

## **Guidance notes for Trainee and Trainer in Palliative Medicine for the Record of Reflective Practice**

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***This replaces previous guidance***

### What is reflective practice?

Reflective practice is an educational idea which has had a large impact on professional training. It is viewed as an integral component in a competent professional and important in medicine in the western world (Australian Medical Council 2009; National Alliance for Physician Competence 2009; General Medical Council 2006, 2009). There is a considerable body of work discussing reflection including a journal dedicated to the subject (Reflective Practice, published by Routledge).

Reflection helps professionals understand the theories, values or assumptions underlying what they do, recognising that individuals are not impartial self observers, that language and power influence reflection and that it can challenge organisations and assumptions: doctors are not robots managing patients but individuals influenced by surroundings and internal workings (Fook 2007).

If experience is not to be 'making the same mistakes with increasing confidence over an impressive number of years' (Driessen 2008) doctors need to learn from professional experience within palliative medicine so that in a similar situation in the future they are able to act, think or feel differently (Tate 2004). Reflecting is one way to do this. It is not simply discussing what happened, it is critically examining why something was done and what may be done differently in the future.

### Why reflect as a palliative medicine trainee?

Palliative Medicine has unique challenges which may focus thoughts and actions on subjects that might not have been confronted previously. Dilemmas are not uncommon and individuals often have to cope with strong emotions from their patients and themselves. The speciality is based on individual care; what is right for one patient may not be right for another. This messiness of clinical practice can be demanding. Reflective practice is one way to recognise and explore these difficulties to enable more effective learning from experience and perhaps prevent burnout and stress (Novack 1997).

Informal reflection does occur, the discussion of the difficult patient in the corridor or quick conversation between patients on the ward round, but it is difficult to critique and hard to know if it impacts on learning or practice.

### What should be reflected on?

What is useful to be reflected on will vary between individuals but the most valuable scenarios are ones which are difficult or have left individuals feeling uncomfortable or unsure of the best management or best response to a situation, a 'disorientating dilemma' (Mezirow 1981).

### How to formally reflect

There are many tools used to enable professionals to reflect but key to all are the importance of being guided - to challenge and support there needs to be a facilitator (Artherton 2010; Johnson 2010; Mann 2009; Sandars 2009, Snadden 1998; Hatton 1995). This can be your supervisor but does not have to be, it could be someone approved by them such as an experienced nurse. It is hoped this may help some trainees reflect on scenarios that they feel highlight poor performance but are likely to have a large number of useful action and learning points. It is expected that trainees will be 'wise, compassionate, non - judgemental observers of their own experience' (Tate 2004)

The guide that is being used is IDEA (see p3), this is based on a discussion of a scenario with a facilitator leading to a definitive action plan or learning points.

These are the steps in the process.

- Step 1 of IDEA: Identify a 'disorientating dilemma'
- Step 2 of IDEA: Synopsis written and given to facilitator, max 500 words
- Step 3 of IDEA: trainee reflects alone and writes supporting notes then meets with facilitator and discusses 30-45mins
- Step 4 of IDEA: action/learning points agreed with facilitator during the discussion
- Synopsis and action/learning points go on eportfolio to support curriculum sign off

Trainees are required to do 2 scenarios a year. They can be used to highlight learning needs, show skills to meet specific curricula competencies, direct training and inform appraisal. They can be on any aspect of practice - not just clinical cases.

The format will be reviewed and feedback welcomed.

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## Appendix 1

### Resources for use with reflection or learning journals

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This is the resources section from my new book on learning journals and their use – Learning Journals – a handbook for reflective practice and professional development (Routledge Falmer, 2006 – second edition). The material in this section may be freely photocopied, though it would be appreciated if the author’s name and the source of the copy were included.

#### GP’s story

##### Account 1

Early January – it is always like that – cold outside, hot and airless inside and the post Christmas ailments come pouring in. I had had a bad night. Our 17-year old had gone out clubbing with her friends and phoned at 2.00am, unable to find a taxi - would one of us come and get her. As soon as the phone was down, Julia, my wife, plausibly argued the case for staying in bed because of her teaching day the next day. (What about my long list in the surgery today?). I didn’t argue – just got up and went. It was hard getting up in the morning and it was a particularly long list of the worried well, with coughs and colds and ‘flu’ being used to hide their family discords and boredoms with work. I’m cynical – OK.

