

# Using Critical Reflexivity to Enhance Clinical Care: A Clinician Perspective

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## Abstract

In the rehabilitation context, critical reflexivity involves an examination of the assumptions, beliefs, and values that underpin established clinical practices and ways of thinking. In this article, two physiotherapists (one Canadian, one Australian) discuss what it was like to be involved in a facilitated process of critical reflexivity as part of a three-year research project across two Canadian children's hospitals. The project employed ethnographic techniques and interactive dialogue with clinicians, clients, and families to examine and rework some of the underlying assumptions inherent to children's rehabilitation. One author was a researcher on the project; the other was a clinician-participant. In this curated interview, we particularly attend to what it was like for the clinician-participant to experience the process of critical reflexivity and how the process affected her clinical practices. The process of critical reflexivity was rewarding for the clinician, and at times challenging. Critical reflexivity helped participants to examine: decision-making regarding what to include in day-to-day clinical practice; the training physiotherapists receive; what constitutes "good" care; and the unintended effects of clinical practice. We discuss three key examples of how the critical

reflexivity process changed clinical practice: attending to negative emotions, rethinking standard care, and noting unintended consequences. This article showcases how engaging in a process of critical reflexivity is both feasible and important for re-configuring clinical practice toward improving the lives of people seeking care.

*Keywords: Muscular dystrophy, reflexivity, critical theory, physiotherapy, patient-centred care*

## Introduction

This article delves into a process of critical reflexivity that the authors were involved in as part of a larger project. We first describe the larger project and how critical reflexivity was actualized within it. We then offer a curated interview with a clinician-participant in the project (the second author). Finally, we discuss implications for critical reflexivity in clinical settings in the context of broader literatures.

The critical reflexivity we discuss here was an aspect of a large research project across two Canadian children's hospitals situated in two different cities. The study used ethnographic and collaborative dialogical methods that

drew from critical social science theory and methodologies to enhance the clinical care of children with long-term health conditions and their families. In particular, the study examined how clinical care attended to the non-biomedical dimensions of living with childhood progressive illness, such as psychological, social, existential, and moral dimensions. One aspect of the project involved the researchers guiding teams of multidisciplinary clinicians through processes of critical reflexivity in order to consider, and at times reconfigure, their care practices. Rather than focusing on project methods or outcomes, our intention with this article is to provide insights into the experiences of a clinician undertaking a process of critical reflexivity, and to provide examples of how the process changed clinical practices. The larger project has been reported on elsewhere, including the key clinical insights<sup>1</sup> and the process of fostering reflexivity<sup>2</sup> from the first year of the study at one site, and various analytic foci including considerations of emotional intensity,<sup>3</sup> the pervasiveness of “cheer,”<sup>4</sup> and how death is (or is not) dealt with<sup>5</sup> in children’s rehabilitation. The current paper is intended to be of interest to two audiences (although there may be others): clinicians interested in examining their practices, and health researchers/educators who employ critical reflexivity to gain insights into an applied context from a participant perspective.

## Critical Reflexivity

*Critical reflexivity* is a term that intersects with other similar terms such as *reflexivity*, and *critical reflection*.

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<sup>1</sup> a NB: The dialogues also necessarily involved processes of reflective practice that did not have critical elements to them; however, it is the critical reflexivity that we attend to in this article.

There are considerable overlaps between definitions and some of the literature we cite uses the other terms. In this article, we use critical reflexivity to refer to processes of examining the assumptions underlying clinical practice, including “beliefs, values, and social and systemic structures” and “how such dimensions influence our daily professional practice.”<sup>6, p.214</sup> The word *critical* is derived from *critical theory*, which is a broad term encompassing numerous philosophical theories, primarily drawing from European philosophy.<sup>7</sup> Although critical theories differ considerably in focus, they all aim to challenge dominant cultural practices and beliefs, and encourage more humanistic ideals.<sup>8</sup> In particular, there is an emphasis on considering the *unintended* assumptions and effects of any actions—in this case, the unintended effects of children’s rehabilitation practices.<sup>9</sup> Critical reflexivity can be used to examine individual practices; however, the emphasis is not on individualistic thought processes or characteristics. Rather, attention is paid to how power operates through the unintended sociopolitical assumptions that play out *through* individual rehabilitation practices, systems, and people.<sup>10,11</sup> Intentionally placing a critical lens on practice has important implications for understanding (and changing) the ethical, moral, and existential aspects of healthcare.

