

## **Article Title: Enabling honest reflection: A Review**

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## Summary

**Background:** Reflective practice provides a backbone to professionalism, a commitment to lifelong learning and competency-based education in the form of reflective portfolios. Changes in healthcare culture have promoted a move towards openness and reflection on challenging clinical encounters.

**Issue:** Engagement with reflection has historically proved challenging to clinical educators. This Faculty Development Review examines this using a case-study from the United Kingdom in which a postgraduate trainee was asked to disclose their reflective portfolio by a patient's legal representation. Critics have consequently questioned whether the educational benefit of reflection warrants these potential legal implications. In the context of pressure from accrediting bodies to demonstrate evidence of reflection, how can learners face this potential conflict of professional versus legal repercussions?

**Educational rationale:** We combine professional guidance from the UK and educational rationale from international settings to produce a guide for good practice. We offer guidance on facilitating reflection for learners in an open and honest way without diluting educationally effective critical reflection. Themes of anonymity, taking a balanced approach, seeking senior advice, focusing on learning outcomes and role-modelling are discussed.

**Take-home messages:** Integrating reflection within the curriculum improves engagement and is key to experiential learning. Clinical educators should be aware of legal and professional guidance applicable to their own context. Both educators and learners should be aware that written reflection is an educational, not a clinical tool, and so requires little or no patient identifiable data thereby ensuring safer reflective practice.

## **Introduction**

Reflection is 'a metacognitive process that occurs before, during and after situations, with the purpose of developing a greater understanding of both the self and the situation' (1). Reflection in the context of professional practice is termed reflective practice. In contrast to medicine, other healthcare professions including nursing, and clinical therapy specialties, have utilized reflective practice for decades, so much so that it is considered routine(2). Governing and accrediting bodies place increasing emphasis on the importance of reflection (Figure 1) (3-5). Reflection is important in embedding a culture of openness and empathy, aiding compassionate care and has been recommended as a key tool in recent healthcare policy (6). It is also important for learning, as described by Kolb (7), and has been postulated to develop the therapeutic relationship and professionalism by challenging underlying beliefs and assumptions (1) and positively impacts upon resilience (8). In essence, open and honest reflection has the potential to provide practitioners with the opportunity to make sense of previous experiences in order to learn and improve.

Enabling effective reflection is not without its challenges however. This Faculty Development Review aims to outline some of these challenges maintaining the stance that critical reflection can be taught. The authors' stance is informed by experience as the academic lead and fellow for professionalism, which includes reflective practice, at a large UK medical school. With this comes the responsibility to address poor engagement with reflective practice in the curriculum as well as updating faculty on relevant professional changes. This review incorporates a recent case study, which has raised concerns amongst professionals regarding the security of written reflection and similar cases may be used to promote discussion for faculty development. We integrate relevant legal and professional guidance with educational theory and our own experience to create a good practice guide to teaching and learning safe, honest reflection for individuals and organisations utilizing reflective learning.

