Being a reflective General Practitioner: PART 1

What is reflection and why is it important?

Reflection is an important human activity. It isn't just important to doctors, it's important to everyone because it is the process by which people 'think with a purpose', i.e. think about an experience, mull it over and evaluate it with the purpose of improving their understanding and future behaviour. It is the way we understand the world in which we live.

Everyone can reflect and most people tend to become better at it once they see the benefits it can bring. For doctors (and especially GPs), patterns of illness and patient behaviours are complicated and in order to become proficient a great deal of understanding is needed. For this reason, becoming a reflective practitioner is vital.

How to use this learning manual

This paper offers three ways of developing reflective practice, an exercise with a short explanation, a theoretical exposition and a set of references and bibliography for further reading. Some people are natural reflectors and find this process easy; others have to work to develop the skills that underpin reflection. Everyone has something to gain by improving their skills.

Behind the exercise and statements there are links to the theoretical background, explanations and further examples. Those who like to know "why" rather than just "how" can explore these further.

This manual is aimed at teachers and learners. In reflective practice we are all learners, some just have more experience than others.

Reflective practice is how we can use the workplace as a rich learning environment and understand our place in it. Why do we need it?

- To increase our knowledge and apply it.
- To widen our professional boundaries.
- To benchmark our performance against our peers and supervisors.
- To develop as adaptive experts.
- To generate the questions that will inform service improvement and research agendas.

Exercise 1

Developing skills to become more reflective requires analysis, practice and further analysis. The aim of this exercise is to introduce you to the idea that high quality reflection has a number of important elements. Once you have completed the exercise you may find that you already do all of these things. More likely some elements are missing or need further development. Further practice will enable you to fill these gaps and make elements stronger and as a result improve you ability to understand your personal and professional experiences.

Task

Think about the last clinical encounter which resulted in a significant piece of learning. You have to decide what is significant. (If you are really stuck then you can try the scenario)

Write the story of the encounter, with a beginning a middle and an end. Do this by yourself, on a clean sheet without referring to any framework.

Now refer to the elements of reflection as listed below, and see which elements feature in your story and how strongly they feature.

The elements of reflective practice

Element	Does what you have written show that:	Demonstrated by:
Observing	You are alert and observant and notice both what is obvious and less obvious about the situation	Observations, questions, looking for the unfamiliar
Self-awareness	You are aware of not only what you think, but what you sense or feel about the experience and are willing to take responsibility rather than put the responsibility on others.	Use of I,
Self-regulation	You recognise when experiences and behaviour are outside what the profession would consider as being competent	Level of competencies
Internal conversation	You have tried to make sense of your thoughts and feelings	Use of feeling words, your reactions to your observations
Openness	You are open and honest about your own performance in relation to what might be expected by the profession.	Seeking feedback against standards
Learning	You have clarified what you need to learn and why you need to take this on.	Statements of learning and impact on performance, plan for review

Not all of the elements will be obvious in each encounter. Over a series of encounters it may become apparent which elements come naturally and which need to be worked on.

Analysis of any event is best done using a method that appeals to you and which you can use consistently. A couple of good examples are, the "Kipling Method" and Mind Mapping which are described in the link.

Exercise 2

Repeat the exercise using another learning situation that was not a direct clinical encounter, perhaps a tutorial, or a seminar, perhaps even reading. If one has occurred, a Significant Event that you were involved in.

This time do this with another individual, record it using the **ePortfolio template** for the relevant session, print it out and analyse each others work, again using the elements above.

How have they done well, **how** could they do better? Be specific; use the rules of feedback.

In this way you will become practiced in the skills of being reflective and recording reflectively. As these skills become imbedded in your day to day work you will become reflexive and deepen your understanding. Rather than reflection being an occasional event, it will become much quicker and more routine and not be dependent on having to write down the details of the encounter..

Whilst it is possible to use the ePortfolio as a journalistic log you will gain more from the tool if you use it reflectively. Examples of both are given in the link.

Reflection doesn't always come easily; it is an active process and does need practice and time. It does, however, bring great rewards in terms of professional performance, self esteem and service improvement. It is an investment worth making.

PART 2

Being a reflective general practitioner, (linked explanatory text)

Introduction

This section is linked in sections to the Front Pages but can be read as a fuller introduction to practicing and recording reflexively, by a trainer or a trainee. If you are teaching any topic a deeper understanding of the topic area is required.

