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Reflexivity in Interprofessional Workplace Learning

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Abstract

Despite a vast literature on interprofessional teamwork, it is still unclear how learning in interprofessional student teams proceed at the workplace. We aim to elucidate reflexivity conceptually in interprofessional workplace learning and describe some possibilities for how reflexivity may drive learning in interprofessional teams. We define reflexivity as the regular exercise of the mental ability shared by all normal people, to consider themselves in relation to their (social) contexts and vice versa. We elaborate reflexivity conceptually through existing theories and seek to construct new aspects of the concept for increased meaning and understanding of the role of reflexivity in interprofessional team learning. We describe how different modes of individuals may interplay, driving the teamwork and the tasks further. The different modes of reflexivity resulting from our analysis may be useful for elucidating how interprofessional learning proceed in a course, and thereby our results be of use for course organizers.

Keywords: *Reflexivity, Interprofessional education, students' learning processes.*

Introduction

Interprofessional Learning and Reflexivity

For several decades, interprofessional teamwork has been a central concept of well-run health services worldwide (Brandt et al., 2018; WHO, 1988; WHO, 2010). A commonly used definition is that interprofessional learning occurs when two or more professions work together to achieve common goals (WHO, 1988; WHO, 2010). The benefits of collaboration allow participants to achieve goals jointly better than they can individually, serve larger groups of people, and develop competences at individual and organizational levels (Greenet al., 2015). Interprofessional learning in health education has been advocated by health authorities in most countries. There

exists a vast body of literature on interprofessional education and how it may be learned and assessed (Rogers et al., 2017). However, there is limited knowledge on *how* learning proceeds in interprofessional student teams in the workplace even though workplace-based interprofessional learning is commonly advocated (Bondevik et al., 2015; Kitto et al., 2015; Uhlig et al., 2018).Rogers et al. (2017) present six key thematic areas in interprofessional learning: 1. role understanding, 2. Interprofessional communication, 3. interprofessional values, 4. coordination and collaborative decision making, 5. reflexivity, and 6. Teamwork. Of these six points, reflexivity may be the least developed in interprofessional literature. Rogers et al. (2017, p. 352) define reflexivity as "the ability to monitor and reflect upon the effectiveness of interprofessional collaboration involving one's self and others, with the aim of continuous improvement". They do not, however, develop the idea of reflexivity in any further detail. Reflexivity is a central concept in modern life, but there exists limited knowledge on how the individual's or the team's reflexive ability may be developed or assessed in interprofessional learning in the workplace (Hutchings et al., 2013).

The capacity for reflexivity may inform clinical decisions and is thereby crucial for the health workers and vital for the patient (Landy et al., 2016). Landy et al. (2016) have in a scoping review elucidated educational strategies to enhance reflexivity among health profession clinicians and students. They identify 68 articles which mainly show a great variety in the definition of reflexivity and in the course design.

In this theoretical article, we aim to elucidate reflexivity in interprofessional workplace learning and describe some possibilities for how reflexivity may stimulatelearning among students in a team.

Methodology and Empirical Point of Reference

This is a theoretical conceptual article where we work on elucidating the concept of reflexivity through selected relevant social theories on learning and understanding. The analytical results will be applied to an empirical reference for interpreting the meaning of our results for interprofessional workplace learning.

As an empirical point of reference, we use the course design at The Centre of Interprofessional Workplace Learning, Bergen, Norway (https://www.uib.no/en/tveps), which covers 17 different health and social programs. Students, one of each profession, are assembled in teams of five. Provided with all data on two patients at a nursing home, they interview these two patients and write a care plan on what the patients may need in addition to what is already provided. The care plan is discussed with the nursing home staff responsible for the patient (Bondevik et al., 2015). In this way, all learn from all. A full description of this program is given in Bondevik et al. (2015) where we also present data on students´ experiences and learning histories.

