ORIGINAL RESEARCH

Putting reflective practice into action: A case study

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ABSTRACT

The McGill University Health Centre Reflective Practice Program, which began in 2003, provides a theory and structure for reflection and is the basis of an ongoing professional development program for nurses in leadership positions. It is designed to improve their knowledge and skills, and to provide support to nurse leaders who are continually facing difficult interpersonal situations involving staff, patients, families and the interdisciplinary team. It is based on a well-developed theoretical framework, a theory-of-action approach to reflective practice (RP). This approach is described in some detail, together with the training program for RP facilitators. This RP program involves regular monthly small group meetings to discuss challenging interpersonal situations. To date, 37 facilitators have been trained and currently about 120 nurses are participating regularly in RP groups. To illustrate this approach a detailed example of a typical RP session is presented, together with some illustrative feedback data collected over several years. We conclude with recommendations for implementing this type of RP program and describe how our theoretical approach has spread beyond the nursing department and has been introduced to some students and faculty in the School of Nursing and to interprofessional staff in one of the clinical groupings.

Key Words: Reflective practice, Nursing leadership, Professional development, Theories of action, Case study

1. INTRODUCTION

Reflective practice is highly valued and strongly recommended in nursing education and practice.[1] Nurses regularly talk to each other informally about challenging situations in their work. Critical incidents and M&M rounds are more formal ways to reflect on practice. Reflective practice is a part of the curriculum and considered a basic competency in many nursing education programs. In this paper we will describe the development of the McGill University Health Centre Reflective Practice (MUHC RP) Program. It provides a theory and structure for reflection and is the basis of an ongoing professional development program for nurses in leadership positions at the MUHC. It is designed to improve their knowledge and skills and to provide support to nurse leaders who are continually facing difficult interpersonal situations involving staff, patients, families and the interdisciplinary team. Difficult situations include for example, giving critical feedback to a colleague, managing conflict/bullying among staff, disagreeing with the boss in public, and dealing with emotionally charged patient and family situations. We will begin with the origins of the program, then outline the theory underlying our approach to reflective practice (RP). The training program for RP facilitators will be followed by a detailed description of our RP program in practice and a typical RP session. We will conclude with some feedback from participants in our program, recommendations for implementing such a program, and how our approach has spread within the system.

In their 2015 review of the empirical literature on nursing reflective practice, Dubé and Ducharme[2] identified the need

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for "a) a more explicit definition and frame of reference for reflective practice; b) the operationalization of reflective practice in terms of verbal and written strategies selected; c) the reflective skills and prior training of nurses in terms of reflective practice; d) the duration and frequency of strategies selected for the implementation of reflective practice; and e) the characteristics of the support offered" (p. 96) to guide research and practice. Our primary focus in the MUHC RP over the years has been on creating, implementing, and enhancing our RP program. We now recognize that it is important to share the details of our program as it provides one example of a well-developed model that fills in most of the gaps identified by Dubé and Ducharme.[2]

The MUHC RP has several special features. It focuses on interpersonal situations that emerge from the clinical context. It provides a well-developed theoretical framework to guide reflection on difficult interpersonal situations, by identifying the values, assumptions and behaviors that cause these difficulties, as well as providing an alternative model to guide more productive ways of thinking and acting. It uses trained facilitators to lead small RP groups of nursing leaders who meet monthly on a continuing basis to discuss difficult situations. We believe the detailed description of our program will provide an important contribution to the literature and knowledge on reflective practice in health care and nursing leadership.

2. Origins of our RP project

As the role of nurse leaders expanded, we realized that they needed not only advanced skills in family nursing (McGill Strength-Based Nursing Model,[3,4] Calgary Family Assessment Model[5]) but also sophisticated negotiation skills in working with multiple colleagues, treatment teams, and health care services. They needed to be able to work with others with divergent views in time-sensitive, high-stakes, stressful, occasionally conflictual, and often highly emotional situations.

To begin to address these needs the Nursing Executive at the McGill University Health centre (MUHC) decided in 2003 to launch the RP Project. It was based on a train-the-trainer model. The original seven facilitator trainees in our Project were chosen based on their clinical expertise, communication skill, general credibility in the organization, their internal commitment to learning more about reflective practice, and on having the support of their bosses in getting adequate release time to do the work. All the trainees were masters-degree prepared. This was a deliberate decision based on the skills these trainees already had and those they would be required to learn in order to facilitate others in leadership positions.

The first wave of the RP Facilitator-Training Project[6] began as a two-year pilot project (with ethical approval from the IRB at McGill) with two RP expert coaches and six expert Clinical Nurse Specialists (CNS) and a family therapist as trainees. Now 15 years later, with the ongoing support of the nursing executive, we have trained 37 RP facilitators, and currently have about 120 nursing leaders benefiting from participating monthly in an RP Group.

Each trainee was assigned an RP Group of leadership nurses: Nurse Managers, Assistant Nurse Managers, CNSs, Nursing Practice Consultants (NPC), or Nursing Professional Development Educators (NPDE) whom they would follow throughout the two-year program. As the trainees learned to facilitate, they also began to teach the components of the models to each participant thus beginning a cycle of expanding the learning and the methods more broadly into the department of nursing. Before we describe how our program works in detail, we want to present the key ideas in our approach to RP.

