

**ADAVB SUBMISSION
IN RESPONSE TO THE DPBV DISCUSSION PAPER RE MANDATORY CPD**

INTRODUCTION

In the Board's Discussion Paper the following two purposes for CPD are highlighted:

“CPD has dual purposes: to assist in the maintenance of professional standards and also, as the General Dental Council has said in a similar discussion, to “improve the quality of the practitioner’s working life” and “increase professional satisfaction”.”

Given that the Board's role is essentially confined to protecting public health and safety, only the first of these purposes can reasonably be considered as a basis for mandating participation in CPD.

Mandatory CPD was considered and rejected during the review of the Medical Practice Act in 2000. Instead, a system of professional performance assessment was introduced. The performance pathway arrangements now enshrined in the Medical Practice Act are expected to become the model for the new statutory framework for the regulation of health professions. That framework is to include provision for registration Boards to monitor participation in professional development, but is not expected to authorise establishment of minimum CPD standards as reportedly proposed by the Dental Practice Board.

Section 69 (1) of the Dental Practice Act includes the following functions for the Board;

- “(c) to regulate the standards of practice of dental care providers;
- (d) to investigate the professional conduct or fitness to practise of registered dental care providers and registered dental students and impose sanctions where necessary;
- (e) to promulgate Codes about the practice of dentistry;
- (f) to issue guidelines about--
 - (i) the minimum terms and conditions of insurance against civil liability in connection with the practice of dental care providers;
 - (ii) appropriate standards of practice of dental care providers;”

It could be argued that the power “to regulate the standards of practice” is confined to the actual delivery of dental care, and does not extend to the level or extent of continuing education undertaken.

As indicated in the Board's Discussion Paper, the current ADA Policy on continuing education is support for all members remaining actively involved in CPD. However, 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 programs 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. We note that hands-on clinical courses may be more effective in improving practitioner performance and therefore patient outcomes. These courses are relatively few in number, most often fully subscribed, **much** more expensive to conduct, and almost always require small group structures to be effective.

The effect on access to care is not discussed at all in the Board's Discussion Paper. Such an omission is significant as there are arguments that mandatory CPD may reduce access to care.

We note that the Board President has expressed the view, when briefing ADA members on 9 May, that the public expects dental care providers to undertake CPD. No research on the actual views of the public on a range of propositions about the nature and frequency of such training appears to have been undertaken to confirm this view. No evidence that would meet the requirements of the NHMRC (as adopted by the Board as a basis for determining policies and Codes) has yet been presented to support the proposed measure.

The ADA VB recognises the political and public perception issues behind the proposal, and consistent with the current policy position, despite the lack of evidence, is willing to lend "in principle" support to a Code of Practice on CPD being introduced.

We have a number of reservations however, about the timing of the implementation of the Code in relation to the Department of Human Services Health Practitioner Regulation Review, and the possible practical implementation problems that could arise, depending on the shape of requirements imposed.

On the first of these concerns, Branch Council received advice from Ms Anne-Louise Carlton at a briefing on 5 May, that the Department would prefer the Board to defer consideration of the proposed Mandatory CPD Code until consultations on the Departmental paper have been concluded, and findings advised.

Ms Carlton also indicated that the Departmental issues paper will include discussion of **extending** the registration boards' powers to conduct performance assessment and to monitor participation in CPD (emphasis added). This suggests that there may actually be some question as to the legal power of the Board to impose the requirements canvassed in the Board's Discussion Paper. Further, were the Board to proceed with adoption of a different model, changes may later be required to bring the CPD Code into line with the new statutory framework.



The Department has expressed its wish to establish consistent measures under model legislation across all 13 regulated health professions. This intention extends to matters relating to CPD.

In the light of the views expressed by the Department, we respectfully suggest that the Board defer consideration of its own Discussion Paper until after the Departmental Review is completed, and legislation is introduced into Parliament in early 2004 (Source: Health Practitioner Regulation Review Newsletter March 2003).

In the event the new statutory framework has the registration Boards **monitoring** CPD, rather than imposing specific hurdle (i.e. a certain number of hours) requirements for registration renewal, all that would be required would be a method by which dental care providers could affirm the number of hours or points of verifiable CPD they had undertaken. The system currently employed by the Branch in administering the ADAVB Professional Development Program (see Attachments 1 & 2) would be quite suitable for this purpose.

In the view of the ADAVB, the Code of Practice on CPD should relate to monitoring of the level of professional development undertaken by practitioners, and use of this measure as one of a set of potential 'triggers' for investigation of professional performance or conduct.

