

Continuing professional development – global perspectives: synopsis of a workshop held during the International Association of Dental Research meeting in Gothenburg, Sweden, 2003.

Part 2: regulatory and accreditation systems and evidence for improving the performance of the dental team

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This paper is the second in a series of two that report on continuing professional development (CPD). Details of the informants and the methodologies used were reported in the first paper. This paper reports the data and information presented on the topics of regulatory and accreditation systems for CPD and evidence that CPD improves the performance of the oral health team. By June 2003, participation in CPD was mandatory in most of the states of the USA, all Canadian Provinces, the UK and Latvia and was likely to become mandatory in a number of other countries in the near future. A variety of accreditation systems were reported including collecting CPD points, which in some countries were weighted depending on the type of CPD activity, and re-certification examinations. Very few studies for the effectiveness of dental CPD were identified. However, in general

it was concluded that there is little evidence for the effectiveness of CPD for the oral health team. The main recommendation from this study is that a systematic review of the effectiveness of CPD in improving the performance of the oral health team and patient based outcomes be undertaken. A range of other research questions was also identified including: how can CPD be best matched to clinicians' needs rather than demands?

Key words: continuing professional development; global perspectives; regulatory and accreditation systems; improved performance.

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THIS PAPER is the second in a series of two which report on the systems for providing continuing professional development (CPD) in 17 countries from four continents. The first paper (1) introduced the methodology and considered the topics of access, funding and participation. The current paper describes regulatory frameworks, accreditation systems for CPD activities, data on effectiveness of CPD in improving the performance of the oral health team, and identifies areas for future research.

Methods

The methods used were described in the first paper in this series (1). The results presented in this paper relate to the following issues:

- mandatory status of CPD including future trends;
- accreditation of CPD activities;
- evidence for CPD activities and on the improvement of the performance of the oral health team.

TABLE 1. Status of mandatory continuing professional development (CPD) for the countries under consideration as at June 2003

Participation in CPD activities is a current requirement for registration as a dentist in:
England
Latvia
United States of America – 46 states
Canada: in all 10 provinces
Participation in CPD activities is likely to become a requirement for registration as a dentist in the near future (within about 2 years) in:
The Netherlands
New Zealand
Hong Kong
Singapore
Australia
Thailand

Results

Mandatory continuing professional development

The current status and future trends for CPD are presented in Table 1. The following explanatory information was given.

The first phase in implementing mandatory CPD in the United Kingdom (UK) started in January 2002. It involved all dentists who had been registered in the UK for less than 10 years. Phase 2 commenced in January 2003 and extends to all dentists who had been registered in the UK for less than 20 years. Phase 3 commenced in January 2004 and was extended to all dentists registered to practice in the UK. The requirement is for dentists to complete a minimum of 250 h of CPD during a 5-year cycle and to continue to do so as long as they wish to retain the right to practice. It can therefore be said that there is a need for all dentists to undertake an average of 50 h of CPD per year, of which at least 15 h must be verifiable* (2).

Broadly similar requirements were introduced in Latvia in January 2001. From this time there has been a mandatory requirement for all dentists who have been registered in Latvia to complete a minimum of 250 h of CPD over 5-year practising cycles. Auxiliary personnel have the same requirements but the number of hours can be different. However, for all members of the oral health team the minimum requirement is for 50 h of CPD per year – a minimum of 20 h must be verifiable (3, 4). It is to be noted also that between 1992 and 2003, all 1707 practising dentists in Latvia passed through a new certification system which includes theoretical and clinical components and an examination. All newly qualified dentists have to pass this certification examination which is taken 2 years after graduation.

*Refer to the description of accreditation in UK in this paper for the definition of verifiable CPD.

In the United States of America, 46 states have a mandatory CPD requirement for dentists, 47 states have a mandatory requirement for Dental Hygienists and 12 states have mandatory requirements for Dental Assistants (Nurses). The cycle length varies, from 1 to 5 years and the hours required from 100 every 5 years to 20 every 2 years.

