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REFLECTIVE THINKING IS A PART OF INTROSPECTION FOR A PHYSICIAN

[1]Prof. Dr. Dhastagir Sheriff* and [2]S.Omer Sheriff

[1]Faculty of Medicine, Benghazi University, Benghazi, Libya.
[2]Faculty of Dentistry, International Medical University, Kuala Lumpur, Malaysia

***Corresponding Author: Prof. Dr. Dhastagir Sheriff**
Faculty of Medicine, Benghazi University, Benghazi, Libya

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ABSTRACT

Reflective thinking and practice have become the norms of medical practice. One of the common problems health workers and practitioners encounter is to deal with patients infected with HIV infection. The fear and social stigma still haunt many in field of Medicine. If a patient who has not disclosed his HIV infection when subjected to a surgical procedure, the surgeon comes into contact with the blood spilled on to his face. That spilling of blood from a HIV infected patient makes him reflect and evaluate the day's proceedings of his practice and the precautions he needs to take to avoid such contacts with a blood infected with HIV.

KEYWORDS : Reflective thinking, practice, Human immunodeficiency virus (HIV), AIDS.

INTRODUCTION

There is a recent trend in medical education emphasizing the need to reflect and practice whether it is teaching or treating.[1] This trend is summed up by the thought that "Unless teachers develop the practice of critical reflection, they stay trapped in unexamined judgments, interpretations, assumptions, and expectations. Approaching teaching as a reflective practitioner involves fusing personal beliefs and values into a professional identity" (Larrivee, 2000).[2] Reflective practice is often seen as the bedrock of professional identity. "Reflecting on performance and acting on refection", as McKay (2008)[3] notes, "is a professional imperative." It is now become imperative to include as a benchmark standards laid down for professional registration and practice. Atkins and Murphy (1993)[4] identify three stages of the reflective process. The first stage, triggered by the professional becoming aware of uncomfortable feelings and thoughts, is akin to Schon's 'experience of surprise' (identify as 'a sense of inner discomfort' or 'unfinished business')[5] The second stage involves a critical analysis of feelings and knowledge. The final stage of reflection involves the development of a new perspective. Atkins and Murphy[4]argue that both cognitive and affective skills are prerequisites for reflection and that these combine in the processes of self-awareness, critical analysis, synthesis and evaluation. Patients with HIV infection provide a challenging perspective for a clinician to handle from diagnosis to therapy.

Encounter with a HIV patient?

Life -long learning is part and parcel of a health professional's life. Reflection is considered as a method of promoting the development of autonomous, qualified and self-directed professionals.[1]

It is considered to be a process associates with improvement of the quality of care, a stimulus for personal and professional growth and a way to close the gap between theory and practice. [3]

Of the different models of reflection Gibbs Reflective cycle[6] could be a better way to contemplate and introspect one's professional status and ways to improve upon one's practice.

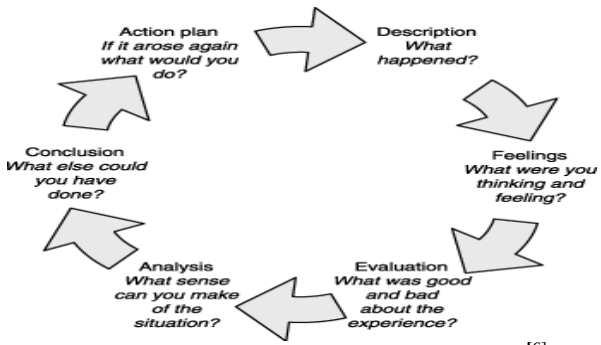

Fig.1. Gibb's reflective cycle. Taken from[6]

Consider a recent experience that happened to you. What was the situation?

A surgeon handled a patient with AIDS who did not reveal that he is a fully diagnosed AIDS patient.The patient needed a surgical procedure to be carried out. While doing the procedure a few drops of the blood spilled and sprayed onto the face of the surgeon. He wore surgical gloves and face mask. Yet after finding out that

the patient was HIV positive he was in a dilemma. (The risks of HIV infection through splashes of blood to the eyes, nose or mouth is even smaller - approximately 1 in 1,000).[7]

What were you thinking and feeling?
The surgeon panicked for a moment and was anxious to know whether he could be infected with the virus? In spite of being knowledgeable as a person had to look for references or expert opinion to clarify whether an accidental spill of a blood from the patient could result in HIV transmission. The first thought in his mind was to wash his face and hands thoroughly with soap and water as it is known to wash out the virus and protect from possible infection.[7]

Once he washed thoroughly he was in a dilemma whether to go for AIDS testing or not. In other words is it necessary to test for HIV. If you undergo such a test what will be the window period. If not whether you have to undergo for quantitative PCR testing for HIV antigens?

Evaluation and what was good or bad about experience
When you were convinced that the spilling or spraying of the infected blood will not cause infection you asked a question how did he miss the information that he is HIV positive. In other words how to enquire whether the patient has HIV infection or not ? Whether it will be useful to screen for such infections every time a patient is posted for a surgical procedure.

