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REVIEW ARTICLE

Critical reflection in team-based practice: A narrative review

Tracey Edelist[1] | Farah Friesen[2] | Stella Ng[2] | Nicolas Fernandez[3] | Marilou Bélisle[4] | Kathleen Lechasseur[5] | Annie Rochette[6,7] | Brigitte Vachon[6] | Marie-Ève Caty[1]

[1]Département d'Orthophonie, Université du Québec à Trois-Rivières, Trois-Rivières, Canada

[2]Centre for Advancing Collaborative Healthcare and Education (CACHE), University Health Network, Toronto, Canada

[3]Département de Médecine de Famille et de Médecine d'Urgence, Faculté de Médecine, Université de Montréal, Montreal, Canada

[4]Faculté d'Éducation, Université de Sherbrooke, Sherbrooke, Canada

[5]Faculté des Sciences Infirmières, Université Laval, Quebec, Canada

[6]École de Réadaptation, Faculté de Médecine, Université de Montréal, Montreal, Canada

[7]Centre de Recherche Interdisciplinaire en Réadaptation de Montréal (CRIR), Montreal, Canada

Correspondence
Marie-Ève Caty and Tracey Edelist, Départment d'Orthophonie, Université du Québec à Trois-Rivières, Trois-Rivières, Canada.
Email: marie-eve.caty@uqtr.ca and tracey.edelist@mail.utoronto.ca

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Abstract

Introduction: Research on critical reflection (a process of recognising and challenging assumptions that frame health care practice) has demonstrated strong potential for making health care more collaborative and equitable, yet its enactment within team-based health care remains underexplored. We conducted a narrative review to advance understanding of how critical reflection develops, occurs in and impacts team-based practice and care.

Methods: We searched three databases (Medline, CINAHL and Scopus) for articles related to the concepts of critical reflection and/or critically reflective practice in the context of team-based health care and examined how teams engage with those theoretical concepts, to inform ideas for a new approach to support critically reflective practice.

Findings: The search identified 974 citations of which nine articles showed elements of critical reflection in team-based practice. However, since only one of the nine included articles explicitly used the term 'critical reflection' in their research, critical reflection as a theoretical concept was found to be largely missing from the current team-based health care literature. Instead, *aspects* of critical reflection were evident in terms of challenging power hierarchies and questioning practice assumptions through dialogue, with a goal of collaborative practice. This sharing of knowledge and skills allowed teams to push boundaries and innovate together in practice. The included articles also emphasised the importance of creating a purposeful environment for open dialogue and practice change to occur.

Conclusion: To support equitable care through collaborative practices, we suggest *dialogue as* and *for* critical reflection should be explicitly developed and researched within team-based health care.

1 | INTRODUCTION

Although reflection[1–7] and, more recently, critical reflection[8–11] have been researched and used extensively within health professions education (HPE) and professional practice, a team-based focus is often missing.[12] By 'team-based health care', we refer to the collaboration of at least two health care providers from different professions working with patients to provide integrated care.[13,14] We explicitly avoid framing team-based health care within a particular team care model (e.g., multidisciplinary, interprofessional or transdisciplinary), as these

terms discount the role of patient/clients as team members. Considering health care is often provided by interdisciplinary teams with inherent power dynamics affecting team relationships, along with suggestions that (critical) reflection is dynamic relational work that should be situated within group contexts,[12] it is important to understand how critical reflection is taken up within team-based health care.

Critical reflection differs from reflection in that its focus is on noticing and questioning societal norms and assumptions and the power relations that uphold those assumptions, rather than a focus on an individual's thoughts, feelings or actions.[15] Informed by critical theories,[16–21] our understanding of critically reflective practice (CRP) involves practitioners challenging taken-for-granted health care practices, including those supported by disciplinary, institutional and societal systems, structures and ideologies, and understanding how those assumptions shape practice, to work towards more equitable care.[10] While both critical reflection and reflection involve taking action to change practice in context, critical reflection involves attending to how hegemonic social, cultural and political ideologies influence practice in ways that create inequities.[22–24] For example, if health care providers assume disabled people are asexual, they may not test for sexually transmitted diseases or offer accessible pap smears,[25,26] or if Black people are assumed to feel less pain, their symptoms may not be taken seriously, and they may not be offered timely pain medication by their health care team.[27,28] Engaging in critical reflection allows health practitioners to recognise health inequities and to challenge the structures and ideologies that perpetuate these inequities. CRP involves using this critically informed knowledge to make meaningful practice changes.[3,5,10,29–32]

Critically informed knowledge encompasses a variety of broad and specific critical concepts, theories and frameworks used outside of and within HPE and practice that challenge dominant ideas and power structures (e.g., broadly: anti-oppressive health care, social medicine, critical disability studies, transformative learning; specifically: anti-ableism, refugee, Indigenous and Black health). Such knowledge can also arise from personal experiences of inequities (e.g., within one's personal life, as a patient, or through a poignant interaction with a patient).[33–35] We consider CRP to be how health care providers integrate critically informed knowledge into everyday practice (i.e., praxis), as an active process of questioning assumptions and changing inequitable practices. This is supported by research that suggests engaging in CRP may lead to opportunities to provide collaborative and equitable care.[8,10,36–38] For example, Sukhera et al.[39] found that after physicians and nurses were trained to notice and question implicit bias through critical reflection, small changes to practice (e.g., questioning inequitable policies, noticing inequitable care and taking on an advocacy role) occurred over time, gradually shifting the behaviour of teams as well. However, how critical reflection is used within team-based health care remains unclear.

We therefore conducted a narrative review exploring the current literature on how critical reflection develops, occurs in and impacts team-based health care. For the purpose of our review, we use the terms 'critical reflection' and 'critically reflective practice' to refer to any process or activity involving the intentional understanding and challenging of individual and societal norms and assumptions to create practice change. This definition includes (critical) reflexivity—'recognizing one's own position in the world both to better understand the limitations of one's own knowing and to better appreciate the social realities of others' (Ng et al.,[10] p. 1123)—as one aspect of critically informed knowledge that informs CRP. Since over the past 20 years health care has increasingly been offered in a team context,[12,13,40,41] understanding how health care teams develop and use critical reflection is important to understand the role and possibilities of CRP in the provision of equitable health care.

2 | METHODS

To find current research on how health care professionals develop and use critical reflection within team-based health care, we first developed a list of concepts related to our definitions of critical reflection and team-based health care and performed preliminary searches to determine the most effective search terms to capture a manageable number of relevant articles. We eliminated some search terms (e.g., critical analysis) and linked some terms together (e.g., workaround and reflection) to reduce the number of unrelated articles found. We searched OVID Medline, OVID CINAHL and Scopus for critical reflection and its synonyms (e.g., CRP and critical reflexivity) or critically reflective concepts (e.g., hierarchy, power structure and social justice) in conjunction with reflection and its synonyms. These critical reflection search terms were combined with terms focused on team-based health care (e.g., collaboration and interprofessional work). Please refer to Supporting Information S1 for a list of search terms. The databases were chosen for feasibility and their broad coverage of medicine and health (Medline), nursing and allied health sciences (CINAHL) and multidisciplinary literature (Scopus) and allowed searching using both database-specific subject headings (MeSH, CINAHL headings) and textwords (keywords). We included English-language (for feasibility) peer-reviewed publications from database inception to 25 July 2022 (search date).

The search strategy was developed collaboratively by the authors, and the search was conducted by FF, a librarian who is also a HPE researcher. Unlike a scoping or systematic review, and in alignment with 'state of the art' narrative review methodology, our search was rigorous but non-comprehensive, with a goal of synthesising current knowledge and offering new perspectives.[42–44] A total of 1288 citations were identified across the three databases. After removing 314 duplicates, a total of 974 citations for title/abstract screening remained. The PRISMA-P flow diagram is shared in Supporting Information S2.