## Group Dialogues

The main platforms for critical reflexivity<sup>a</sup> during the project were two-hour group dialogues, run approximately once every three months at each study<sup>1</sup> site. The dialogues involved group discussions

between the researchers (including the first author, Jenny) and the clinicians (including the second author, Blythe). The researchers facilitated the process of critical reflexivity in numerous ways during these dialogues. These included:

Discussing the field notes made by an ethnographer who had observed the clinicians' work during the study period, and/or emergent researcher analyses of these field notes.

Introducing elements of social theory to facilitate critical discussions of clinical practices. Theories included Annemarie Mol's logics of choice and care,<sup>12</sup> elements of critical disability theory,<sup>13</sup> and other critical theories.

Asking critical questions of the clinicians such as: What constitutes good care? What are the possible unintended effects of these practices? What is the meaning of rehabilitation?

Introducing key topic areas from emergent iterative data analyses that related to the existential, moral, or socio-political dimensions of living with progressive childhood illness. Topics were initially decided on by the researchers, but were increasingly co-determined with clinicians. Topics included: reproduction of stigma in rehabilitation practices; potential pitfalls of positivity; and advocacy and social change as part of clinical practice.

Prompting considerations of how systemic assumptions and power operate in clinical practice. For example, how professional training, or working in the context of paediatric rehabilitation, might influence the way living

with childhood progressive illness is understood and care is focused.

Facilitating activities to implement insights developed from the reflexivity process. These activities prompted: individual clinicians to make specific actionable plans to change their own practices; co-creation of broader recommendations for change within the teams; and outward-looking suggestions for broader systemic changes.

In order to adapt to the emerging foci of the project, these aspects of the dialogues were not predetermined prior to the research process. Rather, they were developed iteratively as the study progressed.

The researchers also worked to establish trust and safety during the dialogues.<sup>2</sup> Critical reflexivity, while quite common in social science research,<sup>10</sup> is still relatively rare in rehabilitation practice and research.<sup>14</sup> The process diverges from more commonly utilized strength-based approaches that focus on what is being done well and how to do it better.<sup>15</sup> Critical reflexivity takes a perhaps less naïve perspective and asks for considerations of what might be (unintentionally) done poorly and how to reconfigure the action. As a result, it can be a somewhat unsettling and potentially emotionally challenging process.<sup>16</sup> Being cognizant of these factors, the researchers were careful to develop trust and safety by, for example, gradually introducing more challenging topics, re-enforcing confidentiality, validating what clinicians were doing well, and providing opportunities for debriefing at the end of dialogue sessions.

## Clinician Interviews

In what follows, we attend to insights from Blythe, who was a clinician-participant in the process of critical reflexivity. We draw primarily from a recorded interview that Jenny (author 1) conducted with Blythe (author 2), which was one of a series of interviews with clinicians at both sites within the larger project. The interviews aimed to: 1) solicit clinician input into emergent project analyses; 2) investigate what it is like for the clinicians to participate in a process of critical reflexivity; and 3) examine changes in clinician thinking and practices. We present Blythe's insights below in a curated interview style. That is, we collaboratively edited the interview to highlight points of interest, including elucidating three key insights into how the critical reflexivity process changed Blythe's clinical practice: 1) attending to negative emotions; 2) rethinking "standard" care; and 3) noting unintended consequences. In order to protect the confidentiality of other clinician-participants involved in the larger project, some details have been obscured or changed; we have focused on Blythe's personal experiences of this process rather than her discussions of the process as it related to the team, or other team members.

