

APIC/CBIC Relationship Clarified

To the Editor:

As president of the Certification Board of Infection Control (CBIC), I am writing to clarify some information that was printed in a recent issue of *Infection Control*.¹

The author states that “. . . Programs to certify ICPs would insure a minimum level of knowledge for all certified ICPs . . .” This statement is correct. However, the statement, “. . . Certification would be one way to assure that all practitioners receive the same foundations . . .” does not follow. The Certification process is not designed to assure that all practitioners receive the same foundations (or education), and there is no way that it can measure how or where ICPs obtained the knowledge they need to pass the examination. The Infection Control Certification examination tests for knowledge that is job-related. The Infection Control Certification examination is based, in part, on the 1982 Task Analysis of ICPs in hospitals (unpublished data) and questions developed from a variety of sources by a number of individuals. Consensus by the CBIC that the questions are appropriate for ICPs with a variety of educational backgrounds who meet the practice requirement of at least two years of full-time or part-time experience in infection control in a hospital is the final step in the preparation of the examination.

The statement “. . . A certification program is now available through APIC . . .” is not correct. The certification process was *initiated* by APIC in 1978 with the formation of the

APIC Certification Committee. In late 1981, the Certification Board of Infection Control (CBIC) was established as a separate agency charged with the responsibility of developing the certification examination. There is a strong link with APIC; that is, APIC has been very supportive of the certification process, the APIC Board of Directors appoints members to the CBIC, and APIC members are provided a reduced fee for the examination. However, CBIC is administratively and legally separate from APIC. The CBIC has its own by-laws, management structure and firm, and a direct contractual arrangement with the Psychological Corporation, the professional testing agency employed to administer the test and provide psychometric consultation for test question review and development.

Finally, the author considers that “APIC’s certification program” provides for training in infection control. Please note that the CBIC does not engage in any training activities nor do its members participate in any training programs that are specifically designed to prepare test applicants for the examination. This activity is viewed by the CBIC as a direct conflict of interest. APIC has developed educational programs and materials for use in preparation for the Infection Control Certification examination, but these educational resources were developed independently of the CBIC.

The separation between the professional association and the certification board is a difficult concept. The CBIC has followed recommendations of the National Commission for Health Certifying Agencies (NCHCA) in estab-

lishing its by-laws. This Agency strongly recommends such separation for legal and other reasons.

REFERENCES

1. Crow S: Training of personnel for infection control. *Infect Control* 1984; 5:38-40.

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Sue Crow, RN, MSN, the author of the article in question, offers her response.

Thank you for clarifying the different roles of the Association of Practitioners in Infection Control (APIC) and the Certification Board of Infection Control (CBIC). There are many Infection Control Practitioners who do not know the definitive differentiation between these two organizations and you certainly have made this distinction clear.

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Criteria for Membership in SHEA Questioned

To the Editor:

The Editorial “Why SHEA” in a recent issue of *Infection Control* summarizes many organizational development questions quite well.

However, I cannot help but come away from it feeling as if “What is SHEA” were the real message. It is clear that SHEA was founded by aca-

demically-oriented specialists with qualifications and positions quite different from that of the average member of APIC; it is not made clear why a branch or divisional structure within one organization focused on infection control would not have sufficed. While I readily agree that SHEA is "... not just a club of academically-oriented chums..." the Editorial strongly implies that it is the realm of *physicians* regardless of their qualification or experience in hospital epidemiology.

Given the young nature of this field, the relative strengths and weaknesses within each of the various disciplines for entry into the field, and the need for collaboration and evolution to a socially-justifiable end result, the question of "Why SHEA" remains. The question of where those of us with graduate degrees and applied research orientation belong remains. If all of the infection control organizations strive for a future role of primacy in the field, we may be in for a painful collision.

