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ABSTRACT

Once the need for continuing learning in professional fields was acknowledged, the idea of voluntary learning evolved into a requirement for mandatory continuing education (MCE) in many professions. Despite the variation among professions and individual states' policies, MCE for professionals is a well-entrenched fact of life for many practitioners in a variety of fields. Major factors in the growth of MCE have been protecting the public welfare and public accountability. The concept of MCE is at direct odds with two primary assumptions of adult learning theory: participants want to be there and program quality is ensured by participants' "votes." Although these objections might be characterized as "philosophical," questioning the foundations upon which a mandatory system rests, more practical limitations have been pointed out. Major arguments against the mandatory nature of continuing professional education involve its effectiveness and the ability to document that students learn by participating. Significant, measurable changes in professionals' methods of practice and/or clients' status have not been documented. Alternatives have been proposed, each with advantages and disadvantages--periodic testing, peer review process, certification programs, education of consumers, modeling by top pros, associations' requirements, self assessment, and reeducation. The specific case of MCE for licensed social workers in Massachusetts points to a crucial need for an evaluation of the effectiveness of mandatory MCE. (Contains 95 references.) (YLB)

THE QUESTION OF MANDATORY CONTINUING EDUCATION FOR PROFESSIONALS

QUALIFYING PAPER
SUBMITTED BY

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NOVEMBER, 1989

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Introduction

The once-prevalent concept that a "professional" person completes their education and is then allowed to practice that vocation "for life" is gone forever. Due to a variety of factors that will be discussed and reviewed in this paper, it has become clear both to professional practitioners and the publics they serve that the education and training a person receives to enter a profession is not enough to sustain the continued competent practice of that profession ten, twenty, or even as little as two or three years following the acquisition of what is mistakenly referred to as the "terminal degree." In virtually any profession under discussion, there is little or no disagreement with this basic idea.

There is, however, a major disagreement that surrounds the concept of continuing professional education. The issue basically involves whether continuing education, which is generally acknowledged to be an important and vital component of good professional practice, should be *voluntary* or *mandatory*. Should professional practitioners be allowed to "stay current" and increase their level of knowledge and skills on their own, without mandate from entities like professional associations or state legislatures? Would the public be better served if practitioners were required to

partake of periodic continuing education activities? These are some of the questions and issues concerning the subject of continuing professional education which, in many cases, remain unanswered.

This paper will discuss these and several other issues related to the topic of continuing professional education (CPE), including the general need for CPE, the historical development of continuing education in selected fields, mandatory versus voluntary CPE, and the effectiveness and evaluation of these types of educational activities. The specific case of continuing professional education for licensed social workers in the state of Massachusetts will also be used as an illustrative example of one particular group of professional practitioners.

Historical Aspects of Continuing Professional Education

The Need for Continuing Education in the Professions

The past three decades have seen a dramatic proliferation of formal continuing education for professionals, with few, if any, professions unaffected by this phenomenon (Kenny, 1985). Although recent trends point to the possibility that the rate of growth in CPE may have slowed considerably (Rockhill, 1983), with the major "explosion" in CPE occurring in the late 1970s and early 1980s, it is important to understand exactly what this type of specialized learning encompasses, and what some of its causes have been.

First, some definitions may be in order. Historically, there has often been a difference in status associated with how a person's livelihood is defined. To many people, a *profession* connotes a higher status than an *occupation*. However, Webster defines an occupation as "a means of filling one's time; regular employment; a job" and a profession as "a vocation," which is defined as "a particular profession, business, or occupation." In effect, then, these two concepts are equal. Queeney (1984) noted that there is still a distinction, in some circles, between the notions of an occupation and a profession, but that this particular distinction should not be considered to be an important one. The idea that Queeney emphasized, and which will also be utilized in this paper, is a broader view of the term "profession"--those fields that rely on some kind of higher

education for initial entry. Thus, in addition to the more traditional professions of law, medicine, and the clergy, other vocations such as teaching, social work, allied health, business specialities, certain technical fields, and many other jobs will be under discussion here.

It is extremely important to recognize the difference between continuing education, in general, and the much more specialized continuing professional education. A very basic description of continuing education in the professions was offered by Vicere (1985), who stated that "continuing education may be defined as educational programming geared to the practicing professional adult" (p. 229). Andrews (1984) offered the following definition in his treatment of continuing education practices:

> A generally accepted purpose of continuing education programs/activities is to help maintain, expand, and improve individual knowledge, skills (performance), and attitude and, by so doing, equally meet the improvement and advancement of individuals, professions, and organizations (p. 3).

Lowenthal, in his 1981 discussion of CPE, noted some purposes he saw for this specialized type of education:

> Continuing education for professionals may be defined as educational training beyond the basic professional degree of license....Continuing education is meant not only to correct outdated information and impart new skills and knowledge,

but it can also help professionals apply knowledge and skills they already had or once knew (p. 519).

This latter definition addresses two very specific needs related to continuing professional education: (1) the more obvious need for professionals to "keep up" with the myriad of new information and technology which may impact on their practice and (2) the need to integrate and apply knowledge and skills, which were often conveyed in a theoretical manner or in a classroom setting, with real-world practice situations. These two components of professional continuing education are the core around which the entire system revolves.

Maintaining professional competence. Regarding the need for professionals to continually update their initial complement of skills and knowledge, the notion of "professional obsolescence"[1] is an important concept. It has been estimated that, depending upon the specific profession in question, one's "professional half-life" (i.e. the time at which *half* of what one originally learned is either forgotten or is no longer valid due to more recent developments in the profession) can be as little as two to five years[2] (Ferrell, 1988; Dubin, 1972). The quality of service rendered by a professional who does not continually keep up with his or her

[1] See Knox (1979b), Livneh (1988), and Dubin (1972, 1974) among others, for more on this concept.

[2] The onset of obsolescence appears to have hastened over time. Ferrell's 1988 estimate of nurses' half-life was 2 - 5 years; in 1972, Dubin had estimated the half-life for physicians to be 5 years, 5 years for engineers (down from 12 years for a 1940 engineering graduate), and 10-12 years for psychologists.

field after getting their degree is subject to question. This is probably the single most crucial factor in support of professionals' need to constantly maintain their knowledge and skills, regardless of the field in which they practice.

