Phronesis; the art of practical wisdom in the day to day working and teaching of GP Trainees

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Abstract
How can insights from *theory* and *practice* be integrated?

Original Study: qualitative research evaluated the nMRCGP learning log (LL) as an educational tool in the development of doctors from GP trainee towards independent practice capable of reflexivity, (Stillman, K. 2012).

The literature indicates structured written reflection facilitates reflexivity but without compulsory assessment *students may not engage meaningfully.* Experience amongst GP trainees and trainers suggest the LL structured templates for written trainee reflection and trainer feedback is unpopular and time-consuming. Trainees perceived reflective practice as important but thought this prescriptive process and quantitative focus interfered with meaningful reflection; adapting to the task without reflexivity.

Applications and outcomes
A taxonomy for reflexivity and performance was established re-integrating theory with experience. As a model for exploring and shaping professional development the work identified stages of cognition and behavioural evolution: techné, praxis to phronesis. This informed a 'values-based' approach in the development and leadership of two GP training programs within HEE KSS and stimulates exploration of the nature of professional identity, 'flourishing', and how to enable this in a global health economy seemingly dominated by short term 'outcome measures' and 'self' above 'other'

Introduction

This paper presents three strands of a personal journey which has culminated in a sense of 'flourishing'. Whether or not this equates to *phronesis* or practical wisdom in the traveller is a matter for reflexion and critique.

The first strand involved original, in the field research as part of a masters qualification in practice education, exploring the use of mandatory structured written reflection amongst GP trainees. This work is presented in some detail on the premise that the development of reflexivity is integral to the concept of 'flourishing' in the professional world of modern General Practice.

The second strand describes practical applications of the original insights through various workshops and training programmes. The linkage of reflexivity to professional performance and 'becoming a professional', as part of GP trainee socialisation into a shifting professional identity, becomes part of a values-based awareness within curricula development.

The final strand considers the initiation of innovative developments in the context of multi and inter-professional education, training and research as part of the development of a locality Community Educator Provider Network (CEPN) or *Training Hub,* as described in the Five Year Forward View, (2014). Is it possible that in establishing this particular community of practice, primary care educators and enablers of education training and research in the community, can flourish and promote resilience?

Part One: the original service evaluation of the nMRCGP LL

(n denoted new at the time of this evaluation)

Overview

The reflective practitioner is deemed to have a mind open to possibilities, regularly and systematically reviewing performance, actively seeking to change practice in response to internal and external forces in order to be fit for purpose and fit for future. This is the ontology of reflexive practice.

This study utilised a methodological strategy of 'realistic evaluation' described by Pawson and Tilley (1997). It explored ten volunteer GP trainee users' narrative experience of the nMRCGP reflective LL as an educational tool for developing reflexive practice. The LL is a mandatory requirement of evidence of formative professional development and part of the summative assessment of competency for licensing for independent practice in the UK.

Participants had completed 24-27m of a GP training programme. The study recognized an interpretivist paradigm and used a phenomenological methodology. Purposive sampling captured trainee diversity. Pilot fieldwork was used to establish interview schedule content validity and a "reflexive researcher diary" for quality assurance. Face-to-face semi-structured audio-recorded interviews were analysed using structured inductive themed analysis following the method described by Braun and Clarke (2006).

Figure 1 An overview of realistic evaluation adapted from Pawson and Tilley (1997)	
Research framework Methodological strategy	Implementation Policy Implementation
Epistemology → Ontology Method	**Conclusions & recommendations** Evaluation contributes to experience with programme to shape stakeholder expertise.

Study background and General Practice Primary Care context

Modernising Medical Careers (Department of Health, 2003, 2004, 2008, Tooke, 2008) has led to extensive re-design and delivery of medical education in the U.K. Concurrent introduction of revalidation in 2012 of all UK doctors, (GMC, 2010), challenges to professional accountability through promotion of evidence-based practice, transparency of performance and public accountability all frame an educational trend in General Practice (GP), for competency-based assessment and portfolios of evidence.

The GP training curriculum uses a national electronic MRCGP portfolio (e-portfolio) throughout the three-year programme comprising a repository of workplace assessments, a reflective Learning Log, (LL) and a Personal Development Plan (PDP). Since 2007 this e-portfolio or Workplace-based assessment (WPBA), is one component of a triangulated, tripartite assessment process for licensing as an independent practitioner (RCGP, 2010a,

Mamelok, 2009). At the time of this study this approach represented a paradigm shift in thinking about how doctors learn and behave if they are to become GPs and maintain that privilege in the future. It also made and continues to make assumptions about trainees and trainers as self-directed learners capable of written reflective practice. Whilst other Royal Colleges and the UK Foundation programme have adopted portfolio approaches RCGP use of the MRCGP LL is bespoke.

In 2010 Miller and Archer's systematic review concluded that there was 'little evidence to date for WPBA as an educational initiative' (p.6), but appeared to exclude the LL component. An evaluation of the Foundation programme also found WPBA 'excessive, onerous and not valued' (Collins, 2010 p.12). Subsequently the Academy of Royal Colleges, (AoMRC), WPBA forum (2010) recommended that the GMC, AoMRC and Conference of Postgraduate Medical Deans, (COPMedD) 'define the most effective outcome of WPBA, and how feedback and reflection are used within the process' (p.13). Whilst some technical refinement of the MRCGP e-portfolio functionality has followed the use of the LL remains unchanged and emotive with both trainees and GP trainers (Curtis *et al.,* 2016). To date, (last literature search 3rd November 2016), **no** published data evaluating the LL as a tool for developing reflexive practice has been identified.

The MRCGP Learning Log

The LL utilizes templates to guide regular reflection on various learning opportunities throughout the training programme. GP trainers as Educational Supervisors (ESs), provide feedback on those entries which GPs in training (trainees), choose to share. Comment on the quality of reflection may be offered but the requirement for assessment is that the ES validates content on the basis of it being:

good enough quality for others in making assessments of performance i.e. that it relates to the chosen competency area and shows a meaningful reflection. Validation does not imply that competence has been achieved (RCGP, 2010b).

In the final review of progression towards certification validated entries illustrate the breadth of learning across the curriculum. The emphasis on the LL is quantitative (Foulkes *et al.,* 2011). The numbers of entries dominate the reflective quality illustrating a positivist reductionist medical culture, (Gillies *et al.*, 2009). Post qualification revalidation maintains this approach to portfolios of reflective evidence of performance (GMC, 2012).

Terminology and definitions.

The RCGP does not define reflexive practice; it describes a 'good quality' LL entry which appears to capture a flavour of the nature of *reflexive practice* as understood within this evaluation.

