

LondonDeanery

Professional Support Unit

REFLECTIVE WRITING SKILLS

REFLECTION AND
REFLECTIVE PRACTICE

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WELCOME

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Credits

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ABOUT REFLECTIVE WRITING SKILLS

This module

This module is structured into several areas of learning:

Examples: There are examples from the reflective practice of other clinicians for you to read through. These may be pieces of reflection or reflections upon the reflective process.

Thinking points: Thinking points ask you to stop and think about what you have just read, or about your own professional practice. It might help if you make notes on your thoughts for these parts of the module.

Try it: The 'try it' sections ask you to engage in a piece of writing or reflective practice to develop your strengths in these areas.

Before you start

Before you start the module we recommend that you spend a few minutes thinking about the following points and noting down some of your thoughts.

REFLECTION AND REFLECTIVE PRACTICE

Reflection is a wide-ranging term for a process that can take place informally over a coffee, or more formally in terms of a learning conversation or journal writing. It can be an internal process, or can take place with others in the workplace, or between friends and family. This module explores the uses reflection, in both individual and collaborative practice and its benefits not just in the training years but beyond into established professional practice. It looks at how reflection can be used as a professional support mechanism and to build resilience against stress.

There are multiple purposes of reflection:

- To develop or to consolidate practice;
- To provide reassurance or criticality;
- To improve performance or understanding;
- To enhance the quality of patient care;
- To provide understanding of and respite from the complex, demanding workplace.

By the end of this module you will have an enhanced understanding of the role of reflection in your professional life. You will have considered the principles of effective reflection and seen some of the benefits of deliberate reflective practice. You will have the opportunity to explore a simple system for reflection and to read about some of the uses it has had in the medical field.

The best way to develop your own reflective practice is to decide what use you will make of it, to consider a range of suggested approaches to reflection and to experiment with your own thoughts either individually or with trusted others.

Thinking points

- How do you usually think about your clinical practice?
- Do you discuss with colleagues and friends or prefer to think about it on your own?

WHAT IS REFLECTION? SOME DEFINITIONS

Reflection is a tool for helping us to understand our work, ourselves at work and the impact our work has upon us as people. It is psychologically, socially, culturally and professionally situated in our practice, and usually occurs subconsciously. Mulling over a patient case whilst in the shower, telling a friend or a partner about a challenging day, sharing memories from previous experiences with colleagues – all of these are examples of reflection.

Deliberate reflection relates to the process of choosing to think consciously about a case, a colleague, oneself or one's practice, often (but not always) with a structure or process in mind to guide our thinking.

“Maybe reflective practices offer us a way of trying to make sense of the uncertainty in our workplaces and the courage to work competently and ethically at the edge of order and chaos...” (Ghaye, 2000, p.7)

Dewey (1933), arguably the originator of the concept of reflection, defined it as:

“the process of internally examining and exploring an issue of concern, triggered by an experience, which creates and clarifies meaning in terms of self and which results in a changed conceptual perspective.”

Example 1

I met an amazing patient recently. I was called down to emergency on my surgery rotation. I was to see a 24 year old woman with cerebral palsy. When I first saw this African-American with short black hair I thought she was a he, so I got confused.

I approached the patient, introduced myself and began my history. It was obvious that the patient was bound to a bed all her life. She couldn't speak clearly and mumbled her words. I began asking her father questions. After a while she mumbled something and her father started laughing. When I asked what she said, he said, 'she says why don't you just ask me the questions?'

I was shocked and ashamed. I apologised to her and began our conversation. Although difficult to understand, I made out her words and realised how direct and concise she was. She was also witty and kept cracking up her dad. At one point I had to stop my 'history' and said, 'I'm sorry but I just have to say you are one of the most inspiring and amazing people I have ever met.' Despite all the crap in medicine, just the fact that I got to meet her makes it all worthwhile.

Maureen Rappaport

From Bolton, G. (2005) *Reflective Practice: writing and professional development* (2nd ed) London, Sage

Thinking points

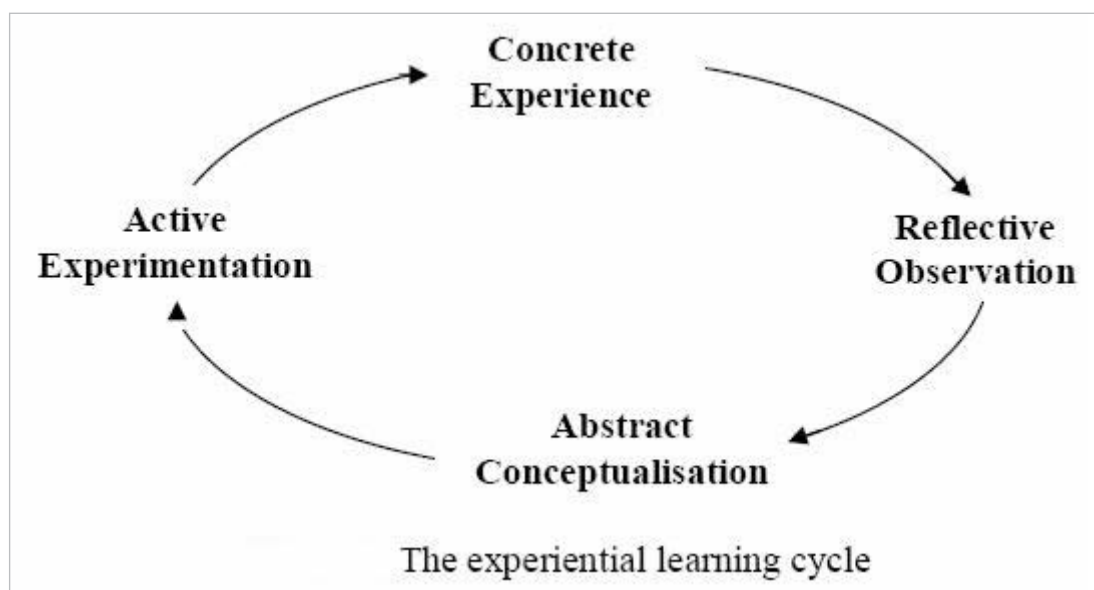
- What benefit do you think the doctor gained from this reflection?
- Can you think of a similar encounter you have had with a patient?

