CPD reflective narratives

The personal stories in this document show how reflective practice has helped these doctors with their development.

Why reflect?

There's growing evidence from research that reflective practice improves the way people perform in their jobs. This is particularly important for medical practitioners to maintain and improve their standard of practice.

Reflective narratives

The GMC and the Academy of Medical Royal Colleges are jointly collecting a series of anonymised reflective narratives, examples of how some doctors have reflected on their practice.

These narratives are not intended to be used as templates about reflection for appraisal. They are instead designed to help doctors with the thought process for reflection, which is an important part of their professional development and appraisals.

In this document

Paediatrics - better communication in emergencies

Dr A is a consultant in paediatrics, working in the emergency department of a teaching hospital. Here he reflects on the need for better communication in emergency situations.

What's the issue you reflected on?

Tell us about an incident/situation/feeling that gave you cause for reflection

A 4 year old child with established epilepsy came to A&E following a prolonged seizure and was admitted to the paediatric ICU following a respiratory arrest. I was the consultant on call that weekend and arrived in A&E about mid-way between the child's arrival in A&E and their respiratory arrest.

What made you stop and think?

It became apparent later that they had received 4 doses of benzodiazepines prior to a loading dose of intravenous phenytoin, the latter of which quickly stopped their seizure. It also transpired that one of these benzodiazepine doses had been doubled in error. In the melee of the situation neither I, nor anybody else, had fully appreciated how many doses of benzodiazepine they had already received until after their respiratory arrest.

It was later agreed that the likely cause of their respiratory arrest was secondary to the number of doses of benzodiazepine they had received across a number of settings: at home from the family, in the ambulance from paramedics, in A&E from casualty doctors and nurses and again in A&E from attending paediatricians.

They needed a short period of intubation and ventilation but fortunately made a full recovery.

There are many ways to reflect - how did you do it?

I discussed this with colleagues in A&E and in my paediatric unit.

I reviewed the literature on the management of status epilepticus independently.

What did you do?

I flagged this as a "near miss" incident in our hospital safety system.

I reviewed the latest literature on the management of convulsive status epilepticus. I ran an update on the status epilepticus protocol for the junior staff in my own paediatric department and A&E, emphasising the correct doses, pathways of medication use and the importance of a timeline.

I asked my nurse colleagues to review the "emergency care protocol" for all children with epilepsy on emergency buccal midazolam so that it was clear how many doses of benzodiazepine their child could have. Families were asked to give a copy of this protocol to the ambulance crew should this be necessary.

We reviewed the communication pathway, how information is gathered on medication and recorded in an acute paediatric "resus" setting.

Tell us what you took away or learned from this experience?

I could have made more stringent enquiries about the number of doses and quantity of doses of benzodiazepine he had already received when I arrived in A&E myself.

This emphasised the importance of team work in this acute setting.

It also emphasised the importance of good communication between parents, ambulance staff, A&E clinicians and paediatricians in an acute, high pressure situation.

How did it change your thinking or practice?

I also took away the importance of good communication. Asking the right questions in the "heat of the moment". Ensuring my team knows about the appropriate management of status epilepticus.

What have been the effects of your changes?

Has it improved your practice and outcomes?

Over the next 6 months, we will audit the number of doses of benzodiazepines a child receives from community through to hospital should a child be admitted with a prolonged epileptic seizure.

I will consider running some simulation exercises with my colleagues to test how well our status epilepticus protocol works in our hospital. This will test knowledge of the team within my unit - and also be a learning exercise for myself.

Top tips

What top tips would you give to doctors in your specialty about how to get the most from reflection or thinking constructively about a particular problem?

- Put aside time to reflect. Record it as something you need to address and remember to complete your reflective notes when this is finished.
- Discuss the situation with your colleagues.
- Look at the literature and any clinical guidance to further inform you. Reflect on how your team functions in addressing a problem.
- Act on what you have learned.
- Communicate what you have learned with your colleagues.

General practice - self-motivation to continue clinical work

Dr D is a general practitioner. Here she reflects on the self-motivation she needed to continue in clinical practice as a locum.

What's the issue you reflected on?

Tell us about an incident/situation/feeling that gave you cause for reflection

Since leaving my partnership, I have not been as diligent in getting locums as I intended. There always seems to be something high priority in my educational and management roles that makes me put off getting my CV out to practices and locum sessions booked in.

I am worried that if I don't get back into primary care clinical practice soon, I will start to lose confidence.

What made you stop and think?

I suddenly realised that three months had gone by without me doing a locum in clinical work (part of that was Christmas).

There are many ways to reflect - how did you do it?

This was an internal area of disquiet, but what brought it up to conscious awareness was that I went on a mentoring course where I chose to raise this issue to discuss in a "mini-mentoring" session with another delegate. We looked at practical strategies to get over the barrier caused by moving into a new way of working - like working out what to charge and where to send my CV.