Along these same lines, Lauffer (1977) maintained that there is no such thing as a terminal degree anymore. Education in a profession continues well beyond the point of initial entry, and should continue for as long as the person is practicing. "Professional education and the professional degree are no longer coterminous....The more technical the requirements for professional practice, the more technical are the qualifications for participation and employment within it" (p. xiv).

Jarvis (1983) brought up the question as to how professions should be viewed--as a lifetime privilege or as a limited time appointment. Without requiring evidence that the practitioner has continued to acquire important knowledge and skills, the latter viewpoint may be a more appropriate model. One need only look at the medical profession, for example, to see instances of this phenomenon. Physicians today are expected to diagnose and treat diseases and disorders that were not even catalogued when most of them attended medical school. AIDS, Seasonal Affective Disorder, and Legionnaires Disease are a few commonly known examples of these "new" afflictions; there are certainly countless others that have not been publicized in the popular press and media.

Knox (1979b) categorized the idea of professional obsolescence into two causal areas: (1) individually-oriented influences and (2) situational influences. See Table 1 (on the following page) for a brief outline of the reasons Knox gave for the phenomenon of professional obsolescence.

The concepts of competence and incompetence, closely related to the idea of professional obsolescence, also play a role in the discussion of the need for professionals to remain current in their field. Competence, as defined by Edwards and Green (1983), is seen as "the constellation of knowledge, skills, values, and attitudes of an individual that is based on a set of criteria or on a level of expectation;...demonstrated proficiency" (p. 44). Bushman, in a 1979 study of professional incompetence, described how lawyers can lose their effectiveness. The following four factors were cited: (1) knowledge from schools is forgotten, skills decline, and attitudes deteriorate over time; (2) knowledge and skills become useless through obsolescence; (3) some services required by lawyers' clients require knowledge, skills, and attitudes the lawyer never had; and (4) new information, skills, and attitudes have emerged. Although the study specifically focused on those in the law profession, these factors are similar to Knox's findings and could easily apply to other professionals, as well.

Table 1

Causes & Contributing Factors of Professional Obsolescence[3]

Individual Influences	Situational Influences
- may never have been proficient - never received the necessary professional experience to become proficient - forgot - occupational life cycle (getting new jobs, positions, etc.) - lack of practice within specific areas of proficiency - ethical violations - lack of peer interaction - no self-motivation to increase proficiency - no achievement motivation - low level of problem-solving ability or action	- new knowledge is created - shifts in client expectations - changes in acceptable "best practices" - changes in societal expectations - influences by other professions - encouragement from one's own profession - organizational climate or work factors - work enrichment activities - staff and organizational development - counseling/career planning

Theory vs. practice - Integration and application. While the previous discussions relate to the somewhat obvious need for professionals to "keep up," Lowenthal (1981) had also mentioned a second component of CPE--professionals' need to integrate and apply pre-service knowledge in their practice. Schein, in a 1972 book on professional education, discussed a "postgraduate approach" as being not only desirable, but necessary for professionals. According to

[3] Table is adapted from Knox's (1979b) "The Nature and Causes of Professional Obsolescence."

Schein, it is not until after professionals are already in practice that they can even see the relevance of the study of certain topics. (From my own personal experience as an educator, this phenomenon is quite clear to me. One of the required courses I teach in an undergraduate social work program, "Policy Analysis," is often met with some resistance on the part of students. Yet, once they begin their fieldwork experience or graduate from the program and begin working, I often hear from these same resistant students that the course content does have utility for them. Many of us, as students ourselves, can remember going through a similar process with subjects we were required to take.) It is also only after being in practice that the professional acquires an optimal level of a pure motivation to learn, according to Schein.

Lowenthal (1981) also noted that, with the professional knowledge base constantly growing, the formal educational process cannot be expected to cover all that needs to be addressed. On-the-job training, some of which can be considered to be CPE, is also needed, in his opinion. While this two-tiered model may seem to be an irrefutable concept, Jones (1968) did raise a question for others to answer regarding exactly what it is that distinguishes out-of-date professionals from new graduates--is it a lack of new knowledge, or a loss of basic knowledge?

Regardless of the answer to the previous question (whether one believes it is a lack of new knowledge, a loss

of basic knowledge, or a combination of the two), the need for continuing education for professionals is clear. Let us now examine some of the responses that have been offered to address this need.

Evolution of Continuing Professional Education

Until continuing professional education became mandatory for some professions (a topic which will be discussed later in this paper), it is difficult to accurately trace the evolution of the CPE concept. Continuing professional education initially existed in a voluntary manner, which eventually led to it becoming mandatory at a later date, after the idea became more popular and accepted. The first instance of mandatory continuing education in a given profession can be found in the field of medicine where, in 1879, physicians in several states had to update their knowledge in order to get relicensed (Edwards & Green, 1983). Therefore, continuing professional education is not the "new idea" that many think it is. Overall, however, Brown and Uhl (1970) reported that there was not much concern with post-graduate medical education until approximately 1960.

Still, the fields of medicine and other health-related vocations were among the first to establish programs in continuing education. Continuing education in dentistry, for example, started gaining importance with some very basic "refresher courses" after World War II. Those basic programs, intended to reorient dentists after they returned from the service, have evolved into a very complex system of

continuing dental education today. All CPE in dentistry was offered on a voluntary basis until 1969 (Kress, 1979).

The Move Toward Mandatory Continuing Professional Education

Professional associations and state authorities. Having seen the need for continuing learning in professional fields, it was probably only a matter of time before the idea of voluntary learning would evolve into a requirement for mandatory continuing education in many professions. Yet there appear to be many more factors involved in this movement than the simple notion of taking what seemed like a "good idea" for some and making it apply to all.

For instance, using dentistry as an example, it was previously noted that 1969 marked the first instance of mandatory CPE in that field. By 1977, only eight years later, 18 states had requirements for mandatory continuing dental education, either by governmental licensing mechanisms or by the rules of state chapters of professional dental societies (Kress, 1979), and a total of 15 states impose similar requirements on dentists (and dental hygienists) today (Phillips, 1988).