## Curated Interview

**JENNY:** Can you describe what it was like to go through a process of critical reflexivity?

**BLYTHER:** Participating as a clinician in this study has been a unique and fortunate experience and yet challenging on a couple of different levels. Challenging in the sense of appraising assumptions I/we have made in our practice, and of being openly critical of our practices in constructive and supportive ways. It has provided an opportunity to ask, consider, and discuss 'big picture' questions as a team, such as: What is the role of our team in the care of the young people we

work with and their families? What is our mission? How do we provide care, and what is our approach to care? To help answer these questions we (clinicians) were facilitated and challenged to think critically to consider our interactions and clinic processes with clients and families.

Practicing critical reflexivity has helped me become more aware of my own professional and personal assumptions, as well as those of society, and recognize how these assumptions may influence my interactions with the families I work with and the clinical recommendations I make. It has involved not being solely focused on doing what I think is clinically important to assess, but also considering the unintended effects of my clinical assessment and recommendations on the client/family. This has helped me to be more cognizant of what really matters for the care of the person at that moment. The process of critical reflexivity helped me become more aware of the potential for unintended harm as a by-product of the way I might, for example, ask a question, or the language that I use when speaking with clients and families.

**JENNY:** Thinking specifically about the dialogues, what was it like to be a part of those group discussion sessions?

**BLYTHER:** When I first attended a dialogue, I didn't know what to expect. I remember wondering what was going to happen. I remember very early on feeling what I guess you could call excitement. I realized that the dialogues gave us the opportunity to really talk about what we do and our approach to care—the deeper questions around this. I was particularly excited to discuss the idea of our overall mission as a team, and discuss our approach to care: how we do what we need to do.

Importantly, the dialogues provided us with the opportunity to develop and practice critical reflexivity. In these group sessions, it was really helpful to have the researchers, as outsiders to the daily practices of the clinic, provide carefully considered comments and thought-provoking questions about our clinical work. It's really important for ideas to be challenged in a non-threatening way because there is a potential to feel judged about your practice habits. Even through the researchers were careful, critical reflexivity can feel like personal criticism at times as it makes us think about how the circumstances could be handled differently. For me, it was a very valuable experience because I like to be challenged in my thought processes and made aware of what might have been an oversight on my part, and to consider the unintended effects of my clinical practice and healthcare interactions in general. Interestingly, after working with us for a while, the researchers felt less like outsiders but rather became a part of the team working toward making meaningful changes to clinical practice.

During the dialogues we debated big questions that are rarely discussed in our busy lives as clinicians. This is not to say that we did not recognize the importance of attending to these broader questions before this process; however, this opportunity has enabled us to ensure we are all on the same page in our team approach to care, and to look for ways to enhance the care we provide. I've appreciated the process, and it is a process. It is iterative and ongoing. The project always built on itself. It's about changing some of the deeper ideas about practice, or being able to practice differently. To first understand an action conceptually, and then put that into practice takes a long time. It would be difficult to get that work done in meetings that are focused on other things as well. The protected dialogue time really helped facilitate our process of

critical reflexivity. It's been a really great opportunity, particularly to do this as a team. It would be nice for every team to have that opportunity!

**JENNY:** The dialogues sometimes involved discussing the field notes from the ethnographer's observations of you and your colleagues while you worked with clients and families. What was it like to be observed and then have these discussions?

**BLYTHER:** One of the researchers (not Jenny) would sit in the room watching and taking notes while each clinician interacted with clients and families. Initially it was a bit daunting; I was quite aware of the observer. However, I fairly quickly forgot that I was being watched as I got into my usual work flow. It helped that the researcher who was observing did it so well. It was really important to have the right kind of person in that position. The clients also commented on this, saying she was unobtrusive and respectful.

Having my practice observed, and then reflected back to me was quite profound. The opportunity to read from start to finish an observation of the entire visit for one client had a really big impact on me. It provided a window into what the experience of a clinic visit is like for the family. For example, I was already quite aware of how long the clinic appointments were before the study started, but to read through the observation for the entire visit, including the researcher's observations of the client and family, provided a whole new appreciation for what it must be like: the number of people knocking on the door, coming in and out, questions, questions, and more questions; and all the information families are juggling, every detail they are diligently keeping track of. To be able to "see" the appointment from this perspective has stuck with me and made me change some of the ways I work.