It only took 30 minutes but it was a really important and thought provoking discussion. I had not realised how much I was inhibited by having to set a price on my time and ask for money.

What did you do?

Tell us what you took away or learned from this experience?

I have realised how helpful it is to talk through things that seem difficult to get on with. I liked being introduced to some ideas about how to deal with procrastination - such as breaking the task down into bite sized chunks, and giving myself mini-rewards for achieving each stage.

How did it change your thinking or practice?

I have stopped allowing my fears about being a locum from stopping me any longer and I have started to take on locums in a variety of GP practices.

I have professionalised my locum work with a clear standard "service level agreement" with each practice.

I have joined the National Association of Sessional GPs.

What have been the effects of your changes?

Has it improved your practice and outcomes?

By getting back into clinical work, my confidence has been restored. I am getting more experiential learning to target my CPD, although I do have some learning needs that are entirely about this career change - such as learning new computer IT systems that we did not use in my practice.

Has it affected others?

I have shared my learning about how to deal with procrastination with some of my friends and colleagues and shared my findings on setting myself up as a locum GP with other new locums in my position (former partners with well-established links into one particular practice and team).

Top tips

What top tips would you give to doctors in your specialty about how to get the most from reflection or thinking constructively about a particular problem?

- Build reflection into everyday practice. To get the most out of reflection, it needs to be something that is part of normal practice. Talking this feeling of disquiet through really helped me to work out why I was procrastinating, as it is not usually like me. I don't think it matters whether reflection takes place alone or in a facilitated way but I do think that it is useful sometimes to take a few minutes to write something down that captures and names the feeling or problem or insight. A few good examples of reflective practice showing how I think about what I am doing as a doctor will keep my appraiser and my RO happy because they can see how I explore incidents that arise in my practice and react to them by making appropriate changes. On the other hand, I think it is essential not to waste time that could be spent with patients, or the leisure time that is so important for recharging the batteries, on a production line of documentation of reflection that becomes a burden or a chore. My appraiser has been very helpful in pointing out where I have been doing more than is needed, out of a misguided perfectionism.
- Use reflection to show how your practice is impacting on others. I am relieved to see the new guidance from the GMC and the Royal Colleges on decreasing the regulatory burden and increasing the emphasis on providing a few good quality examples of reflective practice. I aim to reflect on the most important things that I have learned every year and any significant changes that I have made to my practice. That way I can show how my CPD, and my review of my work and the feedback I get, has an impact on improving my patient care, relationships with colleagues or my own resilience.

Public health medicine - developing effective and fair funding policies

Dr C is a consultant in public health medicine. Here he reflects on developing effective and fair policies with CCGs for funding.

What's the issue you reflected on?

Tell us about an incident/situation/feeling that gave you cause for reflection

I work in health care Public Health and support the local clinical commissioning groups (CCGs) in their priority setting process including commissioning policy development.

As a local health system we were updating the commissioning statement for septorhinoplasty; especially under what circumstances it will be funded. Local ENT consultants wanted further indications to be included so that septorhinoplasty could be funded for these patients.

I found it was hard to define the boundary between clinical need (where there is definite clinical benefit) and cosmetic intervention. The ENT consultants were trying to do their best for their patients by including indications such as severe anosmia and recurrent epistaxis.

As a Public Health consultant I need to consider the cost of performing these interventions on patients who might gain marginal benefit. I did my best to work with CCG GPs and the local ENT consultants to agree a consensus.

What made you stop and think?

I wondered what the appropriate approach to take was in finalising the funding indications for septorhinoplasty. Should I be looking at the best available evidence?

I often find that the evidence is not available at the level I am looking for. It also becomes hard to disagree with the local experts and I need to avoid giving an impression that this is purely a cost cutting measure.

There are many ways to reflect - how did you do it?

I went over the scenario many times and debated with myself what a rational person will do. I also discussed this with one of my trainees to gauge their views.

I challenged myself to defend my course of action, and the indications that I was intending to include/exclude. I thought about the possible reaction of the local ENT consultants, the CCG GPs and the managers.

I thought through the impact the revised statement will have on the patients and the resource implications for the local commissioning arm of the NHS.

What did you do?

Tell us what you took away or learned from this experience?

Evidence may not always be the answer in formulating commissioning policies as it may not be available. Hence local consensus has to be reached working closely with primary and secondary care clinicians.

When there is disagreement between the two it takes a lot of time and effort to agree a common position. The purchaser provider split sometimes could hinder clinical collaboration and cooperation and I need to work around this potential barrier.

Taking the process through established mechanisms in the local health system at times can be cumbersome and frustrating - plenty of time is needed.

How did it change your thinking or practice?

