A Guide to Introducing and Integrating Reflective Practices in Medical Education.

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A GUIDE TO INTRODUCING AND INTEGRATING REFLECTIVE PRACTICES IN MEDICAL EDUCATION

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ABSTRACT

It is a significant challenge for any medical education program to provide adequate training in medical knowledge. It can be just as daunting to include appropriate opportunity to learn about and manage the emotional impact of illness experiences, the healing process, and provider-patient relationships. While there may be only a few basic changes to the core of medical knowledge, advances in medical practice regularly have an impact on the nature of patient care. Life-long learning is essential to maintain one's competence. However, everything doctors and other medical professionals learn about relationships with patients during their training is relevant for the rest of their career. One primary source of this learning are reflective practices. However, there is no guide or description of or comparison among the distinguishing characteristics of reflective processes. In addition, there are no criteria for the selection or integration of reflective processes in medical training or beyond. This article proposes understanding reflection as a complex, three-level process and identifies dimensions which differentiate a variety of reflective process activities. The discussion includes considerations for selecting which activities might be usefully incorporated in education curricula, and identifies conditions of medical training cultures that will support successful integration.

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Key Words: reflective practices, self-awareness, emotional self-care, teaching reflection, mindfulness, Balint Group, medical culture, emotional intelligence, reflection taxonomy, journaling

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INTRODUCTION

Reflection connects our experience to meaning. Few career experiences are as complex or meaningful as providing healthcare. Yet the demands of this work, combined with limited time and the complexity of medical practice, leave many healers detached from the healing process. There are distractions, unfinished business, and multiple intrusions which complicate the medical practitioner's effort to stay focused, think clearly, and remain calm. It is easy to forget our calling to medicine when we feel disconnected from the value of our work.

Every medical training program in the United States has a mandate to address issues of professionalism [1]. Key components of professionalism are self-awareness and reflective practice, and, to this end, many residency programs incorporate some form of reflective practice in their curricula. There are a number of reflective practices commonly used and documented in the literature [2, 3]. However, there is no guide or criteria to consider when integrating a reflective practice into the curriculum. This article first describes the nature of reflection as a complex, three level process, and then describes a range of reflective practices including dimensions of reflective practices relevant to consider in making curricular decisions.

LITERATURE AND PRACTICE

Reflective practices can be organized into at least three distinct approaches: varying forms of meditation, differing practices of writing or narrative, and a variety of group discussions. While Transcendental Meditation (TM) became a significant cultural factor in the United States in the 1960s and mindfulness meditation was introduced in the mid-1970s [4], it was not until the 1990s that mindfulness meditation was explicitly applied in medical culture [3]. A more structured form of meditation, Mindfulness Based Stress Reduction (MBSR) was also developed [5] and successfully applied [6, 7]; however, MBSR was initially developed as a treatment for patients. One additional meditative practice—labyrinth walking—has more recently been introduced for patients and their family members as well as for healthcare providers [8]. In contrast to the usually still practice of mindfulness, labyrinth walking encourages paying attention to the thoughts and feelings that spontaneously emerge while walking the single path into the center of a circular course and then back out. Along with labyrinths that have been constructed on the grounds of hospitals, large portable canvas labyrinths are commercially available [9].

Reflective practice as writing ranges from the spontaneous entries in one's journal [10, 11] to the more analytical and research focus of autoethnography [12]. An increasing number of writings about healthcare experiences both by and about physicians provide a window into the complex emotional and challenging decision-making situations that doctors face [13-17]. Narrative medicine teaches

clinicians to elicit and interpret illness narratives in the service of patient care [18]. Physician CPR (P-CPR) [19] is a variation of narrative with the writing done individually, followed by reading the narrative verbatim in small groups that are facilitated by a trained leader. Finally, autoethnography is a qualitative research method involving personal narrative about medical care which is analyzed through the lens of medical culture [12]. This process is also enhanced by sharing writings in the safe environment of colleagues who are engaged in the same process.

There are a number of group reflective activities with a variety of structure and focus—all of which have been incorporated into medical residencies in the United States. Balint groups [2, 20] have an international history and have been adopted in many U.S. residencies. They may include only residents or may be interdisciplinary, including professionals with varied educational backgrounds. Balint groups are structured group processes led by a specifically trained leader and focused on the emotional impact of one patient case on a member of the group. MegaClinic [22] is a case-based conference focused on learning to manage the emotional impact of a series of patients through the course of a morning or afternoon session. Continuity Case Conference [23] is a case-based presentation which helps to teach residents the cumulative effect that long-term continuity relationships have on patient care. Both of these activities are based on a presentation from the resident's experience. A group reflective activity with less formal structure is a Personal and Professional development group [24]. This process is a response to the challenges physicians in training have developing a well-integrated identity and sufficient adaptive coping skills. Support groups [25] have the least structured content, providing a venue to talk about any of their experiences in their residency. Retreats often take more time and combine a number of different reflective processes. While a retreat can be an individual activity, it is more likely to be a group experience in the context of medical education.

