# Retrospective Reflection Used the Gibbs Model: Personal Experience Essay

During this module I carried out subjective assessments with a model, a peer acting as a patient, I then reflected and developed my approach and performance using both self-reflection and peer feedback. To reflect I recorded and then watched my assessments, this enabled me to critique my verbal and non-verbal communication identifying positive and negative aspects that would have gone unnoticed if I solely used my first-hand experience. To guide my retrospective reflection, I used the Gibbs model (Donaghy and Morss, 2000). The Gibbs model guides users to think critically including what had happened in a situation, how they felt about the experience and what they would change for similar situations in the future situations.

When carrying out my first assessment I found it difficult to remember the questions I had prepared, and this meant that I kept referring to my notes. Upon watching the recording of the assessment, not only was my judgement affirmed but I realised that this felt unprofessional and gave an impression of unpreparedness. This potentially made the patient feel uncomfortable and therefore less likely to be forthcoming with vital information. To address this, I grouped my questions into categories including the history of the present condition, drug history and social history. My approach for the next interview primarily involved asking questions in the order of the newly designated groups; this allowed me to guide the patient through key topics in a logical fashion whilst avoiding segues that may offset the flow of the conversation. From my adaption, not only did the interview gain a more efficient format but I was able to access key information with more ease. Additionally, by completing subjective assessments throughout the module I became familiar with the questions and, consequently I became less reliant on my notes; once I became less dependent on my notes I was able to maintain eye contact with the model, facilitating the formation of a rapport.

One piece of positive feedback I received from my peers was that I asked questions clearly and avoided the use of medical jargon. Therefore, the model could understand the questions and was able to give consistently relevant and accurate answers. An example of this was in my assessment when I used the term “side of your hip” rather than the “greater trochanter” when describing the location of symptoms. Through discussions with my peers and practicing my assessment I found it easier to describe concepts in a clear and concise way, adapting medical terminology and being able to reword questions when necessary. If the patient is unfamiliar with medical terminology it can easily be confusing and intimidating when presented to them; therefore, without intention, this can impact the patient-clinician relationship and, in turn, take value from the patient’s experience. When on placement the ability to adapt your use of terminology, depending on who you are communicating with, is an important skill to achieve efficient and purposeful communication.

My peers also noted that I was using closed questions at times when open questions may have been more appropriate; I also observed this when re-watching my performance. By asking closed questions such as “are you struggling with cooking or showering?”, the patient’s answers are limited to these specific activities; however, by using an open question such as “are you struggling with any daily tasks?”, the patient would be able to draw from their wider experiences and avoid offering preconceived answers. It should be noted that if the patient was

struggling to understand my questions, I would provide examples, as shown in my subjective assessment when I provided examples of pain descriptors. I felt that this was a simple adjustment to my interviewing style although it increases the likelihood of addressing the key needs of patients as open questions are more likely to encourage more detailed and informative answers from the patient. The more information gained from a patient, the greater the likelihood I make an accurate diagnosis and provide the appropriate care.

When completing my final subjective assessment, I took a more holistic approach to the assessment by paying more attention to how the patient's condition was impacting them psychologically and socially. In my first assessment I prioritised the physiological information enabling me to diagnose the condition but this led to neglect of the patient's psychological and social concerns; in later assessments I delegated more time to investigating the effects of the patient's condition on their home and work life. With this information, I used the biopsychosocial model (Rickard, 2017) to identify the patient's main priorities and personalise their treatment plan. When completing my first assessment the biological aspect was the biggest aspect of the biopsychosocial model; however, when I spent equal amounts time investigating the sociological and psychological effects as the biological other priorities for her such as "taking her grandson on walks" became apparent. Psychological factors were not discussed during my first assessment and after approaching the patient again with these concerns in mind, her worries about returning to Zumba surfaced; importantly, I was then able to integrate her concerns into the problem list and develop tailored a goal plan. With regard to placement, this change in approach to my subjective assessment means that the treatment I provide will be more person-centred and the patients' needs and expectations from treatment will more likely be met.

In conclusion, I developed my subjective assessment throughout the module by using the Gibb's reflective cycle to structure my reflection of first-hand experiences, critiquing video recordings and incorporating feedback from my peers. This reflection and feedback enabled me to identify key areas of development and adapt my approach to assessments accordingly. These adaptations and developments included organisation of my questions, avoidance of medical jargon and overuse of closed questions as well as delegating more time towards the social and psychological impacts of the condition for the patient. Following the improvements in my subjective assessment, I will continue to develop on placement where these skills, and my wider patient-care abilities, will continue to be tested.