What direction for Continuing Professional Development?

An attitude survey in a teaching mental health trust

David Newby

Aims and methods A questionnaire survey of attitudes to Continuing Professional Development (CPD) was addressed to all 58 non-training grade psychiatrists working in a large teaching community mental health trust. Ninety-three per cent provided responses. Views were sought on the value of various teaching methods, how CPD should be organised, what barriers to participation colleagues encounter and whether CPD should be made mandatory.

Results These showed strong support for the personal study element of CPD, indicated the range of other teaching modalities used by practitioners including industry supported symposia and found a significant majority in favour of making CPD mandatory. Pressure of time was the main obstacle to participation for most.

Clinical implications The survey provides pointers for the key issues which are likely to affect the readiness of practitioners to participate in CPD, as well as informing decisions on the type of ongoing educational activity that psychiatrists see as relevant.

CPD – the College's programme for Continuing Professional Development – is now just four years old. Recruitment has grown steadily during that time, but there are clearly still many colleagues unconverted to the advantages of a formal programme of CPD. Particularly, it remains a minority interest for non-consultant career grade colleagues – who surely have as much need for CPD as anyone else. Harris (1998) highlights the danger that CPD may be seen as more threat than opportunity and Kendell & Pearce (1997) in their survey of prematurely retiring consultants demonstrate the demoralising effect that imposed or bureaucratic structures can have. It seemed opportune to seek the views of a group of practitioners on their attitudes to and experience of CPD to date. The survey reported here was carried out between October 1997 and December 1997 in a single trust and responses were obtained from 93% of all eligible practitioners making the results representative of prevailing views.

Method

A four-page questionnaire (available on request from the author) was devised based on one used by Williams *et al* (1998) for an earlier national survey of a random sample of psychiatrists. The modified questionnaire was piloted with a small group of colleagues and then mailed to all consultants working in the Leeds Community and Mental Health Teaching Trust as well as all non-consultant career grade doctors working five or more sessions a week (a substantial number of clinical assistants worked one or two sessions a week – it was decided to exclude these and focus on those for whom CPD seems most important, though this begs the question of how and whether such colleagues should be involved in CPD). This gave 58 eligible practitioners. Three surveys were sent out by post followed by reminder letters and 54 were finally returned, that is 93% of the eligible workforce.

Results

Of the 54 respondents, 61% were male and 39% female. The majority (85%) were on National Health Service (NHS) as opposed to university contracts, and 76% were consultant grade. Seniority varied, with 9% being less than 10 years post-qualification, 46% 1–20 years post qualification and 43% greater than 20 years. All major sub-specialities were represented, the largest groups as expected being general, old age and child and adolescent with 41, 28 and 13% respectively of the sample.

Value of various teaching methods and components

Views on different teaching opportunities were gauged with the following question: "The following are important components of CPD:" Responses were invited on a scale of 1–4, 'strongly agree' to 'strongly disagree'. Thus 2.5 is the 'break-even' point for the mean of the responses – a lower value is in favour of the item,

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a greater value disfavours it. Using the same scale, the views on different teaching methods were also obtained with the question: "In my opinion, the following teaching methods are most useful for CPD:" Results from these two questions are shown in Table 1.

It can be seen that no individual component or teaching method attracted particular opprobrium, but personal study was considered the most important component and short workshops (one day or less) were by far the most popular teaching method. Attendance at audit meetings attracted the least support as a vehicle for CPD, and were almost disfavoured. Distance-learning and computerised packages were also relatively low on popularity. It is not possible to say whether this represents a reasoned judgement of their value, or results from ignorance and 'technophobia'. Perhaps computer literacy itself should be an important target for CPD, with increasing availability of and reliance on electronic means of accessing information, not to say the development of electronic clinical information systems.

Current CPD behaviour

Having ascertained views on different teaching methods, respondents were asked to indicate what formal meetings of an educational nature they attended in the last year. Responses are shown in Table 2. As expected, case conferences were the activity attended by most practitioners, despite question marks in the literature about how much this and other 'traditional' vehicles actually influence the clinical behaviour of those taking part (Davis *et al*, 1995). The worrying minority of three who had attended no case conferences in the year comprised one general, one learning disability and one old age psychiatrist, of whom one was a consultant. Section/faculty meetings were most popular among College organised activities, and a significant majority of colleagues made use of industry-supported symposia and similar activities.