3. Key ideas in the theory-of-action approach to reflective practice

3.1 Professional problem solving

Our approach to reflective practice[7] builds on the work of Argyris, Schön, Schwarz, and Kegan.[8–16] In particular, Schön[8,9] in The Reflective Practitioner: How Professionals Think in Action and Educating the Reflective Practitioner presents a model of competent professional practice focusing on handling non-routine or messy situations. The model suggests that when confronted with a puzzle or a surprise, and our normally skillful actions to resolve the problem don't produce the outcome we expect, we must find alternate means to resolve the situation. We begin by framing, or naming, the "problem" to be solved. Sadly, problem situations don't come with names. We impose them. Is this nurse's "performance problem" a lack of knowledge? A lack of self-confidence? A lack of experience? A motivation problem? Relate to conflicts with colleagues? Or something else? The way we frame the problem dictates the actions we choose to resolve the issue, and these actions in turn have consequences. If we don't get the consequences we intend or expect, we enter a cycle of finding new strategies for the old frame, or new frames and different actions and better consequences. This process he calls reflection-in-action.[9]

In our work with nurses we help them to examine how they have framed "problematic situations" and work with them to develop alternative frames which open up new avenues for action. As an example, a new assistant nurse manager (ANM) says she has been avoiding talking to a colleague

about how to do the nursing assignment because she is very uncomfortable with conflict. Can she reframe conflict from "something to be avoided" to "an opportunity to discover" how the other person sees a situation and what the other thinks about how she sees it? If so, the ANM may be more inclined to initiate and continue to engage the other in more productive ways of interacting and thus generating better (more accurate/complete) information. RP helps nurses to examine how their actions flow from the way they are thinking, from the way they frame problem situations.

3.2 Professional competence

Professionals are described as competent if they regularly achieve their intended goals without creating unintended or undesirable side effects.[8, 12] To become competent, professionals need to master two domains – the technical and the interpersonal – and they need to be competent in both.[8] Technical competence includes both acquiring knowledge and the development of nursing practice according to current clinical and professional standards. Interpersonal competence refers to one's ability to interact with others successfully in achieving their goals. It includes emotional intelligence – "the ability to sense, understand, and effectively apply the power and acumen of emotions as a source of human energy, information, connection, and influence."[17]

The focus in RP is on interpersonal competence, rather than technical competence. We examine those situations in professional practice where people do not achieve their goals, despite their best intentions; e.g., situations where the nurse thought a colleague/boss/physician, a patient or their family was being difficult, defensive, resistant and not open to learning. In addition, the nurse was unable to find a way to communicate her/his concerns effectively. Determining whether a specific treatment is the best could be a technical question. However, determining how to act effectively in a difficult interdisciplinary meeting where people are arguing unproductively about different plans requires a high level of interpersonal competence.

Competence does not mean that a person never makes mistakes, or that situations always turn out the way one wants. Competence could be thought of as what you do when you make a mistake, when things are not going as you expect; that is, do you think and act in ways which generate trust, deepen understanding and increase learning from the mistake, or do you try to minimize it, hide it, and save face?[18]

3.3 Single-loop and double loop learning

Learning is the detection and correction of errors; that is, of gaps between what you intend and what you produce.[8] Thus, when you detect a gap you have made an "error". These gaps, or errors, represent significant opportunities for learning and are the major reason in RP that we focus on "difficult situations". If you change your actions in order to achieve your intentions that is called "single-loop learning". If you change the frame/name of the problem to be solved, that is called "double-loop learning". In RP we encourage both single-loop and double-loop learning. For example, if you are looking for different ways to express your anger, you are doing single-loop learning. If you change your frame from angry and furious to surprised and curious, you are double-loop learning, and your actions are likely to be quite different and more effective.

3.4 Theories of action

The theory-of-action framework assumes that individuals design their actions to be effective – to achieve their intentions – and that they have theories about how to design their actions in various situations.[8] There are two types of theories of action. Our espoused theory is the one we offer to explain or justify our actions. Our theory-in-use is the one that determines our actions. When professionals provide explanations for their actions, they usually describe their espoused theories. However, it is more important for learning to uncover/discover their theories-in-use – the reasoning and thinking that informs their actions – and the gaps between the two.

There are often gaps between our espoused theory and our theory-in-use, particularly when we are dealing with situations we describe as threatening or embarrassing, and often involving strong emotions. For example, a person might have an espoused theory about always being truthful, but in practice they frequently say they agree, or remain silent, when those in power offer views with which they strongly disagree. In RP we help individuals identify the theories of action which inhibit their ability to learn, particularly the double-loop learning so necessary for re-framing challenging situations.[8] In health care as we face increasingly more complex situations, the need for double-loop learning or transformative learning increases. Paradoxically, when the situations most require double-loop learning, and/or involve embarrassment and threat, professionals often think and act in ways which limit this type of learning.

