Continuing Medical Education

A survey of consultant psychiatrists' attitudes and practices

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Despite some general interest in the development and evaluation of continuing education for health professionals[1], the voluminous research literature on the subject is unfortunately equivocal as to exactly what approaches work and in which situations. In 1977, Bertram and Brookes-Bertram[2] reviewed 113 studies of continuing medical education (CME): they found that three out of the eight studies which they judged as acceptably designed showed persistent positive effects. More recently, of six studies which examined the effect of CME upon the quality of care, half reported positive effects and half reported no effect, although all the studies demonstrated cognitive improvements.

Thus, CME *can* work, in that it can improve the quality of care. But as to how it should best be implemented there is still dispute. Nevertheless there is general agreement that educational methods and content must be perceived as relevant by the intended recipients who should play a major role in the planning of CME. Note should also be given to research evidence about adult learning generally: as Davies[3] states, "It seems remarkable that postgraduate medical education has paid such scant attention to the methods and controversies of higher education".

In psychiatry, the topic of CME has been hotly debated, not least within the Royal College of Psychiatrists—one reason for the establishment of which was the promotion of study (and research). Over recent years the College has extended its CME activities by a variety of means—improved standards in its *Journal*, and a much expanded scientific programme at annual and quarterly meetings and those of specialist sections and divisions. More recently, it has been recommended that, following its initiative in the area of audit, the College should take a major initiative in this field.

Such an initiative would be timely in view of the widespread discussion in many countries about the possible 're-licensure' of doctors. In the USA, for example, CME is a requirement of membership in state medical societies and/or for re-registration of medical licence in 37 states. There, the American Psychiatric Association has been active, particularly through its 'psychiatric knowledge and skills self-assessment program' (PKSAP) which provides psychiatrists with an opportunity for self-evaluation and confidential peer audit.

In order to provide some baseline data on the situation in the UK and to facilitate discussion and planning here, we undertook a questionnaire study of consultant psychiatrists' attitudes towards the concept and implementation of CME.

The study

A questionnaire was designed and informally pilot-tested which asked respondents about: the perceived value of various available methods of CME; their general attitudes towards CME; their current usage of the principal journals; and the amount of time currently devoted to educational meetings and courses.

Background details of qualifications, age and training were also included, as was a self-categorisation of general approach to psychiatry—psychological/social versus physical.

The questionnaire was then mailed in the summer of 1985 to all consultant psychiatrists in all specialties in the UK. This was undertaken by the education department of the Royal College of Psychiatrists. Two follow-up requests were sent to non-respondents. Data from the returned questionnaires were analysed using the statistical package SPSS-X. The chi-squared test was used for both categorical and ordinal data. A 1% confidence level was set for the establishment of significance. Percentages are rounded to the nearest whole number and thus do not always add up to 100.

Of the 2098 questionnaires which were mailed, 16 were returned marked 'gone away', 'not practising psychiatry', 'retired' or 'deceased'; 1707 were completed satisfactorily. This represents a response rate of 82% of live, accessible and practising psychiatrists.

The respondents

Of the consultants, 78% first qualified in the UK; 26% qualified between 1945–55, 37% from 1956–65, and 37% between 1966–76; 48% had a higher qualification or degree other than M/FRCPsych.

Table I shows the main specialty or area of special responsibility of the respondents. Also shown are the proportions who received the major portion of training in different types of institutions and the type of institution in which they are currently based.

More of those who had first qualified overseas were working in psychiatric units in general hospitals than were home graduates—24% compared with 14%. More over-

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seas graduates also worked in hospitals for the mentally handicapped—10% compared with 4% of home graduates. Few of them are employed in university hospitals—11% (cf. 30% of home graduates)—and slightly fewer trained in this type of setting—56% as opposed to 66%.

