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Health Education East of England

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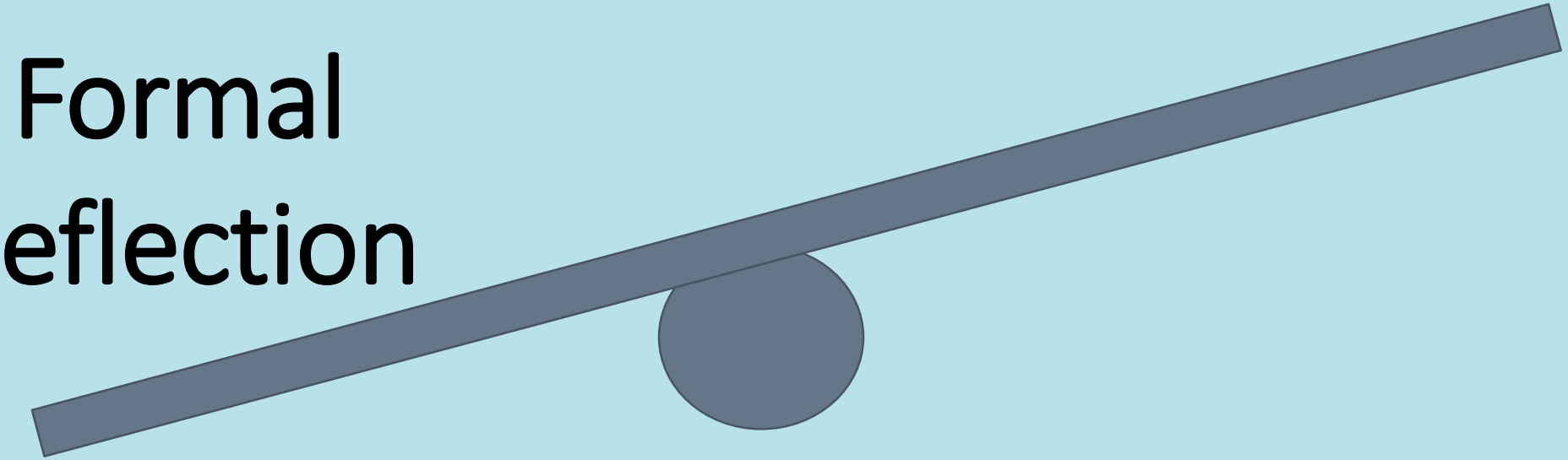
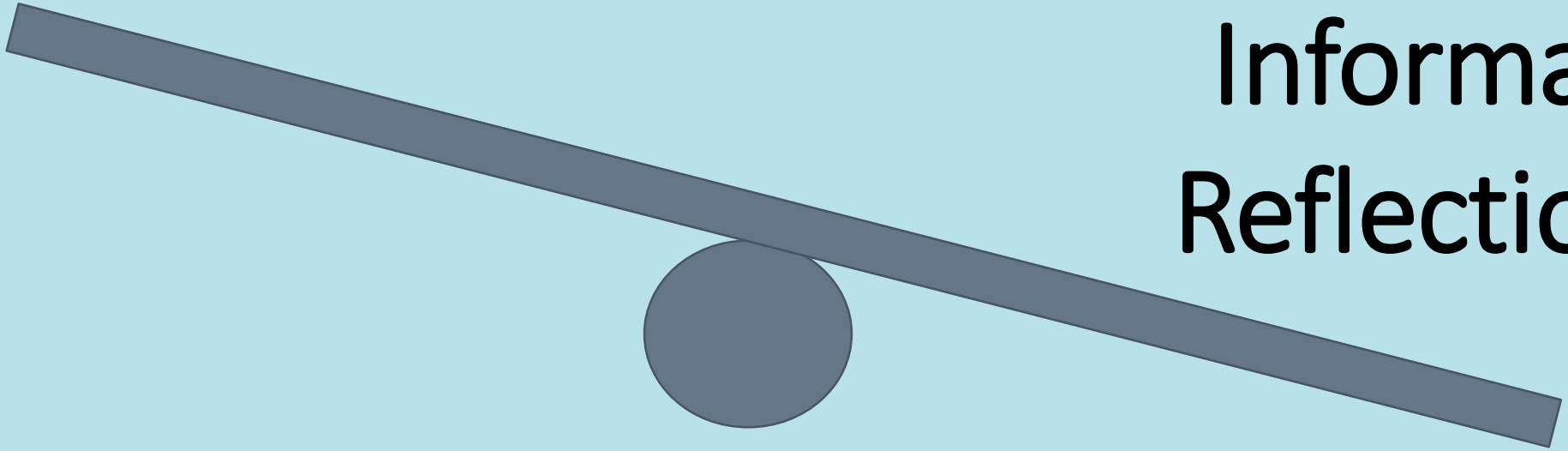
Reflecting on Reflection