We screened for articles that could answer our research question of how critical reflection develops, occurs in and impacts team-based health care by considering three specific questions: (1) how do health care teams learn to use critical reflection in their everyday practice?; (2) how, when and where is critical reflection practised among team members?; and (3) how does team-based CRP support equitable care and/or challenge systemic inequities of care? Articles were included that could answer at least one of the above questions and that focused on clinical practice, including workplace-based learning but

excluding classroom-based education, and focused on interpersonal/interprofessional collaboration, excluding interorganisational/sectoral collaboration. The authors first piloted and refined title/abstract screening inclusion criteria using five articles. Three team members (TE, FF, M-EC) then performed a title/abstract screening independently and resolved any uncertainty through discussion.

Many articles excluded during title/abstract screening that did not meet the criteria of team-based health care instead addressed critical reflection in relation to classroom-based interprofessional education, uniprofessional or intra-professional practice or were related to critical reflection within research teams but not clinical practice. Sixty articles were retrieved for full text review, of which 55 were excluded based on not meeting inclusion criteria. The five included articles were citation chased backwards (reference lists) and forwards (cited by), and four more articles were found, resulting in a final dataset of nine articles meeting our inclusion criteria, shown in Supporting Information S3. The lead author (TE), a critical disability studies researcher with a speech-language pathology (SLP) background, extracted information relevant to our research questions from the articles and interpretively analysed and coded the data. The analysis was discussed with FF, M-EC (SLP) and SN (audiologist), all HPE researchers, during regular meetings.

Categories and subcategories, as outlined below, were created through an iterative, inductive approach (i.e., thematic analysis) that presented how the articles engaged with our understanding of critical reflection in team-based health care.[45] Our search, screening and analytical process were influenced by our social positionings and understandings of critically informed knowledge, particularly important in determining how critical reflection was evident in articles that did not explicitly use the term critical reflection, but did challenge individual and societal norms and assumptions to create practice change. Our research is supported by a multidisciplinary research team, including critical disability studies, speech language pathology, occupational therapy, nursing, audiology, medicine and education. The team is composed of anglophone and francophone researchers committed to applying critical social science knowledge to HPE and research.

3 | FINDINGS

The nine included articles used a variety of qualitative methodologies and methods to explore various topics. Three were related to interprofessional or transdisciplinary teams,[46–48] four reported on team workshops or projects[49–52] and two were general commentaries/reflections based on team-based practice experience.[53,54] Only one[49] of the nine included articles explicitly used the term 'critical reflection' in their research and engaged with critical theories.[49] While the other eight articles did not use the exact term 'critical reflection', they described theoretical concepts and approaches consistent with critical reflection (critically informed knowledge) and provided information about how health care teams understand, foster or enact these skills. For example, components of critical reflection were evident in relation to challenging traditional power hierarchies within the team and questioning practice assumptions through dialogue, which involves an openness to re-examining one's own perspectives and may include challenging one another's beliefs. Overall, the nine articles discussed how the sharing of clinical, experiential and research knowledge and skills amidst a spirit of collaboration allowed the team to push boundaries and create innovative changes to practice. These processes are consistent with our understanding of critical reflection as discussed above and are described in more detail below.

Our findings are organised into three overlapping and interrelated categories: (1) conditions that support the development of CRP in team-based health care; (ii) enactments of critical reflection by health care teams; and (iii) changes supported by team-based CRPs. Several sub-themes describe each category, as shown in Figure 1.

3.1 | Conditions that support the development of CRP in team-based health care

The overriding element found to support the development of CRP was the team environment. All nine articles discussed how relationships between team members were important for fostering feelings of trust and creating a safe environment in which all members could contribute. Taken together, the articles indicated a circular relationship between developing trust and a safe team atmosphere and the reduction of hierarchies to allow for open, respectful dialogue of difficult practice issues. Fostering trust and a safe team environment for open dialogue can be described with the following subthemes: (1) purposeful spaces; (2) building relationships; (3) willingness to challenge one's own assumptions; and (4) facilitation.

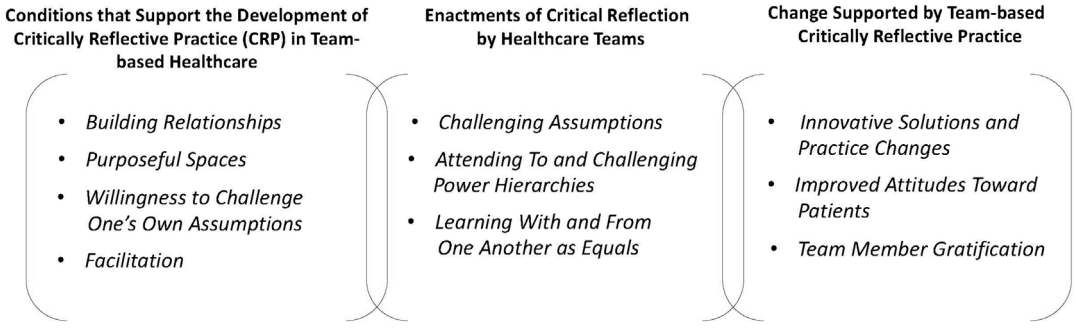

FIGURE 1 Critical reflection in team-based practice: overlapping categories and sub-themes

3.1.1 | Purposeful spaces

Six articles implicitly or explicitly alluded to the need for a team setting that is non-threatening and non-judgmental to facilitate a team environment that supports the open and honest sharing of perspectives that may challenge one another.[51] Uhlig et al.[54] referred to this as 'psychological safety', and Hem et al.[50] explained, 'groups need to feel safe enough in order to (among other things) reveal that one does not know what the right thing to do is, to share emotions, and to disagree with others' (p. 11). Implicitly, Williams et al.[52] had teams develop group rules together to support difficult conversations, and Farr[49] had facilitators create space to allow people to communicate on a personal, human level, rather than a space defined by professional hierarchies.

In their commentary on collaboration in interprofessional health practice and clinical education, Uhlig et al.[54] noted that teams needed to create 'opportunities for collective team reflection' (p. 1443). They found these opportunities to be facilitated when team members worked in the same space rather than being dispersed throughout different floors of a hospital, for example,[54] which McCallin[46] found was easier for smaller rather than larger teams. In addition, Farr[49] found when community spaces were used for team meetings (e.g., a local café), a diversity of community members participated in development initiatives, whereas only patients with experience navigating hospital bureaucracy participated in the hospital-based co-design project. Creating an environment that supports team-based critical reflection may therefore benefit from carefully chosen physical meeting spaces, as well as a non-judgmental philosophy that promotes open dialogue between team members. Such purposeful spaces support, and work in tandem with, building team relationships.

3.1.2 | Building relationships

All nine articles discussed the importance of building relationships among team members to foster an atmosphere conducive to team-based critical reflection. Farr,[49] Gage,[53] Uhlig et al.[54] and Hem et al.[50] pointed to a reduction or removal of power hierarchies, between professionals and/or between professionals and clients/patients, as being key to building relationships. Shaw et al.[48] described the importance of professional synergy within a team, and Randall-James and Head[51] pointed to comradeship and companionship facilitating trust. In a discussion of what is needed for teams to develop synergistic relationships, Gage[53] outlined the importance of 'total stakeholder satisfaction', meaning every team member, including the client, must have their individual needs met for them to become an effective treatment team (p. 2). Similarly, Uhlig et al.[54] noted shifting power dynamics and centring human dimensions of care are important for high quality relationships to develop.

