Ferney-Voltaire, September 28th 2002

Mr Brian Coulter
Chair, Revalidation Working Group
General Dental Council

Comments on the concept of revalidation

Dear Mr Coulter

Thank you for the invitation from GDC to comment on the draft principles for revalidation scheme in UK. Your letter was addressed to Dr Per Ake Zillén of the FDI World Dental Federation, but Dr Zillén had to step down as executive director of FDI in March this year for medical reasons. Dr Johann Barnard, who is the new executive director of FDI, forwarded your letter to undersigned for comments. I am engaged as the FDI Science Manager since 2001 and assist with enquiries related to science issues sent to the FDI head office. My ordinary position is being a professor in clinical dentistry at the University of Oslo, Norway.

These are my initial and personal comments and not representative of FDI's official view. There has not been time to consult with the various bodies within the FDI organisation for further consideration and response. However, we hope to accomplish this after the FDI world dental conference has been arranged in Vienna in October this year. We would appreciate very much to be kept informed of further developments in GDC.

FDI does not have any formal policy statements on professional continuing development. The issue has been discussed in the past in the former Commission on Dental Education and Practice. Several reports from different workgroups in this commission published in the mid-nineties may hopefully be of some value for you:

- FDI CDEP-Commission on Dental Education & Practice WG16. Chair: Sanz M. Flexibility in the dental curriculum. Int Dent J 1996; 46: 525-30
- FDI CDEP-Commission on Dental Education & Practice WG14. Chair: Stanley B. Preregistration and Postgraduate Practice Training Period. Int Dent J 1995;45:141-59
- FDI CDEP-Commission on Dental Education & Practice WG15/ Commission project 93-12. Chair: Allen DL, Caffesse RG, Bornerand M, Frame JW, Heyboer A. Participatory continuing dental education. Int Dent J 1994; 44: 511-9
- FDI Science Commission project 93-12. Chair: Allen DL. A report on compulsory continuing dental education requirements for relicensure. Int Dent J 1994; 44: 637-40

These reports represent the consensus views of the workgroup participants, and should not be considered as official FDI positions.

The Commission on Dental Education & Practice was disbanded together with other FDI commissions in 1992 and replaced by a single commission, which have focussed primarily on scientific issues. Last year this commission was renamed the Science commission, while a new commission titled the Dental Practice Commission was instituted. It is the intention of this new commission to also address postgraduate education, but nothing has evolved yet from the practice commission at such an early phase.

Regarding the text of your draft principles, some comments could be made:

a. Addressing this issue in the opening sentence as an issue of "safety for practice" sounds horrendous. I would venture that it is a question of attempting to provide UK patients with the best and up-to-date dental care, not about whether it is safe or not for patients to visit their dentist.

The term "standards" is just as ambiguous as the term "quality". What is the exact interpretation? A standard, as developed by the International Standardisation Organisation, can be a set of regulations or procedures or minimum requirements that is settled by a majority decision. If this is the interpretation you apply to this term the next question becomes - who do you envisage will be the competent authorities to agree on what is to be considered a standard – bearing in mind that you will never obtain 100 percent agreement? Will it be the faculties? health bureaucrats? GPs? laypeople?

b. The revalidation scheme is a step further from just documenting CDE participation and, as far as I know, it is unique in dentistry internationally. There is a danger that the whole validation scheme becomes in fact invalid if focus is made on measuring performance in some sort of a controlled environment. Perhaps it is easier to understand my concern if one makes an analogue to "revalidating" car drivers. You want to get rid of the ones who takes risk, break the speed limits, don't care about consequences of their actions, creates problems for others, etc. How can one these few individuals be identified with a test – or more nicely worded "assurance of competence in current performance"? The unwelcome drivers can in fact be the best performers if some sort of driving test, or evasive action manoeuvre or whatever other clever test one may concoct.

Thus, I have a general problem with accepting that competency in performance in dentistry can be measured by testing, even if using a battery of tests for, e.g. manual dexterity, diagnostic detection performance, communication skills, accounting or whatever other tests one may invent. I would venture that a competent dentists is one that provide the appropriate therapy on the basis of a correct diagnosis according to the patient's needs. This is a question of attitude and not easily measurable by testing. When you write: "… competence in fields in which a dentist practice" I understand this as possessing the knowledge to prevent, diagnose and treat oral diseases. There is a danger to equal competence with demonstration of technical dexterity or a knowledge test, just because this is

something measurable. However this does not necessarily provide better dental care, and I assume that is really what this whole question is about?

