Acknowledgments :
the Board
the WG members , & Monika Lang

Education Working Group :Equivalence

- Total Number of NDAs; 38
- Answers ; 24 = 63%
- National dentists registered ;316.417.
- Dentists ERO member ;207.330
- 66% [63% from 66%]

* Hours per Year:

10 to 90 hours

Average =50 % 40 to 60

* Sanctions : No 75 %
  Yes 25% .

* Evaluation : Yes 33 %
  No 67 %

Education Working group

- Who is responsible
- Committees/ Institutions
- 30 %
- NDAs 20 %
- Faculties 10 %
- Commercial/others
- 40 %

- E-learning 8 %
- Number of Years
- Required 4-6 year

Answers to Questionnaires 2005-2013

2005	Voluntary Mandatory	38	34	89 %
2010	Evolution	43	37	86 %
2011	Relationship # 1 NDAs	41	21	51 %
2012	Relationship # 2 Faculties	173	62	35 %
2013	Equivalency	38	24	58 %

WG Quality : NDAs Participation 39.2 %

Consequences & Guidelines

* Decrease of the answers : 39 % □
* Questionnaires not completely fulfilled □
* Confederal System : □

Discrepancy between NDAs and number of □

number of Dentists represented. □

Differences between Dentists member of a NDA □

and the total number of dentist in the country □

Number of Dentists member of NDAs and Registered Dentists

Dentists NDAs		Registered	Percentage %
Italy AIO	7.053	59.618	
ANDI	23.043 = 30.096		50%
France	30.098	40.968	73 %
Czech Republic	7574	10.381	72 %

DATA : from the ERO and the FDI

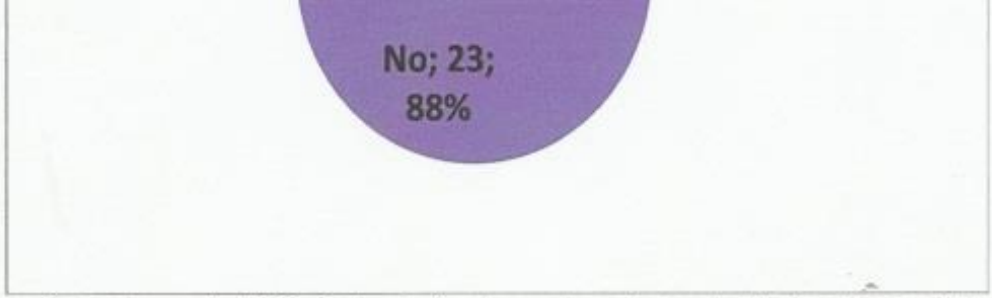
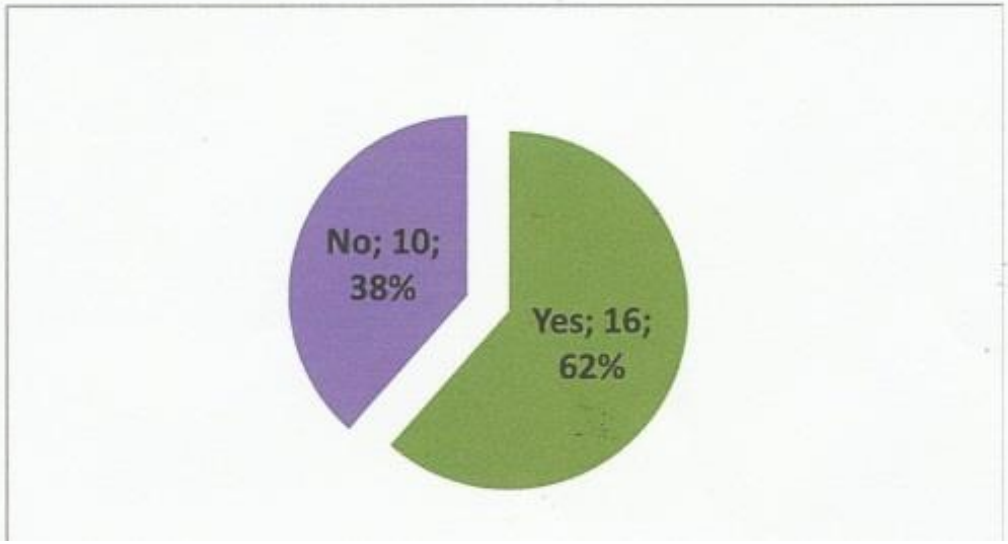


Figure 3. Involvement of NDAs in developing the undergraduate dental education curriculum.



