Reflective Writing in the Competency-Based Curriculum at the Cleveland Clinic Lerner College of Medicine

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Abstract

The Cleveland Clinic Lerner College of Medicine of Case Western Reserve University is a five-year medical school where the major emphasis is to train physician investigators. In this article we describe our experience with reflective writing in our competency-based medical school, which has reflective practice as one of the nine core competencies. We outline how we use reflective writing as a way to help students develop their reflective practice skills. Reflective writing opportunities, excerpts of student pieces, and faculty and student perspectives are included. We have experienced the value of reflective writing in medical school education and believe elements of our program can be adapted to other training environments.

Introduction

The Cleveland Clinic Lerner College of Medicine (CCLCM) of Case Western Reserve University is a five-year program with a major emphasis on the training of physician investigators. First- and second-year students receive basic science and clinical research training that culminates in a master level research thesis completed during years three to five. The medical college opened in July of 2004 and is now in its fourth year of matriculation with the first class to graduate in May of 2009.[1] The class size of 32 allows for intimate learning environments. Students learn the basic science curriculum in seminars and problem-based learning groups. Additionally, students begin their clinical experience early in the first year when they are assigned to a longitudinal outpatient clinic preceptor for a half day every other week during year 1 and weekly during year 2. This is combined with communication skills, physical diagnosis, and clinical correlation sessions. All students participate in seminars and small groups that focus on professionalism, ethics, and other topics relevant to the role of physicians in our society. These seminars occur weekly in the first two years and several times per year in years three to five.

Reflective writing is integrated throughout all five years of the program. Instead of traditional grades, a competency-based portfolio assessment system is used. Students are assigned a "physician advisor" who helps guide them through this process. Funding for the maintenance of the physician advisor program is provided by the medical school because of the commitment to this portfolio form of assessment. Reflective practice—a core of the nine competencies—is defined: *Demonstrate habits of analyzing cognitive and affective experiences that result in the identification of learning needs, leading to integration and synthesis of new learning.* To this end, writing serves either as a stimulus for further development or a way in which to perform reflective practice.

This article describes our experience with reflective writing. We review here a way to help students develop

Table 1. Reflective writing opportunities
Portfolios
Patient logs
Patient journals
Professionalism seminars
Web logs
Forums for sharing spontaneous pieces




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their reflective practice skills with six writing opportunities (Table 1) and six student examples to demonstrate both the value of writing and that the elements of our program can be adapted to other training environments.

The Portfolio Process: Years 1-5

Students in our medical school do not earn grades. They are responsible for constructing written portfolios to document their achievement of the nine competencies (Table 2) throughout the five-year program. Every student writes a series of essays reflecting their progress toward the specific standards that are outlined for each respective competency. They cite evidence to support the conclusions they have drawn from items produced and the feedback on their performance. These formative portfolios are completed at set times during the year with a summary portfolio at year-end to demonstrate meeting the competency standards required to pass that academic year.

As set out in a review of the CCLCM portfolio process, *Reflective practice is the foundational competency of the CCLCM program, underscoring the critical importance of learning from experience and engaging in conversations about practice to develop personal judgment.*[2] Placing the reflective practice competency (Table 3) on the same level as medical knowledge and clinical skills stresses the importance and utility of the development of this skill set to students.

The steps of the assessment system and portfolio process create an environment that necessitates reflective writing.

Excerpt from a Portfolio from Year 1

(Written shortly after the first Summary Portfolio)

… And here, I hit a wall. I had entered a world where I was being trained to elicit the deepest secrets, maladies, and weaknesses of my patients but knew nothing about how to help them. I knew how to calculate the stroke volume of a heart and that the hormones produced by the anterior pituitary roughly amounted to the pneumonic, FLAT PiG, but I did not have a clue about how to soothe a bursitis, relieve the muscle aches of a statin, or help a patient sort out Medicare Part D. I became an awkward ear that took in information but offered little in return. I felt unworthy to be asking and I felt dirty to grasp at canned lines from textbooks only to see them achieve their intended effect. Then, late last spring, much of this changed. I was interviewing a patient struggling with a chronic problem. Appropriately, I said something expressing my concern. My patient thanked me and grinning wildly, turned to my preceptor and said, "Oh, I see you are teaching them empathy these days!" We all laughed, but my perspective on my role in patient care had been fundamentally changed.