3.5 Reflective practice–a theory-of-action approach

In our approach to RP we invite and support nurses to examine their theories of action in difficult interpersonal situations and to identify how they were thinking in order to act as they did; that is, to reflect on how they were reflecting in action. We will briefly describe three key components in our approach to reflective practice:

(1) The two "mindsets" that inform our actions (see Figure 1);
(2) The ladder of inference, or the "way the mind works"; and
(3) The social virtues (e.g., respect, support, etc.)

3.5.1 *Component one: The unilateral v.s. mutual learning model*

Research has shown that although people espouse many different theories of action, their theories-in-use are generally consistent with one of two more general models. These models are composed of three parts which are illustrated in Figure 1:

(1) Our mindset – our values and assumptions – determines our actions, what we say/do;
(2) These values and assumptions are consistent with either the unilateral control or mutual learning model;
(3) Each model, and the behaviors that flow from it, produces positive or negative consequences in interpersonal situations.

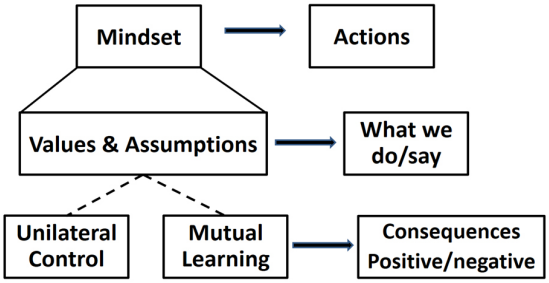

Figure 1. Different theories of action

In RP we use these two models to provide the theoretical framework for assessing the extent to which nurses' ways of thinking and acting (their theories-in-use) are either productive or counterproductive to their effectiveness as problem solvers and to their learning to be more effective.

The Unilateral Control Model (UCM)[12] – describes a mindset and set of behaviors that are inconsistent with generating the valid information and informed choices that are so necessary for effective problem solving.

Table 1. UCM Values and Assumptions

Unilateral Control Model Mindset	
Values	**Assumptions**
• Win, don't lose • Be right • Minimize the expression of negative feelings • Act rational	• I understand the situation; those who disagree don't • I am right; those who disagree are wrong • I have pure motives; those who disagree have questionable motives • My feelings are justified • I am not contributing to the problem

In reflective practice sessions (monthly small group meetings of 90 minutes), we work with the participants to identify the specific behaviors that flow from this mindset and are counterproductive to effective problem solving. More specifically, did they:

- State their views without asking for others' views and vice versa?
- Withhold relevant information?
- Speak in general terms and not agree on what important words mean?
- Keep their reasoning private; not ask others about their reasoning?
- Focus on positions, not interests?
- Act on untested assumptions and inferences as if they were true?
- Control the conversation?
- Avoid, ease-in to, or save face on difficult issues?[13]

The Mutual Learning Model (MLM) is anchored in a different set of values and assumptions than the UCM. Most people agree with (espouse) them, but surprisingly don't practice them in difficult interpersonal situations. In an RP session we invite participants to examine their behavior in terms of the core values of the Mutual Learning Model:[11]

- Transparency – Did they share all relevant thoughts and feelings, their reasoning and intentions? Without this information, it will be difficult to make an informed choice about the most appropriate course of action.
- Curiosity – Were they genuinely interested in the other person's thoughts and feelings and his/her reactions to their own point of view? Without this it will be difficult to generate the information and understanding necessary for effective problem solving.
- Accountability – Did/do they accept their responsibility for the consequences of their ways of thinking and acting? If they withheld information or made judgments that they didn't test, then they are responsible

for the limited learning and the ineffective problem solving, for the misunderstanding or mistrust.

- Informed choice – Did they maximize the making of decisions based on relevant information in such a way as to increase commitment to monitoring the outcome of those decisions? To the extent that people feel they were not free to make an informed decision, they will feel little commitment to follow through and the relationships may be harmed.
- Compassion – Did/do they accept that others have good reasons for their actions, just as they do? Without transparency and curiosity, they will not understand how the other person is thinking in order to act as they do, and they won't learn how their own way of thinking may be limited.

Behavior which is consistent with the values of mutual learning flows from the assumptions we make about ourselves and others. For example: in contrast to the assumptions of the UCM, do you assume: I have some information, and that others also have information? Each of us may see things the others do not? I may be contributing to the difficulty in understanding/resolving the situation? Differences are opportunities for learning for me? People may disagree with me and have pure motives? People's choices make sense to them? People are more committed when they make informed choices?

Thus, in analyzing a case in an RP session, the first step is to determine if the values, assumptions and behaviors are consistent with the Unilateral Control Model or the Mutual Learning Model (see Figure 2).

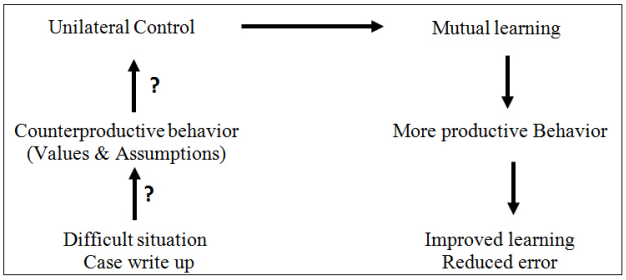

Figure 2. An RP session: The big picture

Later in this paper we will describe in detail how these models are used in an RP session.

