Australian Dental Journal 2001;46:(2):139-142

Continuing education: The 1998 Survey of the Royal Australasian College of Dental Surgeons

P Sambrook,* D Thomson,† R Bastiaan,† A Goss*†

Abstract

Background: Continuing education (CE) is an essential professional activity. In the last decade, CE has been actively pursued by the medical profession in Australia and abroad. However, the uptake of CE in dentistry has been much slower and there is minimal Australian data on dental CE.

Methods: To determine the level of CE activity, in 1998, postal questionnaires were sent to all fellows of the Royal Australasian College of Dental Surgeons. The responses were analysed.

Results: There was a high response rate (90 per cent) but a moderate usable rate (54 per cent). The results show a biphasic distribution between high and low CE activity. The average amount of activity of those involved in CE was 116 hours per year, above the usually accepted minimum of 100 hours/year. Some groups, particularly members of the specialist divisions of oral and maxillofacial surgeons (215 hours) and periodontists (205 hours), have high levels of CE. However, approximately 25 per cent of college fellows reported little or no CE activity. The survey revealed that inactive fellows are more likely to be older and in general practice. Inactive fellows were also tardy in replying to the questionnaire.

Conclusion: The high activity CE group needs to be recognised and encouraged to continue. Specific plans to help the low CE activity group should be developed. Although these findings relate directly to the Royal Australasian College of Dental Surgeons, they are presented as they have implications for the dental profession at large.

Key words: Continuing education, college, survey, dental surgeons.

(Received for publication January 2001. Accepted March 2001.)

Introduction

Continuing education (CE) is a professional responsibility of all practising clinicians. Clinicians must continue to read journals, teach, attend meetings and actively participate in ongoing education. This responsibility is well understood by most clinicians and few accept that one can rely solely on personally directed clinical experience.

Recently, there has been increased public and government interest in the ongoing education of the professions. No longer are self-serving statements from what externally appear to be closed associations sufficient. This has resulted in a new phase in CE, namely that it is a formally validated requirement rather than a voluntary option.

Over the past decade, the medical profession has been proactive on CE. The medical colleges or their equivalent have been active in promoting CE in the United Kingdom,[1] Europe,[2] North America[3] and Australia.[4] Internationally, although there has been a difference in style and thrust, the expectations are similar. Essentially, each practising clinician can reasonably be expected to demonstrate a minimum of 100 hours CE per year over a five-year cycle. This CE activity should be balanced between self-education, internal education at the site of employment, research and teaching and attendance at external conferences and workshop meetings. Internationally, the degree to which these requirements are mandatory is widely variable but, to maintain registration to practice, the trend is strongly toward demonstrated mandatory practice.

The medical profession in Australia has shown a leadership role in CE. Anaesthetist,[5] surgeon[6-7] and general practitioner[8] associations all require ongoing CE from members. Fellows of the College of General Practitioners receive a higher Medicare rebate than general medical practitioners without this qualification and many hospitals in Australia and New Zealand require evidence of CE for maintenance of access appointments.

Oral and maxillofacial surgeons (OMS) have generally followed the lead of the medical profession. To maintain Board Certification of the American Board of OMS, one must show evidence of CE over a five-year cycle or lose certification. In 1994, the division of OMS of the Royal Australasian College of Dental Surgeons (RACDS) undertook a CE survey of its members. This survey had a 78.1 per cent response rate with an

*Oral & Maxillofacial Surgery Board, Royal Australasian College of Dental Surgeons.
†Councillor, Royal Australasian College of Dental Surgeons.

average CE activity of 165.9 hours, range 0-992 hours/year.[9] The OMS division can provide CE documentation for members who require it for continuing hospital accreditation but has not made ongoing CE activity mandatory for retention of the FRACDS(OMS).

There is a small but increasing pool of data for dental CE internationally and, generally, the dental profession has been much slower to embrace this requirement. Over the last five years, many US dental boards have made evidence of ongoing CE a requirement for professional registration.[10]

The Australian and New Zealand Academy of Periodontists (ANZAP) is also active in monitoring the CE activity of its members. Over the past four years, ANZAP has maintained a registry of membership CE. This group has found that, among periodontists, there has been a very high level of CE activity with over 95 per cent of participants exceeding minimum requirements.

