EURACT
European Academy of Teachers in General Practice

Content proposal for the session (90 min)

- 10 min. Introduction to CPD concepts
- 15 min Introduction to the instruments
- 20 min Work in small groups
  - part 1: self-assessment with three methods
  - part 2: simulated peer review
- 5 min Short plenary: how to make a concrete learning plan
- 20 min Work in small group
  - part 3: drawing a learning plan
- 10 min Plenary presentation of learning plans by groups
- 10 min Summing up general reflections

MAKE YOUR PERSONAL LEARNING PLAN!

Jan Heyrman (Belgium), Mladenka Vrcic-Keglevic (Croatia), Paula Vainiomäki (Finland) and members of the EURACT CME –CPD Committee in 2004-2007

EURACT CME/CPD Standing Committee has developed this workshop manual to support all teachers and trainers in general practice/family medicine in guiding GPs and GP trainees in updating their knowledge and skills; it will also help these educators facilitate the trainees implement learned new knowledge and skills in practice and to change their performance to respond to the challenges in the current working environments.

In this workshop, we work in artificial “peer groups”, usually in three subgroups. In our pilot workshops it has come out that 15-20 participants with 3 group leaders are needed for the workshop to be successful, and the approximate time needed will be 90 minutes. If you have more time, all participants may be able to rehearse all three presented assessment tools instead of one only in a short session. For more participants you need more group leaders.

You have to distribute all the forms to all participants (attachment 1). As a tip for the workshop organiser, we recommend printing the different instruments (1A, 1B, 1C) on differently coloured papers, just to make it easier for the participants and you. On the first pages, there is background information to help you in leading the workshop. We have also inserted a small collection of slide handouts (attachment. 2).

It is also possible to present cases with the instruments to be more typical in your own circumstances.

INTRODUCTION

For continuous professional development the focus should be directed on learning and implementation of knowledge.

Lifelong learning is an ethical obligation for all doctors in the environment of progressively increasing medical knowledge and changing demands. For GPs, to stay in the mainstream of the medical evolutions is very challenging but difficult. And further, it is not enough to guarantee learning, but also to guarantee correct performance according to what has been learned. The knowledge has to be implemented in practice, and multi-faceted interventions are needed to change performance.

Traditional CME seldom changes performance

The traditional emphasis on CME has largely proved to be unsuccessful in changing the competence and daily performance of the professionals. Meta-analysis on different methods (Davis ea. 1995) was very clear: the traditional CME through seminars, retraining weeks and regular reading has a minor impact on changes in real practice performance. If the newly learned knowledge is not implemented in the next few days, it is easily forgotten. Multi-faceted interventions are needed for change to happen.

Simply recording attendance at CME does not ensure learning and performance change. Participation in CME may be motivated by other incentives such as meeting friends, belonging to the group, networking, free holiday, etc. Re-certification may sometimes provide disincentives for participation in CPD rather than stimulate it.

Combine quality issues with traditional CME to get outcome.

In a policy document of the quality development board and the educational board of WONCA Europe (EQUIP & EURACT 2003) a plea is made to integrate separate programs of CME learning, and of quality development activities in one process. At the same time, the requirements of health care systems focus on outcome and cost-efficiency. Integrating the more traditional options of CME and the initiatives on Quality Development (QD) form a sustainable environment for CPD. Basic principles are:

- patient and community priorities concerning health care should be central
- CPD should be based on the learners daily working practices
- goals should be set by the GP and/or the practice
- integrating CME and QD should be a continuing process, not series of sporadic efforts
- central instruments are the personal development plan and the learning portfolio
- it should be based on adult learning principles
- during the process, data should be collected and performances analysed, using methods that integrate evidence based guidelines
- to make it a continuous process, practice enabling and reinforcing strategies should be optimized

From individual learning plans to practice development plans

The 'good CPD guide' (Joint centre for education in Medicine 1999) tries to make CPD an instrument at the organisation level. Personal Development Plans (PDPs) have to start from the individual needs, but put in a practice or service context for reinforcement and dissemination, and needs to be discussed with colleagues to form part of the business plan of the clinical unit and so be open to scrutiny and be monitored. They should reflect personal interest but should also encompass corporate needs. Practices or primary care groups should have a clear written CPD policy, and make funds and protected time available; bearing in mind that management of resources is also about better targeting and ensuring value for money. A learning orientated culture should be supported, with a focus on audit, clinical effectiveness and research.

