Reflective Practice

Learning to reflect on and learn from difficult clinical situations in which you have been directly involved is a vital part of being a good doctor. Recognising that a clinical situation is a significant event and then either merely discussing it with colleagues or, worse, ignoring it will lead to a high probability that it will happen again. Risk management processes will analyse the event and make recommendations that should reduce the risk of such an event recurring. Reflection of the analysis will add personal insight which will lead to changes and improvement in your clinical practice. Reflective practice allows you to describe what happened and why, what you have learned and, most importantly, what you would do differently next time.

Reflective practice will lead to you changing practice and you may have to acknowledge that you may have made a mistake. Reflective practice is therefore not always an easy process and the evaluation process should be undertaken with your educational supervisor. However, the process is not about apportioning blame but of recognising and learning from poor clinical practice. For this to be a meaningful process you will need to examine previously and often firmly held beliefs about your practice and also learn to accept that you may have been wrong. Only by continuously evaluating previously held beliefs and assumptions will you be able to learn and move forward.

This section of your logbook is designed to assist you in this process. If you are involved in a difficult situation, record the event and your thoughts about it on the reflective practice form. You should aim to discuss these forms either with your educational supervisor or the consultant directly involved with the case. If the case has been particularly distressing for you, please seek help and support quickly.

It is your responsibility to gather the material required for this section of the portfolio. The material demonstrates your attitude to maintaining good medical practice by regularly taking up learning opportunities and demonstrating the ability to be a reflective self-directed learner.

Use the reflective practice form to help you analyse the critical events. It will form the basis of the discussion with your educational supervisor. An example of a reflective practice situation is included for your information.

REFLECTIVE PRACTICE

Date: _____

Areas for reflection (please tick all relevant boxes)**:**

Clinical skills ☐ **Judgement** ☐ **Communication** ☐ **Decision making** ☐ **Team working** ☐

Clinical situation

What do you need to reflect on?

What is the most important thing you have learnt from this experience?

What would you do differently next time?

Has this experience highlighted any deficiencies in your training and, if so how, are you addressing them?

Summary of discussion with educational/clinical supervisor

REFLECTIVE PRACTICE EXAMPLE

Describe the critical event – what happened?

A missed diagnosis of cervical cancer

A 52-year-old woman was referred to the gynaecological triage unit by her GP, with a 6-month history of increasingly irregular vaginal bleeding which had failed to respond to norethisterone. On the day of referral she had been bleeding heavily but this had settled by the time I saw her. I assessed that she was haemodynamically stable, took blood for FBC and group & save and took a full history from her.

She was Para 2 + 1 having had two vaginal deliveries and one early miscarriage. She had been sterilised. Her periods had been regular until just over a year ago when she had a 3-month spell of amenorrhoea, followed by the current episode. She had participated regularly in the cervical screening programme. Her last smear had been 18 months ago and was normal. She was not currently sexually active. Her GP had previously arranged an ultrasound scan, which had shown a normal uterus with an endometrial thickness of 8 mm.

My presumptive diagnosis was perimenopausal dysfunctional uterine bleeding. I discussed the possible insertion of a Mirena intrauterine system. She seemed keen on this but because the triage unit was very busy, I asked her to make an appointment to attend the clinic for this to be inserted. I recognised that she needed to have an endometrial biopsy taken and discussed this with her but felt it fairer for this to be done immediately before the Mirena insertion as she seemed reluctant to be examined. I suggested that in the meantime she should continue with the norethisterone, together with tranexamic acid as required. Her Hb was phoned back 97 g/l with a microcytic picture and I wrote a prescription for oral iron.

Her clinic appointment was not for another 8 weeks. She continued to bleed constantly and her GP referred her back to triage, where she was seen by another registrar. On examination, she was found to have an ulcerating carcinoma of her cervix. Biopsy result confirmed the diagnosis. Review of her last smear result had shown the presence of abnormal cells which had been overlooked (a false negative smear). She is now under the care of the oncologists.

Why did it happen?

The possibility of a diagnosis of cervical cancer never entered my head. I just assumed that this was a case of perimenopausal DUB given the patient's age and menstrual history and her normal smear history. I also now realise that I should have taken a more careful and detailed history of her bleeding and noted the significance of her failure to respond to norethisterone. The latter was clearly documented in the GP's referral letter.

I had advised her to continue with the norethisterone, which was totally inappropriate given that she had failed to respond so far. Similarly, the suggestion of use of a Mirena was also inappropriate without further investigation.

I was falsely reassured by the normal results of both the ultrasound scan and the smear. It has been impressed upon me in the past that investigations are an aid to clinical assessment and should not be seen as a substitute. The false negative smear is being investigated. I may have used the negative scan result as another excuse for not performing an endometrial biopsy.

The history and presentation in a woman of this age should have alerted me to the possibility that this could be an indicator of either endometrial or cervical malignancy. Above all, there is no excuse for my failure to perform the most fundamental of gynaecological assessments – a pelvic examination. My justification for not having done so at the time was to save her from having to have two separate examinations. However, I was also using this as an excuse because of other pressures within the unit. At the very least, I should have ensured that she was given a clinic appointment much sooner that 8 weeks' time.

I did not discuss this patient with the consultant on call for the day. I felt that the assessment of the patient was within my level of competence and that senior help was not necessary. Had I sought advice, the consultant would certainly have asked for my clinical findings.

I realise that my failure to make the diagnosis will probably not affect her prognosis but this does not make me feel any better about the situation.

What have you learned?

I already knew that abnormal bleeding in a perimenopausal woman should be regarded as secondary to cancer until proved otherwise. I also knew that both smears and scans can give misleading results. The importance of this has now been reinforced and I hope that I will not make the same mistake again.

This case has taught me the importance of thorough history taking and clinical examination and of not relying so heavily on the results of investigations. These have to be interpreted within the clinical context of each case.

I have had to question my own style of history taking and also my ability to recognise warning signs and prioritise cases appropriately. I have also learned not to

let time constraints or patient's anxieties stand in the way of appropriate management. Most patients' fears about clinical examination can be overcome by a sensitive explanation of its importance.

What have you changed?

I always carry out a pelvic examination unless there is very good reason not to do so. If I decide not to do an examination, I always justify my decision in writing.

I am trying to be more thorough and critical in my history taking. For each case, I now think more carefully about the differential diagnosis to ensure that I am not overlooking something that may be important. If in any doubt about my management plan, I always seek more senior help. Even where I do not feel that this is required, I try to reflect on each case as though I was preparing to present it to a consultant or more senior colleague and in this way I hope that I will not attempt to cut corners.