Informal Reflection



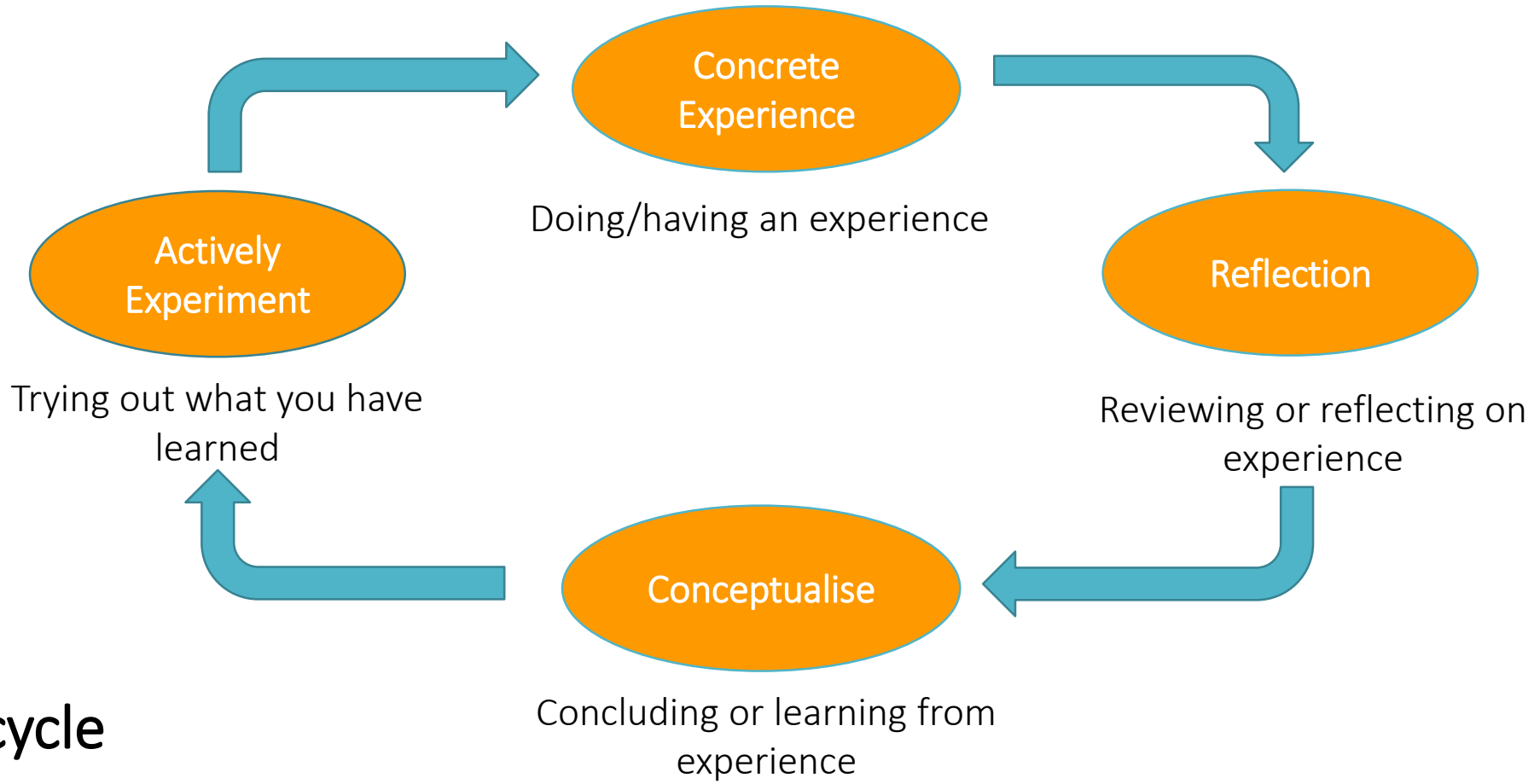
Formal Reflection

Formal Reflection



Informal Reflection

What is reflection?



Kolb's cycle

“The ability to learn from and reflect on your professional practice and clinical outcomes is **essential** for all trainee doctors.”

