Advances in Psychiatric Treatment (1994), vol. 1, pp. 3–8

Introducing continuing professional development

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Rationale for CPD

Most professions have recently realised that basic undergraduate and postgraduate training is not enough to maintain high standards of practice throughout a long career. Continuing professional development (CPD) has become a feature therefore of the working life of these professions, and medicine, which was in the forefront for undergraduate and postgraduate education, has somewhat lagged behind in this. The failure of consultants to keep up to date in their professional knowledge and attitudes is clearly detrimental to patients, to the doctors themselves, and to the Health Service.

The debate

The need for doctors to maintain their standards of practice and keep up to date has always been recognised by those in the profession who reflect upon their work (Royal Commission on Medical Education, 1968), but the pressures of everyday demands have reduced this to a minimum for many practitioners.

Psychiatry, in this, has been no different from other medical specialities. Internationally, the American Psychiatric Association has had a system of giving credits for continuing medical education (CME) workshops for many years, and the Royal Australian and New Zealand College of Psychiatrists has also introduced this; it is recognised that there is a need to take account of known principles of adult education, of the diversity of psychiatric practice, and hence CPD needs, and of whether CPD can alter psychiatric practice (Wright, 1991).

Experience of GPs

In Britain, much pioneering work has been done by the Royal College of General Practitioners over the last 30 years (College of General Practitioners, 1966). General practitioners themselves were, in general, in favour both of the pressure to make CPD in effect mandatory and of professional re-accreditation (Sylvester, 1993): 61% of respondents who were GPs in Cleveland considered that GPs should undergo re-accreditation, and 67% stated that this should be a part of CPD. Despite this early start into CPD, currently GPs in Britain are questioning its effectiveness and proposing a model of self-directed learning which, it is hoped, will improve competence (Al-Shehri *et al*, 1993).

The emphasis that GPs worldwide have given to CPD shows both the high professional standards of the discipline and also the recognition that intrinsic to the nature of their work is the danger of professional and academic isolation. At the same time, it has been shown that it is feasible for GPs to conduct a needs assessment to assist in the identification of GPs' own goals for learning (Ward & MacFarlane, 1993). Speciality education was believed to have contributed most to physicians' daily practice in Germany (Renschler & Fuchs, 1993).

Making CPD effective

Apart from a few who point out that there is no incontrovertible evidence that CME/CPD changes the behaviour of practitioners, the need has been almost universally accepted by patients and their organisations, managers and purchasing authorities, government and the Department of Health, as well as by every major medical body. The challenge has been how to make it effective. To this end, Harden & Laidlaw (1992) have introduced criteria with the acronym CRISIS (Box 1) as a means of both producing and evaluating new CPD materials.

In psychiatry, a course on clinical neurology for psychiatrists was considered by three-quarters of attenders to have enhanced clinical ability (Kaufman, 1988). However, in Britain the current extreme shortage of consultant psychiatrists for an ever-increasing number and scope of demands (Royal

Editor, *Advances in Psychiatric Treatment*, 17 Belgrave Square, London SW1X 8PG

College of Psychiatrists, 1992) jeopardises the availability of psychiatrists to receive CPD, and hence threatens a spiral of increasing overwork and decreasing time for CPD resulting in loss of enthusiasm for intellectual enquiry and loss of motivation for attempting to achieve time and resources for CPD. This threat is real, and has been shown for consultant old age psychiatrists who work very long hours and continue to work after returning home (Benbow *et al*, 1993). For every consultant psychiatrist to take advantage of opportunities for CPD will require contractual, designated time.

All the medical Royal Colleges have recently been concerned about CPD and its being made universally available to their memberships. As an example, the Royal Colleges of Physicians of the United Kingdom produced a report in June 1994 on CME for the trained physician. This discusses a system for CME, methods of regulating and facilitating it, how it should be funded and resourced, and concludes with recommendations that should be implemented by the end of 1994.

Background reasons for CPD

(1) CPD is the final component of the continuous process of medical education which has begun by the time of entering medical school and ends when the individual finally retires from all medical practice. Formal medical education begins at undergraduate level with the pre-clinical and clinical stages, and proceeds to postgraduate training through the relevant career grades in hospital specialities or general practice. After achieving trained status, CPD is required for the rest of that person's career. The emphasis is on achieving the best quality of patient care within available resources, and keeping up to date, which includes learning new information, practising old skills with proficiency, and learning new ones.

(2) New methods of treatment have been introduced into psychiatry over the last few years, and some are of proven effectiveness for certain psychiatric conditions.