The experience of physicians followed a similar path just a few years earlier. In 1967-68, the Oregon Medical Association was the first to propose a system of mandatory CPE for doctors. They initiated a voluntary "phase-in" period in 1969, which became mandatory for all Oregon physicians in 1970 (Pennington, 1970). One of the prime factors behind this development was to have a doctor "realize

[the] public responsibility of a professional to maintain his [sic] skills at the optimum level" (p. 1660). Pennington also discussed some other motivating factors behind the Oregon society's plan, including the "unsettling" discussions about various state and federal government proposals regarding licensing schemes. A profession-based system, developed and implemented by one's peers, was seen as a much more acceptable alternative to government regulation. Following Oregon, New Mexico physicians came under a mandatory continuing education system in 1971 (Rockhill, 1983) and by 1988, 28 states had imposed mandatory continuing education requirements on doctors under their jurisdiction (Phillips, 1988).

Other professional groups followed similar paths. In 1971, the American Institute of Certified Public Accountants, a national professional association for CPAs, urged each state to impose a legislative or regulatory requirement for continuing education programs for their profession (Beamer, 1972). Today, only three states do not require mandatory continuing education for CPAs (Phillips, 1988).

California and Kansas became the first two states for mandatory continuing legal education. In 1971 and 1972, those two states asked their respective state professional associations to implement a system requiring continuing education (Wolkin, 1975). This model, having a professional association as either the primary force behind a mandatory continuing education requirement or as the administrative

body responsible for implementing it, is not an uncommon one. There is an obvious self-interest involved. According to Lauffer (1977), the involvement of a professional association is seen "as a way of protecting the profession's claim to mandate and as one way of increasing or maintaining the competence of its members" (p. 7). This manner of "self-regulation" by those within one's profession also avoids the less desirable alternative of government regulation that was previously mentioned.

Lawyers in Minnesota were the first to have a mandatory continuing education requirement imposed upon them by a state (Heidenreich, 1976; Austern, 1987). It is interesting to note that this requirement, effective in 1975, was challenged in court by lawyers on the basis of the 13th Amendment prohibiting "involuntary servitude," among other claims. (This state requirement was ultimately upheld as being Constitutional.) By 1988, a total of 31 states required continuing professional education for their lawyers, with an additional nine states considering imposing similar requirements in the near future (Phillips, 1988).

All of these "firsts" have spread throughout the states and there is presently some form of mandatory continuing education for professionals in every state and the District of Columbia. Phillips, who has been annually surveying the states on their requirements for 16 different professions[4],

[4] Phillips' list of professions surveyed includes licensed architects, accountants, dentists, engineers, lawyers, registered nurses, nursing

found that, in 1988, the state of Iowa had mandatory continuing education requirements for all of its licensed professionals. Phillips named Florida, Kansas, Minnesota, Nevada, and New Mexico as states with mandatory requirements for the next highest number of professions (all having 14 of the 16 professions surveyed under mandatory requirements), and Hawaii, New York, and Wisconsin as the states with the lowest number of professions under mandatory requirements (only four or fewer professions).

As an example of how four selected professions have progressed over a period of nine years in 51 jurisdictions (all states plus the District of Columbia), see Table 2.

Table 2

Number of States Requiring Mandatory Continuing Education

	1979[a]	1986[b]	1988[c]
Architects	2	1	7
CPAs	28	47	48
Physicians	24	23	28
Social workers	10	19	30

Note. "States" includes the District of Columbia.

[a] From Chronicle of Higher Education, 9/4/79.

[b] From Chronicle of Higher Education, 5/21/86.

[c] From Phillips (1988).

home administrators, optometrists, psychologists, pharmacists, physical therapists, physicians, realtors, social workers, licensed practical nurses, and veterinarians.

Even though there is variation among both the professions themselves and the individual states' policies, mandatory continuing education (MCE) for professionals is a well-entrenched fact of life for many practitioners in a variety of fields. Let us now examine some of the influences and contributing factors that led to the growth of MCE programs.

Reasons for growth in mandatory requirements. In 1972, a report by Insel, Hoggard, and Robinson on a survey of members representing seven different licensed professions[5] in California contained the following conclusion:

> Due to the impact of the knowledge explosion in all disciplines during the past two decades, major changes have occurred in professional services. The desire to protect the public welfare by insuring quality delivery of professional services has generated interest in ascertaining ways in which professionals might keep abreast of the latest developments in their fields (p. 1).

This quote highlights one of the important contributing causes for the growth in mandatory professional continuing education--protecting the public welfare. The desire to protect the public welfare stems from the fact, mentioned earlier, that things simply change too quickly in any

[5] This survey included civil engineers, insurance agents, licensed vocational nurses, psychologists, real estate agents, registered nurses, and pharmacists.

profession. Again, the issue of competence, and making certain that the public is getting the best possible services, is key. This theme is found in the discussion of this subject by other researchers, also. New techniques in a given field (the so-called knowledge explosion) and public accountability were also cited by Queeney (1984) as reasons for the growth in mandatory continuing education. Queeney also mentioned the fact that, since professionals tend to be relatively autonomous with a basic lack of central control, they may come under increasing public scrutiny due to incompetence within the profession.

Lowenthal (1981) also saw public accountability as a major factor in the growth of mandatory continuing education, with state legislatures, increases in the number of malpractice suits, and regulations instituted by consumer agencies and organizations also playing important roles. Another factor on which Lowenthal commented was what he saw as a growing gap between the public's expectations and what the members of a professional community can actually deliver. This theme was echoed by Rockhill (1981), who attributed increased demands for professional accountability not as much to a decline in professionals' performance as to increased expectations of a more educated and vocal public. The consumer movement, she suggested, also led to the public trying to regain control of professionals' services.

Urbano, Jahns, and Urbano (1988), discussing nursing continuing education, noted that

> the need to assure the public of continued professional competence seems to be of primary importance to proponents who regard legislation for mandatory participation in educational activities as a vehicle for encouraging such competence (p. 38).

Some of these questions regarding the competence of professionals were raised by the public, consumer groups, government bodies, legislators, and even the professionals themselves (Edwards & Green, 1983). This latter factor led to the development of CPE standards by many professional organizations, with membership admission and continued affiliation being based upon the members' participating in approved continuing education activities.