3.5.2 *Component 2: Ladder of inference*

The ladder of inference (see Figure 3) captures the way the mind works, and most RP participants find it one of the most powerful tools in identifying ways their thinking gets them into trouble. In any complex situation, a person will/must select data to attend to. With all the information that is available, we are always engaged "in a selection-and-interpretation triage".[19] Individuals then add meaning to the data they have selected, make assumptions and draw conclusions which lead them to act. To the extent that their conclusions are negative, or their actions are "threatening" to them or to other people, their emotions are likely to be high.

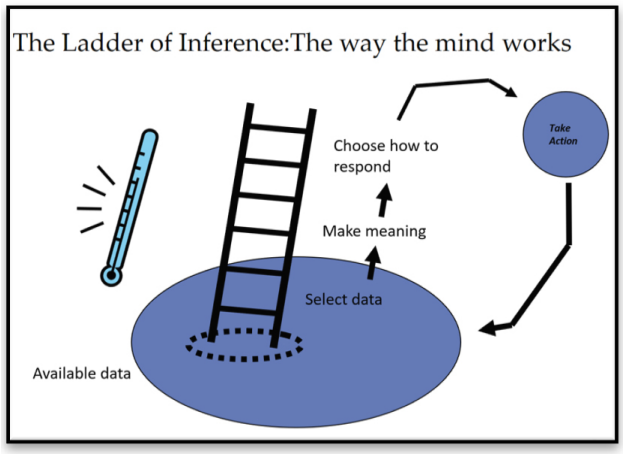

Figure 3. Ladder of inference

For example, an ANM notices that it is 1,600 h and Marie hasn't finished her charting. The ANM adds that Marie is always late finishing her shift and assumes she doesn't know how to manage her workload. Her conclusion/frame is that Marie is disorganized and doesn't fit in with the rest of their organized team. The ANM decides she must talk to (confront) Marie and "get her" to change her behavior (an action based on her frame for the situation). She is anxious because she anticipates that Marie will disagree, she will have "excuses" and the conversation will get emotional (anger and/or tears).

"Being up the ladder" is RP short-hand way of describing how a person can quickly make a judgement, assume it is true without checking it, and act confidently as if it were true. When the other person resists, or disagrees, they are seen as defensive, not open to learning, etc. and this is taken as confirming the original judgment that Marie doesn't fit in with their team. This way of thinking and acting reflects the unilateral control model. The ANM will most likely be blind to the ways in which her approach to Marie is more likely to elicit self-defence rather than a productive dialogue.

Part of our skills as professionals is our ability to analyze situations quickly and to make decisions. However, this often means we go quickly from what we directly observe – what others say or do – to conclusions about what those behaviors mean. Often, without testing our conclusions to determine

if they are accurate, we decide (usually unilaterally) how to act to improve the situation at hand. This describes "how the mind works" and how our skill can sometimes get us into trouble – when we jump up the ladder to conclusions that are not correct, yet we act as if they are true, without knowing. Argyris has called this behavior "skilled incompetence".[20]

3.5.3 *Component 3: The social virtues*

Professionals bring to every situation a set of values and assumptions (our mindset) that inform the way we act, and a "mind that works skillfully" to select and analyze data and decide how to act. Upon reflection, we may acknowledge that we weren't completely transparent, that we withheld information, that we "went up our ladder" quickly, making assumptions that we didn't check yet acted as if they were true. But, we explain or defend our actions by thinking/saying: "But I couldn't say that! It wouldn't be caring, supportive, respectful . . . " The meanings we attach to these "social virtues" also influence how we think and act and may have a counterproductive impact on our ability to problem solve and to learn to be more effective.[19,21]

If being respectful of others means that we defer to them and don't disagree with them, particularly in front of others, or with people in authority, then the quality of information available and the decisions made will suffer. For example, a nurse is in a team meeting with a surgeon and hears him say something about the patient's family coping that she thinks is incorrect, based on a conversation she has just had with the family. She does not speak up because she "has very high respect for the surgeon" and does not want to disagree with him publicly. The team goes on to make a poor decision for the patient and family. On the other hand, respect for others could mean attributing to them the ability and capacity to examine their thinking and behavior without becoming "upset" until we are confronted with compelling evidence to the contrary.

In summary, the values and assumptions (our mindset), together with the meanings we attach to being caring, supportive, respectful and honest (the "social virtues") inform how we think and act. We also skillfully select data and reach conclusions (jump up our ladder of inference). To the extent we make judgments or attributions about others without illustrating or validating them, (transparency and curiosity) we limit the possibility of effective problem solving and learning, particularly in difficult interpersonal situation.

We now examine how the MUHC RP works in more detail, beginning with the 3-phase program to train the people who would facilitate the RP sessions (see Table 2), followed by a description of how the RP program works in practice, and an example from a typical RP session.