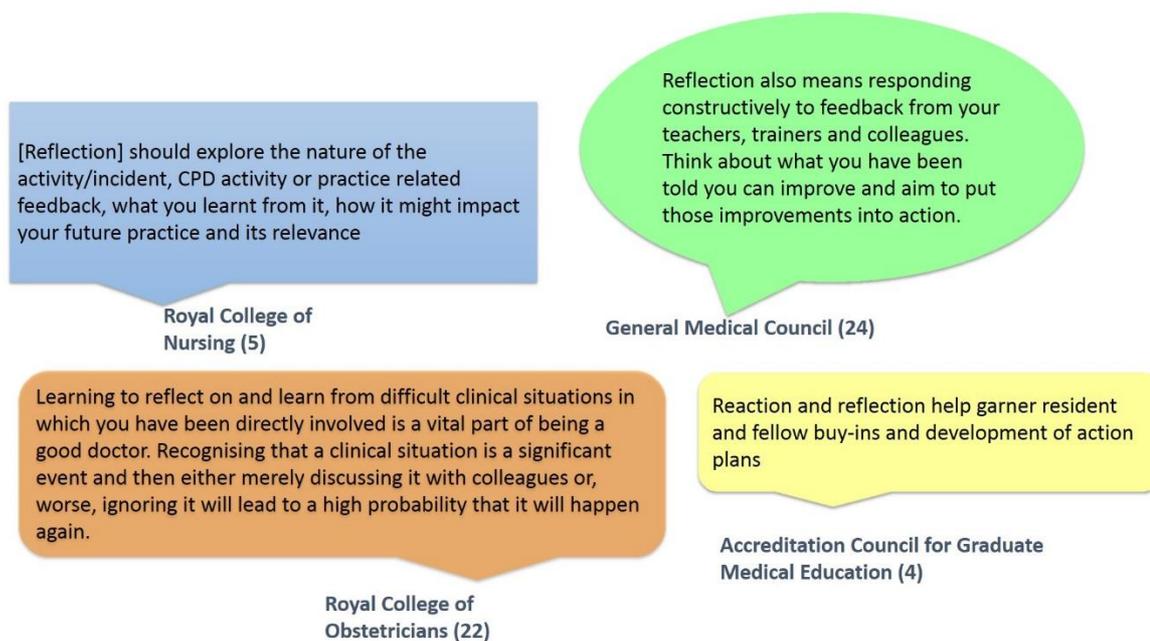


Figure 1. Guidance on how to approach reflective practice from governing and regulatory bodies (4,5,22,24)

### Challenges to facilitating and practising reflection

There is a philosophical debate in the literature about whether reflection can actually be taught. Historically, authors such as Ryle (9) argue that there are no prescriptive reflective models and to assume this is to misconstrue reflective practice. However, the widely held contemporary view is that reflective practice can and should be taught. Supporting this, Russell (10) theorises that;

*'The results of explicit instruction seem far more productive than merely advocating reflective practice and assuming that individuals will understand how reflective practice differs profoundly from our everyday sense of reflection'* <sup>10</sup>

Furthermore the educational impact has been documented in terms of both attainment and wellbeing (11), further supporting this notion.

Schön, widely considered as the modern architect of reflective practice, also theorises that reflection can and should be included in curricula (12). Although he primarily bases his pedagogical theory on more technical occupations, such as architecture and engineering, there is some reference to its use in healthcare education.

Dunne et al. (13) performed a review of reflective teaching strategies used by allied healthcare, nursing and medical professionals, all of which showed positive influences on the depth of reflection that was further enhanced by repeated exposure to that method. Whilst they argue that learners require facilitation to develop critical reflection, there is no consensus over the best model to improve reflective proficiency (13). The critical analysis of different approaches is beyond the scope of this article, but educators should select models which complement their own curriculum, are acceptable to learners and which can be returned to over the course of a clinical career (13).

The remainder of this article will consider written reflective practice in the context of written assignments and portfolios. Portfolio reflection, used across healthcare education, forms a body of evidence to prove learning needs have been met and stimulates reflection on how these have changed practice (1). The article will discuss the roles of both learners (as under- or postgraduate trainees from any healthcare discipline) and educators.

Engagement in reflection can be challenging, especially with written reflective assignments sometimes being viewed by learners as a 'bolt on' to the curriculum (1). Current learners (undergraduate and postgraduate) may prefer group activities or exploring reflection using digital media such as blogs and vlogs (1). Written portfolios can create a tension around the assessment of personal reflections (14). This highlights important ethical considerations: not only may reflections be steeped in emotion following a difficult event but thought must be given as to who can access written reflections and for what purpose (1).

### **A case study from the UK**

Recently, confidentiality and privacy of reflective portfolios came under scrutiny, when a postgraduate trainee in the UK was requested to disclose their reflective portfolio, a mandatory training component, to a patient's legal representative (15). This could be viewed as a "critical incident" provoking examination of the current guidance around reflective practice. Postgraduate UK medical trainees were informed of the events in an email. This reported the portfolio was "subsequently used as evidence against the trainee in court"(15) although it was ultimately not used for this purpose. The details of the case remain confidential; however, questions have been raised over whether the educational role of a reflective portfolio warrants the potential legal implications (16). This could impact upon many clinical curricula: half of US medical schools use reflective portfolios (17) and reflection on action (12) underpins learner-centred competency based curricula with which trainees must engage (4,5). How can trainees face this potential conflict of legal versus professional repercussions? And how are healthcare educators to guide their students in this potential professional minefield?

