Summary of responses from our survey on the role of the GMC in CPD
March to August 2011

As part of the review we held an informal survey for doctors to get a snap-shot of how doctors use CPD and their views on the role the GMC should play in supporting doctors' CPD activities.

Overall outcome of Survey

- Respondents: 1975
  - About 52% of responses from consultants
  - About 16% of responses from SAS doctors
  - About 10% of responses from GPs
  - About 10% of responses from trainees
  - About 83% of responses came from doctors in full time work
  - About 17% of responses came from doctors in part time work

Role of the GMC

When asked what the GMC’s role in CPD should be? (could pick more than one), the top four choices were:

- 20% Working with employers to encourage access to CPD
- 19.4% Describing what CPD is needed to meet the requirements for revalidation
- 17% Setting high level principles, national standards and guidance
- 14% Helping doctors identify areas of CPD that may be relevant to them

- Only 3.5% indicated GMC should not be involved in CPD at all

General comments about the role of the GMC:

Some respondents made additional comments about the role of the GMC. Overall, these comments suggested the GMC should take a high level role in CPD and the details should be left to the Colleges. There was a general concern the GMC may make guidance and CPD requirements too prescriptive. However, there was also strong support for the GMC to set a minimum standard for CPD in terms of quality. Most respondents supported a role for the GMC to work with employers to help doctors get access to CPD. This was particular relevant for SAS doctors.

- ‘Ticking boxes and jumping through hoops does not make a good doctor. Self development does. The GMC should adopt a role of facilitating and promoting this concept.’
- ‘Many of the other roles mentioned above are provided by the colleges and should continue to do so. GMC need to work with the colleges’
- ‘GMC should work with employers and make CPD sessions as mandatory and part of the weekly job plan for SAS doctors, as most of the trusts are service orientated and getting a single session of CPD is sometime difficult for the SAS doctor. Even I have done work at times during my CPD time to meet
the service demands. The only solution to all this issue is personal involvement of GMC in CPD activity.'

- ‘My own view is that the GMC should be setting general principles and more importantly emphasising the need for CPD through making it a requirement of revalidation. It should do this in conjunction with employers to assure access by individuals to CPD particularly to local meetings.’

- ‘The GMC should state unambiguously that Royal Colleges should not become de facto sole accreditors of CPD providers or content - particularly where they also provide CPD content e.g. courses themselves, since this may lead to a monopoly of CPD provision and is a clear conflict of interest (especially if they then charge for both accreditation of providers and provision of their own courses etc).’

- ‘The royal colleges are best placed to advise on CPD for the specialties. Other CPD though is currently being mandated by Employers, Deaneries, private hospitals etc and this needs reigning in as it is unachievable if doctors straddle all of these. Mandatory training required by Trusts, deaneries and private hospitals could be prescribed by the GMC to give uniformity and standards.’

- ‘I think there must be some generic advice & requirements from the GMC about CPD, as there must be some core requirements. Also since some doctors have portfolio careers or work part-time there will be some issues regarding how much is requires and also how much in each role. clearly employers have a vested interest insofar as they will lose staff who are not revalidated, but each employer would probably want the CPD to be covered/funded by another employer.’

- ‘GMC should only have a very broad role- the details should be decided by colleges and similar 'expert' bodies. However GMC should direct employers to make facilities eg funding/ time off available for CPD’.

- ‘1. CPD approval for a meeting can be from a range of approved providers and the resultant educational quality delivered through many meetings is very variable. Often one feels that the content is more for the presenter's or provider's benefit rather than the attender's. Valuable learning points I, and many colleagues, find to be few and far between. I have not ticked the box for the GMC themselves to quality assure but their role in the process needs to be strong. 2. Particular attention needs to be paid to the proper management of CPD as required for revalidation in respect of part-time/locum/part-retiree doctors. Full timers will have this through their employers (which needs to be mandated) but difficult for the others unless undertaken on a perhaps regional basis.’

- ‘Doctors are quite capable of self directed learning. Stop wasting our money.’

- ‘Perhaps the GMC could help ensure that doctors their staff and other colleagues are able to learn together. The Deaneries require teamwork in primary care. There is a shortfall of interdisciplinary education and its practical application

*Primary responsibility for CPD*

When asked if doctors are primarily responsible for their own professional development across all areas of their practice,
• 86% of respondents agreed
• 14% of respondents disagreed or were not sure.

Overall, comments supporting this question suggested that doctors are professionals and therefore must be accountable for ensuring they are competent and up to date. Where respondents disagreed or were not sure about their responsibility, they either indicated it was the responsibility of their employer or suggested a combination of individual and employer responsibility. Again, there was concern over access and time to do CPD.

