Reflection: nursing’s practice and education panacea?

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INTRODUCTION

‘Reflection’ and ‘reflective practice’ are terms that have become very familiar to many nurses and have become contemporary nursing practice. They are also terms that can engender a whole spectrum of reactions, ranging from positive enthusiasm, to feelings of gross ambiguity and/or consternation. The reasons for these divisions will be explored.

It is commonly taught, in the United Kingdom at least, that reflection used both as a teaching and learning tool, will develop nurses’ intellectual capacity to contextualize knowledge to meet patients’ needs (Durgahoe 1996, Hallett 1997, Boud et al. 1998). It is held that reflection facilitates the integration of theory and practice and makes nurses’ critical thinkers’ and ‘doer’s’ (Schon 1991, Reed & Procter 1993, Hallett 1997, Boud et al. 1998). Used effectively, reflection can answer questions about the nature of nursing and can be used to generate nursing theory (Schon 1983, 1991, Boud et al. 1998).

The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC 1990), as part of its framework for post-registration education and practice (PREP), expects all nurses to engage in some form of reflective activity and to provide written accounts within a personal professional profile (PPP). When the UKCC (1995, 1997) outlined steps to build the PPP, reflection became crucial in the second stage, termed ‘self-appraisal’. Of the personal professional profile, it is said: ‘It is based on a regular process of reflection... ’ (UKCC 1997 p. 13),
thus furnishing one with ‘real benefits’, such as developing ‘analytical skills through reflection on what you do’ (UKCC 1997 p. 13).

A document entitled Creating Lifelong Learners (English National Board for Nurses, Midwives and Health Visitors, ENB 1994) confirms that lifelong learning is one of the main aims of Project 2000, whereby student nurses are nurtured to adopt a ‘zest for learning’. Reflective practice is noted as being ‘fundamental’ to this development (ENB 1994 p. 13), with reflection both in and on practice being an essential component of pre-registration nursing education programmes. The focus of clinical supervision is also on reflective practice (ENB 1994 p. 14). More recently, the Government document A First Class Service in the National Health Service (Department of Health, 1998) outlines its aims to develop standards partly through lifelong learning.

The encouragement for a system of lifelong learning for Nurses and Midwives is also echoed in position statement number 10 in the document Breaking the Boundaries (Council of Deans & Heads 1998). Life-long learning, by implication, reaffirms the necessity for nurses to reflect.

A further recent consultative document A Higher Level of Practice (UKCC 1998) contains proposals for the nationwide recognition of such for nurses, within the post-registration regulatory framework, following individual assessment.

This is partly in response to the latest White Paper on the future of the NHS entitled The New NHS: Modern, Dependable (Secretary of State for Health 1997 p. 46), whereby one of the key objectives is the alignment of patient expectations with clinical results; the role of ‘expert nurses’ in achieving this is stressed. In order to be considered as such, section 7:3b of ‘A higher level of practice’ requires that nurses wishing to be considered for accreditation must produce a ‘written reflective account in a supervised setting’ as part of the assessment process.

So, to reflect effectively and to practice reflectively are now requisite skills for all pre- and post-registered nurses, midwives and health visitors.

Before developing the debate in relation to the robustness of the concept of ‘reflection’ and its application to practice, an examination of the main theories relating to adult learning will be investigated, followed by a discussion as to what constitutes ‘nursing knowledge’.

**ADULT LEARNING THEORY**

Brookfield (1991 p. 25) writes that there can be few intellectual quests that for educators and trainers of adults assume so much significance and yet contain so little promise of successful completion, as the search for a general theory of adult learning... Individual learning behaviours are so idiosyncratic as to cast considerable doubt on any general assertions made about adults as learners. So, how do nurses (who are also adults), acquire knowledge? For the sake of simplicity, the main learning theories may be broadly grouped into three, the salient features of which are outlined below.

