Introducing and Integrating Reflective Practices in Medical Education

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Reflection connects one's experience to meaning. Few experiences are as complex or meaningful as providing health care. Yet the demands of this work, combined with limited time and the complexity of the process 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 focussed, think clearly, and remain calm. It is easy to forget one's calling to medicine when we feel disconnected from the value of our work.

Every residency program has a mandate to address issues of professionalism (ACGME, 2013). Key components of professionalism are self awareness and reflective practice, and 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 (Johnson, et al, 2001, Epstein, 1999). However, there is no guide to understand the differences among various reflective practices or criteria to use when making a selection. This article describes the nature of reflection as a three level process, provides a taxonomic description of a range of reflective practices, and adds dimensions to consider in making curricular decisions.

The Process of Reflection

Reflection as a mental activity can be understood as a three level process. First, a person has to be aware of having an emotional experience or be aware of a private thought. These events can be fleeting, and just like an awareness of dreaming, unless we pay attention to it, we can forget the content as well as the emotion. The challenge is to pay attention in a way that the experience is accessible. I refer to this step as 'You have to be it to see it.' One has to pay attention to the primary sources of our internal experiences - our head, heart and gut - to begin this reflective process.

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 level one experience. 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. The essence of this level is 'You have to name it to tame it.' Often, the mere act of naming the experience can be a revelation.

The third level is to share the naming of the 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 which 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.

Literature and Practice

Reflective practices for physicians that are described in the literature include two extremes of Mindfulness (Epstein, 1999) and Balint groups (Johnson, 2001). Mindfulness practice is an individual activity which is private, and because this practice is unstructured, the content will vary from person to person. Balint groups are a group activity, the content is shared within the group, and the structure keeps the focus on one case of a doctor patient relationship. Mindfulness yields minimal vulnerability; Balint groups require an emotionally safe (e.g., trusting) environment which can produce significant vulnerability.

In addition to these two approaches to reflection, there are numerous other individual practices. They include labyrinth walking (Artress), journaling (Baldwin), and varying forms of narrative medicine (Charon, 2001). They are all individual activities which maintains the privacy of the reflection content. Labyrinth walking has been described as a walking meditation. It has the advantage of boundaries of the labyrinth allowing the practitioner to focus on the thoughts that emerge. Mindfulness and labyrinth walking can yield observations or revelations which may then be the stimulus for journaling activities. Writing in a journal or participating in a narrative medicine activity have the added benefit of putting one's thoughts into words - a process which increases self awareness and creates the potential for sharing learnings with others.

Finally, one might consider combining individual and group practices. Journaling about reflective experiences, sharing one's writing and seeking feedback multiplies the benefits of reflection. Walking a labyrinth at the conclusion of a retreat or similar emotionally stirring experience can yield numerous awarenesses. Writing about and sharing these awarenesses with other participants of the original experience, can add levels of perspective. 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 which we know to be true but have no conscious knowledge about previously.

Medical culture

There is a tension between logic and emotion in all health care. 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 - humans, and human reactions to illness are emotional experiences. Emotion impacts 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 (Goleman, 1995) 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, medical education and culture minimizes the role of emotion in healthcare. In addition, many residents resist participation in reflective activities designed to increase their self awareness.

Dimensions of Reflective Practices

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

The following chart provides examples of using these dimensions to better understand a variety of reflective practices:

	Group	Individual	Written	Experiential	Leader	Regular Meeting
Support Group	X			X	Y/N	Y/N
Balint	X			X	X	Y/N
Journaling		X	X			Y/N
MBSR	X	X		X	Y/N	Y/N
Mindful Meditation		X		X	Y/N	Y/N
Mindful Hand washing		X		X		Y/N
Narrative Medicine	X		X	X	X	Y/N
MegaClinic	X			X	X	Y/N
Continuity Case Conference	X			X	X	Y/N
Labyrinth Walking	X	X		X	Y/N	Y/N
Autoethno-graphy	X	X	X	X	X	Y/N

Individual Activity

The single 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 thoughts or emotions. One other individual practice, journaling, may be more problematical because of the fear and risk of exposure of personal thoughts and feelings. One limitation of 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.' One can practice mindful hand washing without identifying the distracting content of one's thoughts or feelings. In addition to not

naming the distraction, one loses the normalizing effect of learning that others have similar distractions, and there is no opportunity to benefit from learning how others deal with or understand such intrusive thoughts.