Gage[53] discussed how it takes time for teams to develop trusting relationships, while both McCallin[46] and Williams et al.[52] noted time was needed for interdisciplinary teams to share, reflect and 'work through predetermined beliefs that supported unsubstantiated myths and assumptions' (McCallin,[46] p. 82). Similarly, Gage[53] argued teams must make time to cultivate synergistic relationships by developing ways to save time in other areas of practice.

Three of the articles suggest that individual differences influence the degree to which team members are willing to engage in critical reflection with their team. McCallin's[46] study of interdisciplinary teams found the relationships the team is able to foster and how well they work together are dependent on the individual personality of team members. This relates to Hem et al.'s[50] finding that professional culture was compromised when not everyone actively participated in ethics reflection groups and Farr's[49] finding that some professionals seemed threatened, withdrawing from the co-design project after watching a film in which patients shared negative health care service experiences. These findings suggest that when team members are uncomfortable having their professional opinions challenged, they may opt out of critically reflective dialogue with their team, compromising relationship building.

3.1.3 | Willingness to challenge one's own assumptions

Seven of the articles noted team members must be open to critique and willing to reflect about their own practice to consider other viewpoints and work towards practice change.[46,48–52,54] For example, Shaw et al.[48] found team members required humility and self-awareness to take in team feedback and reflect on events in progress, changing practice as needed. At the same time and inter-related to the purposeful spaces subtheme above, an emotionally safe environment was necessary to provide for the possibility of critical reflection of one's own assumptions.[50] This relates to how challenging one's own individual ideas and practices amidst processes of mutual learning and collaborative re-exploration of personal and professional worldviews could be uncomfortable.[46,50,51,54] McCallin[46] found team members who were inflexible in their thinking created roadblocks for the reconsideration of 'traditional ideas and assumptions that underpinned controversial ideas' and argued team success was mostly the result of individual team members' efforts to challenge themselves (p. 80).

3.1.4 | Facilitation

The use of facilitators was an important part of creating a team environment conducive to critical reflection in the four papers that described team projects or workshops. They all discussed the importance of facilitators, whether internal or external to the team, in creating a space that allowed practice assumptions to be challenged and innovative solutions to be developed.[49–52] For example, Hem et al.[50] found the facilitator balanced the degree of critical reflection happening in ethics reflection groups with team members' feelings of safety to ensure everyone felt safe to openly contribute.

Randall-James and Head[51] described a particular exercise to facilitate group reflection where the facilitators, as outsiders to the team,

encouraged the team to consider multiple perspectives and challenge assumptions, facilitating 'an opportunity for different dialogues to take place' (p. 457). Similarly, speaking to the importance of facilitation in developing an implementation framework to transform pain care in an emergency department, Williams et al.[52] found facilitation 'enabled curious questions and established a safe, participatory process where critical questioning was normalised' (p. 3).

3.2 | Enactments of critical reflection by health care teams

All of the articles situated the 'doing' of critical reflection within a dialogical process of communication between team members, supported by a trusting team environment, as described above. Building relationships among team members was found to be an overriding thread that links supportive conditions, enactment and outcomes of critical reflection in team-based health care and was key to this dialogical process. Randall-James and Head[51] discovered it was the process of dialogue, rather than any specific questions asked that enabled new conversations to take place, while McCallin[46] found 'the decision to dialogue mindfully with others is essentially individual' (p. 85). Within this dialogical process, team-based critical reflection occurred through (1) challenging assumptions; (2) attending to and challenging power hierarchies; and (3) learning with and from one another as equals.

3.2.1 | Challenging assumptions

Most of the articles described how team members worked to identify and challenge practice assumptions together, with a goal towards developing new assumptions and ways of practice for the team[46,48–54]. As Uhlig et al.[54] wrote, 'A host of deeply held patterns, routines, norms, and expectations must be carefully and respectfully examined, unwound, reconsidered, and reintegrated for new collaborative care processes to be successfully implemented and sustained' (p. 1442). This is described as a relational process that involves questioning the unquestioned, active listening to unpack and challenge dominant practice assumptions, and creating opportunities for new understandings and dialogues.[46,49,51,52]

3.2.2 | Attending to and challenging power hierarchies

As mentioned above, challenging power hierarchies is a way to foster a safe team environment and is also a way critical reflection is practised within team-based health care. Seven of the articles indicated hierarchical relationships should be acknowledged, challenged and power boundaries redefined to foster what Farr[49] refers to as 'humanistic connections' (p. 632), to develop equitable, collaborative relationships where shared decision-making and solutions can occur[46,48,50,52–54]. Gage[53] and Uhlig et al.[54] discussed how power hierarchies can be diminished by re-examining traditional hierarchical team structures and developing a collaborative leadership structure where power is more evenly distributed, generating a sense of 'power *with*' rather than power over ([49] p. 633).

Both Farr[49] and Gage[53] acknowledged the difficulty in achieving a truly equitable position for the client/patient on the team, due to the inherent power differential in client-professional relationships, where clients depend on the services of the professional. This again raises the importance of developing authentic relationships and being aware of the manifestation of inequitable power dynamics, so any threats to equality can be addressed.[49,53]

A few of the papers also addressed how critically reflective processes challenge disciplinary power. Shaw et al.[48] described the importance of decision-making that is not based on single disciplinary scopes of practice, while noting this removal of disciplinary power is difficult to accomplish. Randall-James and Head[51] reflected on personal and professional positioning within an imposed hierarchical institutional identity, while Farr[49] found co-production projects challenged systemic inequities by 'challeng[ing] objectifying and disconnecting bureaucratic processes' (p. 638).

3.2.3 | Learning with and from one another as equals

Many of the articles indicated that when individual team members mutually respect one another as valuable members of the team, space opens up to learn with and from one another[46–48,50,52]. McCallin[46] described this as a 'collective learning experience' occurring through pluralistic dialogue, a process involving discussing differences and integrating multiple perspectives while learning to work together (p. 81). This dialogical process involved a willingness to be open to different ideas and to make and learn from mistakes together.[46]

Learning with and from one another was understood in the articles as an ongoing process occurring in tandem with challenging hierarchies and assumptions. Shaw et al.[48] noted how understanding one's professional role as a contributor, rather than an expert, is important to mutual learning and suggested this is a dynamic process in everyday practice—one that can be assisted by interprofessional education. When team members challenge and question one another and engage in constructive disagreement, mutual learning supports the critical evaluation of practice as ideas discussed through collaborative teamwork are put into action, thus improving work relationships and care practices.[48,50,52,54]

3.3 | Change supported by team-based CRP

The articles pointed to benefits that CRP has for all team members, including professionals and clients/patients, that could potentially lead to improved patient care and better relationships and understanding one another. How team-based CRP might support equitable care can be described with the sub-themes of (1) innovative solutions and

practice changes; (2) improved attitudes towards patients; and (3) team member gratification.

3.3.1 | Innovative solutions and practice changes

Six articles pointed to team innovation being fostered when interdisciplinary team members share knowledge and skills and collaboratively problem-solve solutions to improve practice. For Williams et al.,[52] it was the desire for innovative solutions and practice changes that prompted the use of CRP in the first place, which requires innovators who are willing to take risks to make those changes together.[54] When ideas are developed together without judgement through open dialogue, space is provided 'to think and do things that fall outside the usual protocol' ([53] p. 6) or to create different dialogues that can lead to a new shared direction.[51] For example, Newham and Howie[47] described how a new intervention was introduced for a patient when their desire to not go back on a ventilator led the anaesthetists and nurses to collaborate on a different solution. Similarly, Farr[49] found that interdisciplinary teams working on co-production projects challenged problematic bureaucratic processes, showing how critical reflection and collaboration can '[facilitate] people to undertake new situated actions and instigate forms of social change' (p. 638).