Although reviewing the observations during the dialogues was really helpful, it was hard sometimes. It can be quite alarming to look at yourself in this way. The process required a lot of trust within our clinical team. Each of us knows that everyone always has the families' best interests at heart and we are familiar with, and respect, the roles that each clinician plays. Still, I felt really vulnerable when reading my own interactions with clients and families and reviewing it with the team, or discussing someone else's interactions and how they handled the situation. The key was having the sessions facilitated, because it helped to make sure that different voices were heard, and the reflexivity was productive.

**JENNY:** Can you give any examples of some of the changes to your practice or thinking that happened as a result of this process of critical reflexivity?

**BLYTHER:** Before I do, I want to note that most of the concepts we considered during the process of critical reflexivity were there beforehand to some degree. What is different is that there is now more recognition of the non-biomedical aspects of practices and an explicit shared valuing of these parts of clinical care within the team. There were a lot of ways I changed my practice (and the larger team did as well) but I will give three examples of important changes I have made as a result of the critical reflexivity: attending to negative emotions, rethinking "standard" care, and noting the unintended consequences of care.

*Attending to Negative Emotions.* One of the concepts the researchers brought to the team's attention during some of the dialogues was how we (clinicians) handle so-called "negative" emotions within the clinic visit. Through reflection I was able to see I had a tendency to focus on the positives, even when a family has just commented on a loss, or about feeling sad. We discussed that this was not only

something that we do as individuals, but that this positivity is common throughout rehabilitation, perhaps particularly children's rehab. There is an imperative to focus on positives, on making improvements and "getting better," or "beating illness." However, for many of the children I work with, there is a very gradual, steady decline in strength and physical function. There are accompanying moments along the way where there are big losses for the child and their family—for example, losing the ability to walk. As a physiotherapist, part of my job is to assess walking, and one of the assessments I do is timed testing (assessing how long it takes them to walk a certain distance). For many of the young people I work with the times get progressively slower. So inevitably it is going to come up, this loss of ambulation. Families can, understandably, express sadness that they (or their children) are losing their ability to walk. Negative emotions are something that come up in my work fairly regularly.

I find it difficult to deal with discussing decline with clients/families; nobody wants to be the bearer of bad news. For me it is a hard thing to do because it's uncomfortable, or rather, I'm uncomfortable. I don't like sharing a result a family doesn't want to hear. Like anybody. I'm sure, I would rather not. I think it's also because I worry that I will say the wrong thing. It is hard because it feels like I'm confirming something they may already know but wish was not so, or maybe don't want to know. But that's my assumption; maybe I'm assuming wrong; perhaps they want to know the truth regardless of how it feels to hear it. My own level of comfort with it still is: I wish I had good news to share!

It was really helpful to have the opportunity to sit down with the team during the dialogues to discuss the

importance of recognizing times when it is important not to be simply positive. We shared how to spend time acknowledging and validating the hard and sad moments, and how to do this in a respectful and compassionate way. Practicing critical reflexivity in the dialogues has given me the opportunity to work out new ways of dealing with these types of emotions. The dialogues provided a facilitated environment where I could ask my team mates, “How do you handle...?”. They gave me some really good examples and strategies to try. Hearing the language that other clinicians use is very helpful, and it affirms that it is okay to validate the negative feelings and comments the families or child shares. It sounds silly now, but I wasn’t sure if it was okay to validate that, or if I should be cheering them on, staying positive, positive, positive. I learned that not only was it okay to create space for the negative but that it is important to do so.