Table 2. Training program for RP facilitators

	Focus	Activities
Reflective Practice 1 Five days of intensive training for the trainees with the expert coaches	• Learning about the models, the tools and facilitation • Reflecting on one's own nursing practice • Participating in an RP group	• Regular group meetings • Case writing • Discussion of cases & theory
Reflective Practice 2 Six-eight months of coaching, training & *co-facilitation* of RP groups with an expert coach	• Learning to facilitate • Reflecting on facilitation practice	• Periodic large group meetings • Regular meetings of facilitators & coach to plan and de-brief • Co-led RP sessions with nurses
Reflective Practice 3 Six-eight months of coaching, training & *solo* facilitation	• Learning to facilitate • Reflecting on facilitation practice	• Periodic large group meetings • Solo led RP sessions with nurses • Regular planning/debriefing sessions with an expert coach

4. The training and support program for RP facilitators

Following the initial preparation/training over the first two years, the RP program has provided ongoing support for the facilitators through a variety of events: regular (3-4 times a year) half or full day meetings of all the facilitators to discuss the application of RP to specific issues (e.g., bullying, risky conversations, etc.); monthly lunches to discuss difficult facilitation cases, and periodic observation/feedback sessions.

5. How the RP program works in practice

A typical reflective practice group is:

- A group of 6-8 nurses who have the same role (e.g., NM, ANN, CNS, NPDE), who have common issues

and concerns, meet regularly for 1.5 hours (usually once a month) to discuss a difficult interpersonal case from their practice under the guidance of a trained facilitator.

- An opportunity for nurses to carefully reflect on their practice in order to become more effective.
- Where the reflection is supported by caring colleagues who are interested in learning.
- Where the reflection is guided by a well-developed model of effective interpersonal competence.
- Where the case presentation[22] is structured as follows:
  - Description of the problem
  - Steps taken to solve it
  - Brief section of dialogue and thoughts and feelings that were withheld
  - Reflections now on the situation: where and how they got stuck
  - Help sought
- With role plays of conversation using MLM frame, values etc. with coaching from the group
- And an evaluation of the session and help provided.
- Focused on identifying the unilateral thinking and actions by the case writer, suggesting more mutual learning model ways of thinking and acting, producing the actual words/sentences that the case writer might use in a new conversation, and then evaluating them.

5.1 A case example from an RP group

To illustrate how an RP session might go, we have created a sample RP case which is presented in the standard "RP case format".[22] This case has a typical theme: Giving critical feedback to a colleague. It is followed by examples of how its discussion might go in an RP group. The group discussion typically follows these stages: the group examines the case in terms of the two models (UCM, MLM) and offers suggestions to the case writer on how they might think and act consistent with MLM values and behaviors; the case writer "role plays" the conversation with suggestions/help from the group and the facilitator; and ends with comments about what was helpful in the session and how it could be improved.

Most of the cases nurses bring to their RP Group are "high-stakes" for them, involving important issues, relationships and values. They are talking about situations in which they got stuck, they did not know what to do, they did nothing, they did the wrong thing, they got upset, and generally, they did not look very effective. For many reasons, they must be confident that the facilitator and other members of the group have made a commitment to confidentiality about any identifying details of the cases under discussion.

Melanie, not her real name, wrote up her case a few days after the situation occurred. She sent a copy to the facilitator and to members of her RP Group, reminding them of her concerns about confidentially.

5.2 Melanie's Case [It was a Disaster!]

1) Identify an important problem that you have tried to solve or will try to solve in the near future. There are no limits on the subject selected, except that you should evaluate it as crucial to your own, your department, or your organization's performance. (Provide this in a few sentences)

My boss asked me to design a workshop for a large group of nurses with the goal of improving their communication with patients and families. One of my senior colleagues, Ellen, (not her real name) with whom I have a good relationship was asked to help me with this, and she offered to teach a key part of the theory with which I have a great deal of experience. I sat in on her presentation, as I was talking next on a closely related topic.

During her presentation, I became increasingly dismayed, uncomfortable, and embarrassed. I thought her presentation style didactic when it needed to be interactive, the theory misrepresented, not illustrated by examples, confusing, and not linked to the practice of the nurses in the audience. Her answers to the few questions from her audience seemed both dismissive and vague. I noticed the nurses were becoming restless and disengaged, and wondered if I should intervene, or just stay silent, and talk with her later. I decided to stay silent and became increasingly frustrated and anxious with each word she said.

2) Describe the steps you took (or plan to take) to resolve the problem. With whom did you meet (or expect to meet)? What was (or will be) the purpose of the meeting as you recollect it (or as you expect it to be)? (Provide a paragraph or two on this.

I will have to give her feedback later this week and will also be asked by my boss how it went. This will be uncomfortable because I am still quite upset with her. I think her session was an expensive wasted opportunity for the nurses, may have damaged our reputation/credibility with them, and I am seriously questioning her competence as a teacher. There is nothing positive I can say right now.

3) Divide the next several pages in half. In the right-hand column, write the conversation as you can best recollect it. Begin with what you said, what the other(s) said, what you said, etc. If it is a session that has not yet been held, describe what you plan to say, what you expect other(s) to say, and so

forth. In the left-hand column, write down any thoughts and feelings you had as the conversation proceeded (or what you believe that you will have when you meet sometime in the future) (see Table 3).