Most of us agree on the needs for better research, better tools and resources, education, etc.; however, divisional representation based on professional origin may not be the most desirable strategy. As an MPH-qualified epidemiologist employed as the "Hospital Epidemiologist" in charge of an Infection Surveillance and Control Program, I find it disappointing that I cannot join the same society of epidemiologists that a physician without training in epidemiology may enter. I have a strong interest in furthering the professional standing of hospital epidemiologists, but the Society for Hospital Epidemiologists of America would seem to limit this future to physicians only. Is this truly in the best interest of furthering our documentation of improved health and medical care? Should the goals of hospital epidemiology really be limited to the control of nosocomial infections? In exploring the future of infection control in *Conversations in Infection Control*,² we noted that epidemiology may be applied to many aspects of hospital practice. Since the proper role of epidemiology has been defined by many as involved in planning and evaluation of health services, the most cost-effective utilization of Hospital Epidemiologists may require

broader goals. It may also be more cost-effective to consider "cross-bred" epidemiologists as well as physicians with postgraduate training. "Why SHEA" raises many points for consideration; I hope that SHEA will consider them in the widest terms possible. While not a physician, and therefore not eligible to become a member of SHEA, I would respectfully offer to accept Dr. Goldmann's invitation/challenge to provide advice and help as one who is responsible for infection control.

REFERENCES

1. Goldmann DA: Editorial: Why SHEA? *Infect Control* 1984; 4:437-439.
2. Goldmann DA (moderator): The infection control profession. Its growth and its future. *Conversations in Infection Control* 1983; 4(1).

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Donald A. Goldmann, MD, author of the Editorial, "Why SHEA?" was invited to respond.

Mr. Birnbaum's letter raises a variety of questions, but his principal theme concerns the criteria for membership in SHEA. He believes that qualified non-physicians who are serving as hospital epidemiologists have been unfairly excluded from the Society, while physicians who may have little formal training in epidemiology have been accepted without reservation. I will not attempt to speak for the Society on this complex issue, but will gladly offer my own point of view.

Mr. Birnbaum implies that only physicians will be considered for membership in SHEA. According to the Society's by-laws, a MD degree is not required, but a doctoral degree is. Actually, it was the intent of the Society's founders to be *inclusive*, not *exclusive*. It was clear that the vast majority of hospital epidemiologists were—and still are—physicians, so physicians naturally would constitute the core of any organization of hospital epidemiologists. The MD degree was felt to be a major advantage since so many of the infection control problems that the hospital epidemiologist must confront involve issues of medical practice. Non-physician hospital epidemiologists might acquire exper-

tise in areas of medical practice, but they would still have to gain the respect of the medical staff. On the other hand, it was recognized that well-trained non-physicians might know considerably more about epidemiology than many of their physician counterparts and would achieve credibility by virtue of their skill and expertise. The doctoral degree was intended to serve as a marker of advanced training.

In my opinion, an individual who has not received a PhD conceivably could acquire the relevant skills to be a hospital epidemiologist, while a PhD degree is no guarantee of proper preparation. In retrospect, the doctoral requirement seems arbitrary to me. The President of SHEA, Dr. Richard Dixon, has appointed an ad hoc committee to study membership, so there will be ample opportunity to debate these important issues again.

While I agree with Mr. Birnbaum that SHEA membership requirements deserve a second look, I strongly disagree with some of his other comments. It is incorrect to assume that APIC, SHEA, ASM, and other infection control organizations "intend to fulfill the same destiny" and are "in for a painful collision." I believe that there is room in the infection control field for people with different backgrounds, skills, responsibilities, and goals. As I stressed in the Editorial, the field will be richer if we all work together, recognizing each other's strengths, limitations, and complementary roles. For this reason, SHEA maintains active liaisons with other infection control organizations, and many SHEA members are also active in other societies. Mr. Birnbaum himself is a fine example of the value of a multidisciplinary approach for infection control.

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Effectiveness of Centralized Skin Testing

To the Editor:

Although reported cases of active tuberculosis have been declining since