Reflective Practice and Narrative – collective guidance and example of reflective template

Summary Narrative - UK Foundation Programme Curriculum 2021 p 35 (https://www.pgmeplymouth.com/e-portfolios-arcp)

The summary narrative is a form of written reflection that encourages the doctor to reflect on their overall practice and development. The concept is currently used by non-training grades, including consultants, when preparing for annual appraisal to review practice against the four domains of Good Medical Practice, and thus seeks to encourage reflective practice and prepare the FD for future requirements.

At the completion of each level of training (F1 and F2), prior to the final end of year meeting with the ES, the FD is required to complete a written summary of their progress against each HLO (maximum 300 words), referring, if appropriate, to their choice of evidence to support progress against – or achievement of – the FPCs. The FD should be encouraged to start preparing a short summary of their progress with each of the HLOs at the end of each placement. This short summary should encourage them to critically review their curriculum achievements and consider if they are making sufficient progress to demonstrate the HLOs.

Consideration should be given to whether each FPC has the appropriate evidence, particularly feedback on performance in the clinical environment (SLEs, PSG feedback, TAB etc. corresponding to 'does' in Miller's Pyramid and representing **experiential learning**. Other evidence may be in the form of evidence of core and non-core learning (**direct training**) where the FD has played an active role ('shows' in Miller's Pyramid), or reference to **self-directed learning** as recorded in the Personal Learning Log ('tells' in Miller's Pyramid).

At each of the end of placement meetings, the ES should provide feedback on progress with the narrative and help guide the preparation for the PDP for the next placement. At the end of the next placement, the summary narrative may be built upon as evidence of further progress. The FD should be encouraged not just to comment on fulfilling curriculum requirements and future training needs but also to identify where they have exceeded the requirements and demonstrated excellence.

For those trainees who require remediation for any reason, they can use the narrative as a method of identifying progress. Detailed guidance on how to write the summary narrative is available in the appendix and will be also provided in the e-portfolio guide.

This form of reflection and the way it is recorded is new to the FP but is used in other PG curricula. It is designed to encourage reflection on progress globally and seeks to strengthen the benefits of positive reflection, which can be overlooked when focusing on the details of specific cases/incidents. In using this process, the FP does not seek to undermine the benefits of reflecting on specific cases but acknowledges that this is often better done in a group setting/debrief or privately/with a supervisor. Where the FD has reflected on a specific incident either to consolidate good practice or to record lessons learned, there is opportunity to do this in the e-portfolio and, if appropriate, use this record as evidence against the FPCs.

The summary narrative is used for:
- tracking progress to achieve HLOs,
- demonstrating excellence,
- supporting doctors when they are required to demonstrate progress against poor performance.

Based on Plymouth University Peninsula Schools of Medicine and Dentistry (PUPSMD) Guidance 2021

What is reflection?

Reflection is a specialised form of cognitive activity that requires us to actively engage with an event or learning activity. All reflective models are comprised of three fundamental processes: retrospection (thinking back on events); self-evaluation (attending to feelings); and reorientation (re-evaluating experiences). By entering into a process of detailed examination of an event, we learn not only about the situation, but also about the choices made by all participants, and about ourselves. Schön (1983) was an early writer on reflective practice. He suggested that an **effective** reflective practitioner is able to recognise and explore confusing or unique (*positive or negative*) events that occur during practice; whereas the **ineffective** practitioner is confined to repetitive and routine practice, neglecting opportunities to think about what he/she is doing Thus reflective practice enables us to become wiser, more compassionate, and more effective in our future professional roles.

Why reflect?

Research on reflective practice (Wald et al, 2012) has shown some of the benefits of reflective practice, which:

- Helps identify learning needs
- Develops critical analysis skills
- Informs clinical reasoning
- Enhances professionalism
- Builds expertise
- Guides us in managing complexity and morally ambiguous circumstances
- Helps us develop resilience.

When we share our reflections with others, we:

- Discover blind-spots
- Can make use of feedback
- Become open to new perspectives.

Why written reflection?

Reflection does not come naturally to everyone, but it is known that repeat practice leads to the development of increasing reflective capacity. Writing forces us to externalise an experience. Charon and Hermann (2012) state: "writing itself teaches the skills of reflection…as it unlocks reservoirs of thoughts or knowledge otherwise inaccessible to the writer". You, the writer, and your reading peers and supervisors, will find the deep meaning, or learning in a situation, through your text. Feedback helps to challenge our assumptions, offers new perspectives, and reflective inquiry can help us explore our emotional responses and new possibilities for action.