Licensing - The states take over. Government got involved when the consumer movement, which gained prominence during the 1970s, contributed to a desire on the part of state legislatures to protect the public interest. In many states and for many professions, the legislative response to the consumer movement was to extend the concept of consumer protection beyond goods and to also include professional services. The rise of consumerism was a major reason there was a growing movement toward mandatory CPE (Wolkin, 1975). The public demanded it, and the professions saw mandatory continuing education as a type of "defensive action" to protect their members against malpractice claims and other legal action that questioned their competence. The

malpractice problem had been growing, and the number of lawsuits filed against professionals still continues to rise. Physicians, for example, have been faced with dramatic increases in the number of lawsuits filed against them, the size of the jury awards, and the cost of malpractice insurance, according to the American Medical Association. An AMA survey found that the percentage of doctors facing lawsuits went from 12% in 1979 to 20% in 1985, and the number of claims filed against physicians increased threefold between 1975 and 1985 (Staff, 1985). The situation reached a critical stage recently when the U.S. Department of Health and Human Services announced the creation of a special national data bank for physicians, nurses, and other licensed health professionals. The National Practitioner Data Bank, which will not be accessible to the public, will track "misbehaving" health professionals who move from one geographic area to another and have had some type of disciplinary action taken against them by hospitals, courts, licensing boards, professional associations, peer review committees, and insurers (Staff, 1989).

The medical profession is not alone in this phenomenon of an increasing incidence of malpractice claims. A 1986 national survey by the American Bar Association broke down lawyers' malpractice cases onto the following categories: substantive errors on the part of the attorney (44%); administrative errors, e.g., missing filing deadlines, etc. (26%); errors in client relations (16%); intentional errors

by the attorney (12%); and other or not available (2%). An organization that specializes in this field, the Legal Malpractice Institute, estimated that one out of ten lawyers themselves were sued in 1988, compared with only one out of 50 lawyers in 1980. According to Institute executives, this increase in the incidence of legal malpractice claims is a reflection of the explosion of litigation in all professions. People today are concerned about the duties that professionals owe them, and professionals are now seen as ordinary, fallible people (Berzok, 1988).

Churches and members of the clergy are also the subjects of this growing malpractice problem. Formerly protected by their status as charitable institutions, this exemption from lawsuits has now been taken away in all but a few states. Since World War II, there has been a significant shift in the public's attitude toward churches and ministers. The public, who used to be awed by the religious authority of these institutions and individuals, has now begun to hold churches legally responsible for the actions of its representatives (Schaffer, 1988).

It must be noted that, in most cases, professions have not been "forced" into a mandatory continuing education system. On the contrary, most state laws and regulations are the result of lobbying and advocating by the professionals themselves. By demonstrating that they were "keeping up," professionals could use their participation in continuing education as evidence of their own competence.

The main method that states have used to impose a mandatory continuing education requirement on professionals is that of relicensing. In order to renew a license to practice in a given profession, the practitioner must usually attest to and/or provide documentation that he or she has fulfilled the necessary educational requirements since the last licensing cycle. Linking the continuing education requirement to the renewal of the professional's license to practice has become a very common way of enforcing mandatory CPE in recent years. "Although some argue that participation in CE [continuing education] programs does not guarantee competence, more and more states are making CE mandatory for relicensure of a variety of professionals" (Stetson, 1980, p. 89). This theme will be addressed in more detail later in this paper.

Jaschik (1986) noted that all professions experienced a pronounced increase in the growth of mandatory continuing education in the 1970s. This overall trend appeared to slow down in the early 1980s (although the professions of accounting, pharmacy, law, and real estate had the biggest rates of growth in this time period), but started to rise again more recently in many areas. According to Cross and McCarten (1984), "With the increased emphasis on relicensing in the professions, the continuing education of professionals is becoming compulsory" (p. 25). In 1984 alone, there was an average growth of over 25% in the number of states requiring

mandatory continuing education for various professions (Kenny, 1985).

Mandatory vs. Voluntary Continuing Education

There is a substantial amount of literature, and many divergent opinions, on the subject of whether or not professionals should be mandated to partake of continuing education activities. From my review of the literature, I have summarized in Table 3 some of the more prevalent opinions on this subject, both in support of and in opposition to mandatory continuing professional education. A more detailed discussion of these pros and cons follows the table.

Table 3

Mandatory Continuing Professional Education: Pro and Con

Factors IN SUPPORT of a mandatory system:
- the need for and importance of "keeping up" is reinforced
- there have been positive impacts on the self-reported change in professionals' knowledge, skills, etc.
- professionals gain exposure to new topics and developments in their field
- the public's interest in quality service is protected
- a mandatory system is easily regulated (external control); system is structured and monitored
- individuals who tend toward non-participation are captured

Table 3 (continued)

Factors IN OPPOSITION to a mandatory system:

- key principles of adult learning are violated
- not consistent with the notion of being a "professional" by taking away elements related to discretion, judgement, etc.
- too much reliance on non-educational aspects of the system (regulation, etc.)
- non-voluntary aspect is a disincentive; participants lack investment in the system
- the ultimate effectiveness on practice has not been completely documented
- most "good professionals" already take part in continuing education; mandatory aspect is not needed
- learning may take place via other non-regulated methods (e.g. conferences, networking, reading journals, etc.)

Problems With Educational Philosophy

Rockhill (1983) gave a good summary of what many feel are the deficiencies inherent in a mandatory CPE system. The concept of mandatory continuing education for professionals is at direct odds with two of the primary assumptions of adult learning theory[6]--assumptions which hold that (1) participants "want to be there" and (2) the quality of programs is assured by students who very definitely "vote

[6] See Knowles (1980) and Cross (1981), among others, for more detailed discussions of this concept.

with their feet." Mandatory continuing professional education is usually just the opposite of these principles. The more that continuing professional education moves toward a mandatory structure, the more it tends to resemble what Rockhill characterized as the negative aspects of traditional, authoritarian education--the learner having little, if any, say in what constitutes appropriate learning, and the idea of having to appeal to the what one might call the "lowest common denominator." "Voluntarism as a fundamental principle of adult education is challenged by the recent surge and acceptance of mandated learning for professionals and other workers" (p. 107).

Motivation also played a role in a study of social work continuing education activities. "Instances where training is mandated and employees are required to attend frequently result in at least initial hostility toward the learning experience and the instructor" (Morton & Kurtz, 1984, p. 45).

