



the **reflective practitioner**

Guidance for doctors
and medical students

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Contents

3. Foreword

4. Being a reflective practitioner

- Why being a reflective practitioner is important
- Approaches to reflection
 - A toolkit to support reflection
 - What? So what? Now what?

6. Demonstrating reflection

- Documenting reflective thinking
 - Medical students
 - Doctors in training
 - All other doctors engaging in revalidation and appraisal
- Anonymising details in reflections
- Documenting reflections is not the same as reporting serious incidents
- Being open and honest with patients

10. Disclosure of reflective notes

- Disclosing records to the courts
- Reflective notes and GMC fitness to practise concerns

12. References and further reading

Foreword

Medicine is a lifelong journey, immensely rich, scientifically complex and constantly developing. It is characterised by positive, fulfilling experiences and feedback, but also involves uncertainty and the emotional intensity of supporting colleagues and patients. Reflecting on these experiences is vital to personal wellbeing and development, and to improving the quality of patient care. Experiences, good and bad, have learning for the individuals involved and for the wider system.

This short guide supports medical students, doctors in training and doctors engaging in revalidation on how to reflect as part of their practice. It has been developed jointly by the Academy of Medical Royal Colleges, the UK Conference of Postgraduate Medical Deans (COPMeD), the General Medical Council (GMC), and the Medical Schools Council.

Ten key points on being a reflective practitioner:

1. Reflection is personal and there is no one way to reflect. A variety of tools are available to support structured thinking that help to focus on the quality of reflections.
2. Having time to reflect on both positive and negative experiences – and being supported to reflect – is important for individual wellbeing and development.
3. Group reflection often leads to ideas or actions that can improve patient care.
4. The healthcare team should have opportunities to reflect and discuss openly and honestly what has happened when things go wrong.
5. A reflective note does not need to capture full details of an experience. It should capture learning outcomes and future plans.
6. Reflection should not substitute or override other processes that are necessary to record, escalate or discuss significant events and serious incidents.
7. When keeping a note, the information should be anonymised as far as possible.
8. The GMC does not ask a doctor to provide their reflective notes in order to investigate a concern about them. They can choose to offer them as evidence of insight into their practice.
9. Reflective notes can currently be required by a court. They should focus on the learning rather than a full discussion of the case or situation. Factual details should be recorded elsewhere.
10. Tutors, supervisors, appraisers and employers should support time and space for individual and group reflection.

Being a reflective practitioner

The Academy of Medical Royal Colleges and COPMeD define reflective practice as **‘the process whereby an individual thinks analytically about anything relating to their professional practice with the intention of gaining insight and using the lessons learned to maintain good practice or make improvements where possible’¹**

Why being a reflective practitioner is important

Reflection empowers medical students and doctors to:

- demonstrate insight by identifying actions to help learning, development or improvement of practice, developing greater insight and self-awareness
- identify opportunities to improve quality and patient safety in organisations.

There is a strong public interest in medical students and doctors being able to reflect in an open and honest way.

Approaches to reflection

There are no hard and fast rules on how to reflect – it is personal. Both positive and negative experiences can generate meaningful reflections. The approach taken to reflective practice may be influenced by the nature and scope of individual practice, and personal style of learning.^{2,3}

Thinking should be structured to capture, analyse and learn from the experience. A range of different experiences can be reflected on, including clinical events or interactions, complaints or compliments and feedback, reading a research article, attending a meeting, having a conversation with a colleague or patient, team debriefs, or exploring a feeling or emotional reaction.

Teams and groups improve patient care and service delivery when they are given opportunities to explore and reflect on their work together.⁴ These interactions often lead to ideas or actions that improve care across organisations. Group reflection activities should be encouraged by employers and training providers as they provide mechanisms to identify complex issues and effect change across systems.

Time should be made available, both for self-reflection, and to reflect in groups. Supervisors and appraisers also need time to facilitate reflection.