In this section the following areas are explored

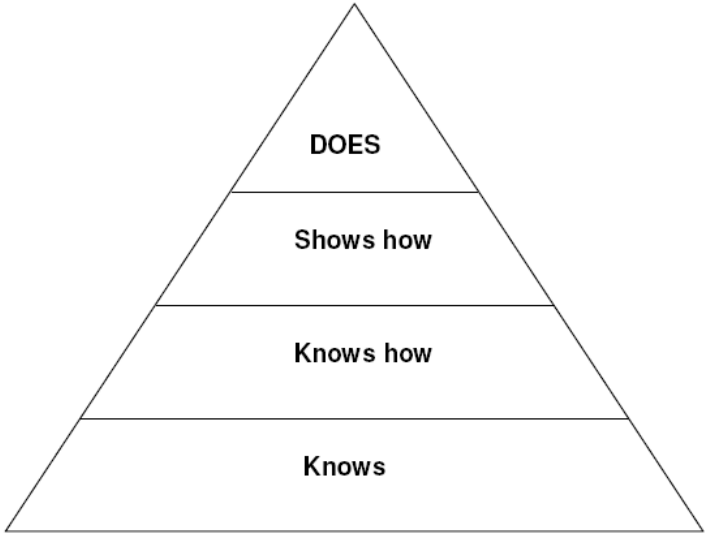
- Why be reflective?
- How to be reflective
  - Background theory
  - Hindrances
  - Making observations
  - Intrapersonal factors including insight and the internal conversation.
  - Feedback
- What is knowledge
- What is all this "feelings" stuff about?
- Reflection and professional boundaries
- Benchmarking and peer referencing
- Professional expertise
- Service Improvement the research agenda and reflective practice
- Reflective Analysis and Recording
- How to record reflectively in the ePortfolio
- Appendices
  - 1. A summary of Schon's Reflective practice
  - 2. A model of Reflective practice
  - 3. Learning at the edge

Why be reflective?

The simple answer might because it is required by the General Medical Council (GMC) as regulator in Good Medical Practice (GMP) (http://www.gmc-uk.org). However, there is a deeper and more meaningful rationale that underpins the statement.

Medicine is a knowledge based profession. In its practice knowledge is applied with skill and artistry. The traditional educational formula of Knowledge, Skills and Attitudes is now wrapped up in the competency model of practice, where the ability to demonstrate performance in the workplace is the test of fitness for practice.

Miller (G E Miller 1990 Academic Medicine, 65, S63 – S 67) articulated the progression from **Knowing** to **Doing,** shown graphically here.



Modern medicine is a service profession where the ability to perform (rather than just "know") is paramount.

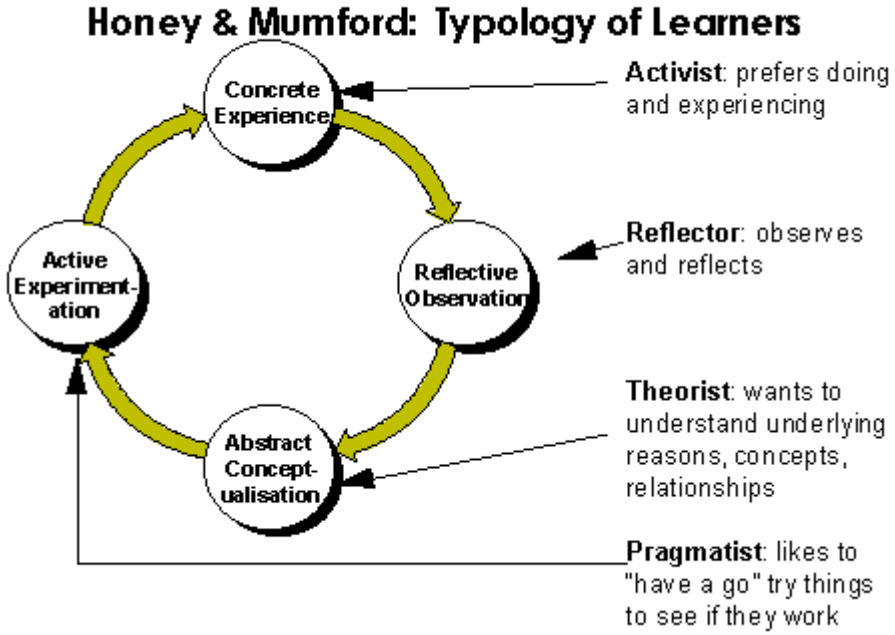
To this is added professionalism which is difficult to define but easy to recognise. It is often expressed as appropriate professional behaviour, keeping up to date, maintaining high standards of practice and knowing professional / competence boundaries. Fitness to practice demands not just knowing the medical facts it is about applying them in the correct manner through appropriate behaviours.

For the doctor in the 21st Century it is necessary to **know** one's limitations (boundaries), to **relate** openly with patients, colleagues and one-self, to **benchmark** personal practice, to **discard** obsolete and **develop** new competencies and to be able to **apply** personal and professional critical review.

Because of public and professional accountability clear and accurate records of professional development are necessary. This is the professional equivalent of a regular service record so that the commissioner of the service or product knows what they are getting.

Background Theory

The theoretical models that underpin reflective practice can be traced back to Plato. More recently Kolb's learning and problem solving circles articulate the relationship between an individual's preferred style and the process of learning how to solve problems. From this work Honey and Mumford developed a learning style inventory that identified your preferred style as Activist, Reflector, Theorist or Pragmatist (http://www.peterhoney.com/). Whatever the preferred style, the person also has the inherent facility to use the other styles to maximise their learning potential in any situation. Individuals can learn the skills to make more use of less preferred styles to improve their overall performance.