**Behaviourist theories**

This group of theories is based upon the supposition that one learns by receiving stimuli from the environment, which in turn provokes a response. The teacher can take control of this process by selecting the stimulus and then positively reinforcing approved responses and conversely, negatively reinforcing (discouraging) wrong ones. It is theorized that the association between the response and the reinforcement (either positive or negative) results in the learning (Rogers 1993, Nicklin & Kenworthy 1997). Nicklin & Kenworthy (1997) affirm that the stimulus-response approach to learning still has its place in nurse education.

**Cognitive theories**

These theories involve the active engagement of cognition in relation to the matter under consideration. It is necessary to understand the information or processes in question before learning can occur (Thompson 1997). The activity is controlled by the inherent structure of knowledge, with feedback being an integral process of the learning practicum (Rogers 1993). This group of views applies to the area of skills as well as to attitudes and patterns of behaviour. Bloom (1964) developed a learning hierarchy by defining a distinction between cognitive learning and affective learning (personal growth element).

**Humanist theories**

This group is more recent than the former two and emphasizes the individual’s drive towards autonomy (whereas all other theories of learning make reference to terms of ‘control’) and competence. The active search of the learner for meaning is stressed, with an emphasis on the social setting within which the learner operates, the engagement of which provides the learning milieu (Rogers 1993). The motivation to learn comes from the individual and the notion that educators should function as facilitators of learning (rather than teachers) is accepted.

Carl Rogers was an influential humanistic psychotherapist and writer. He believed that learning is brought about by a democratic and student-centred environment (Rogers 1969). Responsibility for setting the direction and methods of learning rest as much with the learner as with the educator. Fundamental elements to the relationship...
are trust, mutuality and purposeful interaction (Rogers 1969). Recently, Riley-Doucet & Wilson (1997), in a small study, report a self-directed approach to evaluating learning needs which they suggest can be applied in any clinical setting.

Having outlined the main groups of general adult learning theories, it is useful now to discuss what is meant by ‘knowledge’ and highlight some other related theories and arguments as to what exactly constitutes nursing knowledge.

Glen (1995) comments, that what counts as bona fide knowledge in modern society, remains an insurmountable problem for Western philosophers, whereby the notion of an unquestionable foundation to validate ones knowledge, is simply not apparent.

Reed & Procter (1993) comment on Plato’s view of abstract intellectual knowledge, as being of a higher order than for example, skilled or bodily knowledge. The concept of caring inherent in nursing does not always lend itself to quantitative analysis, though some believe that an ‘academic science’ approach to developing nursing knowledge is the only way forward. The argument is that such an approach has a greater social value and academic status than any other and that in the absence of science, research and theory, nursing will be undervalued and will not be recognized as a profession (Reed & Procter 1993). When questioning which knowledge nurses’ employ, it is not sufficient to rely on traditional techno-rational science, because nurses’ are inextricably bound to the context of caring (Fernandez 1997).

Glen (1995) offers the premise that nursing is a complex body of professional knowledge, comprising skills, attitudes and values, together with factual knowledge.

In a seminal paper, Carper (1978) suggests a framework to elucidate nursing knowledge which is based upon the knowledge that nurses derive from the sciences and from artistry (or creativity). Four patterns of ‘knowing’ were established. As a result, the professional nurse was able to legitimize the domains of moral knowledge, empirics, personal knowing and aesthetics as being essential to being a nurse (Carr 1996, Heath 1998).

Benner’s (1984) work is an example of ‘radical academia’ (which explicitly seeks to uncover knowledge grounded in practice). The characteristics of nursing practice were derived from the epistemology of interpretive phenomenology. Benner’s work has had an important influence on subsequent educational research in nursing (Fealy 1997, Hallett 1997). Whilst she does not dismiss theory per se, Benner asserts that theory alone does not account for expert levels of performance. The work (which was based upon the application of the Dreyfus 1984 Model of Skills Acquisition to nursing), has been important in elucidating what constitutes expert nursing knowledge by charting the progress from novice to expert, making it infinitely more viable for nurses to articulate their own practice (Benner 1984, Reed & Procter 1993, Heath 1998).