TABLE I
Background information on respondents

Main speciality	%
General psychiatry, including special interest posts	62
Child and adolescent psychiatry	18
Mental handicap	7
Other (forensic, alcoholism and addictions, neuropsychiatry, psychotherapy, developmental medicine, liaison psychiatry, family psychiatry, health promotion, rehabilitation, community psychiatry, social psychiatry)	13

Institution where trained and working now	*Trained* %	*Working now* %
Bethlem/Maudsley, Institute of Psychiatry	19	3
Other teaching hospitals	46	23
Total 'university hospitals'	65	26
Psychiatric hospital or psychiatric unit in a general hospital	26	46
Hospital for the mentally handicapped	1	6
Child and family psychiatry service (NHS and local authority)	4	12
Secure unit or special hospital	0	3
Other	5	8

(Percentage figures: n = 1707, max.)

Approach to psychiatry

Respondents were asked to rate their approach to the practice of psychiatry by marking what they felt was the appropriate place on a nine point scale ranging from the one extreme of 'a total commitment to a psychological/social approach' to the other of 'an exclusively physical approach—e.g. drugs and electroplexy', with a halfway mark indicated as 'about an equal mixture of both'; 30% reported themselves at the psychological end of the scale, with 5% at the physical end and 65% in the middle—see Fig. 1. (We subsequently call these three groups 'psychological', 'organic' and 'eclectic' respectively). There is a highly significant difference between the distributions on this variable of the UK- and foreign-trained psychiatrists: more domestic graduates rate themselves as psychological and fewer as eclectic. There are also major differences between specialities – see Table II.

TABLE II
Psychiatrists' approach to psychiatry, by speciality

Main speciality	*Percentage of respondents in the speciality reporting themselves as psychological*	*eclectic*	*organic*
General psychiatry	14	79	7
Child psychiatry	74	26	0
Mental handicap	20	74	5
Other	50	46	4

Chi-squared = 458.9, df = 6, $P < 0.0001$.

Attitudes to CME and its methods

The consultants were asked to indicate their attitudes to a number of statements on CME on a five point scale. The results are shown in Table III. Few respondents felt that CME is a waste of time. Whilst on balance they were against re-certification, they felt strongly that if introduced this should be the College's responsibility. Again on balance, respondents were broadly content with current methods of CME in psychiatry and felt that CME should be based on individuals' diagnostically assessed needs. As a group, they were strongly in favour of both peer audit and the involvement in CME of other health professionals.

An enquiry was made as to what types of CME were felt to be of most value. Most popular, overall, were hospital, district or regionally based activities such as seminars, journal clubs or case conferences, followed by time off from one's usual activities to study or engage in research topics. The least value was attached to 'other' (i.e. non-College)

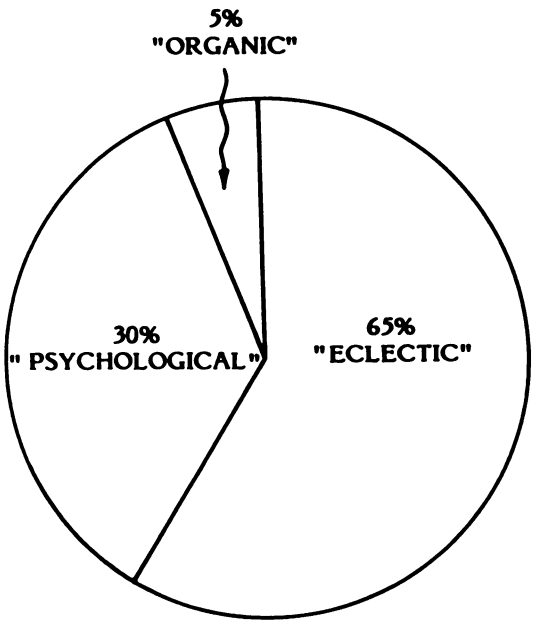

FIG 1. Respondents' general approach to psychiatry

non-residential meetings, followed by international scientific meetings. For details, see Table IV.

Current use of journals and meetings/courses

Respondents were asked about their use of the two major British general medical journals and the two principal psychiatric ones. The results are shown in Table V.

