THE POWER OF REFLECTION

by Joanne Hamilton

Reflective practice is probably the most important activity we engage in for assessing and identifying the limits of our own skills and for addressing these limits through professional development (Eva & Regehr, 2011). However, the ability to self-assess through reflection is not well developed for most of us (Eva & Regehr, 2005). To be effective, reflection needs to be purposeful, relevant to our practice, and include a number of sources of information (not just our own impressions!).

WHY REFLECT?

Reflection is a process of interpreting one's own performance and comparing it to an explicit or implicit standard (Sargeant et al., 2008). Developing the ability to reflect allows you to realistically assess your own knowledge, skills and behaviours to guide your own professional development and measure your progress in achieving your personal goals. Although there is general agreement about the need for reflection, there is less direction on how to reflect.

HOW TO REFLECT?

Two models of reflection are particularly useful for building skills in reflection. The first, developed by Donald Schön (1987) from his work on reflective practitioners, identifies contexts for reflection before, during, and after an event as a way to ensure ongoing competency and provide motivation for learning. The three contexts are as follows:

Reflection – for – Action: This is the process of thinking about what you need to do in preparation for an activity, for example a particular patient visit, a procedure, or teaching session. It includes reflecting on your own knowledge and preparation for the activity, and what you need to do further to get ready, as well as anticipating issues that may arise and preparing for them.

To be effective, reflection needs to be purposeful, relevant to our practice, and include a number of sources of information.

Reflection – in – Action: This is the process of thinking about what you are doing while you are doing it and making adjustments to help ensure things are successful. It often happens quickly, for example, you see by the expression on your patient's' face that they do not understand your question, so you quickly rephrase the question in your mind and ask again. Questions that arise when reflecting in action may be: What is really happening with this patient? What is worrying? What can I conclude about the patient's situation? The patient doesn't seem to be responding well to what I am doing—how can I change it up?

Reflection – on – Action: This is the process of thinking about an experience after it has concluded. Questions that may arise when reflecting on action may be: What went well and what didn't go as well? What do I need to change/learn as a result of that experience? What was I trying to achieve, and did I achieve it? How successful was it? Could I deal with the situation differently?

The second model for reflection comes from the work of Driscoll (1994) called the What? Model. Driscoll provides trigger questions that can help us think about an experience and develop a plan for improved practice. Driscoll's

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model applies well to situations where we are reflecting on practice or for practice. Driscoll's model also asks three questions:

What? *A description of the experience*. What exactly happened? What did you see? What did you do? What was your reaction? What did other people do? (e.g. colleague, patient, family). What do you see as key issues of this experience?

So What? *An analysis - how did it affect you and others?* So what were you feeling at the time? Now? Any differences? Why? So what were the results of what you did or did not do? (good or bad, for patients, colleagues). So what still concerns you? So what were your experiences in comparison to your colleagues, etc.?

Now what? *What actions do you need to take?* Now what needs to happen to improve? Now what are you going to do about the situation? Now what might you do differently with a similar situation? Now what knowledge or skills do you need to develop or improve?

Practice using Driscoll's Model by thinking of a recent clinical or teaching encounter you had (or witnessed) that caused you concern or surprise (use the worksheet on the next page). Use the model and its prompts flexibly, rather than as a directive framework. Our own experiences are the most powerful motivator for driving our learning and improvement. Finally, discussing your reflection with others can help provide guidance and feedback on performance. For example, discussing a negative experience with a patient, a mentor or other colleague can help identify areas that you may have been unaware of that could have influenced the interactions.

SOURCES OF DATA FOR REFLECTION

Other sources of information can be useful in self-assessment and reflection. Don't forget to include things like learner and patient feedback, health records (including your own audits), and feedback from colleagues and supervisors, where appropriate. These can also be powerful sources of information for guiding learning, and in the case of electronic health records and billing data, can provide some fairly objective data regarding performance compared to standards and accepted norms. Data can be incredibly useful for your reflection and self-assessment, whether in the form of number or narratives (Lockyer et al., 2011). As more and more health professional practices and hospitals embrace electronic patient records, accessing patient data has become easier. Table 1 provides some ideas for sources of information for reflection, both on clinical practice and teaching. Can you think of other sources of information you might include?

> Reflection bridges the gap between how we would like to practice and what we actually do (Driscoll, 1994)

Reflective practice is an intentional activity aimed at analyzing actions, assessing effectiveness and making plans for improvement. It is a way for health professionals to expose tacit knowledge and bridge the gap between how we would like to practice and what we actually do and, thus, make sense of complex practice (Driscoll, 1994). Most importantly, it reminds us that learning is a lifelong process.

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References

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Our own experiences are the most powerful motivator for driving our learning and improvement.

REFLECTIVE PRACTICE WORKSHEET

What? (Description of the incident)

So What? (What are the consequences/meaning/ significance?)

Now What? (What actions will you take?)

Adapted from Driscoll (1994).

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Table 1. Example Sources of Data for Reflection for Clinician Teachers

Source	Type	Nature	Questions to Consider in self assessment
Patient	Informal	Comments and concerns raised by patients Patients responses to discussions and plans Patient non-verbal feedback Adherence to plans	How are patients responding to the care I provide? To the care my learners are providing? Are they satisfied? Do they feel well cared for? Am I happy with their care? What can I do to improve?
Patient	Formal	360 Evaluation Patient satisfaction feedback	How are patients viewing the care I provide? The care my learners are providing? How does it compare to others? Is there something I need to do to improve?
Colleagues	Informal	Hallway conversations about patients or learners, referrals and consultations	How does what I do for patient care and/or teaching compare to others? Are there better ways to teach/ manage care?
Learners	Formal	Learner evaluations	What do learners think about my teaching and/or patient care? Are there areas that I can improve or enhance?
Learners	Informal	Conversations, informal feedback, nonverbal communication, nature and number of questions asked by learners	How are learners reacting to my teaching? Does it seem like they are learning? What changes can I make to improve?
Electronic databases	Formal	Patient outcomes, process outcomes (referrals, follow ups, comparison to standards and guidelines)	Are my patients getting the best care I can provide? How do I compare to relevant standards and guidelines? Are learners caring for my patients providing the best care, and what feedback do they need to improve?