Figure 2 RCGP Learning log resource, June 2010

Evidence in the 12 competency areas
Your clinical or educational supervisor can only validate your entries if they are of sufficient quality.
A good quality log entry is one that shows good reflection, which means that it demonstrates your insight into how you are performing and how you are learning from your everyday experiences.
A good reflective log entry will show:

- Some evidence of critical thinking and analysis, describing your own thought processes
- Some self-awareness demonstrating openness and honesty about performance along with some consideration of your own feelings
- Some evidence of learning, appropriately describing what needs to be learned, why and how.

The meaning of *reflexive practice* was a challenge throughout the evaluation. The breadth of literature revealed a variety of definitions and intermingling of terminology creating confusion and ambiguity that goes beyond semantics and represents a lack of conceptual clarity arising from the different philosophical perspectives underpinning our understanding

of professional knowledge in professional practice (Kinsella, 2009). This creates difficulty when making sense of the epistemology of reflexive practice and understanding how reflexive practice is being adopted and used as both a formative process and assessment tool (Mann *et al*. 2009). Thus a working distinction between *reflection* and *reflexivity* was proposed and prior to interview trainee sense-of-meaning was explored. Ultimately the research generated a new taxonomy for reflective capacity.

Figure 3 Terminology: working distinctions derived from contemporary literature, 2012

- Reflexive practice is semantically aligned with reflective practice (Kinsella, 2009, Mann *et al*., 2009).
- Reflexive practice is a behaviour (Bolton, 2001, 2009).
- Reflection is an attitude of mind (Bolton, 2001).
- Reflective capacity involves an aptitude for metacognition (Moon, 2008).
- Reflective writing captures reflexive practice and facilitates reflection (Winter *et al.*, 1999).
- Reflexivity has the potential to transform thinking and behaviour (Playdon & Josephy, 2011, Johns and Freshwater, 2005).

The research question

This study sought knowledge of GP trainee awareness apprehension and understanding of the of the LL as an educational tool for developing trainee *reflexive practice* i.e. *perceptions* (Ostler, 1969), because our understanding of assessments of written reflective practice was extrapolated from other sources. Also, using portfolios makes assumptions about adults as learners (McMullan *et al.,* 2003). Nor is the current approach to the LL morally neutral risking loss of the formative value of reflective practice (Hargreaves, 2004). Whilst 'reflective practice' is an important self-development process (Hobbs, 2007 p.415), it requires student and teacher readiness and ownership (Neighbour, 2005). Holistic use of portfolios as part of an academic continuum of learning may have theoretical justification (Mann *et al.,* 2009, Lazerevic *et al.*, 2010), but GP trainees could be struggling with engagement (Maslow,

1943), new technology, new ways of learning and evidence presentation (Law, 2011, Berger *et al.,* 2011) alongside niggling ethical concerns. Hobbs (2007 pp.410-412) found student teachers had negative preconceptions of reflective practice and 'leading and repetitive writing prompts' resulted in 'strategic' and even 'faked' responses and irritation. If summative assessment of reflective practice instils resentment one must question the validity and moral value of this approach (Ghaye, 2007). This begins with understanding our GP trainees' perceptions and subsequently those of their teachers' and role-models' through an evaluation of the value of the LL as **an educational tool in the process of developing doctors from being a GP trainee to becoming a qualified GP capable of reflexive practice.**

Figure 4 Study Aims and Objectives
Aim: **To evaluate the MRCGP e-portfolio learning log, (LL), as an educational tool in the process of developing doctors from being a GP trainee to becoming a qualified GP capable of reflexive practice.**
Objectives: • **To explore GP trainee experiences and perceptions of the MRCGP e-portfolio learning log as a tool for developing reflexive practice** • **To interpret the function of the MRCGP learning log in GP training** • **To understand the benefits and challenges of using this learning log** • **To make recommendations, if necessary, based on the study findings that can shape how Educational Supervisors facilitate reflexive practice in GP training schemes.**

Study synopsis

Summarised method details are attached in appendix format.

Literature

Figure 5 Summary of key themes from the literature

- There is a lack of clarity regarding the separation of *reflection* and *reflexive practice*
- There is a tension between the formative development of reflexivity and the mechanistic process of frame worked approaches which in the case of the LL also undertakes a summative purpose
- There is extensive use of portfolios to support reflexive practice and develop professional behaviour but little supporting research
- Attitudes towards portfolios tend to be more negative than positive
- Role modelling and facilitation help improve student engagement with reflective portfolios
- Reflection, as described in the literature pertaining to professional development is a Western model that may be a cultural poor fit and linguistically challenging for students from non-Western cultures.

Results

To evaluate the LL as an educational tool for developing reflexive practice in GP trainees three broad objectives were identified: an exploration of GP trainee **experiences and perceptions**, an interpretation of the **function** of the LL in GP training, and an understanding of the **benefits and challenges** of using this learning log.

From the raw narrative data, the thematic analysis captured trainee experiences and perceptions which generated subthemes (table 1a & 1b).

Table 1a Synthesis of subthemes from original data

REFLEXIVE PRACTICE:

Summary point 4.3.1

- Reflective practice is difficult to conceptualise and is mainly described as a retrospective unidirectional activity
- The technical draw backs to the LL and quantitative emphasis affect trainee use of the LL as a formative tool for developing reflective practice
- Trainees develop strategic approaches for managing the LL that prioritise summative considerations above deep reflection

Summary points 4.3.2

- Trainees recognise reflective practice as important
- Trainees recognise and appreciate other approaches for developing reflective capacity

Summary point 4.3.3

- Reflective practice is demanding and needs facilitation and encouragement if it is not to be devalued and reduced to the level of "ticking a box"

Summary point 4.3.5

- Quantitative and external assessments of performance are prioritised over the development of reflexivity

Summary point 4.3.8

- The LL promotes reflective habits but the promotion of reflexivity is time constrained

Summary point 4.3.10

- Trainees spoke more of their personal emotions rather than emotions in others as triggers for reflective learning

THE LL:

Summary points 4.3.2

- The LL is more useful to some than others and this is learning style dependent and context specific
- Quantitative use the LL detracts from the qualitative deep reflection
- The LL serves a governance purpose which influences program delivery and may identify and support trainees in difficulty
- The LL promotes episodic reflective practice
- Use of the LL in hospital environments poses specific challenges linked to time management and contextualisation of learning

Summary point 4.3.4

- Trainees need ownership of their reflective learning and LL
- The timeliness and quality of supervisor feedback is important
- LL guidance needs to be consistent and transparent

Summary point 4.3.5

- The LL can motivate exploration of other e-based learning resources
- The LL is perceived to be more relevant in early stages of career progression

Summary point 4.3.7

- The technical accessibility and ease of using the LL provides potential benefits but current performance detracts from usability

Summary point 4.3.8

- Using the LL takes time and energy which is often managed in personal time

Summary point 4.3.11

- The LL is primarily perceived to track progress

Table 1b Synthesising subthemes

EMOTION & MOTIVATION:

