Exploring radiographers’ attitudes to mandatory CPD in the United Kingdom and New Zealand

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Abstract Introduction: This paper reports the first phase of a two-phase longitudinal study which explored the attitudes of radiographers in two countries (UK and New Zealand) towards CPD, before and after the introduction of a mandatory CPD policy. In addition, this paper outlines in brief the planned phase two of the project, which will be undertaken to assess whether attitudes change over time, following the introduced mandate. Methods: 1739 radiographers across both countries were approached via a survey using a written questionnaire with quantitative and qualitative components endorsed by the relevant professional body in each country (Society of Radiographers and the New Zealand Institute of Medical Radiation Technologists). The questionnaire was statistically analysed using t-tests. In addition, the qualitative components were analysed thematically, to add depth and explanations to the findings. This paper presents the results, focusing especially on the qualitative data in order to fully explore the attitudes demonstrated. Results: The results of the study showed that a degree of apathy surrounded CPD participation, despite the professional expectation that staff be CPD active. On an individual level, radiographers self reported a low level, or a complete lack of formal recording of CPD. A number of barriers were identified, which were perceived by participants to restrict their CPD activity, including, of particular note, poor staffing levels and lack of employer support. Radiographers in both countries appeared to have a narrow understanding of what is perceived to constitute CPD, with an apparent focus on formal, attendance-based activities. Less formal, on-the-job activities were not always considered as CPD by participants in this study. Conclusion: This study outlined a range of factors which impact on attitudes towards CPD, with many similarities in findings across both countries represented. A lack of intrinsic motivation was demonstrated, which is perceived to hamper active participation in CPD. There was a desire for personal benefit from CPD participation to be evident, in order to motivate individuals to get actively involved. The complexity of the current working environment was outlined, with acknowledgement that the mandatory policy towards CPD is not the only factor affecting participation. While further research will be required to examine the impact of all the variables affecting CPD, the results of this study may allow individuals and managers to begin to interact with CPD participation in order to attempt to increase the level and effectiveness of learning in practice.

Keywords: attitudes, international, mandatory, professional development, radiography.

Introduction

Continuing Professional Development (CPD), within the radiographic profession, is now well accepted.¹² In many countries there is a mandatory requirement to participate in CPD activity, linked to registration to practise. This was not always the case and over the last 20 years in health care generally, there has been an attitude and culture shift towards the need for more formal ongoing development.

While the need for CPD is now well established, there has been, and still remains, some debate about whether or not any link to competence to practise can be established from CPD activity.³,⁴,⁵ It is claimed by some that a belief in a positive impact on practice is enough to justify a CPD requirement being introduced,⁶ questioning the need for empirical evidence to show positive effects.

In the UK and New Zealand, at the turn of the century, there were discussions around the introduction of a mandatory policy for CPD, linked to registration to practise. This opened up a one-off opportunity to replicate a study, undertaken in nursing (and subsequently in medical imaging) in America, to show whether or not attitudes towards CPD changed, once such a mandate had been introduced.

Walshe-Arneson’ investigated nurses’ attitudes to CPD pre and post the implementation of a mandatory policy, and in a two-year follow-up study she showed that attitudes towards CPD and participation in CPD activities became more positive. A similar study in medical imaging was also undertaken in Florida.⁷,⁸ This study then aimed to replicate those studies to assess whether the implementation of mandatory CPD had any impact on practitioners’ attitudes in medical imaging in New Zealand and the UK.

CPD for medical imaging practitioners was legislated in New Zealand in 2003 (with the policy being implemented in 2004) and in the United Kingdom in 2001 (though the policy was not implemented there until 2005). Throughout the time of this study, there was then a clear expectation of professionals in both countries to be CPD active. It is worth noting, that while each country approached the implementation of a mandatory policy differently, in both countries there was a delay in actively assessing compliance, particularly in the United Kingdom, which at the time of writing (2009) has
still not audited participation; this may have impacted on the actual levels of involvement in compulsory CPD.