The respondents were then asked to give a rough estimate as to how many days they had spent in the past year attending meetings and courses related to any of their professional activities – clinical, research, teaching, administration. The results were:

None	1%
1–2 days	6%
3–5 days	19%
6–10 days	33%
11–20 days	21%
More than 20 days per year	19%

Attitudes, approach and practices of sub-groups of respondents

Our respondents may be grouped in a number of ways – by orientation, specialty, date of qualification, type of institution where trained or currently working, and the possession of higher qualifications. We investigated whether these groups differ in how they view CME.

With respect to general attitudes to CME, those psychiatrists with an organic orientation are least likely to agree with the proposition that 'CME should involve other professionals'. Child psychiatrists have a very favourable attitude to the involvement of other professionals—49% agreeing with this statement as compared for the group total of 39%.

Who values which type of CME? Those who had qualified most recently saw research time and courses devoted to improving teaching methods as more useful than those who had qualified earlier. Those with higher qualifications attached more value to attending international scientific meetings and the opportunity to take time off for study and research.

Overseas graduates viewed College meetings, those of specialist sections, international scientific meetings and courses to improve teaching methods as more useful than did their home graduate counterparts.

Those who trained at the Bethlem/Maudsley attach particular value to time off for research and less than do others to self-learning activities. Those working in university hospitals attach more value to international scientific meetings and time off for research. Finally, consultants with an organic orientation attach more value than do others to College meetings and other non-residential meetings, and less to specialist section activities.

As regards their use of journals, general psychiatrists and those working in mental handicap spend more time reading

TABLE III

Attitudes of respondents to continuing medical education

	Agree	*Tend to agree*	*Mixed feelings*	*Tend to disagree*	*Disagree*
I think that broadly speaking, CME is a waste of time	1	3	7	21	68
Some form of recertification is desirable for all specialists	7	18	28	21	27
I am broadly content with current methods of CME in psychiatry	11	32	35	15	7
CME should be based on individuals' diagnostically assessed needs	11	33	29	18	9
Peer audit is an effective way of keeping our practice up-to-date	24	35	25	9	8
Ideally CME should involve other professionals in fields related to psychiatry	39	37	13	5	6
If audit/recertification is introduced then it should be the College's responsibility rather than anyone elses to supervise it	57	24	12	3	4

(Percentage figures).

TABLE IV
Perceived value of different types of CME

	Very useful	*Some use*	*No view*	*A little use*	*No use*
Hospital, district or regionally based activities such as seminars, journal clubs, case conferences	57	36	1	6	1
College meetings—annual or quarterly	23	56	3	15	3
Meetings of College specialist sections	38	41	9	10	3
Other non-residential meetings—including drug firms' sponsored events	9	48	10	26	7
Courses or meetings lasting more than one day—including drug firms' sponsored events	24	43	9	17	7
International scientific meetings e.g. World Psychiatric Association	13	26	21	19	22
Time off your usual activities to study or engage in—or write up—a research topic	54	26	8	7	5
The opportunity to visit other units	50	39	3	7	1
Self-learning using educational aids such as audio or video tapes or TV programmes along the lines of the Open University	19	41	14	18	8
Courses or meetings devoted to improving teaching methods or techniques	22	38	15	18	7

(Percentage figures).

than others — especially child psychiatrists. Those who qualified overseas reported spending more time looking at the *British Journal of Psychiatry* and *Psychological Medicine* than their home graduate counterparts. Also, the 'organic' group read more than the 'eclectic' and 'psychological' psychiatrists.

Who takes time off to go to meetings? More often, those with higher qualifications, those working in 'other fields', those trained at the Bethlem/Maudsley and other university hospitals, and those currently working in these hospitals. Consultants who spent less time attending meetings placed a lower value generally on CME; they see activities lasting more than one day and international scientific meetings as of less use than their more frequently-attending peers.

