One new effort is our alignment of the MOC program with the Physicians Quality Reporting Initiative of the US Centers for Medicare & Medicaid Services (CMS). In the recently passed health care reform legislation (US Patient Protection and Accountable Care Act), there is a provision that enables physicians to meet the requirements of Physicians Quality Reporting Initiative and receive a bonus from CMS by participating in an ABMS member board MOC program. ABMS is working with CMS to launch this program in 2011.

However as noted in the paper referenced by Dr. Donohoe,[2] ultimately, ABMS and its member boards seek to elevate the quality of patient care by providing physicians with an ongoing process of assessment and continuous professional development that requires participants to demonstrate clinical competency and keep pace with advances in the field of medicine throughout their entire careers. Although Dr. Donohoe's letter relating his personal experience with MOC is anecdotal, it reinforces what we've heard time and again from participating physicians: MOC results in better care for their patients.

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Re: Parental Acceptance of a Mandatory Human Papillomavirus (HPV) Vaccination Program

To the Editor: An estimated 6,2 million women are infected every year with the human papillomavirus (HPV) in the United States, but the acceptance of the HPV vaccination is low; therefore, improving vaccination uptake is a demanding issue.[1,2]

Compared with several countries and especially the developing world, where the costs of the HPV vaccine must drop for access to improve, in the United States most large insurance plans cover the costs of approximately $125 for each of the 3 doses, and children (up to 18 years old) may be eligible through the Vaccines for Children program.

In Germany, the cost is currently approximately $235 US for one dose; however, according to the National Committee on Vaccination, for girls in the 12- to 18-year-old age group the statutory health insurance covers the costs completely, and, on request, also provides coverage for older women.[3] A study conducted in March 2010 among 298 female high school students in Leipzig, Germany, shows that 59% of the participants were aware of the coverage by health insurance. Nonetheless, the acceptance of the vaccine is suboptimal. Despite complete financial coverage, in 2007 only 3.51% of 147,014 girls eligible for Gardasil received the vaccine.[4]

Although the use of the HPV vaccination has been improving recently, this finding is, unfortunately, similar to that of numerous other industrial countries (eg, Austria reported a vaccination rate of 4% in 2010).[5] Information about the vaccination is widely spread in Germany, mainly by the media; however, 21.8% of the participants in our study had been informed about the vaccine by their family physician. Furthermore, 56.7% of the students indicated that they would prefer to be approached and counseled by their family doctor. Several studies revealed that parents value the information and recommendations provided by their children's health care providers.[6] Although each encounter with an eligible patient might be considered an opportunity to encourage HPV vaccination, recent data show that family doctors are reluctant to recommend the vaccination mainly because of the controversial discussion in Germany about the benefits and efficacy and the concern of the vaccine's possible negative, long-term side effects.[7,8] In addition, several family doctors feel uncomfortable about discussing sexuality issues with adolescent patients.[9] Compared with South Korea, where the first cohabitation takes place, on average, at age 20, in Germany the average age is 15.1 years, according to the Federal Center for Health Education.[10] Therefore, if family physicians would consider approaching young women—focusing on those younger than 15—to help them make informed decisions, it might contribute to an increase the level of vaccination.

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The above letter was referred to the author of the article in question, who offers the following reply.

Response: Re: Parental Acceptance of a Mandatory Human Papillomavirus (HPV) Vaccination Program

To the Editor: We appreciate the comments from Dr. Schneider[1] and concur with her observations about the human papillomavirus vaccines. It seems that German health care providers are confronted with many of the same issues we face in the United States. Given the robust efficacy and excellent safety profile of these cancer prevention vaccines, we too are extremely frustrated by the poor rates of vaccination that are documented in many parts of the world. Furthermore, a high number of individuals do not complete the entire 3-dose series. There is great room for improvement to help reduce the morbidity and mortality associated with human papillomavirus infection. A mandatory HPV vaccination program is one means of ensuring maximum coverage and protection.[2] All health care providers should encourage their patients to receive the vaccine. Dr Schneider's comments about making the vaccines widely available to all inhabitants of our globe are certainly appropriate. My response actually comes from our cervical cancer prevention clinic in Cusco, Peru (www. theincca.org, www. cervicusco.org) where we see women with cervical cancer too often. To think that we now have a vaccine to prevent the horrid suffering associated with cervical cancer is simply a wonderful gift to mankind. Although secondary cervical cancer prevention efforts with cervical cytology have reduced the rates of disease, particularly in developed countries, the developing world does not have the capacity to derive the same benefits. Yet, I believe this same gift of life-saving vaccination will be shared with all one day. In fact, Merck, Sharp and Dohme Corp. has been very generous in sharing their vaccine with the developing world. We are extremely grateful to them and hope that this effort can be expanded in the future.

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Re: A Randomized, Controlled Trial of a Behavioral Intervention to Reduce Crying among Infants

To the Editor: I applaud McRury and Zolotor[1] for attempting to add a validation study of The Happiest Baby on the Block (THB) video to the growing evidence base evaluating this popular approach to calming babies.

Unfortunately, as the authors state, their study has several critical flaws that weaken any conclusions. There was a small study population and a 30% drop-out rate; there was contamination by advising both the control and intervention group about the use of swaddling; a video was used instead of a digital video disc (DVD; a more user-friendly interface); and parents received no instruction in THB video techniques. The factor that most undermined the reliability of this report is that there was little confidence that the intervention was even viewed or used (mothers said they watched, but they did not refer to THB video in their comments and did not swaddle as was demonstrated in the video).

THB[2,3] is a novel synthesis of several steps that have been shown to calm infant crying and promote sleep. It is based on the hypothesis that babies are born with a suite of previously overlooked neonatal reflexes (the "calming reflex") that can quickly soothe most fussing during the first months of life.

The goal of finding an effective approach to crying reduction is not trivial. Infant irritability, and the parental exhaustion that it provokes, are primary triggers for many serious problems (eg, child abuse, failure of breastfeeding, marital stress, postpartum depression, excessive visits to an emergency room or doctor, excessive treatment for acid reflux, disturbed bonding, and perhaps sudden infant death syndrome/suffocation).[4]

Numerous peer-reviewed studies[4] have confirmed the effectiveness of the interventions used in THB video (ie, swaddling, white noise, rhythmic motion, sucking). In addition, a growing body of pilot studies is finding benefits of THB video on early parent–infant interactions.

In 2007, the Department of Public Health in Boulder, CO, reported a study about reducing infant crying. Home-visiting nurses taught THB techniques to 42 at-risk families (teens, drug users, etc) who had fussy babies. Each family was given a THB DVD, compact disc of white noise, and a swaddling blanket. Most families (41 of the 42) reported an immediate, dramatic, and continuing improvement in their ability to calm crying. Many families also reported more than one additional hour of sleep.[5]