Patient Logs: Years 1-5

The focus of assigning first-year students to a primary care faculty preceptor—for a two-year longitudinal clinic—is initiation to the profession and to learn basic interviewing and physical examination skills. After seeing four patients during a clinic session, students create a "patient log" for each encounter. In addition to patient demographics and diagnoses, students summarize their encounter, identify learning issues, and reflect on other issues raised in their mind.

Table 2. Nine competencies
Reflective practice
Research
Medical knowledge
Communication
Professionalism
Personal develoment
Clinical skills
Clinical reasoning
Health care systems

This first opportunity for reflection on patient interactions is meant to be "real time" and is completed by end of clinic day. Faculty provide comments on the interaction and the student's observations. The creation of patient logs continues throughout all clinical rotations, although in years three to five only a subset of logs are reviewed by faculty.

Excerpt from a Patient Log from Year 2

NonHispanic White Male, aged 65 years
Clinic: *General Internal Medicine*
Diagnosis(es): *Alcohol problem*
Student comments:

Patient arrived with his wife for immediate treatment of his alcohol use. An incident occurred last night in which he got up in the middle of night to drink, which, as I learned through our discussion, appears to be a common occurrence. This time he fell; although he had no memory of falling.

When I entered the room and introduced myself, they expressed displeasure that they were speaking to a medical student. The first thing he said was, "I need treatment for alcohol, what are my options?" Although I knew the "categories" of options from our instruction week on substance abuse, my knowledge was still somewhat limited. I informed them that I was not sure of all of the options; the doctor would be the main resource. My goal was to collect the information that would aid

Table 3. Standards for the reflective practice competency
Comfortably and skillfully observes and gives a balanced description of personal performance.
Interprets and analyzes personal performance using feedback from others to identify strengths and weaknesses, citing convincing evidence to document insights.
Evaluates personal performance and makes judgments about the need to change, citing convincing evidence to support these judgments.
Develops realistic plans and timelines to achieve desired outcomes; implements and refines plans, citing convincing evidence documenting correction of deficiencies and/or growth.

the physician in providing his recommendations, such as what they were looking for in a treatment program. I proceeded to ask them what they knew of certain program types, etc. This proved calming and seemed to allow them to put some trust and faith in me. To allow him an opportunity to discuss his feelings, I commented that he outwardly appeared anxious and emotional. My reflection on the encounter is that it was a successful technique. At the end I congratulated him for taking this important but very difficult step, and he expressed appreciation of this acknowledgment.

Thus far in my training, this was one of the most intense situations that I have walked into alone. However, using the communication skills I have learned, I was able to form a rapport with the patient and his wife and gain information that in the end was useful for his treatment decision. I also witnessed the effect alcohol can have on an individual and their loved ones and the challenges they must face even once the problem is acknowledged. In the end, the encounter had a layer of optimism as they both shared some of their fears and concerns with the hope that this would be a turning point.

Patient Journals: Year 2

In their second year of longitudinal clinic students are asked to complete several "patient journals" related to patient encounters. These journals differ from logs in that students explore a focused question or issue in a brief essay, electronically submitted. Whereas the majority of these journal entries focuses on integrating basic science with clinical medicine, students are also encouraged to write about challenges in the other competencies of communication, professionalism, and the health care system. Preceptors guide students in identifying questions and review the entries to provide feedback.