Summary point 4.3.5

- The LL demands high commitment

Summary point 4.3.6

- The Foundation programme and academic experiences were not thought to address reflective learning as required for nMRCGP

Summary point 4.3.10

- Trainees can use personal emotion to trigger reflection but fear showing personal vulnerability
- The LL is an emotionally provocative learning tool
- The LL has a therapeutic role

Summary point 4.3.11

- Relationships based on trust are important safety considerations for trainee engagement with the LL

Summary point 4.3.12

- Trainees censor their exposure of professionalism within the LL irrespective of country of origin

PROFESSIONAL DEVELOPMENT:

Summary point 4.3.5

- The LL is useful to trainees in preparation for revalidation processes, but current format not sustainable

Summary point 4.3.9

- Trainees can adapt to new ways of learning, irrespective of cultural backgrounds with varying degrees of ownership and reflexivity

Summary point 4.3.11

- The LL is used variably to stimulate knowledge acquisition, raise personal awareness and stimulate development

From the subthemes four over-arching categories are visible within the individuals' developmental trajectory of becoming a reflexive practitioner:

- **Reflexive practice**; the technical knowledge, understanding and capability
- **The LL tool**; the framework or tool supporting the context of reflection
- **Emotion and motivation**; the impact of personal characteristics
- **Personal professional development**; the behavioural and transformational steps

Figure 6 Achieving *reflexivity* through use of the MRCGP LL

PROCESS	PERSONAL CHARACTERISTICS	CONTEXT
Reflexive Practice • A spectrum of activity, variously described and achieved • Requires an awareness of self and others • Intensive	**Emotion** • Facilitates reflection & influences engagement with the LL **Motivation** • Enhanced by teaching about reflexive practice • Influenced by the ES, time management, getting help • Culturally sensitive • Previous experience	**The LL** • A summative and formative tool • Time consuming • Technical challenges of LL
Personal professional development – a journey illustrated by adaptive and reflexive behaviours		
THE JOURNEY AS A PROFESSIONAL		

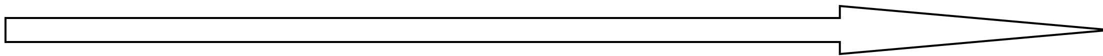
Discussion

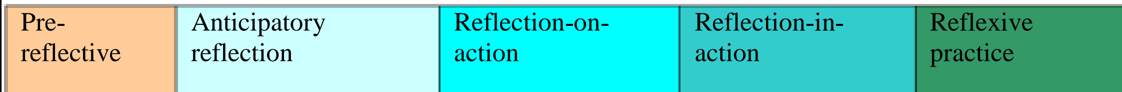
The thematic analysis findings resonated with the original literature and facilitated the construction of the author's understanding of reflexivity. This study suggested the attainment of reflexivity is individually and globally determined, influenced by nature and nurture and developed by recognising and addressing dissonance, using internal and external feedback, (knowledge, skills and attitudes/values). The LL provides a vehicle for expressing, recording, encouraging or obstructing that journey through the prescriptive use of written reflective templates. Reflective capacity encapsulates this continuum of reflective activity and requires motivation on the part of the student and supervisor to understand *why* and *how* to make this journey together, (Figure 7).

Figure 7

Reflective capacity: a journey towards reflexivity and self-actualisation

Motivation





Recognising and using emotional triggers and leakage provides a key to reflective capacity by opening an exploration of student and teacher values which may have to be revealed and challenged before behavioural change is possible. In this way the nature of reflection as described in Western literature appreciates the layers of historical, ethical, spiritual, social and political context that our culture of global learners and citizens afford and reflexivity becomes a culture of mindful practice, 'a way of being' (Johns and Freshwater, 2005 p.7).

This study captured perspectives of reflexive practice. Trainees acknowledged different levels of ability and commitment to such activity were completion of the LL not mandatory but none conceived a better way to record evidence of curriculum coverage.

This highlights the importance of a comprehensive introduction to reflexive practice and the LL as the prescribed tool at the outset of the GP training program when trainer and trainee establish their educational contract. Addressing, not just *how* to use the LL but *why* this facility is important makes explicit the nature of experiential learning (Kolb, 1984, Brockbank and McGill, 1998), and the process of developing intuitive expertise. Otherwise we risk blocking experiential learning and confining medical education to the limitations of

the technical-rationalism model of performance as found by Rubin (1996), cited in Benner (2004). To aid GP training from the outset, the function and future use of the LL must be more transparent. Is the LL

- purely a record of curriculum coverage, *techné*
- a tool for developing reflective writing skills
- an academic facility for developing practitioners' expertise i.e. *praxis*
- an iterative process of raising self-awareness, valuing others and illustrating a personal journey of life-long development as a professional independent practitioner and ultimately *phronesis*?

Currently the LL has potential within all these areas but the journey of novice to expert, (Dreyfus & Dreyfus, 1986, Miller, 1990, Dreyfus, 2004, Benner, 2004, McPherson, 2005), needs to be understood and supported by supervisors who already achieve *praxis*, (apply theory in practice), and exhibit *phronesis*, (practical wisdom and intellectual virtue), as both clinicians and educators. By adopting a reductionist approach towards the LL the formative and iterative journey of professional development towards developing a flourishing expert practitioner is undermined.

This study found GP trainees' reflective capacity is variable because the nature and purpose of reflexive practice is not clearly conceptualised by trainees, or within the literature, so most likely not by their supervisors. As a means of promoting reflexive practice the LL is limited by its functionality and current emphasis on quantitative episodic encounters. Its usefulness is affected by mandatorily advocating reflective inquiry rather than nurturing curiosity and 'conversations inviting change' (Launer, 2002). In spite of cultural differences this study found reflective inquiry can be learnt, subject to motivation, and needs to be learnt within a globally changing environment where knowing *how* is more important than

knowing *what* (Langhorne, 2011, Miller, 1990, Dreyfus, 2004). The pre-eminence of the LL should not be seen as a substitute for other means of written reflection or reflective activities such as facilitated peer learning, one-to-one tutor support, and role-modelling by supervisors but rather a signpost for reflexive aspects of learning. Teachers provide the scaffolding for this learning but their role as e-moderators (Salmon, 2004) is unfamiliar, suggesting need to re-visit or visit anew their own reflexivity. Teachers need to develop alongside students (Fischer *et al.,* 2011). In such action if there is positive regard, (Rogers, 1959), difference without estrangement and unity without confusion, learning and learners rebalance (McPherson, 2005). This study's findings are salient because they make sense of the dissonance expressed through perceptions of the LL by embedding the meaning of reflexivity within the attainment of mindful practice; the phronesis of practical wisdom, which recognises inter-human virtues, and the intellectual virtue of the mind as derived from Aristotle (384-322 BCE/Shields, 2011). When reflexivity inspires change beyond self through wider outcomes practice is advanced for the greater good and transformational change is possible.

