original papers

Psychiatric Bulletin (2001), **25**, 334–336

MARK DAVIES AND MIKE FORD

Towards successful implementation of continuing professional development – a survey of psychiatrists' attitudes

AIMS AND METHOD

This survey aims to aid implementation of continuing professional development (CPD) by determining the acceptability of current proposals and predict problem areas. All non-training grade psychiatrists working in the area of a single deanery were asked about their attitude to CPD and, in particular, focusing on the peer group method.

RESULTS

Of the 115 respondents, 98% said they agreed with some form of CPD. Just under half of respondents thought peer groups were appropriate for CPD planning, with four being the most popular size, and 3 months the preferred frequency of meeting. Problems identified with the peer group structure included individual, speciality-based and organisation-related issues. Regarding sharing of CPD information, 40% of respondents thought the College should receive updates of individual progress, while the medical director was cited in over half. Finally, loss of educational supervisor status was felt to be the most appropriate penalty for failure to adhere to the CPD process.

CLINICAL IMPLICATIONS

These results indicate that although there is general agreement to some form of CPD, peer groups are not universally accepted as the best design.

As part of the development of continuing professional development (CPD) for non-training grade doctors working in the field of mental health, the College has made a number of proposals to modify the CPD process (Katona & Morgan, 1999). A key proposal is the prospective planning of individual CPD requirements with local peer groups. CPD is defined, for the purposes of this paper, as continuing education of an individual throughout professional life with prospective planning undertaken in association with a peer group, this process eventually contributing to an annual appraisal. CPD, delivered in the context of clinical governance and revalidation, will have to meet the needs of both individuals and local services.

In order for CPD to be successfully implemented, potential obstacles must be identified and overcome (Grant & Chambers, 1999). An often quoted barrier to successful introduction of new systems in health care is the resistance of doctors themselves (Gleiner, 1998). Knowing the views of those who have to undertake CPD, and how they might view difficulties with any proposed format, will aid in successful implementation. The aim of this survey was to determine how a group of non-training grade psychiatric doctors would view the proposed CPD format, with particular reference to the peer group planning method.

The study

A list of all non-training grade psychiatrists in the Wessex region was obtained from local CPD representatives. Each person on the list was then sent a questionnaire with an explanatory letter. The questionnaire asked respondents a number of questions concerning CPD, including the size of peer group and a possible frequency of meeting. Respondents were then asked to identify problems that might be anticipated with the peer review method, along with who should receive information from the process and possible penalties if the process was not satisfactorily undertaken.

Findings

In all, 189 non-training grade staff in psychiatric posts were identified in the Wessex region. Of these, 136 (72%) were consultants, 42 (22%) were staff grades and 11 (6%) associate specialists. The total number of respondents was 115 (60.8%). Ninety-four out of 136 (69%) consultants, 16 out of 42 (38%) staff grades and 5 out of 11 (45%) associate specialists responded. When asked whether respondents agreed with some form of CPD,

https://doi.org/10.1192/pb.25.9.334 Published online by Cambridge University Press

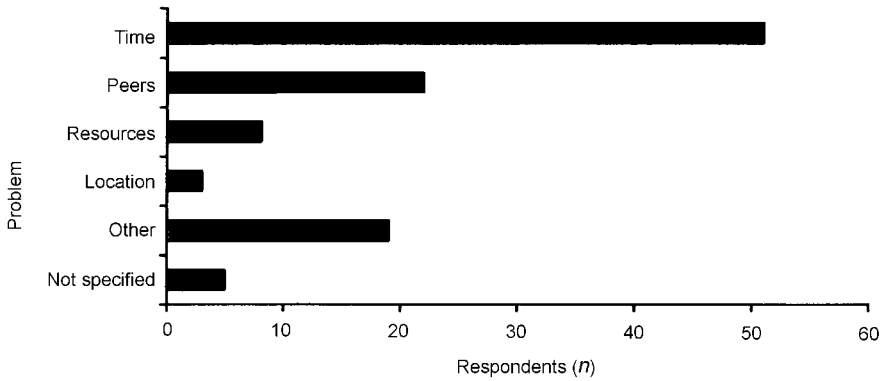

Fig. 1. Problems with peer the review method

113 (98%) said they did, while two (2%) said they were against CPD.

When asked whether respondents were currently registered for CPD, 87 (76%) indicated they were. Of these, all associate specialists were registered for CPD, while 76 (81%) consultants were registered and only 7 (44%) staff grades. Of the 26 not registered for CPD, 15 (58%) intended to register, while six did not intend to register. Five did not specify their intention. When asked about who CPD should be planned with, a majority suggested peer groups, although a significant percentage also suggested other alternatives, such as medical director and manager. Respondents were then asked to specify the optimum number for a peer group. The vast majority of respondents indicated the optimum number in a peer group to be between three and six. The optimal frequency of meetings ranged between 2 and 12 months, with the mode being every 3 months.

The next part of the survey asked respondents to comment on what the single most important problem would be with the peer review method. The three most likely problems cited were availability of time, peers themselves and resources generally (Fig. 1).

Respondents were then asked how peers themselves could be a problem. From the responses three main problem areas were identified, as shown in Table 1, more than half being identified in the 'individual' category.

When asked who should receive information on this process, respondents demonstrated some uncertainty. One-fifth of respondents indicated either the college or medical director, with similar numbers suggesting a combination of the two. A number of alternative suggestions accounted for the other 40% of replies. Finally, respondents were asked to specify a penalty for not undertaking CPD. Again, a variety of answers were suggested, the three most common being loss of accreditation as educational supervisor, loss of individual accreditation and a combination of both.