3.3.2 | Improved attitudes towards patients

When teams were aware of power dynamics and worked to diminish power hierarchies and develop more personal, humanistic connections, this was tied to a better understanding of patient perspectives[47,49,53,54] and improved attitudes towards patients.[50] For example, some team members in Hem et al.'s[50] study reported that the process of critically reflecting on coercion led to improved attitudes towards patients, such as asking patients about their experiences and including patient perspectives in their treatment decisions, thus moving towards patients as *part* of the team. They concluded that ethics reflection groups could challenge the way professionals talk, both to and about patients, and how they act and react to situations in practice, leading to better patient care.[50] However, none of the articles explicitly addressed how critical reflection and innovation impacted patient care.

3.3.3 | Team member gratification

In addition to relationship building being necessary to foster CRP, a few articles suggested developing closer relationships with teammates may also be a positive outcome of teams engaging in CRP. Farr[49] and Uhlig et al.[54] noted how connecting with the perspectives of others while exploring one's own values created stronger bonds between team members and the opportunity for work to become more meaningful and fulfilling. Interactions between team members became more personal rather than professional when 'staff engaged warmly, openly and committedly in the process' ([49] p. 632). In turn, as team members developed deeper connections with one another, felt content with their work together, and built a positive professional culture, patient care was expected to improve.[50,54]

4 | DISCUSSION

The objective of this narrative review was to advance understanding of how critical reflection (a process using critically informed knowledge to recognise and challenge assumptions that frame health care practice) develops, occurs in and impacts team-based health care, to inform an approach for developing CRP. Our findings suggest that dialogue is the main process used by team members to enact critical reflection. More than team discussion, which typically involves the use of authority or disciplinary expertise to persuade others of the best solution to a clinical problem, dialogue focuses on exploring team members' diverse thoughts, feelings and lived experiences to focus on the human dimensions of care.[55] Facilitated by a supportive team environment, critical reflection through dialogue was found to have the potential to improve team relationships and patient care. However, only one article explicitly engaged with critical reflection theories,[49] and only one described 'dialogue' in detail.[46] We identify this lack of engagement with critical theories in team-based health care research and practice, which we consider necessary to inform understandings of critical reflection, as a missed opportunity for health care teams to strengthen their work towards collaborative and equitable care. In this section, we engage with theories of critical reflection and dialogue to discuss how our findings lead us to advocate for the use and importance of dialogue *as* and *for* critical reflection within team-based health care or critically reflective team-based health care. We explore the implications that critically reflective team-based health care may have on clinical practice, education and research.

4.1 | Implications for clinical practice: Advancing collaborative and equitable team-based health care through critical reflection

Team-based health care, where patients and practitioners from different disciplines work together, is a social context that provides an exciting opportunity for developing critical reflection through dialogue, to support collaborative and equitable care. Despite the foundational principle in interprofessional practice that all professions have equally important roles in collaborative practice, there is little research examining how (often invisible) power dynamics affect the way health care teams work together.[56] Critical reflection through dialogue offers a valuable approach for addressing power hierarchies and practice assumptions in team-based contexts where collaboration 'can be fraught with tension and conflicts' ([56] p. 717). By 'dialogue', we are referring to 'a way of knowing' in relation to one another whose purpose is to challenge inequitable structures ([57] p. 379–380).

We are not referring to team members hashing out disagreements to decide on the best way forward but instead attending to how the exchange of information may uphold or challenge inequitable practice and care within a particular time and place. Informed by theories of critical pedagogy,[19,20] dialogue can provide opportunities for teams to value diverse forms of knowledge, and to question and challenge individual and institutional assumptions of practice, while working collaboratively to disrupt and change inequitable practice.

Critically reflective team-based health care adds critical social science knowledge to the process of *collaborative reflection* described in current medical education literature[10,58,59] and situates dialogue within practice instead of education settings, where pedagogies of dialogue are more often researched.[8,55] We suggest the use of dialogue for critical reflection should move beyond formal teaching spaces and clinical learning environments into everyday team-based practice. Within HPE, there has been recent research on critical reflection through dialogue as a teaching approach and collaborative process that may bridge a gap between the recognition of inequitable practice assumptions and taking action toward change.[8,38] Consistent with our review findings, Boyd et al.[8] note that enacting critical reflection in practice can happen when 'dialogue is an open-ended, exploratory, and generative conversation that brings together different perspectives, creating opportunities to learn with and from each other, with the goal of generating new perspectives' (p. 6). Similarly, Kumagai and Naidu[60] describe the importance of identifying dialogical moments within clinical medical education, 'in which reflection and dialogue are engaged in busy clinical environments as a means of opening up new ways of seeing and knowing about the human dimensions of medicine' (p. 512). These education initiatives could be carried over into everyday team-based practice, where team members, in a process of continual learning and toward enacting socially just practice, would work together to make time and space for critically reflective dialogical moments.[8,9,38,60,61]

4.1.1 | Engaging multiple perspectives to challenge individual and team practice assumptions

Our narrative review suggests individual critical reflection must happen along with team-based critical reflection—perhaps one cannot occur without the other. Individual team members must be open to critically examining their own practices and ideologies, coming to understand how those ideas are shaped by disciplinary, cultural and societal ideologies in which they are enmeshed. Ghaye[36] argues that 'actionable knowledge to improve practice' is not an individual endeavour alone but 'occurs in the relationships among individuals as they converse, negotiate, practice their skills and share views of their worlds with one another' (p. 15). This is consistent with Fook's[62] description of critical reflection as not simply either an individual or collective endeavour but something done by an 'individual in social context' (p. 38). Building a critically reflective perspective through engagement with others also aligns with Brookfield's[22] (p. 29) four lenses for critical reflection: (1) autobiographical lens; (2) students' lens (or clients' or patients' lens, to translate this idea to the health care field); (3) colleagues' experiences; and (4) theoretical literature. These four lenses emphasise the importance of multiple perspectives in critically reflecting on one's own assumptions and beliefs. Critical reflection may therefore be supported through team dialogue, where team members engage with other team members who hold different worldviews and social positions, as well as different disciplinary, theoretical and experiential knowledge. By tackling critical questions through dialogue, team members are introduced to other people's perspectives, which can encourage an understanding of one's own place in upholding or resisting inequitable relationships and practices, providing an awareness necessary to enact practice change.

As there are health professionals who question whether practice changes are needed to ensure equitable care, our findings also call for attention to the conditions (relationship building, etc.) that foster and support critical reflection in team-based health care. Facilitation is one way to support the development of everyday team relationships that can promote critical reflection through dialogue as a way of being, noticing and doing.[10] Thoughtful facilitation could provide strategies for team members with diverse perspectives to dialogue with one another, while respectfully supporting team members who may not feel ready to engage in critical reflection. The four papers that described specific team projects or workshops discussed how facilitators had an important role in creating a space that allowed team members to challenge practice assumptions and co-create innovative solutions.[49–52] This is consistent with Ghaye's[36] suggestion that facilitation may assist team members as they experience necessary discomfort to question their own thinking and practices and may be helpful to address tensions that arise between team members. These findings suggest it may be worthwhile to explore how facilitation can occur in everyday practice to foster critical reflection day-to-day, not just during team projects.