Canada has 10 provinces and three sparsely populated territories (Nunavut, Northwest and Yukon). Each of the 10 provinces has a mandatory CPD requirement for dentists. Nunavut Territory does not have a mandatory requirement. Northwest Territories and Yukon Territory did not respond to a request for information on the topic. The cycle length is 3 years and the hours required range from 50 to 90 per 3-year cycle.

In Hong Kong, the Medical Council of Hong Kong has taken the lead. However, CPD is still voluntary for dentists. Nevertheless, the local Dental Association is helping its members in filing CME (continuous medical education) credits. These may result from a range of activities including attending or giving lectures, seminars, workshops, self study and publications. In less than 2 years time, it is expected that CPD will become mandatory for dentists in Hong Kong. In India, the issue is under discussion and mandatory CPD is likely to be implemented. In Singapore it is planned to introduce mandatory CPD in 2005.

In Malaysia, the Malaysian Dental Council is the body that controls the registration of dentists practising in Malaysia as well as their annual practising certificates (licence to practice) and professional conduct. In recent years, the Council has discussed the need for all registered dental professionals 'to acquire the habit' of life-long learning and has been working with the Malaysian Dental Association. Currently a voluntary system administered by the Malaysian Dental Association is in practice.

In the Philippines, in the past, the national Professional Registration Council required all dentists to complete at least 60 points worth of CPD every 3 years in order to renew their practising certificates. The requirement was never a law as such. The requirement was removed. Recently there has been pressure for it to be re-introduced (5, 6). In Thailand, the Dental Council of Thailand has set up a working group to propose a minimum annual CPD requirement for all dentists which could then be incorporated in a mandatory system for re-registration.

In Victoria, Australia, in June 2003, it was anticipated that mandatory CPD requirements for re-registration would be developed in the near future, however this expectation was not evident for the remaining states.

In New Zealand, the Dental Association was developing a new Code of Practice on CPD, in parallel with the Health Professionals Competency Assurance Bill which provides the option for mandatory CPD requirements for recertification of dentists by the Dental Council of New Zealand.

Accreditation for different types of continuing professional development

In the United States of America, each state sets its own rules for accreditation and requirements for recertification. The American Dental Association (ADA) has developed a continuing education recognition program (CERP) and the Association for Continuing Dental Education has a dental school-based verification system which involves site visits to validate programmes and is run via a programme review and approval committee (7). In Canada each province sets its own rules, some rely on the provincial dental association or regulatory board; others rely on the Royal College of Dental Surgeons in their province. Provinces, specialty groups and dental organisations participate in the ADA (CERP) national sponsor recognition programme and the Academy of General Dentistry sponsors approval programmes for continuing education (8). Canadian Dental Schools also participate in the Association for Continuing Dental Education recognition programme.

In the UK, there are two types of accreditation of CPD. They are as follows:

- By the Dental Faculties of the Surgical Royal Colleges as their Members and Fellows are required to complete quotas of annual CPD and prior to taking some Faculty Diploma examinations. All forms of CPD are accredited by these bodies.
- By the Postgraduate Dental Deans, who manage the local delivery of government-funded CPD attendance courses and may accredit privately funded courses to enable those attending to claim attendance fees.

The competent authority (body which maintains dentists' registration and licences the right to practice) for the UK is the General Dental Council. It does not accredit courses. However, it categorises CPD into two classes, which are verifiable and general (non-verifiable). To be classed as 'verifiable' a CPD activity must have defined learning objectives, enable participants to prove that they took part (usually via a certificate of attendance) and give the participants the opportunity to feed back their comments and assessment of the activity to the providers. All other CPD activities are classed as general (non-verifiable).

The Dental Faculties of the Royal Surgical Colleges have quotas for different activities within the 50 h per year of CPD which they require their Members and Fellows to undertake. For example, writing papers may only count for up to 5 h per year. In this sense it can be said that they have a weighting system. The Postgraduate Dental Deans do not operate a weighting system.

In the Netherlands there is the so called 'Q-system' which is owned by the Society of Dutch Dentists. The protocol for accreditation has been set as follows (9): an organisation or course provider applies for accreditation to the Accreditation Committee that in its turn takes action. The provider applies for one test-year to implement quality criteria of the accreditation system.