Excerpt from a Patient Journal from Year 2

(The student's patient log for this encounter is integrated into the journal)

NonHispanic White Female, aged 65 years

Clinic*: General Internal Medicine*

Diagnosis(es)*: Diabetes, hypertension, dyslipidemia*

Patient Log*:*

I have seen this patient before. This kind woman is a challenging patient at times because of what can best be described as her "edginess." I misunderstood her at various points because she would report a few different answers because of uncertainty and then have trouble clarifying (eg, home BP readings). She presented with different issues that were causing her some anxiety.

Patient Journal:

This patient, although easily manageable, did have some characteristics that made her difficult to interview and examine. Upon further reflection, some characteristics she had were high anxiety and appearing exacerbated or annoyed at lines of questioning or physical exam items. My response was to reflect back to her the feeling of frustration I was sensing. The patient then replied that she was annoyed with the situation, not with the exam or with me. However, the experience evoked some feelings in me that I had not encountered before. Generally, I am not relieved when a visit is finished; however, I breathed easier when we left the room. I believe my feelings underlying this were that I felt more "on edge" because of her actions and, despite her comments, felt that perhaps I was somehow contributing to her state.

I consulted James Groves' article: "Taking Care of the Hateful Patient."[5] Whereas the patients described in this article displayed much different and more severe characteristics than the patient I saw, it shed light on the fact that there are always underlying emotions or reasons behind the patient's behavior and responses. For example, the article discusses four types of patient stereotypes: dependent clingers, entitled demanders, manipulative help-rejecters, and self-destructive deniers.

The key points for me to take away from the article and from my more benign experience in clinic are:

1. Recognize that there are underlying reasons for a patient's behavior. *In my patient, I believe her breast pain caused her to dread the possibility of breast cancer due to her breast pain. This manifested itself as anxiety, which caused her to be "uptight" and want to know what the answer was: is it cancer or not? My line of questioning and physical exam was just delaying the answer to this. The pain on the breast exam further reminded her of the problem and possibilities. I think she intellectually realized these were necessary steps, which is why she would catch herself at times and respond with a lighter tone.*
2. Recognize that these underlying feelings in the patient should be acknowledged, treated if possible, and that my actions should try to alleviate those feelings. *Reflective statements to the patient may be very effective. Psychological referral is a possibility in extreme situations such as the article describes. During the discussion I should assure the patient that I am not abandoning him or her and even suggest setting up a follow-up appointment after that referral to help ease the patient's emotions. In the case of my patient, I did acknowledge her frustration through my reflective statement and it proved to be effective.*

3. Recognize the feelings that patients evoke in me as the health caregiver. *This is an important first step to ensure that keypoint No. 4 is met. This requires personal reflection and acknowledgment of feelings that I may be ashamed to admit are present. Although I did not fully reflect or verbalize this at the time of the encounter because I did have associated guilt for these feelings, I worked through them more on later reflection and when composing this entry.*
4. Recognize that it is not how I feel towards the patient that is most important to their care but how I behave. *This requires conscious action not to allow those feelings identified in keypoint No. 3 to interfere with my care. Make sure that my behavior is acting to remedy keypoint No. 2 or to address the medical problems. I feel that I was able to prevent those feelings from interfering with my treatment—but again this was a very mild situation. The key will be to remember this when I do have one of the four "stereotyped" patients and fatigue attempts to hinder my internal regulation.*

Professionalism Seminars / Reflective Writing Assignments: Years 2-5

Students participate in professionalism seminars that often include reflective writing assignments beginning in their second year (Table 4). Students read assigned articles and are asked to share a brief written response to an article with their group.

