What are the CPD needs of GPs in areas of high deprivation?

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**Background**: Addressing health inequalities is a priority for both UK and Scottish governments and, although a call to action has been made for all health professionals in the UK to work actively to tackle inequalities, little is known about what educational needs GPs have in meeting this challenge.

**Summary of Work**: This presentation will describe the results of a focus group discussion between ‘Deep End General Practitioners’ in Glasgow, which was facilitated to better understand these educational needs and to inform subsequent action.

**Summary of Results**: A list of 16 themes emerged from the discussion, which were then prioritised into an agreed list of shared learning needs by use of a modified nominal group technique exercise. Four broad areas of learning need were agreed.

**Discussion and Conclusions**: It is anticipated that the results will be of use to those who are involved in supporting primary care learning for those working in deprived communities in the UK, and more widely. More specifically, these results will inform the module production schedule for the practice-based small group learning programme and ensure that there is an opportunity for at least some of these learning needs to be addressed.

**Take-home messages**: GPs working in areas of high deprivation have CPD needs that relate to the impact on the GPs themselves of working in these environments as well as the healthcare needs of the populations that they serve.

Introducing systematic continuous professional development for GPs

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**Background**: Denmark has a voluntary individually planned CPD programme based on approved public funded CPD activities. This CPD programme is to be supplemented with a systematic and centrally planned programme. In this process we conducted a nationwide multidimensional mutual learning needs analysis.

**Summary of Work**: In order to design an effective and feasible systematic CPD supplementary to the present individually planned CPD programme we performed a three-step multidimensional learning needs analysis. The Danish family medicine curriculum is used as reference in all the analyses.

Step one: 20 practice-based small learning groups for GPs and a group appointed by the Public Health Care Contractors have been asked to identify learning needs for Danish GPs.

Step two: A validation process performed by GP researchers at the universities and a special appointed GP group, which focused on narrative person-centred medicine.

Step three: The data from step one and two are merged into a description of topics feasible for CPD.

**Summary of Results**: We identified topics within 5 domains of family medicine perceived as relevant. Examples will be presented.

**Discussion and Conclusions**: This approach allowed us to identify topics where the GPs, the contactors and the researchers agreed on learning needs, addressing the “wants vs. needs” discussion in CPD. Next step will be to see whether new CPD activities based on this multidimensional analysis will result in improved medical care delivered by general practice.

**Take-home messages**: A multidimensional mutual learning needs analysis was able to detect a number of topics feasible for systematic CPD activities for GPs.
#7K3 (25389) Measuring general practitioners’ intention to use e-Learning in continuing medical education: a theory driven questionnaire

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**Background:** In this study a questionnaire was developed to describe General Practitioner’s (GP) intention to use e-Learning in continuing medical education (CME) by application of the theory of planned behavior (TPB).

**Summary of Work:** The recommended standard steps in developing a TPB questionnaire were followed and the dimensionality of the questionnaire was checked using an exploratory and confirmatory factor analysis. Then we performed a structural equation modeling to explore the causal relationship among variables.

**Summary of Results:** The statistical measures for goodness of fit were in acceptable range (KMO= 0.819 and Bartlett’s Test of Sphericity p < 0.01). We limited the factors to 4 (the constructs in TPB) and all 4 factors had Eigen values above one, and the total variance was explained at 52.97%. Perceived behavioral control and Attitudes had the highest causal relationship with intention (0.54 and 0.68), but for the subjective norms, the relationship was low (0.44). Also there was a good correlation between intention and real behavior in this study.

**Discussion and Conclusions:** The theory of planned behavior can explain underlying factors for using eCME by GPs and measured intention by this questionnaire could be a good proxy of real behavior (electronic version of CME usage). But still we cannot predict real behavior well.

**Take-home messages:** CME has some special aspects in relation to the TPB framework that should be considered when working with this model.

#7K4 (25345) Effectiveness and satisfaction of interprofessional education on CME programs

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**Background:** Evaluation is an important part of the educational planning process that ensures the quality and effectiveness of training programs. Also, designing based on principles of adult learning is an essential part of medical education. Accordingly, mortality and morbidity (m&m) conference designed with interprofessional education approach and CME score. After implementation, educational outcome and its effectiveness evaluated with Kirkpatrick’s Learning Evaluation Model.