I have learned to better validate clients’ negative feelings. For example, I used to try to find something positive in moments where young people and their families were experiencing loss. I would say something like, “Look what you can still do!” Now my approach is more to say, “You know, you are right. This is really hard.” Through the critical reflexivity process with the support of the team I have realized the power in acknowledging or validating someone’s negative experiences. Often at these times people are not asking for a pep talk. I now want to make sure children and families don’t feel as though their comments/feelings were dismissed; that makes it seem like I don’t understand. What children and families often really need from me is for me to hear what they’re feeling and show that I am empathetic to it. Maybe I can’t truly ever understand; I don’t have that lived experience. But if I am saying everything is okay, when it is not, I am kind of telling them it’s not okay to feel like that. And

really, who am I to say? By validating their negative emotions, I am saying, “It’s okay to feel like that. You know, it’s normal; who wouldn’t feel like that?” That has been a fundamental shift in my practice as a result of the critical reflexivity process.

***Rethinking ‘Standard’ Care.*** Another change I made as part of the critical reflexivity process was that I started leaving some of the standardized testing out of my practice. I really considered why I do what I do, and began to re-evaluate doing things just because they are routine or expected. I began asking myself more frequently questions such as, “Is it necessary for me to do this measure right now? What benefit is it going to offer the client as it relates to their priorities for the clinic visit?”

It is common in most healthcare professions to use standardized testing; in physiotherapy it might be standardized strength testing or set outcome measurements. For example, in the ambulatory neuromuscular population, we perform standardized testing including the North Star Ambulatory Assessment (a gross motor assessment), timed testing, and associated functional grades that provide helpful information. But sometimes, some of the children/youth can find the assessment process really exhausting or tiring. They may have already been in the clinic for many hours. They may have come in with so many other priorities. They may have time pressures. So, before, I think I would have tried to do the standardized testing no matter what just because it is something that we have been trained to think is important. Now, however, if I am also considering the importance of the family’s needs and priorities, I feel I can decide not to do the testing that day. Or I might select certain parts of the testing—often the time tests or functional grades—which are still going to give us part

of that information that the team needs to help guide clinical decision-making. Of course, I still see the need for, and importance of, standardized testing; however, I now also consider other things to be important, including how the family is feeling (eg, fatigue) or what they think is a priority.

A recent example was a family who came in with a few different issues. The one glaring physiotherapy issue was that the client's gym teacher was asking the young person (who has muscular dystrophy) to do resisted strength training. This was worrying the family as strength training is contra-indicated for children with this diagnosis. The young person was having more falls and pain from this gym work. Normally I would do standardized functional outcomes tests, strength testing, range of motion assessment, but the family also had a lot of social needs around funding. You could see the angst of the parent who was needing to sort out the funding with the social worker. So, I said to the family, "All I'm going to do today is write a letter to the gym teacher to highlight our joint concerns about the strength training. You can review the letter and make sure you're comfortable with it. We're just going to do the 10-meter walk test. That's it. We're not going to do anything else today." I could see the family's relief as a result. By leaving aside the standardized testing and tailoring my session to the client's needs, I had supported the client/family and had still measured some function that we could monitor over time. While not everything was assessed in that session that I once would have considered necessary, I did what seemed more appropriate for the client that day.

My process to rationalize what components of a clinical assessment to include is different now. I think more deeply about how the information that I get from various assessments is going to inform any decision or

recommendation. I consider: Am I just doing this to have the data? Or am I doing it because I think it's going to make a change to what I am recommending? And, does the testing fit with the concerns of the family?

If what I was planning to assess has nothing to do with any recommendations around family priorities, then that is something I might leave out for that day. This doesn't mean I ignore my knowledge of the prognosis; I keep prognosis and progression in the back of my mind.

Making this change has been an interesting process. In some ways it is almost easier, because it sometimes means not doing as much, being more selective. My hesitation has been a fear of missing something, for the family's sake or even from a legal or regulatory perspective, having done my due diligence. Is there something that I didn't do and I'll look back on and feel like I'm missing that piece of information that would have been really helpful to know? Otherwise it's been quite an easy transition, because it makes sense with this deeper evaluation of why we do what we do.

Knowing that I have the support of the team has really helped. We have made this decision to change our practice in this way; these choices would be more difficult if we were less cohesive in this approach.