Reflective Writing Selection from Year 3

(from the "Humor in Medicine" seminar)

I believe that true humor is the ability to be funny without making fun of another person. The genius of the comedian is one that can tap into something universally human, distort it, and show it back to us like those "fat" mirrors at carnivals. However, we are not comedians in medicine, nor are we expected to be. In fact, many patients appreciate a serious, empathetic physician who can serve as a guide through fear, instability, and great uncertainty. Yet, as both the bearers of bad news and the flickering lights of

Table 4. Seminars and writing assignment example

On Being a Patient: "Practicing Medicine without a Swagger" Read: In the hospital, a degrading shift from person to patient[1] The other side of the bedrail[2] Reflect on your experience thus far as a physician in training that has given you insight into the patient's experience of the medical system
On Being a Patient: "Delicate Balance in Keeping Hope Alive" Read: Doctors' delicate balance in keeing hope alive[3] Each student should be prepared to discuss his or her own experience (as a physician in training or as a patient or family member) of having participated in or seen a patient interaction in which a diagnosis and prognosis was given reflecting the balance of honesty and hope and what the student's reactions were.
Diabetes as a Model of a Social Crisis Read: Diabetes and its awful toll quietly emerge as a crisis[4] How does the US obesity/diabetes mellitis epidemic relate to the societal role of physicians?
Shared and Informed Decision Making Read: The script[5] How comfortable have you become with your scripted role in the patient-interaction process?
Humor in Medicine Read: Does laughter make good medicine? Discuss situations in which you witnessed humor that was directed toward patients. Did you participate? How did you feel in the moment? Afterwards?
Conflicts of Interest Discuss your own views and experiences on conflict of interest as you have seen or experienced them thus far in your career.

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hope, how can we not take on at least some of the emotion of our patients? I heard a pediatric oncologist speak of being admonished in her early career for crying because a crying doctor took the attention away from the patient and family. But what do we do with the emotions and tragedy we inherit so that we do not eventually become numb ourselves?

In steps humor. We laugh, emotion is released, and we feel better. And really, some patients are funny. A recent patient reminded me of this. Here was a man, morbidly obese, who believed he was a woman. Big and sweaty he would make inappropriate advances toward male residents and complain of PMS and spotting between periods. Time and again mornings brought tales of him wandering the wards soaked in urine and sleeping naked on the floors. Admittedly, I laughed. My laugh was not a real laugh; it was more of a middle-school bully—laughing at my own discomfort. He is funny because he is a caricature rather than a person, an uncomfortable reminder of my own incomprehension and lack of understanding.

However, the use of humor at home, behind closed doors, somehow seems acceptable. It is my decompression, my emotional release, my processing of the painful moments of life. In medical training, we alter our perceptions of life from the first day we cut into the lifeless body of another person—life becomes surreal and emotion becomes separated from experience. Naturally, we need to decompress. My concern is that our humor at home, our proclivity to say something inappropriate or demeaning, may in fact alter our interactions with patients. And paradoxically, I worry that our humor, meant to release our own difficult emotions, may hasten our desensitization to tragedy and to sadness. Dehumanizing humor actually builds barriers between ourselves and others and keeps real emotions at bay. It is addicting. We need it to be more frequent and more shocking to keep ourselves feeling, and to keep on laughing. We must ask ourselves at what point do patients become more of a joke than a person, even if we uphold the utmost of decorum and professionalism in their presence? In medical training we can teach the movements of empathy, and perhaps even empathy itself, but we can just as easily unteach empathy and hollow out those much practiced motions.

All of this is not to say that humor does not have its place in medicine. Physicians need to understand their emotions to mature as individuals and to maintain real relationships outside of work as well as within. During my time on the inpatient pediatric psychiatry unit, I was shocked at the raw intensity of each moment and the wide range of emotions. Humor was at times mild and at times frightening, as were the tears and the anger, but I saw it dance the line between making fun of patients and making fun of the situation. What I saw were extremes of emotion demanding immediate response and immediate decompression.

As physicians, we will experience emotion and at times be uncomfortable. We all will be or have been traumatized by our experiences in medicine, which only underscores the need to process and vent emotion. I can see that we must tread this fine line as people and physicians, between laughter and distance, versus incessant crying and emotional stress. My experience tells me that we need to be acutely conscious of this dichotomy in our daily work. Humor is appropriate, but we must be certain that we process our own emotion and not seek to dehumanize ourselves or our patients—we cannot afford that attitude to creep into our minds or emotions. We must therefore strive to be like the artful comedian who turns the fat mirror on ourselves and laugh at the bent and battered soul staring back.