Recertification systems should measure learning and performance instead of participation.

Governments have introduced or are considering implementation of systems of revalidation, re-registration, re-licensing or re-certification for doctors. In addition to questioning how often, when and by whom, this might take place, the introduction of these systems is also a political issue concerning individual professionals, professional bodies, health care providers and purchasers, regulatory authorities, the state and the public. The traditional concept is called Continuing Medical Education (CME), with credit-control, peer review and external inspection or audit as assessment tools.

A central role in the changing process to CPD is expected to come from the re-certification bodies and procedures in the different countries. Traditional CME relates to re-accreditation systems based on credits, collectively acquired in seminars or meetings. They mainly bring new knowledge only. If the focus has to change on the derived competence and performance, the re-certification should adapt to the new paradigm. It will be a fundamental change from counting credits and controlling presence to evaluate personal development plans and to involve in a quality process.

An enlargement of the accreditation from the participating and possibly updated doctors to their performing practice is needed: a new set of instruments, discovering learning needs and how they can be met. It is clear that a flexible system of accreditation is needed, covering re-certification (competency evaluation) and both practice and doctors accreditation (performance evaluation), that still is supportive, transparent and overseen by national authorities. Let's not forget that the all re-accreditation started from decline of public trust in the quality of their doctors.

GPs learn in many ways

In this session we will focus on instruments, procedures, and processes that are related to the CPD options. Participation in conferences and seminars is not the only way of learning. GPs may learn from their patient experiences, daily practise issues, discussing with colleagues, feedback from other specialists, nurses and patients, reading, guidelines and literature. Accreditation should focus also on these learning experiences.

THE CRUCIAL STEPS

The basic message we want to develop in this session is that there is a logical process to follow if a professional GP/FP wants to continue to provide care of a high standard. This standard may be derived from Good Clinical Practice, Professional standards, Current Care guidelines or society requirements.

1. Identify personal learning needs
Everyday practice is full of opportunities that can help. In addition, there are a lot of self-analysis instruments. Some start from daily practice, others from professional task definition lists. Some start from critical events in practice. List of learning needs should be the endpoint of a reflection activity.

2. Make a personal learning agenda
You can not do everything, so concentrate on the most important issues. Identify priorities and prepare a learning agenda

3. Obtain peer review of agenda which becomes a learning plan
Create a support system in your professional group, your practice team with GP's or with multidisciplinary team members to guarantee the desired development.

4. Construct a Personal Learning Plan
Add a time schedule: it should be a lifelong learning process, but please divide this in an annual planning scheme to make it concrete. Written plan at the start of each year that per priority item lists: 1) the educational priorities (not what you want but what you need), 2) ways to meet them: specific learning objectives, 3) evaluation of change: how to judge the effect in practice, and finish the learning cycle.

Do not overestimate yourself: prioritising three specific issues for the coming year is enough. Each year is a subset of a lifetime learning program. Even in the first year one priority can be sufficient to become familiar with the instruments and the options.

5. Keep in track with your "Learning Log", your activity record
A log of actions taken to meet the educational objectives is needed**.** Actions can be activities like reading, participating in meetings, discussing, writing down and objectives can be met by learning, reflecting, collecting arguments. Objectives relate to its applications. It is important to make this very specific.

6. Show your developments through your Educational Portfolio
Finally it is important to prove your process to yourself, your colleagues, your practice team, and your peer group, your practice manager, to your professional group or to the government. Your progress will be documented in a portfolio map. It can consist of three elements: 1) inventory of learning agenda, 2) compilation of documents of learning events and 3) reflection on the personal educational process.

SOME TOOLS TO IDENTIFY YOUR LEARNING NEEDS

1. Consultation Diary: PUN & DEN / PAM

Finding your learning needs by making notes, during the consultation, of problematic aspects, and to analyse which patient's questions or which expectations are not met. It is not unusual that in the clinical work needs from a patient cannot be met. Some of these "Patient Unmet Needs (PUN)" are due to insufficient knowledge or skills. Identifying these gaps in knowledge and skills leads to a definition of educational needs by the doctor "Doctors Educational Needs (DEN)". We all know this: many times it comes into our mind: 'I have to look up this later". At that moment we realise that, if we had this information or skill, we would not have to refer the patient for an opinion or a procedure. The PUN & DEN system helps us to register these needs, and to use this register to identify them and to decide our priority needs for learning.