This conversation happened immediately after Ellen finished her talk, and I was opening my power-point.

Table 3. Left-hand column dialogue

What I thought or felt, but did not say	What I and other(s) actually said
Thoughts/feelings I had but did not say	Me: (What you said.)
Oh NO, she's coming over to me. I really hope she doesn't ask me how it went! (feeling upset frustrated with her)	Other: (What he or she said.)
Of course, she asked me about it. What can I possibly say to her now. (feeling even more frustrated)	Me: (what you said.)
	Ellen: I think that went pretty well…Did you like it?
	Me: Let's debrief on Thursday, when we have seen the evaluations. I need to teach now…
OMG, what planet is she on? It was a disaster! She has absolutely no insight!	*Ellen: Well that doesn't sound very supportive. I worked hard on this. I was pleased I got through all the theory.*
How can I get this workshop back on track? I need to focus on the group in front of me, see if I can get them engaged, I just want her to go away!	*Me: I just can't get into it right now Ellen.*
If I say one more word right now, it is not going to be pretty.	

4) Briefly state what, if anything, puzzles you or stands out for you as you think back on the encounter. *I realize I went "way up the ladder" here by the intensity of my feelings, both at the time, and now, writing up the case. This work is very important to me, and part of my reaction was probably related to my thinking that her poor performance could damage my credibility, make me look less competent, as well as reflecting negatively on our Education Program. I am realizing that I have a very low tolerance for what I see as "incompetence" and because of this, I am having trouble being genuinely "curious and compassionate" with her.*

5) What specific help would you like? *I need help looking at my reaction, coming down the ladder before talking with her. (I see that I am making a lot of assumptions in this case.)*

I need help practicing what I will say if she stays with her assessment that "It went well." (In the past, I have not found her particularly open to negative feedback.)

I am also wondering how I might have intervened during the teaching session, when I thought she was making a series of mistakes.

5.3 RP Group discussion of Melanie's case

In writing up her case, Melanie, who has a few years of experience with RP theory and practice, has already seen some things she did not see while she was in the midst of it (#4 What puzzles her/stands out now). Not only does she realize, when identifying her strong uncomfortable emotions, that she is "up the ladder", but she has reflected on her thinking/framing ("It was a disaster!" "She is incompetent." "It reflects badly on my credibility") and recognizes that these are high-level inferences, not facts. She realizes that she will probably get stuck in the conversation with Ellen, if Ellen continues to say, "I think it went well."

During the discussion in the RP Group, colleagues asked Melanie more about the assumptions she had been making while listening to Ellen's presentation. For example: Is a didactic vs. interactive style always less effective for conveying this information? How did Ellen misrepresent the theory? Could there be other reasons for the nurses' "restlessness"? How did the nurses evaluate the presentations that day? Could there be reasons for Ellen's approach that Melanie does not understand? How did Melanie get to "disaster" and "incompetent"? Did she have any data to support her idea that the nurses would judge her on the basis of Ellen's presentation?

As a result of this discussion, Melanie found herself somewhat less upset (more compassionate) with Ellen, more interested in getting better information (more curious) from Ellen and others, and clearer on how her own theories of what it means to be "competent" had influenced her thinking and feeling.

The RP facilitator asked Melanie and the group what they thought Melanie was and was not accountable for in this situation. Melanie said she had not spoken with Ellen before the Workshop about how she planned to present the material, nor shared her own ideas about what she thought would be most effective. She had assumed that Ellen shared her views and approach and would do it "her way". She thought that this omission had likely contributed to her dismay at Ellen's very

different approach. In the discussion that followed, Melanie continued to clarify her own accountability for the problem; she let go of the idea that she needed to change or "fix" Ellen.

She still thought that there had been many problems with Ellen's presentation, and wanted to give her clear examples of each of her concerns; that is, transparency – sharing relevant information, plus curiosity – hearing Ellen's thoughts on what she was saying. She asked to practice what she might say to Ellen.

During a brief role-play, one of the group members acted Ellen's part, opening with "I thought my presentation went well. Did you like it?"

In the role play, Melanie practiced several opening lines, until she found one that worked for her, in terms of the MLM values, and that she thought she could actually say. She also asked for "stop [the role play] and coach [her]" if she got stuck during the role play, or if group members thought she was getting into trouble.

Melanie: "I did have some concerns and a few questions that occurred to me during your presentation. Is now a good time for me to share them with you? Could we talk about them together?"

"Ellen": "Yes, You obviously didn't like my presentation?" (voice rising, sounding hurt.)

Melanie: "I noticed that several nurses had their eyes shut, others were talking among themselves, and others were texting, especially during the latter part of your presentation. Did you see that?"

"Ellen": "Yes, I did! These young nurses, always on their cell phones, and after lunch is always the worst time to present, they always fall asleep. Still, I'd expect them to be more professional." (sounding annoyed.)

Melanie: "I agree that after lunch is a tough time to present, but I have a different take on their behavior. Can I share my thinking?"