Discussion

As government policy moves towards a more transparent process of quality control in health care, emphasis on the education of doctors becomes greater. For those in non-training grades, this education is provided in the form of CPD. The response to this survey implies that the vast majority who need to register will already have registered, although staff grade doctors may be one possible area of concern. Owing to varying rates of return, results would appear to be generalisable for consultant staff but not necessarily for staff grades and associate specialists.

In psychiatry, CPD will be prospectively planned with the aid of a peer group. However, from this survey, under half of respondents thought peer groups alone should be involved in CPD planning, while over a quarter thought peer groups should not be involved at all. Of those rejecting peer groups for CPD planning, a majority thought another key individual should be involved, such as the medical director or lead consultant.

Regarding peer group size, four was the most often quoted, with six to a group coming a close second. Three months was the most popular meeting interval, the second most cited being 6 months. Both the number in the peer group and the frequency are roughly in line with College expectations, that a peer group of two might be too cosy and more than six too ambitious, and meetings should be at least twice a year.

A number of potential problems were identified with the peer group method. Almost half of those surveyed identified time as being a difficulty. This is consistent with previous studies on CPD (Newby, 1999). One-fifth thought peers themselves would be a problem. More specifically, three problem areas associated with peers were identified; relating to individuals within the peer group; problems between specialities represented within the group; and the relationship between the peer group and other bodies (see Table 1). Poor relationships within the group, for example lack of trust and cooperation, were seen as key difficulties. Similar comments were made concerning relationships between specialities, with lack of mutual understanding and difficulties with consensus being examples. This might be exacerbated by some specialities being underrepresented in a locality, either through vacant posts or through lower workforce requirements. Finally, there was concern over potential for conflict between peer groups and other organisations, for example, over resource allocation and different goals, particularly when peer group decisions are contrary to local or national policy.

https://doi.org/10.1192/pb.25.9.334 Published online by Cambridge University Press

original papers

Table 1. Examples of potential problems identified with peers

Individual	Speciality *v.* speciality	Peer group *v.* trust organisation
Not competent	Competition for courses	No authority to get resources
Uncooperative	Disparate	Coloured by local politics
No commitment to process	Difficulty in reaching consensus	Ineffective
Lack of trust	Lack of knowledge of other specialities	Different goals

The last part of the survey asked about the sharing of information from the peer group process, and the possible penalties for not complying with CPD requirements. Interestingly, only 40% of respondents thought the College should receive the information, while the medical director was cited in half of the replies. Yet CPD will be an integral part of the annual appraisal process in which medical directors will have a key role (British Association of Medical Managers, 1999) and the College will need to be involved in the process of certification.

Regarding possible penalties, over half of respondents cited "loss of accreditation as educational supervisor", either alone or with another penalty, as the most 'desirable' penalty. However, currently this only relates to consultants. Loss of individual accreditation was considered an option in only 10% of respondents. This is at odds with the intention of the General Medical Council to introduce revalidation for all doctors (Buckley, 1999). CPD will play a crucial role in this process, with failure to comply almost certainly resulting in loss of accreditation.

This survey demonstrates that participants in CPD show clear preferences for the way in which CPD is designed and implemented. These preferences may not necessarily reflect national or local CPD policy, either in method or in potential implications if CPD fails in individual cases. These findings suggest that, along with the provision of appropriate resources, the participation of those undertaking CPD should be actively sought at every stage if the implementation of CPD is to be successful.

Acknowledgements

Our thanks to Brenda Holmes and Eileen Jay for their invaluable help in collating the survey data.

References

BRITISH ASSOCIATION OF MEDICAL MANAGERS (1999) *Appraisal in Action*. Stockport: BAMM.

BUCKLEY, G. (1999) Revalidation is the answer. *BMJ*, **319**, 1145–1146.

GRANT J. & CHAMBERS, E. (1999) *The Good CPD Guide: A practical Guide to Managed CPD*. London: Joint Centre for Education in Medicine.

GLEINER, J. A. (1998) Clinician acceptance of information technology. *Journal of Integrated Care*, **2**, 86–89.

KATONA, C. & MORGAN, G. (1999) The future of CPD. *Advances in Psychiatric Treatment*, **5**, 161–162.

NEWBY, D. (1999) What direction for Continuing Professional Development? An attitude survey in a teaching mental health trust. *Psychiatric Bulletin*, **23**, 490–493.

Mark Davies Consultant Psychiatrist, Community Mental Health Team, Waterford House, 142 Station Road, New Milton, Hampshire BH25 6LP ***Mike Ford** Consultant Psychiatrist, Wessex Regional Continuing Professional Development Coordinator, Alderney Community Hospital, Ringwood Road, Parkstone, Poole, Dorset BH12 4NB

Psychiatric Bulletin (2001), **25**, 336–339

ROBERT A. CLAFFERTY, ELAINE McCABE AND KEITH W. BROWN

Conspiracy of silence? Telling patients with schizophrenia their diagnosis

AIMS AND METHOD

We undertook a postal questionnaire survey of all consultant psychiatrists working in Scotland to examine whether psychiatrists themselves may contribute to the misunderstandings surrounding schizophrenia by avoiding discussion of the diagnosis with their patients.

RESULTS

Two-hundred and forty-six (76%) responded. Ninety-five per cent thought the consultant psychiatrist was the most appropriate person to tell a patient their diagnosis of schizophrenia, although only 59% reported doing so in the first established episode of schizophrenia, rising to 89% for recurrent schizophrenia. Fifteen per cent would not use the term 'schizophrenia' and a variety of confusing terminology was reported. Over 95% reported telling patients they had mood disorders or anxiety, under 50% that they had dementia or personality disorders.

CLINICAL IMPLICATION

Greater openness by psychiatrists about the diagnosis of schizophrenia may be an essential first step in reducing stigma.

https://doi.org/10.1192/pb.25.9.334 Published online by Cambridge University Press