The PUN&DEN approach has many advantages. But be careful not to simplify. Not all unanswered questions are relevant or important. On the other hand, the PUN&DEN notification only relates to patient questions. There are other important aspects in the work of the GP. This is only one way to find learning needs. It is important to balance with our strong points, related to the 'patients questions I positively could answer (Patient Actual Met needs (PAM)).

2. Good Clinical Practice options: the POSITION MAP

This method means mapping the level of functioning in relation to the professional content and competence that is listed in an official document on GP/FM tasks, to find out your personal profile. Also in your professional discipline, there are documents or statements on "basic task and function options" that are officially defined and/or generally accepted. The position map helps you to quote yourself in relation to this. It scores your personal opinion as to your expertise and quality, in relation to each of the defined domains. Where am I as a skilled professional, where are my strong and weak points in this?

3. SIGNIFICANT EVENT ANALYSIS

This method is to use events out of daily practice to improve personal or team performance. Many things happen every day in practice. Some are routine, a few are special, but they get our attention somehow. They influence, challenge, change or strengthen our thinking and feeling. They can be negative or positive, but they are there and they have an impact on us. These are called "significant events". Because they are significant, they are the strongest enablers for change. Emotions or reactions at the exact moment it happens often are too loaded to learn the appropriate messages. The best thing to do at that moment is to make a short note, and to identify some issues. After a certain time, you will feel better to really reflect on it, and find the points for change. Then the note page can be very helpful.

As a first step the centrally involved team member makes an analysis of the "significant event". Then all the other involved team members do the same. It is important that every member feels it as free exercise with as main aim to learn from it. It should be finally positive for everyone.

To be efficient it is good to distribute the exact factual information to everyone present at the discussion beforehand, to create a common starting point. Additionally everyone can bring the personal information related to the event to support the discussion (file of patient, notes, search results). Then a shared reflection can start.

We have presented only some of the methods for identifying your learning needs. Please, remember, there are plenty of other methods available as well, but this is a good start.

PEER REVIEW WILL HELP

When letting your peers help to evaluate your learning needs and aims, you will probably find some new areas you should add in your learning agenda. You may need to remove some areas than you planned yourself. Your learning agenda should not include only topics you like very much or are interested in. There should be also topics filling your "blind" areas, and take into account patients' and society's needs.

DRAWING A LEARNING PLAN

A documented learning plan with specific learning aims includes a working plan with partial and stepwise tasks definition, description of how the result can be assessed, and a clear time plan.

What is a good learning plan?

Before starting, it must be clear why this process is to be achieved. From which need, based on which ideal practice concept? Who puts forward these expectations, and are you personally willing to fulfill these requirements and to achieve these aims? It finally should be your choice.

For that reason, one of the included instruments is the function profiler, or the practice audit, or the annual practice report where the common aims, options and endpoints for the practice teams were defined.

2. A learning plan should be SMART!
Specific: the plan should only contain specific changes within the context of the practice development.
Measurable: the development should be able to be measured in the practice. This may be measured using documents, video, reflection in portfolio, presentation in practice staff meetings.
Achievable: three priority points is enough for one year, identify interim steps and plan them realistically.
Relevant: not because that's what you like, but that's what is needed: be honest and open, it will ask for a sustained effort.
Time-bound: don't leave it open, promise steps within a realistic timeframe.

2. A learning plan should be positioned in the context: WHOW!
WHY: what exactly made this a priority item?
WHO is involved: who needs to be involved?
WHAT: in a DO-terminology!
WHICH TIME SCHEDULE?
WHERE?
HOW results will be measured?

Literature

Davis D. Thomsom o´Brien MA, Freemantle N, et al. Impact of formal continuing medical education. Do conferences, workshops, rounds and other continuing educational activities change physician behaviour or health care outcomes? JAMA 1999;282:867-74.

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In 2004-2007 EURACT CME/CPD standing committee has participated in developing and piloting this workshop. The members with different input and commitment for this workshop have been Iuliana Popa, Bernardine Wanrooij, Eva Jurgova, Samira Herenda, Ruta Riba, George Spatharakis, Jaroslava Lankova, Bernhard Rindlisbacher, Ruth Kalda, Philios Phylatou, Razvan Mitfode, Peter Vajer, Sandra Gintere, Elena Frolova.