Perhaps a more appropriate approach is to base a revalidation scheme on a reporting system that allows the public to complain about provided treatments? One scheme can be to advise (or even mandate) all dentists to have pre-addressed, pre-stamped cards available in their waiting rooms and promote publicly nationwide that all patients are invited to provide feedback on what they perceive as inadequate dental treatment. A systematic appraisal of frequency and the nature of all complaints by e.g. peer examiners may lead to identification of professionals with undesirable performance.

c. Again the use of the dreadful term “safe” is applied, this time in context with “limit practice to areas they are safe”. It is a question of whether the dentist feels that he or she is competent or not and whether adequate training has been obtained or not.

d. The description “local remedial measures” sounds a little ominous. Should it perhaps be replaced with professional support?

f. The reference to the “local quality assurance mechanisms” in various institutions is interesting, as this infers that a revalidation system already seems to be present. It is noteworthy to scrutinize the website of BMA and note the lack of enthusiasm for the revalidation concept for physicians. It will be interesting to see what happens four years from now when the first five-year appraisal period is completed and time comes that the actual revalidation will be carried out. I am not at all convinced that this will be carried out without problems. I am therefore surprised that GDC seems to have embraced this revalidation concept at such an early stage without observing how this develops first in the medicine community.

Perhaps it would be an idea to try out the revalidation concept and principles in a forum that seemingly would be receptive to such scheme? I’m specifically thinking of one or more of the dental speciality associations. I am aware that the public dental health dentists in UK regularly needs to document their accomplishments to retain their speciality, but I have the understanding that this is mainly a documentation of CDE courses, eventual papers written etc. This group may be more receptive for what you refer to as “demonstrate that he or she is fit to practice (public health) dentistry”. The experience gained would perhaps provide insight how this could then be applied – if conceived possible – to the full dentistry community.

I can fully understand the desirability of “revalidation should be kept as simple as possible.” Unfortunately I don’t think this ever will be the case. It is not unreasonable to assume that any dentist who stands at risk to fail revalidation will invoke any kind of legal support, as well as research backing, to challenge a decision, justifiable or not. The longer they have practiced, the harder they will

contest a decision, because it will develop into a fundamental personal question of their value as a professional in society.

Anyone who have attempted to clarify the evidence-base for what is being practiced in dentistry know how little is actually scientifically based, and it is not difficult to find “research” that will support specific beliefs. One may just mention amalgam, fluoride uses, local antibiotics for periodontitis, hyperbaric oxygen treatment, infection control measures, temporomandibular dysfunction, etc., etc. A parallel to this is the arguments that have been raised in the ongoing discussion in the letter section of the Journal of the American Dental Association about the US state boards system. The appointed GP’s in these boards seems often to apply consensus and empirical based principles for certification of candidates rather than what are sound principles based on evidence-based research learned in dental schools, e.g. drill-fill vs. watchful control of caries lesions.

In medical history it is not difficult to demonstrate that medical authorities repeatedly have erred in rulings and advocacies when challenged. Bearing this in mind, one needs to be humble when questioning colleagues who on the basis of their practice may not share “established” practice codes. These are, after all, usually only based on consensus and majority resolutions and not on validated research.

There will be a need to organise a legal entity that may occasionally end up to defend a decision in court, as well as a unit of scientists that will have the tough task to demerit the basis for a potential colleague’s beliefs, perhaps also in a court. This will of course incur costs to the revalidation system.

g. It is assumed that the two acronyms CPD and PDC mean Continuing Professional Development and Professionals Complementary to Dentistry. It would help to have this explained in the text.

I hope my comments may be constructive for your further endeavour with the revalidation scheme. This is a preliminary response and is not the official view of FDI, as there has not been an opportunity for wide consultation yet. Your letter and my initial response will be submitted to our Dental Practice Commission for consideration and actions. We would appreciate to be kept informed of your progress and look forward to participate in this debate. In due course I hope we can submit the FDI’s official views on this issue to you.

Thank you

Asbjorn Jokstad
FDI Science Manager

Copy: British Dental Association