



Enabling honest reflection: a review

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How can learners face this potential conflict of professional versus legal repercussions?

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 health care 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 UK 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 health care professions, including nursing and clinical therapy specialties, have used reflective practice for decades, so much so that it is now 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 health care 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 members on relevant professional changes. This review incorporates a recent case study that 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 using reflective learning.

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 have argued that there are no prescriptive reflective models, and to assume this is to misconstrue reflective practice;⁹ however, the widely held contemporary view is that reflective practice can and should be taught. Supporting this, Russell 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.*¹⁰

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

Schön, widely considered as the modern architect of reflective

Reflection is important in embedding a culture of openness and empathy

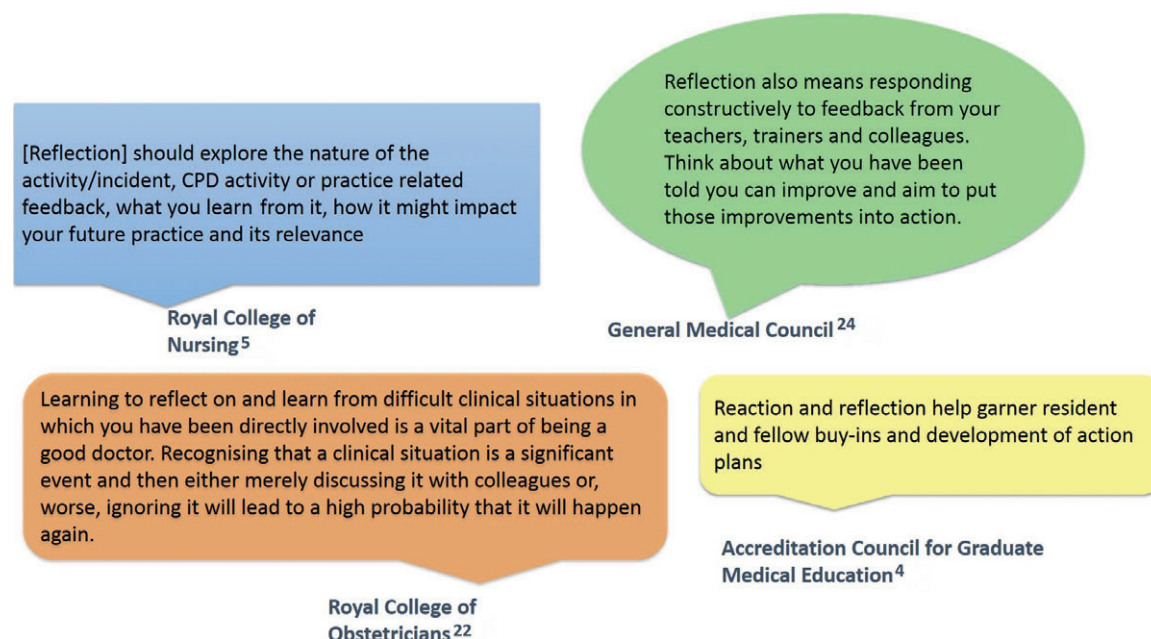


Figure 1. Guidance on how to approach reflective practice from governing and regulatory bodies^{4,5,22,24}

The temptation to avoid reflection in any contentious situation may limit deeper learning

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 health care education.

Dunne et al. performed a review of the reflective teaching strategies used by allied health care, 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.¹³ Although they argue that learners require facilitation to develop critical reflection, there is no consensus over the best model to improve reflective proficiency.¹³ A critical analysis of the different approaches is beyond the scope of this article, but educators should select models that complement their own curriculum, are acceptable to learners and 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 health care 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 undergraduate or postgraduate trainees from any health care 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 e-mail. This reported that the portfolio was 'subsequently used as evidence against the trainee in court', although it was ultimately not used for this purpose.¹⁵ 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 underpins the learner-centred, competency-based curricula with which trainees must engage.^{4,5,12} How can trainees face this potential conflict of legal versus professional repercussions? And how are health care educators to guide their students in this potential professional minefield?

In the UK, documentation about a patient made by a health care 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.

RELEVANCE FOR EDUCATORS

Although 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 the 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 the 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 that creating an account devoid of patient-identifiable data may be virtually impossible when giving an adequate description of the event;¹⁶ however, the heavy reliance on description and narrative,

Table 1. Summary of advice about reflective writing in clinical practice from the Academy of Medical Royal Colleges¹⁹

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 that 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 others 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 colleague.
Consider taking part in other educational activities	In the event of serious incidents, assist in significant event analyses and any educational activities that 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 learned.

history, demographics and details of the team members involved, may not be necessary for critical analysis.

The description of the event is only a small part of the educational process

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 establish the expectations of learners and the level of reflection anticipated from them.²⁰ This can include lessons learned, the applicability to other similar settings and an achievable, time-bound action plan.