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ATTACHMENT 1

WORKSHOP PLAN

Part 1: SELF ASSESSMENT: instruments for structured analysis of one's own work
To identify learning needs it is essential to start from the practice. Different instruments and procedures are developed to help you to come to your real needs. In this workshop we will focus on three of them only. Plenty of other tools are available as well.
In this workshop, depending on time resources, all participants may be able to rehearse one or more instruments.

Part 2: PEER REVIEW OF LEARNING GOALS

Part 3: MAKING A DEFINED LEARNING PLAN

In real life: remember to update your educational portfolio!

Part 1. METHODS FOR SELF-ASSESSMENT

1. A PUN & DEN / PAM

PUN = Patient unmet needs
DEN = Doctors educational needs
PAM = Patients' actual met needs

HOW TO FACILITATE THIS WORKSHOP

1. Divide the group into pairs

2. Each pair has to go through the list of ten consecutive consultations described roughly in the PUN & DEN Diary shown below. (In real life you have collected this data yourself and you remember more of the conditions).

3. Instruments to be used
    a. Use Instrument The PUN&DEN Diary with your pair
    - Fill in our readymade scheme of 10 consecutive consultations
    - PAM, also reflect on needs that you have met with your patients

PUN: which Patient Unmet Needs have you identified. Make your notes specific.
Patient asked a question about drug abuse and I did not give any answer.
I had to give an intra-articular injection, and I gave medication instead.

DEN: try to define as specifically as possible the learning needs related to PUN, in terms of knowledge, attitude and skills. How did it come that these questions were not answered? Write down as honestly as possible your thoughts on this. It is helpful to be clear about gaps in knowledge, attitudes and skills. Add other influencing factors (that are not changeable by 'learning').
I don't have enough information on drug abuse, and I don't know exactly the local support organizations.
I don't have skills for intra-articular injections in the shoulder.

Please note: This is not yet the time to draw up a learning plan

4. Products: Filled PUN/DEN/PAM instrument.

5. Remember, in this workshop we have limited time. Do not worry if you cannot go through all items in the diary. At the end of this part, choose one person to present his/her final learning needs in the larger group. Save some minutes for this discussion.

Instrument: The PUN&DEN DIARY

Fill in the table with your pair. Please, simulate yourself as if you had collected this set yourself.

Details of consultation	**PUN**	**DEN**	**Action**
Example: *Parents of 15y old son consulted with fear around uncontrollable behaviour of their son*	*They asked how to find out about drug abuse*	*I need to know more on specific symptoms on drug abuse. I need to know more on local support facilities so that I can refer more appropriately*	*Consult the local organizations guide, and contact appropriate organizations, or look for good literature*
1. Telephone mother: possible addresses for ADHD treatment for her son 12yr.			
2. Woman 20yr, persistent headache, undefined			
3. Telephone Woman 54yr, mammography: suspect result			
4. Man 63yr, first visit after hospital discharge for resection of colon.			
5. Man 44yr, vague urinary problem, inflamed scrotum			
6. Woman 82yr, Atrial Fibrillation, asks about lowering medication			
7. Woman 76yr, anticoagulant therapy difficult to control			
8. Woman 49yr, history of colon			

carcinoma, persistent pain in left iliac fossa			
9. Woman 52yr, decubitus ulcer			
10.Boy 4yr, cryptorchidie, nurse questions			

Consultation details	**PAM : Patient Actually Met needs**
Student, 19yr epicondylitis lateralis Tel. Woman 54yr, telephone on suspected mammography Man 63yr, visit after hemicolectomy Woman 69yr tendinitis *of what??* Woman 40yr, questions about ADHD	

Select from this exercise 3 learning needs and transform them to learning objectives

1. …….

2. …….

3. ……..

PART 2. PEER REVIEW:

Now choose one person to provide some focus for peer group discussion. The person presents his/her learning objectives to the group, and then another member of the group will simulate a peer and try to help the target person in developing the objectives. Save five minutes for this discussion.

An alternative: Some groups feel it easier to let the selected person to present his/her real learning objectives on any topic instead of those picked up during the previous session.

Result of self-analysis procedures and peer group discussion. The selected person fills in the table and other participants form a peer group.