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LEVELS OF REFLECTIVE PROCESS

One way to understand reflection is to divide it into a complex three-level process. First, a person has to be *aware* of having an emotional experience or a private thought. These events can be fleeting and just like an awareness of a dream, unless we pay specific attention to it, we may forget the content as well as the emotion. One challenge is to pay attention in a way that the experience is accessible. Another challenge is to sort through the sheer volume of fleeting thoughts and feelings that seem to spontaneously occur. Which ones do I pay attention to? Which ones are meaningful to me? Which ones might undermine my beliefs and behavior? I refer to this step as "You have to be it to see it." We have to pay attention to the primary sources of our internal experiences—our head, heart, and gut—to begin this reflective process. There is also the challenge of integrating thoughts and emotions that are puzzling and negative as well as those that are positive.

The second level is to give the experience a *name.* It can be spoken or written. Without one of these actions, the thought or emotion remains a vague awareness. The mere act of naming the experience can be a revelation. Not only does the name provide an identity, but it also conveys some of the characteristics of the thought or the emotion. The naming process can also move an experience from short-term memory to long-term memory, enabling the accessibility of the experience for future processing. A name is necessary to refer to the experience or to share its content or explore its meaning. For emotions, a name allows us to write or talk about the experience without having to re-experience the emotion. One challenge at this level is to find an accurate name for the experience. An inaccurate name may misrepresent the experience and complicate the process. The essence of this level is "You have to name it to tame it" [26].

The third level is to *share* the named experience with someone else, often with a trusted colleague. The challenge at this point is managing the potential risk of sharing one's private thoughts or feelings and the accompanying emotional vulnerability. This experience might include embarrassment, shame, inadequacy, or some other aspect of our experience that we would prefer to keep private. The essence of this level is "You have to share it to bear it." The value of sharing can be experienced in the listening, validating, and normalizing provided by caring colleagues. However, the risk of being judged, isolated, or excluded can all be barriers that keep private thoughts and feelings to ourselves.

Table 1 identifies the various levels of reflection achieved through a variety of reflective activities (arranged from the most private to the most public).

DIMENSIONS OF REFLECTIVE PRACTICES

In addition to three levels of reflective processes, there are six dimensions to consider in understanding the range and nature of reflective practices:

1. Structured vs. Unstructured Reflection
2. Written vs. Experiential vs. Both
3. Regular vs. Sporadic / Episodic occurrences
4. Group vs. Individual Activity

In groups:

5. Leader Facilitated vs. Shared Leadership
6. Closed vs. Open group membership

Table 2 provides examples of using these dimensions to differentiate a variety of reflective practices:

Some of these dimensions are binary opposites. Reflection processes can only be either an individual activity or a group activity. If they are a group activity, they can only be either open to new members or closed to new members. When a new member joins, it is a new group with new group dynamics. Groups that do

Table 1. Levels of Reflection Achieved Using Various Reflective Activities

	Level 1: Aware	Level 2: Name	Level 3: Share
Meditation			
Mindfulness	X		
Mindful hand washing	X		
MBSR	X		
Labyrinth walking	X		
Writing			
Journaling	X	X	
Narrative medicine	X	X	
P.CPR	X	X	X
Auto-ethnography	X	X	X
Group process			
Support group	X	X	X
Personal and professional development group	X	X	X
Continuity Case Conference	X	X	X
MegaClinic	X	X	X
Balint group	X	X	X
Retreat	X	X	X

not meet regularly, by definition are meeting sporadically. Other dimensions are defined by polar opposites and can vary in degree. A support group can be totally unstructured; a personal and professional development group has some structure and focus to the discussion. MegaClinic and Continuity Case Conferences have greater structure in discussing the presentation because of the more narrow focus of the activity. Finally, any group leader should have a clear description of his or her role and responsibility and a demonstrated competence in understanding and managing group process and dynamics. There is a contract between the leader and the group, and an explicit contract leads to clear roles in group functioning.

