Do training and CPD foster truly reflective GPs?

MODELS OF REFLECTIVE PRACTICE

'Know how, and to what extent it might be possible to think differently, rather than legitimating what is already known.' (Michel Foucault)

The concept of the 'reflective practitioner' was first introduced by Schön in 1983,[1] although it has its roots in the writings of John Dewey in the 1930s. Although there are a number of differing conceptualisations of reflection, most emphasise purposeful, critical analysis of experience and knowledge in order to achieve deeper understanding and guide future practice.[2] The ability to reflect is important for the development of all five core capabilities of a GP.[3] The need for GPs to be reflective has also been recognised by both the General Medical Council[4] and the Royal College of General Practitioners (RCGP)[3] as an essential component of Continuing Professional Development (CPD). The literature on reflection suggests the ability to reflect is amenable to development over time and with practice. It appears to be stimulated most often by encountering complex clinical problems.[4]

Most models of reflection regard social reality as objective, amenable to rational, systematic analysis. Learning is viewed as a disembodied, structured cognitive activity. Reflective practice is seen as a means of maintaining critical control over the more intuitive aspects of experience. Knowledge gain is regarded as instrumental for changing future events. Although there is some evidence to support that such reflection promotes deep cognitive learning there is little current evidence for the promotion of self-understanding.[4] The capability of 'Knowing Yourself and Relating to Others' in particular requires the practitioner not only to consider events or situations outside of themselves, but also to contemplate experiences from within.

More recent models of reflective practice recognise the need for reflexivity that elaborates reflection in such a way. Reflexivity, as defined by Fook *'is a stance of being able to locate oneself in the picture, to appreciate how one's own self influences* [actions]*'*.[5] As Fook observes, *'it is potentially more complex than being reflective, in that the potential for understanding the myriad ways in which one's own presence and perspective influence the knowledge and actions which are created is potentially more problematic than the simple searching for implicit theory'*.[5] Reflexivity emphasises praxis and can lead to greater self-understanding and self-change.[6] It has its roots in social constructivism, which proposes that our social realities and sense of self are created between people in everyday interactions and conversations through verbal, non-verbal, and written communication. Knowledge of the world is viewed as socially situated and constructed through interaction. It is an ongoing, dynamic, emergent process.

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Knowledge is not only the result of information and/or theory, but also arises from taken-for-granted ways of sense making that draw on the flow of how we respond, react, and negotiate meaning with others. This process is never fully under our control. Learning is viewed as an embodied activity involving responsive understanding of how our realities and identities are established and maintained. It is often provoked by unease or uncertainty.[6] In practice, the distinction between reflection and reflexivity is blurred, for example, it is difficult to reflect on experience without there being an element of reflexivity. For the rest of the article I will therefore, in line with Bolton,[7] conflate the two.

ORGANISATIONAL PRACTICES AND THEIR INFLUENCE ON BEHAVIOURS

GPs in the current context of the NHS face increasing pressure to remain up to date and true to their ideals. When faced with such unease or uncertainty, being reflective can help us not only recognise the limits of our knowledge, but also understand how our realities and identities are constituted in relational ways. It may involve reflecting inward towards the self, questioning thought processes, feelings, attitudes, values and belief systems, prejudices and habitual actions in order to understand ourselves; outward to the cultural, historical, linguistic, political, and other forces that shape the social world in which we operate; and between, on the social interactions we share with patients and colleagues. This involves locating ourselves in the experience through critical examination of the assumptions underlying our actions, the impact of those actions, and from the wider perspective what constitutes good practice. It can raise awareness of how our behaviours may have been influenced by socialisation, the processes by which we interpret our role as GPs through the lens of our unique background and the current context and culture of the NHS.

The postmodern view of culture rejects the rationalist view of the world in which reality is fixed and understandable and culture discovered. Culture is viewed not as the sum of activities, symbolic and instrumental that exist in the organisation and create shared meaning, but as participants' interpretations of the organisation's activities. Its coherence derives from the partial and mutually dependent knowledge that each individual develops out of the work they do together.[8] During socialisation culture is not transmitted, but co- and constantly re-created as members seek to generate meaning during interactions. Much of what takes place is at a tacit level where what is seen as unusual, non-routine, or incongruous to the outsider becomes commonplace and taken for granted for those within the organisation. It often

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unfolds in a subtle, incremental manner.[8]

Being reflective enables us to become aware not only of how our behaviours may be unduly influenced by organisational shared practices and ways of being, but also by how we may become unintentionally involved in creating professional structures counter to our personal values. Through such reflection we may see why such practices might marginalise groups or exclude individuals and raise awareness of the relations of power that operate in these contexts. This may lead to review and revision of our ways of being and relating, resulting in more responsive, collaborative, and ethical practice.[7,9] However, it must be recognised that, although culture is open to challenge and change, historical and social forces may limit change.

BARRIERS TO REFLECTIVE PRACTICE IN TRAINING AND CPD

Reflective practice should be viewed not as a technique, but as a way of being where we take responsibility for creating the type of practice and NHS we aspire to. It needs to be fostered throughout training and beyond. Its concepts could be introduced to GPs early in training during group work sessions. The Johari window[10] and Lawrence-Wilkes and Ashmore's model[11] are useful tools as they promote a reflective approach that accepts and respects diverse perspectives and produce shared and inclusive knowledge. It is fostered most effectively by strategies such as ongoing internal dialogue promoted by the use of journals and the support of trusted others such as trainers and supervisors. The RCGP portfolio, with its mechanisms for trainer/supervisor feedback that have been shown to be essential for its effectiveness,[12] could provide an ideal instrument to encourage through-the-mirror writing.[8] However, it has become an instrument of accountability, mitigating this potential.

The current structure of training is detrimental to the development of reflection as the majority of time spent in the practice setting is in the final year of training, when the registrars' focus is predominantly on the assessment process of the MRCGP. Situating training mainly in practice would provide more opportunity and time for reflection. Following entry into practice few mechanisms exist to provide the support of trusted others. Balint and young practitioner groups rely on highly motivated individuals and eat into family and leisure time. The appraisal system, like the e-portfolio, is instrumental, providing little opportunity for regular support. Calls for the formal introduction of clinical supervision, valued and established in most of the helping professions, have gone unheeded. As a profession, individually and collectively we need to be reflective about whether current training and CPD arrangements can foster truly reflective practitioners.

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