Radiography (2004) **10**, 251–258

ELSEVIER

THE SOCIETY AND COLLEGE OF RADIOGRAPHERS

Radiographers attitudes to mandatory CPD: a comparative study in the United Kingdom and New Zealand

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Received 22 March 2004; accepted 25 May 2004

KEYWORDS
Continuing Professional Development (CPD);
Mandatory;
Attitudes;
International comparison

Abstract This study explores the attitudes of radiographers in two countries (UK and New Zealand) to mandatory CPD prior to a mandatory CPD policy being implemented. Postal questionnaires were sent to 1739 radiographers (250 in the UK and 1489 in New Zealand), in collaboration with the respective professional bodies in both countries.

The study showed that there is a general ambivalent attitude towards CPD and there are a number of barriers which individuals identify to explain relatively low rates of participation in CPD. The study also showed that there is a very restricted view of what constitutes CPD around attendance at study days and formal activities and subsequently less formal activities are not being recognised and valued. The lack of recording of CPD activity was highlighted along with problems related to poor staffing levels and in places, lack of employer support.

The study will be repeated and attitudes compared two years following the implementation of the mandatory CPD policy in both countries.

Introduction

CPD in radiography is an issue which has been explored in health care for some time. In the UK and in New Zealand CPD has been a voluntary (though expected and some would argue an obligatory) aspect of professional practice. In both countries, however, in 2001 (UK) and 2003 (New Zealand) legislative change has introduced the issue of mandatory CPD, so that the respective countries are now exploring (UK) and implementing (NZ) a mandatory policy. The UK expects to implement the new policy in 2005 and in New Zealand the introduction of the legislation requires implementation by September 2004.

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1078-8174/$ - see front matter
doi:10.1016/j.radi.2004.05.008

In the UK, it is the establishment of the Health Professions Council, which will introduce a CPD requirement as a condition of ongoing state registration. The exact nature of that requirement is not yet clear, but it has been reported that it will relate to demonstration of ongoing competence and will not be purely a points or hours collecting system.

In New Zealand, the Health Professionals Competency Assurance Act (2003), incorporates mandatory CPD. Medical Radiation Technologists (MRTs) will be required to show a minimum of 800 h practice (in each scope of practice) over the previous three years, satisfactory performance review over the last 12 months, satisfactory participation in an approved CPD scheme over the last 12 months, compliance with the MRTB code of ethics, a personal medical statement and a personal competency statement.

In nursing, Walsh Arneson[1] looked at nurses attitudes to CPD before and after the implementation of a mandatory policy. In the follow up study two years later, she demonstrated that attitudes became more positive. This finding is supported by Edwards[2,3] in a similar study completed in Florida, America.

This study conducted by South Bank University London, City University London and UNITEC, Auckland, aims to replicate that study in radiography, in both countries, once the mandate has been implemented. This paper presents the first stage, showing attitudes towards CPD prior to the mandate being introduced.

The Society of Radiographers (SOR) and the New Zealand Institute of Medical Radiation Technologists (NZIMRT) were approached to collaborate on the respective phase of this study to give greater credibility to the questionnaire and hopefully increase the response rates. In both countries the professional body endorsed the questionnaire and their logo was added to the top of the first page.

Method

A postal questionnaire was used, which was designed initially for a UK audience, and was then subsequently adapted for use in New Zealand to ensure appropriate and understandable terminology. For example, the name of the professional body had to be changed, along with the title of the journals sent directly to radiographers. Another change which had to be taken into account was the different career structure and role titles in the two countries.

Table 1 Gender

%	Male	Female
UK	13.9	86.1
NZ	12.9	87.1

In the United Kingdom, a small random sample of 250 radiographers was selected from the Council for Professions Supplementary to Medicine (CPSM) register (prior to the HPC being established). In New Zealand, the questionnaire was sent to all MRTs with a current annual practising certificate, which at that time numbered 1489.

Statistical analysis was performed using SPSS® 11.5 for windows. Statistical significance was set at $p = 0.05$.

Results

In the United Kingdom, of the 250 radiographers in the sample, 130 returned the questionnaire, constituting a 52% response rate. In New Zealand, of the 1489 MRTs in the sample, 44 were returned undelivered due to incorrect postal details. Of the 1444 remaining, 598 responses were received, constituting a 41% response rate.

Following is a sample of some of the main results from within the quantitative data. Qualitative comments are integrated in Discussion. Note that some responders offered no opinion in certain sections as although still registered as radiographers they either had retired or were no longer working in radiography, resulting in a reduced '*n*' used in some calculations.

Tables 1—4 present the main demographic data from the survey.

Part two of the questionnaire was classified into five themes, as shown in Table 5.