EXPERIENTIAL LEARNING

Kolb's (1984) experiential learning cycle is possibly the most familiar model in helping us to visualise the reflection process. This cycle includes four points of endeavour in terms of learning from practice:

- **concrete experiences**, which often trigger the need for reflection;
- **reflective observations**, which allow for looking back and reviewing practice;
- **theoretical or abstract conceptualisation**, which prompts the formation of new ideas; and
- **active experimentation**, where we try out the new ideas in a similar practice.

Two aspects of Kolb's cycle are especially noteworthy: the use of concrete, 'here-and-now' experience to generate and to test ideas; and use of feedback to change practices and theories (Kolb 1984: 21-22). Kolb joins these with Dewey to emphasize the developmental nature of the exercise. He named his model so as to stress the role experience plays in learning.



In the previous example of the patient with cerebral palsy, the **Concrete Experience** was recounted in the 'story' of the encounter, being called to the Emergency Department, speaking to the father then addressing the patient. The **Reflective Observations** made related to the physical description of the patient, the feelings of being 'shocked' and 'ashamed' and the statement the doctor made to the patient about her being 'inspiring' and 'amazing.' The **Abstract Conceptualisation** relates to the thinking that the doctor employed both during and after this encounter. She realised that she had made some incorrect assumptions regarding the patient's gender and her ability to communicate, and she learned that the patient was 'witty,' 'concise' and 'direct.' The doctor does not say what she intends to do with this learning but we can imagine that her future interactions would be different as a result of this encounter.

BENEFITS OF AND BARRIERS TO REFLECTION

Thinking points

- What do you think might be the benefits to you of using reflection?
- What might be the barriers to using it?

Reflection has many benefits and is used for a wide variety of reasons:

- to validate prior learning;
- to attend to the grounds or the justification of our beliefs;
- for problem solving;
- to reflect on the content of a problem;
- to think about the processes involved in a practice;
- to examine the basis of our perspectives;
- to develop greater productivity, greater satisfaction;
- to enhance flexibility and to improve our leadership skills;
- to develop feelings of greater congruity about ourselves and our working practices;
- to acknowledge immediate feelings, followed by later thoughtful scrutiny;
- to reinforce good practice.

However, reflection can be a daunting concept initially.

Barriers to reflection can include:

- fear of the unknown;
- worry about what you might find;
- admission of error and losing face;
- feelings of being emotionally drained;
- pressure to change things;
- sense of being too old to learn new things;
- the culture of 'winging it';
- a sense of isolation.

It is no wonder that many of us shy away from doing it. This module will show you how it can be done easily and effectively to improve your practice and reduce your work based stress.

REFLECTION AS PROFESSIONAL SUPPORT MECHANISM

Work is central to our lives and as clinicians this is especially true:

“Work is what we do with most of our waking lives. Work is central to our happiness and feelings of self worth. We see ourselves reflected in our work, in the outcome and importance of what we do. When we think about our lives we often define ourselves in terms of how we make a living. We spend an enormous part of our life working, trying to make a living and trying to express our individuality.”

(Hamer, 2006, p4)

So when things become difficult at work it is no wonder that we feel stressed and may struggle to cope. We would be very foolish to ignore the significance of work in our lives or the impact of stress from work upon our personal lives.

One way of coping with such stress is reflection:

“We constantly get evidence about how effective or worthwhile our actions are, and how we can change what we are doing according to the evidence of its value. To do so of course requires being reflective.”

(Payne 2002).

Linden West’s research (2010) into the crisis of professionalism in inner city communities in the UK provided a “reflexive space in which emotional insights could develop alongside critical awareness” for the doctors and teachers in the study. While reflective practice in professional preparation and development can be superficial and formulaic, West found that more holistic forms of understanding, combining self knowledge and critical awareness helped to build insight into the self and others.

Reflection as development of “professional artistry” fights with the current political imperatives surrounding targets, financial savings and accountability. Morale and motivation can suffer in ‘unreflective’ work settings and clinicians can become “brutalised early on in their careers” leading them to “adopt mechanical work practices” (Burton & Launer 2003). In addition, there is a continuing tendency to disparage subjectivity in favour of ‘evidence based,’ ‘robust’ objectivity. West’s work with GPs created space for reflection and reflexivity.

One doctor, named Daniel (a pseudonym) discusses the relationship between his own decision to enter into medicine and the treatment of a Somali refugee patient. He said:

Example 2

“I think it is in a way always coming back to the business of a personal search, actually trying to find out what life is about and what you should be making of it and having others there who listen and encourage.”
(West 2010).

In this way Daniel was considering his work in light of his own autobiography and values, allowing him to relate to the patient and transform his perspectives as a result of his reflections.

