CPD five years on: What New Zealand MRTs think about mandatory CPD
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Abstract
This article reports the results of a survey investigating the attitudes of New Zealand Medical Radiation Technologists (MRTs) to continuing professional development (CPD) following the implementation of a mandatory CPD policy. This survey replicated, and is compared with, a study conducted in 2001 that was administered to elicit attitudes to CPD before the mandate was introduced. The results of this survey were published in Shadows: The New Zealand Journal of Medical Radiation Technology in 2004.

Questionnaires were distributed to the 1200 MRTs registered in the New Zealand Institute of Medical Radiation Technology CPD programme.

Since the initial survey there are four main areas where quantitative results indicate a change of some significance. The number of MRTs recording their CPD has increased; the amount of support from their clinical managers and departments has increased; there is a large increase in the number of MRTs considering that CPD should be mandatory; and that MRT perceptions regarding the outcome of CPD have decreased. Several factors do not appear to have changed substantially. These include ongoing concerns relating to the nature of employment, time and costs, and access issues, Overall there has been an increase in the mean total score, although this is only significant for medical imaging.

Keywords: Continuing professional development; Mandatory CPD.

Introduction
In 2001 a research study was undertaken in New Zealand which surveyed the factors affecting participation in, and attitudes towards, continuing professional development (CPD) for New Zealand Medical Radiation Technologists (MRTs). This study was undertaken in collaboration with South Bank and City Universities in London, the Society of Radiographers in the United Kingdom, the New Zealand Institute of Medical Radiation Technologists (NZIMRT), and Unitec Institute of Technology in New Zealand. The results of the New Zealand survey were reported in Shadows: The New Zealand Journal of Medical Radiation Technology in 2004 (Yielder, Henwood, Flinton & Pennick, 2004). The results of the original survey in the United Kingdom (UK) were reported separately (Henwood, Yielder & Flinton, 2004).

The impetus for the research came from a study undertaken on nursing in Iowa in 1985, which looked at attitudes towards mandatory CPD before and after the implementation of a mandatory scheme. With the passing of the Health Professionals Competency Assurance (HPCA) Act in 2003, CPD became mandatory for all New Zealand registered MRTs as of September 2004. To ascertain whether mandatory CPD has had any impact on MRT attitudes in New Zealand, the survey was initially undertaken prior to the mandatory requirement and was replicated in 2008 post-mandate. The same written questionnaire was used to maximise replicability, and was sent to all MRTs registered with the NZIMRT CPD scheme at that time. This article reports the findings of the follow-up survey, comparing them with the results of the initial one reported in 2004. The post-mandate study has also been conducted in the UK. Comparative results for New Zealand and the UK will be reported in Radiography in the future.

Methodology
A survey using a postal questionnaire was used for the study. The questionnaire was originally developed for the United Kingdom and was subsequently adapted for New Zealand use with minimal changes reflecting different terminology and hierarchical career structure. The follow-up survey used the same questionnaire in order to be able to compare data (Henwood et al., 2004).

The questionnaire was sent to all MRTs currently enrolled in the NZIMRT CPD programme, which at that time numbered 1200.

Results
Of the 1200 MRTs in the sample 640 responses were received, constituting a 53% response rate. While some individual questions were left blank, there were no unusable questionnaires.

Following is a sample of some of the main results from within the quantitative data. Qualitative comments are integrated in the discussion section. Note that
some sections were left incomplete by participants, resulting in a reduced sample size used in the analysis. All data analysis was performed in SPSS® 17.

Tables 1 to 4 present the main demographic data from the survey:

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<th>Table 1: Gender</th>
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<th>Table 4: MRT Discipline</th>
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Part two of the questionnaire, the attitude component, was classified into five themes generated from thematic analysis undertaken as part of a PhD study that identified the major themes related to CPD (Henwood, 2003). Each of these have been scored, and given an overall score, as shown in Figure 1. This data failed normality tests (Kolmogorov-Smirnov and Shapiro-Wilk), therefore non-parametric tests were used on this data.

As can be seen in Figure 1 there is a rise in mean total score, with the largest change being seen in the domain associated with recording of CPD. Two domains had a decrease in score although only one (outcome) had a significant decrease.

The pattern of change generally appears to be consistent in both disciplines, as seen in Figure 2. The significance values generated by Mann-Whitney U tests are shown in Table 5.