Did I miss or did I check the patient's previous case history scrupulously.

Or there has to be an improvement in the case history sheet that specifically asks about the medical history of the patient with a query whether the patient is HIV positive as the patient hails from an area reported to be with high prevalence of HIV.

Or whether the patient has hidden the information as he was informed that sometimes a practising dentist may not treat the patient if he is known to be HIV positive.

Analysis
It is possible to witness such situation wherein you may be treating a patient without knowing whether the patient is infected or not. Therefore it is always better to be protected with gloves, face mask and if possible with goggles to avoid such spilling of infected blood on you.
A proper sterilization of instruments, disposal of needles and periodic check-up of instruments including the motor and even the wash and wash solution container could be carried out.

It is better to have a complete knowledge of procedures to be followed during such untoward incidents to protect one from contracting the infection and also the specific washing procedure to be carried by the dentist after the procedure.

As HIV transmission is potential risk factor in the treatment protocol of dentistry all institutes or hospital or clinics must have an information sheet regarding the Exposure and its possible remedial measures to be carried out (a model exposure sheet is prepared for one's safety as well as possible for the department to handle such a situation).

There is still a moral fear with medical practitioners when dealing with HIV infection and patients suffering from AIDS. This fear had driven patients out without being treated in the earlier days.[8-10] This fear may be due to certain facts regarding HIV infection and transmission A patient who has been silent regarding his HIV infection led to his wife's infection and remaining silent like the present case dealt by the surgeon *may perpetuate the disease*.[11]
It is reported that of the 22,759 patients receiving medical care from different US health care providers with HIV infection HIV infection is a possibility but a very rare event.[12]

We should continue to emphasize the absence of scientific data about any transmissions in the operating room environment, so that a healthy atmosphere can be maintained in the minds of patients and the public regarding the problem of HIV transmission

Fact Sheet
Definition of Exposure
Blood-borne Pathogen Exposure Types

Percutaneous: Less Severe
1. Superficial scratch with needle or other sharp object.
2. Injury with needle or other device contaminated with blood/body fluids.
3. Subcutaneous injury that causes bleeding.

Percutaneous: More Severe
1. Deep puncture or laceration with large bore hollow needle or other sharp.
2. Intramuscular injury that causes bleeding.
3. Visible blood on device.
4. Needle causing injury previously in source patient's vein or artery.
5. Injection or transfusion of blood.

Mucous Membrane
Splash to eyes or mouth with blood/body fluid known to carry HIV
1. Small amount (i.e., few drops, squirt) of blood/body fluid, short duration of contact
(< 5 minutes).
2. Large amount (i.e., test tube full) of blood/body fluid, extensive or prolonged contact
(> 5 minutes).

Skin
Splash onto compromised skin (e.g., dermatitis, abrasion or open wound)
1. Small amount (i.e., few drops, squirt) of blood/body fluid, short duration of contact
(< 5 minutes).
2. Large amount (i.e., test tube full) of blood/body fluid, extensive or prolonged contact
(> 5 minutes).

Splash on intact skin is not considered an exposure.
SOURCE EVALUATION
HIV Class Code

HIV Positive Class 1
1. Asymptomatic HIV infection.
2. Low viral load (<1500 RNA copies/mL).

HIV Positive Class 2
1. Symptomatic HIV infection.
2. AIDS.
3. Known high viral load.
4. Potential HIV+ with acute seroconversion illness (mononucleosis-like syndrome, rash, meningoencephalitis syndrome, diarrhoea).

Unknown HIV status
1. No risk factors for HIV.
2. Positive risk factors for HIV:
• History of multiple sex partners (same sex or not).
• Homosexuality; bisexuality.
• IV drug use.
• Hemophilia, blood transfusions or organ transplant before 1985.

Unknown source
1. E.g., needle from trash container.
2. Consideration to be given to location of incident: HIV clinic, hospital infectious
disease floors, Emergency Department, Labor and Delivery, Operating rooms
3. Consideration to be given if blood present on device regardless of location

NB
1. Skin/needle stick: Wash exposed areas with soap and water or an antiseptic such as
70% alcohol or iodophor.
2. Eyes: Flush eyes with normal saline or water x 15 minutes.
Facial and oral mucous membranes: Wash face and/or rinse out mouth with water.

CONCLUSION
He thought he could have been more careful in dealing with such procedures keeping in mind that a patient who comes for a tooth extraction procedure or for root canal treatment could carry such infection. Even though he had the case history from the referral department or the one carried by the patient it will be worthwhile to re-examine the case history to possibly elicit more disclosure from the patient.

ACTION PLAN
To avoid such events and possibly to be more careful the surgeon decided that he will schedule his practice with more care, limit his number of patient referrals for a day . Or if he does not have the authority to control and limit the number of patients to be treated he will take a break with a cup of coffee to relax and continue his consultations.

As an additional measure he has prepared the Fact sheet for educating and preventing him from such exposure which is shown below

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