• ‘I do not believe there is a better ‘profession’ than doctors at keeping themselves up to date. Bring in some sort of compulsory element and we risk losing this ‘professionalism’. It will become a matter of ticking boxes, and when completed will foster the idea of 'I'm ok, why do more'. Self development has and will produce better doctors. However, there is nothing wrong with helping doctors to identify what they need to develop, we are sometimes not aware of how to identify Johari window box 4 (what we don't know we don't know).’
• ‘It has to be self motivated but it must also be informed by appraisal discussions to ensure that areas of weakness are addressed rather than the constant reinforcement of existing good practice. Employers need to be assured that CPD is used to address any issues that they may have about a doctors knowledge skill or behaviours and robust appraisal should be able to address this in a supportive and formative way.’
• ‘Part of what being a professional is about. take it away at your peril’
• ‘With reflection and insight and being a professional a doctor should be able to decide what CPD they require to develop and be aware of gaps in their knowledge or skills’
• ‘I think both me and the hospital that I work at both of us are responsible for my professional development. My responsibility to be always able to achieve the highest standards in medicine and responsibility of hospital that I work at is to give me training courses and involve me in educational programs that help me to achieve that’

Access to CPC activities

When asked if doctors were able to access CPD activities necessary for their role and to help them improve and develop their professional practice,

• 78% indicated they were able to access appropriate learning
• 22% indicated they were unable to access or were not sure.

Overall, most comments suggested that learning activities are accessible to some extent but often the learning is limited or one sided. For example, doctors in rural areas may struggle to get peer based CPD. Many doctors indicated that they accessed CPD but had to arrange and pay for it out of their own pocket and on their own time. This seems to be especially true for locums. Many comments focused on the lack of or difficulty getting funding for larger / national CPD activities and often felt limited to local or free CPD, which was not necessarily appropriate for their specialty. There was also real concern that the current financial situation in the NHS
would further limit access to CPD. There is also some suggestion that the amount of CPD activities and opportunities leads to confusion on what is necessary and of value.

- ‘If a doctor lives near a big city there isn't a problem but for anybody living in more rural areas CPD offers are rather one sided. Organisations like the BMA or royal colleges invariably set up stuff in London which is a reason among others why I feel estranged from them. Attending is expensive requiring transport and accommodation and very time consuming.’
- ‘It is in my own time and as a locum is at the expense of either family life or paid work’
- ‘Yes I do, but the best source is high-quality conferences and funding is limited, requiring substantial personal contribution. This is not right, especially in specialties with little or no private practice. I can readily access CPD points free - but these are of limited relevance to keeping up to date in my clinical specialty and therefore not of great value in this respect. Time availability for study leave is getting much tighter than previously.’
- ‘These days there is plenty of good quality CPD available (at least for General Physicians). The problem is deciding what not to read / attend. The Hospital Trust has always been very supportive.’
- ‘Working in a senior and service orientated post, sometimes it is difficult to maintain CPD activity. I try my best to preserve CPD time for some teaching, audit or some personal reading in the library. we have a shortage of medical staff. This is another reason for not able to utilise CPD time for CPD activity, sometime. My consultant is very supportive for my CPD. I have no SPA time during the week. I only have 1 CPD session a week. I have started teaching non medical prescribers during my CPD time. I personally think that SAS doctors should be given more sessions of SPA and CPD time similar to consultants.’
- ‘I have anxieties about my ability to have the time available to participate in CPD in the current productivity driven NHS. Employers do not seem to understand the importance of interactive or face to face activities in professional development.’

**CPD in appraisal**

When asked if doctors have an opportunity to discuss CPD needs and personal development as part of the appraisal process,

- 81% said yes
- 12% said no
- 7% not sure

Generally, doctors indicated that they discussed CPD at their appraisals but it was often in a broad sense and was not necessarily followed up. Most respondents saw value in embedding CPD in the appraisal process. However, a significant number of comments raised concerns about the quality and effectiveness of their appraisal system in general. Many saw revalidation as the impetus for improving appraisals. Trainees seem to have had the best outcomes for development from their appraisals.
• ‘Appraisal is an excellent opportunity to identify and discuss personal needs. Unfortunately it is still not being practised in the way it should. Guidance and performance standards along with surveillance mechanisms can ensure good appraisal systems through GMC.’
• ‘not is any depth or to much value’
• ‘An extremely important component of appraisal, and one of the hopeful benefits of Strengthened Medical Appraisal is that this areas will be better dealt with by the trained appraiser assessing Supporting Information, seeing what is missing and helping the appraisee see certain areas that may be needed for CPD the individual cannot see themselves.’
• ‘but it's partly only lip-service to development needs - it carries no weight in my Trust, and very little managerial interest. No-one's interested in a great doctor, just one good enough to do an average job without noticeable mistakes’
• ‘my appraiser can't really assess the relevance of particular CPD as he isn't from my subspecialty-he just has to take my word for it. Plus my appraiser has no 'power' to get the Trust /dept to give me the time/ funding’
• ‘BUT time constraints in General Practice- no Slack .Really I could do with going to medical school again for 3 months to get up to date with recent pathophysiology and subject lectures, but this is never going to happen- we have nothing to sell unlike British Airways who can build in training costs into the ticket price.’