Due to the nature of the changes in legislation, this was a time-limited study, which could only be replicated if phase one of the study was undertaken prior to the legislation being implemented. As such, it provides data regarding the attitude of staff towards CPD at that time, and provides a historical record of any attitude shift that might be demonstrated.

(Phase two of the study, comparing attitudes of radiographers in the UK and New Zealand, following the implementation of a mandatory requirement to participate in CPD is being undertaken; this and will be reported separately to see if the results of those previous studies will be duplicated in medical imaging in two different countries.)

Methods

Phase one

A written questionnaire was originally designed for UK radiographers, based on previous work by Henwood et al. on CPD to establish the main themes as part of a survey method of research design. The questionnaire was designed in three main sections to collect: demographic data, attitudes towards CPD, using a Likert scale questionnaire and open ended questions to allow for qualitative data on any aspect of CPD important to the participant.

(An initial pilot questionnaire was used to reduce the size of the attitude survey, through the use of factor analysis, to ensure a short, highly discriminating questionnaire, which would take a minimum amount of time to complete).

The UK questionnaire was subsequently revised and adapted for use in New Zealand to ensure that appropriate and understandable terminology was used. Changes included: the name of the professional body, the title of the journals sent directly to radiographers and the different career structure and role titles in New Zealand.

In the UK, the questionnaire was sent by post to 250 radiographers selected randomly (using a random number generator) from the Council for Professions Supplementary to Medicine (CPSM) register (prior to the Health Professions Council (HPC) being established). A small sample was used to reduce costs, the aim being to establish a base line attitude measure for staff, across the country, from a variety of backgrounds. Sampling bias was minimised by using random sampling. Due to the number of registered professionals in the UK, it was not feasible to sample the whole population, which it is accepted may affect the reliability of the UK data. Prior to the second phase of the study, a t-test sample size calculation was performed using the Sigma-Stat (Aspire Software International, Ashburn, VA 20147, USA) program. An alpha of 0.05 and a power of 0.8 was used to determine the minimum sample size needed to identify a 5% change in the second phase of the study from the first.

In New Zealand, the questionnaire was sent by post to all radiographers with a current annual practising certificate, which at that time numbered 1489. The study was supported financially, making a larger sample size possible and the reduced total number made analysis manageable.

The questionnaires in both countries were distributed with stamped addressed reply envelopes to encourage increased return rates and were unmarked, to allow for anonymous responses. Anonymity was assured to facilitate open and honest responses, to increase the validity of the findings.

The Society of Radiographers (SoR) and the New Zealand Institute of Medical Radiation Technologists (NZIMRT) agreed to endorse the questionnaires, which it was felt would give greater credibility to the survey and hopefully increase the response rates to maximise the reliability of the data. In both countries the professional body logo was added (with permission) to the top of the first page.

Phase one data collection was undertaken in 2002/3 (UK) and 2003/4 (New Zealand) and phase two data collection was undertaken in 2008 (NZ) and 2009 (UK). The bulk of the literature used, to set the scene for this study, reflects the timescales for phase one of this study to highlight published attitudes and opinions at that time, which may have informed participants’ opinions. In addition, newer literature has been used to show how those attitudes, and how they are portrayed in the literature, have changed over time.

Phase one (and the ongoing phase two) of the study were undertaken with approval from the relevant educational institutions’ research ethics committees (City University, London and Unitec Institute of Technology, New Zealand, where research staff from this study were employed).

On return, the questionnaire was analysed using independent samples t-tests in order to compare the various questionnaire’s themes between the two countries. The open questions were analysed thematically, using a descriptive and interpretive framework. The deeper data available was used to support and explain some of the statistical findings, offering a limited form of triangulation to increase the validity of the data.

The UK and New Zealand data were fully analysed in isolation to establish a base line attitude measure for each country, before a statistical comparison between the data sets then being undertaken to offer a comparison of findings between the two countries.

Results

Phase one

In the UK, 52% of the sample returned the questionnaires (n = 130) and in New Zealand, 41% of questionnaires were returned (n = 598), giving a total sample of 728.