"Ellen": "O.K." (sounding hesitant)

Melanie: "At the time, I thought the behavior could be related to your use of a lecture format to present the material without any examples from the nurses' practice. My concern was that they were not relating the theory to the kinds of problems they have with families on their units, and thus tuned out. How do you see that? "

"Ellen": "Are you saying I shouldn't have used the lecture format??? I knew you were presenting after me and you were comfortable with a much more interactive style. I wanted to cover the theory first and thought you would focus on applying it to situation from them."

Melanie: "Oh dear, I realize we didn't talk about this before the workshop. It sounds like we had very different assumptions about how to teach it and what the other would do. And we didn't check them out."

"Ellen": "Yes. I guess so. I find giving the theory first is most effective. The discussion can come later."

As the role-play continued, Melanie and "Ellen" explored their different theories of the best strategies for teaching the material to this group. Melanie struggled to stay focused on presenting her observations and concerns while being curious about "Ellen's" point of view. Several times she needed a "time out" for coaching, when she found herself "going up the ladder." The role-play ended with Melanie and "Ellen" agreeing to get more feedback from the nurses in the group before continuing the conversation and planning future teaching sessions.

Melanie found the role-play very challenging, as "Ellen" initially did not seem to be interested in learning more about her concerns, and she found herself getting frustrated and annoyed when "Ellen" blamed the nurses for their lack of engagement. Melanie also realized that she did not ask "Ellen" about her reaction to the feedback when she noticed "Ellen" was sounding "somewhat annoyed". Melanie did think that the coaching from the facilitator and her colleagues during the role-play would help her in the actual conversation she planned to have with "Ellen" later in the week.

Melanie's case is a classic RP Case, in that Melanie finds herself stuck when wanting to give a very critical evaluation to a colleague. If she is "frank", and tells her colleague that she thinks her presentation was a disaster, the colleague will be hurt and angry, and the relationship will suffer. If she "eases in", by asking leading questions, her colleague may decide on her own that the presentation was flawed, but she may not take the hints, and be confused as to what Melanie is trying to say. The consequence of either strategy would be that neither "Ellen" nor Melanie would learn more about the other's thinking or concerns and would make uninformed choices about how to proceed in future teaching sessions. In either case, the relationship would suffer.

The values, strategies and tools presented in the MLM, and the RP process including the role-play and debriefing, helped Melanie to think differently about her initial assessment and to feel less upset with her colleague. She recognized that she was not accountable for her colleague's work, but she was accountable for offering her the most accurate feedback – her judgments based on all the available data, and for staying open to Ellen's point of view. Her colleague could then

decide if she wanted to make changes in how she presented material, and Melanie could decide if she had made any errors in her initial judgments and if she wanted to collaborate (on the workshop) with her colleague in the future.

The group also went on to provide Melanie with ideas on her other two questions (speak up during the presentations, responding to the boss). At the beginning of the next RP session Melanie will be invited to talk briefly about how the conversation went.

6. What difference does RP make to the Participants? Feedback from facilitators and participants

In our current hectic, chaotic and often discouraging healthcare climate the leaders in our nursing departments are asked to carry heavy workloads and to constantly produce with reduced resources. Stress and burnout levels can be high. The RP program implemented at the MUHC requires a commitment of time and energy. Over time the methods, the models and the language have become part of our culture. Despite the environment and the workload, new leaders ask to be part of the program and regularly negotiate with their directors to be able to allot the time required.

Currently there are approximately 120 nurses in leadership positions participating in 18 RP groups of the NMs, CNSs, NPDEs, or NPCs that meet for 90 minutes once a month.

The most extensive evaluation of the RP project was done in 2006 after the pilot study.[6] It included content analyses of transcripts from RP sessions and extensive feedback from trainees and RP group participants. Some comments from the facilitators-in-training include:

- "I am more sensitive to the fact that when I'm thinking negatively about someone, I've seriously reduced my ability to be effective and helpful to them. I try to stay with my feeling of discomfort and take the time to get more data to better understand their perspective. When speaking with other nurses, e.g., at report time, I practice giving my take on a situation, explaining why and asking if they agree or not."
- "For several years, I and another CNS working in my department have disagreed on some aspects of how to help nurses to . . . lately I have been able to share with her my left column and at the same time I have inquired more about what was in her left column. . . There has been a very big change +++, we can now work together more, learn from each other and teach nurses. . . I feel we can now work as a team."

Some comments from nurses after only one year in RP (8-10 monthly meetings) include:

- "When I am in a difficult situation I'm now more aware of what I think and feel but do not say (left-hand column). I'm probably a better communicator now."
- "Unfortunately, because I am human I often try the old way but when it is not working I will remember discussions and try new avenue."
- "[RP provides] a compassionate, trusting effort by a whole group to work on one problem."
- "Sit back, write and learn about the problem submitted and see where the gap is – realize all the intervention/interaction among people done to solve one problem."