Benner & Wrubel (1989) similarly presented their view that excellence is embedded in practice and that theory is derived from practice. Fealy (1997) comments that this premise derives from neo-Aristotelian thinking and in this way the human social world is not amenable to being explained by any formal theory.

Donald Schon is the major contributor in describing the importance of reflection, both for deriving knowledge from practice and for education (Schon 1983, 1987, 1991). In line with Benner’s work, he recognized that being a competent nurse (or an expert) utilized an ‘inherent artistry’ which he conceptualized as ‘knowing in action’ which was something completely separate from that which was taught in schools of nursing.

The acquired ‘taught’ knowledge, he termed ‘technical rationality’.

The other types of knowledge (or theory-in-action) that he saw nurses relying on were their own generated theories about practice, or ‘theories in use’ which govern the actual behaviours. These theories were acknowledged as having great value for professional practice. This theory was in direct opposition to the scientific approach nurse education had adopted.

The other types of theory-in-action were termed ‘espoused theories’; these are used to justify or explain practice, but are not necessarily congruent with the theory-in-use (Argyris & Schon 1974).

Fealy (1997) asserts that the predisposition within the nursing literature to consider theory and practice as separate entities, whereby the relationship is continuously discussed in varying degrees of incongruence or disintegration, despite attempts by theorists to identify the practitioner and theorist as one (Benner 1984, Schon 1987, Schon 1991, Lauder 1994), merely demonstrates that the ‘applied science’ approach in nursing discourse remains a strong force.

This phenomenon can be seen to be compounded by the feelings expressed by representative nurses, as cited in the report ‘Integrating theory and practice’ (National Health Service Executive 1998). Statements no. 35 and no. 36 (NHS Executive 1998) refer to the fact that theory is seen to be developed by a relatively small and elite group of non-practising academics. These people are seen as being far removed from the real life practice setting, thus rendering such theory as being able to command nothing more than an ‘unengaged spectatorship’.

So why do the UKCC, ENB and institutes of nurse education insist that nurses, at all levels of experience, should reflect? In order to do that, it is necessary to explore the conceptual issues and the assumptions related to reflection.
THE CONCEPTUAL ISSUES

It would be ideal at this juncture to commence with a definitive definition of either the reflective concept or process. However, despite the wealth of literature on reflection, to date no one has clearly defined it as a concept (Atkins & Murphy 1993, Newell 1994, Snowball et al. 1994, Rich & Parker 1995, Wong et al. 1995, Scanlan & Chernomas 1997, Pierson 1998).

Boud et al. (1998 p. 21), despite being enthusiastic proponents, acknowledge that:

... it is difficult to be precise about the nature of the [reflective] process... as yet, little research has been conducted on reflection in learning and that which has been undertaken offers few guidelines for the practical problems which face us as teachers and learners.

This statement raises the question as to whether authors share a common understanding of the term (Atkins & Murphy 1993) and whether the lack of definition of the process renders it difficult to assess what proponents of reflection claim it can do (Newell 1994).

Scanlan & Chernomas (1997) pose the question as to whether nurse educators in general are ‘jumping on the band waggon’ without clearly understanding the basic concept of reflection, which in itself is fundamentally hampered by the lack of clarity of definition. It is suggested that the conceptual muddle in respect of other cognitive processes associated with reflection (such as considering or pondering) can result in nurses believing that they are reflecting, when in fact they are not (in the context that is meant in nursing). Atkins & Murphy (1993 p. 1191) thus suggest that the lack of definition ‘...has made the concept difficult to operationalize’.

Reflective theory

Reflection, it was theorized, facilitated the identification and development of one’s ‘theories in use’ (Schon 1983, 1987). Schon made a temporal distinction between ‘reflection in action’ and ‘reflection on action’, whereby the former process is the modification and development of ideas (by utilizing a problem solving approach) during practice (Scanlan & Chernomas 1997); the latter being a cognitive post-mortem, looking back at past practice. This enables the practitioner to analyse ‘hunches’ and associated theories-in-use (or tacit knowledge). The identification of the contribution of each to the particular practice experience and to the actual outcome (or even to the unintended outcome), enables these motivating theories to be made explicit and then be analysed critically.