Interprofessional learning occurs in collaborative practice, and the team members' ability to engage individually and collectively is equally basic in interprofessional learning and development (Bondevik et al., 2015). Interprofessional action in the workplace often brings forth knowledge embedded in culture-based meanings and forces actors to negotiate their positions at the workplace. These outcomes in turn induce reflexive engagement in the interplay between the known and the unknown, negotiating contradictions and challenges arising in the encounter between the actors and the workplace (Engeström & Sannino, 2010).

Social Aspects of Reflexivity

Interprofessional team learning at the workplace is always situated, located in time and space in its social surroundings. Thereby it may be difficult to analyze the processes in general terms. We have earlier shown how such learning may be analyzed utilizing expansive learning theory as an analytical tool (Baerheim & Raaheim, 2019). We will follow this analytic strategy and start here by presenting some central social theories addressing reflexivity before we define reflexivity as a part of the social room.

According to the social philosophers Scott Lash and Ulrich Beck the modernity in which we live may be divided into the first and the second modernity (Beck et al., 2003; Lash, 2003). The first, simple modernity was linear, with fixed social roles, behavioral rules, and stable social structures. The second, reflexive modernity is non-linear. The social space is more open, and the rules and the roles of the first modernity no longer apply. Half the population is no longer in the kitchen, and the bank is no longer at the corner. Reflection (within fixed frames) belongs to the first modernity, and reflexivity belongs to the second. In the second/late modernity, reflexive behavior and social reflexivity are more predominant than before due to diminished social and cultural restraints.

In this text we will follow Margaret S. Archer's definition of reflexivity as *the regular exercise of the mental ability, shared by all normal people, to consider themselves in relation to their (social) contexts and vice versa* (Archer, 2012, p.1). She states that reflexivity is derived and emerges from the ongoing internal dialogues of every human, facilitated by the relative absence of social guidelines in the late/second modernity. Reflexivity always involves the self in interacting the social surrounding / the others.

Archer's basic principle is that the internal dialogue that all people perform is more unfettered in the late/second modernity and provides a basic reflexivity in social exchange. This is a central definition of reflexivity. There are also other definitions, all situated in their respective contexts. In this article, we show how some other aspects of reflexivity may inspire further thoughts on reflexivity in interprofessional workplace education.

Based on research by qualitative interviews, Archer divides reflexivity into the following four modes, thereby attributing different reflexive modes or levels to an individual's internal conversation: a) fractured reflexivity, which does not lead to reflexive practice but to distress and excessive action; b) communicative reflexivity, which needs validation from others before action and which is typical in closed, stable social conditions; c) autonomous reflexivity, which is self-contained, leading directly to action; and d) meta-reflexivity, which incorporates self and society in critical evaluation upon action (Archer, 2012). According to Archer (2012), fractured reflexivity may be more frequent in late modernity. She states that reflexivity is not a homogeneous process but is developed in diverse ways in different relations and contexts.

This categorization of reflexivity may also be regarded as a continuum, indicating how individuals' reflexive capabilities may be quantified, and how they by relevant stimulation may attain higher levels of reflexivity, gradually progressing from the non-functioning fractured reflexivity, via the socially dependent communicative reflexivity and the self-contained autonomous reflexivity, to the actively interacting meta-reflexivity. However, reflexivity is not a competence possessed by someone but a personal ability that is socially situated and works differently in various social situations. Simply placing a person's reflexive abilities on a scale overlooks this fact. Although people normally have a dominant modality of reflexivity, Archer cites an example of how someone may use all four modes of reflexivity in social exchange during a single narrative over a few hours, depending on whom one speaks with and on the surroundings (Archer, 2012, p.12). Transporting Archer's narrative into the workplace with the interprofessional team, the story could be sound like this:

Nurse student Tor is on his way to the second meeting with his interprofessional team at a nursing home. He follows partly unknown streets, stops at a traffic light, and goes on consulting the map on his phone. He is in an autonomic mode of reflexivity, incorporating himself passing through the surroundings. Entering the nursing home, he chats with some residents, refill a cup of tea for another. He is in a communicative mode of reflexivity, adjusting to actions which are accepted at the site. Then in the cafeteria he spots his team. He walks up to them, greets them and is being greeted. Once he is there, they start planning the day's work. He is in a meta-reflexive mode incorporating himself, the others, and the surroundings. Suddenly a nurse comes up to him telling him she saw him shoplifting yesterday. He is bewildered, speechless and in disbelief; he enters a fractured mode of reflexivity. Soon, however, the misunderstanding is cleared, and slowly he re-enters a meta-reflexive mode.