***Noting Unintended Consequences.*** One of the other important things that I learnt during this process of critical reflexivity was to consider the unintended consequences of what I recommend clinically. For example, the recommendation to wear AFOs (ankle foot orthoses) has *intended* consequences such as helping to maintain range of motion and as a result



preserving ambulatory function, and positioning the feet comfortably on the footplates of the wheelchair or in shoes to avoid skin damage. Knowing this, I have always explained to young people and their families the rationale behind, and importance of, wearing the AFOs, and what will happen if they are not used. But, through the process of critical reflexivity, I also now consider more explicitly the need to recognize the *unintended* consequences of wearing AFOs—not just the physical aspect where the AFOs may be uncomfortable or disrupt sleep, but also the emotional consequences of such, as there may be a power struggle within the family to have the child wear them. I have realized that if I dwell too much on something like compliance with wearing AFOs or doing a home exercise I have suggested, another *unintended* effect might be to make the client/family feel guilty. They may feel like they aren't doing enough, or that they have to justify themselves to me. If I check every single time whether they are wearing their AFOs, they may come to dread that component of the clinical session. One of the things we don't really get taught in (physiotherapy) school is to look out for those sorts of unintended, negative consequences.

Sometimes I think we clinicians think that we have to “give” our clients something; it makes us feel like we have done a good job. But is important to be cautious about this assumption. It may be that you've only added to their burden. Sometimes it is enough to say, “You're doing a great job; just keep doing what you're doing.” It may just be reassurance, and that is enough. Selfishly, perhaps, we sometimes think that in order to feel like we have added value to the client's care we need to give them some recommendation to follow, or we do it because we feel the family expects that of us. Now I ask myself, “Do I really have to give that? Am I doing that for me, or for the client?”

## (Un)conclusion

This article highlights how reflexivity prompted a review of clinical practices in one applied context, providing a working example of how critical reflexivity can play out *in situ* in clinical care settings. The process of critical reflexivity explored in the interview above called attention to assumptions underlying dominant thinking and practices in healthcare and, more specifically, children's rehabilitation. In particular, we identified the assumptions that positivity is always and necessarily beneficial in clinical care, and that particular dominant practices such as standardized testing are always required for “good” care. Aligned with the definition of critical reflexivity we introduced at the beginning of this article, this individually-situated review of practices sits within broader social and political assumptions that play out through individual rehabilitation practices. We briefly discuss some of this broader context below.

## RE-EXAMINING POSITIVITY

Blythe's interview highlighted that a prevailing narrative of positivity in clinical care may at times have unintended negative effects for child and family care. Thus there can be pitfalls to assuming that positivity is necessarily beneficial. Other authors have similarly discussed problems with the assumed benefits of positivity including happiness,<sup>17</sup> success/transcendence,<sup>18,19</sup> and/or hope.<sup>20,21</sup> Berlant<sup>21</sup> argued that there is a “cruel optimism” in attaching to hopes of achieving “normality” in healthcare. The “cruelty” of positivity is perhaps particularly evident in children's rehabilitation settings where hopes of attaining “normal” developmental milestones are pervasive, and fears of “lost” futures are acute. Put simply, in many instances, clinical care attends to how

to get people “better” but not how to go on the journey with people as they get worse.<sup>4</sup> Noting such omissions suggests a reconfiguration of clinical care toward practices that attend to a wider narrative. Potential benefits of such a reconfiguration have been discussed elsewhere in healthcare. For example, Diedrich<sup>19, p.36</sup> has argued for the value of “anti-heroic cancer narratives,” suggesting that a greater engagement with loss and the “failure” of health can be highly productive for integrating emotional and existential aspects of living with ill-health or disability. This article demonstrates how reconsidering positivity offers opportunities to critically re-evaluate and rework usual children’s rehabilitation practices with the ultimate goal of working toward better lives for young people and families.