4.1.2 | The importance of considering patient perspectives in dialogue

Another implication for practice is the potential for critically reflective team-based health care to support valuing and understanding patient perspectives. We found that understanding patient perspectives was both an outcome of critically reflective team-based care and also a necessary part of such care. Traditional health care hierarchies work against the valuing of patient perspectives in health care, as doctors, nurses and other health professionals are positioned as experts responsible for the care of patients, with patients relying on the health professionals for their care. This well-established hierarchy, as well as an unfamiliarity navigating health care bureaucracies, could present barriers to genuine patient participation in team-based care and warrants further attention in practice. Metersky et al.[63] postulated that

> The hesitance of HCPs [health care providers] to include patients as full team members with equal sharing of their expertise seems to imply a lack of

> willingness by HCPs to share power within present health care environments. Unequal power distribution is synonymous with the exertion of control over others, and is often linked to a lack of trust development. Metersky et al.,[63] p. 6

Using dialogue to support critical reflection may provide strategies to decrease the patient-professional hierarchy within health care settings and support the equitable involvement of patients as full members on their health care teams. This is especially important in recognising and valuing the perspectives and needs of socially marginalised patients, who often experience inequities in care.[64,65]

CRP through dialogue is an innovative approach that can allow for meaningful collaborative relationships through the redistribution of power and positioning patients as co-creators of knowledge and care. This approach is in-line with the newly revised Canadian Interprofessional Health Collaborative's (CIHC) interprofessional competency framework, which explicitly centres 'collaborative relationships' between practitioners, patients, families and community members.[66] Enacting critical reflection in a team-based context can therefore be a practice that supports the implementation of CIHC competencies as well as other interprofessional competency frameworks, specifically, ensuring patients' genuine involvement on the team.[66,67]

4.2 | Implications for education: Bringing team-based critical reflection into Interprofessional education

Teaching critically reflective dialogue, a critical pedagogy explicitly merging complementary theories of dialogue and critical reflection, within both classroom and clinic settings, prepares future clinicians for enacting team-based CRP. Just as team-based practice provides an opportune social context for developing practitioners' critical reflection skills through dialogue, an interprofessional education (IPE) context provides an opportunity for health care students to learn and enact critical reflection in dialogue with other professionals and patients. Interprofessional education teaches students skills such as team communication, collaborative leadership and how to handle team disagreement,[66] but scholars have highlighted the lack of attention to power dynamics and implicit biases in IPE.[56,68] We suggest teaching critical reflection skills through dialogue may be an effective way to attend to power hierarchies and practice assumptions in interprofessional education. Doing so would bring critical reflection into interprofessional education, where it currently tends to be taught as a skill learned by an individual, rather than by and within interdisciplinary groups.[69,70] A few initiatives, such as those by Boyd et al.[8] and Ng et al.,[38] have demonstrated promising outcomes in employing critical reflection and dialogue within interprofessional training contexts, supporting a need for further work in this area.

Critical reflection through dialogue provides a pedagogical approach to maximise students' potential to learn about, with and from one another as is endorsed through interprofessional education efforts.[71–73] Modelling the regular use of dialogue within HPE, particularly interprofessional education, could be one way for health professionals to become more comfortable with critical reflection in team-based practice settings. It could also support movement beyond using patients as storytellers who have 'lived experience' to share with students, towards genuinely valuing patients' knowledge as team members.[74–78]

Along these lines, two articles identified in our search but excluded due to not meeting our critical reflection criteria suggest interprofessional student-run free clinics (SRFC) could be a promising team-based setting for future research about how student practitioners can develop CRP.[79,80] Student-run clinics/initiatives or student-led practice environments often provide interprofessional learning experiences and serve marginalised populations, addressing and filling system gaps through clinical services. If these student experiences were to be designed and informed by principles of critical pedagogy, they have the potential to foster critical reflection skills and enable equitable team practices which may carry forward into students' future clinical practice.

4.3 | Implications for research: An opportunity to bring critical reflection into team-based health care research

The scarcity of critical reflection theory in peer-reviewed literature focused on team-based health care contexts suggests a gap in research into how critical reflection develops and is used by health care teams in practice. This gap raises questions about how or if health professionals call on critical reflection theories and critically informed knowledge within team-based care, and how critically reflective team-based health care may influence patient care. Given evidence of the potential the enactment of critical reflection may have for positive care outcomes,[8,38,81,82] research exploring the application of critical pedagogies to foster critical reflection through dialogue within team-based health care is necessary.

Although our literature search found few articles on the theory and use of critical reflection within team-based contexts, many excluded articles focused on how critical reflection has been taken up in non-team-based contexts. These contexts include: research, such as how research methodologies can be improved with critical perspectives and how to better incorporate participant perspectives[83–87]; interprofessional education, such as how critical reflection, can help students challenge assumptions about patients as well as their own and other disciplines[88–90]; and by individual health professionals or disciplines, such as critical questioning of practice assumptions, often influenced by personal community interactions, or attending to power relations in collaborations between a professional and marginalised clients/patients.[91–95] Although not directly related to team-based health care, the engagement with critical reflection in these other contexts can provide useful information for how to move forward with research exploring critical reflection in team contexts (e.g., ideas for study design or future research).

Another area of recommended research is whether and how critically reflective team-based health care may lead to more efficient care. Our results are consistent with other research showing that team-based approaches to critical reflection require time and space for engaging in meaningful dialogue to mitigate the risk involved in questioning taken-for-granted aspects of everyday working life, performing workarounds, or advocating for positive change.[36,55,60] In one promising methodological research study, Thille et al.[82] facilitated three interactive reflexive dialogues with a children's neuromuscular clinical team, as a way to enhance human dimensions of care. The team learned to apply one specific critical social theory (Mol's logic of care) to examine routine team practices from a broader, more critical perspective. Although the three sessions allowed the team to begin to reflexively question assumptions, there was not enough time to address all the assumptions identified (e.g., gender assumptions). We recognise that health care teams often work under immense pressure and time constraints and suggest future research is needed to examine if and how incorporating critical reflection through dialogue into teamwork may be a way to provide efficient and equitable care. This idea is supported by Metersky et al.'s[96] finding that when health care professionals took time to build relationships with patients and worked towards reducing power hierarchies, time was saved in future encounters with those patients.

Finally, how team-based critical reflection improves patient care was notably missing from our review. Some articles indicated that when hierarchies were challenged and assumptions questioned together as a team, this questioning continued into health professionals' encounters with patients/clients and improved attitudes towards patients.[49,50,54] The authors insinuate these are positive attitudinal changes that would improve patient experiences; however, few researchers reported patient outcomes at all, let alone directly asked patients/clients about their experiences, consistent with the findings of Metersky et al.'s[63] scoping review on the role of patients in interprofessional teams. In line with challenging hierarchies within CRP and ensuring meaningful patient involvement on health care teams, it is essential to centre patients' experiential knowledge in research on patient outcomes. Furthermore, as the concept of 'care' in health care education has been understudied, future research of patient care outcomes should include a discussion of the meaning of 'care' itself.[97,98] Research on how critical reflection through dialogue can support equitable patient care should therefore attend to how outcomes are measured and/or described, to understand who benefits and in what ways.

5 | STRENGTHS AND LIMITATIONS

Although we included many related terms for both critical reflection/CRP concepts and team-based practice in our search, we may have missed relevant articles that used different terms. It is also possible that our database search on published, peer-reviewed literature did not capture other initiatives focused on team-based critical reflection in health care that were not shared in peer-reviewed publications. In addition, and particularly as a bilingual team, we recognise that by limiting our review to English-language articles, there could be French-language articles (and articles in other languages) of relevance that were missed. In the spirit of critical reflection and aiming to transform rather than reproduce existing hierarchies and structures, future reviews might include books, non-English articles and non-peer-reviewed publications, which might reveal different findings.

6 | CONCLUSION

Our narrative review findings suggest that deep engagement with critical reflection as a theoretical concept is largely missing from the current team-based practice literature. However, *aspects* of critical reflection were evident in the articles that we organised into three overlapping categories: conditions that support critically reflective team-based health care, how critical reflection is enacted by teams, and changes that are supported by team-based CRP. Most articles described antecedents that would support components of critical reflection, specifically the need for teams to establish a purposeful environment to facilitate open dialogue to challenge one another and collectively create innovative solutions. This finding suggests building a culture of trust and mutual respect is an important precursor to and process of team-based critical reflection. Adequate time and space were needed for critical reflection to occur, as well as the willingness of individual team members to challenge their own assumptions, while support by facilitators was found to aid the process. The articles described critical reflection occurring as a dialogical process that supports team members to learn from and with one another while challenging power hierarchies and questioning individual and disciplinary practice assumptions about care. Such equitable and open dialogue had the potential to improve patient care through the development of innovative changes to collaborative practice, a positive professional culture and work experience, and an improvement of health professional attitudes towards patients as team members.