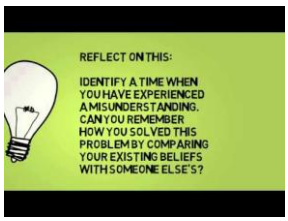
Repeat use of structured reflective templates helps you to internalise the process of reflection until it becomes second nature. You will learn that reflection is particularly valuable where a situation has challenged or unsettled you in some way. There is evidence (Aronson et al, 2010) to show that use of reflective templates improves diagnostic accuracy in junior doctors, increases the number of trainees passing all competencies.

How to reflect:

The *processing cycle* (Midmer, 2002):

- *The experience*
- *This is what I saw/heard/palpated*
- *This is how I felt about it/this is how I reacted*
- *This is what I am left with*
- *This relates to these wider issues…*
- *This is what I will do next to take my learning further…..*

An article about reflective learning, including some of the difficulties doctors face with it:
http://careers.bmj.com/careers/advice/view-article.html?id=20009702
This is a good article for those who doubt whether reflection is useful:
http://careers.bmj.com/careers/advice/view-article.html?id=20009702
The following video pertains to the generic skill of reflection in learning:
https://www.youtube.com/watch?v=2wHANninAl4



Reflection in Learning: A Basic Introduction - YouTube
This video is ideal for introducing university students to the role of reflection in learning. Watch now...

PUPSMD Reflective Template:

The Structured Reflective Template (SRT) invites you to reflect on events or patient encounters in depth. It is expected that SRTs will include reflections on learning from your personal research, and from your reading of guidelines, protocols, and patient-aimed resources. (**See appendix 1**)

What is Narrative?

Rita Charon – Narrative Medicine, Honouring the Stories of Illness

Stories with a teller, a listener, a time course, a plot, and a point
Medicine practiced with the narrative competence to recognise, absorb, interpret, and be moved by the stories of illness.
The content of the story, recognise the multiple, possibly contradictory meaning of words and events described.
What can I infer about the disease/health/social problem/imagine the situation of the teller?
We need to understand the world that the patient sees and inhabits.
Does it tell me about how I can help the patient/person?

Person specific narratives:

We all have narratives. Our narrative begins before we are born and is affected by the attitudes, culture, society, and environment we are born into. It is therefore affected by family, schooling/education, friends, the economic/social/political environment, our abilities and disabilities and the perception of these, and beyond i.e., everything we encounter and experience. This leads towards our beliefs, values, hopes for the future, different codes of conduct, attitudes to health and ill-health.

As a listener you will interpret your patient's story with your own experiences and background. At some points you may feel that you are both talking different languages, i.e., in metaphors – because of the different words and phrases you both use to describe events, feelings, symptoms. It's about their understanding of experiences and events, or even them *not* being able to understand these experiences, or express themselves, or get the chronology in the right order. You need to be able to read their uncertainties, ambiguities, hopes and fears. They may feel shame, guilt, have beliefs about causality. The way we take our histories from patients may feel straight forward to us but feel accusatory to patients. We see the global science and research behind our medicine, they are more likely to think of what it means to them as an individual and the impacts on their life.

You need to ask, inquire, be curious, to be able to begin to understand their story. Read their silences. This aspect of our work is not only fulfilling to us but engenders trust and perhaps an ability for them to reveal more, information that they were aware of, and other aspects they perhaps weren't aware of, but feel safer to reveal. This potentially will enable acceptance, adherence to advice and treatment, not feeling abandoned.

We also need to be aware that we may find it difficult to enter the realms of what the patient fears. There will be emotions that we will be uncomfortable to feel and perhaps not want to go there, potentially shutting the patient/clinician conversation down.

You will bring your narrative and agendas to the conversation - the narrative you bring from pre-birth onwards, and even on that specific day e.g. I didn't sleep well last night, I've not eaten yet, I must leave on time to pick the kids up, I have a meeting to go to, a report to write/deadlines etc.