FROM THE SELF-ANALYSIS, I SELECTED AS PRIORITY LEARNING OBJECTIVES: 1 ……..……..… 2 …… 3 ……
THE PEER GROUP DISCUSSION HELPED ME IDENTIFY THESE KEY ELEMENTS: (SHORT REPORT OF THE DISCUSSION) • …… • …… • ……
☐ The three learning objectives I decided to work on remain unchanged (see above) ☐ The three learning objectives I decided to work on, after discussion with my peers, are restructured or modified. My final learning objectives • ……..……...…… • ……. • …….

PART 1. METHODS FOR SELF-ASSESSMENT

1 B. Good Clinical Practice options: the POSITION MAP

HOW TO FACILITATE THIS WORKSHOP?

1. Divide the group into pairs

2. Each pair has to go through the position map (in real life you are able to select your list according to the rules and conditions in your own work). Filling in the position map is a stepwise procedure
   1. First give a mark to which degree you think you have progressed in knowledge, skill and attitude and in the implementation in your daily routines and procedures. Circle the corresponding mark

   6 = very skilled (knowledge and skills are integrated in daily practice behaviour)
   1= not very skilled
   2. Then again go through the list, and score your willingness to work on any item now and learn more. Score N= no, or Y=yes. A lot of Y marks do not mean that you have to do everything you scored.
   3. Look at the whole list, and mark 3 to 6 items as your priority to work on in the near future (score from 1 to 6 in the last column)
   4. Finally, based on the position map, fill in your Personal Reflection Form. Describe, where are you good, and where are your gaps.

Instruments to be used:
Position Map and strength/weakness analysis
Personal Reflection Form on Position Map (PF-PM).
Both instruments together are the basis for a reflective discussion with your colleagues or peer groups

Products:
Filled Position Map
Minimum 3 learning needs, noticed in a Personal Reflection Form

Remember, in this workshop we have limited time. Do not worry if you cannot go through all items in the position map. At the end of this part, choose one person, to discuss his/her final learning needs in a peer group. Save some minutes for this discussion.

Instrument 1B: POSITION MAP & STRENGTH/WEAKNESS ANALYSIS

Professional Task and Performance definition	Not known ----- very skilled	To work on it now?	priority
Evolutions in family medicine			
-follow evolutions in family medicine	**1 2 3 4 5 6**	**N Y**	
-take care for implementation in practice	**1 2 3 4 5 6**	**N Y**	
Family Practice skills			
-master family practice skills conform rules	**1 2 3 4 5 6**	**N Y**	
-use most of the normal procedures in practice	**1 2 3 4 5 6**	**N Y**	
Consultation skills			
-know the consultation & communication model concepts	**1 2 3 4 5 6**	**N Y**	
-implement them in daily practice consultations	**1 2 3 4 5 6**	**N Y**	
Medical Record Keeping			
-use of electronic medical record in patient contact	**1 2 3 4 5 6**	**N Y**	
-use EMR on practice population level to organize prevention, audit, scientific evaluations	**1 2 3 4 5 6**	**N Y**	
Using Medical Literature			
-can judge the scientific basis of an article, a review and a guideline	**1 2 3 4 5 6**	**N Y**	
-master modern search strategies to find appropriate literature sources	**1 2 3 4 5 6**	**N Y**	
-can translate practice problems in researchable questions	**1 2 3 4 5 6**	**N Y**	
Evidence Based Medicine			
-know the basics of EBM	**1 2 3 4 5 6**	**N Y**	
-critically reflects on daily practice experience	**1 2 3 4 5 6**	**N Y**	
Protocols and guidelines			
-know GP/FM protocols and guidelines	**1 2 3 4 5 6**	**N Y**	
-implement guidelines in daily practice	**1 2 3 4 5 6**	**N Y**	
Medical decision making			
-can analyze patient cases in diagnostic elements ---	**1 2 3 4 5 6**	**N Y**	
and therapeutic decision making elements	**1 2 3 4 5 6**	**N Y**	
Therapeutic Formulary			
-use a defined therapeutic formular y	**1 2 3 4 5 6**	**N Y**	
-base pharmacotherapy on EBM-information	**1 2 3 4 5 6**	**N Y**	
Multidisciplinary patient approach			
-active in multidisciplinary collaboration	**1 2 3 4 5 6**	**N Y**	
-use of local social organizations map	**1 2 3 4 5 6**	**N Y**	
-use of administrative procedure and legislation	**1 2 3 4 5 6**	**N Y**	
Prevention			
-systematic organization of prevention programs in practice	**1 2 3 4 5 6**	**N Y**	
-appropriate knowledge on epidemiology, public health, cost/efficiency	**1 2 3 4 5 6**	**N Y**	
-appropriate skills on communication to patients	**1 2 3 4 5 6**	**N Y**	
-appropriate health promotion materials	**1 2 3 4 5 6**	**N Y**	
-preventive attitude in dealing with patients	**1 2 3 4 5 6**	**N Y**	
Professional Development			
-active organization of personal learning and development	**1 2 3 4 5 6**	**N Y**	
-active collaboration in practice group and peer group discussions	**1 2 3 4 5 6**	**N Y**	
Ethical and Social functioning			