The Board already has a range of triggers for such action, including:

- Complaints from the public
- Reporting by colleagues or organisations
- Reporting of settlements larger than \$10,000
- Reports of criminal court proceedings
- 'Own motion' action by the Board e.g. response to Yellow Pages advertising.

Adopting CPD reporting requirements would enable the Board to add a further trigger for use of its existing investigative powers and systems to ensure that registered dental care providers are practising in a way that protects the health and safety of the public, without introducing complicated registration renewal requirements.

The use of such a trigger system is simple and easy to administer, whereas setting specific hurdle requirements for registration renewal is much more complex and difficult to administer, and may have undesirable outcomes.

We note that the March 2003 edition of the British Dental Journal has reported only 50% compliance by dentists in the GDC's statutory CPD program. This suggests that even with a staged introduction, there are serious implementation problems for mandatory schemes. What would the Board do for instance if 50% of dentists failed to meet their requirements? How would the Board's obligation to promote access to care be served by removing the right to practice for 50% of the workforce?

**POSSIBLE MODELS**

The following options seek to explore alternative approaches and the pros and cons for each, rather than respond to the specific questions posed by the Board in its discussion paper on the proposal. These options are listed in order of preference.

Option 1 Delay awaiting HPRR**Features**

- The Department of Human Services Health Practitioner Regulation Review intends to address issues of professional performance and the officer responsible for the Review advises that this will include “extending the powers of the Board” to monitor professional development undertaken.

Pros

- No decisions that might pre-empt the application of consistent performance assessment and CPD measures across all thirteen health practitioner fields.
- Avoids extra costs and effort by the Board and providers, if the Board has to change its Code as a result of the Review outcomes.

Cons

- Nil

Option 2 Monitoring Model**Features**

- Reporting of involvement in CPD e.g. as per the NSW Dental Board model.
- The Board would set minimum expected levels of participation, say 20 hours of verifiable activity for dentists and 10 hours for allied dental personnel (i.e. registered oral health providers other than dentists)
- All registered dental care providers should participate, with exemptions for students, those who have completed a qualification within the previous twelve months, and those not practising.
- No special provision should be made for part-time practitioners. They need to be just as up to date.
- Activities available to dentists to do ‘at home’ are able to be assessed and gain recognition within the ADAVB Professional Development Program. These activities include responses to Clinical Update articles and questions accompanying conference video recordings.
- Allied dental personnel may need to have access to equivalent activities – a matter for their associations and course providers to address.
- A bureau service (refer Attachment 1) could be used to assist providers in recording their participation.



Pros

- The Board is able to be actively and visibly involved in promoting and monitoring participation in CPD.
- Allows the Board to use its existing investigative powers and systems to ensure that providers are practising in a way that protects public health and safety.
- Low or non participation in CPD can be used as a trigger for an investigation which can then be tailored to the circumstances, with options including counseling, professional performance assessment, informal hearing or formal hearing, as is the case for other triggers.
- It is simple for the Board to administer, and it eliminates problems such as a provider being an hour or two below set levels, and the need for multi year cycles.

Cons

- This may not involve a reported level of participation appearing in the web version of the dental register.

Option 3 Mandatory

These comments are made without prejudice, assuming that mandatory CPD is to proceed.

Features

- A one-year cycle is considered most practical, with current membership and certification cycles working on a financial year basis. This would need to be taken into account if a declaration system was to be used by the Board. However this should not be a problem, as it is already the case with the Professional Indemnity declaration. The use of a simple declaration should mean minimal cost to the Board, if it were not performing an accreditation role. In fact the current declaration form could be modified to cover this issue, without any further cost. Using this approach, registration renewal would be the best time for the Board to affirm compliance with its mandated requirements.
- All registered dental care providers should participate, with exemptions available on application to the Board for those who have been ill, on maternity leave, overseas, etc.
- There should also be exemptions for
 - full time students;
 - those who have completed a qualification within the previous twelve months, and
 - any persons allowed to be registered as non-practising dental care providers e.g. retirees etc.
- No special provision should be made for part-time practitioners. They need to be just as up to date.