The Australian Dental Association (ADA) is establishing a national network database for CE but this is not yet complete. Once this network has been established, it could be available for access by the state branches of the ADA, the RACDS and eventually state dental boards for the purpose of accreditation and monitoring of individual CE activity. In New Zealand, the Dental Council and Dental Association are well advanced in planning the implementation of mandatory CE for all practitioners.[11]

The RACDS has a strong interest in continuing postgraduate education and examinations on a binational basis for Australia and New Zealand. The RACDS has held primary and general fellowship examinations for over 30 years and has also conducted its primary examination in Hong Kong. In the last two decades, the RACDS has developed specialist fellowship examinations in all the recognised specialities. The FRACDS(OMS) is now the Australian Health Insurance Commission recognised standard for the surgical speciality of OMS.

Recently, the college introduced the affiliate in general dental practice (AGDP). The regulations, guidelines, study guide and reading list for this examination have been finalised and the candidate can select from a range of study modules and also gain credit for work done in other educational settings. Much of the study will be web based.[12] However, to maintain the qualification, evidence of ongoing CE over a five-year period must be provided.

As part of its commitment toward ongoing CE for fellows, the RACDS commissioned this study to determine the CE activity of RACDS fellows in 1998.

Materials and methods

A detailed questionnaire covering all aspects of CE activity in the calendar year 1998 was developed, trialed on a small number of fellows, and the final version mailed to all members of the college in mid-1999. (Copy available on written request.) A followup of non-respondents was undertaken three months later. The survey was also publicised in the college's *Presidential Newsletter*. Mailing and initial receipt of the survey were undertaken by the college office and the forms were then forwarded to the Oral and Maxillofacial Surgery Unit of Adelaide University for analysis.

The initial analysis was undertaken to determine the overall frequency, average and range of hours per year spent in CE activity. The survey followed the same methodology as the 1994 OMS CE survey.[9] Various activities were then weighted with self-directed reading weighted at 0.5 and presentation of lectures weighted at 2.0. Publications were assigned eight hours for case reports and 16 hours for a research paper. Hours were not assigned for teaching, examining and professional committee involvement. Analysis was also performed to determine factors which predicate to either high (above 100 hours/year) or low levels (below 50 and 100 hours/year) of CE activity.

All records were maintained under appropriate conditions of confidentiality and security and completed questionnaires were returned to the college office.

Table 1. The overall CE activity of all respondents, including those who had no activity in some areas. The linked area of CE activity follows those commonly used in other medical CE surveys (n=621) (1-10)

CE activity	Hours	% involved
International meetings	6.8 (0-120)	27
National meetings	18.8 (0-203)	52
Self education	52.9 (0-180)	86
Publications		
– Case reports	1.3 (0-84)	
– Research papers	6.26 (0-192)	
Teaching		
– Undergraduate	No hours assigned	26
– Postgraduate	No hours assigned	30
– Examiner	No hours assigned	14
Professional committees	No hours assigned	17

Results

One thousand one hundred and fifty-two questionnaires were mailed and 1,071 (93 per cent) were returned. Of these, 188 (16 per cent) had retired from practice; 143 (12 per cent) submitted largely incomplete forms and 86 (8 per cent) declined to participate. Thirty-three (3 per cent) reported they had no CE activity in 1998. Thus, there were 621 (54 per cent) usable replies. Of these, 341 (55 per cent) were in registered specialist practice and 280 (45 per cent) in general practice.

The overall results are presented in Table 1. In each activity, some respondents had no involvement. A large group of respondents' only activity was the minimum amount of self-directed CE. The effect of removing this low activity group is presented in Table 2.

Table 2. Results following removal of those with no activity in the various categories (n=actual number involved)

CE activity	n	Hours
International meetings	170	43.2 (8-120)
National meetings	323	36.2 (8-203)
Self-education	534	61.6 (30-180)
Publications		
– Case reports	61	14 (8-88)
– Research publications	111	36 (8-192)

In Table 3, the levels of CE are grouped by number of hours, showing high (more than 100 hours/year), low (less than 100 hours/year) and very low (less than 50 hours/year) CE activity.

Analysis of the results to determine which groups had high or lower CE proved to be generally unrewarding. Age, gender, practice and location had no statistically significant effects on the level of CE activity. The high CE activity group was mainly specialists and the low activity group was more likely to consist of general practitioners often close to retirement. The speed of response to the questionnaire was predictive with the first one-third of the respondents having over 200 hours CE/year and the remaining two-thirds well below average.

Discussion

This study shows, generally, fellows of the RACDS have an acceptable level of CE activity. CE is a primary activity of the RACDS as gaining fellowship by examination is often the first major commitment, after leaving dental school, graduates make to the active pursuit of postgraduate education. The college considers this commitment is only the first step in any dentist's professional education. The maintenance of education levels is essential for all members of the profession and it is not difficult to keep up to date as the college and many other educational organisations regularly provide CE programs, ranging from evening meetings to fulltime degrees.