Table 1a. Answers to the question: "The following are important components of CPD:"

	Mean response[1]
Attendance at case conferences	1.68
Skills workshops	1.66
Case conferences	1.72
Journal clubs	2.07
Personal study	1.05
Attendance at audit meetings	2.42

Table 1b. Answers to the question: "In my opinion, the following teaching methods are most useful for CPD:"

	Mean response[1]
Small group work	1.75
Didactic lecture teaching	1.96
Distance learning packages	2.37
Computer-based learning	2.16
Short workshops (one-day)	1.44
Residential courses (several consecutive days)	2.24
Courses one day per week over several weeks	2.05
Courses over several months	2.25

1. On 1–4 scale, strongly agree to strongly disagree (therefore 2.5=break even)

Preferred timing of education sessions

Respondents were asked to rank order what timing they would prefer for local educational sessions. Half-day sessions were most popular (mean ranking out of five, 1.94). Lunch-time and full day sessions came next (mean rank 2.39 and 2.81 respectively) and evening courses and those lasting more than one day were least popular at 3.92 and 3.91.

Personal development plans

It appears that for many of us, CPD has been a relatively unplanned, reactive process. Practitioners attend activities in a haphazard manner – going to those things that happen to attract attention or fit with a particular interest – rather than structuring learning to the developmental needs of the individual and taking into account their working situation. The Personal Development Plan (or PDP) is a means of making learning more proactive and amounts to an individual 'educational prescription'. Respondents were asked how important PDPs were in CPD. The mean on the previously described (1–4 scale) was 1.87, indicating a significant degree of support. When asked what method for devising PDPs would be preferred

Table 2. Numbers out of 54 attending at the following activities in the past year

	n	Percentage
Audit	38	72
Journal club	26	49
Case conferences	50	94
College		
Division	11	21
Section meetings	23	43
Special interest group	14	26
Annual or 'quarterly' meeting	13	25
Drug company supported meeting	30	57

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'buddies' and peer group review were well supported, but mentor review was less popular.

Obstacles to participation in CPD

These were ascertained with the question: "The following are obstacles to my participating in CME/CPD activities (whether or not you are formally registered for CPD):" Nine potential reasons were listed and respondents asked to tick as many as applied to them. The results show that the overriding problem here is pressure of time, with 68.5% citing this as an obstacle. Another significant problem was with junior and senior cover (26% and 22%), and wrong content or timing of educational events (30 and 42% respectively).

Should CPD be mandatory?

Respondents were asked whether they felt CPD should be mandatory. The percentage of the whole group agreeing or strongly agreeing on this question for various groups was as follows: college tutors, 80%; educational supervisors, 81%; fellows, 85%; all non-training grades, 67%. These represent surprising majorities even allowing for the fact that many of those in this sample are 'converts'. Making CPD mandatory, however, immediately raises the question of what sanctions could be employed to enforce it, a matter under current debate. If there is an overriding advantage to mandatory CPD, it lies with the fact that if compulsory, practitioners will simply have to be supported in it by their employing authority. This may be particularly helpful in those 'hard-pressed' areas where it is most difficult to take the time out for professional development – perhaps those areas in fact most in need of it.

Conclusions

This survey presents views from 93% of all CPD-eligible practitioners in a single teaching trust, about 70% of whom are CPD-registered. It provides a 'snapshot' of current attitudes to different teaching methods and formats. Personal study emerges as a particularly important vehicle for CPD in the perception of respondents. Efforts to optimise the gain from this activity should be profitable, therefore, although distance-learning and computer-based learning packages do not appear particularly popular in this survey. As a generality, more research would be valuable to ascertain the type of learning most likely to be effective in CPD as judged by the impact on clinical practice and therefore quality of care.

With respect to current CPD behaviour, industry-supported symposia remain an important learning source for many practitioners. The established role of drug companies in supporting Continuing Medical Education appears to be an accepted fact. This immediately raises ethical issues, and there must be concern regarding the 'editorial' control the information practitioners derive from this source. 'Prepackaged' conferences go against the grain of a self-directed learning programme based on individual need.