- Graded consequences should apply for failure to comply with set requirements, with a first reported failure receiving a caution and an extension of time to meet the requirements, and subsequent failures being subject to penalties of increasing severity. The simplest approach here would be to require that the shortfall be made up by the end of the following year. Failure to meet the extension could result in suspension until the points had been accumulated and satisfactory evidence presented to the Board of that completion. Third failure to achieve the required points might result in compulsory suspension for 3 months and a requirement to complete the missing points.
- If there were to be some restriction on the type of CPD to be undertaken e.g. infection control and CPR, then this may necessitate a three-year cycle just to deal with the logistics. However, such restrictions or requirements are not supported. If limited to infection control and CPR, then the former would need to be a one day course, and the latter – a certificate course. Such specific requirements would be likely to see supply meet demand, through the unnecessary creation of an “industry”.
- An alternative model is a rolling three-year cycle, with the average annual rate (say hours p.a.) over the past three-year period required to be at or above a nominated level. This is not supported however as it is more complex and does not fit the annual registration cycle.
- The PDC operated by the ADAVB and The University of Melbourne requires 25 points of recognised clinical education, plus another 5 non-clinical points to qualify. The ADAVB considers this is *best practice* and that it should **not** be set as the *minimum standard* for registered persons. Indeed 20 points (equivalent to 2 full days) should be sufficient in any one year to meet the Board’s mandatory requirements for dentists, and 10 or 15 points should be sufficient for allied dental personnel.
- The ADAVB would prefer to see greater weight attached to hands-on clinical courses, and non-Board practice audit activities, than for hotel style seminar programs. A point system is therefore preferred to a flat hours model.
- Allied dental personnel should be required to achieve fewer points than dentists given their scope of practice. If dentists are required to do at least two days of course work, then allied dental personnel should only be required to do one or one and a half days.
- Dual registered dental care providers, e.g. a person registered and practising as both a dental therapist and dental hygienist, could be required to complete a higher number of points than other auxiliaries.
- Verifiable points only should be involved. Non-verifiable points are of no value.
- Courses on other matters, such as stress management, communication etc, and those outside a provider’s scope of practice could be eligible for recognition, but perhaps with a lower point weighting.



- The only time a Board audit is likely to be required will be when a person is under investigation by the Board's investigative officer, and this too is not likely to generate additional costs. No increase in registration fee is therefore justified.
- Activities available to dentists to do 'at home' are able to be assessed and gain recognition within the ADAVB Professional Development Program. These activities include responses to Clinical Update articles and questions accompanying conference video recordings. Allied dental personnel may need to have access to equivalent activities – a matter for their associations and course providers to address.

Pros

- Dentists need only provide a statement from the ADAVB's Professional Development Program that they have been awarded a certain number of points within a designated period, or keep a record themselves proving attendance at approved courses (as may be the case for non-association members).

Cons

- If restricted to clinically recognised courses that apply directly to the scope of practice, then sufficient material is available for dentists, however this may not be the case for allied dental personnel, who will need to advise on their capacity.
- This approach lacks flexibility for dental care providers.
- Such an approach would also need to be more closely tied to registration renewal.
- The hurdle requirement is more difficult for the Board to administer than the trigger approach.

PHASED INTRODUCTION

For either of Options 2 or 3, there should be at least a two-year lead up before the requirements become fully operational – similar to the approach taken by the General Dental Council in the UK. This would allow opportunity for all registered persons to become fully aware of the pending changes and to reorient their approach to continuing education by degrees rather than requiring a sudden change. It would also allow opportunity for associated systems and processes to be designed, piloted and modified for efficiency.

**ATTACHMENT 1****POSSIBLE BUREAU SERVICE**

The Branch has held preliminary discussions with representatives of the other associations representing dental care providers, and they are favourably disposed to use of a bureau service being offered by the Branch that would permit all dental care providers – whether members of the participating associations or not, to enroll in the Professional Development Program (PDP), and so ensure that a clear record is maintained for their CPD participation.

The ADAVB has proposed a method by which members of each of the dental care provider associations would be able to have their participation in recognised courses recorded on a common database. Key features of this concept involve:

- Courses prepared by the associations able to be recognised by a central accrediting committee, with nominees from the participating associations (not involved in course design and delivery) invited to act as consultants to the committee regarding recognition of courses designed specifically for their members.
- Association members would be enrolled as participants in the PDP for a fee set according to whether the association enrolled all their members, or those members were able to elect to enroll on an individual basis.
- Enrolled participants in the PDP would be entitled to a statement of participation once or twice each year, depending on the fee paid, with such statement being used as evidence of compliance with the Board's requirements.
- These statements could be provided to the associations for distribution to their members along with their own certificates or other relevant material, if available. Alternatively, the central administrative function could undertake to provide the mailing service as a bureau.
- Non-association members wishing to enroll in the PDP could do so on an individual basis.