In this way, new knowledge (embedded in practice) and theory can be generated (Schon 1983, 1987). Benner’s (1984) phenomenological research accords with Schon’s premise that only by clarifying and making explicit what it is that nurses do, will it be possible to add to the established body of nursing knowledge (Rich & Parker 1995).

Reflection has broadly been conceptualized into varying stages, depending on the author (for example Mezirow 1981, Schon 1987, Johns 1992, Boud et al. 1998), but as Rich & Parker (1995) note, it is not essential to use a framework. All authors appear to concur that the initial stage of reflection commences with an awareness of an uncomfortable feeling due to the realization that the knowledge being applied during the practice was not sufficient in itself to explain what happened (Rich & Parker 1995).

However, to novices of reflection and those concerned to make the reflective activity productive (that is, to encourage synthesis, analysis, critical thinking and evaluation, rather than merely pontificating or ruminating over an experience), a suitable model and framework can be essential tools. Andrews et al. (1998) note that what passes for reflection is often not, and calls for nurses to distinguish between real reflection and mulling over an event in an unpurposeful fashion. Synthesis, validation and appropriation of knowledge are outcomes as well as being integral to the reflective process (Boud et al. 1998).

Single and double loop learning

These are models of reflective learning which have arisen from Argyris & Schon’s (1974) work in relation to the theory of action.

Essentially, single loop learning is afforded when strategies, values and goals are taken for granted; it is the result of ‘means-end reflection on action’ (Greenwood 1998).

Double loop learning occurs when learning systems and one’s role (norms, values and social relationships which underpin action) in its framing are questioned (Wong et al. 1995, Greenwood 1998).

Greenwood (1998) reviewed the British and Australian reflective literature for a framework which explicitly sought to achieve double loop learning and found that none exist in the United Kingdom (UK). Without exception, all frameworks for reflection were single loop. She asserts that Schon’s model of reflective practice is essentially flawed because of the failure to recognize the importance of reflection before action (Greenwood 1998). The potential irony highlighted is that single loop learning frameworks could lead students (or practitioners) to do wrong things, correctly (Greenwood 1998).

Andrews et al. (1998) debate the extent to which reflection derives from practice, due to the repetitiveness of certain nursing skills which they claim are undertaken as a result of habit rather than a conscious analysis of action. Mezirow (1991) argues that habitual action (such as swimming), even when the act gives rise to thoughts or feelings, cannot be reflective. Reflection can only occur when one challenges the validity of prior learning (Mezirow 1991).
Hallett (1997) demonstrated parallels between student subjective experience and the theories of Schon. However, she goes on to report an important difference, in that the role of ‘technical rationality’ should be emphasized more, to guide and enlighten the practitio-

ner, who will then be able to draw links between it and the ‘theories in use’.

Teaching reflective skills

In order to encourage practitioners to reflect, writing (in various forms) is largely advocated, for example writing in a ‘reflective diary’ (Schon 1991) about experiences, the aim of which is to help nurses clarify the knowledge underpinning their actions. This can be enhanced by documenting ‘critical incidents’, a method originally used by Benner (1984) to analyse the link between the science and art of nursing (Rich & Parker 1995).

Other modes of writing employed to help with learning through reflection are journals and autobiographical writings (Atkins & Murphy 1993). This learning practicum is further enhanced by a reflective ‘coach’ or supervisor (Schon 1987, Snowball et al. 1994).

Hallett (1997) discusses the role of the supervisor in learning through reflection, stating that it was found that they encouraged the students to think ‘rationally’ in order to develop their own ideas about nursing practice. They also assisted the students to reflect in a number of ways, by spending considerable periods of time (Hallett 1997) with them, asking open-ended questions to facilitate reflection on action, and developing a nurturing, safe environment in which the students could learn (by adopting positive regard and empathic understanding).