(3) Recent changes in psychiatric practice have increased the competing pressures upon the time of the consultant psychiatrist. The consultant needs to learn how to use available treatment options for the maximum benefit of each patient. Some of the changes in working practices that have made time demands upon consultants are: the NHS Act 1991, and its consequences; the move towards community care for mental illness; and the effects of a reduction in junior doctors' working hours.

(4) There is much more litigation against all medical practitioners. This penalises ignorance as well as negligence. An ill-informed doctor is not only dangerous to patients but also a hazard from the employer's standpoint.

Box 1. Criteria for effective CPD

C Convenience
R Relevance
I Individualisation
S Self-assessment
I Interest
S Speculation and Systematic

(5) Patients, their relatives, and relevant pressure groups are now better informed of the full range of psychiatric treatments available, their potential hazards, and their relative efficacy. Increasingly, better practice is being demanded, with a wider range of options to give patients choice. This requires attention on the part of the consultant both to clinical skills and knowledge about treatment methods and also to ways of providing a high-quality service.

(6) Self-regulation of the profession, as carried out by the General Medical Council, was, in the past, concerned with bad practice resulting from professional misconduct and the ill health of doctors. In future, the General Medical Council will act when consistently poor performance by medical practitioners has become evident.

(7) Purchasing authorities are charged with the responsibility of buying services of an acceptable clinical standard. As quality measurement of clinical standards improves and becomes more directed to outcome measures, purchasing authorities will demand more expertise from the staff of provider units.

Box 2. Reasons for CPD

1 Continuous medical education from undergraduate to retirement
2 New methods of treatment
3 Changes in psychiatric practice
4 Litigation against doctors
5 Patient choice
6 Self-regulation
7 Purchasing-authority demands
8 To provide for those who do not educate themselves
9 Audit activities

https://doi.org/10.1192/apt.1.1.3 Published online by Cambridge University Press

(8) Until recently, continuing education for consultants has largely been *ad hoc*, and has depended more upon the dedication of the consultant than the needs of the service. It is excellent that many consultants are enthusiastic about their professional development, but there are some consultants who for various reasons do not receive continuing education and risk falling behind in their professional expertise.

(9) Relatively formalised audit activities take place in most hospitals and mental health services. Continuing education is an essential part of the audit cycle to correct deficiencies in the service or in individual practice. It will usually require further training or re-learning to rectify the problem; this will require a personal programme of CPD for each consultant, and its effectiveness should be monitored as part of audit activities.

Benefits accruing from CPD

To patients

Being treated by a consultant who takes part in CPD should result in more consistently high standards of clinical evaluation, and more knowledge of the indications for methods of treatment and their contraindications, side-effects, and disadvantages. Some patients have stated a preference for psychological methods of treatment: CPD should indicate when such approaches are applicable and relevant, whether their efficacy has been evaluated, and the precise manner in which they should be administered. As new methods of treatment are introduced, consultants should be enabled to learn them so that they can include them in their therapeutic repertoire.

To consultants themselves

Keeping up to date with the speciality helps the consultant maintain professional interest and personal self-esteem; it helps to prevent 'burn-out'. It is more likely that such a person will be involved in teaching others and in research. Continuing to enjoy clinical work is likely to result in the consultant performing better clinically, for longer.

To management

Provider units or trusts will clearly benefit from having consultant staff maintaining their clinical skills with CPD. It can be related to standards of clinical excellence that will be set by purchasing authorities. It also has potential benefits in association with litigation: it is to be hoped that poor practice will be less likely among doctors undertaking CPD, although currently there is no evidence to support this. CPD gives opportunities for specific retraining where this has become necessary. Purchasing authorities have had difficulty in finding direct measures for assessing mental health practice; involvement in CPD is at least measurable.

The consultant is responsible for the treatment of the individual patients under his or her care. Hence, ensuring that consultants contracted to provide services are receiving CPD appropriately should increase the likelihood of a satisfactory service for all patients. Management will need to ensure that there are adequate resources available for CPD.

To the general public

Well informed, professionally active consultants make a contribution to the local society beyond the hospital and the homes of their patients. They can make an educational contribution to the work of social services, schools, voluntary organisations, employers, and elsewhere.

What is CPD?

A valid CPD activity includes any educational or professional activity directed towards developing knowledge, skills and attitudes of the psychiatrist with the aim of improving practice. This should be interpreted broadly in deciding both the range of topics and the methods of learning. It is important that consultants maintain knowledge and skills covering many aspects of psychiatry and not spend all their available time for CPD on a single narrow speciality; at the same time, the highly developed specialities of a few individuals will benefit the whole profession.