This study shows college fellows have an annual CE average of 116 hours/year (range 0-507) which compares with the usual medical college standard of 100 hours/year. However, only 41 per cent of all college members who completed the questionnaire achieved above this standard of 100 hours/year and a small group greatly exceeded the requirement. Thus, for example, the two specialist groups in the RACDS with full divisional status (OMS 215 hours and periodontists 205 hours) on average doubled this standard.

Table 3. Grouping of respondents by number of hours spent in 1998 on CE activity. Following standard CE evaluation, these are grouped into very low (<50 hours), low (50-100 hours) and high (>100 hours)

<50 hours	50-100 hours	>100 hours
24.3 n=163 (26%)	71.8 n=213 (34%)	217.0 n=245 (39%)

The survey revealed a problem group for the college and dentistry in general. Thirty-three (3 per cent) respondents stated they had no CE activity in 1998, comparable with the medical college figure of 5-10 per cent with low CE. However, there was a group of 25 per cent of fellows who had some CE, less than 50 hours/year, largely self-education with no outside supervision. Under most systems of audited CE, such activity does not count and the study did show that part of this latter group were older fellows, who were either no longer in practice or close to retirement. However, the younger low activity group does need to be targeted to determine why they have not pursued CE activity.

The importance of CE has not been broadly discussed by the dental profession. However, recent significant professional and political changes necessitate CE becomes an important ongoing topic of discussion. Other professions, in particular medicine, already have well developed and more adventurous CE programs than dentistry. The UK and Australian medical colleges have operated active and extensive CE programs for at least a decade and developed efficient infrastructures to monitor and record members' CE activity. The cost of CE activities is built into the member fees and, in some instances, college reregistration is dependent on achieving a satisfactory level of CE activity over a set period.

The drive to expand this concept of CE into all areas of health is increasing. In part, this is due to very rapid change in the expectations non-healthcare authorities have about the maintenance of professional standards. These changes in expectations are now flowing on to state dental boards, reflecting their increasing non-dental membership, and other healthcare authorities will be under pressure to follow. It would be reasonable to expect these revamped organisations may review the CE activity of the profession and note that currently there are no annual reregistration requirements to undertake CE activities. The growing importance of the Australian Dental Council (ADC) could be further expected to influence the issue of CE as a prerequisite for board registration and the ADC is well placed to act as a national coordinator of many dental educational activities, including CE.

Third-party healthcare providers play an important role in the CE debate. These healthcare providers could find an ally in state and federal governments in implementing a CE requirement as part of health rebate schemes. For example, the health insurance industry could elect to pay a higher rebate to dentists who could demonstrate a commitment to higher CE. These pressures have also been placed on other health professionals.

Philosophically, some people may believe CE is an issue that is best ignored. This is unwise as if the profession fails to take a lead in defining positive CE

activity and setting standards at an appropriate level, then there is no question that there is the legislative will and capability to make CE compulsory. A real risk also exists in that if a health profession is not invited by the regulatory body to formulate the requirements for CE, then that profession's ability to control its destiny is irrevocably lost.

With the above issues in mind, the council of the RACDS has been proactive in developing CE and this study provides a baseline measure against which future activities can be measured. The RACDS has a component of mandatory CE built in to its new Affiliate of General Dental Practice (AGDP) qualification, the first time in Australia that a compulsory component is a prerequisite for reregistration. The adoption of this principle has been commended by state dental boards.

The college is preparing a further, comprehensive CE program for consideration by its fellows. It is envisaged by council that there is an essential requirement to work in conjunction with the dental schools and the Australian and the New Zealand dental associations. The number of participants in the dental profession in Australia and New Zealand is too small to run independent CE programs and it is crucial the main postgraduate organisations coordinate their efforts on a trans-Tasman basis.

Continuing education is a vital issue for the dental profession. This paper is presented to provide a factual basis for further planning by the college and aims to stimulate wider thought and discussion by the profession on the key concept of CE.

Acknowledgements

This study was conducted and funded by the Royal Australasian College of Dental Surgeons with data analysis by the Oral and Maxillofacial Surgery Unit, Adelaide University. We gratefully acknowledge the assistance of Ms Alexis Smith, executive director RACDS, and Ms Lynda Eves, Adelaide University.

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Address for correspondence/reprints:
Professor Alastair Goss
Royal Australasian College of Dental Surgeons
64 Castlereagh Street
Sydney, New South Wales 2000