Letter from California - Mandatory continuing education

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In Britain, mandatory continuing dental education is on its way. In California, we have had mandatory continuing dental education for some twenty-five years. Maybe it would help to see some of the good and bad sides of this, learn from some of our mistakes and see what does work and what does not work — at least in California.

In the USA, issues relating to dental and medical licensure, discipline, and continuing education are handled at the state level and each state has its own requirements. This has advantages in that things are handled locally, but it also has obvious disadvantages in that there are different requirements in different states and they are often incompatible.

Of the fifty states, seven still have no continuing dental education requirement. Those without are generally the more rural states and also the island state of Hawaii. The vast distances and small numbers of practitioners have always been felt to make any form of continuing education difficult to obtain. Interestingly enough, nobody has ever done a study to see whether the dentists in these seven states have a better, or worse, knowledge of new developments and standards in dentistry. However, in such states the situation may change in the near future with the arrival of distance learning via the Internet. It is now possible to receive all your continuing education without ever leaving your home or practice.

As an aside, the arrival of telemedicine in dentistry via the Internet is having some interesting legal repercussions in California. Many patients are now requesting the equivalent of a consultation over the Internet and many doctors and dentists are receiving these requests on a daily basis. Since in many cases, you do not know the place of origin of these requests for advice and consultation, giving the required advice means you may be practising medicine or dentistry without a license in the state, or even the country, from which the request emanates. This has been brought to the attention of legislators who are now considering the possibility of a specific telemedicine license, which would enable you to practice medicine or dentistry over the Internet without infringing state or even national laws.

The remaining forty-three states have some kind of mandatory continuing education requirements and in virtually all cases it is linked to license renewal: you cannot renew your dental license unless you have the mandatory number of continuing education hours. In many states, licenses are renewed every two years so you generally have two years in which to acquire your continuing education hours. In California, you actually require 50 hours every two years. However, states vary considerably in how strict they are regarding proof of attendance at classes. For instance, in California your license renewal form merely asks two questions:

1. Have you fulfilled the continuing education requirements of 50 hours in the past two years? Yes / No
2. If required, could you produce evidence to support this? Yes / No

I am not aware of any practitioners who have ever been asked to produce evidence of their continuing education requirements but one must assume that every practitioner could produce evidence if required.

In Britain, with a centralized, computerized registry, there should be a better way of doing this. In California, once you have mandatory continuing dental education, there has been temptation to use it for political ends. Whenever there is a problem of any kind, particularly one where there is any degree of public disquiet, it is very easy to adjust the continuing education requirements in an effort to assuage public concern.

This is easy to do in California where the dental licensing authority is an arm of the state government. In Britain, where the General Dental Council still has some independence from the legislative process of government, this should not be as big a concern. In California, for instance, when HIV and hepatitis became a concern, a mandatory four hours of instruction in infection control was added to the requirements and we still have to fulfil this requirement every two years.

More recently, a mandatory requirement of three hours of instruction in dental jurisprudence every two years was required. This was perhaps enacted because of all the recent changes in the rules and regulations regarding dentistry and a desire to make sure that all dentists were acquainted with them. Additionally, anybody giving any form of sedation or general anaesthesia

In brief

This explains:

- The concept of continuing education in the USA.
- The American experience of what type of continuing education works, and what does not.
- That this information can be borne in mind when continuing dental education becomes mandatory in the UK.

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must also carry out a mandatory 14 hours of continuing education in these particular issues every two years for license renewal.

These all come from within the 50 hours required so that by the time you have fulfilled these requirements, you may only need another 29 hours of education every two years.

A standard lecture with its question and answer session will normally carry one hour of continuing education credit whilst a one-day course will generally carry seven hours. A three-day meeting such as the BDA annual meeting would generally confer about 21 hours of continuing education credits.

I have some grave doubts about the continual tinkering with the requirements. Requirements in specific areas are constantly added whilst being politically very difficult to remove. The net result is a constant addition to the required continuing education courses.

From the provider's point of view

Some of the requirements for providing an approved continuing education course in California may be of interest.

The first requirement is a 'needs assessment.' This means showing the Board of Dental Examiners that there is a need for the lecture or programme being produced. Therefore, a course on the importance of cohesive gold fillings would probably not be approved.

Evidence that there is a need for the course includes: producing articles in the literature which says there is inadequate knowledge on a particular point, by surveying dentists to find out where they feel weak, or by producing comments from dentists who have been on similar courses. For example, comments such as 'all dentists should attend a course such as this' would be extremely valuable in fulfiling the 'needs assessment.'

Once you have shown the need for the lecture or course, you must show what it is supposed to teach dentists and then you must show how you intend to find out if it has achieved its goal. The latter is usually performed by means of a questionnaire completed at the end of the course where practitioners state what they have gained from the course and how they think this might help them in practice. They are also often surveyed later (six months would be a critical time) to see if the course actually did change behaviour in any way. In general, the aims of the course are to impart new information and to modify previously known information and also for dentists to be able to incorporate this into their practice in order to in effect a change of behaviour.