-use ethical and social reflections in dealing with patient problems	**1 2 3 4 5 6**	**N Y**	
-use health economical principles	**1 2 3 4 5 6**	**N Y**	
-skills in communication on ethical aspects	**1 2 3 4 5 6**	**N Y**	
Scientific Research			
-take part in external scientific projects	**1 2 3 4 5 6**	**N Y**	
-organises/take part in practice projects	**1 2 3 4 5 6**	**N Y**	
Practice organization			
-organization of appropriate appointment systems	**1 2 3 4 5 6**	**N Y**	
-involvement in practice organization	**1 2 3 4 5 6**	**N Y**	
-involvement in teamwork	**1 2 3 4 5 6**	**N Y**	

Personal Reflection Document after the Position Map.

Try to define – based on the information from the Position Map – to define your strong points and your problem areas that could lead to your learning needs. Be as specific as possible about your learning needs and what they exactly mean to you.

ISSUES WHERE I FEEL STRENGTH
ISSUES WHERE I FEEL NOT SO GOOD
Based on the Position Map in relation to the Function List of GP/FP, I note for myself the following learning objectives: 1. 2. 3.

PART 2. PEER REVIEW:

Now choose one person to be the focus for peer group discussion. The person presents his/her learning objectives to the group, and then one of the other members simulates a peer and tries to help the target person in developing the objectives. Save five minutes for this discussion.

An alternative: Some groups feel it easier to let the target person to present his/her real learning objectives on any topic instead of those picked up during the previous session.

Result of self-analysis procedures and peer group discussion. The chosen person fills in the table and other members of the group form a peer.

FROM THE SELF-ANALYSIS, I SELECTED AS PRIORITY LEARNING OBJECTIVES: 1 ……..……..… 2…… 3. ……
THE PEER GROUP DISCUSSION HELPED ME IDENTIFY KEY ELEMENTS: (SHORT REPORT OF THE DISCUSSION) • …… • …… • ……
☐ The three learning objectives I decided to work on remain unchanged (see ABOVE) ☐ The three learning objectives I decided to work on, after discussion with my peers, are restructured or modified. My final learning objectives 1……..……...…… 2……. 4. …….

METHODS FOR SELF-ASSESSMENT

1.C SIGNIFICANT EVENT ANALYSIS

Personal Analysis of the Significant Event

HOW TO FACILITATE IN THIS WORKSHOP

1. We have described a situation for you: time and date, event, circumstances, involved persons. You have to set yourselves in the situation described and take the role of the doctor. One person has to work as a secretary of the group. (In real life all the involved will be within the discussion, but this time we concentrate on the role of the doctor)

2. What went well in the situation?

3. Make a fishbone diagram: this is a help to find the causes and related consequences and to write them down in a consecutive and related order. It is a form of relational diagram, where all causal elements are listed in a sideway of a consecutive pathway that has lead to the present significant event. We have made this partly ready for this workshop.

4. What did not go well? Analyze shortcomings, mistakes and misjudgements, eventually with their reasons, if you can.

5. Reflect on alternatives: how could it have been done differently?

6. Identify your personal learning needs: how can I change my shortcomings?

At the end of the session, and especially in real life, it is important to note clearly the crucial points of the discussion in the part “important issues formed in the discussion”, and to write down concrete action points. Also suggestions and recommendations can find a place.