The General Medical Council

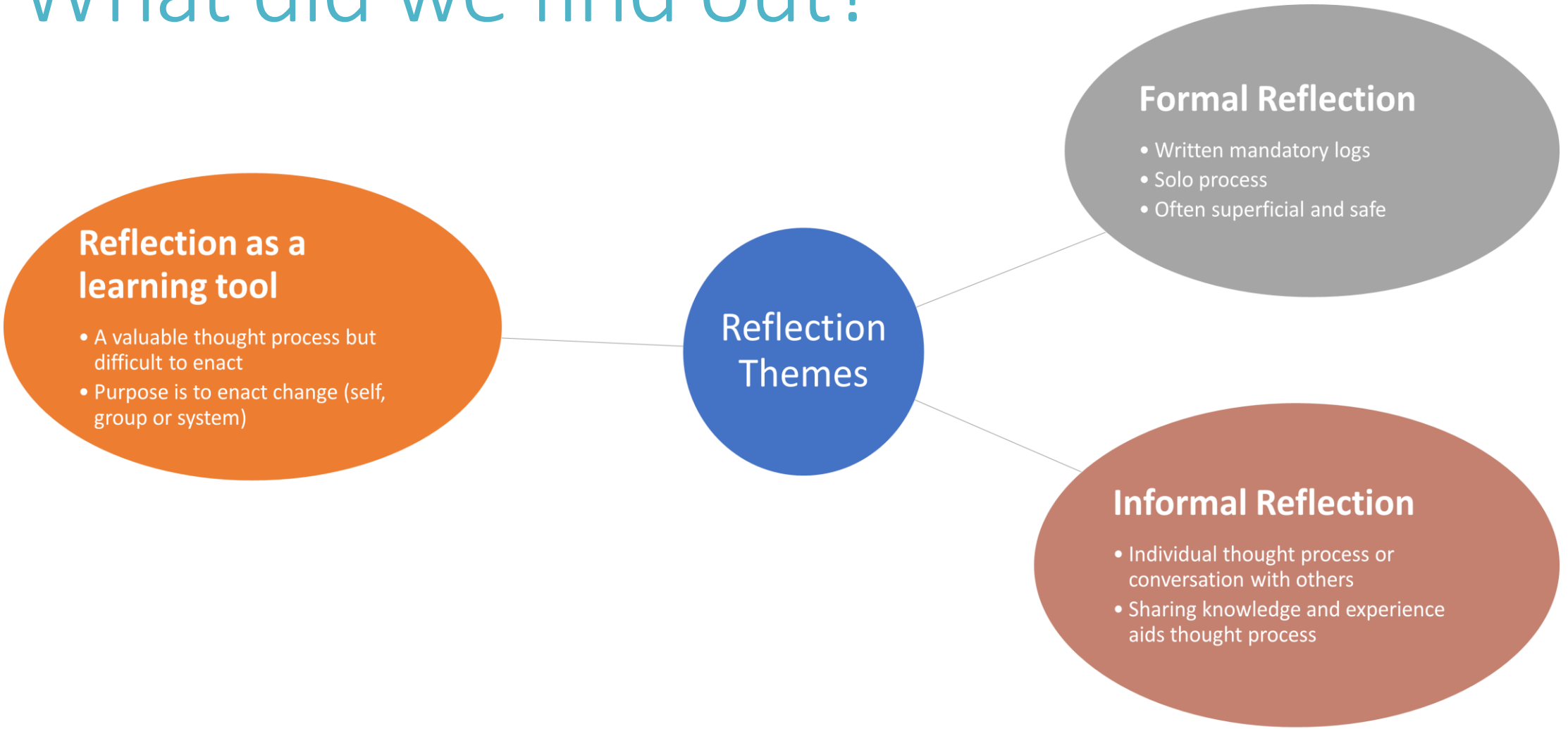
Generic Professional Capabilities

The end of written reflection?

What did we do?

- Invited foundation doctors to participate in focus groups at two EoE NHS Trusts
- Undertook three focus groups, each lasting 45 minutes.
- Semi-structured format.
  - Doctors views on the value of reflective practice
  - The risks and benefits
  - How it could be made better
- Thematic analysis of results.

What did we find out?



What did they say?

Reflection as a learning tool

So I think it's a good way to go back, and actually make yourself go back and try and see if there's ways to improve from that situation happening again, because I don't think it's that easy when you're actually within the moment … B2

... I just think it feels artificial and synthetic. I don't think it feels natural, and I think I self-reflect a lot, and then...I don't know, to have to put that into words just doesn't... to have to actually write it down … it makes it something that it wasn't to begin with for me, and like it changes that event for me. I don't think it's always an accurate portrayal of what happened... C1

Formal Reflection

Informal Reflection

…you're just not sure and you don't quite know what you're missing but obviously there's a piece of the puzzle that you can't work out and you just need someone to point it out to you. Without… And I always find it a bit frustrating when you can't pick up on something yourself unless they point it out to you and then it's really obvious. A2