**Summary of Work:** This is a triangulation study. Monthly morbidity and mortality conferences with CME score was held during one year in 22nd bahman teaching hospital. First and second levels of Kirkpatrick’s model was evaluated by pre and post-tests and a satisfaction questionnaire developed by the researcher.

To assess change in behavior according to third level of model, semi structured interview and observation in field was done. The result of intervention and forth level evaluated by comparing the mortality rates one year before and after intervention.

**Summary of Results:** 202 medical professional people with average 37 years old include 71% female and 29% male. 96% of participants have assessed attractiveness of these programs as very good. Pre and post-tests scores showed significant differences(p-values<0.001) and indicate increased of the learners’ knowledge. In qualitative data analysis, 95% of participants stated that will change their behavior, clinical reasoning and decision making. Also they found improvement in professional interpersonal communication, awareness of system based practice, effectiveness of interprofessional education and learning from real errors, patient safety and quality of care as the positive outcome of it.

**Discussion and Conclusions:** High satisfaction that expressed by these medical professionals confirmed the effectiveness and fairness of the conferences. So this program was Success in four levels of the Kirkpatrick’s model.

**Take-home messages:** M&M conferences are suggested for inter professional education.
An explorative study unraveling motivational profiles of Pharmacists regarding continuous education

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Background: Continuous Education (CE) is important to support healthcare professionals in maintaining and developing their knowledge and competencies. Although lack of motivation is known to be one of the most important barriers among pharmacists for participation in CE, nothing is known about the quality or the quantity of motivation. Self-determination Theory (SDT), which describes autonomous motivation as generating from within an individual and controlled motivation as generating from external factors, was used as a framework for this study.

Summary of Work: The scores of 425 pharmacists on Academic Motivation Scale were subjected to K-means cluster analysis in order to create motivational profiles.

Summary of Results: Four motivational profiles were found: (1) a good quality (GQl) profile, (2) a high quantity (HQt) profile, (3) a poor quality (PQl) profile, (4) a low quantity (LQt) profile. Female pharmacists, “pharmacists-working in-a-hospital-pharmacy”, “pharmacists-working-more-than-10-years” and “pharmacists-not-in-training” were highly represented in the GQl profile, while “pharmacists-working-in-a-community-pharmacy”, “pharmacists-working-less-than-10-years” and “pharmacists-in-training” were highly represented in the HQt profile. The distribution of male pharmacists was not very different between the four profiles. The highest percentage of “pharmacy-owners” was shown in the LQt profile and the highest percentage of the “non-owners” was shown in the GQl profile.

Discussion and Conclusions: Pharmacists exhibit different motivational profiles which are associated with their background characteristics like gender, ownership of business, practice setting and current training. Motivational profiles could have implications in the development of CE courses for pharmacists.

Take-home messages: Based on SDT, pharmacists can be categorized into different motivational profiles, good quality, high quantity, poor quality and low quantity.

Reflections on the National CPD Accreditation Standards for Qatar- Feedback from Accredited CPD Providers

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Background: The Qatar Council for Healthcare Practitioners (QCHP) is responsible to develop and implement a mandatory CME/CPD system for in the State of Qatar by 2016. Since 2013, a set of provisional CPD accreditation standards were developed and piloted with 8 CPD provider organizations.

Summary of Work: CPD provider organizations who voluntarily participated in the accreditation process were invited to complete an evaluation form to provide their feedback. The evaluation form included 14 MCQ questions and 3 open ended questions to enable participating organizations to reflect on their experience, share ideas and propose recommendations to enhance the process.

Summary of Results: Overall, the providers unanimously agreed that the accreditation experience provided a better understanding of the provider accreditation standards and requirements. However, four provider did not think the accreditation experience helped them learn about available accreditation resources. Two of the providers suggested revisions to the application form to reflect different types of providers (i.e. academic versus hospital). Other suggestions included providing a section for frequently asked questions or sample applications to minimize document preparation time. All the providers found the summary report, particularly the recommendations section to be particularly helpful.

Discussion and Conclusions: Feedback provided by the piloting CPD provider organizations provides a positive opportunity for QCHP-AD to learn from and consider improvements to the CPD accreditation process based on revisions to the CPD accreditation standards being developed for implementation in 2016.

Take-home messages: Feedback from accredited providers provides essential information to evaluate and refine CPD accreditation services and standards.