Doctors are increasingly suffering from stress related complaints and there is evidence of declining morale and problems with recruitment, retention and increased turnover. In *Doctors on the Edge* by Linden West “Pat” details how she felt:

Example 3

“I was easily stressed by it. I was often very stressed by work. I suppose I felt a mixture of things. I felt resentful that it was taking up so much time.”
(p156)

Another research participant described his work related issues:

Example 4

“...the difficulty I am facing personally has coincided with the changes I have just described and it is sometimes difficult to disentangle or see them separately, and if you get down, are you getting down because of what is happening in the personal and private and have you just got to try and keep a clear head about which belongs where?”
(p194)

He used anger as a deflection for his encroaching depression and said that he got depressed when he was confused and did not know how to deal with what was oppressing him. As a participant in an extended process of reflection and reflexivity, “David” found the connections he was making to be “therapeutic.” (p200). He claimed at the end of the process:

Example 5

“This has been therapeutic to me in the sense of having to piece together bits of it and come up with an answer. It is helpful because you are being challenged to make connections that you wouldn’t normally do. So you can’t avoid, in a sense, being therapeutic.”
(p202).

Thinking points

- Think of a time when you felt stressed in your professional role?
- What helped you to manage the stress?

GETTING STARTED ON REFLECTION

Reflection can be done in the head, on paper and verbally. It often helps when initially getting started to try writing. Many people say that they are not 'creative writers' and that they cannot therefore write. However Bolton (2005) has found that everybody can write once they let go of their pre conceptions.

She advocates free writing for 6 minutes.

Try it

Take a notebook and a pen and find a quiet place where you will not be side-turned. The aim of this exercise is to just write. The content of the writing is of no consequence at all. The object of the activity is to feel the words spilling out of the pen even if they make no sense whatsoever.

Write about what's in your head. What you did today, something that is worrying you, what you are feeling about this activity, or something else. It really does not matter.

Set a stop watch for 6 minutes and just write. Ignore the grammar and spelling (nobody is going to read this but you.) Let the words flow.

Once you have finished sit back and think about the process you have just engaged in.

Thinking points

- What do you think might be the benefits to you of using reflection?
- What might be the barriers to using it?

Try it

Take some more paper, and write for at least 10 minutes and no longer than 20 minutes on the following subject:

A time I learned something vital at work.

Let the pen flow again without any regard for spelling, grammar and punctuation; just get your thoughts down.

Thinking points

- How did this second process of writing make you feel?
- What did you learn from the story you wrote?

PRINCIPLES FOR EFFECTIVE REFLECTION

The ten 'C's of reflection

Johns' (2000) approaches to reflective practice has been used extensively in health care. He advocates ten principles, which underpin effective reflection:

- **Commitment** – believing that self and practice matter; accepting responsibility for self; the openness, curiosity and willingness to challenge normative ways of responding to situations. We therefore need to have faith in the process.
- **Contradiction** – exposing and understanding the contradiction between what is desirable and actual practice. We need to be able to live with this gap.
- **Conflict** – harnessing the energy of conflict within contradiction to become empowered to take appropriate action. We need to understand that conflict can be helpful.
- **Challenge and Support** – confronting the practitioner's normative attitudes, beliefs and actions in ways that do not threaten the practitioner. We need to be supportive of ourselves.
- **Catharsis** – working through negative feelings. We need to know that it may hurt, but that the hurt may well make it better.
- **Creation** – moving beyond self to see and understand new ways of viewing and responding to practice. We need to remember that reflection can lead onto better things.
- **Connection** – connecting new insight within the real world of practice; appreciating the temporality over reality. We need to see that there are new links to be made which can revitalise us in our practice.
- **Caring** – realising desirable practice as everyday reality. We need to be kind to ourselves.
- **Congruence** – reflection as a mirror for caring. We need to remember that being caring to ourselves can help us be caring towards others.
- **Constructing** personal knowing in practice – weaving personal knowing with relevant extant theory in constructing knowledge. We need to understand that reflection can often lead to new knowledge, understanding, practice and a different view of ourselves.

People often find reflection very helpful once they learn how to do it:

Example 6

One doctor wrote a vehement and dramatic long-term 'diary' about his relationship with his health authority; when he reflected upon it later, he wrote; 'I am much less emotionally reactive in all these management meetings I have to go to, and certainly not as nervous!'

Bolton 2005, p.27

MODELS OF REFLECTION

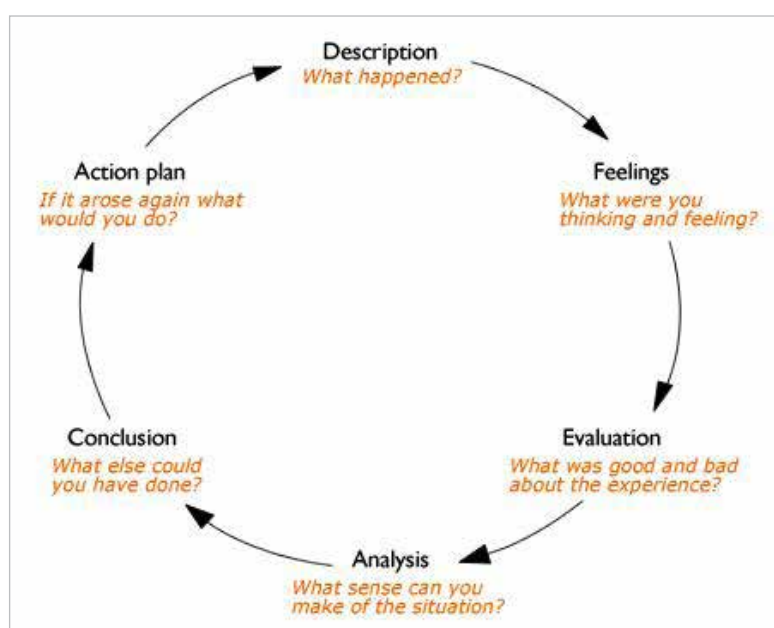
Most clinicians have experience of using reflection albeit in a very focused way: audit; critical incident analysis; dealing with complaints; quality improvement projects all involve reflection of some sort.