Requiring practitioners to keep their own records is an attractive option to many organizations because it is inexpensive (for the organization) and easy to administer. However, we believe that collective record keeping is a better system for the following reasons.

- Practitioners are already burdened by a large number of time-consuming statutory requirements for record keeping. It would be desirable not to add further to these obligations.
- The monitoring body can issue periodic reports to all practitioners, advising them of their current point or hour status. This is of great help in maintaining a satisfactory rate of attendance. In particular, a report issued, say mid-year, may warn a practitioner that extra participation is required to fulfil the quota.



- It is easier and less expensive for activity providers to send a single list of participants to the monitoring body than to issue an individual named certificate to every participant.
- Once established, the cost-per-participant of a computerized system of collective record keeping is quite low – much less than the time-cost for an individual practitioner to keep his or her own records.



ATTACHMENT 2

PDP HANDBOOK

Details regarding the ADAVB Professional Development Program

What are the aims of the Professional Development Program?

The Professional Development Program was established by the Australian Dental Association Victorian Branch Inc. with the co-operation of The School of Dental Science, University of Melbourne to:

- (1) encourage dentists to participate regularly in Continuing Dental Education (CDE) activities;
- (2) ensure excellence of such activities by means of an evaluation process; and
- (3) recognize an appropriate level of participation by the award of a Certificate of Professional Development.

Who runs the Professional Development Program?

The Program is managed by the Professional Development Committee, a standing committee of the ADAVB, comprising representatives of the Branch and the School of Dental Science.

Record keeping and day-to-day administration of the Program are handled by ADAVB staff members. Enquiries should be directed to:

Australian Dental Association Victorian Branch Inc.
PO Box 434
TOORAK VIC 3142
Tel: (03) 9826 8318 Fax: (03) 9824 1095



How does the program operate?

All graduate members of the ADAVB are automatically enrolled in the Professional Development Program.

CDE activities such as lectures and participation courses are assessed in accordance with published criteria and, if recognized as appropriate, are allocated credit points. Depending on the subject matter, CDE activities may be recognised in one of two categories – Clinical and Non-Clinical. Clinical subjects are those directly addressing the scientific or technical aspects of dental care. Non-Clinical subjects are those indirectly related to, but supportive of, dental care, such as practice management, dento-legal responsibilities and dental teaching skills. Subjects principally related to the dentist's welfare, such as practice marketing, personal finance and the mental or physical health of the dentist, are not eligible for CDE credit.

Credit points are also allocated for activities such as participation in a formal program for a higher qualification, preparation and presentation of a lecture at a recognized CDE course, and publication of a dental scientific article in a refereed journal.

Members participating in recognized activities receive the allocated number of points, which are recorded at the ADAVB office and accumulate through the program year, 1 July to 30 June. A Certificate of Professional Development is issued each year to members achieving a total of 30 or more points, of which at least 25 are in the Clinical category.

What is the procedure for assessment of a CDE activity?

Organizations planning a CDE activity directed at Victorian dentists should submit a formal **Provider Application** to the ADAVB office. Provider Application Forms are available on request and include details of the criteria by which the activity will be assessed. The application should be submitted at least 6 weeks prior to the event to allow time for assessment.

Providers must agree to forward a list of Victorian participants to the ADAVB office within 2 weeks following the activity.

Members who attend interstate or overseas CDE activities which have not been assessed should submit a **Member Application**. Member Application Forms are available from the ADAVB office and must be received no later than 31 July following the program year in which the activity took place.

Member Applications are not normally accepted for attendance at activities which should receive a Provider Application.



Provider Applications which fall within certain guidelines are processed by the office staff. Other Provider Applications and all Member Applications are assessed by the Professional Development Committee. If the activity is recognized, credit is allocated at 1, 2 or 3 points per hour, with the majority receiving 2 points per hour. A maximum of 10 points is allocated for a day's activity and a maximum of 30 points for a multi-day course or meeting.

How can country members obtain sufficient credit points?

Each month, the ADAVB Newsletter includes a Clinical Update section consisting of one or more scientific articles followed by a Clinical Update Review of 10 multiple-choice questions. Members who complete the Review and return it to the ADAVB office with a least 9 correct answers receive 2 CDE points. Members whose principal practice is more than 75 km from the GPO may include 20 points from this source in their annual quota. Metropolitan members may be credited with no more than 10 such points.

Other recognized questionnaires based on written material are available from time to time and it is planned to include internet-delivered activities in the future.

(Issued June 2001)