Conversely, even though people may use different modes of reflexivity, they usually have a personal dominant modality of reflexivity operating most of the time. The inner dialogues become shared inner conversations in the team. Vandenberghe (2010) states that as self-interpreting individuals, people not only carry out these conversations; they *are* these conversations. The intersubjectivity associated with the shared inner conversations builds the interprofessional team reflexivity, which consequently may be regarded as the interplay among the team members' reflexivity (Olson, 2019; Vanderberghe, 2010).

Referring to Vandenberghe (2010), there is no subjectivity without intersubjectivity, and no intersubjectivity exists without language. The subject becomes an object to oneself, fully conscious of the fact that one exists. Thanks to the others, one becomes reflexive and conscious of oneself as the other. This perspective is directly applicable to interprofessional health student teams because each student, both as a subject (self) and as a developing professional, is conscious of these self-identities in ongoing conversations with team mates while working with the patients at the health workplace. This self-conscious and interacting working mode is reflexive, and the resulting reflexivity is also a prerequisite for the interprofessional team interchange.

Four Reflexive Practices

Alvesson et al. (2008) have undertaken a comprehensive literature review on possible reflexive practices in organization and management research. As discussed above, Archer offers a classification of reflexivity based on empirical interviews in the community; describing how the individuals interplay with each other and with their social surroundings (Archer, 2007; 2012). Similar to any other concept, reflexivity depends on its actual use and may be defined differently when situated differently. The workplace varies from society in several ways, and both differ from research practice. In this section, we will show how a review on reflexivity from the perspective of organization and management research practice may provide some further understanding of reflexivity in the interprofessional students' workplace learning. We will then combine the elucidations on reflexivity by Archer and from Alvesson and show how these combined concepts may shed light on interprofessional workplace learning.

In their literature review, Alvesson et al. distinguish between four distinct modes of reflexive research practices (Alvesson et al., 2008). We will describe these four practices in some detail and show how they may be extrapolated to the interprofessional students' workplace practice.

*Reflexivity as multi-perspective practice*is close to the very definition of interprofessional practice. Each student has a theoretical or professional position with his/her own perspective and knowledge base. In reflexive practice, these perspectives come together in a dialectic relation. The dialectic differences and the tensions among the perspectives may open for new creative ideas and understandings, which draw something from each perspective in reflexive processes. No single specific perspective covers all that needs to be known, and in interprofessional student healthcare practice, the students may collectively elucidate how the different professional competencies are related and how these may interact for better patient care. Together, the students may elaborate on what is not yet established (Baerheim & Raaheim, 2019). This reflexive multi-perspective practice therefore has an innovative potential (Laing & Bacevice, 2013).

Reflexivity as multi-voiced practice. The participants collaborate using their respective voices, which are expressed aspects of their personalities and professional competences, to develop meanings from different common practice aspects. From this point of view, they do not put themselves in the practice field. Rather, they shape themselves in the field, and the practice field helps to make them what and who they are. This process of creating their own presence with their own voices incorporates substantial reflexivity, which may be further collectively developed through the multi-voiced practice. The resulting reflexivity becomes a necessity for creative collaboration, where each participant collaborates by questioning his or her own voice in the community. The different voices collaborate with their own choices in the multilogue. This line of thought is close to Bakhtin's idea of "heteroglossia" as constituting a multitude of voices, modes, and social languages, which may create a new social meaning and positioning (Bakhtin, 1981). Heteroglossia can be perceived as another's speech in another's language. It is about serving two speakers simultaneously and expressing two different intentions and is thus a double-voicedand when expanded multi-voiced discourse.