I will start a dialogue with the respective specialists and will involve the lead GP from the CCG. However this may not always be possible due to time constraints. But I will endeavour to adopt this approach.

Unless there is local buy in from secondary care specialists in commissioning policy development, it is almost impossible to implement these locally.

What have been the effects of your changes?

Has it improved your practice and outcomes?

This needs to be seen. I hope that the new approach will lead to better engagement and commissioning policies that are agreeable to local clinicians.

Many commissioning policies are coming up for review and I will be adopting this approach. A well-developed policy with local clinician engagement and approval will benefit patients in the greatest need and avoid the opportunity cost of treating patients who are unlikely to benefit from an invasive intervention.

Has it affected others?

Yes. The revised policy will make the intervention available to wider groups of patients. Procedures will be offered to patients quicker as the clinicians are clear what is being commissioned and which patients they can operate on.

This will also help if the local commissioning organisation decides to introduce prior approval for procedures as the criteria is clearer and has the agreement of local clinicians.

Top tips

What top tips would you give to doctors in your specialty about how to get the most from reflection or thinking constructively about a particular problem?

- If you feel something has gone particularly well then it is worthy of reflection to identify actions, approach or areas to copy for future work.
- Similarly if something has gone badly this is certainly worthy of the investment in time and effort to learn from it so that there is less of chance of this happening again.
- Keep an open mind and try not to blame someone else or yourself for that matter.
- The objective is to learn and improve on an ongoing basis.
- As far as possible write some brief reflective notes as soon as possible.
- Always use a selection of reflective notes during your appraisal and discuss these with your appraiser.

Public health medicine - giving an effective TV interview

Dr B is a consultant in public health medicine. Here she reflects on how to give an effective TV interview.

What's the issue you reflected on?

Tell us about an incident/situation/feeling that gave you cause for reflection

I was asked to take part in a TV interview to support the public health campaign for bowel cancer screening. A patient who had done the test and discovered invasive cancer was part of the feature.

What made you stop and think?

Although I had had media training previously, this was the first time I was to undertake a taped TV interview. It was going out to a range of audiences all at once - I had to reflect on why it was important, and why others would want to listen and take heed.

There are many ways to reflect - how did you do it?

Preparation for the interview is part of the reflective process - it helped me be very clear about what I was to say, and the purpose behind it.

I anticipated likely questions and made sure I had the most up to date information on bowel cancer. I also went through the process from the patient point of view by using tips and resources compiled by my team.

I spoke to someone who had done the test, and to a patient whose screening test had picked up an invasive tumour.

Following the interview, I had a feedback session with a colleague. This showed me that I could have widened the scope of the message to tackling inequalities.

What did you do?

Tell us what you took away or learned from this experience?

I sourced lots of information that I did not use. I found out that they were actually looking for 20 second sound bites, with no straying off topic.

The interview stated that the process was straightforward, but I know this isn't the case for people with mobility problems or a disability. And people find it embarrassing or unpleasant. There are also practical barriers like being unsure how to take the sample and instructions being hard to read. On reflection, I could have pointed out all these issues and how they can be overcome.

It was a good opportunity to talk about the subject openly on air.

How did it change your thinking or practice?

The media picked up our campaign because we had a great patient story to go with it. They interviewed the patient first, then me (the public health expert). So, for campaigns to raise awareness, press releases and quotes from experts are not enough - a personal story has the impact.

Also, I developed a working relationship with the local health journalist through this programme of awareness. And the patient and public get to see and hear the messages in high visibility.

What have been the effects of your changes?

Has it improved your practice and outcomes?

I am cautious about media assignments now - I make sure I only accept ones I am competent and knowledgeable about.

If it is a difficult news story with experts pitched against each other, I would need to develop skill in handling challenging questions and making the points I needed to make.

Has it affected others?

I hope my reflections can remind others of the purpose of our media stories; about how we would like to make a difference and reach people to raise awareness of important issues.

Top tips

What top tips would you give to doctors in your specialty about how to get the most from reflection or thinking constructively about a particular problem?

- CPD is not something we do for the Faculty or to tick a box for the GMC. It is the learning we document for ourselves.
- CPD is what we get out of the job in learning and experience; it is different from the effort we put into our jobs as outlined in our work objectives.
- The four key questions that we reflect on for our CPD are a structured way of experiential learning:
    - Why did I choose this activity?
    - What did I learn?
    - How am I going to apply this learning in my work?
    - What am I going to do in future to further develop this learning and/or meet any gaps in my knowledge, skills or understanding?
- Go back to your reflective notes from a few years ago and you can track the journey you have been on.
- A personal development plan is important to start you off on your cycle of CPD - plan, reflect, review, plan again.
- Reflecting with a peer or buddy enables you to reflect more deeply as they can question to help you find the answers for yourself.