Table 5 reports the results of the questions by classification into discrete themes, where a score greater than four is positive, and less than four is negative. This is shown differently in Fig. 1 where the average deviation from the neutral position is demonstrated with confidence limits. This figure shows both the differences between NZ and the UK and whether the issue is being viewed in a

Table 2 Age

%	Mean age	S.D.
UK	40.15	9.0
NZ	38.67	9.9

Table 3 Break from service

	Break in service (%)	No break in service (%)	Length of break (years)	S.D.
UK	33.8	66.2	5.8	5.3
NZ	53.1	46.9	5.8	5.4

positive or negative light. The confidence bars represent the statistics: if the bars go through 0 then there is no statistical difference even though a positive trend may be indicated. Fig. 1 shows that most of the bars would not reach zero and therefore there is a true negative/positive feeling around the theme. Note that the bars are always smaller for the NZ people reflecting the larger numbers in the NZ sample.

From this set of figures, only two of the themes showed statistical significance in terms of differences between the two countries. These two themes were 'support', $t = -2.4$, df $= 98.6$, $p = 0.02$ and 'outcome', $t = -2.2$, df $= 544$, $p = 0.03$. In all cases except 'activity', New Zealand MRTs are generally more positive in their overall approach/view towards CPD, with support and outcome showing a significant difference. The type of questions contributing to these two areas included:

Support: whether radiographers get financial support, time off, help in CPD selection, information on notice boards, departmental CPD activities etc.

Outcome: the opinion that CPD maintains or enhances competence, improves patient care, maintains confidence, positively affects practice, helps to protect the public etc.

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

The quantitative data were subject to statistical analysis. No significant differences in attitudes towards CPD were established between the two countries in respect to gender, age or length of breaks in service. However, there was a difference ($p = 0.002$) in the percentage of MRTs/radiographers who have taken a break in their service (higher in New Zealand).

Table 4 'Type' of MRT/radiographer

%	Diagnostic	Therapy	Dual qualification
UK	84.8	1.3	13.9
NZ	87.6	10.7	1.7

Table 5 Mean scores by CPD classification

Mean score	Nationality	*n*	Mean scale 1−ve−8+ve
Total (CPD score)	UK	79	4.1
	NZ	467	4.3
Recording	UK	79	3.7
	NZ	467	3.7
Activity	UK	79	4.4
	NZ	467	4.2
Support	UK	79	3.9
	NZ	467	4.2
Status	UK	79	4.3
	NZ	467	4.5
Outcome	UK	79	4.5
	NZ	467	4.8

Discussion

The demographic results from the two countries were surprisingly similar. In addition, few statistically significant differences were demonstrated when comparing the attitudes of MRTs and radiographers in the two countries. One area of concern for both countries is the overall lack of recording of CPD, which will be an issue once a mandate is introduced and evidence of participation in CPD is required. The percentage of those recording CPD is slightly higher in the UK and this may reflect the length of time a CPD policy has been in place (1997 as opposed to 2000 in New Zealand) indicating that staff in the UK have 'got used' to the idea and CPD is beginning to be incorporated into the professional culture. In addition, from very early on it has been 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 recording mechanism to all members (initially at cost, but subsequently free), although studies have shown that this has not been widely utilised.[4]

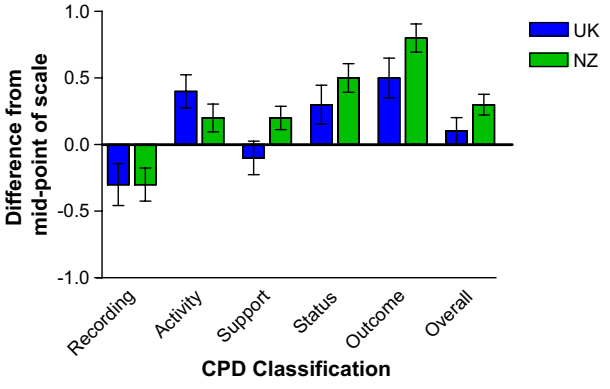

Figure 1 CPD classification of themes.

Table 6 MRTs recording their CPD activity

Country	% Recording CPD	% Not recording
UK	38.0	62.0
NZ	27.2	72.8

Like the number of radiographers recording CPD, the percentage of radiographers who think CPD should be mandatory is also slightly higher in the UK (57.7% as opposed to 42.3%). Again this may reflect on the fact that radiographers in the UK have had longer to acclimatise to the idea of compulsory CPD. Anecdotally, however, there is some suggestion that the continual delays to the actual implementation of the mandate has raised questions as to whether it will happen in practice and may have contributed to a decrease in attitudes towards CPD over time.

The qualitative comments about CPD frequently indicated very emotive and polarised attitudes and 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 staff from the two countries can be identified.) The qualitative comments were clustered into several themes.

Financial implications

There was an expectation that CPD would be either funded in full or assistance with funding would be forthcoming from the employer:

> *Unless hospitals/departments are willing to fully support CPD and financially aid them it is difficult to get people to volunteer to do CPD*

> ***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 programme 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.***

Table 7 Should CPD be compulsory?

Country	Compulsory (%)	Not compulsory (%)
UK	57.7	46.1
NZ	42.3	53.9

Cost has previously been shown to be a significant barrier to CPD participation[5–12] and clearly remains to be so in the new century.