The importance of emotions to trigger reflection, and reveal opportunities for motivating behavioural change both positively or negatively, within the LL were highlighted. Whilst hours of practise establish proficiency (Syed, 2010), expertise depends upon critical and detailed analysis at strategic times of novelty or surprise (Cook-Sather, 2006). Here 'emotional responsiveness guides perceptual acuity *and* responsiveness to change' (Benner, 2004 p.190). Fewer quality strategically placed entries were more meaningful to trainees than *"forced"* and *"repetitive"* reflections especially when trainees in hospital settings were disconnected from their GP context.

Trainees also illustrated linkage between positive patient outcome as a result of changed clinical behaviour and professional development based on reflexive practice. This is new evidence justifying a mandatory approach for reflective practice within progression towards CCT.

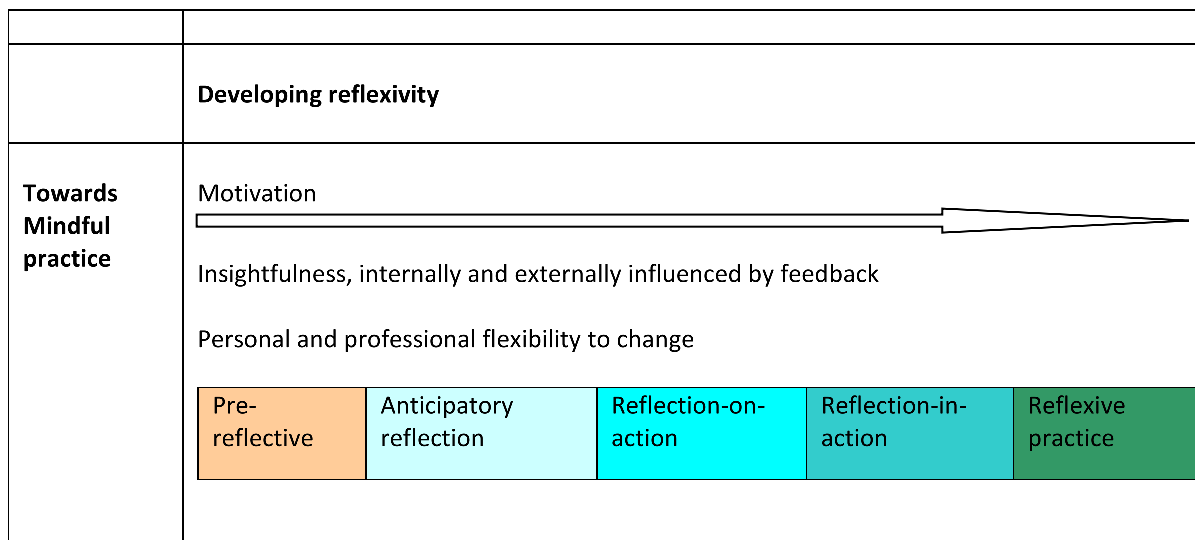
Conclusion

KEY POINTS:

- **How to define reflection?**
- **Reflective practice/capacity has to be taught and practiced**
- **Writing reflectively is difficult but enables reflexivity**
- **There are other ways to nurture reflexivity which we may have lost sight of**
- **Reflexivity depends on feedback**
- **We have separated learning events, reflective activity and feedback**
- **Confusing summative and formative processes exacerbates the difficulties and devalues reflexivity**
- **The future links performance and reflexivity**

Figure 8 Summary of research conclusions

SUMMARY	The LL as a tool for developing reflexive practice
Function	• Recognises reflexive practice as important (formative) • Provides evidence of curriculum coverage (summative)
Benefits	• Provides a framework for identifying learning objectives dependent on reflective capacity
Challenges	• Emphasis on summative outcomes risks undermining the formative potential of reflexive practice; low consequential validity • Adopts a style of learning that requires commitment, time and energy • Is heavily dependent on supervisor support and quality feedback • Requires flexibility and insightfulness on the part of users



This study asked **how valuable is the LL as an educational tool in the process of developing doctors from being a GP trainee to becoming a qualified GP capable of reflexive practice.** It finds the LL of limited value, (low consequential validity), because Trainees *adapt* to the LL. *Evolution* of reflexivity is variable since the *process* of learning to become a reflexive practitioner should be in balance with the *content* of learning, and the *learners' context* of being. This means defining reflexivity, taking into account trainee learning style and behaviour (Honey and Mumford, 1992, Heron, 2001), teaching the meaning of reflexive practice to trainees and trainers, and making use of other opportunities for developing reflexivity. It also takes time, energy and motivation. When poorly understood, mechanistically implemented, technically cumbersome and quantitatively biased, the LL devalues reflexive practice but when learner and learning are in harmony transformational development was possible.

Engagement with the LL is behaviourally and stylistically influenced and most useful at key points, some of which can be identified using emotional cues. Supervisors' feedback and influence appears significant, but, were it not mandated, trainees would not develop

reflexive practice naturally nor engage with reflective writing which concurs with others' experience of professionals' use of reflective portfolios.

The LL is the golden thread within what can be a fragmented and highly challenging 3year training programme. Arguably, since the focus is behavioural the LL could be seen as the pinnacle of WPBA which itself represents the highest measure of performance for the MRCGP; yet it remains undervalued and also subsumed by the external examination components (Applied Knowledge Test, AKT and Clinical Skills Assessment, CSA).

Recommendations

If *adaptation* to the use of the LL is to enable the evolution of a *reflexive practitioner* who is able to act "wisely" and "rightly" within present and future scenarios, and above all "flourish" (Toon, 2014), a number of recommendations arise from this study, (table 2):

Table 2 **Summary of Research recommendations**
Reflexive practice: • Needs to be taught and facilitated independently of the LL • Is contextual and not unidimensional. Opportunities for reflective discourse such as action learning sets and peer discussion must not be forgotten but nurtured whether or not these contribute to a written portfolio. This concurs with Foulkes *et al*. (2011) work with Wessex GP trainers • The nature of reflexive practice is a Western concept which requires demystification and further analysis in the multicultural arena of globalized health care in order to enable all trainees to engage meaningfully in written reflection • Focusing on the maintenance of reflection over time with attention to key personal landmarks such as

changing rotation, patient handovers, personal points of revelation, stress or difficulty may be more pertinent that specifying type of reflective entry • Should be modelled continuously throughout training • Requires explicit exploration of behaviours and values using emotional cues • Requires time space and energy i.e. motivation, commitment and flexibility • There should be separation of log maintenance for governance which is a quantitative indicator and qualitative analysis for personal feedback and formative development
The LL: • RCGP guidance for using the e-portfolio LL should clarify what the LL aims to bring to the acquisition of MRCGP versus the aspirational possibilities of developing the reflexive practitioner • Trainers should look out for cues in the emotional construction of entries and trainees need help with recognition and use of emotional leakage from others • Quality timely feedback is important • Trainee relationship with supervisors is central to trainee engagement so trust must be built from induction and regularly revisited within an explicit contractual agreement • Educator, Regulator & Standard setter advice should be congruent transparent and explicit • LL templates should be less repetitious and allow for other approaches to written reflection • Needs technical improvements • Reassurance of how the LL is or is not used for governance or will be used in the future • Promote the 'unshared' (private) facility for developing reflective capacity in high challenge and disorientating occasions
Professional development: • Fewer entries in the LL of high quality reflection • Separation of summative and formative considerations • Promotion of threaded reflection and supervisor feedback • Importance of reflexivity at times of significant change • More attention needs to be given to trainee and trainer behavioural characteristics • The use of learning style assessment and behavioural profiling could facilitate engagement with the LL • The ethical implications of evidence of personal performance and the performance of organisations gained through the learning log must be addressed