In sum, while critical reflection has gained traction in HPE, our review suggests work is needed to study how critical reflection, explicitly drawing on critical theories, can be developed in team-based practice. To support equitable care, and as a complement to existing collaborative practices, we suggest dialogue should be explicitly developed and researched as an approach to foster critical reflection within team-based health care.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

ETHICS STATEMENT

This study did not require ethics approval.

AUTHOR CONTRIBUTIONS

Marie-Ève Caty conceived and designed the project, with input from Stella Ng and Tracey Edelist. Tracey Edelist, Farah Friesen and Marie-Ève Caty conducted the title abstract screening. Tracey Edelist

extracted information from the included articles, analysed the data and wrote the first draft of the paper, in close collaboration with Farah Friesen, Marie-Ève Caty and Stella Ng, during bi-weekly meetings. Farah, Marie-Ève and Stella contributed greatly to data interpretation and critical revisions of the manuscript. Tracey Edelist took the lead in writing, reviewing and editing the manuscript. The remaining authors contributed to the conception of the work, critically reviewed the manuscript and provided final approval of the paper to be submitted.

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DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article, as no new data were created or analysed in this study.

ORCID

Tracey Edelist https://orcid.org/0009-0009-8342-5939
Stella Ng https://orcid.org/0000-0003-1433-6851
Nicolas Fernandez https://orcid.org/0000-0002-3840-2641
Marie-Ève Caty https://orcid.org/0000-0003-3909-6639

REFERENCES

1. Caty M-È, Kinsella EA, Doyle PC. Reflective practice in speech-language pathology: a scoping review. *Int. J. Speech Lang. Pathol.* 2015;17(4):411-420. doi:10.3109/17549507.2014.979870
2. Fragkos K. Reflective practice in healthcare education: an umbrella review. *Educ. Sci.* 2016;6(3):27. doi:10.3390/educsci6030027
3. Kinsella EA, Caty M-È, Ng S, Jenkins K. Reflective practice for allied health: Theory and applications. In: English LM, ed. *AdultHealth and Education*. University of Toronto Press; 2012:210-228. doi:10.3138/9781442685208-015
4. Mann K, Gordon J, MacLeod A. Reflection and reflective practice in health professions education: a systematic review. *Adv. Health Sci. Educ. Theory Pract.* 2009;14(4):595-621. doi:10.1007/s10459-007-9090-2
5. Ng SL, Kinsella EA, Friesen F, Hodges B. Reclaiming a theoretical orientation to reflection in medical education research: a critical narrative review. *Med. Educ.* 2015;49(5):461-475. doi:10.1111/medu.12680
6. Nguyen QD, Fernandez N, Karsenti T, Charlin B. What is reflection? A conceptual analysis of major definitions and a proposal of a five-component model. *Med. Educ.* 2014;48(12):1176-1189. doi:10.1111/medu.12583
7. Schaepkens SPC, Veen M, de la Croix A. Is reflection like soap? A critical narrative umbrella review of approaches to reflection in medical education research. *Adv. Health Sci. Educ.* 2022;27(2):537-551. doi:10.1007/s10459-021-10082-7
8. Boyd VA, Woods NN, Kumagai AK, Kawamura AA, Orsino A, Ng SL. Examining the impact of dialogic learning on critically reflective practice. *Acad. Med.* 2022;97(11S):S71-S79. doi:10.1097/ACM.0000000000004916
9. Halman M, Baker L, Ng S. Using critical consciousness to inform health professions education: a literature review. *Persp. Med. Educ.* 2017;6(1):12-20. doi:10.1007/s40037-016-0324-y
10. Ng SL, Wright SR, Kuper A. The divergence and convergence of critical reflection and critical reflexivity: implications for health professions education. *Acad. Med.* 2019;94(8):1122-1128. doi:10.1097/ACM.0000000000002724
11. Rowland P, Kuper A. Beyond vulnerability: how the dual role of patient-health care provider can inform health professions education. *Adv. Health Sci. Educ. Theory Pract.* 2018;23(1):115-131. doi:10.1007/s10459-017-9777-y
12. Boud D. Relocating reflection in the context of practice. In: Bradbury H, ed. *Beyond Reflective Practice*. Routledge; 2010:25-36.
13. Baik D. Team-based care: a concept analysis. *Nurs. Forum (Hillsdale).* 2017;52(4):313-322. doi:10.1111/nuf.12194
14. Mitchell P, Wynia M, Golden R, et al. Core principles & values of effective team-based health care. *Institute of Medicine*; 2012.
15. Kilminster S, Zukas M, Bradbury H, Frost N. Introduction and overview. In: Bradbury H, ed. *Beyond Reflective Practice*. Routledge; 2010:1-9.
16. Foucault M. *Birth of the Clinic*. Tavistock Publications Ltd.; 1973.
17. Foucault M. *Discipline and Punish: The Birth of the Prison*. Random House; 1977.
18. Foucault M. Truth and power. In: Rabinow, Rose, eds. *The Essential Foucault: Selections From Essential Works of Foucault, 1954–1984*. The New Press; 2003:300-318.
19. Freire P. *Pedagogy of the Oppressed*. Continuum; 2005.
20. Hooks B. *Teaching to Transgress: Education as the Practice of Freedom*. Routledge; 1994. doi:10.4324/9780203700280
21. Kafer A. *Feminist, Queer, Crip*. Indiana University Press; 2013.
22. Brookfield S. *Becoming a Critically Reflective Teacher*. Jossey-Bass; 1995.
23. Kemmis S. Action research and the politics of reflection. In: Boud D, Keogh R, Walker D, eds. *Reflection: Turning Experience Into Learning*; 1994:139-163.
24. Reynolds M. Reflection and critical reflection in management learning. *Manag. Learn.* 1998;29(2):183-200. doi:10.1177/1350507698292004
25. Mykitiuk R, Chadha E. Sites of exclusion: disabled women's sexual and reproductive rights. In: Rioux M, Basser LA, Jones M, eds. *Critical Perspectives on Human Rights and Disability Law*. Martinus Nijhoff/Brill Publishers; 2011:157-199.
26. Streur CS, Schafer CL, Garcia VP, Quint EH, Sandberg DE, Wittmann DA. "If everyone Else is having this talk with their doctor, why am I not having this talk with mine?": the experiences of sexuality and sexual health education of Young women with spina bifida. *J. Sex. Med.* 2019;16(6):853-859. doi:10.1016/j.jsxm.2019.03.012
27. Hoffman KM, Trawalter S, Axt JR, Oliver MN. Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Psychol. Cogn. Sci.* 2016;113(16):4296-4301. doi:10.1073/pnas.1516047113
28. Meghani SH, Byun E, Gallagher RM. Time to take stock: a meta-analysis and systematic review of analgesic treatment disparities for pain in the United States. *Pain Med. (Malden, Mass).* 2012;13(2):150-174. doi:10.1111/j.1526-4637.2011.01310.x
29. Brookfield SD. The concept of critically reflective practice. *Handb. Adult. Continuing Educ.* 2000;2:33-49.
30. Carr W, Kemmis S. Staying critical. *Educ. Action Res.* 2005;13(3):347-358. doi:10.1080/09650790500200296
31. Fook J, Gardner F. *Practising Critical Reflection: A Resource Handbook*. Open University Press; 2007.
32. Kemmis S. Knowing practice: searching for saliences. *Pedagog. Cult. Soc.* 2005;13(3):391-426. doi:10.1080/14681360500200235