## REDEFINING ‘GOOD’ CARE

The critical reflexivity process also examined the assumption that particular types of practices were key to delivering “good” care. For example, Blythe highlighted that practices such as the use of standardized assessment techniques, felt like “good” physiotherapy care. The reflexivity process emphasized some of the assumptions underlying both authors’ shared professional backgrounds as physiotherapists. As such, this adds to literatures that suggest that we (physiotherapists) are not prepared for some aspects of care that comprise part of physiotherapists’ daily work and are important to good outcomes for clients.<sup>22</sup> We learn to attend to particular aspects of living with childhood disability over others. Of course, some of this is about professional boundaries: physiotherapists arguably focus on the physical dimensions of care, while others might attend to other aspects (eg, a psychologist attending to the psychological or social aspects) of care. However, lives are not so simple to

divide up, and challenges arise when clients require attention to, for example, the psychological and social aspects of living with the physical aspects of disability.<sup>23</sup> As Blythe discussed in relation to her care practices, these aspects of care deserve more attention in physiotherapy and related professions; they offer possibilities for making shifts in clinical practice to re-focus and improve care for children and families.

The process of critical reflexivity encourages both individual rehabilitation clinicians, and researchers more broadly, to consider the underlying assumptions in clinical care. It is time to better consider the multiple ways we affect the people we work with—and identify the potential hidden harm inherent within some of the ways we work.<sup>24</sup> Our team’s application of critical reflexivity provided many opportunities to shift and improve practice.

Attending to the assumptions underpinning contemporary clinical practice is not always easy. As the interview with Blythe highlights, critical reflexivity is unsettling work. It is personal, social, and even political. However, we believe it is ethically important to critically examine our work as rehabilitation professionals. Critical reflexivity is inherently creative; it opens opportunities to reconfigure thinking and practice. This article showcased how engaging in a process of critical reflexivity is feasible, practical, and important for examining and re-configuring clinical practice toward helping to craft better lives of the people seeking care.

## Acknowledgements

The authors wish to thank all the people involved in this project, including those who were research participants and part of the research team. This

research was supported by an AMS Phoenix grant, a BRI Centre for Innovation Grant, and an AHSC AFP Innovation Grant. The first author is supported by a National Health and Medical Research Council of Australia fellowship (APP1157199).