Part two: the reflexive traveller

Many themes arose from the evaluation of the LL, notably the author's sense of reflexive practice as a foundation for *phronesis* and the need for "flourishing" in an increasingly challenging professional environment. This often mirrored student experience. Indeed, this writing is part of that iterative journey. And whilst the original research implies a linearity within life-long professional development the nature of that journey is neither unidirectional, nor mapped to a pre-determined end point. For the traveller, sense-making,

and the generation of new theory in practice in an age of 'functional stupidity', (Alvesson and Spicer, 2012), overwhelmed by bureaucracy and managerialism, (Toon, 2014, Launer, 2015) requires a constant circularity of critique and reframing illustrative of the very nature of what it is to be reflexive.

Johns and Freshwater have developed their conceptualisation of the span of reflective practice and conceive a journey from 'doing reflection' to 'reflection as a way of being' (2005). It seems the research presented in part one followed a similar trajectory. This is illustrated by a continuum of cognition and behavioural change; reflection to reflexivity as a paradigm of mindful practice, Figure 9.

Figure 9 REFLEXIVITY and PERFORMANCE						
Maslow	**GPST programme; LL context**	**Bloom**	**Learner**	**Reflexivity**	**Novice to expert Adapted from Dreyfus & Dreyfus (1986 to 2005)**	
Self-actualisation	Deep autonomous learning	*Synthesis, evaluation*	**PHRONESIS** Mindful practice established in day to day work **PRAXIS**	Reflexive practice Reflection-in-the moment Internal supervision	Vision & leadership: Innovative practice Expertise: behaviourally aware, inspires & inspired Intuitive	**B E H A V I O U R**
Esteem needs	Contribution, seeks	*Application,*	Quality of	Reflection-in-	Proficient:	

	and recognises learning opportunities, achievement • Taking ownership of the LL • Valuing the reflective learning process	*analysis*	reflection increases	action	insightful Holistic	**C O G N I T I O N**
Social/affiliative needs	Social presence • Part of a peer group • Programme design • The working environment	*Comprehension*	Growing confidence, trust Non-threatening interaction Wider opportunities for developing reflective practice	Reflection-on-action / on-experience	Competent: understands, responds & plans ahead	
Safety needs	Trainee difficulties identified and supported • Teaching and modelling of reflection • Security of written reflection • Feedback	*Basic knowledge*	Defining reflection and using the learning log	Anticipatory Reflection	Advanced beginner: knowledge is situational	
Basic physiologic needs/survival	Basic computer access and technical ability to use e-portfolio	*Program materials*	Innate ability, preference or prior experience of reflection **Techné**	Pre-reflective	Novice: knows about Heard of. Rule governed.	

Whilst the concept of reflexivity was alien to trainees they demonstrated varying levels of awareness insight and application of "reflective practice", (the preferred terminology of trainee and trainer). The negative implications of the LL for developing reflexivity were notable as was the pivotal role of ESs in facilitating reflexive practice, in spite of and in addition to the LL, by differentiating the formative and summative tensions. In so doing conscious competence may be attainable so long as external influences and internal values are embraced. If reflexivity is a paradigm of mindful practice, which is in turn wise and enacted with virtue, it's conceptualisation within GP training appears in need of further development in order to appreciate the different ways of *knowing* and *being* that are required to balance the human condition in mindful practice.

Created from the research findings presented here and building on work from Terry and Leppa in 2005, Figure 9 illustrates a hierarchical conceptualisation of the development of reflective activity as a continuum shaped by engagement with the LL and mapped against the development of expertise, self-actualisation and deep learning. This is analogous to the hierarchy of professional development identified by Mann *et al*. (2009).

Is it possible that through reframing our understanding of reflexivity and contextually aligning educator and trainee engagement with the LL the power of reflective capacity can be unleashed rather than diminished?

Practicalities

The technical knowledge (techné) of reflective practice contextualised within the boundaries of the MRCGP WPBA and the practice of reflexivity derived from this study was shared through locality and national presentations and workshops for GP trainers and GP educators. Subsequent workshops have explored the transferability of sense-making and ethical challenges with non-GP educators (International conference on Reflective practice, 2013) and a *self-selected* mixed group of medical students, junior doctors, medical educators and GPs (Papanikitas *et al*., 2014).

The experience and themes first identified from the evaluation of GP trainee use of the MRCGP LL remained, and predicted challenges have become reality. For example, the trainee LL has been used in a legal setting where concerns were raised regarding possible clinical negligence and revalidation for GPs in the UK specifically links evidence of continuous demonstration of standards of performance through written evidence of reflection. So whilst many GPs, trainers and trainees continue to find the knowledge and practice of written reflection novel and challenging the bias for summative versus formative use of written reflective practice is now embedded and firmly associated with the highest

anxiety stakes: professional competence, maintaining safe practice and continued livelihood. So what of professional well-being, resilience and a sense of flourishing as opposed to a reality of defensive practice which might masquerade under the banner of ‘patient-safety’, ‘evidence-based practice’ and preventing ‘burn-out’? This is where the formative value of reflexivity can pay dividends by providing potential for cultivating wisdom, virtue, and enabling a sense of flourishing. By embracing and seeking cognitive dissonance one can through the *art* of reflexive practice rise above the “box-ticking” approach and understand the ‘functional stupidity’ that pervades not just the NHS (Alvesson and Spicer, 2012). However, as highlighted by the trainees this is technically difficult and morally challenging. When supported formatively, written reflection can be transformative but developing reflexivity requires attention to aspects of curriculum and self often ‘hidden’, or simply not formally paid attention to: philosophy, ethics, economics, law, clinical leadership, systems theory, behavioural and organisation psychology, ‘emotional intelligence’, medical humanities, NHS economics and politics. It is in this rich territory that the author has been able to innovate two specific training programs on behalf of Health Education England’s Kent, Surrey & Sussex local team (HEE KSS).