The key features of polyphony (from Bakhtin's (1981) point of view) are the independence and the plurality of voices. Although independent, the voices in polyphonic interaction are not isolated because they cannot occur and be meaningfully uttered in the absence of the others. When addressing another voice, each voice also expects to be addressed; thus, each implicitly addresses itself, thereby establishing the structure of reflexivity. In the multi-voiced practice, reflexivity is thereby created and exists from moment to moment, exerting its dynamic force as an inspiration for further exchange, building from utterance to utterance in the collaboration.

Reflexivity as positioning practice. The positioning in the practice landscape may limit the activity, but this limitation may stimulate a new activity among the interplaying positions. Reflexivity is stimulated in this interplay. It creates the participants' practice and is mirrored therein, encompassing the whole situated field of practice, with its social organizing, institutions, and the objective and the mental aspects of the participants positioned in the workplace landscape (Archer, 2007; Alvesson et al., 2008).

Reflexivity as destabilizing practice. Based on the works of Derrida and Foucault, this mode of reflexivity is used here to challenge existing knowledge. All established authoritative knowledge tends to freeze social relations, and new knowledge needs the destabilizing of these relations to find its own place. Destabilizing practice may often involve a personalized focus, which may make the individual authoritative locally. Destabilizing practice must be

a continuous activity to preserve the dynamics in the social space, as when students advance their own views on an established practice in order to question it.

These four reflexive practices only partly fit the four modes of reflexivity proposed by Archer (2007; 2012). Archer's mode of fractured reflexivity is mainly an absence of reflexivity and if present in a person, may impose a burden to any interprofessional team. Archer's mode of communicative reflexivity occurs in close surroundings with set rules, such as in small villages where social contracts are plural and determinative for action. This reflexivity is relevant for interprofessional team training in solving acute medical and life-threatening problems, usually conducted in simulated surroundings. In heart-arrest management or in similar training, only certain modes of action or utterance are acceptable. Another typical example from the health workplace is the operating room, where most social rules are set, and the modes of communication are restrained. Such training areas may stimulate the use of communicative reflexivity, and the debriefing at the end of the training will be a base for arriving at a collective agreement.

Archer's mode of self-contained autonomous reflexivity may be a necessary aspect of reflexivity as a personal drive in lifelong learning but does not involve others to any noteworthy degree. The remaining mode is Archer's actively interacting meta-reflexivity which is most informative for interprofessional workplace learning. Archer (2007) states that this mode is increasingly prevalent in late modernity, mainly among the well-educated. Combining these concepts of Archer and of Alvesson et al., and transporting the latter's concepts all the way from research practice to interprofessional workplace practice and then to interprofessional workplace learning, we thereby end up loading all four reflexive modes proposed by Alvesson et al. (2008) mainly onto Archer's (2007, 2012) mode of meta-reflexivity. This transportation may be sound as both cases involve interacting professionals in the practice field.

Reflexivity in Interprofessional Workplace Learning

We have so far elaborated on reflexivity through existing theories with examples from interprofessional practice. We now take our analysis a step further, applying these elaborations on interprofessional workplace learning.
At the start of any interprofessional workplace training, the students meet somewhere for the first time and start to establish their team. Individuals who do not know one another shall figure out how they may work together. They cross one another's personal or professional borders in verbal interchanges. Their internal dialogues blend, and reflexive processes appear. In the training, several of the four reflexive practices presented by Alvesson et al. (2008) are possible. Multi-perspective practice with its innovative potential will appear as each student shares his or her own professional perspective, and these perspectives blend (Laing & Bacevice, 2013). This process also has the potential for reflexivity by multi-voiced practice since a set of individual voices already exists. However, if one or more students are uncomfortable or shy in the beginning, they may start with a positional reflexive practice, thereby sending positional restricting reflexive stimuli to the rest of the team. The resulting dialectic processes in the team may solve the tensions.