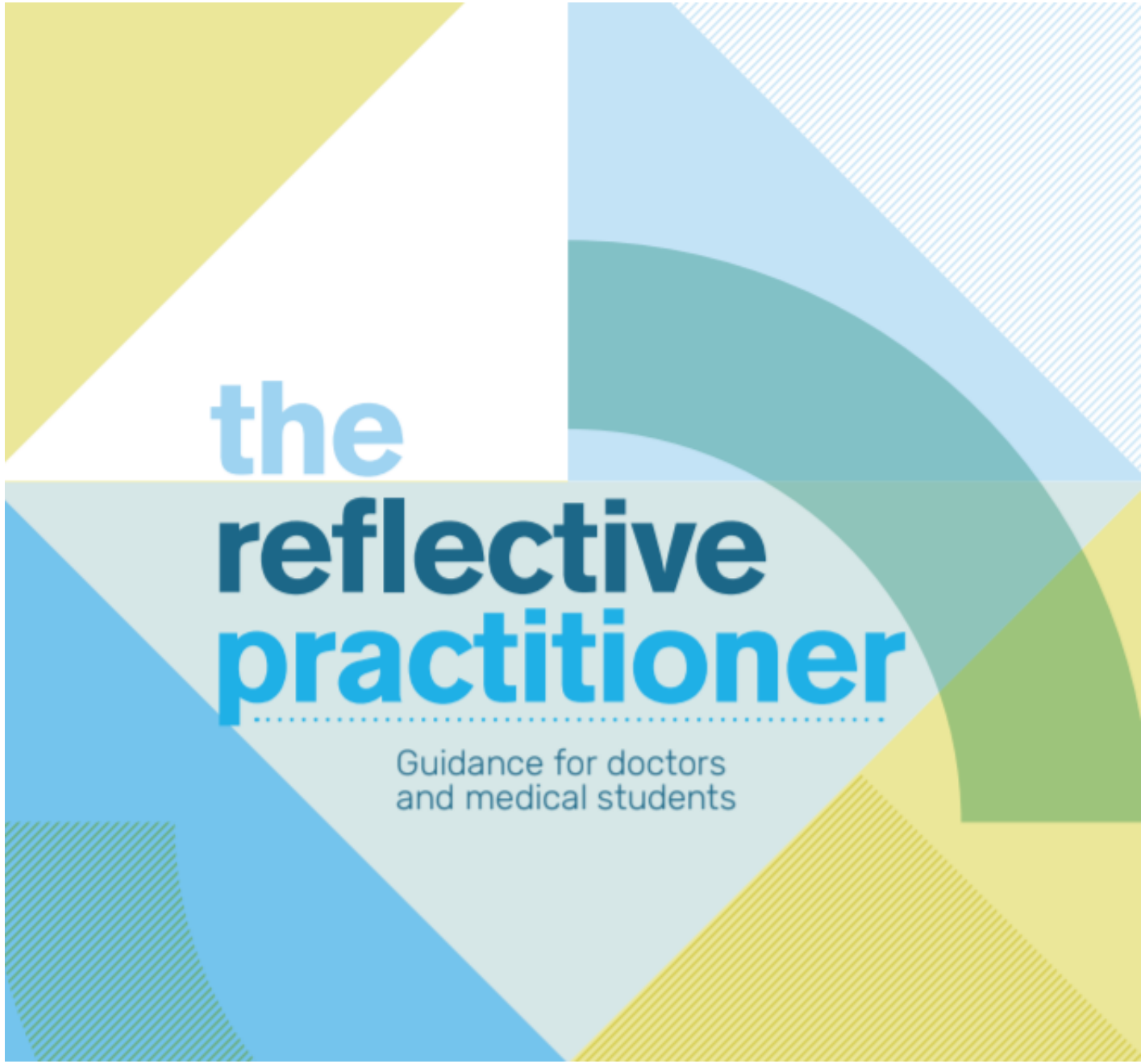
Making a change

- Foundation doctors value **learning from reflective conversations** with more experienced doctors.
    - Reflective learning must be made explicit
    - The value of group learning should be promoted

- **Formalise** the 'informal' reflective encounters.

- **Promote self-agency** within your junior doctors and encourage reflective thinking.

- Ensure junior doctors reflect in a **safe** and **anonymised manner**, in keeping with the **Reflective Practitioner Guidelines.**



General Medical Council
+
Academy of Royal Medical Colleges
+
Conference of Postgraduate Medical Deans (CoPMed)

Ideas for your hospital

- Teach junior doctors how to safely reflect
- Protected time with supervisors and trainees for reflective conversation
- Departmental ‘Balint’ groups or ‘clinical reflective groups’
- Schwartz rounds
- Reflective practice conversation ‘eTickets’

Thanks for listening.

Thanks to:
Mr Ian Grant at Cambridge University Hospitals
East & North Hertfordshire Foundation Team
Dr Nicholas Schindler for his expertise and support
Our EoE foundation doctors who participated in the study

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Evaluation of the educational value of simulated scenarios for Foundation Doctors with a focus on debriefing

Aleksandra Bartnik


89
99
CO2 No Sensor
89
17

Research question

What is the educational value of debriefing in relation to:

- Content and conduct
- Faculty
- Psychological safety

Methodology

Phenomenologial approach concerned with perceptions, experiences and expectations

Combined deductive and inductive approaches

Framework analysis

Questionnaires for 26 FDs as the main source of data

Complemented by focus groups for specific topics

Contrasted with data from 2 interviews with the faculty to triangulate data sources

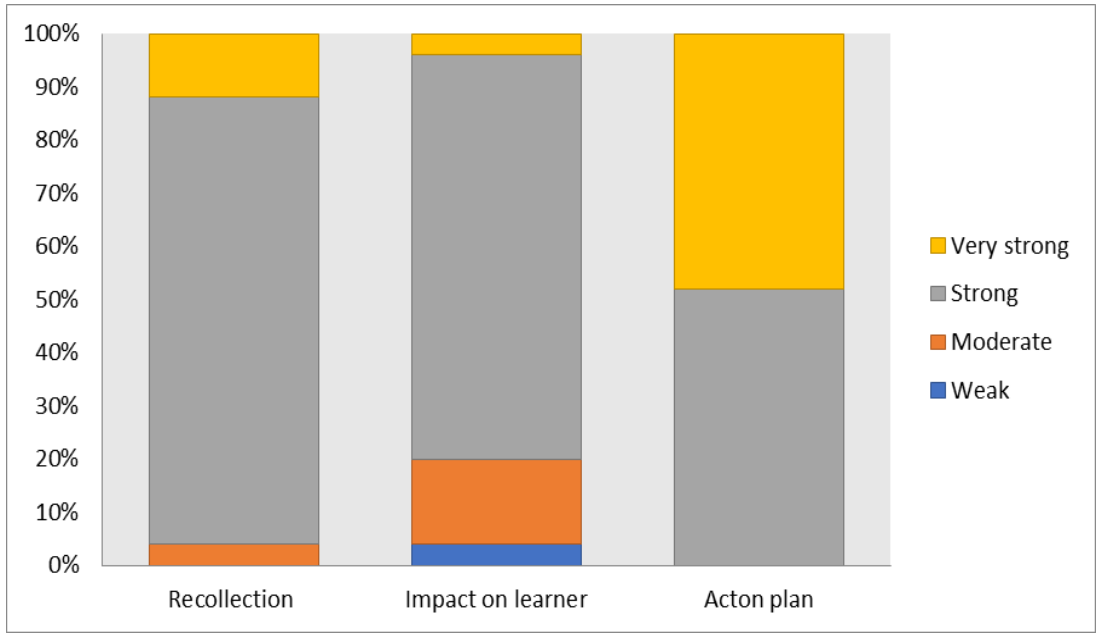
Timing of data collection directly after debriefing sessions