In the UK, documentation about a patient made by a healthcare professional or student within the National Health Service (NHS) constitutes part of that patient's NHS record. Therefore any reflective writing relating to a patient is subject to all of the requirements for data protection, including access by patients (18). The Academy of Medical Royal Colleges (AoMRC), a coordinating body for the UK and Ireland's medical Royal Colleges and Faculties, offers further practical advice regarding portfolio documentation, principally that patient anonymity is key. It advises that reflective notes cannot be requested by third parties if they do not contain patient identifiable data (19). In addition, where both clinicians and students are involved in significant incidents or errors, evidence of critical reflection and learning are viewed as protective, especially when written objectively (19). Table 1 summarises this advice.

Professional Advice	Practical Implications
Anonymity	Use no patient identifiable data and only a brief description of the events. Avoid date of birth or initials. Avoid identifying colleagues.
Take a balanced approach	Avoid writing defensively and blaming others involved but also avoid being judgemental of yourself. Consider the bigger picture and other factors which may have had an impact as well as your own actions.
Discuss with a senior colleague	Seek other opportunities to make sense of the situation. Take advice from senior colleagues and other involved before documenting your thoughts.
Avoid reflection in the heat of the moment	Take notes when the event is still fresh in your mind but avoid documentation when emotions are still raw or before the event has been discussed with a senior.
Consider taking part in other educational activities	In the event of serious incidents, assist in significant event analyses and any educational activities which follow. This may be teaching sessions or Quality Improvement projects. These also provide evidence to reflect on and fulfil curriculum requirements.
Focus on learning outcomes	Rather than discussing what you would do differently, change the focus from what went wrong to what you and your organisation learnt.

Table 1: Summary of advice about reflective writing in clinical practice from Academy of Royal Colleges (19).

### **Relevance for educators**

Whilst this example is UK-centric, and to date there are no reports in the literature of similar cases within other legal systems, the resulting strength of feeling may impact upon uptake of critical reflection globally. Educators have a responsibility to continue to introduce and guide learners through reflection, whilst ensuring that they do not introduce unnecessary risk to themselves. The temptation to avoid reflection in any contentious situation may limit deeper learning from the event for both clinicians and institutions involved. The remainder of this article identifies how professional advice, summarised in table 1, can complement educational theory to facilitate reflection in an open and honest way.

### **Anonymity**

Critics suggest creating an account devoid of patient identifiable data may be virtually impossible when giving an adequate description of the event (16). However, heavy reliance on description and narrative resulting in educationally ineffective reflection is a common pitfall for many novice learners (20). Considering Kolb's experiential learning cycle, the description of the event is only a small part of the educational process (7). For experiential learning, a much larger emphasis should be placed on reflective observations, analysis and influencing learning for future events (figure 2). We can see therefore that potentially identifiable data, such as medical history, demographics and details of team members involved, may not be necessary for critical analysis.

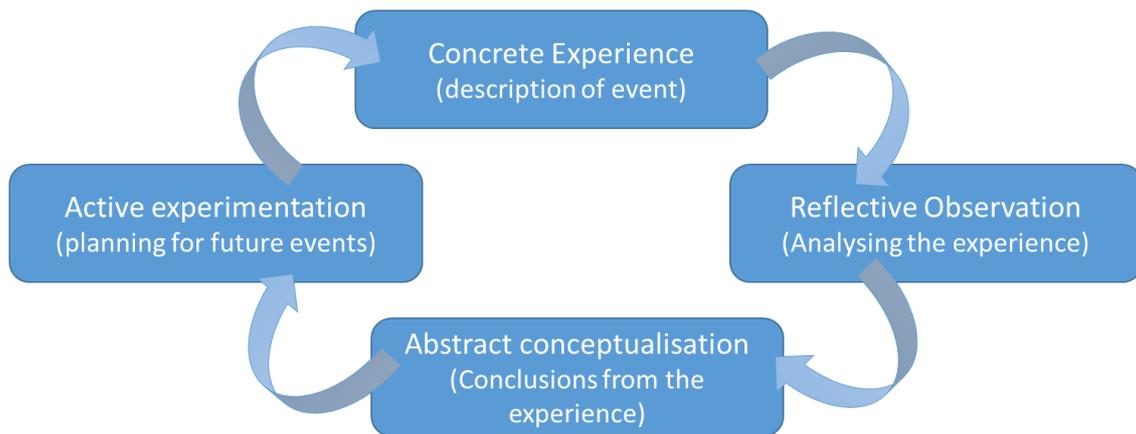


Figure 2. Adapted from Kolb's experiential learning cycle (7). Most learning does not take place by describing the event but by analysing and making conclusions.