Imagine that we follow this team further into the health workplace, where the students meet and work with a patient. In highly functional teams, which in our experience are most prevalent, the rise of interpersonal and emotional complexity will reflect the increasing interchange among team members, and with the patient and the workplace staff, and with social activities in the workplace.

The different internal dialogues from the individual team members may mingle polyphonically. As team members interact with one another, they participate with their own different voices. According to Bakhtin (1981) a voice is a point of view that is expressed through utterances. The voices will always be reflected in the different utterances and dialogues occurring among the members of the team and thereby in the team as a team process. Everything is said as a response to other statements and in anticipation of future statements. Thus, the dialogical word will always be in an intense relationship with another's word and intended to both address a listener and anticipate a response. Reflexivity may be described by these responses and anticipation in the team, echoed and carried forward by each team member's internal dialogues.

An interprofessional team will have many different ways of understanding the world, and these different voices also represent a learning potential because new knowledge, perspectives, and insights arise in the encounters among these voices. If every team member thought in the same way, there would be limited learning; it is in the

interprofessional tension where most learning occurs. Therefore, in a health team consisting of a variety of perspectives, a great learning potential also exists.

However, learning is not achieved automatically, just by bringing together these different perspectives represented by the various group members. There must be some additional relational skills involved to avoid relational conflicts and interpersonal difficulties. According to Ness and Riese (2015) specific relational conditions are involved in successful interprofessional teamwork, such as: openness (being open to other people and ways of perceiving the world), curiosity (being interested and seeking to find out and explore others' knowledge and viewing these as resources for the team), and respect (being respectful to others even when disagreeing), along with trust. Olson and Dadich (2019) claim that interprofessional practice depends directly on trust. In interprofessional practice, team members negotiate the best action for the patient in their care at any given moment (Olson &Dadich, 2019). Team reflexivity will develop from the interplay among the team members' internal dialogues, stimulated by the tensions from collectivized and individualized emotions (Archer, 2012). Olson and Dadich (2019) further postulate that work in the interprofessional team requires emotional reflexivity, whereby team members interact trustfully with one another.

The health workplace has a general task to improve the lives of the patients, and the health and social student team will usually participate willingly in this task. Working on gradually better defined tasks, each student's internal voice will address its own professional knowledge base. In interplay with the knowledge bases of the others and that of the patients, new knowledge may emerge, at best helping the patients to live better lives. The related reflexivity will be close to Alvesson and colleagues' reflexivity by multi-perspective practice and multi-voiced practice, as every student in the team has one's own profession and will use one's knowledge base intentionally to voice and share one's internal dialogue with the others. The team intersubjectivity will often stimulate mutual positive emotions, further fostering both the individual and the team reflexivity.

These elucidations may show how reflexivity is incorporated in interprofessional learning. For practical implications we have indicated that by increasing the multifaceted aspects of the task for the team will also stimulate the intensity of the team reflexivity. The more demanding the task is, the more learning. The common nursing home patient usually represent a hypercomplex combination of health and social problems which may be solved only partly and temporally.

Concluding remarks

Reflexivity may be defined as the regular exercise of the mental ability, shared by all normal people, to consider themselves in relation to their (social) contexts and vice versa.

We have referred to a review on reflexivity from the perspective of organization and management research practice and how this provides a framework for understanding reflexivity by interprofessional workplace learning. We have elaborated on reflexivity through existing theories before taking our analysis further, applying these elaborations on interprofessional workplace learning by imagining that we have followed an interprofessional team into the health workplace.

We have described how different modes of individual and team reflexivity may involve through interaction, thereby driving the teamwork and the task further, and stimulate the team members for further development of reflexive capabilities. Consequently, we may regard the team reflexivity as a motor that drives the team learning activity forward, fueled by the individual team members' emotions and reflexivity. The different modes of reflexivity we have described above may be useful for analyzing how interprofessional learning proceed in a course, and thereby be of use for course organizers.

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