Comment

Perhaps the most notable and important finding of this survey is the overwhelming support of respondents for the concept of CME: only 4% thought that CME was, broadly speaking, a waste of time. They also support the involvement of other professionals but oppose recertification, although if it were to be introduced then they believe that it should be the Royal College's responsibility. The majority give support in various degrees to the idea of peer audit.

International scientific meetings are rated relatively low in value, but the College's activities—especially specialist section meetings—are seen as useful. However, the most value is attached to hospital, district or regionally based activities.

Different sorts of psychiatrists like different types of activity. There is therefore a need for a range of CME activities to cater for different interests, approaches and needs. Although many people would reportedly welcome more time off to engage in research, 60% were taking fewer than the allocated number of study leave days each year. This discrepancy suggests that a great many psychiatrists cannot —or feel that they cannot—take their statutory period for education off. This is particularly disturbing when it has been shown[4] that participation in CME can enhance standards of practice.

This finding emphasises the need for more educational activities to be situated not too far from consultants' places of work; these could be organised by hospitals, universities and the College. The last will have a major role to play in the provision of CME activities—one example would be to encourage an increase in the frequency of divisional meetings with the content of the scientific programme reflecting the need for CME. Further initiatives will need to be considered, paying attention to those in operation elsewhere such as the American 'PKSAP' approach referred to above.

It has been suggested that older doctors may be less likely to participate in CME programmes. We found no evidence to support this in terms of psychiatrists' attitudes, nor their reported use of journals or attendance at courses.

TABLE V
Time spent by respondents reading a typical issue of each of four journals

Journal	*'Don't normally look at it'*	*'Glanced through only'*	*'More than a glance, less than 1 hour'*	*'One to two hours'*	*'More than two hours'*
British Journal of Psychiatry	1	5	29	48	18
Psychological Medicine	37	13	23	20	8
British Medical Journal	11	20	50	18	2
The Lancet	52	21	22	4	1

(Percentage figures).

But perhaps the most worrying result concerns the use of journals. Over half the respondents did not normally look at *The Lancet*, with fewer than 27% giving it more than a glance. Similarly, only half gave more than a glance to one of the two leading British journals in the field of psychiatry, *Psychological Medicine*. This is despite a general acceptance for the idea of CME. Through the use of such techniques as journal clubs, organisers of CME must address this apparent paradox.

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REFERENCES

[1] ABRAHAMSON, S. (1984) Evaluation of continuing education for the health professions: the state of the art. *Evaluation and the Health Professions*, **7**, 3–24.

[2] BERTRAM, D. A. & BROOKES-BERTRAM, P. A. (1977) The evaluation of continuing medical education: a literature review. *Health Education Monographs*, **5**, 330–362.

[3] DAVIES, I. J. T. (1981) The assessment of continuing medical education. *Scottish Medical Journal*, **26**, 125–134.

[4] QUICK, S. K., ROBINOWITZ, C. B. & WILSON, P. T. (1981). Results of the APA self-assessment program. *American Journal of Psychiatry*, **138**, 1587–1591.

Note. At the Editor's request, only principal references and those specific to psychiatry are given. A full list of references is available from the authors.

The 1983 Mental Health Act in Practice

The MSD Foundation, in collaboration with the Open University and with funding from the National Health Service Training Authority, has developed a new pack of educational materials for use by general practitioners, psychiatric nurses, psychiatrists and social workers on the workings of the 1983 Mental Health Act. The materials aim to help them to examine their own experiences and to consider how the Act has affected patients and their families.

The pack is designed for use in multi-profession or single-profession groups and consists of one *Course Leader's Book* which provides detailed guidance about setting up and running a course, together with considerable background information about the Act; one *C45 videocassette* of trigger material to be used during group meetings and seven *Course Members' Notes* which provide a summary of the course, background information and group exercises. Additional packs of seven *Course Notes* are available for larger groups.

The course is designed for three $1\frac{1}{2}$ hour group meetings, each of which comprises a series of exercises, some using video material. Further information: The MSD Foundation, Tavistock House, Tavistock Square, London WC1H 9LG (telephone 01 387 6881).