Related points were made in a more recent study (Newbern, 1989) discussing the elements of adult learning theory which state that adults learn best when they are involved in planning their own learning, when they perceive a need to know, and when there is an immediate use for the learning. Newbern, writing about nurses, also argued that mandatory professional education violated both adult learning theory and free choice in that MCE dictates what, how much, and in what time frame the learning is to occur. In an

interesting twist on the lawyers' earlier court challenge, Newbern wrote that

> the difficulty in documenting that mandatory continuing education actually enhances nursing practice and thus "protects the citizenry," along with current concerns about the proliferation of regulations and an ideological shift toward a more individualistic, competitive society, may presage a legal challenge to the constitutionality of mandatory continuing education (p. 5).

Using compulsory public school education as a similar situation, Newbern speculated that a legal challenge to MCE would be upheld, but probably with the stipulations that the public underwrite some costs, that a variety of learning modes be allowed, and that effective evaluation be provided.

Johnson (1980), discussing continuing medical education, stated that

> professional education is not an end in itself, but only and always a means to an end....When the educational process takes on a regulatory role or any other role other than educational, there is a high probability that the educational process will not accomplish its true objectives....[Professional education] should be nonthreatening and should not be used as a disciplinary tool, because it becomes counterproductive under such circumstances (pp. 928-929).

On the other hand, Mattran (1981) debated the basic nature of what is--and is not--mandatory. Mattran dismissed the idea of "mandatory" as being as negative as it is often perceived. He saw mandatory continuing education as a desired type of self-discipline, with the "mandate" coming from either personal or professional motivation or being self-imposed only after serious consideration, debate, and consensus within one's profession. Mattran made the argument, also noted earlier in this paper, that even legislatively-imposed mandates requiring continuing education are in place because professions, voluntarily, want to improve services to the public.

The idea of "generic mandation" (Kenny, 1985), somewhat related to Mattran's point above, showed how, even in cases when not under a legislative mandate, professionals are expected to participate in continuing education because of many other factors that pressure them to do so. Kenny includes in those factors consumerism, competition for higher professional status, certification and fellowship programs, membership in professional associations, institutional quality control, possibilities for promotion and salary increases, and special professional recognition programs. Regardless of what "laws" may exist, in other words, professionals must be involved with continuing learning for many other reasons. This concept was supported by a study of nurses and continuing education in Florida (Jahns, Urbano, & Urbano, 1985). Even though the nurses were subject to a

mandatory requirement of twenty-four hours of continuing education in every two-year reporting period, this study found that 39% of licensed nurses completed over thirty-five hours of CE activities, and another 46% completed between twenty-four and thirty-four hours.

Basic philosophical differences among those supporting or opposing mandatory continuing education were discussed by Scanlan (1985). He characterized CPE has having three different orientations: (1) remediating deficiencies, (2) fostering growth, and (3) facilitating change. Scanlan felt that proponents and opponents of mandatory continuing education often represent different orientations. People who support MCE tend to hold the opinion that the deficiencies noted above need to be corrected by making professionals participate in a structured and monitored continuing education process, whereas those who oppose MCE believe that professional growth is more likely to occur when people voluntarily choose to expand their knowledge base.

Problems With Effectiveness and Evaluation

While the preceding arguments might be characterized as "philosophical" in nature, questioning the foundations upon which a mandatory system rests, others point to much more practical limitations. One of the major arguments against the mandatory nature of continuing professional education involves its effectiveness, as well as the ability--or lack of ability--to document that students actually learn anything by participating in these kinds of activities. Performance

evaluation is important for the learner, for the sponsoring organization, and for the instructor of the continuing education activity.

> Unfortunately, evaluation still presents one of the greatest difficulties in the whole arena of continuing education for professionals. The fact is that no universally accepted basis exists regarding criteria, methods, or approved authority in the field of evaluation... (Frandson, 1980, p. 69).

This issue is not concerned with the quality of the training or education itself, but rather with the concept of outcome(s). Continuing professional education has moved from a basic "infusion of knowledge" to goals that relate to the "improvement of practice" (Queeney, 1984).

Often, only the most basic type of evaluation mechanism is utilized in continuing professional education. Most evaluations concentrate on criteria such as instructional style and technique, resources utilized, the interaction between instructor and student, and student performance in relation to instructional objectives--all of which have little to do with what the student actually does on the job. "The ultimate test of the quality of training is the impact the trained person has on some unknown future situation" (Pratt, 1979, p. 350). Davis (1974) had a similar view of evaluation, stressing that the best kinds of evaluation

focussed on simulations or approximations of behavior used in "real life" situations.

Spitzer (1979), in his critique of continuing professional education, talked about the most basic form of evaluation there can be--simply "showing up."

> Participants in programs are generally rewarded for attendance rather than performance. In most other educational areas, attendance as a criterion for credit is a thing of the past. In CE, it tends to be the *only* criterion for credit....Such criteria frustrate attempts at educational quality and can make a mockery of attempts to implement effective educational innovations....Virtually no mechanisms for evaluating the effectiveness of continuing education currently exist (p. 27-28).

[In fact, the Continuing Education Unit (CEU)[7], the most common form of documenting continuing professional education, is subject to question by some professions because it measures time spent in learning, not what has actually been learned (Frandson, 1980). Although some may question the integrity of the grading system for regular academic courses, the fact that most regular credit hours are assessed, graded, or evaluated in some way beyond mere attendance in the course makes them different from CEUs.] Spitzer grouped CPE

[7] The accepted national standard, according to the Council on the Continuing Education Unit (Andrews, 1984), is that 1 CEU is equivalent to 10 contact hours (e.g., a 12-hour training program would be worth 1.2 CEUs).

programs into four categories of evaluation: (1) no form of evaluation, (2) an end-of-course attitude survey only, (3) information-level cognitive tests, and (4) those that assess the impact of the CPE experience in the "real world." Spitzer's examination of CPE programs over several different professions led him to conclude that there are too many programs that fall into the first category, and not many that fall into the last.

Discussing those in the law profession, one author concluded that

> few will dispute that mere attendance at continuing legal education courses will not necessarily enhance competence. Presence is not evidence of learning. Attendance may be passive or active. What is heard in the classroom, without advance preparation, classroom participation, review, and application, is unlikely to be retained (Wolkin, 1975, p. 578).

