How do pediatric faculty and residents teach, learn and use reflective practice? A multi-institutional qualitative study

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ABSTRACT BODY:

Short Description: Our study utilized focus groups to explore the understanding, perceived value, and use of reflective practice by pediatric faculty and residents. Reflective practice is incompletely understood. Faculty and residents often reflect in clinical settings, but may not identify it as such or not reflect in growth-promoting ways. Strategies to address barriers include developing knowledge/skills related to reflection, providing performance data to inform reflection, and creating “space” for safe reflection and mentorship to guide the process.

Abstract: Purpose:

Despite a growing focus on reflection in medical education, there are limited data on faculty and learners' knowledge of and experience with reflective practice[1]. Our aim was to explore the understanding, perceived value, and use of reflective practice by pediatric faculty and residents.

Methods:

We conducted 6 focus groups with a convenience sample of pediatric residents and teaching faculty from 3 institutions using a semi-structured facilitator guide until thematic saturation occurred. Interviews were recorded, transcribed and analyzed through inductive iterative review using grounded theory. Two investigators independently coded transcripts and reconciled codes to develop themes. All investigators reviewed the coding list and developed a final list of themes through consensus. This study was IRB approved.

Results:

Twenty residents and 17 faculty participated in 6 focus groups (1 resident + 1 faculty group/institution). The following themes emerged. Reflection is identified as happening post-hoc (“on-action”), with reflection “in-action” occurring subconsciously. Reflection is initiated in response to triggers, often negative, including: awareness of competency gap, uncertainty about patient management, unexpected clinical events, emotional events and performance data. Motivation to reflect includes intrinsic intellectual curiosity or desire for accountability towards others. Barriers include negative attitudes towards reflection, underdeveloped reflective skills, and competing demands. Facilitating factors include trusted mentorship and protected time and space. Some engage in unproductive, self-deprecatory, rather than goal-directed reflection. Reflection on positive encounters is less common but valued as important to learning and professional growth.

Discussion/Conclusion:

Reflective practice is incompletely understood by residents and faculty. They often reflect in clinical settings, but may not identify it as such or not reflect in growth-promoting ways. Strategies to address barriers include developing knowledge and skills related to reflection[2] (including shifting away from negative triggers), providing performance data to inform reflection[3], and creating “space” for safe reflection and mentorship to guide the process[4].

Level of Audience: Mid-career

Focus of Presentation: Continuum