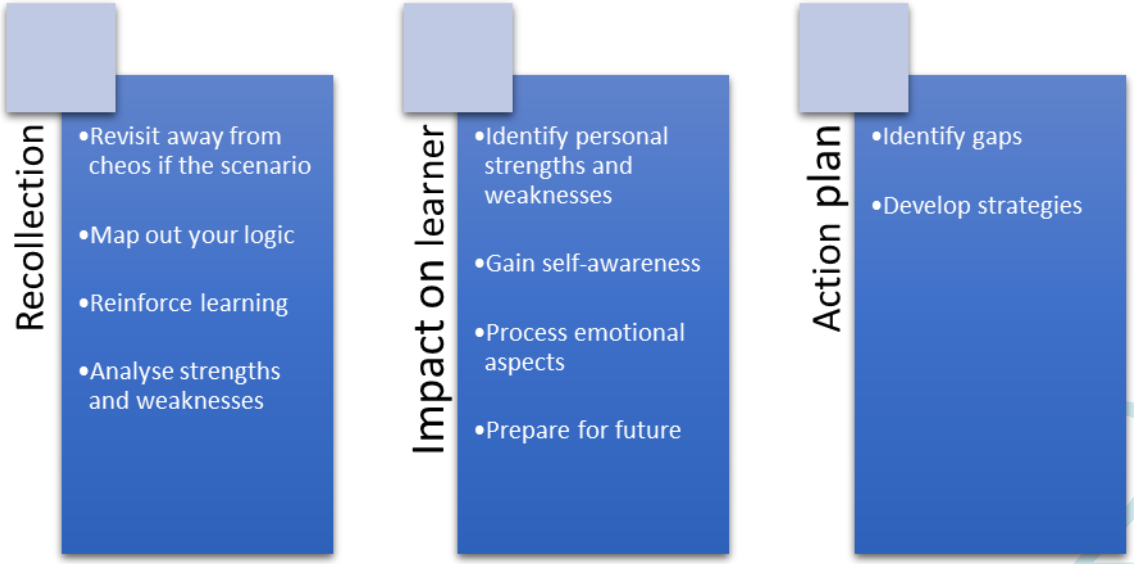
Formal UCL Ethics Committee Approval

Results –

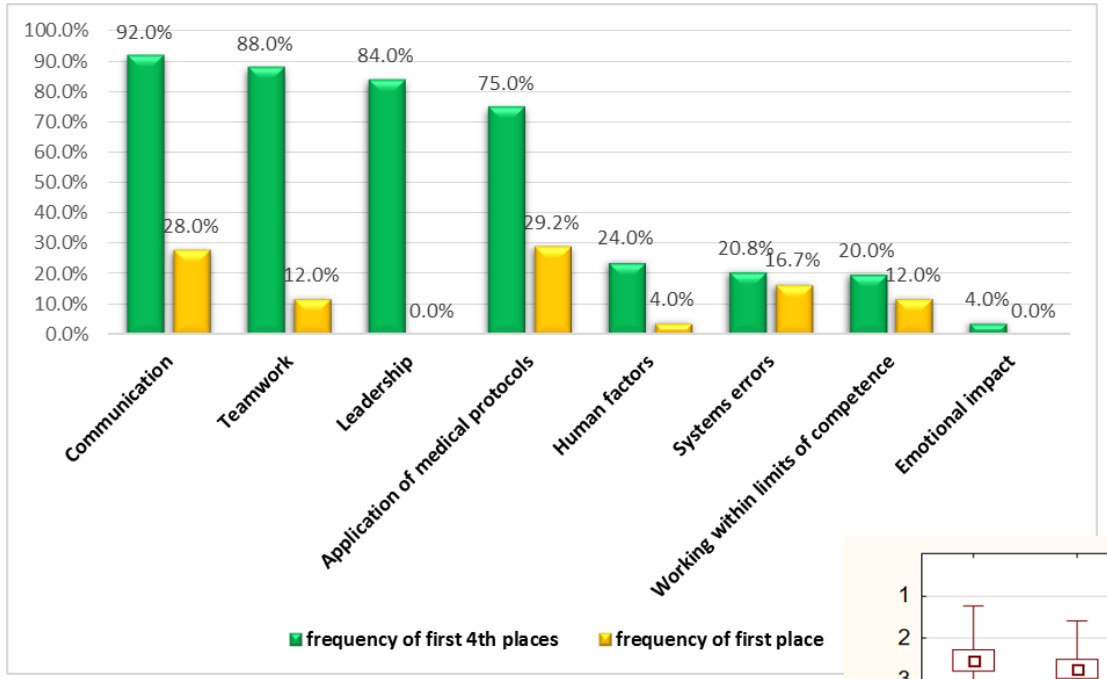
	Content	Conduct	Outcomes	Faculty	Psychological comfort
Foundation doctors	Communications skills, teamwork, leadership and application of protocols are the most important topics The learning points should be general and for everyone	Everyone should be involved in debriefing It should not be overly negative or target individuals Recall in debriefing helps make sense of chaos	The aim of debriefing is to gain understanding and develop strategies	A dedicated lead for debriefing is essential Leaders personality and non-clinical skills are more important than clinical expertise Leader should be amiable and enthusiastic about simulation	Supportive familiar peer group is a single most important factor improving comfort followed by introduction and small size groups A degree of discomfort is common among FDs Stress is inevitable like in clinical work
Faculty	The emotional impact on the learner is the most important topic but technical skills may have to be covered beforehand	Leader and group should be honest with the learner and not provide false reassurance	The aim of debriefing is to encourage participation in simulation and to help learner understand their actions	Faculty is essential for quality debriefing	Learning cannot occur without discomfort Faculty should allow learner to express discomfort