The changes in domain scores for both radiation therapists and diagnostic radiographers follows the same pattern, however for radiation therapists, although the change in total mean showed an increase, as did diagnostic, the change was not significant; see Table 5. This shows the significance value for each domain, first looking at all respondents (Radiation Therapists and Diagnostic Radiographers together), and then at each profession separately.

Figure 3 shows the differences on the basis of full or part-time employment. Most of the domains show an increase in score from 2001, the 2001 score being represented by a horizontal bar in the column. The change to the 2008 score is represented by the same coloured area above this horizontal bar. Where there is a decrease in score from 2001 to 2008 the difference is shaded red, so the maximum value represents the 2001 score and the horizontal bar below the red shaded area the 2008 score. The pattern of change is constant for most domains, but in the ‘activity’ domain there is a small fall in score for full-time workers, but a small increase for part-time workers against ‘activity’. Also there is a larger increase in ‘recording’ score for part-time MRTs when compared to their full-time counterparts.

Two further key questions from the survey asked whether MRTs currently record their CPD activities and whether or not they thought CPD should be compulsory, as shown in Tables 6 and 7.

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<th>Table 5: Statistical Significance for Changes in Domain Scores</th>
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There is a noticeable change in recording of CPD (Table 6). Support for compulsory CPD has also increased (Table 7). A chi square test indicated a large change in opinion as to whether CPD should be compulsory or not, \( p < 0.001 \). This will be further discussed in the following section.

**Discussion**

Since the original study, further literature about CPD has been published, however the central tenets reported from the original survey (Yielder et al., 2004) have changed very little. Studies regarding the mandatory versus voluntary nature of CPD (Field, 2004) indicate that the debate remains controversial. Those investigating barriers to CPD (Hofsteede & Yielder, 2009) have identified a recurring list of similar factors that impede the uptake of CPD.

The study by Hofsteede and Yielder (2009) was a small scale research project conducted in New Zealand in 2007. It investigated whether attitudes had changed in two medical imaging clinical centres since mandatory implementation of CPD. Difficulties and possible improvements that could be made were also identified. This study found that the general attitude of MRTs towards mandatory CPD had become more positive since implementation. It concluded that approximately 25% of the 29 respondents could identify practical difficulties relating to meeting the requirements of their chosen programme, mostly relating to lack of time and lack of opportunities. They identified that there is still room for improvement, particularly in the area of opportunity, expressing a need for a wider variety of CPD topics, and the development of online CPD opportunities.

In this study, quantitative data indicated the following trends:

- The number of MRTs recording their CPD has increased. This is not a surprising result since mandatory CPD requires the formal recording of CPD events either in a credit-based or portfolio format, which is submitted for assessment and must be available for audit by the Medical Radiation Technologists Board (MRTB). Perhaps what is a surprising result is that one third of respondents are still not recording CPD even though the sample was taken from those registered in the NZIMRT CPD scheme.

- The respondents indicated that the amount of support from their clinical managers and departments has increased. This may relate in part to the professional development allowance now in the employment contract of most MRTs, certainly in the public sector, and to requirements for accreditation of private practices.

- There is a large increase in the number of MRTs considering that CPD should be mandatory. We can speculate that this could be due to the actual experience MRTs now have of being involved in CPD, that perhaps it is not as difficult as perceived before beginning CPD, that they have become used to the idea over time, or that they can see benefits for themselves personally and the profession. This latter assumption is not supported by results recorded against the outcome questions (below).

- There is a small decrease in 'status', elicited from questions relating to whether CPD impacts on how others see the profession and whether it raises the profile of the profession. There was no indication of the reasons given for this decrease in the qualitative comments.
• The one area that has a significant decrease with mandatory implementation is MRT perceptions regarding the outcome of CPD. For example, whether CPD improves patient care, or whether it increases their ability to do their job. This conflicts with the other trends shown in the results. While the qualitative comments did refer to opinion in this regard, it needs to be remembered that these comments came from relatively few respondents, so the reason for this trend is not evident across the data.

One hundred and forty of the 640 respondents (22%) took the opportunity to make qualitative comments. Of these, approximately one third were generally positive, two thirds were critical of, or resistant to CPD, and around 50% made constructive suggestions for the future. The qualitative comments about CPD frequently indicated emotive and polarised attitudes, as they also did in the 2001 survey. They have been clustered into themes which differ slightly to those established in the 2001 study due to a decrease in the number of concerns being raised. For example, short staffing, salary and unsupportive employers no longer appear to be major issues for the profession.

