

Commentary: “I Hope I’ll Continue to Grow”: Rubrics and Reflective Writing in Medical Education

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Abstract

One respected tradition in medical education holds that physicians should struggle to maintain sensibility, openness, and compassion in the face of strong contravening tendencies. However, today’s medical education is structured around a more recent tradition, which maintains that physicians should struggle to develop emotional detachment as a prerequisite for

objectivity. In this model, sensibility and reflective capacity are potentially subversive. Reflective writing is one component of a revisionist approach to medical education that explicitly addresses reflective “habits of the mind” as core competencies and builds on existential concerns voiced by medical students. In response to Wald and colleagues’ study, the authors reflect on

the role of repeated formative feedback in developing reflective capacity. Formative feedback is as critical in this process as it is in traditional clinical learning. The authors emphasize that well-designed rubrics can assist learners in delineating desired outcomes and teachers in providing appropriate guidance.

Editor’s Note: This is a commentary on Wald HS, Borkan JM, Taylor JS, Anthony D, Reis SP. Fostering and Evaluating Reflective Capacity in Medical Education: Developing the REFLECT Rubric for Assessing Reflective Writing. Acad Med. 2012;87:41–50.

“I worry that I’m not good enough or worthy of this profession.”

“I’m anxious about my own level of maturity: I hope I’ll continue to grow as a person and as a physician.”

“Trying to reconcile the science of medicine with the human patient [is troubling].”

“The challenge will be finding a balance between being objective and being compassionate.”

These are a few of the sentiments expressed by incoming Stony Brook medical students during Orientation Week when we ask them to reflect on the issues most troubling to them as they

begin medical school. Many students, of course, list obvious concerns, like mastering an avalanche of material or paying off their loans. However, a substantial number identify deeper anxieties about virtue and character. In the small-group sessions that follow, this latter type of concern is often the focus of discussion.

These students will soon discover that medical education neither fosters open discussion of character and virtue nor provides the learner with much guidance in developing reflective skills, like empathy and practical judgment. The educational climate they encounter is largely at odds with a key insight of physician educators of the past. These physicians had framed professional development, at least in part, as a struggle to nourish “sensibility of heart,” “affectionate, sympathizing spirit,” “tender charity,” and “intensely personal values”^{1–4} in the face of medicine’s “manifest tendency to harden and corrupt the heart”² and to desensitize “the human heart by which we live.”⁵ They warned that unless students and practitioners devoted “time, sympathy, and understanding”⁴ to this endeavor, they would be vulnerable to “this coldness of heart, this moral insensibility.”³ They obviously believed that character development during medical education was an attainable goal and that teachers bore substantial responsibility for guiding students toward its attainment.

Although many physicians voiced similar concerns during the last half century, medical education in practice adopted a different perspective. Given the new scientific and economic context of health care, the growth of professional virtue, although avowedly still important, was no longer considered an explicit goal of medical training. Rather, this new tradition held that virtue, empathy, and compassion could not be taught. Moreover, medicine’s tendency to harden the disposition underwent a sea change. Reframed as “detachment” and “objectivity,” this process, once considered a disastrous side effect of medical practice, now emerged as a highly beneficial outcome for engaging in “hard” medicine. “An affectionate, sympathizing spirit”¹ was replaced by detached concern. In 2003, Thomas Inui,⁶ surveying the result of these changes on professionalism in American medical schools, wrote:

Every source of information I can find suggests that the lived experience of medicine is best characterized as a struggle. The circumstances into which we are thrust—because of the very nature of our work—challenge us, and this idealistic view of medicine, regularly.

Yet, he concluded, “The formative trajectory of medical students is one that prepares them poorly for the kind of life commitment that we as faculty ... hope they make in their careers.”⁶

Long before Inui wrote these words, academic physicians had adopted the

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term “professionalism” to characterize a large, unruly crowd of character traits, virtues, duties, skills, manners, and professional practices. The explosive growth of the movement to introduce this concept into medical education generated many creative new initiatives but also collateral damage. For example, frequent, mantra-like repetition of the word “professionalism” can seem a one-size-fits-all solution for deep-seated problems in medical education. Likewise, students, who already labor under the weight of a Sisyphean educational burden, can experience professionalism language as preachy and didactic. The movement has provided a wealth of opportunity for academic probers, definers, organizers, builders, debunkers, and politicians. Fortunately, it has also inspired exciting new strategies, including the introduction of narrative medicine, reflective practice, and, specifically, reflective writing, into the curriculum.⁷ In a quick search of databases available through Stony Brook University’s Health Sciences Library, we discovered that the topic “reflective practice” first made its appearance in the literature in the late 1990s and included only 14 articles before 2006. This increased to 150 articles between 2006 and 2009 and to 609 from 2009 through July 2011. “Reflective writing” showed the same explosive growth.