The skills required to reflect are also somewhat vague in the literature, but many emphasize general attributes as being prerequisite. These appear mainly to be open-mindedness and a motivation to reflect (Atkins & Murphy 1993). Implicit skills, the majority of which are notably higher mental processes such as critical analysis, self-awareness, synthesis and evaluation (which form the basis of degree level study) are deemed to be critical (Atkins & Murphy 1993, Burrows 1995, Durgahee 1996).

The assertion is made that reflection is an important aspect of the process of critical thinking and synergistically, unless critical analysis is achieved (which reviews and links experience to the past or future), reflection will not occur (Scanlan & Chernomas 1997).

Burrows (1995) reports that research indicates students under the age of 25 years may lack both cognitive readiness and the experience required to execute mature, critical reflection. She goes on to postulate that simple models have a greater chance of success.

Paterson (1995) cites four factors which impact upon students’ ability to reflect, that she delineates from nursing educational research.

First is the individual’s ‘developmental level of reflection’; followed by the individual’s perception of the tutor’s trustworthiness; the individual expectations of journal writing; and finally the quantity and quality of feedback from the tutor.

The reflective practicum is, according to Snowball et al. (1994), a ‘virtual world’, where nurses support each other in reflective dialogue, the purpose of which is to integrate taught theory and skills with theory derived from the reflection in practice of competent nurses (Snowball et al. 1994).

Andrews et al. (1998) comment that if reflection is seen by the nurse as part of a developmental cycle, whereby new knowledge is integrated with old rather than knowledge attainment being an end to itself, then changes in practice are more likely to occur.

Reflection: the claims

Durgahee (1996) states that the basic aim of reflective practice is to improve the quality of patient care delivered by an autonomous, thoughtful and knowledgeable practitioner. Fernandez (1997) adds that by employing a consistent critical reflection-in-action and on-action, there will be an improvement in professional knowledge and capability.


Glen (1995) stresses that nursing research should be grounded in practice because it is a social phenomenon rather than a theoretical activity. This is echoed in so much of the reflective literature in particular, the reasons for which have been outlined.

It was observed (statement no. 36, National Health Service Executive 1998) that there is a lack of evidence to demonstrate theory being generated from practising nurses (Newell 1994, Andrews et al. 1998, National Health Service Executive 1998). This is despite the fact that all nurses in the UK are required to reflect. The gravity of this situation should be acknowledged by nurses and the professional bodies. It ominously suggests that something with respect to either the facilitation or the implementation of the reflective process might be amiss. Perhaps it can be seen to pose the question: Are nurses generally not reflecting (or at an insufficient standard) because they feel ill equipped for meeting the requirements or because they have not developed the necessary skills? (Andrews et al. 1998). The work by Wong et al. (1995) can be seen to support this reasoning in as much as, when comparing the
level of student reflection between ‘critical reflectors’ and mere ‘reflectors’, they found that the latter (unlike the former) did not demonstrate effort either to validate assumptions or to demonstrate signs of making knowledge their own.

Reed & Procter (1993), Wong et al. (1995), Burrows (1995), Bellman (1996) and Hallett (1997) agree that reflective learning encourages student nurses to integrate theory with practice. However, the question still remains as to whether reflective practice produces better patient care (the driving motivator behind reflection). There is no evidence in the literature reviewed, yet most reflective authors or researchers call for such investigation, stating that the ultimate outcome of reflective practice is an improvement in patient care.

Newell (1994) refutes the validity of the concept of reflection per se, coherently identifying its characteristics as those of a ‘pseudo science’. He continues that, if reflection is nonetheless to be acknowledged as a creative art, in the sense that the benefits it confers are intrinsic to the pursuit of the activity, then those benefits are neither amenable to empirical refutation or support (Newell 1994).

Atkins & Murphy (1993) also questioned the methods employed by researchers, many of whom at that time used questionnaires and interview, which (being a quantitative approach) is a questionable method to study (subjective) reflection in action (Atkins & Murphy 1993).