Clinical leadership in commissioning, CLIC in east Kent

Self-selecting trainees in year two of their three-year envelope are able to spend two days a week in this program whilst in their 4month GP placement. They must be making good progress in their training as judged by their supervisors and WPBA. The trainees undertake a quality improvement project (QIP) which provides experiential linkage to commissioning and clinical leadership. The project is supervised within the Clinical Commissioning Groups (CCGs) or Public Health. Trainees are supported by an action learning set once a week and attend a taught program which specifically addresses this wider curriculum as well as

mapping to the MRCGP curriculum area of 'community orientation'. Whilst the trainees, and by default their trainers, learn about 'leadership theory' and 'commissioning technicalities' the richness that trainees regularly discover lies in their awareness of self as professional 'mindful' beings. The complexity of 'professional identity formation' (Sharpless *et al., 2015,* Wald *et al.,* 2015) is unpacked consciously and unconsciously, sometimes after years of institutionalisation and adverse experiences.

Trainee assessment makes *formative* use of the MRCGP LL alongside introduction to other models for reflective practice and some educational theory to develop their reflective capacity. A final presentation as a group to peers and supervisors which must address personal learning about self, as well as the individuals' project overview is also required. Individual feedback is provided using the MRCGP Case base discussion concept.

This programme receives year on year positive evaluation and whilst initially trainees needed significant encouragement and trust to embark on this novel journey the consistent student feedback is: "why don't all GP trainees do this?". Some GP trainees now elect to train in east Kent, (a hard to recruit to area), because of the CLIC programme and others opt to remain in east Kent in anticipation of our next-step programme for year 3 trainees. Moreover, those who have settled in east Kent have become substantive local clinical leaders, continuing in various commissioning roles and leading on New Care Model developments. Some also take up the mantel of clinical education. The overriding theme is one of empowerment and a *sense of flourishing* which is visibly embodied in the individuals' powerful personal narratives, sense of well-being and achievements.

In turn, we are able to build on this ethos of "growing our own workforce", (critically important for our current recruitment and retention crisis), by maintaining and developing

the relationships with those who participate as student or teacher within the CLIC programme.

From the outset this program has taken a person-centred, multi-professional, value-based approach. The student development and patient focus is central, with specific teaching and experiential learning designed to challenge perspective and widen experience outside of the traditional medical technical-rational models and silos of individual GP Practices and hospital settings. In this way we promote the 'artistry' and 'wisdom' of practice required of the polymath GP.

Enhanced GP Specialty training Program, (EST3) 2016

In EST3 program we aim to build on the CLIC experience. This programme is open to all KSS trainees though specific application in Year 3 of training. Attainment of MRCGP AKT and CSA as well as WPBA competencies is required. It provides an extra 3m in training before certification with plans to extend to 4m. This year's pilot provided 6m teaching input one day per month in small group format, and project work in CCGs and Public Health for one day a week. Curriculum design was mapped to the required MRCGP competencies for enhanced training, and as with CLIC also maps against the NHS Leadership framework, (2016). Twelve trainees completed this pilot: one chose it because of the positive experience with CLIC and several others because of word of mouth from previous trainees undertaking former iterations or CLIC.

In this new programme we have been able to take a visionary view of the challenges for the future workforce and start to co-create with the students a programme that tackles the components described in the Five year forward view, (2014). We have drawn on 'big data' expertise, experience with New Care Models development, new technologies and genomics challenges, as examples of stimuli and cutting edge education for beginning conversations

rooted in NHS Values (NHS Constitution, 2015), acting ‘rightly’ and what does ‘flourishing look like’; a pedagogy in practice.

Initial evaluation is positive and informs our next steps where we hope to build academic rigour and align the project work with PG certification as part of a new master’s program.

Part three: What is wisdom?

> We all live in our own world,
>
> But if you look up at the starry sky,
>
> You will see that all the different worlds up there
>
> Combine to form constellations,
>
> Solar systems, galaxies.

(Veronica decides to die by Paolo Coelho, 2004 p.57)

In a reflexive journey currently concerned with the nature of professional identity consideration of “purpose” is inevitable. But what does acting “rightly”, “wisely” and “resiliently” mean? How do we teach, example and model in the ‘swampy lowlands’ (Schon, 1983) and the ‘complex zones’ (Plsek and Greenhalgh, 2001) where professionals learn their craft, and yet endeavour to flourish? One element involves embracing uncertainty, understanding risk and the meaning of intuition. We cannot do any of this in isolation, without curiosity, challenge, constantly questioning and learning from observation, experience and with others. Reflective processes such as ‘Conversations inviting change’ and ‘Reflecting teams’ (Launer,2002, Launer 2016), Clinical supervision, Coaching and Mentoring invite dissonance and feedback whilst maintaining positive regard (Rogers, 1959). Such approaches recognise value in *being a professional* self. Is it possible that the art of reflective writing can facilitate and enhance a more mindful self? The act of writing with

critical reflection involves a different type and greater depth of mental processing than thought or conversation alone. It provides personal narrative, deeply linked to our being human and the importance of 'story-telling' (Launer, 2002). Here we do well to turn away from the reductionist techno-rational predominance of science and embrace the humanities in order to widen our perspectives. In the here and now of healthcare transformation this means learning to work collaboratively within teams and networks of other professionals who may challenge our deepest sense of professional being. This final strand introduces the concept of multi-professional and inter-professional faculty development (Cruess *et al.,* 2009).

The CEPN

CEPN's (Community Educator Provider Networks) have been captured in the Five year forward view as 'training hubs' but in essence the concept in East Kent is for a 'Community of Practice' (Wenger, E. and Wenger-Trayner, B., 2015) that is truly collaborative and values-based (Thistlethwaite, 2012). The network brings together GP Practices, Universities, Clinical Commissioning Groups, Social care, Public health, hospital care and many more in primary care, (all that is outside hospitals), who have a concern for using education, training and research as *enablers* of quality health and social care in the community, (Health and Social Care Act, 2012). Some representatives are accredited educators, others are not. However, we are all now either contractually or, arguably, morally responsible for educating, teaching, nurturing and caring for a multi-professional workforce, and a profession 'not at ease' (GMC, 2016 p. iii).

It is here that our values, sense of being and identity as different professionals will be fundamentally tested. Can we grow together through 'faculty' development and collectively act rightly, not for personal or organisational gain but with virtue and wisdom?

Summary

Wald *et al*. (2015) describes how pedagogic strategies of reflective practice, professional identity formation and faculty development have bridged the gap between theory and practice with medical students in the USA. The journey as presented here has similarities. Both recognise the fundamental importance of 'the development of reflective skills, core to professional competency' (p.1).