I was getting towards the end when the door opened on Marissa. She came in, – hunched shoulders, grey faced as usual – and clutching her bag in that peculiar way. She is 30, but always manages to look twice her age. Our practice is well aware of Marissa and her aches and pains. I was a bit surprised to see her because she had not been on the list when I first saw it this morning so that meant that Trisha, our receptionist, must have squeezed her in. Trisha’s expertise at judging who needs to be ‘squeezed in’ is usually accurate and would not usually include the heart sinks like Marissa.

I welcomed Marissa in. She had a wrenched shoulder this time and she said that it had happened when she was lifting a bed in her mother’s house. It was a slightly unusual one for Marissa. She was more of the tummy-ache and headache brigade. I had a quick look and prescribed painkillers. I typed the prescription and looked up, expecting the relieved look, but it was not there and she asked me if the painkillers would really take away the pain. I was a bit perplexed and I asked her why she had been moving furniture. She started to tell me how she had decided to move back to live with her mother. In my tired state at this end of the morning, I prompted questions about her family relationships and she seemed to open up. I felt I was doing the right thing – even felt noble about giving her the time on that morning, but I knew I was not very ‘sharp’ about it. I thought that just letting her talk for a few moments was probably helpful to her.

Marissa had been born long after the other children and felt as if she had been seen as a nuisance, particularly by her mother. But now she could not cope alone and was moving back in with this cold mother. I had got her talking and I brightened, thinking I was doing a good job. I wondered why I had not let this talk flow before. We ran out of time, and I asked her to come back to talk more. I was thinking that we might be able to get on top of these recurrent visits to the surgery.

I did actually feel better after seeing her. My attitude to my 'success' with her changed the next week. Marissa did come back – but not to me. She chose to come back when Geoff, the senior partner, was on. She was still complaining about the shoulder and she told Geoff that I had obviously thought that her shoulder was to do with her family – but it was not and she needed more than painkillers. Looking at the shoulder, Geoff agreed with her and referred her for physiotherapy. This little incident has perturbed me a bit. It stirred up my professional pride. I had thought I was doing a good job.

## Account 2

There was a recent event that made me think a bit about the way I see patients and the manner in which I work with them. I'd had a short night and there were some bad feelings around at home. It was difficult to feel on top of the job and to cap it, was also early January. We tend to get into the surgery lots of patients with the after effects of the Christmas period then – the colds, the 'flu's and those who do not want to go back to work. All this makes me irritable when the lists of genuinely ill patients are almost too long to manage. I am not sure how much this generally bad start had to do with the event – how much has my own state to do with how I function?

So it was the end of this particularly long morning when Marissa walked in. Marissa had not been on the list that I had seen earlier and I was surprised that Trisha (the receptionist) had added her – since it is the 'genuinely' ill patients who are added once the list has been made up. Marissa is a regular with minor aches and pain. Sometimes there is just not time for these patients - but how do we solve that? I welcomed Marissa. She was pale and hunched as usual. She told me that she had a wrenched shoulder from when she had been moving a bed in her mother's house. I had a quick look: I had probably diagnosed a simple muscular sprain even before I examined her shoulder. I made out prescription for painkillers. When I looked up, she was still looking at me and asked if the painkillers would really take the pain away. I was surprised at her question – and clearly should have taken more note of it. Instead, I launched into a little bit of conversation, hoping to shift on to the next patient quite quickly. I asked her why she had been moving furniture and she started to tell me how she could not cope alone any more and had decided to move back in with this mother who did not seem to care for her. As she talked, I thought that she seemed to brighten up and I felt that I must be on a helpful track. I wonder now if I brightened up because I thought I was being helpful for this patient. We ran out of time and she agreed to come back the following week to discuss it all further. I was hoping after that to pass her on the counsellor and we might be able to sort something out that would prevent the recurrent visits.