**CPD that improved practice**

When asked if doctors think that their CPD activity over the last 5 years helped to improve the quality of service provide or the care given to your patients,

- 79% said yes
- 6% said no
- 15% said not sure

We also asked doctors to feedback what activities have influenced or changed their practice the most. Unsurprisingly, examples given were wide and varied ranging from national conferences, e-learning, local courses and advice and support from colleagues and peers. The variety of responses seems to support a flexible approach to CPD based on individual needs and preferences. There were also quite a lot of examples where doctors valued learning done with team and peers. Many doctors also identified value in reflecting on their learning and performance.

- ‘Educational update courses with networking with colleagues. Reflective practice is good but sporadic. online activities not quite as good’
- ‘General medical updates with specialists highlighting important recent changes in practice. Even just attending internal grand rounds I get reminders about certain less common conditions or new style of practice. Specialist interest group meetings have also helped my management of Parkinsons patients.’
• ‘local leadership course - being a better clinical lead in developing the unit I work in. sim faculty training - using human patient simulation training to develop doctors using technical and non-technical skills and crisis resource management to improve safety. College conference- sharing ideas and looking at what's new’

• ‘1. Local interaction with colleagues in the team, both formally via our weekly meetings and informally, stimulate accessing and acting on new developments; 2. Reading specialist journals, and using newer online resources such as UpTo Date and Medscape. 3. Participation in national organisations which both provide CPD and set standards raises ones own CPD standards. 4. Attendance at national and international meetings remains important - getting away from the coalface is an opportunity to study and learn.'

• ‘1) Frequent advice about advances and handling these. 2) Reviews of current practice. 3) Teaching others of the field.’

• ‘Increased confidence knowing other centres have similar day to day problems. Using a communication technique suggested for breaking bad news.’

We also gave respondents an opportunity to further comment. Most comments reiterated value in high level principles and a plea to not introduce more bureaucracy and even more tick-boxing. Many also reiterated concerns for funding and the potential shake up of the NHS in England.

• ‘The GMC is doing an excellent job.’ [OK – just need a bit of self grandising]

• ‘needs to be a champion of this approach and to ensure that employers make it a high priority , and not just pay lip service to it ie. CPD.’

• ‘Budgets for CPD and study leave need to be protected. Sponsored activities should be entirely free of influence of sponsors. Sponsored travel should be allowed to continue.’

• ‘Provide the framework in general terms but support the employers in getting tough on strengthening appraisal, including assessment of CPD, to reduce the self-certification / self assessment nature of the present system. It is far too easy to tick the boxes and play the game currently.’

• ‘I would like the GMC to have some understanding and acceptance of the difficulties of part timers undertaking the same level of CPD as those employed full time.’

• ‘If CPD is to be successful regarding those doctors working outside the NHS ie those employed by ATOS particularly part-time, on behalf of the government, then it needs to be brought home to the employer that they have a stake in maintaining our professional development. They cannot just transfer their responsibility to some commercial organisation which purports to provide support with the CPD process as has been suggested. It matters little to me now as I realise that experience counts for little these days & am going to retire!’

• ‘The Royal Colleges and faculties have primary responsibility for CPD. The GMC's role should be in setting overall standards, matters related to revalidation, and filling gaps, e.g. for people in non-mainstream specialties for whom the work of the faculties and colleges is largely irrelevant.’
• ‘Lots of flexibility needed, especially in terms of high cost CPD activities. Needs and circumstances are vastly different across the profession. Especially true for locums who are not based in one department'
• ‘CPD should remain a professional activity not a bureaucratic exercise to soothe the anxieties of an ignorant central office. With personal reflection professionals are best placed to identify their own learning needs. Heavy handedness from GMC will increase risk by disenfranchising the profession from its own learning.’
• ‘The GMC should continue to lead the way in setting standards for excellence in medicine- they are a strong role model for other professions. Supporting and demanding CPD is fundamental to this function.’
• ‘I think the GMC should be assertive about its expectations in terms of outcomes expected from doctors in relation to CPD, the time that should be available to doctors for CPD(apart from collecting and collating audit data, VLE and reading; CPD is not something that can be done in isolation)and the responsibility of employers to facilitate both.’
• ‘If you ask a bunch of kids to walk along a beach and keep their feet dry, the vast majority will comply and a quick glance will be sufficient before they board the bus home. If you go to an airport everyone is treated as a potential terrorist. Which model do you want?’

Summary

There was also a general feel that doctors value and support CPD as part of their professional practice but seem cynical about the current appraisal arrangements and the value of their CPD as a measurable outcome. Most comments suggested that the role of the GMC was to support CPD through high level guidance and principles that should not be prescriptive. However, doctors did see value in the GMC working with employers to improve the access and quality of CPD at local levels. Many comments stressed the difficulty doctors may face from employers to access CPD resources and concern that these will become even more limited in the future. There was a great degree of support for Colleges as the bastions of specialty good practice and strong support for their involvement in the detail and quality assurance of CPD. On the margins, there was significant comment and concern about revalidation and what will happen if doctors fail to obtain appropriate CPD.