Instruments to be used:
Significant Event Analysis and Reflection

Products:
Filled instrument 1C by the main concerned person
Filled form by the other person, acting as secretary from the discussion round

Remember, in this workshop we have limited time. Do not worry if you cannot go through all items in the list. At the end of this part, choose one person, to discuss his/her final learning needs in a peer group. Save some minutes for this discussion.

INSTRUMENT 1 C: SIGNIFICANT EVENT ANALYSIS & REFLECTION

Fill in all the empty places together.

Description of the event **date/time** May 2006 200x, 11:00

Consultation (man, 63yr). He returns from hospital after partial resection for colon tumour. I have not yet received correct medical information from surgeon, and hope the patient will have a letter. Patient has a discharging letter with some information on the operation and the postoperative phase. No anatomo-pathology, no prognostic elements in it. "I hope they have been able to resect everything," the patient says, and I replied "I hope so myself also". I immediately felt it was wrong to say so. I saw fear in his eyes, but he did not say anything, and I felt too uneasy to reply myself. I organized his homecare in a practical way but could not come back to the discussion. I felt annoyed with it the whole day.

What went well

I realized the anxiety of the patient at once, and decided immediately to deal with it.

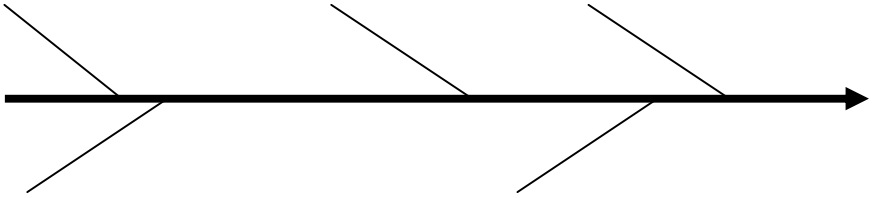
1. ……..

2 ……

3. ……

Fishbone diagram (fill in)

Patient	***Clinical Situation***	***Doctor***
Indirect communication style	Cancer insecurity	Insecurity with palliation
……..	…….	……
……..	…….	……



No electronic record at home	Slow information
…….	……
…….	……
Practice Organizations	***Medical Organization***

What did not go well

1.Correct and complete information availability before seeing a patient

2 …….

3. ……..

How could I have done it differently

1.Discuss the insecurity in patient and discuss openly how to clarify it for the future

2……

3……

Identification of learning needs

1……

2……

3. …….

REFLECTION NOTES ON SIGNIFICANT EVENT ANALYSIS (secretary fills in)

Important issues from the discussion
Suggestions, recommendations and proposals
Action points (Who is doing what, in what timeframe, how to follow up?) Learning objectives 1. …… 2. …… 3. ……

PART 2. PEER REVIEW:

Now, you have to change roles to a peer group, where you discuss your colleague's learning objectives. Some days have passed since the significant event discussion. Choose one person to be the focus for peer group discussion. The person presents his/her learning objectives to the group, and then other members simulate a peer and try to help the target person in developing the objectives. Save five minutes for this discussion.

An alternative: Some groups feel it easier to let the target person to present his/her real learning objectives on any topic instead of those picked up during the previous session.

Result of self-analysis procedures and peer group discussion. The chosen target person fills in the table according to the previous session and other members of the group form a peer.

FROM THE SELF-ANALYSIS, I SELECTED AS PRIORITY LEARNING OBJECTIVES 1 ……..……..… 2…… 3……
THE PEER GROUP DISCUSSION HELPED ME IDENTIFY KEY ELEMENTS: (SHORT REPORT OF THE DISCUSSION) • …… • …… • ……
☐ The three learning objectives I decided to work on remain unchanged (see above) ☐ The three learning objectives I decided to work on, after discussion with my peers, are restructured or modified. My final learning objectives 1……..……...…… 2……. 5. …….

Part 3: DRAWING A LEARNING PLAN

Task: working in the same group of participants
Time: 15 minutes

Take one of the 3 chosen learning aim points, and develop a concrete learning plan for this topic (time schedule, where, when, supported by whom, how the result are measure etc.).