I felt better in myself after the session. It felt like one of those times when the professional work is going well. Trisha even commented that I looked brighter. 'Yes', I said, 'I did some good work this morning with Marissa'. I wished I had not said that.

Marissa did come back, but she came back at a time when Geoff, the senior partner, was on. She said to Geoff that I had been asking her all sorts of questions about her family and that what she wanted was help for her shoulder. She said that the painkillers were no good – and she had known that at the time I had prescribed them - hence, I suppose, the comment that she had made. Geoff had another look at her shoulder and was not happy about it. He referred her for physiotherapy. And then he told me all about the session with her and I felt very responsible for my mistake. I did not say anything to Geoff about how I had been feeling that morning. It felt relevant but perhaps I should be superhuman. When I look back

on this incident, I can see that there are things that I can learn from it. There are all sorts of intersecting issues and feelings tangled up in there. Life is so difficult sometimes.

### Account 3

A particular incident in the surgery has bothered me. It concerns Marissa, a thirty year old woman who visits the surgery regularly for minor complaints (abdominal discomfort / headaches). She presented with a wrenched pain that was incurred when she was moving a bed in her mother's house. I diagnosed a muscular strain and prescribed painkillers. I suppose that I assumed that because it was Marissa, it was likely to be similar to her usual visits and that she may need little more than a placebo. She came back to the senior partner, Geoff, a few days later saying that I had not taken her shoulder seriously enough. He examined her and referred her for physiotherapy, as I can now see as appropriate management.

The event stirred up a lot of other things. The context was important. It was a January morning with the surgery full of worried well with 'flu's and the post-Christmas traumas. I came in tired and irritable because of family issues at home. Marissa was not on the list to start with. Trisha (our receptionist) added her because she judged that she needed to be seen that morning. Instead of taking note of Trisha's excellent judgement, I took this as a usual visit. This was a cue that I missed. Trisha knows Marissa and knows her behaviour when she books an appointment. She recognised this as different. This is an aspect of the teamwork that we aspire to in the practice.

Marissa came in and I did look at her shoulder – but I know that I had already made a judgement about it before I examined her. This was Marissa, looking, as usual, pale and hunched – and I saw any symptom as an expression of her state and nothing else. My look at the shoulder was an irrelevant act in the circumstances. I think about the many discussions of how easy it is to get misled by preconceptions and there was I doing just that. I can see that I should have taken the shoulder more seriously. Marissa, herself, asked if the painkillers were all she needed. What would it have taken for Marissa to have said to me that I was on the wrong track that day, and to have brought my attention back to her shoulder? I wonder if she knew that I was feeling 'off' that day. I suppose I did respond to Marissa's persisting discontent by launching into questions about her family situation – in particular her relationship with her mother and why she was going back to live there – things that later Marissa said were irrelevant.

When I stand back now and think of the event like a film, I can see how I was wrong-footed when Marissa questioned the initial prescription and did not seem any happier as a result of getting it. I just grabbed at the story she had given me. When she seemed willing to talk more about her family, I turned it to my favour – seeing myself as 'obviously' being helpful. That day, I think I needed to feel successful. If I am utterly cynical, I would say that I used Marissa's situation to alter my mood. But then again, I suppose, that in turn might have helped the patients whom I saw after her that day.

I need to think, too, about Geoff's role in this and about my relationships with him and the rest of the team. I am the most junior and I tend to look up to them. I suppose I want to impress them. I could talk this one over with Steve, one of the other partners, he might see it all differently.

**Account 4**

I write about an incident that continues to disturb me. I have gone over it several times and my perspectives seem to change on it – so I talked it over with Steve (one of the other partners) to see how he saw it. The incident concerns Marissa, a thirty year old woman who visits the surgery frequently with various aches and pains (mostly tummyaches and headaches). The symptoms have never been serious, though she never looks well, nor does she seem happy. On this visit she presented with a wrenched shoulder which she said resulted from moving a bed. I did a brief examination and prescribed painkillers. There still seemed to be something bothering her so I engaged her in conversation about her family relationships (this arose from the circumstances of moving the bed). I thought she was responding well and we might be getting somewhere. Time ran out and I invited her to continue the conversation next week. I wanted to get her to a point where I could easily refer her to the practice counsellor. She agreed to come back - but came back to see Geoff, the senior partner, still complaining about the shoulder. He gave her a more detailed examination and referred her for physiotherapy. He told me that she said that I thought that her family was the problem when it really was her shoulder.