It may not be clear, particularly to undergraduate clinical students, that going beyond this narrative is what is required for reflective practice. Traditionally the purpose of reflection has not always been explicit and obvious to both teachers and learners. Therefore, when setting reflective tasks it is important to outline expectations of learners and the level of reflection anticipated from them (20). This can include lessons learnt, applicability to other similar settings and an achievable, time-bound action plan.

### **Taking a balanced approach *and* involving a senior colleague**

Whilst some students may seize opportunities for reflection, others may require support in selecting appropriate cases and scenarios which will draw out deeper learning. The need for tutors to offer support and advice is twofold. Firstly learners who find reflection more challenging may need guidance (21); secondly clinical scenarios may be associated with strong emotions, clouding the reflector's

judgement and limiting the educational impact. The need to take a balanced approach comes from both a professional and pedagogical standpoint. By taking a largely personal approach to the reflective cycle, practitioners can be overly negative towards their own skills, knowledge and behaviours creating barriers towards learning (21). Relating this back to Kolb, educators and learners should also aim to focus their reflection on 'what lessons have been learnt' (19). This has potential benefits for both the clinician and institution, helping to inform future actions.

### **Take part in other education activities and focus on learning outcomes**

In addition to the demonstration of professional development, reflection and experiential learning have wider implications in the context of patient safety. As mentioned in Figure 1, there is a duty for clinicians to reflect and learn from adverse events in order to prevent them from recurring (22). Learners and supervisors should seek out opportunities to take part in educational activities or quality improvement in addition to personal reflective accounts (19). These, in turn, can provide further experiences on which to reflect, fulfil appraisal and curriculum criteria and help learners focus on "what was learnt" as opposed to the more negative "what could I have done differently". The notion of being open about mistakes to stimulate institutional learning reflects culture changes in healthcare towards both openness and compassionate care (6).

Reflecting on the self and situations has a wider impact upon the development of professionalism and lifelong learning than simple acquisition of skills or knowledge (1). Most definitions of professionalism include reference to the importance of lifelong learning (1) and governing bodies emphasize the importance of establishing foundations for this during undergraduate and early post-graduate training(3).

It may be advisable for institutions to offer a variety of reflective models to address different learning preferences. In our experience, students broadly favour facilitated group reflection such as small group tutorials. Larger reflective fora exist, such as Schwartz Rounds, where a panel discuss a chosen topic or case before inviting comments from the wider audience (23). This has the added benefit that challenging clinical cases can be discussed in a confidential manner with the potential to drive further institutional change.

### **Educators as role models**

Vivekanda-Schmidt et al. showed students recognise the relevance of reflection. Despite tensions between private and public thoughts, writing was found to be a useful exercise which facilitated deeper understanding (14). Assessment of reflection was viewed as useful only in the context of developing reflective skills and furthermore, students sought reassurance that their reflections were kept confidential and only viewed by trained tutors. Teaching by role-modelling and championing good reflective practice was also seen as key (14).

In the climate of professional uncertainty regarding the safety of open and honest reflection, a key factor in developing reflective skills will be the role-modelling offered by tutors and senior colleagues (20). Defensive responses resulting in avoidance of addressing contentious issues (16) or removing learners from early clinical exposure will have negative implications, failing to prepare them for future clinical practice. We postulate that avoiding reflective practice may contribute to the threat of professional burnout, although this is as yet unsubstantiated in the literature. Professional advice highlights the role for senior guidance before learners commit reflection and learning to paper. It is therefore vital that educators understand their governing bodies' professional and legal guidance as well as the educational rationale for adopting reflection. Table 2 summarises both these aspects and offers practical tips from the authors with regards to implementing these in practice.