A toolkit to support reflection

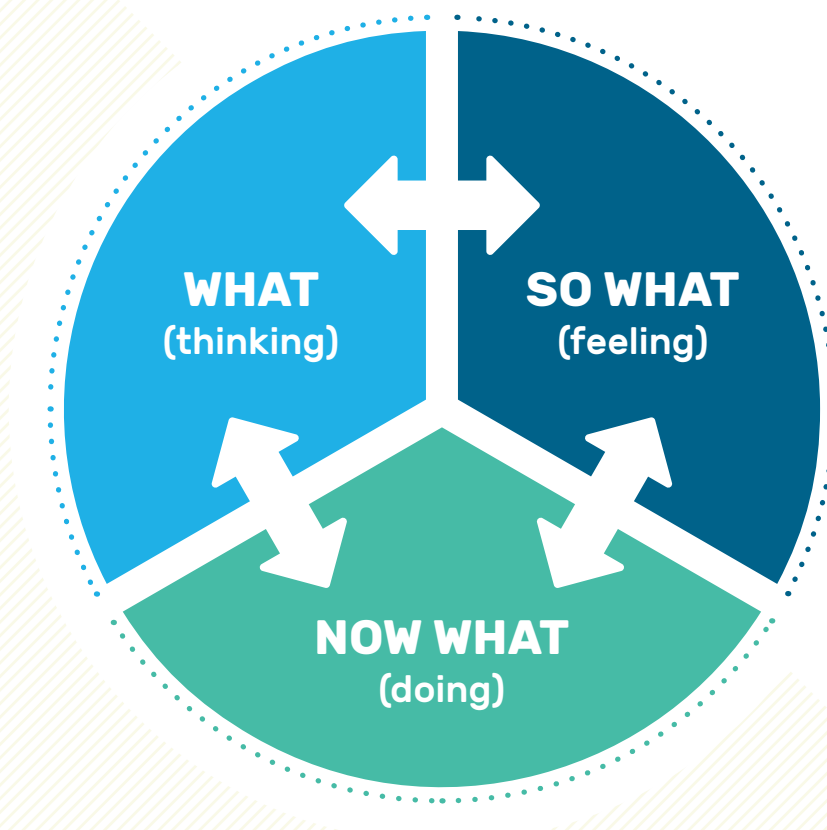
The Academy of Medical Royal Colleges and *COPMeD's Reflective practice toolkit* describes the principles for effective reflective practice and includes a number of templates and examples.⁵ This should be considered alongside this guidance.

What? So what? Now what?

There are many approaches to reflection. The **What? So what? Now what?** framework is one example of a simple way to structure reflections, whether it be of a single event or of a period of time.^{6,7} It could include personal experience, interaction or observation of others and formal/informal learning events.

Key elements in this framework that might be helpful to consider:

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| <ul style="list-style-type: none">• What? focuses on thoughts at the time of an experience. It explores thought processes when a particular action or decision was taken and how those may have impacted on actions and feelings. <p>eg 'What was I thinking when I took the actions or made the decision that I did'</p> | <ul style="list-style-type: none">• So what? involves considering the significance of what happened as well as the values and feelings at the time of and prompted by the experience, and why these may influence future learning or actions. <p>eg 'How did I feel at the time of and after the experience, why was it important?'</p> | <ul style="list-style-type: none">• Now what? looks at the processes and opportunities that can help learning from the experience and identifying future actions, reflection on those actions, and how to use these to develop further. <p>eg 'What can I learn from or do differently next time'</p> |
|---|---|---|



Demonstrating reflection

Sometimes medical students and doctors may want to discuss or write down their reflections, or may be required to as part of their education, training and development.

Documenting reflective thinking

Reflecting helps an individual to challenge assumptions and consider opportunities for improvement.

Developing the capacity to reflect should focus on the reflective process and how to use it productively rather than on a specific number or type of reflective notes.

Engagement in reflection can be demonstrated in different ways, depending on career stage.

Medical students

A medical student, by the time they graduate, must be able to:

- *‘explain and demonstrate the importance of engagement with revalidation, including maintaining a professional development portfolio which includes evidence of reflection’*⁸
- *‘develop a range of coping strategies, such as reflection’* to demonstrate awareness of the importance of their personal physical and mental wellbeing.⁹

This skill is often developed by writing structured reflections, commonly with constructive feedback. These are used as part of the evidence that certain curricular outcomes have been met.

Each medical school will have more detailed guidance explaining how the outcomes can be met for their own curriculum.

The opportunity to reflect in practical and clinical settings is also beneficial.

Doctors in training

Doctors in training, as part of their generic professional capabilities, must demonstrate *‘an ability to learn from and reflect on your professional practice and clinical outcomes’*.¹⁰ This is part of the revalidation requirements for doctors in training.

Doctors in training should discuss the experiences they are planning to reflect on, or have already reflected on, with their clinical and educational supervisors. Discussion assists with the learning aspect of the reflective process to make it more meaningful. It also helps to demonstrate engagement in reflective thinking as an educational and professional tool.

Doctors in training should include insights gained and any changes made to practice in their learning portfolio. Supervisors should confirm in the learning portfolio that the experience has been discussed, and agree appropriate learning outcomes and what actions are planned.