After the test-year a team of auditors, appointed by the accreditation committee, will assess if the provider has applied the accreditation system correctly. Their report will be sent to the provider. Thereafter the final report will be submitted to the accreditation committee, which in its turn decides on granting the Q-hallmark. A positive decision to accredit the provider can be made with or without restrictions for a period of 3 years. A course provider can enter a protest against the decision to the accreditation committee. After having completed the first test-year successfully, the provider can apply the Q-hallmark for another 3 years. Re-assessment takes place in order to verify if the provider can be accredited for another period of 3 years. The course provider self determines for which courses the Q-hallmark applies. The criteria for recognition are applied to these courses.

In Latvia, certification and re-certification is performed by the Latvian Dental Association (LDA) in collaboration with the Faculty and Institute of Stomatology, Riga Stradins University, the State Dental Centre, the Latvian Physicians Society and representatives from industry (3, 4). The 5-year recertifications required by all dentists since 2001, are achieved by attending lectures, seminars, practical courses and congresses. Forty per cent of the credit points must be gained by attending academic lectures, organised by the LDA and the staff of the Faculty and Institute of Stomatology. These lectures and courses cover all areas of clinical dentistry.

In Hong Kong, the accreditation body for general dental practitioners is the Dental Council of Hong Kong and for specialist dentists, the Hong Kong Academy of Medicine. The Academy's requirement is 90 credit points (1 point for every hour of accredited lectures, etc.) during a 3-year cycle.

In India, the Dental Council of India is responsible for accrediting dental training and registering dentists,

and is considering accrediting CPD programmes in future. However, at present guidelines have not been framed.

In Malaysia, the accrediting body is the CPE Committee of the Malaysian Dental Association, using guidelines developed by the Malaysian Dental Council. For courses and scientific meetings, a full detailed programme of exact activities carried out and duration of each activity with information of speakers or those conducting the course, need to be provided for assessment of point allocation. For study clubs, there is a need to provide details of activities.

In the Philippines, the Philippines Dental Association sets requirements for the recognition of specialist groups. The different dental chapters are required to provide continuing dental education for its members (5). In Singapore, the Singapore Dental Association accredits CPD, and in broad terms approves the contents of the course and the course organiser. In Thailand, the Dental Council of Thailand and the Universities which have dental schools accredit CPD. CPD providers submit their course(s) and/or programme(s) to the Dental Council or the Universities or Academic Institution for approval and weighting, for example, how many points or credits will be granted for the course(s) or programme(s).

In Australia, the states of Victoria and Queensland have formal accredited CPD systems. In Victoria the accrediting body is the Australian Dental Association Victorian Branch. Proposed CPD activities are assessed by Professional Development Committee and classified as clinical, non-clinical or ineligible. Credit points are awarded (2 points per hour) in the clinical or non-clinical categories. Members who obtain 30 points in the programme year, of which at least 25 are in the clinical category, receive a Certificate of Professional Development. It is a voluntary scheme and all members are automatically enrolled.

In Western Australia, courses are not accredited by a formal body. However, the University Continuing Dental Education Committee (University of Western Australia) informally assigns credit points to activities based on the Australian Dental Association Victorian Branch points system. In South Australia, an accreditation system is planned. Moreover, an overarching national CPD accreditation system is being considered.

In New Zealand, the New Zealand Dental Association is the accrediting body. There is an application process in which the association approves dentally related courses for accreditation of CPD hours. Essentially it is an accounting system for hours done and is not weighted. However, a weighted system is pro-

posed that takes into account the type of course (lecture when compared with 'hands on'), the qualifications and experience of the presenter and whether or not an evidence-based approach is taken to the Dental Council. Feedback suggests that dentists want credibility in the process and that CPD courses are given weighted accreditation (validity) if CPD is going to be mandated. The proposed changes to the Code of Practice include changes to the accreditation system for CPD.

Effectiveness of continuing professional development in improving the performance of the oral health team

The responses for the United States of America/Canada and Europe could be summarised as "there is no 'documented', 'hard' or 'research' evidence that participation in CPD improves the performance of the oral health team". The informants from England and Latvia conceded that anecdotal or feedback from participant-type evidence is available. The information for South-east Asia involved a wide range of comments including there is 'no available evidence', 'there is no formal evaluation published', there is 'anecdotal evidence', whilst the contributor from Myanmar indicated that some performance improvement has been noted for CPD participants although the type of data on which this conclusion was based was not described.