Reflection is commonly thought to be something that cannot be taught, but can only be developed with experience. Models for reflection abound, and share much common ground. There is debate around how useful they are, and accusations of 'tick box' exercises question the genuine reflection produced. However, it is useful to look at some of these approaches, to help structure and guide our reflection.

Most models are retrospective and introspective and involve three fundamental processes:

- Retrospection: thinking back on an experience or an event
- Self evaluation: critically analysing the strengths, weaknesses, feelings and thoughts, maybe using some theoretical perspectives
- Reorientation: using the results of the self-evaluation to influence future similar experiences.

Gibbs's is one model which has been used with success by a range of healthcare practitioners. Gibbs takes as his starting point the event, or experience around which the reflection is based, and begins by asking the reflector to describe what happened. The process moves through feelings at the time, an evaluation of the experience in terms of good and bad practice, further analysis asking for 'sense making', or theoretical perspectives, before reaching a conclusion and following up with an action plan. Whilst this has been useful for many people beginning on their reflective practice journey, it has been criticised for being too formulaic and reducing reflection to a series of steps or 'tick boxes.'



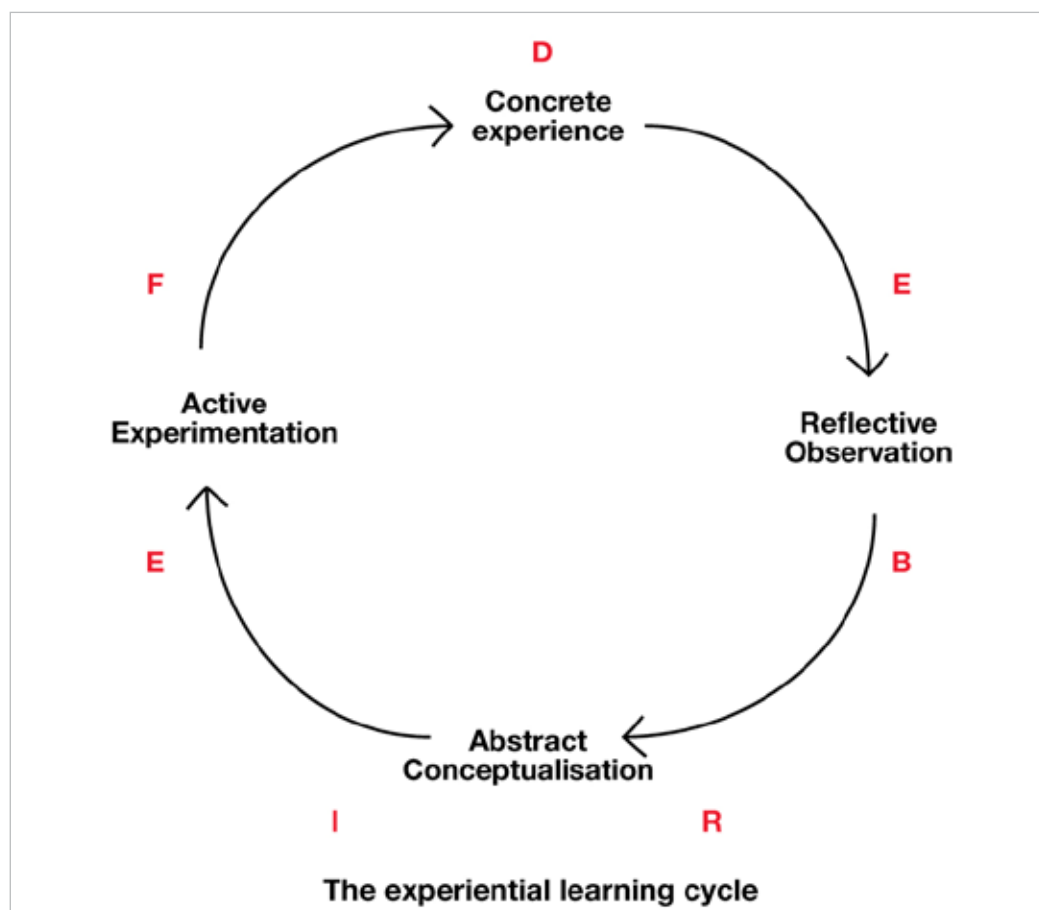
Gibbs' Reflective Cycle (1988)

Whilst Gibbs' model offers some useful steps with which to structure reflective processes, it has been argued that a broader approach is needed. Examination of values, beliefs, assumptions with a view to change, quality development and respect for difference are called for.

A model currently used with both medical students and trainee surgeons (Allan 2012) is the **DEBRIEF** model which blends the important elements of the previous two models:

Describe	<ul style="list-style-type: none"> • Events as factually and dispassionately as possible
Evaluate	<ul style="list-style-type: none"> • What went well/you were pleased with? • What you would like to change next time?
Bring out	<ul style="list-style-type: none"> • Emotions/values/beliefs/assumptions that underpinned the actions you took
Review	<ul style="list-style-type: none"> • In light of previous similar experience; • How would someone else have done this?
Identify	<ul style="list-style-type: none"> • Learning points
Establish	<ul style="list-style-type: none"> • Follow up actions to bring about change
Feedback	<ul style="list-style-type: none"> • Seek feedback on actions, changes and developments

DEBRIEF maps onto the Experiential learning cycle, but breaks up some of the stages to allow for deeper analysis:



DEBRIEF model for reflection (Allan 2012)

DEBRIEF: AN EXAMPLE OF REFLECTION

Example 7

The following example of reflective writing, by a core trainee in surgery follows the DEBRIEF model:

Describe events

During a night shift on call I was in theatre with a locum SpR assisting with a laparoscopic appendicectomy. The trauma bleep went off and it was announced that the call was a code red - meaning that there was an unstable patient. I left theatre and went to A&E. On arriving in resus, I found the rest of the trauma team (A&E consultant, orthopaedic SpR and nurses) with a 19yr old male who was intubated and ventilated, who had been transferred from Newham Hospital, following stabs to the left arm, chest, buttock and thigh. He had a systolic blood pressure of 60 and a tachycardia of 152 bpm and the A&E consultant asked me to insert a chest drain, which I did. As I had missed the primary survey (because I was in theatre), and the patient was unstable I reviewed it for myself and then suggested that a stab check was done - on removing the left arm bandage I noticed that the patient was exsanguinating from a lacerated brachial artery, and he had blood going through a cannulae distal to this in his left forearm which was why he was not responding to fluids. I applied a pressure dressing and asked the A&E consultant to call the surgical Trauma Consultant on call and ask him to attend. The consultant was there in 20 minutes and a tourniquet was applied and the patient went for a CT angiogram and then straight to theatre.

Evaluation

On reflection, I think the team worked well and quickly together once we had realised what the problem was. There was clear communication between each member of the team and life threatening issues were dealt with quickly and efficiently, even though we only had limited staff available.

Bring out emotions etc.

Given my previous experience of trauma I quickly knew that the patient was unwell and I realised that if we didn't quickly find the cause for the hypotension he would arrest and would need a clamshell thoracotomy, which I had never performed alone before and without the support of my SpR or consultant this would have been terrifying. I was aware of how afraid I was about the possibility of having to do a thoracotomy if the patient arrested.

Review in light of previous experience

The last time I felt so out of my depth was when a patient arrested on the ward and I was first on scene as an F1. I didn't deal with it as quickly as I could have and the nurse had to call the crash team. I was worried I would not be able to deal with the thoracotomy if I had to do it.

Identify lessons learned

I learnt the importance of reviewing the primary survey if the patient remains unstable and as in this case it was easily reversible with re-siting the cannulae into a different arm. I am also glad that I did not hesitate to call in my consultant as the patient went straight from A&E to theatre for repair of his brachial artery to save his left arm. Also, I found that being in such a stressful situation as a junior SHO can be emotionally quite challenging and I continued to replay the sequence of events over again in my mind to see if there was anything I could have done differently. I realise now that if that had been necessary I could have called upon the A&E consultant.

Establish follow up actions

Following the incident, I reflected with my consultant and the A&E consultant and suggestions for improvement included applying a tourniquet earlier to the left arm, rather than a pressure dressing. I had considered this at the time, but I was not sure why I hesitated. Next time, if I think of applying a tourniquet I will just put one on and make a note of the time of application. I think that discussing the case with consultants and colleagues afterwards helped me to feel more confident and identified important learning points. The follow day I did some reading about thoracotomies.

Feedback on those actions

I intend to follow up this learning by linking this case to a future case which either covers similar clinical ground or in which there is the question of calling for senior help.

Thinking points

- What do you think the trainee learned from her experiences?
- How has she used the DEBRIEF model to guide her thoughts?
- How effective do you think this was for her processing of the event?

USING DEBRIEF TO REFLECT

PART A

In the next two exercises, you are asked to do some reflection yourself, firstly on another case, and secondly on one of your own.

In the first case, you will be able to read the 'Description' part of the reflection. Once you have done that we will ask you to think about how the trainee could take the reflection further.

Example 8

Read through the following event.

Case (D)

A failed kidney transplant patient, he had spent large part of his life in and out of hospital even though he was only seven. He knew all about doctors and nurses, blood tests and operations. He did not like being in hospital and he did not like being told what to do.

On the morning in question, I needed to take a blood sample from him. I introduced myself as I had not met him before. He looked at me suspiciously and told me he wanted to eat his lunch first. I thought this was a reasonable request and said I would come back.

When I came back he said he did not want his blood taken. I explained why it had to be done. There then followed every excuse he could think of as to why he should not have his blood taken then. He wanted to play some more first. He wanted his mum to have her blood taken first. He wanted another doctor to do it. He wanted to go to the toilet first. I dealt with each argument but he became more and more distressed. He swore and shouted and cried and tried running away.

His mother said we should go ahead. The minute the needle touched his skin, he was quiet. He stopped crying and calmly watched the blood enter the specimen tube.

I asked him why he had been so distressed. He said he had to make a fuss 'so that I would be careful'. I said I could understand his logic but that perhaps in future he did not need to make quite so much fuss.

Thinking points

- What questions would you ask this trainee to encourage her to analyse this experience further?
- Turn to the next page to complete this exercise

USING DEBRIEF TO REFLECT

PART B

Some of the questions you might have asked the trainee include:

- How well do you feel you dealt with the incident? (Evaluation)
- What would you want to do differently next time? (Evaluation)
- How did you feel about the patient while he was deferring the test? (Bring out emotions etc.)
- How did you feel about him after the event? (Bring out emotions etc.)
- Has this kind of thing happened before? (Review)
- Have you learned things from patients before, or seen their experiences from their perspectives like this before? (Review)
- What learning points arose from this case? (Identify)
- What follow up actions are you going to take? (Establish action)
- How will you gather feedback and evidence those actions? (Feedback)

Here is the case in full:

Example 9

Read through the following event.

Case (D)

A failed kidney transplant patient, he had spent large part of his life in and out of hospital even though he was only seven. He knew all about doctors and nurses, blood tests and operations. He did not like being in hospital and he did not like being told what to do.

On the morning in question, I needed to take a blood sample from him. I introduced myself as I had not met him before. He looked at me suspiciously and told me he wanted to eat his lunch first. I thought this was a reasonable request and said I would come back.