Individual Activity

The most significant factor to support reflective practice is emotional safety. This consists of freedom from blame, judgment, shame, or embarrassment. The variety of individual mindful practices (MBSR, meditation, labyrinth walking) all increase a practitioner's self-awareness without revealing any of one's private

Table 2. Dimensions of Reflective Practices

	Group vs. Individual	Written vs. Experiential	Leader	Regular meeting	Struc-ture	Open/ Closed
Meditation						
Mindfulness	I	E	N	Y/N	Y	O
Mindful hand washing	I	E	N	Y/N	N	O
MBSR	G/I	E	Y/N	Y/N	Y	O
Labyrinth walking	I	E	Y/N	Y/N	Y	O
Writing						
Journaling	I	W	N	Y/N	N	O
Narrative medicine	G	W	Y	N	Y	O
P.CPR	G	W	Y	N	Y/N	O
Auto-ethnography	G	W	Y	Y/N	Y	O
Group process						
Support group	G	E	Y/N	Y	N	C
Personal and professional development group	G	E	Y	Y	Y	C
Continuity Case Conference	G	E	Y	Y	Y	C
MegaClinic	G	E	Y	Y	Y	C
Balint group	G	E	Y	Y	Y	C
Retreat	G/I	W/E	Y	Y/N	Y	C

Key: G = Group; I = Individual; W = Written; E = Experiential; W/E = both; Y = Yes; N = No; Y/N = possible, not necessary; O = Open; C = Closed.

thoughts or emotions. Journaling may feel risky to some people because of the fear of discovery of personal writings. On the other hand, writing can be particularly useful if one dates all their entries. The result is a record of the evolution of one's reflections. Judgment only comes from oneself, and that may become a subject of future reflection. One limitation of some individual reflective activities is the loss of a second or third level of reflection—"name it to tame it" and "share it to bear it." For example, one can practice mindful meditation without identifying the distracting content of one's thoughts or feelings. Further, one may lose the validating and normalizing benefit of learning that others have similar distractions, and there is less opportunity to learn how others manage or understand such intrusive thoughts.

Group Activity

Emotional safety in a group reflective activity is more complex. It can be best supported with a regularly meeting group that is closed to new members, that has a focus on a particular topic, and that is led by a group leader with specific training and clear responsibility for group safety. These conditions increase the opportunity for group members to get to know and trust each other, and learn to trust that the leader is attentive to the emotional well-being of each group member. Finally, the leader's task is to maintain an agreed upon focus such as a case that is presented. This helps to insure that the group discussion is limited to that case and individuals' personal boundaries are respected. Central to the development of group trust are guidelines that are established at the outset, including confidentiality, sharing the "floor," respect for a variety of perspectives, and speaking for oneself using I-messages. Even with these guidelines, all groups progress through a series of predictable developmental stages [27]. Every time a new person joins the group, this process of trust building begins anew—hence, the value of a closed group. Leader training in group process is crucial because of the dynamics that occur in all groups. Examples include issues of competition, inclusion or marginalization, sharing the time, use of jargon, acceptance of diversity, and shared vulnerability.

Writing vs. Experiential

Writing is a discipline that produces all the benefits of naming our experiences while protecting our privacy from others' responses or reactions if we were to express our thoughts out loud. Writing helps us to clarify our thoughts and feelings and still maintain the freedom to choose what we share or decide to keep private. Writing is equally beneficial as an individual or in groups. However, when writing in groups, leaders must be clear about whether participants will be asked to read their writings out loud or may decide what, if anything, they wish to reveal. An example of combining writing with discussions may be: "Write a narrative about a patient appointment that did not go well. Describe what happened and include your thoughts and feelings about these events. You will not have to share anything you write, but we will talk about the issues or challenges that emerge." Residents have the freedom to explore their own experience without fear of exposure; however, the discussion will very likely include sharing many aspects of their struggle that may not have emerged without the writing.

Frequency

Regularly occurring reflective activities have a number of benefits compared to episodic or sporadic meetings. The primary benefit is the advantage that occurs with practice, like the practice of any skill. The regular activity of writing one's thoughts and feelings in a journal, or regular meditative practice in between

patients, or frequent use of meditation for stress reduction all improve one's ability to engage in that practice. Integrating reflective practice requires a commitment to new habits that are a change from our usual or typical state of being. Entering this state is more easily accomplished when it is intentional, when it is accompanied by some ritual (including timing, location, and activity), and when it is practiced regularly. Like any other skill, we get out of practice as a result of not using the skill. A second benefit to regular practice is its availability to apply to all kinds of experiences or needs. If we only write or meditate in a crisis, the practice becomes associated with crisis, and we reduce the value of this practice. The regular use of reflective practice allows the integration of that practice into our routines and our identity. Rather than something we do, reflection is part of who we are and it integrates the benefits of each practice into all of our experiences.