A range of the quantitative results is set out – qualitative com-

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**Table 1: Gender.**

<table>
<thead>
<tr>
<th></th>
<th>Male %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK</td>
<td>13.9</td>
<td>86.1</td>
</tr>
<tr>
<td>NZ</td>
<td>12.9</td>
<td>87.1</td>
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</table>

**Table 2: Age.**

<table>
<thead>
<tr>
<th></th>
<th>Mean age</th>
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<tbody>
<tr>
<td>UK</td>
<td>40.15</td>
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<tr>
<td>NZ</td>
<td>38.67</td>
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</table>

**Table 3: Break from service.**

<table>
<thead>
<tr>
<th></th>
<th>Break %</th>
<th>No break %</th>
<th>Length (Yrs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK</td>
<td>33.8</td>
<td>66.2</td>
<td>5.79</td>
</tr>
<tr>
<td>NZ</td>
<td>53.1</td>
<td>46.9</td>
<td>5.82</td>
</tr>
</tbody>
</table>

**Table 4: ‘Type’ of MRT/Radiographer.**

<table>
<thead>
<tr>
<th></th>
<th>Diagnostic %</th>
<th>Therapy %</th>
<th>Dual qualification %</th>
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</thead>
<tbody>
<tr>
<td>UK</td>
<td>84.8</td>
<td>1.3</td>
<td>13.9</td>
</tr>
<tr>
<td>NZ</td>
<td>87.6</td>
<td>10.7</td>
<td>1.7</td>
</tr>
</tbody>
</table>
Table 5: Mean scores by CPD classification.

<table>
<thead>
<tr>
<th>Mean Score</th>
<th>Nationality</th>
<th>n</th>
<th>Mean Score 1-ve - 8+ve</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total (CPD Score)</td>
<td>UK</td>
<td>79</td>
<td>4.1</td>
</tr>
<tr>
<td></td>
<td>NZ</td>
<td>467</td>
<td>4.3</td>
</tr>
<tr>
<td>Recording</td>
<td>UK</td>
<td>79</td>
<td>3.7</td>
</tr>
<tr>
<td></td>
<td>NZ</td>
<td>467</td>
<td>3.7</td>
</tr>
<tr>
<td>Activity</td>
<td>UK</td>
<td>79</td>
<td>4.4</td>
</tr>
<tr>
<td></td>
<td>NZ</td>
<td>467</td>
<td>4.2</td>
</tr>
<tr>
<td>Support</td>
<td>UK</td>
<td>79</td>
<td>3.9</td>
</tr>
<tr>
<td></td>
<td>NZ</td>
<td>467</td>
<td>4.2</td>
</tr>
<tr>
<td>Status</td>
<td>UK</td>
<td>79</td>
<td>4.3</td>
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<tr>
<td></td>
<td>NZ</td>
<td>467</td>
<td>4.5</td>
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<td>Outcome</td>
<td>UK</td>
<td>79</td>
<td>4.5</td>
</tr>
<tr>
<td></td>
<td>NZ</td>
<td>467</td>
<td>4.8</td>
</tr>
</tbody>
</table>

One area of concern for both countries during phase one was the overall lack of recording of CPD, which is an issue being studied again in phase two, following the mandate being introduced. The percentage of those recording CPD was slightly higher in the UK and this may have reflected the length of time a CPD policy had been in place (1997 in the UK, as opposed to 2000 in New Zealand), indicating that CPD was incorporated into the professional culture earlier, with staff ‘getting used’ to the idea before the first questionnaire was distributed. In addition, from very early on it was anticipated that the UK policy would move from voluntary to mandatory and this may have encouraged radiographers to put a recording mechanism in place. The SoR also made available a portfolio style recording mechanism to all members (initially at cost, but subsequently free) which may have contributed to higher recording figures in the UK. However, in both Physiotherapy and Nursing, it has been found that practitioners had poor skills in reflective practice and recording of CPD and struggled with the concept of portfolios, despite portfolios having been in place for some time. These findings indicated that availability and expectation alone are insufficient to bring about effective usage of portfolios to record CPD.