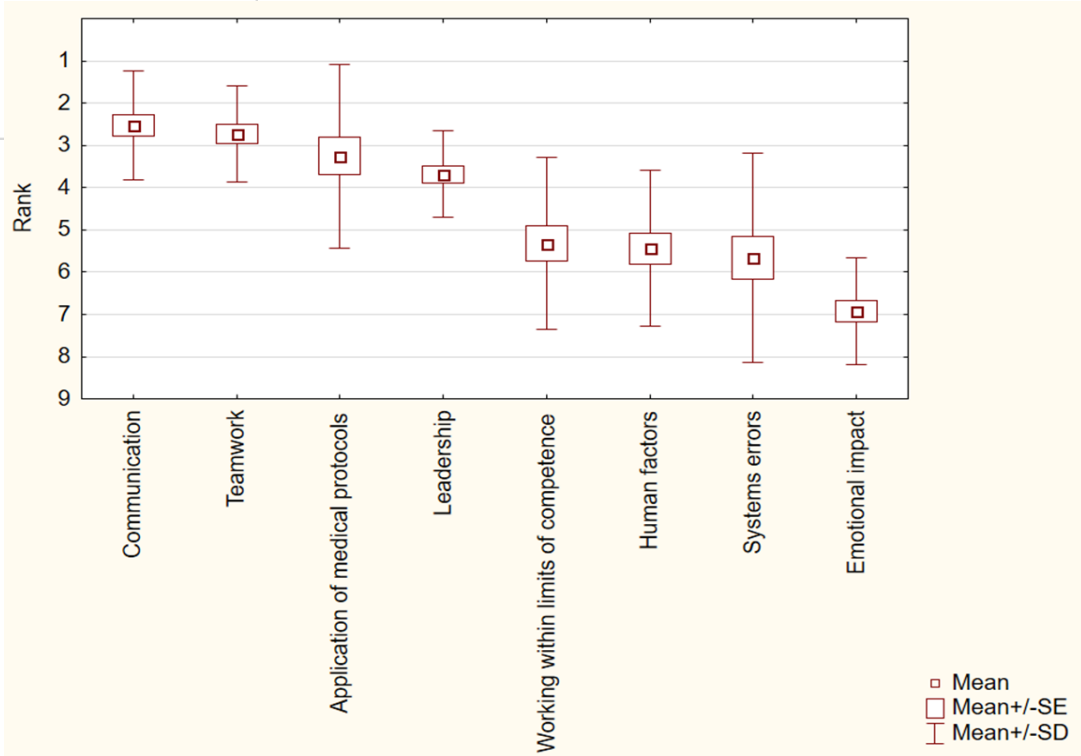
Educational value of core elements of debriefing as perceived by Foundation Doctors





The ranking of topics for debriefing according to Foundation Doctors





Features of debriefing help and hamper learning as perceived by Foundation Doctors