From:
http://www.learningandteaching.info/learning/experience.htm

Not every doctor is a natural reflector. A study by Lewis & Bolden, using the Honey and Munford version of Kolb, found that GP (non trainers) and GP trainees have reflector / pragmatist tendencies, whereas GP trainers tend to be reflector / theorists. (AP Lewis, K Bolden J R C GPs 1989 39: 187 – 189)

You can find your own learning style preference and explanations of that style by visiting http://www.peterhoney.com/

Hindrances to reflective practice?

What stands between the need or desire to be reflective and the actual practice apart from internal preferences? The feedback from GPs attending workshops about reflection from 2007 to 2009 indicated that the following themes can be identified.

Time – Personal time
Organisational time

This is about how reflection is valued both personally and organisationally

Service Pressure - but reflective practice results in more effective service
Personal fear - see section on feedback
External Control - professional paranoia or realism? N.B. Regulation usually has a reason
Not seeing the reason for it – see above
Defensive attitude - see reaction to feedback

As is so often the case, an analysis of the factors involved also indicates a possible way forward. The major element is the value placed on the process of reflection; the rest will fall into place. So often clinicians will blame the organisation but managers of organisations will say that if a professional demonstrates the utility for actions then they will be accommodating.

Making observations

From almost the first day in medical school you will have been taught about making observations and you will have practiced them daily since then. Giants of diagnosis and detection are held up as examples for writers and ourselves. Observation is also the key skill of anthropologists and sociologists and indeed for every scientist and artist. The picture that is drawn is dependent on how we detect and record these observations, usually according to our "tradition" or "professional culture". Several people who observe a single event will record it differently; some of this is through thinking and some of it is through sensing. It is important that we understand how we as individuals can affect the final picture, colouring it with our personal values and attitudes which determine our interpretation of events.

In order to build up a picture we need to use all our available senses and practice using them. Everyday life situations offer a rich opportunity to practice and to interpret, because to develop our understanding, we not only need to recognise the event (the freeze frame) but to think about the story behind the picture. It is often our senses that determine our reactions and therefore feelings. Smell is a very potent recall process that establishes context, fixes stereotypes and half finishes the picture, the smell of cooked cabbage and urine in a run down old-persons' home, the acrid smell of an unkempt homeless person.

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Wider reading

These are classics from the world of sociology

J P Spradley, 1980 *Participant Observation.* New York: Holt, Rinehart and Winston.

E Goffman, 1956 *The Presentation of Self in Everyday Life*, University of Edinburgh Social Sciences Research Centre. Anchor Books edition 1959.

Intrapersonal factors

The concept of **"insight"** in relation to personal performance is strong. It has widespread currency in the management of poor performance, but it is hard to find a clear definition and has its origins in psychological theories.

Those whose performance is giving concern are often described as lacking insight. So by contrast it could be argued that those who are performing effectively have insight.

In the realms of psychotherapeutic theories (Hobson, Mears) insight is dependent upon the ability of the individual to have an **internal conversation**, to have a language that can articulate feelings and to take **ownership** of their beliefs and actions. The internal conversation is not about the first sign of madness; in fact it is a marker of sanity. It can be objective, cool and journalistic. If it is to have an impact on the individual then it needs to have a vocabulary that articulates feelings. Not necessarily dramatic emotions but real feelings. Feelings are the facts that shape our beliefs and attitudes and in turn determine our behaviours. (Fishbein)
Acknowledging the discomfort of a particular encounter can help you to manage it both in the present and potential in the future. When a particular patient makes your heart sink, don't label the patient, analyse your feelings and belief set. Previous experiences and indeed traumas can hinder the ability to have the internal conversation and stunt the vocabulary.

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Further reading

Internal conversation and insight
R Hobson, *Forms of Feeling*, Tavistock Publications, 1985.
R Mears*, Intimacy and Alienation*, Routledge, 2005

Beliefs and behaviours
Fishbein, M., & Ajzen, I. (1975). *Belief, Attitude, Intention, and Behavior: An Introduction to Theory and Research.* Reading, MA: Addison-Wesley

Reacting to Feedback

In practice the ability to handle **feedback** about personal performance is a marker of **insight**.

Assumption: "As a clinician you are trying to deliver the highest possible standard of care in the prevailing environment – to do the best for your patient or group of patients"

No one apart from champion performers totally relish feedback. Only when you are trying to shave microseconds off your personal best or to create the most exquisite artistic performance are you thirsty for feedback and then only from a trusted source.

Because our performance always carries an element of our personality, feedback or criticism creates a level of anxiety or possible harm even if it constructed to conform to all the rules. (Rules of feedback)

Exercise about receiving feedback:

Task

Recall the last time you received feedback on your performance. How do you react? Which set of words most accurately describes your reaction?