Developing CPD

All medical Royal Colleges are currently concerned with CPD. The Council of the Royal College of Psychiatrists has recognised the need for further training and maintaining the skills of consultant psychiatrists (Tait, 1994): the Special Committee on Continuing Medical Education (now Continuing Professional Development) was established in February 1992; a steering group on courses has organised several short courses, workshops and other teaching activities, for both psychiatrists and others; the need for a College journal dedicated to CPD was accepted by Council in 1993 and has led to this publication; and in March 1994 Council accepted in principle that the College should offer prospective accreditation for consultant psychiatrists.

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Survey of opinions

A questionnaire was sent to a random sample of 307 consultant psychiatrists in the UK in November 1992. By May 1993, 243 responses had been received (a 79% response rate). It was found that consultant psychiatrists were involved to a considerable extent in attending local meetings, and also in teaching. However, 5% of respondents did not regularly attend any local meetings; 19% of respondents who attended few local meetings undertook minimal teaching duties, and they were less likely to attend any type of College meeting, and marginally less likely to attend regularly more than one type of non-College meeting. It would seem that those who do not attend educational activities locally are less likely to take advantage of other opportunities. Consultants with few local colleagues and those not involved in teaching junior medical staff or medical students are less likely to be involved in CPD. Failure to obtain locums or to get paid study leave were infrequently used as reasons for non-attendance at meetings.

The consultant psychiatrists surveyed were positive in their views towards CME; the majority of respondents considered that CME should be mandatory, and 57% considered there should be regular formal assessment.

Accreditation

From the random survey of consultant psychiatrists, the Royal College of Psychiatrists knows that a high proportion of its members in the UK participate in continuing education. It is the expressed wish of the majority of consultants that continuing education should be mandatory and that there should be some form of regular assessment.

Council of the College has accepted in principle the proposal to introduce accreditation of CPD for consultants. A certificate of accreditation will be provided prospectively, on request, for three years. These certificates will be confidential, and will constitute a contract between the College and the individual consultant; however, the consultant will probably wish to notify the management of the employing authority. There will be stipulated requirements of CPD for the consultant to fulfil; these will be appropriate to the speciality of psychiatry and the particular needs of the individual consultant post, and will detail requirements within each of four modules:

(1) psychiatric conferences and symposia, regionally, nationally and internationally
(2) specific training courses, seminars, and workshops dealing with particular aspects of patient care
(3) case conferences, clinical and audit meetings and other local activities
(4) reading, personal study and various forms of distance learning; *APT* will be of relevance for this module.

Clearly, there is a cost in providing accreditation for consultant CPD. If this were to be met by the College, it would require an increase in the membership subscription which would fall upon psychiatric trainees and overseas members as well as upon consultants in the UK. The College will therefore make a specific charge for accreditation; as accreditation of consultants is clearly to the advantage of employers, it is anticipated that they will reimburse consultants for these costs. Registration for accreditation is now available and will take effect from 1 January 1995.

What are other Colleges doing?

Representatives concerned with CME/CPD from the medical Royal Colleges met in March 1994. The detailed information from this meeting remains confidential at the time of going to press; however, all those represented had made some progress towards establishing and systematising CME. There was no consensus on the terminology – CPD or CME!

Consideration has been given to the situation where an individual might have affiliation to more than one College and also to the needs of those in part-time or staff-grade posts. There has been discussion between the Colleges as to whether College-based CPD should be mandatory and, if so, whether and what sanctions should be available. No decisions have yet been made, but there is both a general reluctance to introduce sanctions and an insistence that receiving CPD is the responsibility of every consultant.

The Colleges differ in their approach to monitoring participation and accreditation. There is also, at present, no uniform scheme for giving credits or even what activities should count towards credits. This is wholly understandable because the requirements for different specialities vary enormously. Funding CPD and finding the necessary resources is also a matter of debate between Colleges. At the time of going to press, formal CPD schemes have already been introduced by the Royal College of

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General Practitioners, the Royal College of Obstetricians and Gynaecologists, and the Royal College of Radiologists, and pilot schemes in geographical areas or among random cohorts have been established by several other Colleges.

There is considerable activity towards implementing systematic CME/CPD by all the medical Royal Colleges, and it seems likely that most will have some structure for accreditation by the beginning of 1995. The impetus for this has come both from inside the Colleges to improve standards and as a requirement to a perceived thrust in this direction from management and the Department of Health.

Who is responsible for CPD?

The consultant

Ultimately, consultant psychiatrists must be responsible for their own CPD, for ensuring that they keep up to date, learn new skills and maintain contact with developments in psychiatry. Inexperience and lack of required knowledge is no defence to an allegation of negligence, and the standard of skill expected of a consultant is that of those with whom he/she claims to have similar skills. The consultant must choose educational activities, and a record of accreditation will be maintained in association with the Royal College of Psychiatrists. It is the responsibility of the consultant to make sure that there is such a record and that it is kept up to date; it is also the responsibility of the consultant to make clear to management what resources and finance are needed.