Result: write the learning plan on the flap. Appoint one volunteer in your group to present the learning plan to the plenary group (max. 2 minutes)

INSTRUMENT 3: PERSONAL DEVELOPMENT PLAN

General learning aim and finalization time
Specific learning aims I want to achieve and interim time steps
Partial elements in my working plan
How to report on it in practice

Making your own learning agenda

EURACT

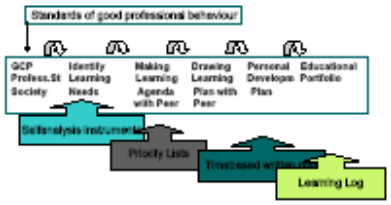
Content of the session (90 min)

- 10 min. Introduction to CPD concepts
- 15 min Introduction to the instruments
- 20 min Work in small groups
  - part 1: self-assessment with three methods
  - part 2: simulated peer review
- 5 min Short plenary: how to make a concrete learning plan
- 15 min Work in small group
  - part 3: drawing a learning plan
- 10 min Plenary presentation of learning plans by groups
- 10 min Summing up general reflections and evaluation

From CME to CPD

- Traditional Continuing Medical Education
  - Focus on « teaching » and « knowledge absorption »
  - Credits in controllable environment
  - Problem: it does not change practice performance!
- Continuous Professional Development
  - Start from practice and focus on change in practice
  - Proof of process: educational portfolio
  - Problem: requires a new set of instruments

Continuous Professional Development



Consultation diary: PUN/DEN/PAM

- Patient unmet needs
- Doctors educational needs
- Patients actually met needs

- originates from real practise
- not all PUNs lead to DENs
- there are also other DENs

PUN/DEN/PAM

Details of consultation	PUN	DEN	ACTION
Parents of 15y old son consulted with fear around uncontrollable behaviour of their son	*They asked how to find out eventual drug abuse*	*I need to know more on specific symptoms on drug abuse. I need to know more on local support facilities so that I can refer more adequately*	*Consult the local organizations guide, and contact appropriate organizations, or look for good literature*

PAM= you will find on paper

Position mapping Strenght/Weakness

- lies mostly on official documents or job descriptions
- should be done regularly to show your development
- can be used alone, but your peer can help you remarkably
- sometimes is connected with wages and, may be felt harmful

Position mapping

Professional Task and Performance Definition	Not known —— very skilled	To work on it now?	Priority
Consultation skills know the consultation & communication model concepts	1 2 3 4 5 6	Y N	
-implement them in daily practice consultations	1 2 3 4 5 6	Y N	

SIGNIFICANT EVENT ANALYSIS

- something goes wrong or very well
- can be done alone, but will be more fruitful in groups with all the concerned
- a trustful atmosphere is needed
- sometimes sensitive

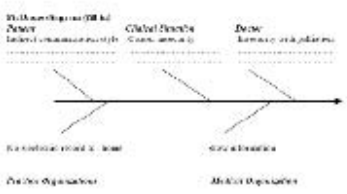
Example: Significant event analysis

Consultation (man, 63yr). He returns from hospital after partial resection for colon tumour. I have not yet received correct medical information from surgeon, and hope the patient will have a letter.

Pt. has a discharging letter with some information on the operation and the postoperative phase. No anatomo-pathology, no prognostic elements in it. "I hope they have been able to resects everything" the patient asked, and I replied "I hope so myself also". I immediately felt it was wrong to say so.

I saw fear in his eyes, but he did not say anything, and I felt to much uneasy to reply myself. I organized his homecare technically, but was really blocked somehow to come back on it. I felt annoyed with it the complete day.

Fish bone diagram as a help



Part 2. DISCUSSION WITH PEER

- is very useful, but not often done
- adds more aspects to the learning needs you have discovered yourself
- takes better into account the needs and objectives of the whole practice
- there are learning needs for you from the society, patients etc.

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Part 3 : Drawing up a learning plan

- Define your final domains with clear learning objectives: 3 domains a year is enough!
- Be spesific : concrete initiatives, learning modules, registration and reflection elements
- Put them in a concrete plan, including timing and and substeps
- Clarify already now how you plan to make changes visible in your practice work.
- Create your support system: peers, practice team, managing staff
- CLEARLY WRITTEN THIS IS YOUR Continuous Development Plan for the coming year

Part 3: Elements of concrete « learning plan »

- WHAT : concrete learning aims (in do terms)?
- HOW : interim steps – to realise for when?
- TOWARDS WHICH TIME: targettime?
- BY WHO: tasks and responsibilities?
- PRODUCT : how to show aims are met?

W W W H =Who is doing What, Which time, Where and How to follow up :

SMART = be Specific, Measurable, Achievable, Relevant, Timebound

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