We need to be aware of our own unconscious biases. Being aware that these biases may affect our interactions. Our patients/colleagues/team members will have biases too and have impressions of you in your role. They may try and change their narrative to meet what they perceive to be your moral and ethical compass. You as a healthcare provider may work under the feelings that you might disappoint or be sued. Your patient may feel that you will solve everything, have high expectations of the power of medicine. Or the patient may be angry with the system due to time delays, difficulty in accessing the systems of healthcare. They may feel like a commodity on an assembly line, losing their singularity, isolated. They may not even be able to tell their narrative due to the anxiety of the encounter with you and the environment they are in. Or their narrative may be influenced by the family member or carer who has come in with them.

Their narrative is not just their thoughts, and language they use, it also inferred by their tone of voice, pace, silences; it is projected non-verbally, in their body language. Note, that there may be a mismatch between body language and what is said verbally e.g., the person who says they are fine, but in fact talk with a flat affect, sit hunched and don't make eye contact e.g. they may say their sciatic nerve root pain is ok that day, but limp in and struggle to get on the couch.

Being fully present in the encounter will help you read this.

These moments of truly listening authentically can be transformative.

Reflexivity - as you interact with others you will be adding to and changing their narrative and yours. It is bidirectional, or multidirectional, if more than two people. This is reflexivity – a circular relationship between cause and effect. Also known as intersubjectivity. In working with reflexivity listen to your inner voice, could be called a third voice, about what the situation is telling you and what it might be stirring up.

Our healthcare environment specific narrative:

This is about understanding the socio-political and economic environment we work in,
the agendas of individuals in the team, the teams within the healthcare environment, drivers locally in your trust/other healthcare providers, and nationally/internationally.
It is about the demands of our roles, acknowledging and considering what works, went well, what hasn't, or could be improved upon. Overall, this involves the systems we work in and all that influences these, the systems' history, social structure, politics, policies, guidelines, challenges to these, nationally and locally.

References:

Aronson, L, Niehaus, B, DeVries, CD, Siegel, JR, O'Sullivan, PS (2010) Do writing and storytelling skill influence assessment of reflective ability in medical students' written reflections? *Acad Med* 85 (10) 529-532
Charon,R *Narrative Medicine, Honoring the Stories of Illness*, Oxford University Press, 2008
Charon, R and Hermann, N (2012) A sense of story, or why teach reflective writing? *Acad Med* 87(1) 5-7
Gibbs, G, Rust, C, Jenkins, A, Jacques, D (1994) *Developing Students' Transferable Skills.* Oxford Centre for Staff Development
Mann, K, Gordon, J and MacLeod, A (2009) Reflection and reflective practice in health professions education: a systematic review *Adv in Health Sci Educ* 14:595-621
Midmer (2002) BMJ Careers
Schön, D. (1983) *The Reflective Practitioner: how Professionals Think In Action*, Basic Books
Wald, HS, Borkan, JM, Scott Taylor, J, Anthony, D and Reis, S (2012) Fostering and evaluating reflective capacity in medical education: developing the REFLECT rubric for assessing reflective writing. *Acad Med* 87 (1) 41-50

Helpful guidance to access:

https://foundationprogramme.nhs.uk/resources/reflection/

http://www.aomrc.org.uk/wp-content/uploads/2018/09/Reflective_Practice_Toolkit_AoMRC_CoPMED_0818.pdf

Dr Daranee Boon
Foundation Training Programme Director Y1

Mr James Dunn
Foundation Training Programme Director Y2

Kate Talmage
Foundation Training Programme Manager

Derriford Hospital, Plymouth

Nov 2021

Structured reflection on significant experience – PUPSMD

Name:		**Date of experience:**	
Title of experience:		**Date of completion of form:**	

Description

What happened? What did I see and hear?

Reaction

What did I feel? What did I think?

Evaluation

What went well?

What could have been done better or differently?

Analysis

What further issues and questions does this raise for me?

What can I use to help me address these? e.g.:

Prior learning?

New reading - research, guidelines, theories, models?

Discussion with seniors and peers?

Examining the components of the situation in detail coupled with critically analysing the evidence is an essential stage in learning

Conclusion

What have I learnt from this? e.g.:

About myself?

About my work?

About patients?

About the healthcare system?

Learning may result in new perspectives or a sense of breakthrough, or new knowledge or skills

Action Plan

What will I do as a result of what I've learnt?

What one or two goals can I set?

Learning may result in a change of behaviour – e.g. in me, others, the healthcare system

Make goals SMART and succinct and state review date