1. Defensive
2. Head in the sand
3. Mildly anxious
4. Take it or leave it
5. With open arms

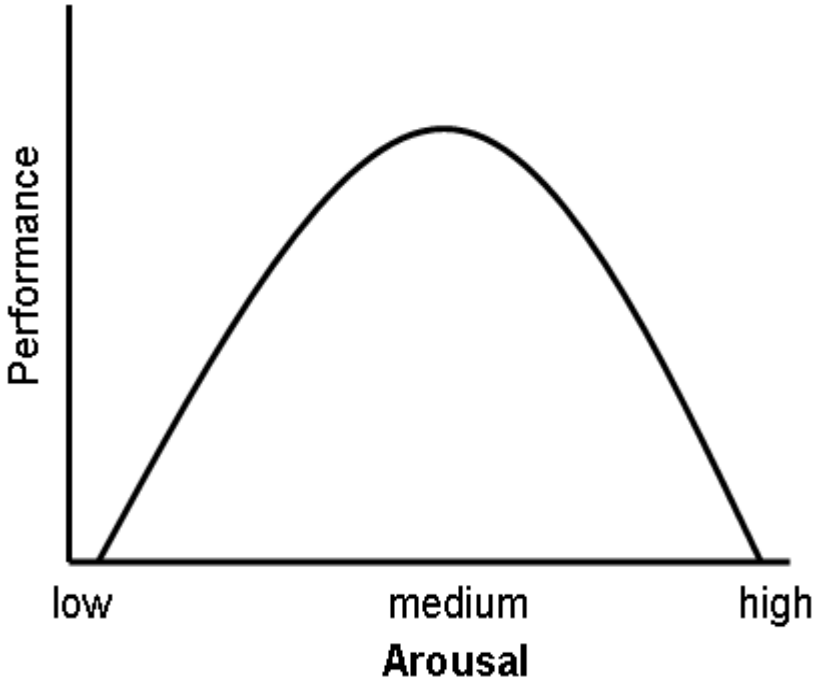
More ..

Let's examine these responses all of which we have probably exhibited from time to time. If we can find reasons for our actions we might find a way to modify them for the future.

Indifference (Answer 4) hides a mass of potential blockers and needs serious reflection, indifference is not a professional response to feedback.

Mild anxiety is associated with more effective learning, the so called Yerkes – Dodson curve.

(Yerkes, R. M., & Dodson, J. D. (1908) The relation of strength of stimulus to rapidity of habit-formation. *Journal of Comparative Neurology and Psychology, 18*, 459-482)



So mild anxiety should be welcomed as an indicator that we have our faculties primed for success, it is the normal arousal response to a challenge. This can also be called learning at the edge.

The head in the sand (answer 2) is a defence mechanism to avoid challenge used in the hope that bad things will pass. Such a reaction can be due to poor experiences in the past or by observing and repeating behaviour patterns in respected role models. The problem for medical practitioners is that such behaviour leaves them more and more in the past; an endearing quality in mystics but not valued in modern therapists. If this is your preferred response ask your self why and explore it with a trusted person such as a mentor. You need to find sufficient personal security to experience and using the challenge of feedback.

More …

At its extreme the **defensive** (answer 1) response represents a lack of personal ownership and for actions taken. The straightforward defensive response is often displayed as putting the responsibility on others, and this happens all the time in normal life and is a manifestation of not taking ownership or responsibility for personal actions. "- still waiting for the lab", when the lab is in reality still waiting for you." "The nurse advised it", but you signed the script. Untruths presented as explanations – "not my fault". This sort of reaction is often the result of teaching by humiliation. Good for a laugh in *Doctor in the House* but it has no place in modern education or service.

Learning from feedback requires the learner to be secure and for the person giving feedback to create a safe environment. Neither happens with humiliation.
If you still feel the effect of such teaching talk about it with your trainer or educational supervisor. Don't underestimate its impact on your continued learning and practice. Your future learning depends upon your self esteem.

(A.H. Maslow, *A Theory of Human Motivation*, Psychological Review 50(4) (1943):370-96)

For those heroes who welcome feedback, put aside your halos for one moment and ask yourself, "Is this a devise to deflect the more challenging elements?"

A question for everyone.

Do you know what to do with the feedback being given to you?
Can you own it, internalise it and learn from it?

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Theories of Knowledge

The Data, Information, Knowledge, Wisdom (DIKW) theory of knowledge starts with facts or data as a raw element that is fashioned into information. Individuals take information and transform it into knowledge. Knowledge is then synthesised and analysed through experience into wisdom. In this model knowledge does not exist outside of a person, it is either data or information until it is internalised by the individual and processed so that it has an impact on performance. Reflection is part of the processing, it is the iterative reviewing element that enables the individual to incorporate good practice, build on good practice and discard obsolete practice. Because knowledge is part of our individuality this process involves our feelings. In an historical review of this topic Wallace ascribes this particular concept of knowledge to TS Eliot (Choruses from 'The Rock'. There are many internet sites that have to text that can be accessed via Google)

Where is the Life we have lost in living?

Where is the wisdom we have lost in knowledge?