Looking at the views of radiographers on CPD, the percentage of radiographers who thought that CPD should be mandatory was slightly higher in the UK (57.7% as opposed to 42.3%). Again this may reflect the fact that radiographers in the UK had longer to become used to the idea of compulsory CPD. Anecdotal however there is some suggestion that the continual delays in the actual implementation of the mandate raised questions as to whether it would actually happen in practice, and may have contributed to a decrease in attitudes towards CPD over time.

The thematic analysis from the qualitative comments about CPD frequently indicated very emotive and polarised attitudes and because of the depth of those comments, this paper concentrates on that qualitative data, giving depth and understanding to some of the issues raised and attitudes highlighted. (New Zealand quotes are presented in italic text and UK quotes are presented in bold italic text so that the country of origin can be identified.) Following analysis the qualitative comments were clustered into several themes. In each theme, the comments set out here represent opinions from radiographers in both countries at the time of the survey.

Discussion

The results comparing UK and New Zealand radiographers showed surprisingly similar results. Following statistical analysis, few statistically significant differences were demonstrated when comparing the attitudes of practitioners in the two countries. One area of concern was the overall lack of recording of CPD, which is an issue being studied again in phase two, following the mandate being introduced. The percentage of those recording CPD was slightly higher in the UK and this may have reflected the length of time a CPD policy had been in place (1997 in the UK, as opposed to 2000 in New Zealand), indicating that CPD was incorporated into the professional culture earlier, with staff ‘getting used’ to the idea before the first questionnaire was distributed. In addition, from very early on it was anticipated that the UK policy would move from voluntary to mandatory and this may have encouraged radiographers to put a recording mechanism in place. The SoR also made available a portfolio style recording mechanism to all members (initially at cost, but subsequently free) which may have contributed to higher recording figures in the UK. However, in both Physiotherapy and Nursing, it has been found that practitioners had poor skills in reflective practice and recording of CPD and struggled with the concept of portfolios, despite portfolios having been in place for some time. These findings indicated that availability and expectation alone are insufficient to bring about effective usage of portfolios to record CPD.

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Discussion

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Table 6: Radiographers recording their CPD activity.

<table>
<thead>
<tr>
<th>Nationality</th>
<th>Recording CPD %</th>
<th>Not recording %</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK</td>
<td>38.0</td>
<td>62.0</td>
</tr>
<tr>
<td>NZ</td>
<td>27.2</td>
<td>72.8</td>
</tr>
</tbody>
</table>

Discussion

The results comparing UK and New Zealand radiographers showed surprisingly similar results. Following statistical analysis, few statistically significant differences were demonstrated when comparing the attitudes of practitioners in the two countries.

Table 7: Should CPD be compulsory?

<table>
<thead>
<tr>
<th>Nationality</th>
<th>Compulsory %</th>
<th>Not compulsory %</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK</td>
<td>57.7</td>
<td>46.1</td>
</tr>
<tr>
<td>NZ</td>
<td>42.3</td>
<td>53.9</td>
</tr>
</tbody>
</table>

Discussion

The results comparing UK and New Zealand radiographers showed surprisingly similar results. Following statistical analysis, few statistically significant differences were demonstrated when comparing the attitudes of practitioners in the two countries.
“I think initially the only way forward would be to have clear cut guidelines and a statutory obligation from the NHS to provide more funding.”

Staff in both countries expressed concern at the cost of joining a recognised CPD program in addition to having to pay for CPD events:

“Opposed to the use of the NZIMRT system for recording CPD, but support continuing development. I will not pay to register for the NZIMRT system.”

“The society is out of touch and usually has an ulterior motive in everything and I would begrudge paying them any more money than I do. I would be tempted to leave rather than pay them for something that they don’t contribute to in any way.”

Cost of undertaking CPD activity has consistently, over time, been shown in studies to be a significant barrier to CPD participation in healthcare. It would appear that the cost of belonging to a CPD program is also a consideration to staff, in addition to the cost of individual CPD activities.

Remoteness/access

There is clearly an issue of access for staff working in remote regions of New Zealand:

“Consideration needs to be given to MRTs working in small or remote areas, where access to courses and funding may be more difficult.”

