STIF Competency

Reflective Practice for STIF Competency
Self- Revalidation

What is the purpose of reflection?

Adults learn through reflection. Something happens, we think about it, deconstruct what happened, try and work out why it happened and come up with a plan for what we might do next time in a similar situation.

Structuring reflections

Following a formal structure to reflect, and recording these reflections as part of revalidation has several advantages:

- Going through a formal structure helps prevent jumping to conclusions (see example 1: the angry patient)
- Regular reflections might help people develop a habit of reflective practice
- Formal reflection can more accurately guide personal and professional development, particularly with effective action planning (see example 2)
- Emotional aspects of learning are often neglected; a formal model can help ensure that the effects of emotion are considered. Emotional aspects are believed to be central to learning from experience [1]
- Formally recorded reflections provide evidence that you are committed to continuing improvement [1]

A word on Action Planning

Good reflection results in a plan for action or for change. Good action plans are SMART:

Specific	What, who, where?
Measurable	It should be clear so you know when it is completed
Achievable	Good goals should stretch you but not be impossible
Relevant	Is it relevant to the task?
Time-Bound	When will the goal be completed?

An example of a poor action plan

I will update on treatment of vaginal discharge

A much better (SMARTer) action plan might be

By the end of the month I will have gone through and made notes on the e-Learning for Healthcare sessions on the diagnosis and common causes of vaginal discharge and the treatment options. Over the next 2 months I will keep a record of women I see with vaginal discharge and review a selection of their notes with my supervisor together with their test results.

Footnote

[a] Within Medical Education, there are competing discourses of competence, described clearly by Hodges (2006)[1] as competence-as-knowledge; competence-as-performance; competence-as-reliable test score; and competence-as-reflection. Your reflections will demonstrate this fourth domain.

Depth of reflection

Reflective commentaries may be of different depths. Moon (2004) [2] summarises the literature to suggest that there may be four levels of depth:

- Descriptive writing, with no discussion beyond description
- Descriptive reflection – some reflections but only from one perspective
- Dialogic reflection – exploring others' perspectives and points of view
- Critical reflection – considers multiple perspectives, discourses and contexts

The assumption is that deeper levels of reflection lead to more profound learning.

For STIF intermediate revalidation we are looking for reflection at Dialogic or Critical level. We strongly recommend that you revisit some of your reflective accounts after a period of time and reflect again on the issues and your action plans.

For the revalidation process, self-certified route we would like you to use the Gibb's reflective cycle to structure a reflective narrative.

Models of reflection

Gibbs' reflective cycle

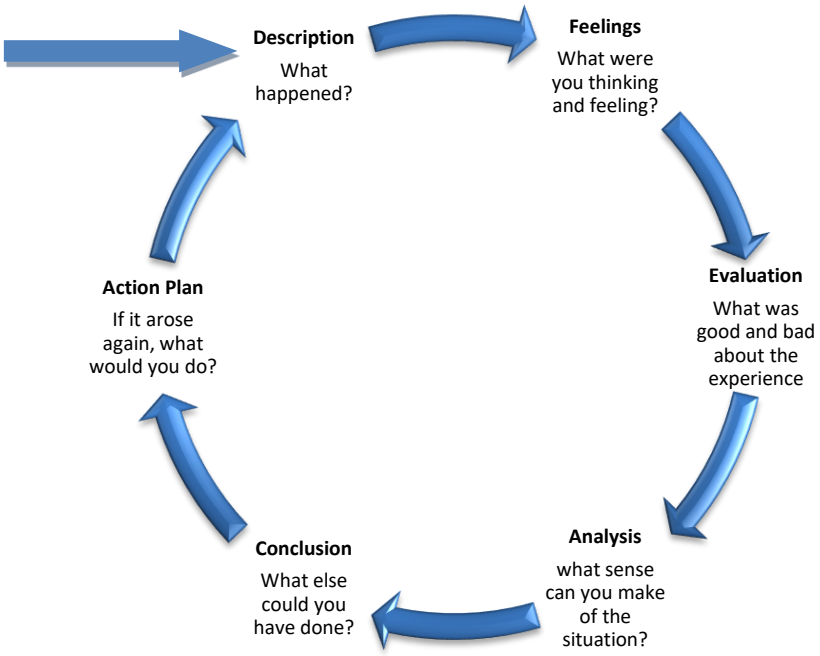

Figure: Model of reflection based on Gibbs (1988) taken from Evans and Brown (2009)[3]

Kolb's experiential learning cycle, adapted from Jarvis [4]

A simple reflective pro forma – based on Gibbs' model

What happened?