Where is the knowledge we have lost in information?

(Wallace, Danny P. (2007). *Knowledge Management: Historical and Cross-Disciplinary Themes*. Libraries Unlimited)

The language of feelings is romantic and has been devalued by the scientific language of modernism. The success of techno-rational science has been in the revelation of detail; the success of humanities has been to reveal the complexity of the whole. The language of reflexivity has as much to do with the humanistic as the scientific traditions. Medicine as a discipline bestrides both of them.

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What is all this "feelings" stuff about?

Feelings are facts as much as your height and weight, but unlike these your feelings will have a major impact on your ability to hold a fluent functional **internal conversation**. The internal conversation is the skill that will enable you to have and develop insight and deep learning. In this way you develop your beliefs and attitudes that determine actions and thus performance.

(Fishbein, M., & Ajzen, I. (1975). *Belief, Attitude, Intention, and Behavior: An Introduction to Theory and Research.* Reading, MA: Addison-Wesley)

Fluency in any language written or oral is achieved through practice, first in rehearsal then for real. Check your fluency with experienced practitioners; ask them for critical review and feedback on how you might improve.

As with all other skills, practice leads to development if not perfection. There will be at least one tutorial a weeks, one GP VTS session or equivalent per week, then there are the professional conversations with your supervisor, your personal reading courses and so on. No lack of opportunity to make reflective recordings.

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Reflection and Professional Boundaries

Schön investigated the reflective practitioner and developed a model of reflective practice. In essence it is dependent upon the reflective practitioner working within a zone of mastery and being sensitive to the unusual, what he termed the surprise, or where the data doesn't fit the pattern. It is feeling this and responding to it that enables the practitioner to learn from experience and to build expertise or increase their zone of mastery. **Learning** in this model does not occur until the proposal to deal with the surprise is acted upon and reviewed. The novice and the competent practitioner will have relatively small zones of mastery. An accomplished reflective practitioner can solve problems that do not fit established patterns by drawing on experience that has been converted into the expertise that lies within their zone of mastery. This model fits well with that of the **adaptive expert**. A numbness to surprise from whatever reason results in the rich learning opportunities being lost or lessened.

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D A Schön's two classics

- 1. The Reflective Practitioner, (1983) Basic Books Inc. ISBN 0-465-06878-2
- 2. Educating the Reflective Practitioner, (1987), Jossey-Bass Ltd, ISBN 1-55542-220-9

Benchmarking and peer referencing.

As the practise of medicine progresses the practitioners are required to keep up to date with these changes. To do this it is important to know what current knowledge is from trusted sources and to know what current practice is in terms of skills and behaviour. What is expected of the GP of today is not that which the GP trainees of yesterday trained for. Knowledge, skills and culture move on and medicine is part of that movement. Professional and social isolation can result in individual professionals loosing touch with what is thought to be acceptable clinical behaviour. Maintaining professional development is a major part of GMP, demonstrating it is part of certification and revalidation.

Clinical Audit, Significant Event Analysis, talking with colleagues, networking at seminars and conferences are all good methods of keeping in touch with contemporary professional standards and benchmarking our own performance against these. Some of the best evidence for this comes from our reflective records.

This aspect of a GPs work goes on in practices, thus the benefit of group or federated practices, and in local GP groups. The case based postgraduate groups are the ideal medium to define learning points from the stories doctors tell.

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Professional expertise

Expertise, including medical expertise, is a much researched topic. Various models and theories have been proposed.

One model that sits well with reflective practice is that of *Routine* and *Adaptive Expertise*. These two aspects of expertise have been observed in all areas of practice.

Routine expertise is practised when the practitioner performs well within guidelines and protocols to assumed internal patterns.

By contrast the *Adaptive Expert* performs well within the guidelines but can use imagination and or experience to solve problems that do not conform to orthodoxy or are new.

The development of the adaptive expert requires reflexive practise and professional alertness. (

Current research indicates that this is not a continuum but a style of practice that an individual can be trained into. We need to ensure that current methods of training and assessment do not restrict or inhibit creativity.

This is a relatively new area that is subject to new research in medical education.

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(Mylopoulos, M. and G. Regehr (2009). "How student models of expertise and innovation impact the development of adaptive expertise in medicine." Med Educ **43**(2): 127-32.)

John D Bransford (University of Washington, Seattle, USSA, has written well on the topic and a useful summary paper of his is at this website.
http://www.vanth.org/docs/AdaptiveExpertise.pdf

http://en.wikipedia.org/wiki/Adaptive_expertise)

Rules of Feedback

As has been mentioned several times in this presentation feedback is fundamental to effective learning. Badly delivered feedback can and does have an impact and this can often be mistaken for effective learning. In fact it is more like scarring and is often difficult to change.