“We are a small rural hospital with only two staff covering a 24 hour service. This makes our free time very valuable and also means that we cannot always (or even often) get to CPD lectures etc, especially as travel is usually involved.”

This was not raised as an issue by UK radiographers in this study, but in other studies in the UK, distance away from London in particular, and other areas remote from established educational facilities with provision for radiographers, was shown to be an issue.

Short staffing/sole charge roles facilitating CPD

Inadequate staffing and associated high workloads were raised in both countries as a major stress in relation to the ability to participate in CPD activities.

“We are too tired, busy, during the day due to being short staffed to attend any CPD activities. We are always filling in due to sickness/ holidays, time off can’t be confirmed for further education, especially due to staff shortages.”

“To put it succinctly, unless we can attract staff or are allowed to appoint/ employ extra staff to release existing staff, I would find it impossible to entertain the aspirations of CPD.”

“With the pressure of work and due to staff shortages, CPD is difficult to maintain and it is difficult to get time off for CPD.”

“With over stretched manpower and far too much on call – exhaustion is the chief concern!”

Related to this was the perceived value of CPD and how high a priority it should be given in the current climate of staff shortages. There is, as yet, no proven link between CPD and any direct improvement in patient care or any link to competence to practice. Some studies have shown links, at least in the short term for very specific skills-based courses, but in terms of a general and broad CPD policy, there is no empirically demonstrated link to improvement in outcomes for the individual, the patient or the professions. Some staff expressed the view that until such a link could be demonstrated, they would be reluctant to pay further pressure on existing staff by taking time out of the working day to undertake CPD.

It is important to note that the staff represented in this study, were reluctant to use their own time to undertake CPD activity; in practice CPD (as defined by those practitioners) was not being undertaken by many. This shows variance from at least one other recent study undertaken across Europe, which showed that radiographers, on average, were prepared to give seven hours a month of their own time for CPD. This may indicate a different attitude to CPD across Europe, outside of the UK, or that attitudes have changed in recent years. Phase two of this study will explore this in more detail.

Other commitments

Commitments outside of work lives were often cited as a reason why CPD was not undertaken more often by radiographers. Interestingly, part-timers saw that their other commitments were of more significance than for full-timers, while those working full time saw this as even more reason why outside commitments had precedence:

“I’m only working two days per week – have two young children and no time to do CPD as it disrupts home/work balance. As long as I stay reasonably up to date and perform within the limits of my work environment then I feel competent.”

“I have three young children — more time will be spent on CPD when they are older and more independent.”

“CPD is important in order for a professional to keep up to date with new ideas and techniques but to make it mandatory would make it difficult for someone such as myself (a mother of two small children) to keep the career going.”

“Full time MRTs have minimal free time anyway and part-timers have other important commitments (usually children).”

Interestingly, the last participant did not immediately think that those working full time might also have similar outside commitments such as children.

Studies by Yielder, Dowsell, Hewison and Hines and McQuillan have shown that when ranking the importance of barriers, family commitments and personal activities were considered to be a moderate barrier, ranking on average fourth out of the list of identified barriers. (In this study participants were not asked to rank the barriers.)

Time and timing

Many comments were made about the lack of time available and the need for time to be made available for radiographers to be involved in CPD. Most felt that employers should allow time during the working day. Again, this area generated strong opinions:

“I resent doing CPD. I feel very pressured to give up my time to do it. I sometimes read interesting articles of my own choice. My manager is very supportive, finance is given, but as a part timer I am expected to do it in my time! This is precious to me and I am fully committed in it. I do not think CPD enhances patient care. University graduate MRTs lack people skills and experience and are rigid in their practice. Reading about it doesn’t make you good at it.”

“… it is difficult to get time off for CPD.”

The qualitative data in this study suggests that if provision was made for study leave by employers (an issue which has been lobbied for by the Society and College of Radiographers in the UK for several years, this could make a difference to individual attitudes. A joint statement was released in 2007 requesting six days per year protected study time for nurses and allied health professionals in the UK.