Sharing original, non-anonymised information with supervisors is important, but factual details should not be recorded in the learning portfolio.

Doctors in training (continued)

The ***Gold Guide*** (guidance for postgraduate specialty training in the UK) suggests that educational supervisors should assist in developing the skills of self-reflection and self-appraisal that will be needed throughout a professional career.¹¹

Self-reflective learning logs may be reviewed as part of the Annual Review of Competence Progression (ARCP) process.¹² These should not contain the full details of experiences or events – the focus should be on learning outcomes and action plans.

All other doctors engaging in revalidation and appraisal

Revalidation requires all licensed doctors to participate in regular appraisals that consider information drawn from their whole practice. The GMC's ***Guidance on supporting information for appraisal and revalidation*** explains that reflection is a core requirement for revalidation. It describes how to reflect on learning and development as part of the annual whole practice appraisal.¹³ Doctors in training will demonstrate this by meeting the requirements for their ARCP.

Responsible Officers will normally take account of discussions and reflections considered at annual appraisals or with a doctor's supervisors, when they come to consider their recommendation about the doctor's revalidation.

A doctor should discuss the experiences they have reflected on with their appraiser, and maintain a note of these discussions. The doctor may be asked to record these in an online appraisal or learning portfolio system approved by their organisation. These notes should focus on the learning identified and any planned actions arising from their reflections. Factual details should not be recorded in appraisal or learning portfolios.

Appraisals should also be used to reflect on the most important things learned or changed over the past year.

Responsible Officers and education providers should consider what support is necessary for supervisors and appraisers to help them develop skills in evaluating the quality of reflection.

Anonymising details in reflections

Anonymised information will usually be sufficient for all purposes other than the direct care of the patient, so should be used wherever possible in reflection.

The Information Commissioner's Office considers data to be anonymised if it does not itself identify any individual, and if it is unlikely to allow any individual to be identified through its combination with other data. Simply removing the patient's name, age, address or other personal identifiers is unlikely

to be enough to anonymise information to this standard.¹⁴ The GMC guidance ***Confidentiality: good practice in handling patient information*** supports how to do this.

The GMC guidance ***Confidentiality: disclosing information for education and training purposes*** gives advice to doctors on anonymising and managing personal data in training records, including when it can't be anonymised.¹⁵ The same principles apply to reflective notes.

Documenting reflections is not the same as reporting serious incidents

Reflecting on the learning resulting from a significant event or serious incident is an important part of continuous improvement and a requirement of medical education and revalidation. Reflection cannot, however, substitute or override other processes that are necessary to discuss, record and escalate significant events and serious incidents. See the GMC's ***Guidance on supporting information for appraisal and revalidation*** for details about reflecting on significant events.¹⁶ Factual details should not be recorded in reflective discussions but elsewhere, in accordance with each organisation's relevant policies.

Where there are concerns or questions about the content of reflection, the advice of a supervisor or appraiser should be sought as to whether the information is appropriate. The purpose of the reflection is to indicate learning and, where appropriate, future plans.

The Academy of Medical Royal Colleges' ***Guidance for entering information on e-Portfolios*** recommends that doctors involved in a serious incident should *'set out the narrative on paper immediately so that the events are recorded while still fresh in your mind, but formally documented reflection is probably better done after some consideration.'*¹⁷

Being open and honest with patients

All doctors have a professional duty to be open and honest with patients and those close to them where something goes wrong. See the guidance ***Openness and honesty when things go wrong: the professional duty of candour***.¹⁸ Medical students are expected to follow similar advice in ***Achieving good medical practice***.¹⁹

All members of the healthcare team should have opportunities to reflect on and discuss what has happened openly and honestly when things go wrong in a supportive and confidential setting. This is different to an individual's personal reflections about, and learning from, the incident and what actions they plan to take, but represents a vital aspect of systematic and organisational development.

Disclosure of reflective notes

It should be rare for a reflective note to contain factual details that have not been recorded elsewhere, or already discussed with the patient and/or their family. Reflective notes should focus on the learning, not a full discussion of the case or situation.

Disclosing records to the courts

Recorded reflections, such as in learning portfolios or for revalidation or continuing professional development purposes, are not subject to legal privilege. Disclosure of these documents might be requested by a court if they are considered relevant.

The GMC guidance ***Confidentiality: good practice in handling patient information*** says that information must be disclosed if it is required by statute, or if ordered to do so by a judge or presiding officer of a court.²⁰

The guidance explains that, if disclosure of confidential patient information is required by law, 'you should:

- *satisfy yourself that personal information is needed, and the disclosure is required by law*
- *only disclose information relevant to the request, and only in the way required by the law.'*²¹

Where a disclosure request is received, the owner of the learning portfolio or other reflective note should seek advice from their employer, legal adviser, medical defence organisation or professional association.