The Royal College of Psychiatrists

Courses

The College has a duty to ensure that CPD is available nationally and locally; this can partly be done by the College itself providing courses, workshops, conferences and so on, both nationally and locally, and also by the College encouraging and approving the courses and other formats for education arranged by other bodies, such as university departments and postgraduate deans. The College must make sure that there is a wide range of appropriate educational activities available for consultant psychiatrists and notify consultants of these. It must also pay heed to managers, consultants and consumers as they express needs for the training of consultants. The College should try to achieve the best format for each type of educational activity, based upon educational knowledge and theory.

Accreditation

It is the responsibility of the Royal College of Psychiatrists to provide accreditation of psychiatric CPD. This will be organised individually for each consultant psychiatrist registered for accreditation. Confidentiality will be maintained and the College will accredit the psychiatrist prospectively for three years, during which time regular accounts on fulfilment of CPD requirements will be made by the consultant. CPD will be assessed within the four modules listed above.

This journal

Advances in Psychiatric Treatment is a journal specifically dedicated to CPD. Personal reading and study will form one of the required modules for CPD, and *APT* will be so designed that it enables consultant psychiatrists, at least in part, to fulfil these requirements.

The employing authority

The provider trust, unit, or other employing organisation will be required to acknowledge the importance of CPD for consultant staff and support its availability; this is part of maintaining standards which will increasingly be required by purchasing authorities. The employing authority will be required to allow consultants time to undertake CPD and also to defray reasonable costs, including the costs of educational courses, conferences and other activities; necessary travel and accommodation for such educational activities; maintaining the service in the absence of the consultant who is receiving CPD; library facilities and essential costs of private study. The administrative costs of accreditation should reasonably be met by the employing authority.

Advances in Psychiatric Treatment

Advances in Psychiatric Treatment is an official organ of the Royal College of Psychiatrists. The Editor answers to the Editor of the *British Journal of Psychiatry*, and the Editorial Board of *APT* to the Journal Committee, which is a Standing Committee of Council of the College. Currently, the Editor of *APT* is also Chairman of the Committee for Continuing Professional Development, which is a

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committee of the Court of Electors, and it is intended that the journal will be closely related to requirements of the College in CPD activities.

For the time being it is intended that *APT* will have six issues per year, issues appearing at two-monthly intervals and containing four short articles in each issue. 'Psychiatric treatment', in the title, is to be interpreted broadly, and so includes all aspects of clinical care and treatment, management of a service, training therapists, and research into the efficacy of specific treatments. For the time being it is intended that, in general terms, there will be one article in each issue on psychosocial aspects of treatment; one on physical treatments; one on management issues – managing a consultant-led service, including training junior psychiatrists and working with, training and learning from other professions; and one on treatment in a subspeciality of psychiatry. There will usually be a few multiple choice questions set at the end of each article. The intention is to link the articles of an issue thematically on some occasions, and also to extend a theme over related articles in successive issues. It is the intention of the Editorial Board to try to make as many of the articles as possible relevant not only to generalists, but also to consultants in the psychiatric specialities.

The articles will be comprehensive and informative, with an emphasis on a layout that facilitates assimilation. There will be opportunities for the reader to test what has been learnt from each article in the form of a few multiple choice questions.

Advances in Psychiatric Treatment will also contain information on what is available in CPD for consultants via the Royal College of Psychiatrists. The range of courses and workshops provided by the College is to be considerably expanded, and notices of these will be regularly enclosed. It is anticipated that others, such as university departments of psychiatry, other professional organisations like the Royal Society of Medicine, and perhaps government bodies will also arrange appropriate meetings, and when these have been approved by the College they will be advertised.

Ultimately, the quality of *APT* will depend to a considerable extent upon you, the reader. We intend to keep the topics of articles and their content closely directed towards the needs of consultant psychiatrists carrying out their day-to-day work. Although consultants differ enormously in the nature of their work and the setting in which it is carried out, there are more common themes than would at first appear, and most of the topics covered will be of some benefit to consultants in all specialities of psychiatry.

We would welcome suggestions from you for future articles. Have you been faced recently with a difficult clinical or managerial situation? We would like to accept the challenge to find an appropriate author to write on this topic – it is most unlikely that your problem was unique. In preparing for publication of *APT*, enquiry was made of the eight specialist sections of the College:

(1) What topics do you think all psychiatrists should be informed about?
(2) What topics do the consultants of your Section need to be informed about specifically?
(3) On what topics could experts from your Section usefully inform consultant psychiatrists who are not in your subspecialities?

Many of the articles in this and subsequent issues arise from their responses.

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