## Enabling Honest Reflection: A Review

Tip	Educational rationale	Advice
1. Place less emphasis on narrative	<ul style="list-style-type: none"> <li>Define reflection and what is expected from students (20)</li> <li>Place greater emphasis on the other steps of Kolb's learning cycle</li> </ul>	<ul style="list-style-type: none"> <li>Avoid detailed descriptions which could include patient or colleague identifiable information (19)</li> <li>Tutors and students/trainees should use written portfolios as educational tools only, focussing on learning</li> <li>Should learners wish to follow-up patients, patient identifiable information should be kept separately to educational outcomes within the portfolio.</li> </ul>
2. Base reflections on appropriate clinical experiences	<ul style="list-style-type: none"> <li>Reflective ability is more easily developed following meaningful clinical experience (14)</li> </ul>	<ul style="list-style-type: none"> <li>Developing deep and critical reflection aids learning from errors and is supportive in fitness to practice cases (19)</li> <li>Integrate early clinical exposure and reflection within the curriculum (20)</li> <li>Reflection based on clinical experience provides evidence for competency based curricula (2-4)</li> </ul>
3. Tutors should teach by role modelling and operate an open-door policy for troubleshooting	<ul style="list-style-type: none"> <li>Tutors should role model and "champion" good reflective practice exhibiting deep and critical reflection (14)</li> <li>Tutors should be flexible to guiding some students towards appropriate cases when needed (21)</li> <li>Tutors should be aware and able to discuss difficult cases which may cause negative emotions in the learner (20)</li> </ul>	<ul style="list-style-type: none"> <li>Reflections, particularly around clinical errors or contentious issues should always be discussed with a senior</li> </ul>
4. Take a balanced approach	<ul style="list-style-type: none"> <li>Overly inward-looking reflections concentrating on negative aspects of learner's behaviour or skills can act as a barrier towards learning (21)</li> </ul>	<ul style="list-style-type: none"> <li>Avoid being judgemental of yourself or others when reflecting.</li> <li>Avoid reflections in the heat of moment</li> <li>All incidents should be discussed with a senior or tutor prior to formal documentation (see above). (19)</li> </ul>
5. Ensure methods for formative feedback and privacy for reflective writing	<ul style="list-style-type: none"> <li>Provide a method by which learners can have formative feedback on their reflections in order to develop critical reflection</li> <li>Consider who has access to these reflections to allow students to reflect in an uninhibited way (14,20)</li> </ul>	<ul style="list-style-type: none"> <li>Ensure institution is working within local and national data protection policy (20)</li> <li>Seek consent from students if reflective assignments are used for any other purpose</li> <li>If a third party requests access to a portfolio, seek advice from your medical indemnity organisation(19)</li> </ul>

Table 2. Top tips for enabling honest reflective practice.

## Conclusions

Reflective practice is an essential activity for healthcare professionals as it aids development of professionalism, resilience and experiential learning (1,8). Portfolio evidence of deep reflection is also protective following professional mistakes (19). Whilst this article is written by British doctors, much of the discussion is transferable to other disciplines as well as other countries. Using the above case study as an example it may be tempting, particularly with undergraduates, to avoid any clinically based reflections or contentious topics. However, concrete experiences are key to experiential learning. This should be considered when designing healthcare curricula allowing for early and meaningful clinical exposure (14). This could have a positive effect for engagement, allowing reflection to seem less like an 'add-on' activity (20).

Reflective practitioners should be aware of contemporary professional and legal guidance relevant to their own context. The reflective portfolio is educational not clinical, and therefore normally requires no identifiable patient or staff information. Reflection, as a tool for development, should focus on how clinical events have developed the learner into a safer, more insightful healthcare professional.

## References

1. Sandars, J. The use of reflection in medical education: AMEE Guide No.44, *Med Teach*. 2009 31(8): 685-695. DOI: 10.1080/01421590903050374
2. Nelson, S. The lost path to emancipatory practice: towards a history of reflective practice in nursing. *Nursing Philosophy*. 2012. 13(8); 202-213. DOI: 10.1111/j.1466-769X.2011.00535.x
3. General Medical Council. Outcomes for Graduates. 2015. [cited 30/05/2017] Available from: [http://www.gmc-uk.org/education/undergraduate/undergrad\\_outcomes\\_about.asp](http://www.gmc-uk.org/education/undergraduate/undergrad_outcomes_about.asp)

