Reflection based of Rolfe et al (Example 1)

What? (a description of the event) Excessive request to cover 'on call' shifts
What happened? What did I do? What did others do? What did I feel? What was I trying to achieve? What were the results? What was good or bad about the experience?

During my first month as a Core Trainee I was asked to work several 'on call' shifts covering general surgery, as there were no other trainees in the unit, due to poor workforce planning and poor rota design. On the first day I had worked 8am-6pm and was asked by the Clinical Director (CD) at 3pm to cover the night shift, which I agreed to. I was subsequently asked by the same CD to work 10 out of 14 shifts on call, including two consecutive weekends, all at short notice and not as per the rota. Towards the end of this two-week period I was in theatre with another consultant who was trying to teach me how to perform an inguinal hernia repair, but performed poorly, barely even able to suture accurately, due to my exhaustion. I also began to miss simple cues in presenting patients, leading to delayed diagnoses.

So, what? – (An analysis of the event)
So, what is the importance of this? So, what more do I need to know about this? So, what have I learned about this? So, what does this imply for me?

Even though I identified that what was happening was wrong, I took no steps to resolve the problem, and it required the intervention of another consultant to point out the unfair and dangerous shift pattern I had been working.

Even though this was my first month as a trainee surgeon, I should not have allowed factors beyond my control (poor planning, colleagues' sickness) to impede my training, and to severely compromise my ability to perform even the simplest tasks, potentially threatening patient safety.

I should have alerted senior colleagues to the situation, especially once I started to make mistakes and should have emphasised how I was being exploited as a new Core Trainee, eager to do well. It would have been difficult for those senior colleagues to justify my work pattern in that context.

Now what? (Proposes a way forwards following the event)
Now what could I do? Now what should I do? Now what would be the best thing to do? Now what will I do differently next time?

This scenario also taught me that as a future consultant and trainer, I should look to identify occasions where poor planning leads to individual patients and staff being put at risk, saps trainee confidence and produces poor performance. With more experience and professional confidence, I have learned to speak out against these working conditions and will always consider that more junior colleagues may be more at risk, feeling unable to speak out.