As Grabowski (1983) noted, it cannot be assumed that, even with proper training (a big assumption itself), learners will intuitively transfer classroom information to new job situations. Barriers such as the comfort of old habits and the time it takes to integrate new methods or skills into one's practice tend to make the automatic transfer of learning less than a given. Mandatory continuing education focuses on individual participation, according to Edwards and Green (1983), but just participating is meaningless. What

should be viewed as important is what the individual does as a result of participating.

Knox (1979a, 1985) discussed the need for "impact evaluation studies" of CPE programs as a way of justifying their effectiveness. Since participant satisfaction is not a true indicator of a change in actual performance, Knox advocated for evaluative methods that could detect improvements that are the result of educational participation in CPE programs. However, the problems of the additional cost, time, and complexity of these kinds of studies, as well as the problems with intervening variables and a potential for embarrassment on the part of program sponsors and participants, tend to sometimes act as insurmountable barriers to effective impact evaluation studies (Pratt, 1979). However, impact evaluations do have their drawbacks, also. Davis (1974) cautioned that impact evaluations can tell only whether a desired outcome did or did not occur, but cannot tell how it occurred unless a control group were utilized. Without employing a control group that does not participate in the educational activity being studied, there is no way of determining whether the activity itself was the cause of the outcome, or whether the outcome was the result of other unstudied factors.

In a report summarizing continuing dental education and other allied health professions, Kress (1979) cited four levels of evaluation for continuing education: (1) assessing perceptions and/or opinions, (2) assessing knowledge gained

and/or attitudes changed, (3) assessing changes in clinical behavior, and (4) assessing the resulting impact on the patient. The ultimate proof of the value of continuing education, said Kress, is if detectable improvements in patients' health can be observed. Kress summarized several different surveys that showed that "the majority of continuing education courses in dentistry have little or no favorable impact on the quality of care delivered by the dentists who attend them" (p. 453).

Examples from other related medical fields are equally critical of mandatory continuing education. Ferrell (1988) talked about the rarity in nursing continuing education of evaluating programs in terms of either changes in the behavior of students on their jobs, or in terms of measuring improvements in patient care. She reported "no significant differences in the self-reported nursing behaviors between these nurses [who took continuing education courses] and those who did not attend these offerings" (p. 22). A study of physicians (Johnson, 1980) concluded that punitive and regulatory types of continuing education programs do not help doctors to improve their knowledge, techniques, or behaviors. Thomas (1986), studying nurses in Kansas, did not see legal requirements as a major factor motivating nurses to participate in CE programs; instead, factors such as a desire to increase professional knowledge, the possibility of professional advancement, and the improvement of skills were found to be of more influence on nurses' participation.

Clayton, Schmall, and Pratt (1986) looked at outcomes related to continuing education for social service workers and found that, even though the training was rated positively, only 29% of the participants reported actual changes in agency functioning or programs. Some barriers mentioned that accounted for this lack of positive outcomes on the job included shortages of both time and resources, even though staff attitudes and supervisors' commitment were seen as favorable. However, positive changes in many participants' knowledge, skills, and comfort level in dealing with targeted populations were found in this study, especially in instances where follow-up consultations were provided.

In summarizing this issue of mandatory continuing education, Cross and McCarten (1984) ask, "What is the responsibility of the state to ensure the quality of professional services? Is the practice of 'mandating' continuing education for licensed professionals the most effective way to ensure consumer protection" (p. 27)? They also offer a very telling observation: "Apparently, no state has any very effective method for ascertaining the extent and contributions of the providers of continuing professional education..." (p. 27).

Some of these questions were answered in another study on professional education (Stark, Lowther, & Hagerty, 1986) which stated that "debate about mandatory versus voluntary learning has become dominant despite research demonstrating

that professionals' inner standards of achievement are more important than mandated continuing education in enhancing knowledge and skills" (p. 69). This is similar to the findings of Thomas (1986), which discussed the motivations underlying nurses' participation in CE activities in a mandatory CPE state. Thomas determined that legal requirements were not a major motivating factor for this group; increasing professional knowledge, a desire for professional advancement, and improving one's social welfare skills were all ranked higher in the reasons why nurses participated in these activities.

Another type of criticism of mandatory programs was offered by Queeney (1984), who wrote that

> required continuing education is sometimes viewed as a means of forcing practitioners to remain up to date in their professional field. Others see it as a way to keep providers' coffers filled, and yet others consider it at best a meaningless exercise (p. 17).

Knox (1979b), one of the foremost authorities in the field of continuing education, summarizes the issue as follows: "The conclusion that all continuing education programs have a major impact on the subsequent performance of participants is clearly not warranted. However, the conclusion that some programs do have an impact is irrefutable" (p. 118).

One of the biggest dangers this observer has had concerning the issue of mandatory continuing professional education is the potential for a "false sense of security" on the part of the public who, ostensibly, is supposed to be protected by a mandatory system. The public, through its elected officials and policy-makers, may be incorrectly assuming that all professionals are competent because of these mandatory requirements. This assumption does not appear to be warranted, and other observers (Stone and Williamson, 1972; Rockhill, 1983) have made similar arguments.

Clearly, the topic under discussion here--the issue of whether continuing professional education should be mandatory or not--appears to be a matter of (1) the *degree* to which participants learn and (2) the *extent* to which they are able to utilize this learning in their field of practice. If the assumptions underlying a mandatory CPE system are that these latter two outcomes are happening to a *large degree* and to a *great extent*, those assumptions (and the policies that have resulted from them) certainly deserve to be reexamined. In fact, some professions have already started to study this question. Based on the lack of evidence to support the effectiveness of MCE, some professions have taken a stand against this practice. The American Medical Association (AMA), for example, supports the idea of individuals being voluntarily responsible for their own continuing education. Other professions, however, are still not convinced. The

American Institute of Certified Public Accountants (AICPA), representing a viewpoint opposite that of the AMA, supports mandatory continuing education because AICPA feels that the public interest is being served (Jaschik, 1986).

Alternatives To Mandatory Continuing Education

If it appears, as it certainly does, that mandatory continuing professional education is not as effective as it should be, the next question must deal with alternative ways that professionals can remain competent. While still acknowledging the tremendous need for CPE (as documented earlier in this paper), several authorities have proposed alternate methods of addressing this issue. On the following page, Table 4 summarizes the pros and cons of some of these alternatives.