TAKING A BALANCED APPROACH AND INVOLVING A SENIOR COLLEAGUE

Whereas some students may seize opportunities for reflection, others may require support in selecting the appropriate cases and scenarios that 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

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

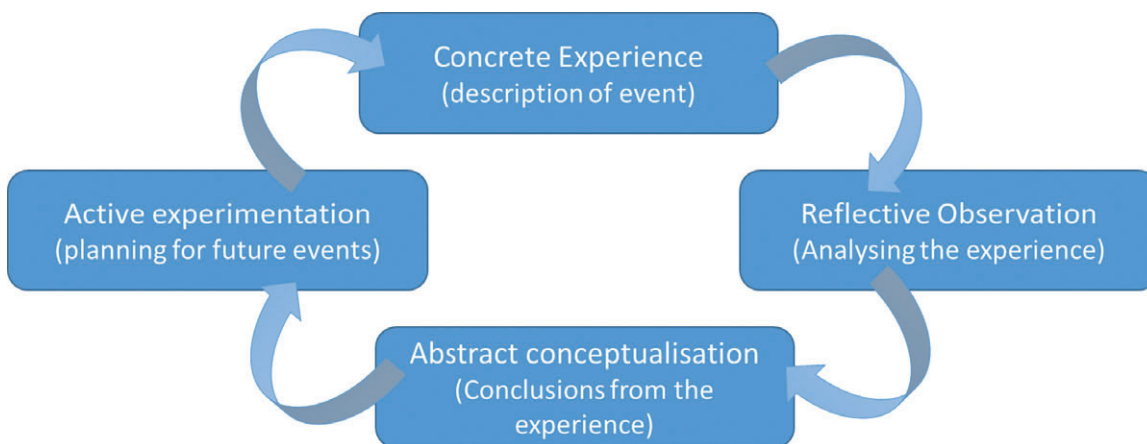


Figure 2. Adapted from Kolb's experiential learning cycle.⁷ Most learning does not take place by describing the event but instead by analysing and making conclusions

Educators and learners should also aim to focus their reflection on what lessons have been learned

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 learned*.¹⁹ This has potential benefits for both the clinician and the 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 on 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 In turn, these activities can provide further experiences on which to reflect, fulfil appraisal and curriculum criteria, and help learners focus on 'what was learned' 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 health care 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 the simple acquisition of skills or knowledge.¹ Most definitions of professionalism refer to the importance of lifelong learning,¹ and governing

bodies emphasise the importance of establishing foundations for this during undergraduate and early postgraduate 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 forums 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

Vivekananda-Schmidt *et al.* showed that students recognise the relevance of reflection.¹⁴ Despite tensions between private and public thoughts, writing was found to be a useful exercise that facilitated deeper understanding. The assessment of reflection was viewed as useful only in the context of developing reflective skills and, furthermore, students sought reassurance that their reflections would remain confidential and would only be 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 the avoidance of addressing contentious issues,¹⁶ or removing learners from early clinical exposure, will have negative implications by 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.

CONCLUSIONS

Reflective practice is an essential activity for health care professionals as it aids the development of professionalism, resilience and experiential learning.^{1,8} Portfolio evidence of deep reflection is also protective following professional mistakes.¹⁹ Although this article is written by British doctors, much of the discussion is transferable to other disciplines as well as to 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 health care 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 helped the learner to develop into a safer, more insightful health care professional.

Reflective practitioners should be aware of contemporary professional and legal guidance relevant to their own context

Table 2. Top tips for enabling honest reflective practice

Tip	Educational rationale	Advice
Place less emphasis on narrative	<ul style="list-style-type: none"> • Define reflection and what is expected from students²⁰ • Place greater emphasis on the other steps of Kolb's learning cycle 	<ul style="list-style-type: none"> • Avoid detailed descriptions that could include patient or colleague identifiable information¹⁹ • Tutors and students/trainees should use written portfolios as educational tools only, focusing on learning • Should learners wish to follow-up patients, patient-identifiable information should be kept separately to educational outcomes within the portfolio
Base reflections on appropriate clinical experiences	<ul style="list-style-type: none"> • Reflective ability is more easily developed following meaningful clinical experience¹⁴ 	<ul style="list-style-type: none"> • Developing deep and critical reflection aids learning from errors and is supportive in fitness-to-practice cases¹⁹ • Integrate early clinical exposure and reflection within the curriculum²⁰ • Reflection based on clinical experience provides evidence for competency-based curricula²⁻⁴
Tutors should teach by role modelling and operate an open-door policy for troubleshooting	<ul style="list-style-type: none"> • Tutors should role-model and 'champion' good reflective practice, exhibiting deep and critical reflection¹⁴ • Tutors should be flexible to guiding some students towards appropriate cases, when needed²¹ • Tutors should be aware and able to discuss difficult cases that may cause negative emotions in the learner²⁰ 	<ul style="list-style-type: none"> • Reflections, particularly around clinical errors or contentious issues, should always be discussed with a senior colleague
Take a balanced approach	<ul style="list-style-type: none"> • Overly inward-looking reflections concentrating on negative aspects of learner's behaviour or skills can act as a barrier towards learning²¹ 	<ul style="list-style-type: none"> • Avoid being judgemental of yourself or others when reflecting • Avoid reflections in the heat of moment • All incidents should be discussed with a senior colleague or tutor prior to formal documentation (see above)¹⁹
Ensure methods for formative feedback and privacy for reflective writing	<ul style="list-style-type: none"> • Provide a method by which learners can have formative feedback on their reflections in order to develop critical reflection • Consider who has access to these reflections to allow students to reflect in an uninhibited way^{14,20} 	<ul style="list-style-type: none"> • Ensure that the institution is working within local and national data protection policy²⁰ • Seek consent from students if reflective assignments are used for any other purpose • If a third party requests access to a portfolio, seek advice from your medical indemnity organisation¹⁹

Reflection should focus on how clinical events have helped the learner to develop into a safer, more insightful health care professional

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