These methods are still commonly used today (for example, Wong et al. 1995, Andrew 1996, Durgahee 1996), though it appears that ‘action research’ (which aims to facilitate the systematic analysis of problem-solving strategies aimed at improving practice) is also becoming popular (Bellman 1996, Bailey 1995).

Despite the fact that Atkins & Murphy’s (1993) paper was titled: ‘Reflection, a review of the literature’, it contained only 20 references. This may be due to the fact that it was undertaken in 1993 and there was not the plethora of literature that there is today. Even so, the UKCC had already implicated the reflective concept as being integral to professional development (UKCC 1990).

Durgahee (1996) is the only author in the literature reviewed who partly attempted to investigate the impact of reflective practice on patient care (by investigating how student nurses perceived their development and practice after 12 months of reflective practice).

The results comprise many postulated generalisations, but provide inconclusive evidence to support the premise that reflective practice improves patient care.

In concurrence with Newell (1994 p. 80), such studies which investigate students’ perceptions of personal and professional benefits in relation to using reflection are of interest, but remain merely accounts of how ‘people believe they have benefited’.

Andrews et al. (1998) comment that there is little evidence to demonstrate that personal benefits are transmitted to patients, rendering it impossible at this time to assert that reflection improves patient care.

Bellman (1996) reports that through reflection, nurses gain a greater insight into the meaning of nursing practice and are able to link theory to practice. These two ‘outcomes’ were claimed by the author to result in ‘patient centred enhancement’. However, this observation was only theorized and not supported by empirical evidence.

Other work describes a reflective process, the content of which is descriptive but not prescriptive (for example Sturch 1994). It is suggested that a more precise and focused approach to assessing both the skills required to reflect, as well as patient outcomes as an indication of effectiveness, is urgently required.

Barriers to reflection: time, accuracy of recall, ethical issues, emotional difficulties and intrusion of privacy

Bailey (1995) and Andrews et al. (1998) both identified a number of barriers to the development of reflective practice. For example, a lack of theoretical knowledge of reflection and skills development was compounded by poor skill mix and decreasing resources, making it very difficult for nurses to find either the time or the energy to undertake anything other than ad hoc reflection. This view is echoed by Pierson (1998).

The comment relating to the time required to reflect, represents one of the most prominent criticisms in the literature and is acknowledged as such by Snowball et al. (1994) and Heath (1998).

Another ‘major difficulty’ cited is that reflection-on-action relies on the memory (Newell 1994, Andrews 1996, Andrews et al. 1998). These authors note that uncertainties in the accuracy and recall of events, together with hindsight bias and the mediating effects of anxiety, can mean that sometimes people may not always do as they say they do (Andrews 1996). This has implications and ramifications when determining the value of reflection as a way to improve practice (Andrews 1998).

Rich & Parker (1995) provide warnings in respect of reflection. They advocate a humanistic, Rogerian approach to reflective support sessions, which can involve the divulgence of challenging incidents, giving rise to ‘a great deal of uncontrolled emotion’ and catharsis.

They warn that (despite the dearth of rigorous empirical evidence to support the use of reflection), the reflective process and critical incident analysis, in the absence of explicit and thorough preparation of practitioners, may be counter-productive or even harmful (Rich & Parker 1995). Furthermore, without competent support, deep-seated coping mechanisms may be threatened and vulnerabilities exposed in practitioners, increasing their anxiety rather
than reducing it. This in turn may result in psychological morbidity (Rich & Parker 1995).

Scanlan & Chernomas (1997) note that in recent years, reflective journal keeping for students has become de rigeur, the assumption being that they will develop as reflective practitioners. Paterson (1995) reports common problems cited with reflective journal writing. These include postponing writing entries, a decrease in vigour or enthusiasm about the exercise (resulting in non-reflective writing), concluding with a general unwillingness to reflect. She states that these difficulties require the nurse educator to engage in ‘a struggle’ to find alternative solutions and preventive measures to overcome resistance to reflective journal keeping on the basis that ‘reflective ability is necessary for practitioners to effect meaningful growth and change in nursing practice’ (Paterson 1995 p. 219).