The rules which are based on common sense have been written and rewritten but condense down to the following:

1. create a supportive, safe environment – remember Maslow
2. start with the individual's self assessment – make the learning relevant for the learner
3. be specific to what can be changed – be focused and clear
4. be balanced, offer positives and negatives – nothing is really all bad
5. summarise with clear actions – everyone know what they have to do

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Service Improvement the research agenda and reflective practice

GPs are in essence the participant observers in the action research field called family medicine. We will not all become national leaders or full time researchers as such, but we can all play a part to ensure that the questions that inform future delivery and patient care are articulated and followed.

Patient services depend upon clinicians being actively involved in the changes to and development of services. This happens at the individual patient level, through the practice and local heath economy to national level. Clinicians need to demonstrate leadership qualities in their day to day work to achieve the real changes that matter to patients. These changes can often be translated into other contexts to make major transformations to care. The GP is the butterfly in Brazil the flapping of whose wings causes the tornado in Texas. Small changes result in major changes, one of the principles of complexity theory. This is the story of how general practice has contributed to improvements in primary care in the UK.

The story is the data for most of primary care research. The important questions for general practice have and need to continue to come out of general practice. The practitioner and the patient narrative form essential elements of qualitative research. General practice research methods depend heavily on good quality quantitative research.

We depend upon hearing the patient story to make accurate diagnoses and the illness narrative to monitor progression. It is also the medium through which we contribute to general practice service improvement and research agendas.

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Wider reading

C Johns, Guided Reflection: advancing Practice: Research in Practice, 2002, Wiley Blackwell

K Sweeney and F Griffiths eds. Complexity and Health Care, 2002, Radcliffe Medical Press, Oxford

J Engel, J Zarconi, L Pethtel and A Missimi, Narrative in Health Care, 2008, Radcliffe, Oxford

Leadership

Leaders come in all forms but usually fall with thin the general description of heroic. A newer model is that of **distributed leadership**, and it is this model that the NHS has adopted in the Medical Leadership Competency Framework. This model concentrates on function rather than status and is better described as leadership practice.

The concept is that individual clinicians because of their greater understanding of the reality of delivering care can offer leadership practice to make changes that will result in service improvements. There is a potential within professionals that can be realised to the greater good if they have appropriate attitudes tempered by knowledge and skills. This is not to deny the role of strong visionary leaders but it is to enable everyone to realise and practice leadership in their own spheres of influence.

The competency framework describes 5 domains that in turn contain individual competencies all of which are to be found in the GP curriculum. The values and beliefs that underpin this approach are those GPs will recognise and aspire to in their day to day work. The focus has shifted towards harnessing them in the drive to increase quality and innovation and for all clinicians to own this as their responsibility and vision.

Competency in this area can be demonstrated through undertaking a clinical audit or a service development project, with the emphasis moving away form the numbers to the discretion of how with processes and systems.

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Wider Reading

Medical Leadership Competency Framework
http://www.institute.nhs.uk/building_capability/enhancing_engagement/enhancing_engagement_in_medical_leadership.html (accessed 29 06 09)

R Bolden, Distributed Leadership
http://eric.exeter.ac.uk/exeter/bitstream/10036/32292/1/manag0702.pdf (accessed 29 06 09)

Reflective analysis and recording

Scenario

You see a child of 3 years with his mother. The mother talks anxiously about the poor health of her child, "he always has something wrong". You notice that the boy is small for his age and he sits very quietly with his mother who looks sad.

She is a single parent but in the last 6 months has started a new relationship. Her new partner has his own daughter aged 5. She works as a nurse at a local hospital and says she knows you from there. You ask if you can examine the child's chest and she raises his clothes at the front. You ask if she can take his clothes off and she asks, "Is that really necessary?" You say that it is and whilst she does so she starts to explain "the bruise on his back is from where he crawled out from under the table and stood up too quickly." You wonder about this explanation and the way it was delivered.

You undertake a full examination and find no reason for his "chronic ill heath" or any other evidence of bruising or neglect. You tell the mother that your examination is normal but that you want the Health Visitor to follow up on his small size.

She leaves you feeling uncomfortable. You feel you might have seen your first case of child abuse. You felt you had been through in your examination but had lack the courage to talk about your suspicion with the mother.

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In making a **reflective analysis** of any encounter you might employ Kipling's 6 honest serving men (R Kipling, *The Elephant's Child*)

So the **questions** you need to answer are:

- **What** could I have done better?
- **What** did I do well? *Some people would like you to answer this one first, experience usually works the other way around.*
- **How** do I feel?
- **Why** do I feel this way?
- **What** is the feeling telling me?
- **What** words can I use to describe the feeling?
- **Who** should I speak to?
- **What** are the boundaries of my competence?
- **What** have I leant, been made aware of?
- **How** can I develop my competencies?
- **How** will I put them into practice?
- **How** will I know that I am developing?

And probably others too.

I KEEP six honest serving-men
(They taught me all I knew);
Their names are What and Why and When
And How and Where and Who.

I send them over land and sea,
I send them east and west;
But after they have worked for me,
I give them all a rest.

I let them rest from nine till five,
For I am busy then,
As well as breakfast, lunch, and tea,
For they are hungry men.