What was I thinking? Feeling?

What was good, what was bad about the experience?

What sense can I make of the situation?

What other options are there that I could have done?

What will I do next time if this arises?

Action planning based on this

Example 1

What happened?

The patient came in to the consultation angry, complaining about the health system, the wait, the temperature and even the water in this country and how it made her itch. I was rather abrupt with her and then she started shouting. I reluctantly apologised even though I hadn't done anything wrong. The consultation was challenging all the way through as she was very defensive. When I examined her and told her that the lump was completely normal, she stopped being angry and bizarrely thanked me quite nicely before leaving.

What was I thinking? Feeling?

I was irritated. The clinic was overrunning and the waiting room wasn't the only room that was stiflingly hot, my room was too. Patients who complain about the health system in this country always get my goat, I think we do a really good job, but if they hate it so much, what are they doing here?

What was good, what was bad about the experience?

I don't think being abrupt in response was helpful, it escalated things. My salvage wasn't bad, I tried to be very thorough and explain everything after that, and not let my irritation affect the care I gave. There was a good outcome, at least she seemed pleased at the end, although I wish I could have dealt with her quicker.

What sense can I make of the situation?

Thinking about it, I wonder if I might have read her wrong. I wonder if her anger was, in fact, displaced anxiety – she certainly seemed a lot happier suddenly when I told her that the lump wasn't anything serious. If her complaining was just a defence to hide her worry, then I guess my abruptness didn't help – if anything it might have reinforced her perceptions of the health system here. The waiting room certainly was hot and uncomfortable, and we were running late, I wonder if she had somewhere else to be. There might have been a cultural issue, or even a gender issue here, which didn't occur to me at the time.

What other options are there that I could have done?

- *I could have just listened to her rant for a little while, sometimes it's good to get it off your chest, I know that's what I prefer when I am irritated*
- *I probably should have apologised more quickly for the wait and the temperature, some empathy would have been useful*
- *Because she seemed angry, I don't really think I explored what she was really worried about; I guess in retrospect that she was frightened of cancer, given her family history and the location of the lump. I could have done that a lot better.*
- *I was hot and flustered and rushing when I called her in. I could have had a sixty second break and grabbed a glass of water; if I had been calmer then this consultation would have been much quicker*

What will I do next time if this arises?

- *I will try and notice the waiting time and waiting room temperature, and comment on this to patients when I introduce myself.*
- *I think next time I will ask the angry patient if she would like a cool glass of water and get her and me one, that quick break will be enough for me to regain my composure.*

Example 2

What happened?
I saw a patient for emergency contraception in a busy clinic, took a brief history and gave her Levonelle. I passed her on to a colleague to advise on on-going contraception. The colleague later informed me that the patient had been taking St John's Wort, and so they had doubled the dose of emergency contraception as it was an enzyme inducer.

What was I thinking? Feeling?
I was feeling a bit flustered and was relieved that this seemed like a straightforward consultation where I didn't have to examine the patient or take swabs.

What was good, what was bad about the experience?
Although I asked about medication, I did not elicit that the patient was taking St John's Wort. I did refer the patient on appropriately for longer term contraception.

What sense can I make of the situation?
In retrospect I have been a little blasé about prescribing emergency contraception, and didn't think enough about cautions and contra-indications. My medication history and knowledge around this subject may be poorer than I believe.

What other options are there that I could have done?
I could have asked about over the counter / non-prescription medications as well as prescribed medications.

What will I do next time if this arises?
As above
Action planning based on this

- *In the next month, I will do the e-Learning for Healthcare sessions about prescribing progesterone-only contraception including Levonelle.*
- *Every time I take a medication history over the next month I will also ask, "Do you take anything else from the pharmacy, from the health food shop or the gym? Any other pills, patches, drinks or creams?" and see how many times this yields additional information.*

References

1. Hodges B. Medical education and the maintenance of incompetence. Medical Teacher 2006: 28 (8): 690-696.
2. Moon JA. A handbook of reflective and experiential learning: theory and practice. London: Routledge Falmer, 2004.
3. Evans D, Brown J. How to succeed at medical school: an essential guide to learning. Oxford: Wiley-Blackwell, 2009.
4. Jarvis P, Holford J, Griffin C. *The theory and practice of learning*. 2nd ed. ed. London: Kogan Page, 2003.