Journal of Health Services Research & Policy
0(0) 1–3

DOI: 10.1177/1355819616649212
hsr.sagepub.com
SAGE

Recalling communities of practice

Simon Turner

Wenger E. *Communities of practice: Learning, meaning, and identity*. Cambridge, England: Cambridge University Press, 1998.

This is one of the few books that I have kept from my PhD days. Why might this one be worth a second look? Etienne Wenger, a social learning theorist turned management guru, develops the concept of 'communities of practice' in this book. It builds on an earlier account of apprenticeship – defined as increasing participation in socio-cultural practices – across five diverse social groups.[1] *Communities of Practice* is an ethnography of learning within a large U.S. company. Wenger uses vignettes of a day in the life of a health insurance claims processor ('Ariel'), and her various interactions with colleagues and objects in performing her job, to develop a social theory of learning. The theory emphasises the importance, for individuals, of learning through participation in activities (rather than acquiring knowledge in mental representations) and, for groups, of developing communities through ongoing interaction ('mutual engagement') and by developing resources (a 'shared repertoire') that bring meaning to those activities; that is, negotiating on a daily basis the joint enterprise of a community. The book has received over 35,000 citations to date according to Google Scholar; the idea of communities of practice has been influential among researchers and practitioners alike within health services, and more widely across the public and private sector.

In health services research, use of ethnography (e.g. non-participant observation) as a method for analysing health care practices, and the idea that key processes – such as professional learning or service innovation – are interactive and social in nature, have become reasonably well established. This article's purpose is to return to *Communities of Practice* and see what insights the book's original approach might offer to current debate on practices of learning in health services research literature.

The vignettes of everyday work from Wenger's one-year ethnography of insurance claims processing are relatively short (the two vignettes represent 20 pages of a 318-page book) and little methodological detail is provided. However, Wenger does state that he was an 'observer-participant', rather than a non-participant which is more often seen in contemporary health services research. He sought to become as immersed as possible in the setting, 'by attending training classes, including exams for new recruits and a mock job interview... I processed claims at my own desk and participated in the conversations and social events in the unit' (p. 284). Such an approach allowed Wenger to provide a fine-grained description of working life in the company, including interactions in the elevator, dress codes, the office layout, the documents and systems used for processing claims, reporting of conversations ('I can't understand your note') and gossip ('what's the big deal with that mud bath?'), the sharing of birthday cake, and perceptions of work (e.g. 'this stupid system', 'that was a pretty quick morning... a unit meeting always helps'). This rich detail is used to develop and illustrate different aspects of the concept of communities of practice – for example, that work takes place in a historical and social context in which the tacit and explicit are combined. Such attentiveness to the reporting of situational detail might add further insight to future ethnographies conducted within health services research, by offering a way of describing the 'invisible work' performed by health care professionals,[2] notably informal activities that are surely familiar to us as part of 'work' but rarely recognised as such in formal evaluations.

The concept of communities of practice draws on, and seeks to synthesise, a range of social theories of learning, including the interplay between social structures (e.g. professions or organisations) and human agency,[3] and the 'everyday' nature of learning through situated or practical experience.[4] However, current theorisations of communities of practice tend to neglect this underpinning theoretical background. While Wenger's engagement with such wide-ranging ideas in

Senior Research Associate, Department of Applied Health Research, University College London, London, UK

Corresponding author:
Simon Turner, Department of Applied Health Research, University College London, London WC1E 7HB, UK.
Email: simon.j.turner@ucl.ac.uk

service of a single theory of learning may raise as many contradictions and tensions as it generates insights, the concepts that underpin communities of practice could be used by others to develop and test multiple hypotheses about learning at different levels (e.g. individual, group, organisation) in health care settings.

Wenger was keen to stress that learning is not limited to interactions among human participants, as social practice also has a material basis. Through ongoing mutual engagement, communities produce a 'shared repertoire' of resources for learning. These heterogeneous resources might include 'war stories', symbols, tools and technologies, books, and institutional procedures. For Wenger, these resources contribute to, and carry meaning in relation to, communities of practice (even institutional artefacts, such as medical claims forms, are said to be re-appropriated and understood locally). In relation to health care, such insights have contributed to the study of knowledge-based boundaries among different professional communities in relation to innovation adoption[5] and research implementation,[6] and the understanding of tensions between managerial systems for enabling learning and direct observations of how front-line practitioners learn about patient safety.[7,8] However, as well as looking at the boundaries defined by communities, further research could examine the internal dynamics of communities, particularly aspects dealt with by Wenger that have received less attention such as the impact of change on practitioners' identities and the spatial formation of communities.