Web log: Years 3-5

In the program's fifth writing opportunity, students are encouraged to anonymously post and respond on a private *Difficult Conversations* Web site. Faculty monitor the site content and provide additional responses. Similar to the patient logs students have realtime opportunities for reflective practice and writing.

Web log Selection from Year 3
Revelations

A young gentleman died today. This being my first sight of death at work, my impressions are: 1) Despite education/knowledge and experience, powerlessness inevitably prevails. It is a sight to witness great minds stand helpless over lifelessness; 2) Death is not death until it becomes death, until the process is witnessed; 3) Life moves on, except for mine.

Death is powerful and comes to us all no matter the age or profession. It is a simple idea, but as physicians I feel as though we really need to internalize that idea—to understand death because we deal in death. And that is not to say I am skeptical or embittered at this early stage, because I am in this for my amazement of people and life.

Spontaneous Reflective Writing

Ideally, a curriculum with structured opportunities for reflective writing will initiate a process where students will begin to use reflective writing to process their experiences, ie, become spontaneously *mindful*.

Spontaneous Writing from Year 3

(Written after finishing a 16-week core block of clinical rotations)

OB/GYN … PEDIATRICS … PSYCHIATRY … NEUROLOGY … the electronic medical record grants us the luxury of creating patient lists with the ease of a few clicks. As I progressed through my first four rotations during my third year of medical school, I diligently performed this task to increase my efficiency during morning prerounds and to allow me a few more minutes of precious sleep. Now, having reached my last day of the four-month stint, I click through the lists in a reminiscent fashion. As I see the patient name, I remember the individual, the disease, the physical findings, and the management plan. Many of these patients I only interacted with briefly, because either I switched to another service or they were discharged during my cherished days off. I interacted with most of these patients during a particularly vulnerable time as I gained knowledge of intimate details of their life during history taking … placed my hands on their damaged bodies for my education … and was present for elating or heartbreaking conversations regarding their mortality. Although short in duration, many were powerful interactions. It had been recited to me during discussions about humanity in medicine that being a physician is one of the only professions in which one is allowed to share such raw and poignant moments of human existence with previous strangers. However, much as a murmur of aortic insufficiency doesn't come alive until you hear one, I never gained a full appreciation of the sacredness of that position until I experienced full-time clinical medicine.

I continue to click through the lists. Some names bring a much stronger emotional response:

Mrs Jones a quadriplegic female, aged 55 years, with Stage IV sacral decubitus ulcers who passed away a month after I left the service … discovered only through my periodic checking of former patients. I will always remember her because she was the first patient I had cared for who passed away. Her words resonate in my head, "I don't want to die—I have so much left I want to do," as she lay unable to move in her frozen prison of a body. She taught me unsinkable hope.

A female pseudoseizure consult, aged 65 years, with whom I spent hours talking with as she finally released the details of the sexual, physical, and mental abuse she had received during her childhood. Whereas the texts and teachings from my attending on pseudoseizures are now part of my medical knowledge bank, I remember most vividly her huge embrace and kiss on the cheek. As we parted she said she would never forget me because I walked with her through one of the most monumental moments of her life. She taught me true survivorship.

Hindsight has given me much more respect for these interactions. The blur of the rotations hindered my ability to reflect; energy instead went to maintaining alertness despite constant sleep deprivation, trying to fill the never-ending knowledge deficits, and attempting to complete new tasks with skill. Yes, I have new clinical knowledge and skills, my treatment plans are more fully developed, and my presentations more concise. Yet, I now also have the personal and raw human stories from this list of patients before me … their pain, fears, hope, and strength. These do not fit into the portions of my intellect that are filled with the academic lessons specific to their cases. Instead, these fill my heart and soul and create an unexpected weight that I am struggling to cope with. I suppose as I progress through my career my soul will become a bottomless reservoir that each patient encounter will add to. The stories of patients will resurface periodically when I see a glimpse in the face or the actions of another patient … that unsinkable hope or that true survivorship. Others will quickly sink far into my memory and never re-emerge. Yet, they are each there because they are a part of my collective experience. Just as the medical knowledge I am gathering is building my medical library, these encounters are also shaping my soul. Realizing this, I now carry the weight of their stories with honor and privilege.