The responses for states in Australia varied depending on whether the contributor was based in a university or the dental association. Three of the four contributors based in dental associations considered that there is 'no evidence', the other contributor considered there to be only 'anecdotal evidence' or feedback from participant-type data available. Two of the four contributors based in universities referred to 'beliefs' about improved effectiveness (including linking performance to the type of CPD undertaken), a further indicated that local surveys had not been successful in addressing the issue and the remaining respondent indicated that a report was being developed on the matter. In New Zealand no 'direct' evidence was considered to be available, but reference was made to peer review statistics which suggest that more complaints arise for dentists who undertake lower levels of CPD courses.

Discussion

There is an apparent trend for more countries to impose a mandatory requirement for dentists to take

part in regular CPD, however, there appears to be very little firm objective evidence that participation in CPD is the primary factor which improves the quality of clinical oral health care provided for patients. Evidence-based dentistry is an issue which has recently been addressed in consideration of the multi-factorial nature of challenges to changing professional practice (10).

Apart from the recent introduction of mandatory CPD for dentists in the UK and Latvia, the results indicated that several other countries have either decided to introduce such a requirement in the near future or are considering doing so. Furthermore, it was reported that one country which had a mandatory requirement for its dentists to participate in CPD and terminated this requirement, is now likely to reinstate the requirement.

In Victoria, Australia, in October 2003, the state's Department of Human Services commenced a review of the system which regulates Victoria's registered health professions (11). The review had three main objectives:

- 1 To ensure the framework for regulating Victoria's health professionals is up to date, responsive and equips health practitioner registration Boards to protect the public and address emerging challenges.
- 2 To promote consumer and community confidence in the operation of Victoria's regulatory scheme.
- 3 To ensure good links between mechanisms that oversee practitioner quality and those that ensure health system quality (11).

Models for regulation of the health professions considered within the review were, self regulation, negative licensing, co-regulation, reservation of title only, reservation of title and core practices, reservation of title and whole of practice. The latter model currently applies to the practice of dentistry in Victoria. Although it is the most restrictive, its main criticism was that there are 'little if any added public benefits in terms of greater protection' (11).

The Australian Dental Association Victorian Branch subsequently submitted a formal response to the Dental Practice Board of Victoria (12) in November 2003 regarding the Board's draft code of practice for CPD which expressed the view that:

support for making participation in an arbitrary number of CPD hours requirement of registration renewal is contingent on evidence showing its effectiveness in improving public health and safety, and improving access to care. No such evidence on safety is provided in the Discussion Paper nor are we aware of any such evidence having been established by research anywhere in the world. Indeed the available evidence

seems to suggest that whilst it is assumed that attendance at professional development program designed to keep practitioners up to date and to enhance their knowledge should be efficacious, it does not actually reduce the incidence of adverse events.

It was concluded within the response that: *there are significant disadvantages with a statutory requirement for mandatory CPD, it is viewed as a very blunt instrument for addressing concerns about a practitioner's professional competence and there are more effective ways of achieving the same objective.*

Nevertheless, following considerable deliberations, the Dental Practice Board intends to formally introduce mandatory CPD in Victoria in 2005, following an introductory phase during 2004 (13).

In New Zealand the Health Professionals Competency Assurance Bill received Royal Assent as of September 2003 and will come into force 12 months later. The new legislation will radically overhaul the regulatory framework for health professionals in New Zealand with requirements for recertification which include peer contact (14).

Pressure to introduce mandatory CPD in all areas of health care can arise after there have been dramatic incidents in which health care workers have been shown to be incompetent (15). The view that all professionals who care for the general public and may potentially cause them harm if their knowledge, skills or attitudes are lacking is a powerful incentive for some Governments to impose mandatory requirements for life-long learning. However, participation in CPD cannot necessarily guarantee public safety, as it may improve knowledge and skills but may not influence attitudes or personality traits. 'Untargeted' participation in CPD may result in individuals becoming more proficient in some areas of practice that they like, as they attend courses or seek other CPD related to these topics, but cannot guarantee any improvement in areas in which their skills are poorly developed, dislike and do not seek to improve (16).