33. Edelist T, Zaman S, Katzman E, Jarus T. "Patient" or "professional"? Negotiating accommodations and identity in fieldwork education. *Med. Educ.* 2024;1-10. doi:10.1111/medu.15365 Advance online publication.
34. Jabbar A. Language, power and implications for interprofessional collaboration: reflections on a transition from social work to medicine. *J. Interprof. Care*. 2011;25(6):447-448. doi:10.3109/13561820.2011.601822
35. Montgomery P, Mossey S, Rice C, et al. Healthcare providers' experiences as arts-based research participants: "I created my story about disability and difference, now what?". *Can. J. Nurs. Res.* 2019;51(4):255-263. doi:10.1177/0844562119835130
36. Ghaye T. *Developing the Reflective Healthcare Team*. John Wiley & Sons; 2005. doi:10.1002/9780470774694
37. Kumagai AK, Lypson ML. Beyond cultural competence: critical consciousness, social justice, and multicultural education. *Acad. Med.* 2009;84(6):782-787. doi:10.1097/ACM.0b013e3181a42398
38. Ng SL, Crukley J, Brydges R, et al. Toward 'seeing' critically: a Bayesian analysis of the impacts of a critical pedagogy. *Adv. Health Sci. Educ.* 2022a;27(2):323-354. doi:10.1007/s10459-021-10087-2
39. Sukhera J, Milne A, Teunissen PW, Lingard L, Watling C. Adaptive reinventing: implicit bias and the co-construction of social change. *Adv. Health Sci. Educ*. 2018;23:587-599. doi:10.1007/s10459-018-9816-3
40. Gilbert JH, Yan J, Hoffman SJ. A WHO report: framework for action on interprofessional education and collaborative practice. *J. Allied Health*. 2010;39(3):196-197. https://scholar.harvard.edu/files/hoffman/files/18_-_jah_-_overview_of_who_framework_for_action_on_ipe_and_cp_2010_gilbert-yan-hoffman.pdf
41. World Health Organization. *Framework for action on interprofessional education and collaborative practice*. WHO; 2010. https://www.who.int/publications/i/item/framework-for-action-on-interprofessional-education-collaborative-practice
42. Grant MJ, Booth A. A typology of reviews: an analysis of 14 review types and associated methodologies. *Health Info. Libr. J.* 2009;26(2):91-108. doi:10.1111/j.1471-1842.2009.00848.x
43. Paré G, Kitsiou S. Chapter 9—methods for literature reviews. In: Lau F, Kuziemsky C, eds. *Handbook of eHealth Evaluation: An Evidence-based Approach [Internet]*. University of Victoria; 2017 Feb 27. https://www.ncbi.nlm.nih.gov/books/NBK481583/#
44. Sukhera J. Narrative reviews: flexible, rigorous, and practical. *J. Grad. Med. Educ.* 2022a;14(4):414-417. doi:10.4300/JGME-D-22-00480.1
45. Sukhera J. Narrative reviews in medical education: key steps for researchers. *J. Grad. Med. Educ.* 2022b;14(4):418-419. doi:10.4300/JGME-D-22-00481.1
46. McCallin AM. Pluralistic dialogue: a grounded theory of interdisciplinary practice. *Austr. J. Rehabil. Counsell.* 1999;5(2):78-85. doi:10.1017/S1323892200001083
47. Newham C, Howie A. Reflection on a patient receiving high frequency oscillatory therapy. *Nurs. Crit. Care*. 1996;1(1):42-44; discussion 45.
48. Shaw L, Walker R, Hogue A. The art and science of teamwork: enacting a transdisciplinary approach in work rehabilitation. *Work*. 2008;30 (3):297-306.
49. Farr M. Power dynamics and collaborative mechanisms in co-production and co-design processes. *Crit. Soc. Policy*. 2018;38(4):623-644. doi:10.1177/0261018317747444
50. Hem MH, Molewijk B, Gjerberg E, Lillemoen L, Pedersen R. The significance of ethics reflection groups in mental health care: A focus group study among health care professionals. *BMC Med. Ethics*. 2018;19(54):1-14. doi:10.1186/s12910-018-0297-y
51. Randall-James J, Head A. Taking conversations forward: a systemic exercise for teams threatened by service restructures. *J. Fam. Ther.* 2018;40(3):447-458. doi:10.1111/1467-6427.12184
52. Williams S, Keogh S, Herd D, Riggall S, Glass R, Douglas C. Building effective engagement for implementation with i-PARIHS: a collaborative enquiry into paediatric pain care in the emergency department. *BMC Health Serv. Res.* 2022;22(1):330. doi:10.1186/s12913-022-07740-w
53. Gage M. From independence to interdependence: creating synergistic healthcare teams. *J. Nurs. Adm.* 1998;28(4):17-26. doi:10.1097/00005110-199804000-00006
54. Uhlig PN, Doll J, Brandon K, et al. Interprofessional practice and education in clinical learning environments: frontlines perspective. *Acad. Med. J. Assoc. Am. Med. Colleges*. 2018;93(10):1441-1444. doi:10.1097/ACM.0000000000002371
55. Kumagai AK, Naidu T. Reflection, dialogue, and the possibilities of space. *Acad. Med.* 2015;90(3):283-288. doi:10.1097/ACM.0000000000000582
56. Sukhera J, Bertram K, Hendrikx S, et al. Exploring implicit influences on interprofessional collaboration: a scoping review. *J. Interprof. Care*. 2022;36(5):716-724. doi:10.1080/13561820.2021.1979946
57. Freire P, Macedo DP. A dialogue: culture, language, and race. *Harvard Educ. Rev.* 1995;65(3):377-403. doi:10.17763/haer.65.3.12g1923330p1xhj8
58. van Braak M, Veen M, Muris J, van den Berg P, Giroldi E. A professional knowledge base for collaborative reflection education: a qualitative description of teacher goals and strategies. *Persp. Med. Educ.* 2022;11(1):53-59. doi:10.1007/s40037-021-00677-6
59. Veen M, de la Croix A. Collaborative reflection under the microscope: using conversation analysis to study the transition from case presentation to discussion in GP residents' experience sharing sessions. *Teach. Learn. Med.* 2016;28(1):3-14. doi:10.1080/10401334.2015.1107486
60. Kumagai AK, Naidu T. On time and tea bags: chronos, kairos, and teaching for humanistic practice. *Acad. Med.* 2020;95(4):512-517. doi:10.1097/ACM.0000000000003083
61. Ng SL, Forsey J, Boyd VA, et al. Combining adaptive expertise and (critically) reflective practice to support the development of knowledge, skill, and society. *Adv. Health Sci. Educ.* 2022b;27(5):1265-1281. doi:10.1007/s10459-022-10178-8
62. Fook J. Reflective practice and critical reflection. In: Lishman J, ed. *Handbook for Practice Learning in Social Work and Social Care: Knowledge and Theory*. Jessica Kingsley Publishers; 2015:440-454.
63. Metersky K, Orchard C, Adams T, Hurlock-Chorostecki C. Patient roles within interprofessional teams: a scoping review. *J. Interprofessional Educ. Pract*. 2022b;28:100523. doi:10.1016/j.xjep.2022.100523
64. Karanth SD, Akinyemiju T, Walker CJ, et al. The intersectionality between race, ethnicity, and residential-level socioeconomic status in disparities of head and neck cancer outcomes: A SEER study. *Cancer Epidemiol. Biomarkers Prev.* 2023;32(4):516-523. doi:10.1158/1055-9965.EPI-22-1167
65. Liu JC, Egleston BL, Blackman E, Ragin C. Racial survival disparities in head and neck cancer clinical trials. *J. Natl. Cancer Inst.* 2023;115(3):288-294. doi:10.1093/jnci/djac219
66. CIHC. *IP Competency Framework Refresh*. Canadian Interprofessional Health Collaborative; 2024.
67. IPEC. (2023). IPEC core competencies for interprofessional collaborative practice: version 3. Interprofessional education collaborative. https://ipec.memberclicks.net/assets/core-competencies/_Core_Competencies_Version_3_2023.pdf
68. Paradis E, Whitehead CR. Louder than words: power and conflict in interprofessional education articles, 1954–2013. *Med. Educ.* 2015;49(4):399-407. doi:10.1111/medu.12668
69. de la Croix A, Veen M. The reflective zombie: problematizing the conceptual framework of reflection in medical education. *Persp. Med. Educ.* 2018;7(6):394-400. doi:10.1007/s40037-018-0479-9