But different folk have different views;
I know a person small-
She keeps ten million serving-men,
Who get no rest at all!

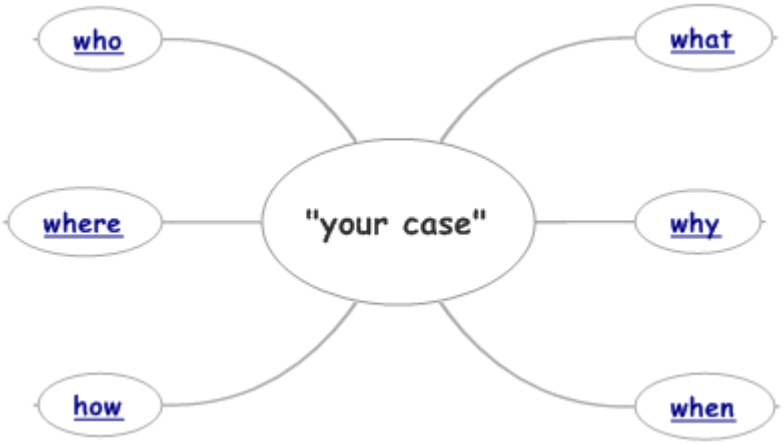
She sends'em abroad on her own affairs,
From the second she opens her eyes-
One million Hows, two million Wheres,
And seven million Whys!

The Elephant's Child

more ….

A *mind map* template can help explore all the elements in the case using this analytical framework.

If you write down the answers to these questions you will have recorded the story of your experience, you are venturing in to narrative based medicine.



(Mindmaps – Tony Buzan has written various publications to support the pen and paper method)

e versions www.freemind.sourceforge.net freeware

Need to pay but remember you are in education,
www.mindjet.co.uk for MindManager
http://www.buzanonline.com/ for iMindMap

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Getting it into the **ePortfolio**

Review the scenario imagining it is your first such case, in hospital or general practice.
Now fill in the boxes in the **clinical encounter part of the learning log eP**.

Whatever your analysis, the record can be **journalistic**, a record of events as you perceived them or **reflective**, the impact on you and your practice. Here is a comparison of the two styles

The **journalistic** record

What happened?	Saw a single mother with her small three year old boy, "ill all the time" Child has bruise on his back
What, if anything, happened subsequently?	No feedback yet
What did you learn?	How to refer a possible case of child abuse.
What will you do differently in future?	Use referral system early
What further learning needs did you identify?	Find out about child abuse
How and when will you address these?	In the next 2 weeks, do BMJ Learning sessions, and get certificates.

Its appeal is in its brevity, but it offers neither yourself nor your supervisor any understanding of any thinking or learning that has taken place and of its potential impact upon your practice.

more …

the **reflective** record

What happened?	A consultation with anxious single mother, who felt her boy was ill all the time, discovered a bruise on the back, mother reluctant to show me, claimed she knew me, she is in a new relationship. I referred to the HV
What, if anything, happened subsequently?	I spoke with the HV, she has arranged a home visit, when she has done this I will speak with her and we will do a joint visit I spoke with my trainer
What did you learn?	Lectures don't prepare you for the impact of reality. I felt uncomfortable and didn't know how to bring the subject up with the mother. I was uncomfortable with her trying to establish a personal relationship I managed the difficulty with the consultation and used time and a referral to find out some more, There is a named doctor in the practice who leads on these issues.
What will you do differently in future?	I will involve the HV or the named doctor at the time of the consultation and my trainers as well.
What further learning needs did you identify?	I will find out about the local referral process and people, case meetings and reviews. I will ask the PDs if we can have a case based group session on the half day release I will ask to go to social services for half a day
How and when will you address these?	referral protocols etc in the next month next terms programme for the GPST group - I will volunteer to lead the session Make an appointment to visit social services in the next 2 weeks.

more ...

A reflective record in the log
is worth ten journalistic bites.

Now think, how much of this will you transfer to your Professional Development Plan (PDP), if so what and how? (If you need an answer to *how* then the question is, *"where is your eP handbook / manual?")*

Make the objectives in your PDP **SMART**,

Simple,
Measurable,
Achievable,
Relevant and
Time-based.

The record in your PDP should also be reflective especially when you come to review the outcome of your learning; did the learning make any different to what you do?

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Appendix 1

The process of reflective learning (Schön)

The *expert* practitioner uses knowledge and skills influenced by attitudes to solve problems in the work place, this is her ZONE OF MASTERY. This solving process is automatic, routine and intuitive - it requires little critical thinking. This is the area of KNOWLEDGE **IN** ACTION.

When the facts or features do not fit the usual pattern then a SURPRISE is said to occur. The larger the field of mastery the less surprises occur. The fewer surprises that occur means that the practitioner has to be extra sensitive to recognise them.