Opposition to CPD
The arguments against CPD largely centred around the opinion that CPD does not make a person more competent:

“I think CPD is a bit of a waste of time. Most people only go to lots of things because they ‘need points’, not because they want to. And I don’t actually think it makes people better at their job. In fact, it can discourage people from returning to the work force.”

“Does doing CPD make me a better MRT? I don’t think so – it is inherent in a person regardless (to be competent at the job you trained for – are qualified for).”

One respondent qualified this view with reference to ensuring relevance and recognition of learning needs:

“Much of CPD is done for the sake of getting points. I don’t believe CPD is useful in any way unless it is relevant to an individual’s practice and learning actually takes place. CPD should be targeted to learning needs, otherwise it has nothing to do with ensuring competence.”

It is noted that none of the respondents holding a negative view of CPD with respect to competence acknowledged that CPD is only one component mandated by the MRTB as evidence of competence for an Annual Practicing Certificate (APC).

Opinion about when CPD is of most benefit was strongly divergent. Some felt it should only be for new graduates, while new graduates thought that they were the very ones who did not need it:

“I totally oppose this imposition on my stressed out life! CPD should only be for young inexperienced that want it!”

“As a new graduate you are learning things constantly as you have to work by yourself during shifts, and I do not agree that CPD should be required for at least the first year of being a qualified MRT.”

The Case For CPD
While comments overall seemed polarised, the negative ones often very emotive, there were many thoughtful responses regarding the importance of CPD, with an acknowledgement of the understanding that: “CPD is an inherent part of being a health professional and most of the CPD you do is part of the role – not an extra” – an understanding that seemed to be absent in 2001. For example:

“CPD is essential for advancement of knowledge, keeping up with current trends and techniques in practice and advances the profession as a whole. One should strive for continual improvement of delivery of service to the patient. At the end of the day, that’s what we are in this job for – delivering our best in patient care!”

The following comment argues for the importance of CPD on a personal level, even if it cannot be shown that CPD increases competence:

“If you are interested in your profession and any change – you easily gain CPD points as you want to know more. It may not make you more competent as a radiographer – some people feel they know how to do radiography and CPD will not help – but it makes you more competent as a person. It’s amazing what you learn.”

However, others commented that just doing the job makes people competent:

“Professional development should be compulsory if you have been out of the workforce for two years or more, but I certainly feel that if you are working, this mere fact keeps you competent. After all our films are all reported by a radiologist.”

“As a radiographer that has 20 years of general x ray (experience) I did find it almost insulting and disrespectful to have to do CPD in this area.”

These comments indicate an attitude perhaps related to working in an ‘occupation’ as opposed to a changing profession. It is well recognised that a primary qualification is not adequate to see a professional through their working career (Benseman, 1996; Walker, 1995) as knowledge and skills change constantly. Those changes occur so rapidly in medical imaging that constant updating and expanding of knowledge and skills will be a life-long process. The comments also indicate that some MRTs appear to abdicate responsibility to radiologists rather than functioning as professionals who take responsibility for their own standards.

Mandatory Versus Voluntary CPD
Again, there were arguments given on both sides of the mandatory/voluntary debate. From the quantitative questions it was seen that there has been a significant increase in the number of MRTs who now consider that CPD should be mandatory. Some qualified this in the qualitative comments, for example: “Those who are sloopy at their work need compulsory CPD.”

The opposite side of the debate mostly relates to the needs of adults to take responsibility for their own learning if it is to have value. As stated in Yielder et al. (2004, p. 23): “As professionals we should be self-directed enough to undertake further training and education from an autonomous rather than a mandatory motivation.” The following comments are thoughtful opinions that recognise the value of CPD, however the respondents do not believe it should be compulsory:

“While the concept of CPD is to improve professional standards, patient safety etc, to solve those things seen as ‘problems’, it appears to me that unless individual practitioners can see value of CPD to themselves, they
will not tend to make the most use of CPD options to improve their practice. To make CPD most valuable practitioners need to be ‘infected’ with the desire to be more interested in professional, technical and caring aspects of their roles and be more committed in researching their work and practices thereby resulting in improvements in their working practices and results."