On re-reading *Communities of Practice*, I was surprised to see that Wenger does not go as far as the fashionable claim popularised by actor-network theory[9] that objects and other material artefacts have agency too and can therefore 'act back' and shape human practices, in ways that exceed our own thoughts and behaviour. Insights from actor-network theory have been used in studies of health care innovation to show the reciprocal, and often uneasy relationship between new technologies and changing professional roles and relationships that may thwart implementation of such technologies.[10] The concept of communities of practice could be combined with actor-network theory to provide more theoretically informed insight into the ways in which professional roles and relationships are situated within broader communities and how, in turn, their collective norms evolve in interaction with innovations, especially internet-based technologies that now allow different forms of work and interaction when compared with the time of Wenger's research.

The concept of communities of practice has been translated from a theory of situated learning into a management tool. During the mid-2000s, ideas about building communities of practice within the English National Health Service (NHS) started to gain currency, aided by the since disbanded NHS Institute for Innovation and Improvement. Emphasis on the social aspects of organisational learning and innovation always competed though with the government's use of national targets to manage the NHS, the so-called regime of 'targets and terror'.[11] Today, both approaches appear to have given way to a more pessimistic vision of health services, a vision based on prioritising the cutting of costs to meet efficiency targets for a public service that has become too expensive and thus unsustainable according to the narrative of austerity. However, the learning and experimentation needed to produce more radical forms of innovation that may both improve quality and reduce cost, is likely to require slack and redundancy.[12]

Wenger's ideas about designing organisations to promote such learning processes do not, on the face of it, seem incompatible with seeking efficiencies. These ideas include: having minimal structures that still maintain coherence and continuity, identifying obstacles to emergence and experimentation, focussing on an organisational identity that keeps different communities together, and feeding back the learning developed by front-line staff communities to benefit organisations as a whole. Further research could address the potential contradictions in attempts to create or harness communities (e.g. challenges for managers in encouraging joint enterprise as a 'bottom-up' process, or aligning a community with organisational or system level goals without undermining the local forms of authority that govern interactions).

It seems to me that the unmet challenge set by *Communities of Practice* is to ensure that insights from social science theory concerning processes of learning and innovation are incorporated more fully into health services research and have an influence on practice. Responding to this challenge might involve, first, translating ethnographic research findings more effectively into practical implications for organisational and systems design and, second, identifying ways of developing and communicating evidence from social science research that demonstrates its relevance to 'real-world' decision-making[13] such that it has maximum impact on health care policy and practice.

Acknowledgements

I am very grateful for comments from Naomi Fulop on an earlier draft of this article.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

ST was supported by the NIHR Collaboration for Leadership in Applied Health Research and Care (CLAHRC) North Thames at Bart's Health NHS Trust. The views expressed are those of the author and not necessarily those of the NHS, the NIHR, or the Department of Health.

References

1. Lave J and Wenger E. *Situated learning: legitimate peripheral participation*. New York: Cambridge University Press, 1991.
2. Allen D. *The invisible work of nurses: hospitals, organisation and healthcare*. London: Routledge, 2014.
3. Giddens A. *The constitution of society: outline of the theory of structuration*. Berkeley: University of California Press, 1984.
4. Heidegger M. *Being and time*. Malden, MA: Blackwell Publishing, 1962.
5. Ferlie E, Fitzgerald L, Wood M, et al. The nonspread of innovations: the mediating role of professionals. *Acad Manage J* 2005; 48: 117–134.
6. Kislov R. Boundary discontinuity in a constellation of interconnected practices. *Publ Admin* 2014; 92: 307–323.
7. Waring J. Constructing and re-constructing narratives of patient safety. *Social Sci Med* 2009; 69: 1722–1731.
8. Turner S, Ramsay A and Fulop N. The role of professional communities in governing patient safety. *J Health Organ Manag* 2013; 27: 527–543.
9. Law J. *After method: mess in social science research*. Abingdon, Oxon: Routledge, 2004.
10. Cresswell K, Worth A and Sheikh A. Implementing and adopting electronic health record systems: how actor-network theory can support evaluation. *Clin Govern Int J* 2011; 16: 320–336.
11. Bevan G and Hood C. What's measured is what matters: targets and gaming in the English public health care system. *Publ Admin* 2006; 84: 517–538.
12. Nohria N and Ghoshal S. *The differential network: organizing multinational corporations for value creation*. San Francisco: Jossey-Bass, 1997.
13. Turner S, Morris S, Sheringham J, et al. Study protocol: DEcisions in health Care to Introduce or Diffuse innovations using Evidence (DECIDE). *Implementation Sci* 2016; 11: 48. DOI: 10.1186/s13012-016-0412-8.