Radiographic literature on this subject is mixed. McQuillan and Henwood and Huggett demonstrated that participants had
a clear preference for attending CPD activities in work time, whereas in Yielder’s study,13 respondents were divided, with many indicating a preference for CPD to be conducted outside of working hours. In nursing Gould, et al.1 showed nurses objected to being expected to use their own time. Although this study appears to focus on formal study with assessments, it does demonstrate recent attitudes towards using time for CPD and clearly this remains controversial.

Management/employer attitudes and support

Radiographers cited both positive and negative experience in terms of attitudes towards their staffs’ CPD activity. Positively it was said that:

“At our practice we do not record CPD but have a strong commitment to ongoing education and all staff are encouraged to attend lectures and conferences wherever possible. Records are kept of all attendances.”

“I feel very strongly in favour of CPD and am very privileged to have the support of my manager and Charge MRT. I realise that I am also working in an exceptional circumstance, where we can schedule a study day in for all our staff, and we can re-schedule appointments (none of us do call or weekend work). Also, the fact that our managers have always supported staff workshop/study days and this has become integrated into our year (two to three every year for all staff). It’s not like that in most departments/practices. The benefits for all staff are considerable and not just the radiographers.”

And negatively:

“Where I work, it doesn’t matter where your gift or skill is, management do not want to recognise it, especially if extra money is involved. The bottom line is, management DON’T CARE!”

“From what I hear and see, some employers do not give their staff encouragement to stretch themselves at all.”

“I am in a small department – my boss and the district superintendent make no effort to encourage or support any CPD effort on behalf of myself or the other ‘general’ radiographers – the sonographers are required to attend the main unit for meetings and appraisals – they also get study days. The department nurse whose boss is in the main unit gets to go on study days. I was a senior before my career break and found when I returned that I had more skills than the Superintendent III in charge of me. She is reluctant for me and other radiographers stuck doing general duties to do any role expansion at all. We would enjoy the opportunity for CPD but are told that most of the things we are interested in are of ‘no benefit’ to our job here!”

However there was a general view that:

“Bosses/management should see the benefits of professional development.”

In the literature, managers have been perceived as ‘gatekeepers’ to CPD opportunities1 and Ellis and Nolan14 and Hughes,22 reported that they were key to permitting or withholding opportunities. Lack of support by managers generally has been reported as an ongoing barrier to CPD participation.20

Career structure/salary issues

Participants expressed concerns about the lack of a career structure and poor salaries, and felt that improvements in both areas may help more staff to “buy in” to CPD. For example:

“I do strongly feel that if I am expected to do a lot of postgraduate study to maintain my skills as a ‘professional’ then our wages need a review as they definitely don’t support the view that we are ‘professionals’.”

“Until MRTs are paid as professionals with a salary that reflects our status and importance in a hospital environment. Otherwise why should we bother?”

“I feel I do a good job which is appreciated by my patients, although the salary and recognition fall far short. The members of the public make me want to keep working.”

In two studies on retention and job satisfaction,16,22 it was confirmed that MRTs in New Zealand think that better promotion and CPD opportunities would increase their level of job satisfaction and aid in retention of staff. This view is supported by Henwood22 in the UK. It could be noted too that in this study there was still an incorrect perception being expressed that CPD equates to post-graduate and formal, attendance based study.

Lack of information/understanding

There was generally a poor awareness of the breadth and scope of activities that constitute CPD. Many of the more negative comments stemmed from the continued misconception that CPD is about having to do courses or attend study days. For example:

“The thought of sitting a degree is mind-boggling. I could not do it. As long as the doctors and radiologists are happy with my films then I see no need to sit any exams.”

“As our profession is very practical, a lot of academic work/reading does not necessarily mean we will be better at our job, providing a better service.”

“Going on a course especially if it is not particularly relevant to your job does not make you a good radiographer.”

There was little conception in this study as to the range of activities which could be considered to be CPD. This means that in practice radiographers are unlikely to recognise or value the CPD they are already undertaking (and this might also explain why it is not being recorded as CPD activity).

Many participants were adamant that they are completely competent and did not need to do CPD:

“I am very competent at the job that I do. CPD would not affect or enhance my competency in any way.”