We should relate to the number of Dentists

Only 63 % of answers ; participation of NDAs in CE 62 %; 62 % of 63 %

in total = 39 %

The Georgian experience

Prof. V Margelashvili , Prof. Alex Mersel

Before the Lecture Motivation	**The LECTURER**	**The Topic**	**The Accreditation**
2010 Batumi	23 %	72 %	5 %
2011 Tbilisi	11 %	87 %	2 %
2012 Tbilisi	64 %	77 %	1 %
Evaluation in Cont.Education	Questionnaire Management		

Evaluation after the lecture : Satisfaction

	Presentation	Application	Question Answers	Facilities
2010 Batumi	39 %	60 %	68 %	51 %
2011 Tbilisi	59 %	36 %	52 %	68 %
2012 Tbilisi	77 %	65 %	67 %	78 %

A new approach in continuing Education

by Prof. Alex Mersel, Prof. Jonathan Mann and Dr. Yuval Vered

A new approach in continuing education

Introduction

The dental team consists of five various professions-disciplines; the dentist, the dental hygienist, the dental assistant, the dental technician and the dental supplier.

Any information provided to one of these five entities will elevate the level of all the team. Hence, it is of superior importance to invest in upgrading the knowledge of these components in the pyramid defined as dentistry.

The knowledge could be and should be provided through various continuing education methods; frontal lectures, professional meetings, internet, hands on courses, literature review etc.

Most of the developed countries who see the importance of knowledge upgrade, and do not believe that the majority of health providers will join continuing education courses voluntarily, request a certain level of credit points in order to be able to re-license a work permit. Yet, some countries have no system for re-licensing or continuing education. Some of these countries do not require/enforce this for political difficulties based on the relationship between the Dental Association and the Ministry of health. [1]

In Israel, for example, the Dental Association offers courses. Accumulation of a certain number of C.E. points will credit the participant with an updated verified certificate. Yet, only a minor percentage of dentists become "updated" since this is a voluntary system. On the other hand the Israeli Medical Association (IMA) has no obligation for its members to take C.E. courses or re-licensing, hence, the Israeli Dental Association (IDA) follows this direction. Only following the IMA will the IDA start thinking about implementing such a system, more over, the relationship between the IDA and the ministry of health will always be a major obstacle for a C.E. program which is becoming a necessity, especially today, when the bank of data is changing dramatically and increasing steadily. [2, 3, 4, 5]

Because of the various changes in dentistry, dental materials, sterilising procedures, new methods of treatment and many other components which are part of dentistry/medicine have followed through. All of the above leads to a definite conclusion. C.E. should be compulsory. [6]

In an editorial by Dr. Glick in JADA [12] the two different proficiency-education and training were discussed, as necessary tools to provide oral health care.

"Knowledge and technology are emerging at an unprecedented, speed, and access to information has never been easier". The debate is both regarding undergraduate students and all other care givers.

Over and above the questions mentioned, an additional financial aspect is raised. Who will pay for continuing education provided; the provider, the government, the dental association?

So, four dilemmas have been raised in this introduction;

- Continuing education; Compulsory or voluntary.
- What balance should be provided in C.E. – art and science?
- How does one solve political issues involved?
- Who would cover expenses?

It seems as if the first two dilemmas are international and the other two local problems are more of administrative issues and less of basic and fundamental issues.

Those countries considered to be "advanced" should and do have continuing education as an obligation, mainly for the well being of the public. We could look at those countries that have no mandatory C.E. and no matter what the reasons are "third world countries", in order to enforce it, C.E. and re-licensing should be, inter-dependent. [7, 8, 9 10]

Each country providing C.E. should provide it in a mix suitable for servicing the population in that country. Some would put more emphasis on art, others would put further emphasis on science; clinical versus knowledge. [11]

Is there a way to bridge over the gap of politics -any way to join forces between dental associations to a ministry? We believe such a bridge is extremely important and could be done by developing an interim entity in which representatives from all organisations involved take part in, this should be forced by by-laws or any other channel which would push our profession to a better and more advanced future. [13, 14, 15]

One of the major concerns with C.E. courses is its efficacy. Not only the relevance of these courses to the provider, but also its efficiency as a tool for promoting C.E. If we have a suggested evaluation method, should it be

used prior to the course, prior and post, or only post? What are the limitations of the evaluation? What aspects do we wish to evaluate? [16]

This evaluation has to be considered, based on our major target on C.E. courses – the transmission and the upgrade of the knowledge and skill of the practitioners.