Structure

Structure in reflective practice includes timing, frequency, and duration in addition to the content. An example would be a support group that meets regularly at the same location, with shared leadership and unstructured content. This structure provides the opportunity and familiarity to support discussions of any urgency. Balint groups are an example of a more structured group process; these groups have a leader who is trained in Balint group process, and the discussions focus exclusively on the doctor-patient relationship in one case. No one has to share personal information, and participation consists of empathy and speculation about the doctor's and the patient's experience. Unstructured practices might include journaling, which can be done any time a person chooses for as long as s/he wants and on whatever topic s/he decides. Labyrinth walking has the structure of the labyrinth—there is only one path—but has no other built-in structure. The content is whatever thoughts or emotions that spontaneously arise while walking. Since there is only one path into the middle and one path out, there is no distraction from or decisions about where to walk.

Leadership

The role of a leader, either for a group or as a guide for an individual, can be instrumental to the success of the reflective practice. It is natural for many people to lose their focus, add associations, explore tangents, and in other ways veer off of a chosen and desired path of reflection. When this tendency is multiplied by the number of group members, the challenge to stay on target is great. A group leader or facilitator is essential to keep the group focused on their target. Balint groups are an excellent example of the crucial nature of a group leader with specialized training. The leader brings the group's focus back to the case from a related but not essential tangent, and s/he can bring the group's attention to related issues that they may have avoided. The leader also makes sure there is a balanced amount of time to consider the doctor as well as the patient. Finally, this leader can

ask participants to explain jargon for the benefit of anyone who may not understand, can invite diverse or contrary perspectives, and has the responsibility of monitoring the time. There are at least two other case-based, structured group processes that operate in a similar manner to Balint groups, each with a particular focus, structure, and leader role and that are ideal for residency training. MegaClinic is designed to teach about the emotional impact of patient care; Continuity Case Conference is designed to teach the nature and value of continuity relationships with patients.

DISCUSSION

Medical Culture

There is a tension between logic and emotion in all healthcare. Logic is clearly necessary for accurate diagnosis and treatment recommendations. Learning to develop useful differential diagnoses or to calculate risk and benefit ratios of testing and treatment procedures are all essential parts of medical teaching and practice strategies. However, all physical ailments are brought to the doctor by patients—human beings, and human reactions to illness often include emotional experiences. Emotion affects the ways the illness story is told, and both the patient's emotions and the doctor's reactions are filters which impact the doctor's access to diagnostic clues. Emotional intelligence [28] is essential for developing relationships, understanding the impact of illness on individuals, integrating culture as a factor in healthcare, and using communication skills to develop effective healthcare partnerships. All medical professionals have patients they like, patients they have "allergies" to, patients they dread to have on today's schedule, and patients who they barely remember. Despite these universal experiences and the reality that emotion trumps logic [29, 30], medical education and culture minimizes the role of emotion in healthcare and healthcare education. In addition, many residents resist participation in reflective activities designed to increase their self-awareness.

Recommendations

A commitment to reflective practices is signaled by scheduled, regular, and dedicated time for resident participation. Sporadic group meetings can help to process critical incidents; however, there needs to be a culture that supports reflection on a more regular basis to reinforce this learning opportunity. Regular faculty participation in reflective activities is a powerful example. In addition, it is very helpful to have a faculty champion who is trained and competent in group processes and dynamics to lead resident groups. Because of the normal fears and barriers to sharing personal thoughts and feelings, structured team building activities can help small groups increase their comfort level with each other and facilitate later reflective activities.

With varied comfort levels, it will be important to begin with the least emotionally threatening activities. Examples may be discussions of readings in the

literature of other physician experiences. Residents might be encouraged to begin journaling about their patient care experiences as an opportunity to learn from these experiences. Mindfulness meditation can be introduced as a treatment mode for patients and a stress management tool for themselves. Support groups and/or Personal and Professional Development groups may also help residents deal with the challenging patient care experiences they have in their training. Once a culture of reflection is established, a wider range of activities can be added.

The principle is that we process our life experiences at multiple levels simultaneously and not always consciously. As we begin to pay attention to the impact of our experiences, we learn about ourselves and the ways we process and respond to these experiences. Often, the result is an increased self-awareness in ways that affect relationships with and treatment of our patients. It is crucial that the facilitator provide a safety net for the inevitable anxiety that some residents may experience. This may be related to their struggle with their developing competence, or the patient with a serious illness they may not be able to heal, or their own self-questioning about being able to do this work. Being able to access and express these emotions will be valuable to residents as they progress through their training, learn to integrate their varying roles, and emerge as professionals who can productively manage both their professional and their personal lives.

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