When I came back he said he did not want his blood taken. I explained why it had to be done. There then followed every excuse he could think of as to why he should not have his blood taken then. He wanted to play some more first. He wanted his mum to have her blood taken first. He wanted another doctor to do it. He wanted to go to the toilet first. I dealt with each argument but he became more and more distressed. He swore and shouted and cried and tried running away.

His mother said we should go ahead. The minute the needle touched his skin, he was quiet. He stopped crying and calmly watched the blood enter the specimen tube.

I asked him why he had been so distressed. He said he had to make a fuss 'so that I would be careful'. I said I could understand his logic but that perhaps in future he did not need to make quite so much fuss.

I thought I dealt with this situation well by letting the patient eat his lunch and coming back later and I was glad that I asked him why he had been so distressed, because I learned something from that. However, I could feel myself getting angry with him and only just managed to control that. **(Evaluation)**

I was very busy that shift and could have done without this, but something made me curious about this child's behaviour. **(B)**

I have to say I admired him in a way for his strategy. **(B)**

When I thought back over this case later that evening, I recalled talking to a parent of a sick child a few months ago and she said how much she hated her powerlessness. She said she felt as though she and her daughter were victims in the machinery of the healthcare system. That comment stayed with me, and I wondered today if this child's behaviour over the blood sample was driven by the need to exert some control over what was being done to him. **(R)**

I realized that we would do well to remember how vulnerable patients feel, and that we need to earn our patient's trust and it is often best to tread carefully at the start. **(I)**

When I am working with patients in future, I will endeavour to give them as much choice as possible over their care, even down to when I take their blood. **(Establish actions)** I would like to look at the patient feedback forms and see whether there is scope to ask them about choices in their care. **(F)**

USING DEBRIEF YOURSELF

Now it is your turn to think of a case and to use the DEBRIEF structure to reflect on it.

Try it

Think of an incident you have had in your professional practice. Try to select an example of something you feel is not fully resolved for you. It could be a patient encounter, an organisational issue, a colleague related incident or indeed something else.

Describe events:

Write down an outline of what happened, as factually and briefly as you can. Do not try at this stage to analyse your emotional or the patterns you might observe, or any possible solutions. Just focus on getting the story written down.

Once you have done this you can go back through the story, asking yourself the relevant questions for each stage of the process:

Evaluate your role – what went well and what would you change next time?

Bring out your emotions, beliefs, values, assumptions that were underpinning your behaviour? How did you feel at the time and afterwards? What assumptions did you make about this situation? What values and beliefs did you bring to the encounter?

Review the event in light of previous experience and think of how others would have approached it if they had been you. Has this kind of thing happened before? Is there a pattern emerging? How would a respected colleague have acted in this situation?

Identify what you learned from this reflection.

Establish your follow up actions – how can you implement now what you have learned through reflecting on this incident? Does it require a change in behaviour or action or policy? How will you share your learning?

How will you seek feedback on your actions and evidence them for your own learning? Could this be discussed with a colleague or friend? How can you take this forward?

Write down your answers to these questions.

Thinking points

- How did it feel to use this tool to reflect on past experience?
- What did you learn about reflection as you were doing this?

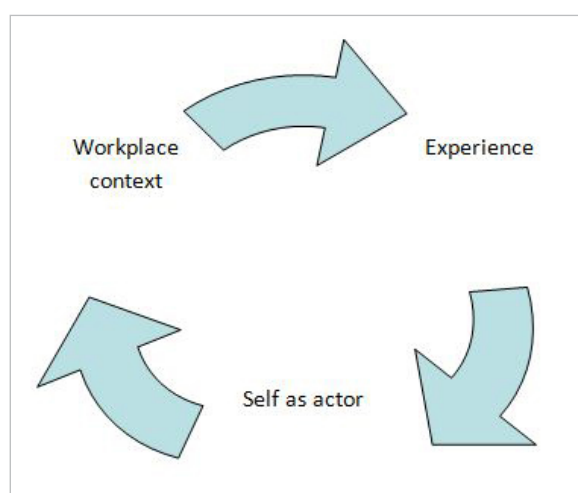
TYPES OF REFLECTION – WHERE TO USE IT?

The term reflection carries multiple meanings that range from the idea of individual professionals engaging in solitary introspection regarding themselves and their practice, to that of engaging in reflective and critical dialogue with others. This may be with a peer, a colleague, a senior colleague, a friend or a family member. Reflecting with others does not have to be confined to dyadic conversations; it can be useful to reflect in groups or teams, and in healthcare and medicine, this arguably occurs in multi disciplinary teams and in clinical governance pursuits as well as between educators and learners.

There is debate about the extent to which practitioners should focus on themselves as individuals rather than the larger social and professional context. There is currently a trend in contemporary literature to move reflection away from the practice of internal, individual reflection and to situate it in collaborative workplace based contexts (Boud 2010). Pitts warns that reflection is not a “form of armchair relaxation best carried out alone,” (2010) and Clouder’s (2000) definition focuses on professional practice:

“In its broadest sense reflective practice involves the critical analysis of everyday working practices to improve competence and promote professional development.”

However, it would seem disingenuous now to attempt to separate individual and professional practice; when reflecting on workplace and professional practices, it is inevitable that our thoughts will involve both ourselves as professional practitioners and the contexts within which we practise.



The relationship between individual and situated reflective practice

It is difficult to see how we can reflect upon the practice of our professional community without considering our place and role in that community. In the same way, it is just as challenging to see how we can engage in reflection about ourselves without considering what we do, who we are and how our values impact on our activity at work.