Materials and methods

In order to evaluate the importance and the effect of a new evaluation system for C.E. courses, two questionnaires were tested.

The first was the classic questionnaire which has been used by various lecturers and providers, one which each participant was asked to fill, following the course/lecture with no introductions. This includes questions dealing with the program content, quality of lecturer, handouts, visual aids and training venue, in addition to an over all satisfaction, usually, having the space also for written comments. The classic evaluation was used for improvements and changes. The "new" suggested evaluation method is based on a pre course questionnaire which is mandatory to fill prior to the lecture which includes questions such as; the reason you are participating in the course – lecturer, topic, accreditation. Expectations - what are the main points the participant wishes to acquire in participating during the course; Basic knowledge on clinical procedures, laboratory and what does the participant see as the main topic he would like the lecturer to put emphasize on.

Following the course the participant had to fill a second evaluation form similar to what we defined as "classic". This includes program content, the lecturer, and the venue.

Filling the first form in the new system necessitates the participant to think about his expectations.

In order to see if any differences were found between the two systems, two C.E. programs were organized and taught by one of the authors. One course had 107 participants in which the classic evaluation was used and in the second who had 73 participants, the new approach was used.

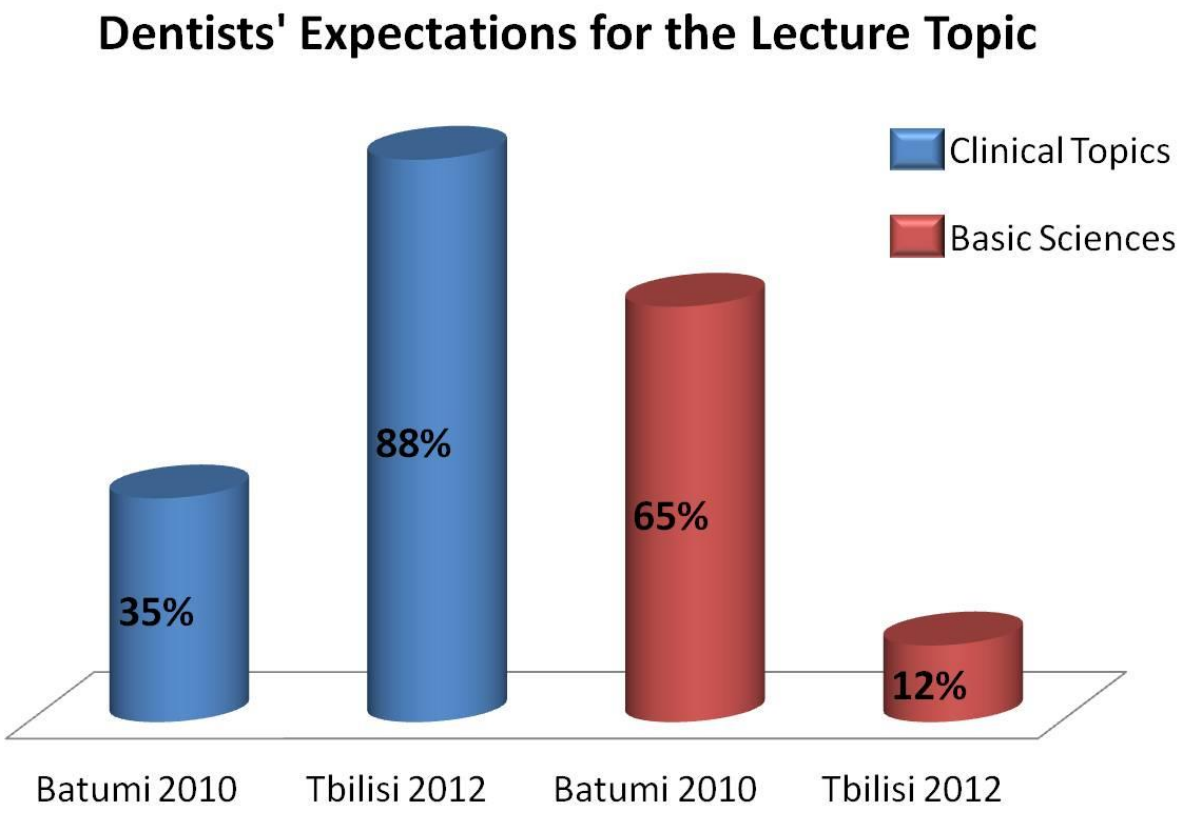
Results

Results were presented by percentages of satisfaction when mainly descriptive information was provided.