Although it has met with resistance from some professionals, the idea of periodic testing has been proposed in several fields. In an article discussing the pros and cons of MCE in the field of accounting (Stone & Williamson, 1972), requiring CPAs to take a test every few years to demonstrate their competence was mentioned as a partial solution to several negative points which had been presented in this debate. Talking about professions in general, Frandson (1980) also mentioned periodic redeterminations of competence by exams, performance evaluations, or other means as one acceptable approach to CPE. A major disadvantage here is the difficulty inherent in using a "paper and pencil" test to capture the specific skills necessary in the practice world, as well as the obvious questions of what to test and who makes that decision.

The utilization of a peer review process and the development of certification programs were outlined by

Table 4

Selected Alternatives to Mandatory Continuing Education

Methodology	Positive(s)	Negative(s)
Periodic Testing	- able to incorporate current trends, etc.	- too standardized - who decides on content?
Peer Review Process	- those in profession know field best - tests practice skills, not just theory	- not objective - conflicts of interest possible
Certification Programs	- public confidence	- too controlled by profession itself
Education of Consumers	- *caveat emptor*	- not comprehensive enough
Modeling by Top Pros	- strong incentives for own career development	- who decides who is "tops"? - selection method
Requirements for CE by Associations	- utilizes knowledge of each profession - "self-policing"	- lack of public confidence
Self-Assessment	- completely individualized - confidential	- no external motivating force
Re-Education	- concentrated and focussed	- disruptive to one's practice

Hohmann (1980) and were included in several ways that she proposed to influence the behavior of professionals. The peer review process would address any "public" form of professional misconduct, for example, and certification programs, also discussed by Rockhill (1983), could be used by the public as evidence of acceptable levels of professional competence. Spitzer (1987) also commented on the abundance of certification or recertification programs that were set up by professional associations. There could be problems in the public's perception of both of these alternatives. Regarding peer review, the potential for conflicts of interest is very strong in a system which relies on individuals who are known to each other, even if only through a professional or working relationship. Certification programs could also be seen as a problem by the public, since there may be other factors (philosophical differences, elements of racial/ethnic/sexual discrimination, political alliances, etc.) that could be used to exclude professionals, beyond the stated criteria of skill level.

Hohmann (1980) also mentioned two other very unique and interesting plans. The first involved educating consumers, not the professionals, so that the public could learn to recognize "good" professional practice. This idea was also proposed by Rockhill (1981), who thought that education can be used by the public (i.e., non-professionals) to assure themselves of competent services. Said Hohmann,

> consumers are the ultimate judges of the quality of work offered by a professional, either directly as recipients of services, or indirectly as citizens and voters on public policy. Consumers ultimately decide whether a bridge, a medical remedy, a sermon, or a legal opinion is satisfactory (p. 93).

To me, this alternative is simply not comprehensive enough; the public is not the "problem" here. Hohmann's second unique alternative did involve educating professionals--but only the top 5% of each profession's members. This plan, according to Hohmann, would lead to modeling behavior on the part of other professionals (those who are not at "the top" of their occupational group) in order for their practice to survive competitively. In this way, the competence level of the entire profession would be raised, and those that voluntarily choose not to participate would simply "go out of business," eventually, due to consumers choosing other professionals for services. The major question with this alternative is, again, who decides who is "tops" and what methods are used to determine the "standings."

Another type of indirect regulation of professionals, making continuing education required not by state licensing authorities, but by professional associations, employers, or insurance providers, was advocated by Rockhill (1983). As previously mentioned, some states are finding there is now a backlash against licensure policies. "At question," said Rockhill, "is whether licensure laws exist in protection of

the public's interest, or in order to protect the self-serving interests of occupational groups and educational entrepreneurs" (p. 108). The same arguments may be used as criticisms of a profession-controlled continuing education system, in my opinion.

Self-assessment as an alternate evaluative tool was mentioned by some opponents of mandatory continuing professional education (Lowenthal, 1981; Johnson, 1980; Knox, 1979a). Under this method, traditional continuing education activities would still be part of a professional's efforts to remain current, but the topics which one takes would be determined by a diagnostic audit (or similar confidential self-assessment) of the professional's skill level. Gaps in knowledge which are identified in this process can be addressed and corrected by existing traditional CPE programs, and desired outcomes would be more likely to result due to the focussed and purposeful nature of the training. While I think that there is a great deal of potential for this kind of system, it seems to me that this idea lacks the crucial elements of external control or motivation that may be necessary for its ultimate success.

A system of periodic re-education, in which practitioners would re-enter professional schools under a regular, predetermined schedule, was the idea of Dubin (1972). He proposed various alternative timelines, such as one month of re-education each year or a three-month re-education period every three years, for example. The major

difficulty with this idea would seem to be the logistics of the system. Regardless of the profession in question, it would be very disruptive, not to mention expensive, to close one's practice for these lengthy periods of time.

Andrews (1984) proposed a variety of assessment techniques which could be used to gauge the competence level of professionals. His alternatives included performance tests, simulations, interviews, and assessment centers, as well as essay exams and objective written exams.

Of course, there are many other alternatives including reading in professional journals and other relevant publications, observation of peers and colleagues, sabbaticals or "job switching," and any number of other self-directed activities. There are many viable alternatives to a system of mandatory continuing education.

Concluding Thoughts

The issue of mandatory continuing education for professionals is not an easy one to decipher. One of the major difficulties, perhaps, is having to divorce the overwhelming evidence of the need for professionals to continue learning after they are in practice from the "obvious" solution of making people learn. Yet it is clear that this separation must take place in order to effectively evaluate the effectiveness of MCE.

This paper has attempted to address both of those very different and separate points--the need for continuing education, on the one hand, and one possible solution to that need, on the other hand. In my review of the recent literature on this subject, the "answers" appear to be very clear.

Regarding the need, there does not appear to be any question that professionals must be engaged in some form of continuing learning following their initial entry into professional practice. This fact has been well documented in the literature, and there is no opposition to wha is now considered to be a fact of life for any competent professional practitioner.