“It’s not that I’m against CPD as such it simply to my mind is not that effective in what we are trying to achieve – fantastic radiographers. Basically you can lead a horse to water but you can’t make them drink. For me personally, I feel that I was doing as much before compulsory CPD as I am now if for nothing but my own personal gratification. I think in general most radiographers are actually that way inclined and in some ways compulsory CPD makes me feel like a school child being directed on how to improve myself."

Our results support this comment, as activity levels have not changed significantly.

**Financial Aspects and Responsibility**

Several respondents commented that MRTs in New Zealand are now very well supported to engage in CPD (as shown also in the quantitative results). For example:

“Funding here in NZ (well where I work) is very generous in both terms of time off to attend study/CPD events, as well as funding registration etc… The onus for CPD activity is always on the individual MRT, not the individual’s manager (I feel quite passionate about this).”

There were also a number of negative comments that indicate that some would like a greater financial contribution from their employers. For example: “I feel we should be paid not only the CPD fees for each session, but also paid for the hours we spend attending these sessions”; and “It can be expensive, my work contributes $150/staff member/year, but this does not nearly meet costs of time, travel etc.” Some of the negative comments seem to be bundled up into a negative frame of reference towards CPD more broadly. For example:

“CPD has become a very expensive process. It takes away a lot of our time and money. I don’t think it adds any value to our profession. Heaps of staff are running away from the profession and vacancies have risen dramatically. Apart from our normal working hours, we have to spend extra hours for CPD and do not have much time left for us and our family. Looking at other professions, they are better off as they are better paid and do not require such compulsory means to prove their competency.”

Several respondents indicate that the responsibility for funding CPD needs to be considered a joint one between the individual professional and the employer. The employers have a vested interest in the quality of service their department provides, while at the same time the individual has a personal professional responsibility, for example:

“The expectation for funding for CPD activities should be ‘shared’ between employee and employer depending on the direct benefit to the modality the MRT works in. There has to be a purpose and learning outcomes explicit if employers are expected to fund.”

“There is a balance between personal professional responsibility and that supported by employer. Negotiating that balance is sometimes professional development in itself ie setting goals, justifying how this activity will benefit employer and patients.”

While comments about funding were similar to those reported in the 2001 questionnaire, at that time there was “little understanding evidenced that CPD is for the individual practitioner’s benefit as well as for the benefit of the service provided to the public” (Yielder et al., 2004, p.19). The kind of attitude expressed in the two comments above does support an individual professional focus that seeks ongoing learning improvement and excellence in practice, although since these comments were non-directed, there is no indication of how many MRTs maintain this attitude.

**The Nature of Employment: Full-time Versus Part-time**

In common with the responses from the 2001 questionnaire, MRTs are still divided in respect to whether part-time employees should be expected to engage in the same CPD requirements as full-time staff. In 2001 part-time employees viewed their commitments outside work, such as family, as a more important factor for them than for full-time staff, while those working full time saw outside commitments as having higher precedence over CPD precisely because they had less time available outside work (Yielder et al., 2004). This conflict in opinion was sustained in these results, for example:

“For part-time staff obtaining credits is more difficult due to other commitments (the reason they are part-time) – perhaps another level of credits should be available for MRTs who work 0.5 FTEs or less a week, otherwise the costs of CPD (in money and time terms) is unfairly biased against part-time workers.”

“I think radiographers work hard enough as it is – especially those on a full-time roster – and it is tiring and difficult to do CPD on top of that.”

“I feel part-time A & E radiographers should do some CPD (may be six points per year) but the reality is that people in that role are normally working mums or people topping up another career and it is very simplistic role not worthy of the points required.”

The last comment could be debated since emergency department work is one area where technique needs to be adapted, and decisions made, based on what is found. In some departments this is also an area where MRT opinion is sought by medical staff, which involves a high degree of personal professionalism and confidence.

The part-time respondents in both surveys did not show any understanding that part-time MRTs need to evidence the same level of competence as full time MRTs (that is, they cannot be half as competent, thereby reducing the need for CPD by half), or that it may be more difficult to maintain expertise when working part-time. These arguments however, presuppose that CPD does actually affect competence and outcomes, which respondents in the 2008 survey seem to be questioning.