Given the reality of industry-supported teaching, however, further debate on how such experience should best be regulated and accounted for in an overall CPD strategy appears essential. Allowing for all the ethical concerns, there may be a case made for 'exploiting' this means of educational access to colleagues if it is likely to happen anyway and thus ensuring a professional lead in the events laid on by drug companies. There is support for making CPD more systematic through something like PDP, but different methods are favoured.

Of all the obstacles to participating in CPD, sheer pressure of time is the most significant. Increasing calls are made on the practitioner's time to satisfy demands for involvement in Clinical Audit, compliance with new procedures such as Care Programme Approach and the Supervision Register, as well as general NHS bureaucracy and the contracting process. Kendell & Pearce (1997) identified this as a significant factor contributing to loss of consultants by early retirement. It is evident, therefore, that there is a danger that over-formalised CPD will be seen by some to be an irksome burden representing one more impediment to delivering direct clinical care. The sample presented here shows a significant majority in favour of mandating CPD in one way or another. This could help those under most pressure (and perhaps most in need) to participate, but further consideration is required of how CPD might be made compulsory, and whether the profession wishes to embrace this. Public pressure and the need for credibility will push in this direction anyway: urgent debate may help psychiatrists to remain in control of how this process evolves.

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David Newby, *Deputy Regional Adviser for CPD, Yorkshire and Coordinator for CPD, Leeds Community & Mental Health Teaching Trust, Millfield House, Kirk Lane, Yeadon, Leeds LS19 7LX*

Higher psychiatric trainees and the Calman reforms

Paul Cavanagh and Fabian Haut

Aims and method The specialist registrar (SpR) grade was introduced in 1996, taking the place of the senior registrar (SR) grade. We surveyed higher trainees in Scotland in order to draw comparisons between the two grades and assess satisfaction with the changes. A postal questionnaire was sent to all higher trainees (n=129) in Scotland seeking information on structure of training, work patterns and views.
Results Sixty-two per cent of trainees responded. There was little difference in the activity and structure of training between SRs and SpRs. Seventy per cent of responders felt that the SpR grade had not improved training.
Clinical implications The survey uncovered dissatisfaction with the new grade, but little objective evidence of differences between SRs and SpRs. More flexibility for time in higher training and restoring the SR title would help to improve morale.

In 1996 the first wave of specialist registrars (SpR), the new higher training grade, took up posts in Scotland. The grade was introduced following the publication of the report of the working group on specialist medical training by the Department of Health in 1993 – the Calman report (Department of Health, 1993). Protracted discussions between the various Royal Colleges and professional bodies concerning implementation followed, particularly in the context of earlier Department of Health work on medical manpower (Department of Health, 1987). The working groups had been set up as a response to Britain's requirement to fall in line with the European Commission's directives on specialist recognition. However other factors played a part: the need to reduce junior doctors' hours as a consequence of the *New Deal* (NHS Management Executive, 1991); concern often arising from clinical audit of excessive reliance on junior doctors to provide services and a desire to move to a consultant led service (Department of Health, 1987), and a sense that specialists were spending too long unproductively in training (Hunter & McLaren, 1993).

The Calman report stimulated much debate on the likely implications for consultants and trainees (Charlton, 1993; Ross, 1993; Mather & Elkeles, 1996). Possibilities envisaged were that consultants would do more emergency work and trainees would be largely supernumerary, or that a junior consultant grade would need to be developed (Charlton, 1993). There was controversy over interpretation of the European Commission directives and manpower plans set out in achieving a balance (Brearley, 1992; Ross, 1993), exposed differences in opinion regarding what training should be expected of specialists in the UK and what the nature of consultant work should be (Johnson, 1995). In contrast to other clinical specialities where the registrar and SR grades were merged, the Royal College of Psychiatrists chose to use the SpR grade to replace the senior registrar (SR) grade and merge the senior house officer (SHO) and registrar grades, using the MRCPsych Examination as entry into higher training (Caldicott, 1993). We thought it timely, after 18 months as SpRs, to survey the

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