The real dilemma surfaces when trying to determine exactly how this learning should take place. Mandatory continuing education, at first glance, appears to be a very logical solution to this problem. If it is agreed that professionals must continue to learn throughout their

practice, why not "force" them to learn by mandating that they attend required courses and other kinds of learning activities? In this case, the literature is much less definitive. It is true that these activities are often rated as positive by those who engage in them, and there is even some proof that some "factual" content is successfully delivered to and retained by the participants. The case for mandatory continuing education begins to lose credibility, however, when the criteria for success includes significant, measurable changes in either the professionals' method(s) of practice and/or the status (e.g., health, legal, psychosocial, financial, etc.) of the professionals' clients or patients. If these criteria represent the standards to which mandatory CPE is to be held, then the policy's success is, at best, inconclusive and, at worst, a failure.

Two different researchers, several years apart (Jones, 1968; Hohmann, 1980), made the same criticism of continuing professional education: that each profession tended to "go it alone" and not share with others their experiences related to professional standards, appropriate educational programs and technologies, target populations, learner motivation, impact on job performance, etc. Jones' viewpoint, over 20 years ago, was that many professions rushed to do something about the problem of professional competence without benefit of a shared body of knowledge.

It is only recently that these shared experiences are being considered among educational theorists, legislative

officials, and professional practitioners. Those that are not wholeheartedly embracing the concept of mandatory continuing professional education, and those that are questioning its effectiveness where these policies are already in place, are to be congratulated and supported. It may only be a matter of our collective failure to develop evaluative mechanisms with which we are comfortable; however, until we do so--or until the current methods yield more conclusive results--the practice of mandatory continuing professional education clearly merits further study.

Social Workers in Massachusetts - A Brief Case Study

Using the material presented in this paper, I would like to briefly describe the experience of social work professionals in the state of Massachusetts. I am offering this "addendum" to the paper for two reasons: (1) to help further clarify, by way of specific example, some of the discussion presented in the paper and (2) to introduce some further research I hope to conduct on this population. This qualifying paper will form the basis for a future analytic paper which is intended to study, in greater detail, the experience of mandatory continuing education for Massachusetts social workers, possibly including an evaluation of the actual impact on participants in these types of continuing education activities.

Since October of 1988, social workers in the Commonwealth of Massachusetts who want to renew their state-issued license to practice must comply with regulations requiring mandatory continuing professional education. Depending on their "level" of licensure[8], Massachusetts social workers must accrue between 5 and 30 hours of approved educational experiences in every two-year licensing cycle (Commonwealth of Massachusetts, 1986, 1988). As was mentioned earlier in the paper, using mandatory continuing education in conjunction with a relicensing requirement is

[8] Massachusetts licenses social workers at four different levels: Licensed Social Work Associate (LSWA), Licensed Social Worker (LSW), Licensed Certified Social Worker (LCSW), and Licensed Independent Clinical Social Worker (LICSW).

probably the most prevalent form of "control" that states exercise over professionals.

The specific mechanism of control which is utilized by the state is its Board of Registration of Social Workers, to whom social workers must apply for a license to practice (or to renew a current license). On their license renewal form, social workers must attest to the fact that, under penalty of perjury, they have taken the required number of hours of approved educational experiences. "Audits," requiring the licensee to submit copies of actual documentation (transcripts, certificates of completion, etc.), are performed at random to ensure compliance with this mandatory system. A similar process is also used for the other eight professions[9] that fall under mandatory continuing education requirements in Massachusetts. This system for reporting and monitoring is not unlike that used in many other states, for social work and for other professions.

The development of MCE for social workers in Massachusetts is, in many ways, typical of many of the other professions discussed in this paper. Consumer protection, for example, did play a significant role in the legislation that originally established the Board of Registration of Social Workers. The Board currently oversees a total of approximately 25,000 licensed social workers, and the Chair of the Board's Continuing Education Sub-Committee did

[9] CPAs, dentists, registered nurses, nursing home administrators, optometrists, pharmacists, physicians, and licensed practical nurses.

volunteer the fact that consumer protection is seen as an important part of the Board's responsibilities (Aida Bruns, personal communication, September 13, 1988).

David Moffenson, the former Vice-Chair of the state legislature's Committee on Human Services recalled that bills establishing licensing requirements for social workers had been filed for several years before the legislation was finally passed in 1977. (The bill that was passed in 1977 did begin the practice of licensing social workers, but the mandatory continuing education requirements under that legislation did not become effective until the 1986-1988 relicensing cycle.) Moffenson, a major supporter of this bill, was concerned about the implications to consumers of unqualified people calling themselves "social workers," and he saw a need to license qualified members of the profession in order to exclude those who were not competent. However, the Speaker of the Massachusetts House at that time, Rep. Thomas McGee, did not feel that the issue was an important one. According to Moffenson, there was some serious opposition to the bill, not against social workers, but more like philosophical arguments about licensing another professional group and creating another Board of Registration. To summarize the political process very briefly, the bill successfully made it out of committee after Moffenson convinced McGee about the merits of licensing social workers. (D. Moffenson, personal communication, March 3, 1988).

Moffenson and other state legislators had been lobbied very actively by members of the Massachusetts chapter of the National Association of Social Workers (NASW). It appears as though a provision of the bill allowing "third-party reimbursement" (allowing social workers to bill for their services through health insurance plans, etc.) was a prime force behind NASW's lobbying efforts. This obvious self-interest on the part of the professional association parallels similar situations mentioned earlier in this paper. Although NASW had been involved with previous attempts to pass the licensing legislation, it was not until its leadership mounted a concerted lobbying effort and letter-writing campaign that the bill finally passed.

The legislation that was passed basically established the entity of the Board of Registration of Social Workers and charged it with, among other duties, the power to "establish regulations for continuing education requirements for licenses" (Massachusetts General Laws, Chap. 13, §84). The education regulations which are now in place were developed several years later by the Board's Continuing Education Sub-Committee. It is indeed interesting to note that, for most of the individuals from whom I obtained this "background information," continuing education was not a major issue in the discussions of the original legislation. The licensing of social workers was clearly the primary focus, which brings me back to my proposed future research. To me, this brief descriptic of how the Massachusetts social work legislation

was developed and implemented points to a critical need for an evaluation of the effectiveness of the mandatory continuing professional education policy in this area.

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