Scanlan & Chernomas (1997) suggest that the assumption that ‘thinking’ documented in journals is transferred to nursing practice, should be examined empirically.

Continuing the debate in respect of reflective journals or diaries, Bellman (1996) found that, despite stressing that the journals were private and no one else would see them, the students involved with her research concluded that writing reflectively was ‘painful, too difficult, but in the main, unnecessary’. This was cited as being due to perceived social support (Bellman 1996 p. 136).

On a more positive note, Durgahee (1996) comments that the students taking part in her research, despite the scrutiny of practice sometimes being ‘painful and disturbing’, report that lateral and critical thinking were promoted, together with self-concept.

Rich & Parker (1995) also question the ethics of reading a document which contains potentially very sensitive and personal information, declaring that such practice constitutes an intrusion of privacy.

Wong et al. (1995) demonstrate in their research that when using journals for assessment purposes, it is very difficult to define or assess levels of reflection. Scanlan & Chernomas (1997) develop this issue further by asserting that journals should be read only to clarify the meaning of the experience and that they are not suitable as an assessment tool (because using them as such may abrupt the requisite trusting relationship between coach and reflectee). Arguably, it might also result in the student ‘tailoring’ writing to accommodate what he/she thinks the assessor would like to read.

**DISCUSSION**

The theme repeated over again in the literature is that in almost every respect of reflection (and its process) there exists a dearth of robust empirical evidence to support the claims made by reflective theory and reflective proponents.

This is not to suggest necessarily that reflection is incapable of fulfilling the very many claims made for it; rather that the claims have not, as yet, been substantiated empirically (Fernandez 1997, Andrews et al. 1998, Pierson 1998).

Despite this, nurses must reflect: Is it sensible that we have adopted an idea that has not been rigorously tested and supported empirically since its conception some 16 years ago?

Does encouraging the ability to reflect in students improve learning and create thoughtful, critical nurses? The literature remains predominantly anecdotal.

Will reflective accounts in portfolios accurately demonstrate continuing learning and professional development, rather than being a perfunctory exercise in order to comply with the UKCC’s (1997) requirements for re-registration?

Does reflection do nursing a disservice by virtue of the fact that its philosophical approach to care is in direct opposition to the demands of the internal market (with its emphasis on financial constraints and throughput, Naughton & Nolan 1998). Might this fuel feelings of frustration and cause even more nurses to exit from the profession?

Finally, will coercion to reflect ultimately defeat the purpose of the exercise? Reflection requires motivation and lots of time. Being forced to reflect does not suggest that the exercise would necessarily be a fruitful one.

It appears that reflective theory and practice has not been adequately tested, but neither for that matter has it been rejected. Schon himself, together with most proponents of reflection, acknowledges that what is needed most is some hard research evidence, most importantly including evidence to demonstrate irrefutably the effectiveness of reflective practice with respect to patient outcomes.

Perhaps nurses should concentrate for the time being on using reflection to try to develop practical skills, as echoed by Durgahee (1996) and not worry about emancipation or developing critical theory.

In line with Wong et al. (1995) and Greenwood’s (1998) work, nurses might consider putting to one side single loop reflective models and substitute ones that incorporate a combination of both single and double loop learning. Such models are, however, inherently complex. Others would take issue with such a complex model being used for students because of the evidence that these models are unsuitable for younger people, who have neither the experience or cognitive skills to use them (Burrows 1995). Despite the rising percentage of mature students in nursing, it may nevertheless be best to recognize and use two levels of frameworks, for pre- and post-registered nurses.

**CONCLUSION**

Notwithstanding all the criticisms presented, it is felt on balance that there should be a place for the application of
reflective principles because if reflection really can inform nursing practice, help nurses to think critically before, after and in practice with subsequent improvements in the care that patients receive, its plausibility as an essential skill for the profession to acquire becomes evident. At present, a conceptually defined, less flawed, more supported, but equally practical alternative, is simply not available.

References