REFLECTION **IN** ACTION is where

- ◊ the surprise is recognised,
- ◊ the problem is reviewed,
- ◊ alternative hypotheses are raised, which might lead to research
- ◊ further information is sought
  - ⇒ from the patient / client
  - ⇒ from the body of professional knowledge
    - * colleagues
    - * meetings
    - * information systems

The problem is then *solved* with the new information (the gathering of more or new knowledge does not necessarily mean new learning)

REFLECTION **ON** ACTION is where the surprise and its resolution are reviewed. This then leads to new learning. This process often raises more questions which require further information. Such information can come from the body of professional knowledge or by doing research or self inquiry - audit; both of which will add into the pool of knowledge, skills and attitudes that make up the **zone of mastery**.

LEARNING OUTCOMES that add to the zone of mastery are:

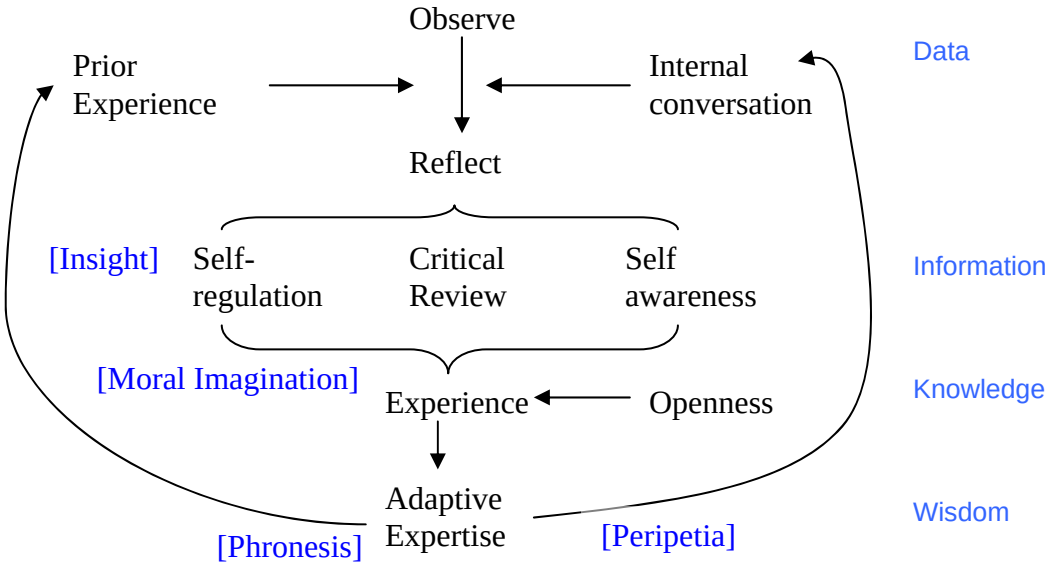
1. new practice
2. discontinuing out-moded practice
3. continuing professional education
4. reinforcement of *established* effective practice

D A Schön
The Reflective Practitioner, (1983) Basic Books Inc. ISBN 0-465-06878-2
Educating the Reflective Practitioner, (1987), Jossey-Bass Ltd, ISBN 1-55542-220-9

Appendix 2

This model of reflection is not presented as a linear process but rather a complex one. At any one time in the reflective process any or all of the factors will be in play. I have placed within the model (in blue) words that are from other well know concepts in an attempt to offer some synthesis or at least acknowledgment of the complexity of the topic. The black text and lines is the basic model.

A model of reflective practice



Arthur Hibble 5/05/09

Appendix 3

Learning at the edge

Two theories one old and one new can be brought to thinking about the potential for learning in situations of heightened anxiety. John Bowlby built upon Freud's work to form his attachment / separation theory. Basically a child develops normally by moving away from mother until they reach a boundary defined by a level of anxiety. At which point they move back towards the mother and increased comfort. Each adventure into the unknown results in learning about their world. A good parent encourages this exploration and helps the child to tolerate the uncertainty and anxiety. The point being that learning happens effectively at the boundary but with parental support. Eventually they break into adulthood and use their own internal support system to explore further.

The other theory is relatively modern and subject to much popular scientific writing, Complexity Theory. This has provided the mathematical proofs for what philosophers have struggled with for centuries. That is whilst to investigate systems there is a tendency to make them linear; in life the reality is complex. It seems that all systems can be analysed through complexity theory from weather to society to people to quantum physics. All systems have an apparent stable state but from time to time and often as a result of a very small change major disturbance occurs. This is the move towards chaos. The point where the system starts to be come unstable is called the *edge of chaos*. It is the place where things happen. In medicine it is the point where learning can be maximal providing the learner has the necessary internal and external supporting processes. It is the point where adaptive expertise is developed.

This is *learning on the edge*. For this to happen the learner needs to be where the action is, in the work place, and at the same time the supervisor needs to ensure support is to hand.

Further reading:

Attachment and Loss: Attachment volume 1, John Bowlby, Pimlico Revised Ed 1997. This is the first volume in a classic series of three volumes the second being Separation and the third Loss.

Complexity and healthcare: an introduction By Kieran Sweeney, Frances Griffiths, Published by Radcliffe Publishing, 2002

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