What is reflective capacity? In 2000, Donaghy and Morss⁸ defined it as “the higher order intellectual and affective activities” in which practitioners engage “to critically analyze and evaluate their experiences in order to lead to new understandings and appreciation of the way they think and operate in the clinical setting.” Wald and colleagues⁹ summarize a number of roughly similar definitions from the last decade. We are particularly fond of using Epstein and Hundert’s¹⁰ phrase “habits of the mind” because it captures the idea that reflective capacity is a core competency that allows “the practitioner to be attentive, curious, self-aware, and willing to recognize and correct errors.” For example, a competent physician

should be able to judge his or her level of anxiety when facing an ambiguous clinical presentation and be aware of how the anxiety of uncertainty may be influencing his or her clinical judgment.¹⁰

The idea that students learn useful clinical skills through reflective writing contradicts two premises of recent medical education. First, because reflective writing aims to enhance empathy and compassion, it rejects the idea that such qualities cannot be taught. Second, its focus on enhancing sensibility of heart restores the pre-1960s realization that excessive detachment diminishes physician effectiveness. Other participatory learning techniques that engage the student’s emotion and imagination contradict these principles as well. However, these efforts still take place against the background of a crammed curriculum and a toxic hidden curriculum. Do they work? Is there evidence that reflective writing actually accomplishes its goals? The answer depends on which end points you consider meaningful. Sandars⁷ concludes that “there is no evidence of the benefits of reflection on ... [medical students’] long-term development, especially in their subsequent clinical care.”⁷ Nonetheless, a number of studies do demonstrate significant improvement in short-term objective outcomes, like measures of self-awareness, professionalism, and humanism.^{7,11}

The traditional model of clinical learning in medicine presupposes guidance by exemplary physicians with expert understanding of skills and outcomes to be assessed. Despite the traditional macho aphorism “Watch one, do one, teach one,” trainees attain expertise in medical procedures only through repetitive *guided* practice. Likewise, if the goal of reflective writing is to build specific qualities and skills, then trainees require expert guidance here as well, not in writing as such, but in the relevant “habits of the mind.” Thus, formative feedback is of key importance. The content, context, and style of accurate reflective feedback are so different from most teaching in the clinical setting that even experienced clinical faculty are apt to flounder. This is where rubrics can be useful tools for both learners and teachers by directing them to the desired outcome and providing relevant examples. Rubrics can identify and characterize “core processes of the reflection construct” including “presence, recognizing ‘disorienting’ dilemmas, critical analysis of assumptions, attending to emotions, and deriving meaning.”⁹ Wald and colleagues⁹ are leaders in the

development of rubrics to assess reflective writing in medical education. Their current study, describing the iterative, theory-based process by which they constructed and evaluated the REFLECT (Reflection Evaluation for Learners’ Enhanced Competencies Tool) rubric, summarizes and extends their earlier work.

The REFLECT rubric is notable for its good psychometric properties and its plausible claim to validity—that is, actually measuring critical reflection. Likewise, the authors’ iterative process of construct development is a model of careful, systematic thinking. Wald and colleagues⁹ maintain the focus on teaching and assessing reflective skills by specifying outcomes that require critical reflection—confirmatory learning, which provides support for “frames of reference or meaning structures,” and transformative learning, which introduces the student to new ways of conceptualizing his or her experience. Both have relevance “for gaining insight to guide present and future behavior.”⁹ The authors argue that, as is the case with any type of skill, reflective skills require practice, feedback, and more practice. This perspective generates their most important recommendation: “We propose the use of the REFLECT rubric as a developmental tool within medical education ... for formative rather than summative assessment purposes.”⁹ Guiding, not grading, is the key.

Reflective writing is one component of a revisionist approach to medical education that explicitly addresses existential concerns voiced by medical students. Accurate formative feedback is critical to this process, just as it is in learning direct patient care. One respected tradition in medical education holds that physicians must work hard to maintain sensibility, openness, and compassion in the face of strong contravening tendencies. However, today’s medical education is structured around a more recent tradition, which maintains that emotional detachment should be sought and sensibility suppressed. Reflective writing is an important tool for restoring reflective “habits of the mind” to core competencies of medical practice.

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