I can see that the shoulder was a problem and I missed it and misconstrued the situation, engaging in the talk about her family. This was a multiple mistake. I did not pay attention to Trisha's judgement in adding Marissa to the list, I missed the shoulder problem itself when I examined it, but I also missed the cues that Marissa gave me when she was not happy with the prescription. But I was tired and out of sorts – not as sharp as I need to be when I am with patients. I am human, but I am a professional human and professionalism dictates that I should function well. I suppose that the problem was not so much that I missed one – or even two cues – then I could have put things right. I missed all three at the same time.

I then headed off on the wrong track – getting into the discussion that I assumed was relevant about her family. I think of a consultation with our local GP when I was 14. I did not agree with his diagnosis about my foot - he just said I should come back in four weeks if it was not better. I did not say anything then, though I knew in myself that it needed treatment. I ended up in plaster for six weeks. There is a power thing there. Looking at it from Marissa's point of view, she may have known that I was on the wrong track, but she probably would not have been able to do anything about it because I am a doctor. Someone like Marissa would not question a doctor's judgement at the time. How often were principles like this drummed into us at medical school – and yet it seems so easy to ignore them.

There is something more there too, though – this is what Steve suggested. That day, maybe I needed to feel helpful even more than usual – I needed more satisfaction from the situation so I was looking for cues from Marissa that suggested that she was pleased with me. I had to make do with the cue that suggested that she was no longer unhappy and I suppose I made up the rest – thinking that the conversation about her family was helpful. Maybe I can be more self critical when I am in a better mood and less tired. Maybe I need less and can give more then.

It is possible, of course, that the conversation was not wrong in general, but wrong for that time. It may be helpful to her in the longer term – I just need to wait and handle the situation more mindfully when she comes back.



I can see that there are lots more issues in this – for example, I need to consider why I was so disturbed by the incident. I know I made a mistake, but I think if it had been Steve whom Marissa had consulted, I would not have been so bothered. It was worse because it was Geoff. Steve would have mentioned it and laughed. Once we have discounted serious symptoms it is not unusual to rely on patients returning quite quickly if they feel that a symptom is not disappearing in response to initial treatment. Geoff preached a bit and I responded by getting into my 'I am only junior' mode.

**So what have I learnt?**

- I am apt to see things differently when I am tired.
  - I should pay attention to Trisha's judgements. She is the point of first contact and is pretty experienced in perceiving a patient's needs.
  - I should be more aware about the power issues and how they silence patients. Maybe there are ways in which I can deal with this better. I will think on this.
  - It was really useful talking the matter through with Steve. Hearing what I said to him enabled me to get it better into perspective and to see the issues in different ways.
  - .....Etc etc etc (more issues listed).
- Or what are the key themes, practical, theory and emotion that influenced actions, what guidance and resources are there and future practice (Fade)

## Appendix 2

### IDEA

These questions are a guide to support facilitated reflection. All of the questions will not be appropriate all of the time.

1. Identify an event or situation which has caused you to have uncomfortable thoughts or feelings: a disorientating dilemma (Mezirow).

2. Describe the situation

What happened?  
Who was involved?  
What were you trying to achieve?

3. Evaluate the situation

What thoughts and feelings did you have at the time?  
What did you think and feel afterwards?  
Why did you think and feel that way?  
What sense can be made of the situation?  
What caused you to act in the way you did?  
What other factors affected the outcome?  
What sources of knowledge did you use?  
What other knowledge would have been useful?

4. Analyse any learning which has occurred

Form a list of 'things I have learnt' and an action plan  
What would you do if you were in that situation again?