In the UK our rapidly evolving and expanding primary care must pay more attention to safe multi-professional learning, and working at scale, and pace. In nursing the importance of reflective practice is well established and more formatively focused than in medicine, (RCN, 2015), but what of the raft of professionals, who now come together through our gestational *Primary Care Faculty*, the CEPN/Training Hub? Whilst our future GPs and current medical workforce struggle with the mandated MRCGP LL and revalidation portfolios, it is incumbent on us all not to lose sight of the importance of reflexivity, neither individually nor within the organisational structures we inhabit and co-create. We have both opportunity and need for cultivating reflective capacity collectively and through a variety of approaches, in spite of, and not because of, mandated constructs. This is especially important where organisational memory is lacking, when working across boundaries and in ever fragmenting service provision under pressure, but most especially where attitudes, values and behaviours touch our core (Neighbour, 2016). Perhaps this is a call for courage, flexibility and the attributes of the polymath. For a workforce with low morale and struggling with recruitment and retention, (GMC, 2016), the importance and opportunity for promoting careers which enable phronesis and flourishing could not be more apposite.

'Yield and prevail. Bend and be straightened. Empty and be filled……'

(Lao-tse in the Tao Te Ching cited by Hoff, 1992 p.415).

Conflict of Interest
None declared

Governance
No ethical approval was required for this paper. The original Evaluation of the nMRCGP LL had ethical approval from London South Bank University, KSS deanery and Kent, Surrey and Sussex PCTs.

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Appendix: Summary of study methodology and critique

Table A1 Approach for searching the literature databases and wider written sources in the English language pertinent to the nMRCGP portfolio LL	
Search criteria	• Written in English • Abstract, journal, book • Conference paper and reports from relevant national and international organisations
Search Focus	• Specific studies of the nMRCGP LL • Primary research where a reflective learning log was used in a similar fashion to the LL with undergraduate and postgraduate doctors and nurses primarily and more broadly for the purpose of understanding

	the ontology of reflexive practice applicable to professionals within health care environments. *Professional* is used loosely to include a breadth of healthcare undergraduates and postgraduates
Search data bases	• Medline, Embase, CINAHL and ERIC • Supplemented by Google Scholar and Google.
Search terms	• Eportfolio or e-portfolio or (e and portfolio) (any field) • [Nmrcgp or mrcgp (any field) or (Explode general practice or explode family practice)] • Explode Education Medical (major subject heading) • Reflection or reflective or reflexive or reflect (any field) • Supplementary searches were undertaken on each database using the following search terms: (trainer adj perception*) or (trainee adj perception*) or (programme adj director) (any field) (learning adj log*) (any field) • Other publications by relevant authors from the search results were also identified to assess whether relevant to the topic of the dissertation • Any research article deemed to be relevant was located within South Bank University library or on Google Scholar. Authors who had cited these articles were identified • Authors in the subject area were also searched via Google
Search timelines	• Data pertinent to the MRCGP between 2007-2011 since the nMRCGP was only introduced in 2007 • Where appropriate and possible in a specific database results were limited by date (2010- current) and to research articles • Electronic and manual search was re-run periodically to capture new emerging literature
Search supplementary resources	• Secondary pertinent references were accessed. • Hand search of British Journal of General Practice, Education for Primary Care, Medical Education and Clinical Teacher • Direct approach to an independent course tutor and researcher
Search dates	• 18th October 2010 • 18th May 2011 • 23rd June 2011 • 8th December 2011 last search for Evaluation submission
Search outcome	• Electronic and manual searching identified 86 potentially relevant studies from 672 results but only one directly involved the nMRCGP LL, (Makris *et al.,* 2010) in the initial search • Two unpublished papers regarding one directly relevant study was identified in discussion with a course tutor, (Cowan, D. 2009a, 2010) • Two further directly relevant studies newly published were identified during the timeframe of writing this dissertation, (Foulkes *et al.,* 2011, Sabey and Harris, 2011)

Table A2 Summary of study method research Tools:
• Ten 60 minute face-to-face digitally-recorded semi-structured interviews up loaded onto a secure laptop for manual and digital transcription using a pilot pro-forma interview schedule developed from the literature review and pilot fieldwork • A reflexive researcher diary was maintained throughout the study, (extracts submitted for dissertation)

Pilot Field work:
• Established content validity, (Bowling, 2010, Cowan, 2009b) • Using themes for inquiry from the literature review open questions were constructed forming a consistent framework for exploration with all participants • Questions were tested and refined in a brainstorming session with three other trainers and our three trainees who were starting their third year of training at one of our trainee-trainer meetings provided which opportunity to check for any themes of inquiry that may not have been identified in the literature review

Table A3 Summary of study method procedural steps:
1. Obtained approval for study from Deanery and various Ethics and Research Governance committees: • Confirmed that NHS ethics approval from National Research Ethics Committee was not required • Separate ethical approval from Deanery and University obtained. • As trainees were employed in Primary Care and an audit survey contacted trainees throughout the Deanery ethical approval from all Primary Care organisations was obtained
2. Conducted in house brainstorming and piloting session: • Developed and fine-tuned the schedule for interview questions derived from the literature review • Introduced research project and methodology, (one-to-one meetings), to the year three trainees in my practice and three experienced GP trainers and shared initial themes and questions • Asked for additional or rephrasing of questions based on their experiences with the LL as learners and teachers • Refined the questions and established a running order for the research interviews, (Appendix three) • No new themes that had not been identified in the literature were identified but the breadth of enquiry was widened and became more focused in each aspect of research questioning
3. Advertised for volunteer participants via Deanery communiqués using emails to teacher-trainee networks and an audit survey questionnaire: • All trainees in the Deanery entering their third year on 3rd August 2011 received a personal email advertising the study, providing the audit survey questionnaire and study information leaflet. • Deanery staff sent out the audit survey which was formulated into an electronic questionnaire template using deanery IT facilities • Those choosing to fill in the audit survey indicated if they wished to volunteer to be interviewed or not • Advertised in person at trainer meetings and via our PDs who meet with the trainees for teaching so that trainees could be alerted to the research and look out for the email or contact me directly • Three reminders were issued during the total advertising period of four weeks
4. Used audit survey questionnaire for purposive sampling: • Four female and six male participants were eligible
5. Timetabled interviews and booked locations through email & telephone liaison: • From the returned data survey a purposive sample was identified. • All respondents received an email thanking them for their participation in the audit and those who indicated they would like to be interviewed were provided with an availability chart from which mutually convenient times and venues for interview were arranged • Time was scheduled for setting up and closing the interview process
6. Personally conducted audio recorded interviews which were then transcribed: • The participant information leaflet was provided again prior to commencing the interview

- Written consent was obtained prior to the interview and checked at the end
- Two audio recordings were uploaded to the secure laptop from which direct transcription was possible

7. Thematic analysis of data transcripts by researcher, (*Braun* and Clarke, 2006):

- Details of the analytic process provided

8. Provision of participant access to study findings and any subsequent publication by email and notification to ethics and research governance committees of final study findings:

- Details held securely in keeping with Data Protection Act (1988)

Table A4 Purposive sampling

Sample size

- Personally conducted thematic framework analysis is time consuming and in-depth interviews generate large quantities of data so the sample size was limited to ten participants

Data saturation

- Data saturation was achieved so no further participants were required

Time constraints

- Time constraints prevented longitudinal and comparative study across years spent in programme.
- Selecting year three trainees, at the start of their final GP placement allowed for a minimum of four months experience of GP placement in the host Deanery and two years usage of the LL

Diversity

- To capture the diverse population of GP trainees, male and female participants were invited from the following groups at 24-27months into programme:
    - International Medical Graduate
    - European Economic Area Medical Graduate
    - Post Foundation Programme UK graduate, (prior experience of an assessment portfolio)
    - Post Foundation Programme non-UK graduate, (prior experience of an assessment portfolio)
    - UK graduate without portfolio experience

Inducement

- **This study did not include inducements to participate**

Selection

- Using the Deanery data base all ST2 trainees entering ST3 on August 3rd 2011 were surveyed to determine eligibility for the study through survey monkey email technology
- Audit survey ran for 4 weeks.
- From the results trainees who met the categories within the window of trainee and researcher availability, (3rd August-7th September, 2011), were selected
- Trainees who were not available for interview in this period or did not respond within the time frame were excluded from selection.
- Response rate to survey was 66 out of approximately 250 trainees
- 4 female and 6 male participants rather than one male and one female in each criterion as initially hoped for out of 34 trainees who were willing to be interviewed
- Demographic details presented

Table A5 Applying Braun and Clarke's thematic analysis (2006)
• Deemed suitable for novice researcher
• Guides the unraveling of multiple competing realities using an inductive method where links in these data are created as the researcher gains understanding of data meaning. Any measurement by numeric analysis of data would shift the focus into a quantitative analysis
• **Six stage framework:** o Familiarization o Coding o searching for themes o reviewing themes o defining and naming themes o reporting
• Using an independent researcher to review analyzed data provides inter-rater reliability, (Bowling, 2010)

Table A6 Ethical considerations
1. Ethics committees' requirements and approvals identified and where necessary obtained from NHS National Research Ethics Committee, (NHS REC), and Deanery wide Primary Care Trusts and Consortia Research Governance Committees (Appendix six), Deanery and London South Bank University Faculty of Health and Social Care Ethics Committee, (Appendix five) **NREC confirmed their approval was not required for this study as it was a service evaluation**
2. Participants have the right to withdraw at any stage. Data is anonymised and has no impact on participant assessments. Confidentiality maintained and Information handled and stored in accordance with the 1998 Data Protection Act
3. Written information about the nature and purpose of the study with an invitation for participants via Deanery communiqués, trainers' workshops and trainee teaching sessions
4. Written consent from volunteers prior to interview, reviewed after interview. Findings made available to participants on request

Table A7 Process of data analysis adapted from Braun and Clarke, 2006

Phase	Description of process
1. Familiarisation with data	• Recordings transcribed by a professional transcribe • Transcripts were repeatedly listened to by the researcher to correct any transcription error, appreciate participant nuance and understand meaning. • Identifiable names and locations were removed • Each transcript was formatted in the same way with identifiers for every point and paragraph prefaced by the participant identifier e.g. A1.6. Example of a full

	transcript was submitted • Transcripts taken in chronological order and broad ideas annotated on paper in list and mind map format before transposing onto a word document for reference. Some ideas emerged during and directly after the interview process whilst seeking meaning and checking understanding through the process of interviewing • Each transcript was reviewed by the researcher on the day of interview enabling initial auditory processing to find interesting ideas • Face-to-face interviewing helped capture the nuance of interpretation at the time and initial ideas but since video approval was not sort the interpretation of body language and visual cues is limited by personal recollection and feelings created in the researcher at the time of interviewing • Transcripts were shared with an experienced researcher together with some examples of the auditory recording to verify accuracy and validity of transcribing

2. Generating initial codes	• Pattern recognition from collated extracts of text within each participant's transcribed data set
	• Interesting features in the transcripts were coded systematically in three ways:
	  ○ Writing phrases/concepts in a list
	  ○ Writing phrases/concepts in a thematic map using mind-mapping technique
	  ○ Line by line colour highlighting the word document for each transcript where concepts or phrases of interest occurred

3. Searching for themes	• Sentences/concepts were drawn into initial themes which were represented in a summary word document with one or two words to describe a theme
4. Reviewing themes	• 'Second level review' after all transcripts had been analysed by going back through all these data to code for missed themes however none were identified • Themes reviewed against thematic map • The themes were checked against the transcript line by line using the colour coding method to highlight new examples of text and check initial coding
5. Defining and naming themes	• Final themes with subthemes illustrating specificity of each colour coded data extract with a line identifier for all of the participant transcripts • Essence of the themes overall was defined and from these insights into the meanings and assumptions behind the themes the interpretative analysis was constructed. • Sharing interpreted data with the expert researcher the thematic analysis was found to be congruent with expert researcher opinion
6. Producing the report	• Re-visiting the data analysis and the study argument through reflection-in and on-action and a process of critical analysis against Braun and Clarke's audit criteria • Selection of extracts which relate to the research question and literature

Table A8 Justifications for study limitations
Literature review – extensive search criteria but limited to a search of published material (and two unpublished) written in English. However, reflexivity has been shown to be a primarily Western concept and English is recognised as the international language of the internet. The contextual specificity of material as discussed in chapter two limits transferability and generalisation of findings but provided a breadth of

potential areas for inquiry in this study which could not be expanded upon further in the fieldwork or by participants.
Sampling – only one GP Deanery area was included in this study, however this is a large Deanery and there is no reason to believe the Deanery was unrepresentative.
Lone novice researcher – The researcher is a clinical educator who was supported by an experienced mentor.
Sense-making - Only in the concluding sense-making are the pre-conceptions and fore-structures illuminated, (Smith *et al*., 2009). This is acknowledged through the reflexive approach of phenomenological research.
The particular versus generalisation - Cohen *et al*. (2007) recognise reflexivity as a feature of naturalistic research, where the researcher is aware of their integration within the social world of their research and the influences this afford. The interpretation of findings were rigorously scrutinised and audited. However, the researcher remains situated in a personally contextualised interpretation conveyed only by the craft of writing. Braun and Clarke's checklist guided the report writing and engagement with the tutorial process enabled the researcher to respond to feedback together with personal reflexive practice. The work presented requires the critique of others to bring to consciousness what is unconscious to the author, (Smith et al, 2009) and the final quality assurance.
The greater good - This study has not explored the content of the LL as a resource for cumulative practical wisdom which could be shared for others benefit in learning how to develop reflexive practice and write reflectively. The LL belongs to trainees irrespective of supervisor input. This would be an area for further study.