Whilst reflection rarely occurs without both individual and context being analysed, there are different foci that can be taken:

Internal reflection: This is often but not always triggered by internal discord, or a feeling that something is not right. It usually places the self centrally, with the aim of reviewing what was appropriate and what requires changing. It may examine values and assumptions. It may result in a change in understanding or perspective;

Reflective conversation: (Ghaye 2000) This involves mutual collaboration in a participatory, dialogical approach to reflection. It is usually dyadic and may take place between trainer and trainee or between colleagues and may be in a supervision session. It may look at the effects of the organisation on the individual;

Socio-cultural/organisational critique: This form of reflection focuses on the wider social, cultural and political context, perhaps looking at systems and organisational structures within a department or a hospital. It requires sharing, mutuality and reciprocity. It may open up to look at the contribution of the individual to the organisation.

Thinking points – consider your workplace:

- What kinds of reflection do you engage in?
- Where would you find benefit in using more individually focused reflection?
- Where would you find benefit in using more organisationally focused reflection?

WORKPLACE AND ORGANISATIONAL REFLECTION

In medicine, professional practice is ever changing. It is viewed increasingly as a collective rather than an individual pursuit and is multi disciplinary in character. That is to say that most working practice occurs in settings with multiple players who need to cooperate closely to perform their professional duties. Increasingly patients are being viewed as co-participants in their care.

Read through the following reflection, using the DEBRIEF model, and consider how this individual's thoughts and actions can contribute to the collective practice of her unit.

Example 10

Reflective example: Massive haematemesis

Situation

- ITU resident on night shift.

The case (D)

We had a fifty one year old gentleman with NASH who had presented with haematemesis on our ITU outreach list. He had presented on the Friday with a litre of haematemesis witnessed in A&E. There was no gastro on call over the weekend so he was waiting for his scope on Monday. Soon after starting my night shift, I was asked by the med reg to come and see him as he had just had another episode of haematemesis of about 1L.

When I got there, he had just been reviewed by the surgical registrar and looked unwell. As I went to examine him, he vomited again- about 1.5L over my shoes and on to the floor. I asked for help, assessed what kind of IV access he had and squeezed the bag of blood that was up. A nurse soon arrived and the surgical reg. I asked them to fast bleep the anaesthetist on call and someone went to look for a Sengstaken-Blackemore tube.

The SB tube was put down which stopped the bleeding and more blood was ordered. The plan was to take the patient to theatre and do an OGD. I left the patient with the surgical registrar and the anaesthetists and went back to the unit. They would contact me if there was any deterioration and we made a bed available for the patient post-theatre.

A few hours later, I was called by the medical registrar on call to say that they were in the process of trying to get the patient transferred to the KCH Liver ITU. The SB tube balloon had been pulled out and the surgeons on call could not band varices and there were no gastroenterologists available. I went back to the ward to assess the situation.

The patient now had an arterial line and a CVP line. The SB tube was back in place. The patient was still receiving blood and blood products. I spoke to KCH and they accepted the patient for transfer. It was decided that the patient should be intubated for transfer and that it was best to do this on the ward rather than transferring him up to the unit first. The surgical registrar, medical registrar, anaesthetic SHO and registrar and the ITU consultant (over the phone) were all involved in this decision.

There was delay in intubation so that after the SB tube had been removed, the patient vomited blood again and then arrested (PEA). It was a difficult intubation but successful and the SB tube was then re-sited. The patient received 3 cycles of CPR with adrenalin and atropine with return of spontaneous circulation. The initial BP was 100 systolic. The patient's daughter (a paediatrician) arrived soon after the start of the resuscitation but did not stay for long to observe.

I understood that this was likely to be futile. I explained that the patient could either be brought up to ITU for ongoing support but that the outcome was likely to be poor. The alternative was to keep the patient comfortable on the ward. The family decided that they wanted the patient to be kept comfortable on the ward.

The situation was then again discussed with the members of staff present and with consultants over the phone. The consensus was that treatment should be stopped and the patient kept on the ward. He died soon thereafter with his family at the bedside.

The patient however was not able to maintain his BP, despite boluses of adrenalin and ongoing transfusion. The BP was barely maintained at 70 systolic. The situation was re-assessed and it was decided that transfer was no longer an option. The family had not yet been spoken to. I was nominated to speak to family, with the medical registrar.

Example 10 continued

The family (wife, daughter, son) understood that the situation was serious and that we had tried to get the patient stable enough for transfer to a specialist unit but that this had not been possible. They wanted active treatment but understood that this was likely to be futile. I explained that the patient could either be brought up to ITU for ongoing support but that the outcome was likely to be poor. The alternative was to keep the patient comfortable on the ward. The family decided that they wanted the patient to be kept comfortable on the ward.

The situation was then again discussed with the members of staff present and with consultants over the phone. The consensus was that treatment should be stopped and the patient kept on the ward. He died soon thereafter with his family at the bedside.

My evaluation (E)

Things that went well: good communication between different members of staff, good decision making process, patient's best interests always foremost, dignified death at the end. Areas for improvement: awareness of ward nursing staff of seriousness of situation, hospital logistics (availability of SB tube), delay in intubation, out of hours gastroenterology availability.

Feelings (B)

This case left me with a feeling of slight unease; whilst I knew we had done all we could – and we had facilitated a calm and dignified death at the end of the process, I just felt like we could have been slicker in our management. I was frustrated by the nursing staff who did not seem to grasp how ill the patient was. I could feel myself getting angry with the lack of availability of the equipment and the out of hours gastro cover system. I felt like I was doing my very best for this patient but around me the staff and the hospital infrastructure were taking it all at a much more casual pace. We work hard and intensively and when that is not matched by the system or other colleagues it can be infuriating.

Review (R)

I have treated patients with similar problems before and have also been with patients at the end of their life. I think the reason this case affected me was because I felt overpowered not just by the inevitability of the patient's death, but also by the small inefficiencies of the hospital system.