It seems as if most variables were high, excluding the actual benefit from a course; did it provide me with any tools (72%) and did it add any knowledge to my pool of knowledge (76%).

The participant's main reason to attend the course was the topic. The clinical application had also a relatively high

Results of new comprehensive approach



Thank You !

A new evaluation approach in Cont- Educ

Article

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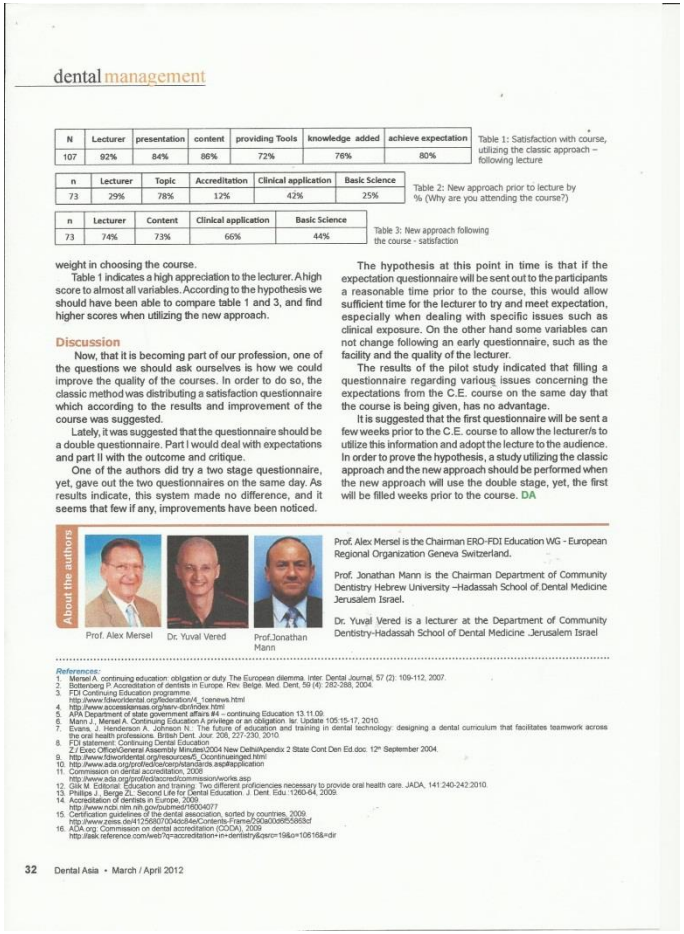
Dental Tribune -Asia



dental management

N	Lecturer	presentation	content	providing Tools	knowledge added	achieve expectation
107	92%	84%	86%	72%	78%	80%

Table 1: Satisfaction with course, utilizing the classic approach – following lecture

n	Lecturer	Topic	Accreditation	Clinical application	Basic Science
73	29%	78%	12%	42%	25%

Table 2: New approach prior to lecture by % (Why are you attending the course?)

n	Lecturer	Content	Clinical application	Basic Science
73	74%	73%	66%	44%

Table 3: New approach following the course - satisfaction

weight in choosing the course.

Table 1 indicates a high appreciation to the lecturer. A high score to almost all variables. According to the hypothesis we should have been able to compare table 1 and 3, and find higher scores when utilizing the new approach.

Discussion

Now, that it is becoming part of our profession, one of the questions we should ask ourselves is how we could improve the quality of the courses. In order to do so, the classic method was distributing a satisfaction questionnaire which according to the results and improvement of the course was suggested.

Lately, it was suggested that the questionnaire should be a double questionnaire. Part I would deal with expectations and part II with the outcome and critique.

One of the authors did try a two stage questionnaire, yet, gave out the two questionnaires on the same day. As results indicate, this system made no difference, and it seems that few if any, improvements have been noticed.

The hypothesis at this point in time is that if the expectation questionnaire will be sent out to the participants a reasonable time prior to the course, this would allow sufficient time for the lecturer to try and meet expectation, especially when dealing with specific issues such as clinical exposure. On the other hand some variables can not change following an early questionnaire, such as the facility and the quality of the lecturer.

The results of the pilot study indicated that filling a questionnaire regarding various issues concerning the expectations from the C.E. course on the same day that the course is being given, has no advantage.

It is suggested that the first questionnaire will be sent a few weeks prior to the C.E. course to allow the lecturer/s to utilize this information and adopt the lecture to the audience. In order to prove the hypothesis, a study utilizing the classic approach and the new approach should be performed when the new approach will use the double stage, yet, the first will be filled weeks prior to the course. DA

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