**Timing**

A preference for CPD opportunities occurring during working hours was evident in the qualitative comments. This supports the findings of the 2001 study and an earlier New Zealand study conducted by McQuillan in 2000, where 93% of respondents had a clear preference for attending CPD activities during work time. For example:
“I feel CPD should be carried out entirely in work time. Most of us have a life outside radiography— we want to work to do our job, to the best of our ability, during the time we are paid, and then we want to go home and get on with our lives, enjoy our families and interests.”

The 2001 study maintained that time seemed to present a real barrier to participants, and that: “If provision was made for study leave by employers, this could make a difference to MRT attitudes” (Yielder et al., 2004, p.22). However it would appear that most CPD opportunities are still scheduled on weekends. Respondents in both this study and the study by Hofsteed and Yielder (2009) have suggested that online opportunities are needed so that MRTs can participate in CPD at a time that is suitable to their individual circumstances.

Some respondents commented on the length of time of the CPD cycle. Currently in New Zealand the majority of MRTs are enrolled in the NZIMRT CPD programme, which has a two year enrolment and reporting cycle. It was suggested that a longer cycle would be beneficial, particularly for part-time workers:

“The CPD timeframe should cover a longer time ie three or four year cycles to promote better study days, courses, conference attendance where there is limited funding for all to attend. This may help part-timers who struggle to get points or days worked.”

“CPD is great but think the 2 year compulsory period should be extended to 4 years. It is sometimes hard to find new things to look at if you have been in the same job a while. Stuff doesn’t always change fast. Part timers are only given time on a pro rata basis. Think this should change to make it easier for them to attend.”

It may be worthwhile evaluating the current enrolment period to ascertain whether a cycle that aligns with the three year MRTB audit could possibly save confusion for some MRTs.

**Recoding Options**

MRTs enrolled in the NZIMRT CPD programme have the choice of two recording options: a credit-based recording system, or a professional portfolio. The credit option is the most popular choice of recording system (95% of enrolments), involving the recording of NZIMRT approved CPD activities as CPD credits established from a credit allocation list. The activity record is submitted every two years, along with appropriate evidence of attendance, for recognition (NZIMRT, 2008). The professional portfolio aims to encourage MRTs to reflect on their professional practice. While it is more flexible in terms of the activities that can be recorded, it encourages MRTs to take responsibility for their own learning and for integrating new knowledge into practice by stressing the importance of reflection on CPD activities (NZIMRT, 2008). Generally MRTs who have tried both options find the portfolio option more rewarding, but also more work. The argument of value versus effort can be seen in the following comments:

“I am at the wrong end of my career (winding down) to be interested in the portfolio option. The points option is OK, easy to manage but I do find myself going to things just to get the points or dismissing them because the effort vs. points ratio is disadvantageous.”

“The amount of effort involved in doing the portfolio version of CPD is a lot higher than collecting points. Being a “well rounded” individual I do find myself neglecting my portfolio at times due to having to spend my precious home time on work matters. I do not get time to do CPD within work hours – and a busy family life means minimal time to “invest” in CPD.”

“I would like to see the credit option gradually phased out and more emphasis on reflective learning – think this makes for better practitioners rather than “getting points” for attending something and scribbling a few lines about it.”

It appears that some MRTs still believe that CPD is only about “collecting points”, possibly not realising the benefits of undertaking the professional portfolio, as can be seen in the following comment:

“I know I have some conflicting thoughts here. I have always been active in seeking knowledge. I don’t believe enforced points collecting improves anything. For me it is counter productive. I find myself thinking “I have my points, I will leave that till next year”. I also hear people choosing to go to or do things because it is convenient etc rather than useful. So much is repetitive and therefore of little impact.”

It is of note that in the UK an outcomes-based portfolio approach is used, linked to professional competencies, which is available as a supportive, self-evaluative, on-line learning and recording tool rather than in the paper-based format of New Zealand.

**Access**

In the study conducted by Hofsteed and Yielder (2009), it was suggested that online CPD opportunities need to be developed to decrease the ‘difficult access’ barrier whether due to location or working hours. Participants in this study noted in particular the difficulties encountered by rural radiographers, for example:

“Please consider rural / small department MRT Groups. Rural areas have added problems of staffing; time for travel all add to cost factor which is not always subsidised.”