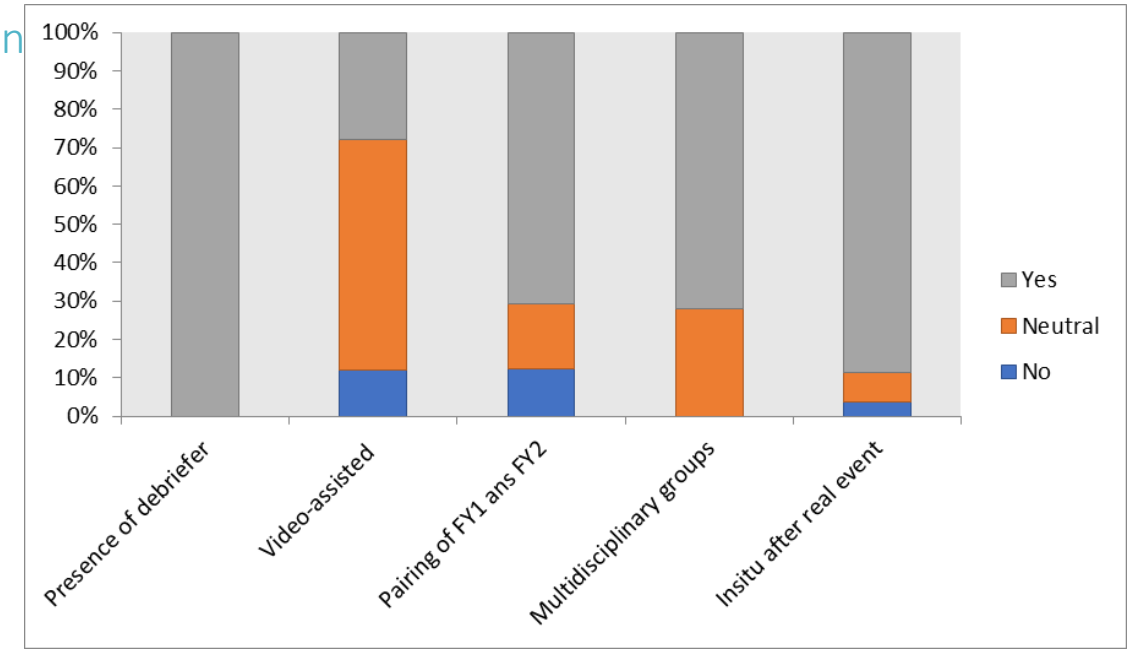
HELP

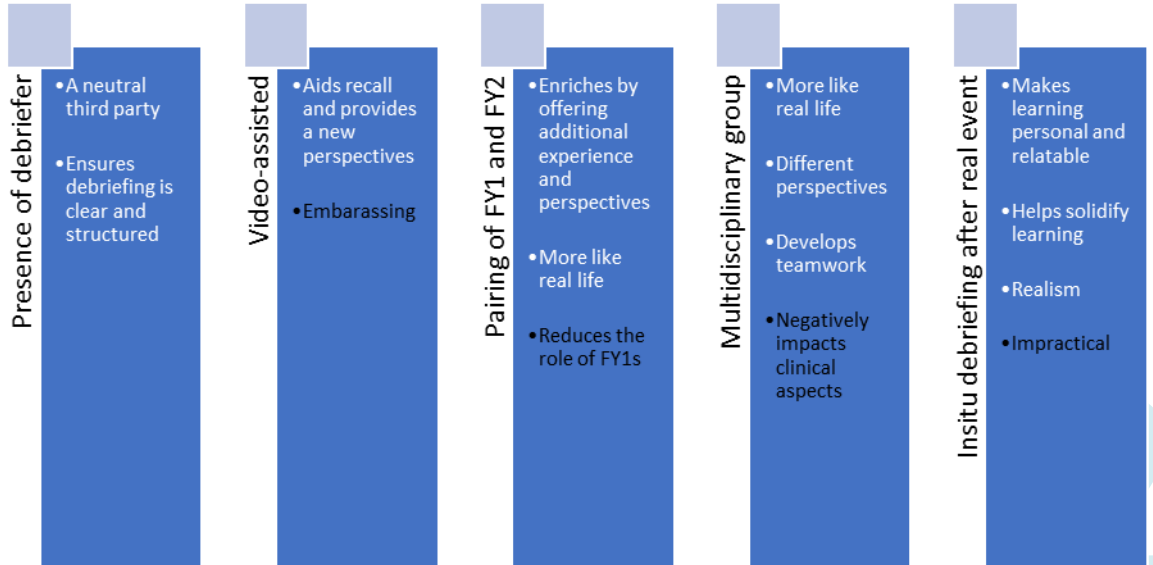
- Content
  - Analysis and reflection
  - What went well and what can be improved
  - Identify learning points
- Conduct
  - General
  - Everyone involved
  - Constricive feedback

HAMPER

- Modifiable
  - Targeting individuals
  - Focus on the negatives
  - Repetitive
  - Too long
- Innate
  - Embarassing in front of colleagues