“What worries me is the system run by the NZIMRT doesn’t allow for a lot of part-time older staff, who have been doing the same things for years and have no intention of developing into a CT/MRI or whatever MRT. They don’t need CPD to x-ray chests and wrists etc.”

“CPD is not really necessary for a radiographer in the last 5 years of a career. All the reflective daily practice is automatically done mentally as a professional.”

This was, as outlined by the comments above, often related to their particular role or stage of career.

Others were less negative towards CPD, but could see no need to formalise it:

“I feel I don’t need the NZIMRT board to decide whether or not my CPD is up-to-date or good enough for them, via the paperwork I put forth. I would struggle to find a radiographer who hasn’t improved their career in one form or another within the last two years.”

These comments are a reflection of the general negativity and apathy that was evidenced from many of the qualitative comments in this study. Many radiographers could not see how CPD could impact on or improve their job, and this may have contributed to the overall negative attitude towards CPD. This may in part be explained by findings from other studies which show that practitioners seem unable to recognise benefits unless the course content relates directly to the work they are currently undertaking: they appear to have difficulty applying what they learn in
practice. Sim and Radloff have also identified low self-esteem and apathy in relation to ongoing learning in radiographers in Australia, possibly indicating a widespread negativity in medical imaging professionals, which if empirically evidenced would be of concern for the future development of the profession.

Positive attitude
While there were many negative comments in the qualitative section of the questionnaire, there were also some extremely positive comments in support of CPD. Some agreed that CPD is a good idea, but do not accept that mandatory CPD will be beneficial:

“CPD is a good idea, but I do not agree with compulsory involvement. Staff will only learn if they are participating willingly.”

This is certainly supported by theories of adult education. For example, Morrison (cited in Yielder, Henwood, Flinton & Pennick) argues that any form of compulsory education, particularly for re-licensure, is not congruent with the nature of both being a professional and an adult learner. As professionals we should be sufficiently self-directed to undertake further training and education from an autonomous rather than a mandatory motivation. However, the argument for mandatory CPD, according to Maple (cited in Yielder, et al.), is to protect the public from professionals who are too lazy to participate voluntarily, to remove people who no longer practise, to increase professional interchange, and to foster and maintain public confidence in the profession. It could be argued that if all radiographers were participating voluntarily there would be no need to implement a mandatory policy.

Positive comments seemed to come mostly from people who have already tried it. For example:

“I am enjoying doing the CPD – it is not as hard as I thought it would be, and it has encouraged me to be active in ensuring my own education. I would encourage all MRTs to give it a go.”

“Taking up study in my 50s was personally very fulfilling, and humbling too; I had forgotten so many basics over 30 years, and that shouldn’t have happened.”

The main qualifications to these comments were that it needs to be achievable, flexible and that there needed to be more opportunities provided for CPD participation. This feedback concurs with the results of previous studies by Yielder, McQuillan and Henwood. With the advent of advanced and consultant practice, it may be that staff choosing to practise at a higher level will demonstrate increased involvement in CPD as they will be personally motivated to achieve higher levels of practice. This aligns with the views of McQuillan, Henwood, et al. and Henwood, who found that the main motivations for staff who undertake regular CPD were fulfilment of personal interest, often related to career advancement. Yielder’s study specifically identified job enhancement as the main motivator for involvement in CPD, followed by personal interest. Over time it will be interesting to see if staff remain motivated towards CPD once they have been practising at a higher level for some time.

Conclusion
This study showed that, on the whole, radiographers in New Zealand and the UK had a fairly ambivalent attitude towards CPD before the mandatory policy was implemented. There were few significant differences in attitude identified between the New Zealand and the UK respondents, other than New Zealand MRTs showing a slightly more positive attitude overall towards CPD than their UK counterparts. Phase two of this study will show whether there has been any change to these attitudes over time and with the introduction of a mandatory CPD requirement.

Professional bodies and employers could use the results of this study to explore local attitudes to each of the variables outlined in order to establish ways to enhance positivity towards CPD. Making clear the benefit to each individual would be one way to enhance perceived benefits, with minimum investment of time or effort required.