The barrier of remote locations was also identified in the previous study (Yielder et al., 2004). An alternative suggestion to providing online CPD opportunities was for CPD providers to travel to smaller centres that otherwise do not have access to workshop or conference opportunities:

“I feel smaller centres are often disadvantaged with the lack of study days offered as it can be costly both financially and time wise to travel to main centres. I have sometimes wondered if the lecturers could be paid to travel to the smaller centres to maybe help with this situation.”

It needs to be noted, that in New Zealand, the portfolio option was developed specifically to enable those MRTs working in more remote areas to achieve their CPD requirements through self-directed learning. However, it is understandable that this does not necessarily compensate for the stimulation of face-to-face learning opportunities attended with colleagues. A further comment made in regards to access to conference and workshop opportunities is the competition within departments for funding and rostering opportunities that enable attendance.

**Suggestions**

Several suggestions were made by the participants, mostly echoing those offered in the Hofsteed and Yielder (2009) study, such as: more online opportunities; a wider variety of topics; and increased opportunities/different requirements for part-time MRTs. In addition, the following suggestions were made:
An online CPD recording system/ a simplified method of recording

More guidelines as to how much is expected and better clarity about activities/categories.

More guidance with regard to self-reflective practice and self-development.

A system whereby points can be accrued within the portfolio option.

Inclusion of articles in Shadows dealing with general work as a refresher.

A re-examination of the quantity of CPD required for those MRTs with a dual scope of practice.

Finally, a suggestion was made that reflects concerns regarding safety to practice:

“CPD is essential, however I see my colleagues getting CPD points for things like health and safety meetings etc which is good but has no impact whatsoever on their professional practice – dangerous practices are still occurring. I believe compulsory peer review would impact on practices and practicing safely.”

It is noted that CPD activities are audited by the MRTB at a rate of 10% per annum, however it could be questioned whether there is a place for peer review of CPD to be an additional requirement for Annual Practicing Certification. This participant’s comment also opens up the debate as to what constitutes professional development. Is it about up-dating clinical skills, or is it about ongoing development of a professional in the context of clinical practice? The latter is a broader view that encompasses other aspects that contribute to professional practice outside the realm of direct clinical skills. To return to the definition of CPD adopted by the NZIMRT and the Society of Radiographers in the UK, CPD is understood to be:

“The systematic maintenance, improvement and broadening of knowledge and skill and the development of personal qualities necessary for the execution of professional and technical duties throughout the practitioner’s working life (Clyne, 1995, p.15).”

This definition highlights that it is centrally concerned with broadening and deepening knowledge, skills and expertise in addition to updating them (Yielder, 1997), and that it involves the development of personal and professional qualities as well. According to Houle (cited in Clyne, 1995) it also involves building a sense of collective responsibility to society. As such, it may be argued that learning opportunities outside the realm of direct clinical skills may be relevant in the ongoing development of professionals. According to Beneseman (1996), CPD should be aiming to help professionals to critically analyse the technical and ethical choices they make in their work, which involves moving MRTs away from a functional approach to CPD and more towards transforming awareness of their role in practice.

**Conclusion**

This article has reported the findings from a survey of New Zealand MRTs about their attitudes to CPD. It was a follow-up study conducted after CPD became mandatory under the HPCA Act (2003), and it found that in the seven years between the first pre-mandate survey and survey post-mandate, attitudes have changed in four significant respects:

1. The number of MRTs recording their CPD has increased.
2. The amount of support from their clinical managers and departments has increased.
3. There is a large increase in the number of MRTs considering that CPD should be mandatory.
4. MRT perceptions regarding the outcome of CPD have decreased; where outcome relates to whether CPD improves patient care, or increases their ability to do their job. No clear reason for this trend was evident. A small decrease in perception about the status of CPD was shown, however there was no indication as to why this perception had changed, and the change was not significant. A further change in attitude that seemed to be indicated within the qualitative comments was an increased awareness that CPD may enable professionals to strive for ongoing learning and excellence in practice, that is, be of intrinsic benefit to the individual practitioner, rather than solely for the benefit of service to the public. Overall there has been an increase in the mean total score, which aligns with the original study conducted in nursing in Iowa (Walsh-Arneson, 1985), indicating an increase in positive attitude. This result however, is only significant for medical imaging.

Several factors do not appear to have changed substantially. These include ongoing concerns relating to CPD expectations in respect to the nature of employment, location and access issues, time and costs.

This study is being conducted currently in the UK and comparative results will be analysed to establish whether there have been any post-mandate trends in common between the two countries.

**References**