Identify learning points (I)

Communication between everyone involved in case is vital - staff present but also other centres and consultants over the phone, consensus in decision making is important and not easy, but sometimes we cannot always offer patients the care they need or we would like to offer.

Establish follow up actions (E)

The equipment issue is something I can do something about so I intend to do process mapping on such essential pieces of kit, and ensure that there is a system in place to have all kit kept fully stocked and up to date for future cases.

Further reading/study: [STEP Case of the month: http://estepcore.rcseng.ac.uk/secure/cotm/view_case_html?case_id=55](http://estepcore.rcseng.ac.uk/secure/cotm/view_case_html?case_id=55)

Feedback (F)

I have spoken to my consultant about the equipment project and he suggested I could submit the results as a Quality improvement Project to the next QIP conference the Deanery run.

When I am working with patients in future, I will endeavour to give them as much choice as possible over their care, even down to when I take their blood. **(Establish actions)** I would like to look at the patient feedback forms and see whether there is scope to ask them about choices in their care. **(F)**

Thinking points

- What were the learning points for this doctor?
- How did she ensure they contributed to the organisation's learning?
- What kinds of organisational reflection do you participate in?
- How could organisational reflection help you in your role?

DEVELOPING RESILIENCE THROUGH REFLECTION

When burdened by work related stress, our resilience is reduced and we feel that we struggle to cope.

Resilience is defined as a “positive adaptation in the face of significant risk or adversity,” (Masten & Powell, 2003; Luthar, 2006). It is a dynamic developmental process and is studied by looking at how competence develops in the face of adversity. When people’s adaptive abilities are in good working order, they can withstand hardship, but when they are stressed or overloaded this becomes more difficult.

In medicine it is easy to feel that our successes are rare, there is little or no value to what we do and that we have little or no power and these feelings can result in feeling discouraged and hopeless.

How then can reflection help to maintain or to rebuild resilience?

Example 11

An example of reflection connects the traumatic experience of seeing a younger brother killed in a road accident as a child with the inability of a GP to cope with the death of a child patient. Mark talks of his experiences using reflection to deal with a long standing problem he has had in both his professional and personal life:

“I had never before in detail talked about what I was feeling at the time when Simon died. Now I have written about it I can and do talk about it.

Until I did this writing I felt guilty about Simon’s death...

In the past my feelings about Simon’s death disabled me for dealing with the death of child patients. Everyone finds it difficult but for me they used to bring all sorts of things to the surface. I remember one child who died, I was totally disabled and unable to cope with consultations with the parents. I cried with them, and told them about Simon and that I was crying for him.

The writing has made me feel completely different about Simon’s death, has made me deal with it in a different way. I can now see I wasn’t responsible;

I didn’t know I was carrying so much guilt. Now I know I don’t need to carry it. I will cope differently now when a child patient dies.”

Bolton (2005 p. 29)

Mark's reflective writing helped him for the reasons stated above; He had the support of the group he was working with. But even if we are not in a group, finding someone to share our reflections with can be very helpful. Mark was also able to think critically about his past behaviours. This does not mean he criticised himself for being a bad person, but that he was able to ask questions of his behaviour, himself and his feelings. 'Why' questions are often the most frightening but also the most powerful. Mark does not talk about collaboration at work with this example, but there is collaboration in his reflective group. Reflection can be isolating and it is good to find someone to share it with if possible.

Reflection can therefore be used to address three of the key elements required for resilience:

- Support
- Critical thinking
- Collaboration

Support is an essential component of resilience development. We all need to feel that we are not alone and that we are valued and our work appreciated. Taking time to talk to a peer or a friend can help to clarify feelings of worthlessness and impotence. The support mechanism of another person listening and asking how you felt, what you would have liked to have done and what your underlying values were, can mean that we feel supported a little more.

Try it

Ask a friend to use the DEBRIEF structure to discuss an incident or an area of concern with you

Being able to **think critically** as the participants in West's research did, can help to clarify the way through unclear and complex situations. Mark in the following example found it difficult to separate work issues and personal life issues, but found that being asked some thought provoking questions enabled that level of criticality to move the mists of confusion and to see things more clearly.

Try it

Use some of the questions in this module to provide a starting point for your thinking of the relationship between your professional and your personal life

Resilient professionals are very often highly collaborative. Working in teams and with other people helps to mitigate against some of the feelings of hopelessness. Using reflective practices to identify ways to collaborate further and how to maximise those collective endeavours, can lead to a higher sense of value and contribution.

Try it

Set up a group at work to consider some of the things that annoy you the most. You may be able to implement some change.

TO SUM UP

Reflection is a wide ranging term for a process that can take place informally over a coffee, or more formally in terms of a learning conversation or journal writing. It can be an internal process, or can take place with others in the workplace, or between friends and family. This module explores the many variations of reflection, its use in both individual and collaborative practice and its benefits not just in the training years but beyond into established professional practice. Its purposes are multiple: to develop or to consolidate practice; to provide reassurance or criticality; to improve performance or understanding; to enhance the quality of patient care or to provide respite from the complex, demanding workplace.

- To maximize the chances of your reflective practice working for you, you should pay attention to the following points
- Be clear about the reasons for reflecting; why are you doing it and what do you want to achieve?
- Be honest to yourself in examining your values, beliefs, emotions, assumptions and motives for action
- Think about what can realistically be achieved in the time available
- If reflecting with others, be aware of issues of professional confidentiality, clinical governance and ethics
- Develop a network of peer reflection buddies with whom you can reciprocate listening and reflecting
- Reflection is a part of lifelong learning and does not stop when you finish being a student or trainee. It can often be even more beneficial to the experienced professional
- Good reflection can contribute to minimising the stressful effects of a job, collaboration with colleagues and teams and can improve systems and patient care.

FURTHER READING

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