Group Activity

Emotional safety in a group reflective activity is more complex than in individual activities. It can be established with a regularly meeting group that is closed to new members, that has a focus on a specific topic, and that is led by a group leader with this specific training and responsibility. 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 to maintain an agreed upon focus or topic helps to insure that the group discussion is contained and individuals' personal boundaries are respected. Central to the development of group trust are guidelines that are established at the outset and that consist of agreements about confidentiality, sharing the 'floor,' respect for a variety of perspectives, and speaking for oneself using I-messages. Even with these guidelines, all groups proceed through a series of predictable developmental stages (Tuckman, 1965). Every time a new person joins the group, this process of trust building begins anew - hence, the value of a closed group. Groups that meet regularly with a stable membership get to know each other better and develop a more intimate comfort zone in a shorter time frame. 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 and shared vulnerability.

Frequency

Regularly occurring reflective activities have a number of benefits that episodic or sporadic meetings do not have. 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 mindful hand washing in between patients, or frequent use of meditation for stress reduction all improve one's ability to engage in that practice. Every reflective practice is 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, 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 the availability to rely on this practice for all kinds of experiences or needs. If we only write or meditate in a crisis, the practice becomes associated with crisis, and we lose the value of this practice as applied to a wide range of experiences. Finally, the regular use of reflective practice allows the integration of that practice into who we are. Rather than something we do, reflection as part of who we are integrates the benefits of each practice into all of our experiences.

Structure

Structure in reflective practice includes time limits or the focus of content or meeting frequency or, if practiced in a group, the membership can be limited or closed. 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 structured group process; in addition, 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 for the doctor and speculation about the patient.

Structure in individual practices can be as simple as a regular meeting day, time, place, duration or focus of the practice. Examples include a regular time and place to write or meditate or walk. The ideal circumstance is that the practice is regularly occurring and that it satisfies the need of the individual.

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 desirable 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 / facilitator is essential to keep the group focussed on their target. Balint groups are an excellent example of the crucial nature of the role of a group leader with specialized training. In addition to bringing the group's focus back to the case from a related but not essential tangent, the leader can bring the group attention to related issues that they may have avoided. An additional role is to make 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(Sternlieb, 2008, Sternlieb, 2012). One is designed to teach about the emotional impact of patient care, and the other is designed to reflect on the nature of continuity relationships with patients.

Discussion and Considerations

Emotional arithmetic suggests that when we share positive experiences with trusted individuals, the positive emotions are multiplied. When we share negative emotional experiences with trusted individuals, the emotions are divided. In other words, sharing our emotional experiences with trusted individuals has no disadvantage. The key is trust - trust that personal vulnerabilities will be respected, emotional reactions will be validated and normalized, and that people will not be shamed or embarrassed when sharing these experiences.

Supporting emotional safety and contributing to a more open and safe learning environment can include taking attendance at reflective activities without evaluation, normalizing emotional experiences, inviting and validating diverse responses and

reactions, and respecting privacy by allowing residents to decide what they are comfortable sharing.

Selecting activities with less vulnerability led by trained leaders and structured around patient care may support reflective practice. A combination of individual and group practices may provide a range of experiences which increases the opportunity for a good fit for everyone.

The success of reflective practices depends on the level of trust and the sense of emotional safety within the training program. The complexity of patients' illness experiences combined with doctors' mandate to do no harm complicate woundedness and healing. Human emotion in these experiences will often interfere with developing a logical formulation of the nature of the woundedness and therefore the prescription for healing. Emotions trump logic, and ignoring emotion compromises care.

In addition to acknowledging the importance of addressing the emotion factor and the need for an emotionally safe learning environment, success will be directly proportional to establishing a dedicated time for reflective practice and demonstrating that the faculty also engages in this practice. Without sufficient time, administrative support or trust, reflective practice will not succeed.

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