While this study was looking at attitudes towards CPD prior to the implementation of a mandatory policy, it is clear that prior to phase two, other significant variables will also have been introduced, including:

- The introduction of a four tier career structure in the UK enabling career progression to higher levels, namely advanced and consultant practitioner roles. Plus the move to accreditation of higher levels of practice which explicitly require appropriate CPD activity to support those advanced roles (SoR).
- The introduction of the knowledge and skills framework in the NHS in the UK, with a focus on competency to practice and a personal development plan being required each year by radiographic staff (SoR).
- The drive towards leadership in the allied health professions and across health care provision, in the UK, which may have changed the leadership styles in departments with a consequent move towards supporting and developing staff in practice (SoR).
- The proposed move in 2008 in New Zealand to introduce an advanced practitioner role (Yielder, Sinclair & Murphy). As a result attitudes may change over time because of those changes, as well as being due to the introduction of mandatory requirements for CPD participation. This raises questions, which will need to be tackled, over the discriminatory nature of, and the validity of, the proposed phase two and how those other variables will be taken into account.

This study has demonstrated the need for individual practitioners to be more intrinsically motivated towards CPD. This is in line with Henwood who placed the ‘Individual’ components of CPD participation centrally to both: whether or not staff participated in activities; and also whether or not any involvement was effective in impacting on practice. Walsh-Arnason and Edwards demonstrated that the introduction of a mandatory CPD policy enhanced individual motivation and attitudes towards ongoing development. It is recommended that phase two of this study is undertaken to demonstrate whether or not similar changes are evidenced in this population. In practice, it is also recommended that key stakeholders explore ways to increase individual intrinsic motivation towards CPD, by both inhibiting perceived barriers and promoting perceived drivers.

This study has outlined a range of factors, which impact on attitudes towards CPD. In particular, attitudes may become more positive if energy is expended to raise the awareness of radiographers to the full scope of possible CPD activities, away from the current focus on formal, attendance-based events (which certainly persisted up until the time of this study). It would also be worth exploring how practitioners can be guided to have activities impact most effectively on their own personal practice. A broader perspective of what constitutes CPD may also impact on the perceived costs involved in undertaking CPD as well as the accessibility to CPD opportunities.
In relation to senior roles, radiographic managers may not be aware of the impact their own attitude towards CPD has on their staff. This study has shown that managers are key to encouraging and supporting CPD activity of staff and a lack of such a positive work environment is a significant inhibitor to staff involvement in CPD. This study could be used to reflect on those individual attitudes and how they influence (positively or negatively) staff participation in CPD.

Finally, for some people, a positive attitude does exist, and it is recommended that where this exists, it is built on to further influence the culture of the profession towards CPD, by building a positive culture of learning in the workplace. This study has shown that radiographers are searching for personal benefit, greater understanding and support in relation to CPD. It seems that this is all achievable with little monetary cost and could hugely impact on long term attitudes towards, and commitment to, CPD activity, which will influence the standards of future care provision.

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References
11 Henwood SM. Continuing Professional Development: Components of Effectiveness 2009; VDM Verlag, Saarbrucken, Germany.
13 Royal College of Nursing Faculty of Emergency Nursing. Clinical and Educational Competency Framework 2002; RCN, London.
16 Westbrook C. To MSc or not to MSc — that is the question? Synergy 1997; January: 34–5.
28 McQuillan C. Medical imaging: The barriers to continuing professional development 2000; Unpublished research report, Auckland: Unitec Institute of Technology.
34 Tubb E. Medical imaging staff retention: A study into the job satisfaction of medical radiation technologists in New Zealand 2003; Unpublished research report, Auckland: Unitec Institute of Technology.
37 Pelletier D, Donohue J, Duffield C. Australian nurses’ perceptions of the impact of their postgraduate studies on their patient care activities. Nurse Ed Today 2004; 23: 434–42.
40 Henwood S, Yielder J, Flinton DM. Radiographers’ attitudes to manda-

41 Society of Radiographers. Education and Professional Development: Moving Ahead. 2006; SoR London.

