails more than knowing about the latest trends. Instead, it means we must all have the tools to better determine what is really significant in this cascade of so-called "new" information. Maybe we should put less emphasis on re-educating and changing behaviour and more emphasis on nurturing the skills of thinking.

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References

1. Barratt A, Wyer PC, Hatala R, McGinn T, Dans AL, Keitz S, et al. Tips for learners of evidence-based medicine: 1. Relative risk reduction, absolute risk reduction and number needed to treat. *CMAJ* 2004;171(4):353-8.
2. Kondro W. Lifelong medical licences may end in 5 years. *CMAJ* 2004;171(4):317-8.

DOI:10.1503/cmaj.1041650

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