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 with educational facilities was shown to be an issue.[13]

Short staffing/sole charge roles

Inadequate staffing and associated high workloads was 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 no proven link between CPD and any direct improvement in patient care or any link to competence to practice. Some studies have shown links,[14–16] 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 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 put further pressure on existing staff by taking time out of the working day to undertake CPD. It is important to note though that staff were not keen to use their own time to undertake CPD activity, which means that in practice CPD is not being undertaken.

Other commitments

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

I'm only working 2 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 2 small children) to keep the career going

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

Interesting that the last participant did not immediately think that those working full time might also have similar outside commitments, in addition to full time hours.

Studies by Yielder[12] and McQuillan[17] have shown that family commitments and personal activities were considered to be a moderate barrier, ranking fourth out of seven and fourth out of eight (respectively) in order of importance. (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 MRTs/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.*

Time should be made available for CPD

*…****it is difficult to get time off for CPD***

The qualitative data in this study suggest that if provision was made for study leave by employers (an issue being pursued by the SOR in the UK), this could make a difference to individual attitudes.

Radiographic literature on this subject is mixed. McQuillan[17] and Henwood and Huggett[6] demonstrated that participants had a clear preference for attending CPD activities in work time, whereas in Yielder's[12] study, respondents were divided, with many indicating a preference for CPD to be conducted outside of working hours.

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 on-going 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 as 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 Supt. Ill 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.

Career structure/salary issues

Participants expressed concerns about lack of 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 recent studies on retention and job satisfaction by Tubb[18] and Blaas,[19] 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 is supported by Henwood[13] in the UK.

Lack of information/understanding

There was generally a poor awareness of the breadth and scope of activities which 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 as to the range of activities considered to be CPD. This means that in practice they are unlikely to recognise or value the CPD they are already undertaking.

On occasions when the wider aspects of CPD are recognised, how to record them was in some cases causing difficulty:

I started off with good intentions with the first Society software. As time has gone on I am getting more frustrated as to what and how to record any reading activity as well as occasional tutorials within department.

I Don't Need It

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.*
>
> *As long as the doctors and radiologists are happy with my films then I see no need to sit any exams*
>
> ***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. Many radiographers cannot see how CPD will improve their job, and unless a positive effort is made to educate them in regard to why CPD is important, they are likely to ''be dragged along, screaming and kicking, having lost the opportunity for taking control of their own destinies''.[20(p 24)]

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 theory on adult education. For example, Morrison[21] argues that any form of compulsory education, particularly for relicensure, is incongruent with the nature of both being a professional and an adult. As professionals we should be self-directed enough to undertake further training and education from an autonomous rather than a mandatory motivation. However, the argument for mandatory CPD, according to Maple,[22] is to protect the public from professionals who are too lazy to participate voluntarily, to remove people who no longer practice, to increase professional interchange, and to foster and maintain public confidence in the profession. 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 need to be more opportunities. This feedback concurs with the results of previous studies by Yielder,[12] McQuillan[17] and Henwood.[13] Employers and organisations providing CPD programmes and CPD activities will need to provide positive incentives for involvement until attitudes change. This will mean information, time, financial support, and the introduction of flexible and interesting activities.

In terms of personal motivation, the main motivating factors identified by McQuillan[17] and Henwood[13] were the fulfilment of personal self-interest. That is, they had an intrinsic motivation to be involved in CPD. Yielder's[12] study identified job enhancement as the main motivator, followed by personal interest. With the desire to fulfil personal self interest identified as such a high motivator it is imperative to identify those interests in order to try to fulfil them within CPD if we want to enhance current CPD activity, both in terms of participation in CPD and positive outcomes from undertaking any activity.

Conclusion

This study has shown that, on the whole, MRTs/radiographers in New Zealand and the UK have

a fairly ambivalent attitude towards CPD. There were few 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. It will be interesting to see if this impacts on the results of the follow up study once mandatory CPD has been implemented. Other minor differences included that a slightly higher percentage of radiographers in the UK record their CPD and also more think it should be compulsory, though neither difference was statistically significant.

The qualitative comments from this questionnaire were mostly received from New Zealand respondents (due to the larger sample size). They were grouped into several themes, which were largely congruent with two other CPD studies conducted on MRTs in New Zealand prior to this one. They indicated that there are several factors that MRTs perceive to be substantial barriers to participating in CPD. However, it is also noted that unless MRTs can become intrinsically motivated to participate in CPD, they are likely to create barriers out of any difficulty encountered. In order for an attitude change, they need to first come to a full acceptance of responsibility and accountability for their professional status, excellence and quality in practice, and to support the growth of their profession.

It is anticipated that this study will be replicated two years after CPD has become mandatory in New Zealand, then in the UK, to ascertain whether there have been any changes in attitudes towards CPD by MRTs/radiographers as was shown by Walsh Arenson in Iowa.

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