The Value of Reflective Writing and Reflective Practice

How do reflective writing and reflective practice shape physicians in training? What is the perspective of students and faculty, especially the physician advisors

Professional Competence

Epstein and Hundert define professional competence as *"the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and the community being served."*[1] To act with clarity and insight requires the capability for critical self-reflection—central to "mindful practice"—as practitioners tend to their own physical and mental processes during ordinary everyday tasks.[2]

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who play a central role? We offer our view and some concluding thoughts about the process.

Student Perspective

While reflective practice truly originates in internal monologues, reflective writing is one of the most powerful and concrete ways for a student to learn the art of reflection. Reflective practice is initially foreign and abstract. Outlining tangible steps, such as in the portfolio process and the guided prompts in the curriculum, provide a roadmap for the student to follow. The actual process of committing words to paper forces the student to proceed through reflection in a stepwise fashion and to formulate a level of reasoning behind each step. Though it initially feels awkward and forced, the students who begin to see its positive effects tend to embrace it holistically, incorporating its practice into both their professional and personal lives. On the continuum of reflective practice, some students will reach the ideal point where internal motivation, instead of these external requirements or prompts, becomes the driving force behind their reflection. This can then lead to continual and spontaneous reflective practice. Another value of putting pen to paper is that they have a written record that can be revisited later, gaining even more insight and growth. Thus, some will embrace reflective practice while others will not. It is truly an individual choice. For those who do not, simply being exposed to the concept provides an initial foundation that may be built upon in the future. Meanwhile, for those who do embrace it at the outset, they have an invaluable tool to use as they process the magnitude of experiences on their path to becoming a physician.

Physician Advisor Perspective

A role of physician advisors is to facilitate student growth as reflective practitioners through guided reflective writing and conversations. The guided writings include those described in this article, which transcend multiple settings across the curriculum. These, along with guided conversations, encourage introspection into their authentic performance on the basis of their assessment of evidence. The experience of the physician advisors over the past four years suggests that over time, reflective writing allows students to deepen their level of reflection. Their writing develops a very objective approach regarding the significance of experiences to their own learning and personal development. Students begin to own the process and adopt a general application of reflection to other life experiences. Students are not the only individuals who benefit from this process. Physician advisors, as the student's mentors, gain not only insight in how to better guide the reflective process, but also into their own capacity to be a reflective person.

Conclusion

All of our students are exposed to the curricular components described. Data from our surveys have suggested that students perceive value in most instances even though initially many are skeptical of a portfolio assessment in medical school education. Our experience thus far suggests that creating an environment that fosters reflective practice is vital for the personal and professional development of medical students. Reflective writing is a key way to stimulate and further develop this skill set. The inherent reflective writing components of the portfolio system in this curriculum have led to the natural development of other avenues through which to stimulate this form of writing. We have identified six opportunities for students to write reflectively based on their patient encounters and clinical experiences. However, we hold no illusions that this will be an easy process or be embraced as worthwhile by all students. In our experience students engage in the reflective process at different depths and energy. Two students who have found reflective writing to be critical to their growth and have successfully used it to process medical school experiences agreed to include examples of their writing. We recognize that there are unique aspects of our medical school that do not easily translate to other institutions. Nonetheless, we have identified a variety of reflective writing opportunities, many of which can be modified and tried in other settings. We hope to encourage other medical educators to consider incorporating reflective writing in their training programs. ❖

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