**Conflicts of interest:** There are no conflicts of interest to report.

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## References

1. Setchell J, Thille P, Abrams T, McAdam L, Mistry B, Gibson BE. Enhancing the human aspects of care with young people with Muscular Dystrophy: results from a participatory qualitative study with clinicians. *Child Health Care Develop*. 2018;44(2):269-77.
2. Thille P, Gibson BE, Abrams T, McAdam L, Mistry B, Setchell J. Enhancing the human dimensions of children's neuromuscular care: piloting a methodology for fostering team reflexivity. *Adv Health Sciences Edu*. 2018;May 26:1-23.
3. Abrams T, Setchell J, Thille P, Mistry B, Gibson BE. Affect, intensity, and moral assemblage in rehabilitation practice. *BioSocieties*. 2018:1-23. <https://doi.org/10.1057/s41292-018-0115-2>.
4. Setchell J, Abrams T, McAdam L, Gibson BE. Cheer\* in healthcare practice: what it excludes and why it matters. [Forthcoming.]
5. Abrams T, Setchell J. Living with death in rehabilitation: a phenomenological account. *Human Studies*. 2018;41(4):677-95.
6. Kinsella EA, Caty M, Ng S, Jenkins K. Reflective practice for allied health: Theory and applications. In: English L, ed. *Adult Education and Health*. Toronto, Canada: University of Toronto Press; 2012:210-228.
7. Crotty M. *The Foundations of Social Research: Meaning and Perspective in the Research Process*. London, England: Sage; 1998.
8. Gibson BE, Nicholls D, Setchell J, Synne-Groven K. Working against the grain: criticality for an otherwise physiotherapy. In: Gibson BE, Nicholls D, Setchell J, Synne-Groven K, eds. *Manipulating Practices: A Critical Physiotherapy Reader*. Oslo, Norway: Cappelen Damm; 2018:14-32.
9. Eakin J. Educating critical qualitative health researchers in the land of the randomized controlled trial. *Qualita Inquiry*. 2016;22(2):107-118.
10. Maton K. Reflexivity, relationism & research: Pierre Bourdieu and the epistemic conditions of social scientific knowledge. *Space Culture*. 2003;6(1):52-65.
11. Halman M, Baker L, Ng S. Using critical consciousness to inform health professions education: a literature review. *Perspect Med Educ*. 2017;6(1):12-20.
12. Mol A. *The Logic of Care: Health and the Problem of Patient Choice*. London, UK: Routledge; 2008.
13. Goodley D. Dis/entangling critical disability studies. *Disabil Society*. 2012;28(5):631-644.
14. Setchell J, Nicholls D, Wilson N, Gibson BE. Infusing rehabilitation with critical research and scholarship: a call to action. *Physiother Canada*. 2018;70(4):301-302.]
15. Seligman MEP, Csikszentmihalyi M. Positive psychology: an introduction. *American Psychologist*. 2000;55(1):5-14.
16. Frambach JM, Martimianakis MA. The discomfort of an educator's critical conscience: the case of problem-based learning and other global industries in medical education. *Perspect Med Educ*. 2017;6(1):1-4.
17. Ahmed S. *The Promise of Happiness*. London, UK: Duke University Press; 2010.
18. Gibson BE. *Rehabilitation: A Post-critical Approach*. Boca Raton, Fla: CRC Press; 2016.
19. Diedrich L. A bioethics of failure: anti-heroic cancer narratives. In: Shildrick M, Mykitiuk R, eds. *Ethics of the Body: Postconventional Challenges*. Cambridge, MA: MIT Press; 2005. 135-152.
20. Mattingly C. *The Hope Paradox: Journeys Through a Clinical Borderland*. Berkeley: University of California Press; 2010.
21. Berlant L. *Cruel Optimisim*. Durham, NC: Duke University Press; 2011.
22. Setchell J. What has stigma got to do with physiotherapy? *Physiother Canada*. 2017;69(1):1-4.
23. Nicholls DA, Gibson BE. The body and physiotherapy. *Physiother Theory Pract*. 2010;26(8):497-509.
24. Setchell J, Nicholls DA, Gibson BE. Objecting: multiplicity and the practice of physiotherapy. *Health*. 2017:1-20.

## *About the Authors*



Dr Setchell is a Research Fellow at the School of Health and Rehabilitation Sciences, The University of Queensland (Australia). Her research interests include critical perspectives on rehabilitation, and on physiotherapy specifically. She is particularly interested in post-modern and new-materialist theories. Dr Setchell has been awarded numerous fellowships, grants and awards for her work, including a prestigious National Health and Medical Research Council of Australia Fellowship. She has presented and published extensively across disciplines. She has 20 years of diverse clinical physiotherapy experience in Australia and internationally, primarily in the musculoskeletal and sports sub-disciplines. Dr Setchell is co-founder, and on the executive advisory committee of the [Critical Physiotherapy Network](#), an international network of more than 700 physiotherapists across 30+ countries working toward more critical, sociopolitical understandings of rehabilitation. She co-edited the first collection of critical physiotherapy work in book form, [Manipulating Practices: A Critical Physiotherapy Reader](#). Dr Setchell has also been an acrobat and a human rights worker.



Blythe Dalziel, MScPT, is a paediatric physiotherapist currently working at Holland Bloorview Kids Rehabilitation Hospital in Toronto, Canada. Blythe works in both neuromuscular and neuromotor physiotherapy providing care to young people and their families. She enjoys working with family-centred approaches which strive to enhance quality of life for children/youth and their families. As a clinician Blythe has had various opportunities to be involved in research and values the continuous learning these opportunities provide. She has presented at conferences including OACRS annual conference (Ontario Association of Children's Rehabilitation Services) and the AACPDM annual meeting (American Academy of Cerebral Palsy and Developmental Medicine). Blythe is married with two young children. She was a competitive swimmer and continues to enjoy swimming, camping and exploring outdoors.