4. Holmboe, Edgar and Hamstra. The Milestones Guidebook. Accreditation Council for Graduate Medical Education. 2016. p22. [cited 07/02/2017] Available from: <http://www.acgme.org/Portals/0/MilestonesGuidebook.pdf>
5. RCN.org.uk [internet].Royal College of Nursing: Reflection and reflective discussion.c2017. [cited 28/02/2017] Available from: <https://www.rcn.org.uk/professional-development/revalidation/reflection-and-reflective-discussion>
6. Francis, R. Report of the Mid Staffordshire NHS Foundation Trust Inquiry. London. The Stationery Office. 2013
7. Kolb, DA. Experiential learning: Experience as the source of learning and development. New Jersey: Prentice Hall. 1984.
8. Wood, D. Mens sana in corpore sano: student well-being and the development of resilience. *Med Educ.* 2015 Jan; 50 (1): 20-3. DOI: 10.1111/medu.12934
9. Ryle, G. The Concept of Mind. New York: University of Chicago Press. 1949.
10. Russell, T. Can Reflective Practice be Taught? *Reflective Practice.* 2005; 6(2):199-204. DOI: 10.1080/14623940500105833
11. Baumeister R. Vohs, K. (Ed). Handbook of self-regulation: Research, theory and applications. New York: Guilford Press. 2004
12. Schön D. Educating the reflective practitioner. San Francisco; Jossey-Bass.1987
13. Dunne, M. Nisbet, G. Penman, M. McAllister, L. Influences and outcomes: A systematized review of reflective teaching strategies in student healthcare placements. *International Journal of Practice-Based Learning in Health and Social care.* 2016. 4(1):55-77. DOI: 10.18552/ijpblhsc.v4i1.342
14. Vivekananda-Schmidt, P. Marshall, M. Stark, P. McKendree, J. Sandars, J. Smithson, S. Lessons from medical students' perceptions of learning reflective skills: A multi-institutional study. *Med Teach* May 2011; 33 (10):846-850. DOI: 10.3109/0142159X.2011.577120

15. Health Education England. Re: Position Statement on Trainees Written Reflections. April 2016. [cited 05/01/2017]. Available from: [http://www.stfs.org.uk/sites/stfs/files/2016%203%20\(23rd\)%20HEE-EM%20Letter%20-%20Statement%20on%20Trainee%20Reflections%20\(2\).pdf](http://www.stfs.org.uk/sites/stfs/files/2016%203%20(23rd)%20HEE-EM%20Letter%20-%20Statement%20on%20Trainee%20Reflections%20(2).pdf)
16. Furmedge, D. Written reflection is dead in the water. *BMJ online*. 2016 [cited 05/01/2017] Available from: [http://careers.bmj.com/careers/advice/Written\\_reflection\\_is\\_dead\\_in\\_the\\_water](http://careers.bmj.com/careers/advice/Written_reflection_is_dead_in_the_water)
17. Chertoff, J. Wright, A. Novak, M. Fantone, J. Fleming, A. Ahmed, T et al. Status of portfolios in undergraduate medical education in the LCME accredited US medical schools. *Med Teach* 2016. 38(9):866-96. DOI: 10.3109/0142159X.2015.1114595
18. Department of Health. Records management code of practice.London. 2016. [cited 10/4/2017] Available from: <https://www.gov.uk/government/publications/records-management-code-of-practice-for-health-and-social-care>
19. Academy of Royal Colleges. Guidance for entering information onto e-portfolios. 2016. [cited 28/02/2017]. Available from: [http://www.aomrc.org.uk/wp-content/uploads/2016/11/Academy\\_Guidance\\_on\\_e-Portfolios\\_201916-5.pdf](http://www.aomrc.org.uk/wp-content/uploads/2016/11/Academy_Guidance_on_e-Portfolios_201916-5.pdf)
20. Aronson, L. Twelve Tips for teaching reflection at all levels of medical education. *Med Teach* 2011 33 (3):200-205.DOI: 10.3109/0142159X.2010.507714
21. Smith, E. Teaching critical reflection. *Teaching in Higher Education* 2011 16 (2); 211-223. DOI:10.1080/13562517.2010.515022
22. Royal College Obstetricians and Gynaecologists. Reflective Practice. 2013. p1. [cited 26/05/2017] Available from: <https://www.rcog.org.uk/globalassets/documents/careers-and-training/core-curriculum-pre-august-2013/ed-reflective-prac.pdf>
23. Barker, R. Cornwell, J, Gishen, F. Introducing compassion into the education of healthcare professionals; can Schwartz Rounds help? *Journal of Compassionate Health Care* 2016 3:3. DOI: 10.1186/s40639-016-0020-0

24. General Medical Council. Medical students: Achieving good medical practice. c.2017. p10

[cited 26/05/2017] Available from: <http://www.gmc-uk.org/education/undergraduate/26612.asp>