Reflective notes and GMC fitness to practise concerns

The GMC does not ask a doctor to provide their reflective notes in order to investigate a concern about them. The GMC's focus in a fitness to practise investigation is on facts and evidence relating to a serious allegation. Following a significant event or a serious incident, factual details should not be recorded in reflective discussions but elsewhere, in accordance with each organisation's relevant policies.

Evidence of insight and remediation may reduce the need for the GMC to take action. It plays an important role in how the GMC assesses whether a doctor's fitness to practise is impaired. Doctors are invited to provide evidence of insight and remediation as part of their defence, but whether they do this and the form it takes is for the doctor to decide. The GMC advises doctors to get legal advice before sending any documentary evidence.

References and further reading

1. Academy of Medical Royal Colleges/COPMeD. *Reflective practice toolkit*, 2018.
www.aomrc.org.uk/wp-content/uploads/2018/08/MCJ15414-Academy-ReflectivePractice-Main-v3.pdf
2. Peter Honey and Alan Mumford. *The Manual of Learning Styles*. 3rd Edn, Peter Honey publications, 1992.
3. David Kolb. *Experiential Learning: Experience as the Source of Learning and Development*. Prentice-Hall, 1984.
4. Nina Dutta, Lewis Peake, Jude Tweedie and Andrew Goddard. *Improving teams in healthcare Resource 4: Team development*. Royal College of Physicians, 2017.
5. Academy of Medical Royal Colleges/COPMeD. *Reflective practice toolkit*, 2018.
www.aomrc.org.uk/wp-content/uploads/2018/08/MCJ15414-Academy-ReflectivePractice-Main-v3.pdf
6. Terry Borton. *Reach, touch and teach*. Hutchinson, 1970.
Adapted by Colin Melville 2018
7. Andrew Grant, Judy McKimm and Fiona Murphy. *Developing reflective practice: A guide for medical students, doctors and teachers*. Wiley Blackwell, 2017.
8. General Medical Council. *Outcomes for graduates* (para 2t), 2018
www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/outcomes-for-graduates
9. General Medical Council. *Outcomes for graduates* (para 3c), 2018
www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/outcomes-for-graduates
10. General Medical Council. *Generic professional capabilities framework*, 2017
www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/generic-professional-capabilities-framework
11. COPMeD. *A Reference Guide for Postgraduate Specialty Training in the UK (Gold guide)* (para 4.24iii), 2018
www.copmed.org.uk/images/docs/gold_guide_7th_edition/The_Gold_Guide_7th_Edition_January_2018.pdf
12. COPMeD. *A Reference Guide for Postgraduate Specialty Training in the UK (Gold guide)* (para 4.39x), 2018
www.copmed.org.uk/images/docs/gold_guide_7th_edition/The_Gold_Guide_7th_Edition_January_2018.pdf

13. General Medical Council. *Guidance on supporting information for appraisal and revalidation*, 2018
www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/guidance-on-supporting-information-for-appraisal-and-revalidation/meeting-our-revalidation-requirements---overarching-principles
14. General Medical Council. *Confidentiality: good practice in handling patient information*, 2017 (para 81)
www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/confidentiality/using-and-disclosing-patient-information-for-secondary-purposes
15. General Medical Council. *Confidentiality: disclosing information for education and training purposes*, 2017 (para 14-19)
www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/confidentiality---disclosing-for-education-and-training-purposes/disclosing-for-education-and-training-purposes
16. General Medical Council. *Guidance on supporting information for appraisal and revalidation*, 2018
www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/guidance-on-supporting-information-for-appraisal-and-revalidation/your-supporting-information---significant-events
17. Academy of Medical Royal Colleges. *Guidance for entering information on e-Portfolios*, 2016
www.aomrc.org.uk/publications/reports-guidance/academy-guidance-e-portfolios/
18. General Medical Council. *Openness and honesty when things go wrong: the professional duty of candour*, 2015
www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/candour---openness-and-honesty-when-things-go-wrong
19. General Medical Council. *Achieving good medical practice* (paras 16-19), 2016
www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/achieving-good-medical-practice
20. General Medical Council. *Confidentiality: good practice in handling patient information*, 2017 (para 17)
www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/confidentiality/disclosing-patients-personal-information-a-framework
21. General Medical Council. *Confidentiality: good practice in handling patient information*, 2017 (para 88)
www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/confidentiality/using-and-disclosing-patient-information-for-secondary-purposes

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