The accreditation systems for different types of CPD vary around the world. Many systems involve points allocated for hours of activity undertaken and weighting systems typically pertain to the following:

- whether the activity is clinical or non-clinical;
- the method of presentation, lecture when compared with whether the course involves a 'hands on component' or not;
- the use of evaluation to assess the effectiveness of the activity;
- characteristics of the course providers.

Perhaps because they are relatively easy to access and assess at a later date, increasing focus is being

directed towards the quality of electronic options for providing CPD such as CD-ROMs and online activities (17, 18).

Challenges for the future with regard to the accreditation for different types of CPD include:

- the international recognition of activities;
- intra-regional mobility with respect to course attendance, given that registration requirements may vary between states and temporary registration may be required if the course involves the treatment of patients;
- the roles of new technologies such as interactive virtual reality simulations in improving clinical performance;
- the interface of CPD to the current continuing competency debate which has emerged in the United States of America, in that mandatory CPD frameworks have been questioned because they do not objectively satisfy consumer demands, with regard to the goals of the programmes, namely, to protect the public (19);
- access to CPD courses which may be more effective such as 'hands on' courses which have higher accreditation weightings.

Overall, it appeared that the information from different countries indicated differing perceptions about what constitutes evidence to describe the effectiveness for CPD. Although research evidence may have been developed in some countries regarding the effectiveness of CPD it was not acknowledged (20). It was also interesting to note that in Australia, the responses made by dental association-based respondents differed from those of university-based respondents. A part of the explanation may relate to the way different types of evidence are valued by different stakeholders. In this study respondents concluded that there is very little of any type of evidence to support the effectiveness of CPD in improving the performance of the oral health team.

Evidence from medical CPD suggests that it can be said that learning outcomes and changing clinicians' behaviour to improve the outcomes of patients and health care are far more important than participation. In continuing medical education, several systematic reviews have been carried out to analyse the change of doctors' performance and health care outcomes. Davis et al. (21–23) showed that continuing medical education activities such as conferences and courses showed mixed effects; small group interactive education with active participation showed positive effects. According to a recent systematic review of 235 assessments, traditional approaches to improve uptake of research findings, e.g. clinical guidelines, better access to

electronic sources of information, continuing education, and conferences may be all that is needed to ensure the uptake of some simple changes, but most innovations require further efforts with additional interventions (24). The cognitive content of an intervention is at least as important as how that content is delivered. 'Plans for change should be based on characteristics of the evidence or guideline itself and barriers and facilitators to change' (24).

The effect sizes for educational outreach are moderate and could be improved by use of additional interventions (25). Thus, implementing change seldom entails a single action, but instead a combination of approaches on different levels (doctor, team practice, hospital, wider environment), tailored to specific settings and target groups (24). Before a strategy, such as CPD, to implement change is selected, the obstacles to change should be identified. To date most of these approaches were more based on belief than on scientific evidence. 'Evidence-based health care should be complemented by evidence-based implementation' (24). In general, evidence shows that no approach for transferring evidence to practice is superior to all changes in all situations.

Another issue to be stressed is that in their future professional lives, dental students should be able to judge in which areas they need further education. The foundation for the attitude towards continuing learning should be laid during undergraduate education and the ability to assess one's own competence is important in undergraduate programmes. Dental students should therefore be supported to increase their responsibility and independence, parts of the learning process, to direct their own learning during undergraduate programmes.

To our knowledge no systematic analysis of evidence for the effectiveness of CPD for improving the performance of the oral health team, as opposed to reports of individual studies, has been carried out.

Future research issues relating to dental continuing professional development

The need for research into a wide range of aspects of dental CPD has been highlighted. These include:

- Does CPD contribute to improved care of patients?
- Does CPD enhance clinician's competence?
- Does CPD change the practice profile of the oral health team?
- What are the clinician's needs for CPD?
- How can CPD best be matched to dental clinician's needs rather than demands?

The main recommendation from this study however, is that a systematic review be undertaken to consider

the effectiveness of CPD in improving the performance of the dental team and patient-based outcomes.

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