We regularly collect feedback the participants in RP groups. In a recent survey, participants (N = 54) described "RP in one word" (see Table 4), and the "Best part of RP" (see Table 5), and "How I used RP" (see Table 6):

Table 4. RP in one word

Describe RP in one word	N	%
Helpful/enriching/supportive	44	82
Sparse due to hospital move	6	10
Necessary professional development	1	2
Somewhat helpful	1	2
Challenging to bring a case	1	2
Useful tools	1	2

Table 5. Best part of RP

The best part of RP	N	%
Sharing with colleagues–I am not alone	29	51
Learning new tools	28	51
Time to reflect	15	28
A safe, supportive environment	6	11

Some of the participants' comments include that RP:

- "Alleviates the sense of immense responsibility and isolation that one can sometimes have as a manager, having to address multiple personnel and patient issues."
- "Helps me, I try to reflect on being the other person or other side, not just my own."
- "RP gives me the tools I need to prepare for meetings with staff and a safe community for debriefing difficult situations. It also helps me learn from my mistakes (and those of my colleagues)."
- By having more curiosity in investigating an event I was able to come up with a better solution to and comprehension of the problem. RP is helping me deal with doctors' responses to changes in their clinics, giving me the ability to address it in a professional manner, or simply to address it, versus keeping it to myself and developing symptoms of high stress like not sleeping.

Table 6. How I used RP last year

How I used RP last year?	Number of responses	%
Helps me survive	1	2
Positive impact on my personal life	2	4
Benefit from group reflection	3	6
Not alone–alleviates isolation	3	6
Calm and Hope	3	6
Stress Reduction	4	8
Learn from my colleagues	6	11
Deal better with emotional situations	8	15
Learn to reflect better	9	17
Positive impact on communication with staff, inter-professional colleagues and patients	9	17
Tools to manage emotional conversations	10	19
Helps me prepare my response	14	27
Has helped me develop useful tools: transparency, compassion, curiosity, ladder of inference	22	52

7. Discussion and conclusions

Our approach to reflective practice is based on a solid theoretical framework and has been refined and implemented over 14 years at the MUHC. The model for training RP facilitators and the data from participants have demonstrated that the program is working and that it has made an important difference for those involved.

Based on our experiences the successful implementation of an RP program like this would require:

- The explicit and ongoing support of Senior Leadership in terms of providing time and resources for the training of facilitators, and the release time for both facilitators and nursing leaders for monthly RP sessions.
- The identification of potential facilitators among advanced practice nurses who are willing and able to reflect on their practice and to assist others.
- The initial training and ongoing development of the facilitators by people knowledgeable in using this approach.
- The ongoing collection of feedback/reflection on the program to continue to improve its effectiveness.

Strategies to sustain the program include:

- Ongoing Senior Leadership support of reflective practice as an organizational value.
- Dedicated funds to train/engage facilitators.
- Explicit strategies to renew/replace the pool of facilitators and to enable/encourage participants to attend regularly.

Although we regularly collect feedback from the participants in order to improve our practice, we have not conducted an extensive formal evaluation study of its impact, beyond the initial pilot study. This is a limitation of our work and we are currently working to remedy this. Despite the positive results and the clear indications from the participants that they find the program supportive (when so few supportive programs for leaders exist) and strategic in advancing their own skills, the program has been under constant threat during budget cuts. It has been vital that the expert/coaches, the facilitators and the participants systematically discuss the usefulness of the program and the real-life changes that the approach has had to solving clinical and professional issues in their work.

Over the years the key ideas behind our approach to RP have been incorporated into several other programs. For the last 6 years, The Ingram School of Nursing (ISON) of McGill Masters' program in Nursing has provided half-day sessions for their students in our approach to RP. This year, the ISON introduced a modest pilot program to train some of their faculty members in these ideas with the view that they could be incorporated into some of the courses in their program. In one of the MUHC's clinical groupings these reflective practice ideas formed the backbone of a 23-hour program to train an interdisciplinary group of 12 health care professionals to run short programs for all staff in the hospital to support their work in providing patient and family centered care. Over 560 people, from doctors to nurses to clerical staff, have participated in short (1–3 hour) sessions over the past two years.

Kegan and Lahey have described what they call "deliberately developmental organizations" (DDO) where everyone – not just select "high potentials" – could overcome their own internal barriers to change and use errors and vulnerabilities as prime opportunities for personal and company growth.[16]

They indicate that DDOs have three common features:

- An edge–aspirations/goals for their own professional (and personal) development
- A groove–a model/method/practices to organize and facilitate development
- A home–a trustworthy community to support people on their developmental journey

It has been our experience that the MUHC RP model and program provide a profound environment for learning and support to nurse leaders – many of whom state that they model and use these ideas with their staff on a daily basis. The RP project was targeted to nurse leaders, but we have observed, and have survey data that suggests, the developing culture around the interventions has had implications for the staff nurses and colleagues with whom the leaders work. The MLM provides an edge – in that it identifies gaps between what people espouse and what they do; it provides areas/behaviors that they might work on developing. It provides a groove – a way through case write-ups and review for working on identifying the gaps, as well as more productive alternatives. And finally, it provides a home – a supportive group where individuals feel safe to identify their "errors" and work towards producing more effective behaviors.

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CONFLICTS OF INTEREST DISCLOSURE

Smith and Andrews are paid consultants for the RP program. Oliver and Chambers-Evans work or have worked for the MUHC. We have no conflict of interest to disclose.

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