70. Diaz BA, Rieker J, Ng S. Teaching critical reflection in health professions education with transformative-Vygotskian praxis. *Adv. Health Sci. Educ.* 2023;28(4):1191-1204. doi:10.1007/s10459-023-10209-y
71. Kumar K, Roberts C, Thistlethwaite J. Entering and navigating academic medicine: academic clinician educators' experiences. *Med. Educ.* 2011;45(5):497-503. doi:10.1111/j.1365-2923.2010.03887
72. Thistlethwaite J, Jackson A, Moran M. Interprofessional collaborative practice: a deconstruction. *J. Interprof. Care.* 2013;27(1):50-56. doi:10.3109/13561820.2012.730075
73. Thistlethwaite J. Interprofessional education: a review of context, learning and the research agenda. *Med. Educ.* 2012;46(1):58-70. doi:10.1111/j.1365-2923.2011.04143.x
74. Bell T, Vat LE, McGavin C, et al. Co-building a patient-oriented research curriculum in Canada. *Res. Involvement Engagement*. 2019;5(7):7. doi:10.1186/s40900-019-0141-7
75. Getchell L, Bernstein E, Fowler E, et al. Program report: KidneyPRO, a web-based training module for patient engagement in kidney research. *Can. J. Kidney Health Dis.* 2020;7:2054358120979255. doi:10.1177/2054358120979255
76. Harrington RL, Hanna ML, Oehrlein EM, et al. Defining patient engagement in research: results of a systematic review and analysis: report of the ISPOR patient-centered special interest group. *Value Health*. 2020;23(6):677-688. doi:10.1016/j.jval.2020.01.019
77. Kalocsai C, Agrawal S, de Bie L, et al. Power to the people? A co-produced critical review of service user involvement in mental health professions education. *Adv. Health Sci. Edu* 2024; 29: 273-300. doi:10.1007/s10459-023-10240-z
78. Vat LE, Finlay T, Jan Schuitmaker-Warnaar T, et al. Evaluating the "return on patient engagement initiatives" in medicines research and development: a literature review. *Health Expect*. 2020;23(1):5-18. doi:10.1111/hex.12951
79. Hu T, Cox KA, Nyhof-Young J. Investigating student perceptions at an interprofessional student-run free clinic serving marginalised populations. *J. Interprof. Care*. 2018;32(1):75-79. doi:10.1080/13561820.2017.1363724
80. Hu T, Cox KA, Nyhof-Young J. IMAGINE-ing interprofessional education: program evaluation of a novel inner city health educational experience. *Can. Med. Educ. J.* 2017;8(1):e67-e75. doi:10.36834/cmej.36796
81. Mykhalovskiy E, Choiniere J, Armstrong P, Armstrong H. *Health Matters: Evidence, Critical Social Science, and Health Care in Canada*. University of Toronto Press; 2020. doi:10.3138/9781487536961
82. Thille P, Gibson BE, Abrams T, McAdam LC, Mistry B, Setchell J. Enhancing the human dimensions of children's neuromuscular care: piloting a methodology for fostering team reflexivity. *Adv. Health Sci. Educ. Theory Practice*. 2018;23(5):867-889. doi:10.1007/s10459-018-9834-1
83. Manias E, Street A. Rethinking ethnography: reconstructing nursing relationships. *J. Adv. Nurs.* 2001;33(2):234-242. doi:10.1111/j.1365-2648.2001.01660.x
84. Northway R, Howarth J, Evans L. Participatory research, people with intellectual disabilities and ethical approval: making reasonable adjustments to enable participation. *J. Clin. Nurs.* 2015;24(3–4):573-581. doi:10.1111/jocn.12702
85. Reiger KM. "Knights" or "knaves"? Public policy, professional power, and reforming maternity services. *Health Care Women Int.* 2011;32(1):2-22. doi:10.1080/07399332.2010.529218
86. Ross F, Smith P, Byng R, et al. Learning from people with long-term conditions: new insights for governance in primary healthcare. *Health Soc. Care Community*. 2014;22(4):405-416. doi:10.1111/hsc.12097
87. Viscardis K, Changfoot N, Rice C, et al. Difference within and without: health care providers' engagement with disability arts. *Qual. Health Res.* 2019;29(9):1287-1298. doi:10.1177/1049732318808252
88. Haines C, Livesley J. Telling tales: using storytelling to explore and model critical reflective practice in integrated children's services. *Learn Health Soc. Care*. 2008;7(4):227-234. doi:10.1111/j.1473-6861.2008.00188.x
89. Schiff T, Rieth K. Projects in medical education: "social justice in medicine" a rationale for an elective program as part of the medical education curriculum at John A. Burns School of Medicine. *Hawai'i J. Med. Public Health*. 2012;71(4 Suppl 1):64-67.
90. Wright A, Hawkes G, Baker B, Lindqvist SM. Reflections and unprompted observations by healthcare students of an interprofessional shadowing visit. *J. Interprof. Care*. 2012;26(4):305-311. doi:10.3109/13561820.2012.678507
91. Boland L, Cunningham M. Homelessness: critical reflections and observations from an occupational perspective. *J. Occup. Sci.* 2019;26(2):308-315. doi:10.1080/14427591.2018.1512006
92. Chappell Deckert J, Koenig TL. Social work perplexity: dissonance, uncertainty, and growth in Kazakhstan. *Qual. Soc. Work*. 2019;18(2):163-178. doi:10.1177/1473325017710086
93. Ng SL, Mylopoulos M, Kangasjarvi E, et al. Critically reflective practice and its sources: a qualitative exploration. *Med. Educ.* 2020;54(4):312-319. doi:10.1111/medu.14032
94. Trede F, Higgs J. Re-framing the clinician's role in collaborative clinical decision making: re-thinking practice knowledge and the notion of clinician-patient relationships. *Learn. Health Soc. Care*. 2003;2(2):66-73. doi:10.1046/j.1473-6861.2003.00040.x
95. van Stormbroek K. 'The hand belongs to someone': a therapist perspective on patient compliance. *South Afr. J. Occupational Ther.* 2020;50(3):30-39. doi:10.17159/2310-3833/2020/vol50no3a4
96. Metersky K, Orchard C, Adams T, Hurlock-Chorostecki C. Patient roles in primary care interprofessional teams: a constructivist grounded theory of patient and health care provider perspectives. *J. Interprof. Care*. 2022a;36(2):177-185. doi:10.1080/13561820.2021.1892616
97. Baker LR, Martimianakis MAT, Nasirzadeh Y, et al. Compassionate care in the age of evidence-based practice: a critical discourse analysis in the context of chronic pain care. *Acad. Med.* 2018;93(12):1841-1849. doi:10.1097/ACM.0000000000002373
98. Coccia C, Veen M. Because we care: a philosophical investigation into the spirit of medical education. *Teach. Learn. Med.* 2022;34(3):341-349. doi:10.1080/10401334.2022.2056744

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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