There is no Section 63 or other kind of support for anyone either running a course or attending a course. So, if you are going to run a course you must at least break even and hopefully make a profit. Otherwise, it does not make a lot of sense. You must pick popular topics and speakers who can draw an audience.

With continued state support these incentives may not be quite as strong in Great Britain and this will have both advantages and disadvantages for those organizing a course or participating in one. Advantages might be that you can successfully run a course on an important but relatively unexciting topic and not worry quite so much about the financing.

From the attendees point of view

A dentist in California who has to fulfil the 50-hour requirement for continuing education every two years will be bombarded by approved courses. Since there is no financial support or expenses to attend these meetings (although the cost of attending are tax-deductible within certain limits), you are going to be very particular about which courses you choose to attend. It would be very nice to say that this would cause you to sign up for the most relevant and important courses given by the best speakers but, unfortunately, this is not always the case. There is a great tendency to think that if you are paying money (often a lot of money) to attend one of these lectures or courses, you may sign up for one that could potentially make you a lot of money. Courses in practice management that promise to make a practice more efficient and profitable are often very well attended, as are courses teaching new and potentially lucrative areas of dentistry such as tooth whitening and bleaching techniques. Unfortunately, courses that may be very important but do not help generate a lot of money a practice may be harder to sell. In particular, this may apply to courses on the early detection of oral cancer. Unfortunately, there is very little financial gain for a dentist to screen and detect early oral cancer. In fact, it may cost a considerable amount of money since you have to spend time and effort referring patients to specialists, and while they are there, you cannot be doing the crowns and fillings that you have originally planned. Hopefully, in the kinder and gentler system envisaged by the NHS and the General Dental Council, market forces may not be quite so dominant. As with courses anywhere in the world, 'you can take the horse to water, but you can't make it drink.' This means it is not at all unusual to see people sign up for a course, realise it was not what they anticipated and leave early, but still collect their full attendance certificate for continuing education credit. I also suspect that when I look around the audience at some of the more mandatory courses on infection control or dental jurisprudence, etc., that there are some people physically in the lecture room but mentally hundreds of miles away.

Does it work?

At the end of the day, what we really want to know is whether mandatory continuing education actually improves a practitioner's skills, leads to changes in behaviour and improves patient care. The evidence for this has been hard to gather in California and I hope that in Great Britain there will be a mechanism in place to evaluate these criteria. It has been shown that the standard 45-minute lecture with a 15-minute question and answer session generally does very little to alter behaviour. The time involved is not long enough and the practitioner does not feel any kind of relationship with the person who gives the talk and is not in any position to know whether to trust them or not. There are, of course, exceptions and occasionally a one-hour speaker may have one extremely relevant fact to offer or may spark some

enthusiasm in the practitioner to attend a longer course to learn some new techniques. The one-day course can be better but even this has a very limited effect in changing behaviour. This is particularly so if a one-day course consists of multiple lecturers because then it is really only seven one-hour lectures. If, however, a one-day or a weekend course is given by one or two people, then it does give the practitioner time to form a relationship with them and they are then much more likely to be influenced by what they say and probably change behaviour as a result.

Surveys have shown that many practitioners actually obtain a lot of their knowledge of new materials and new techniques from representatives of the various drug and equipment companies who call on them. A lot of the information the dentists receive from these sources is biased in favour of a particular product but nevertheless, many of these representatives have built up a relationship with the dentists over many years leading to a position of trust. Also, if these representatives actually visit dentists in their practices, they can make comparisons between practices and can tell a dentist what seems to work in one practice may not work in another. One should not underestimate the value and power of the competent company representative in influencing dentist's decision as to choices of materials and techniques.

It has been shown that the type of course which is most likely to alter behaviour is a longitudinal course held over an extended period of time, for example, one day per month for a year or so. This is especially true if it is given by a small group of instructors and is even more so if it is a hands-on type course where the practitioner actually gets to do something. This is because they get the chance to practice and reinforce what they have been told in the lectures, to see if a particular technique really is as easy or as relevant as the lecturer suggested. In this respect, a study group appears to be especially valuable.

I was very pleased to see that the British model does appear to emphasize study groups and hands-on courses. A peer-review of courses by other similarly qualified instructors may be valuable but probably not as valuable as the evaluations by the attendees themselves. In particular, comparing the evaluations immediately on completion of the course with those carried out six months later to see if there was any long-term impact of the course.

If you make the rules strict enough you can certainly get practitioners to produce a certificate to say that they have attended the required number of hours of continuing education. This is particularly true if you link the certificate to license renewal and continued registration. The object of the exercise should be to educate practitioners, keep them up to date, modify behaviour where it needs to be modified and lead to enhanced patient care and patient protection. I hope the British model can show that it does this since it has certainly been hard to show in California.