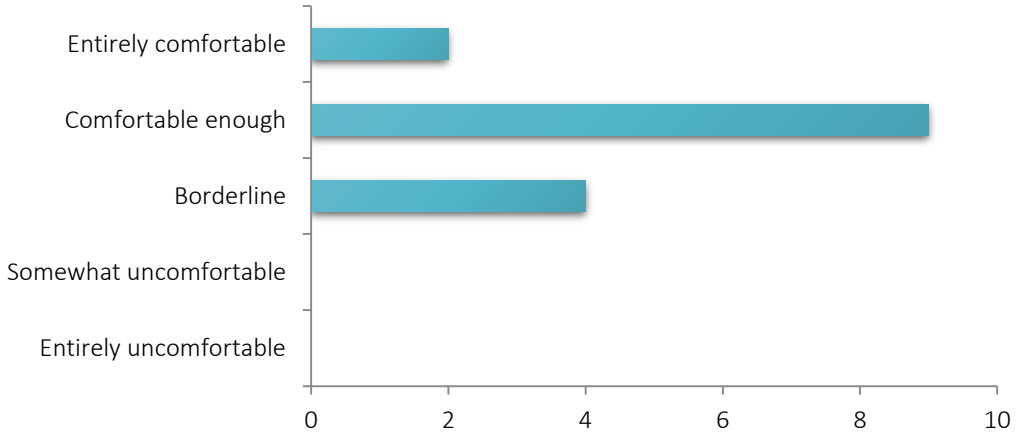
Would Foun

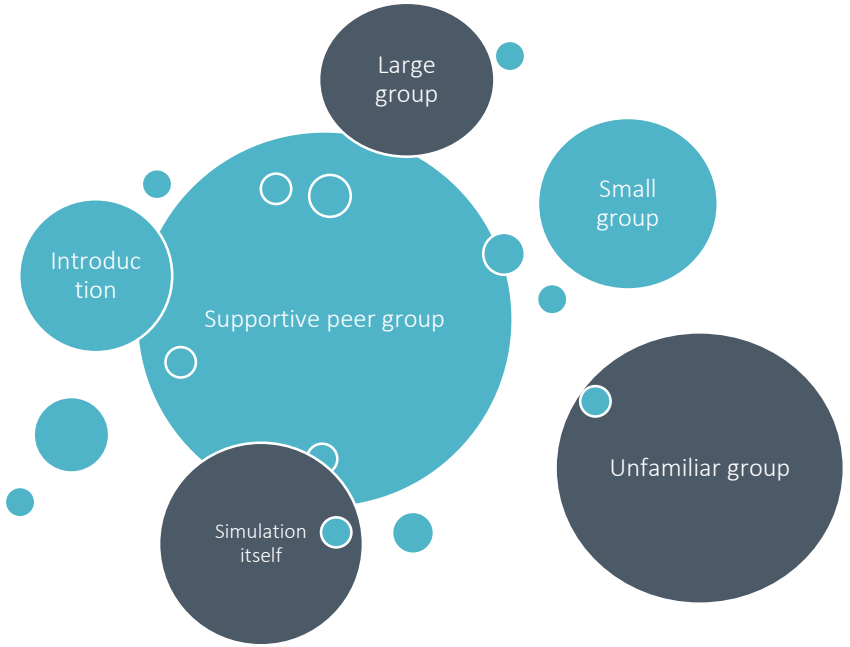

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Presence of debriefer
Video-assisted
Pairing of FY1 ans FY2
Multidisciplinary groups
Insitu after real event
Yes
Neutral
No


Presence of debriefer
•A neutral third party
•Ensures debriefing is clear and structured
Video-assisted
•Aids recall and provides a new perspectives
•Embarassing
Pairing of FY1 and FY2
•Enriches by offering additional experience and perspectives
•More like real life
•Reduces the role of FY1s
Multidisciplinary group
•More like real life
•Different perspectives
•Develops teamwork
•Negatively impacts clinical aspects
Insitu debriefing after real event
•Makes learning personal and relatable
•Helps solidify learning
•Realism
•Impractical

What do FDs expect of faculty

Psychological comfort





Main themes and discussion

Content and conduct of debriefing

Shared understanding as the key outcome of debriefing (Wallace 2007)

Debriefing as a tool to make sense of chaos (Gallagher 2005)

Communication, teamwork, application of protocols and leadership are the most valued topics. (the issues with comparison between studies)

Emotional impact – a stark divergence between the learners and faculty

Main themes and discussion

Faculty

Presence of faculty to lead debriefing is essential

Task-versus-relationship dilemma (Rudolph 2006)

Advocacy-inquisitive style

Personality and attitudes are superior to clinical expertise (Tan 2005)

Main themes and discussion

Psychological comfort

Peer group attitude is the single largest determinant

The importance of confidentiality and introduction

Moving the heat from the individual to the group (Rudolph 2013)

Psychological discomfort is an element of the learning environment (Ledderman 1992)

Reflection on methodology

The use of pre-determined themes and the emergence of the 4th theme

Why boundaries between themes are artificial

Why knowing what the learner wants is important and did I answer the research question?

The challenges of nomenclature and comparison between studies

Questionnaire design and the order effect

Implications for designing debriefing for Foundation Doctors

1. Debriefing should focus on communications skills, application of medical protocols, leadership and teamwork.

2. Recollection of the events from the scenario should form an integral part of debriefing

3. Critical feedback should be conveyed in a way that is clear and honest without the use of conciliatory techniques such as “sugar-coating” or “sandwich feedback”.

4. The primary aim of the faculty should be to understand the learner as the first step to help the learner modify their behaviours

5. Faculty should open the discussion to the group early and avoid dwelling on critiquing the individual in the hot seat

6. Faculty leading debriefing should be selected based on personality and excellent non-clinical skills. Faculty less senior then consultant can lead debriefing as clinical expertise is a secondary requirement.

7. Learners should be challenged in order to achieve a degree of psychological discomfort

8. Groups should be small and consist of colleagues who know one another

9. Debriefing must always be proceeded by introduction and assurance of confidentiality

Thank you