Health Practice Relationships

Joy Higgs, Anne Croker, Diane Tasker, Jill Hummell and Narelle Patton (Eds.)

HEALTH PRACTICE RELATIONSHIPS

PRACTICE, EDUCATION, WORK AND SOCIETY

Volume 9

Series Editor
Professor Joy Higgs AM
The Education for Practice Institute
Charles Sturt University, Australia

Advisory Editorial Board
Professor Della Fish
Chester University, UK
Adjunct Professor, The Education for Practice Institute
Charles Sturt University, Australia

Associate Professor Debbie Horsfall
Peace and Development Studies, School of Social Sciences and Psychology
University of Western Sydney, Australia
Adjunct Associate Professor The Education for Practice Institute
Charles Sturt University, Australia

Associate Professor Franziska Trede
The Education For Practice Institute
Charles Sturt University, Australia

Other books in this Series:

1. Higgs, J., Horsfall, D., & Grace, S. (Eds.). (2009). *Writing qualitative research on practice*. Rotterdam, The Netherlands: Sense Publishers.

2. Higgs, J., Cherry, N., Macklin, R., & Ajjawi, R. (Eds.). (2010). *Researching practice: A discourse on qualitative methodologies*. Rotterdam, The Netherlands: Sense Publishers.

3. Higgs, J., Fish, D., Goulter, I., Loftus, S., Reid, J., & Trede, F. (Eds.). (2010). *Education for future practice*. Rotterdam, The Netherlands: Sense Publishers.

4. McAllister, L., Paterson, M., Higgs, J., & Bithell, C. (Eds.). (2010). *Innovations in allied health fieldwork education: A critical appraisal*. Rotterdam, The Netherlands: Sense Publishers.

5. Higgs, J., Titchen, A., Horsfall, D., & Bridges, D. (Eds.). (2011). *Creative spaces for qualitative researching: Living research*. Rotterdam, The Netherlands: Sense Publishers.

6. Higgs, J., Barnett, R., Billett, S., Hutchings, M., & Trede, F. (Eds.). (2012). *Practice-based education: Perspectives and strategies*. Rotterdam, The Netherlands: Sense Publishers.

7. Higgs, J., Letts, W., Sheehan, D., Baldry Currens, J., & Jensen, G. (Eds.). (2013). *Realising exemplary practice-based education*. Rotterdam, The Netherlands: Sense Publishers.

8. Loftus, S., Gerzina, T., Higgs, J., Smith, M., & Duffy, E. (Eds.). (2013). *Educating health professionals: Becoming a university teacher*. Rotterdam, The Netherlands: Sense Publishers.

Health Practice Relationships

Edited by

Joy Higgs
The Education For Practice Institute
Charles Sturt University, Australia

Anne Croker
The University of Newcastle Department of Rural Health
The Education For Practice Institute, Charles Sturt University, Australia

Diane Tasker
The Education For Practice Institute, Charles Sturt University
Mountain Mobile Physiotherapy Service, Wentworth Falls, NSW, Australia

Jill Hummell
Brain Injury Rehabilitation Service, Westmead Hospital
The Education For Practice Institute, Charles Sturt University, Australia

and

Narelle Patton
The Education For Practice Institute
Charles Sturt University, Australia

Printed on acid-free paper

TABLE OF CONTENTS

JOY HIGGS

SERIES INTRODUCTION

Practice, Education, Work and Society

This series examines research, theory and practice in the context of university education, professional practice, work and society. The series explores spaces where two or more of these arenas come together. Themes that are explored in the series include: university education of professions, society expectations of professional practice, professional practice workplaces and strategies for investigating each of these areas. There are many challenges facing researchers, educators, practitioners and students in today's practice worlds. The authors in this series bring a wealth of practice wisdom and experience to examine these issues, share their practice knowledge, report research into strategies that address these challenges, share approaches to working and learning and raise yet more questions. The conversations conducted in the series will contribute to expanding the discourse around the way people encounter and experience practice, education, work and society.

Joy Higgs AM
The Education For Practice Institute
Charles Sturt University, Australia

FOREWORD

Health practice is about the provision of human services to people who are seeking enhanced wellbeing. In this book we place the human dimension of relationships at the centre of our discussion of healthcare and portray these relationships in the contexts of professionalism and healthcare operating systems. In the current context of healthcare and of societies that are facing global financial and population pressures, the imperatives of funding and organising systems can conflict with people's needs for humanity as well as technical competence in their healthcare experiences.

This book illuminates and challenges professional healthcare relationships. The authors examine the nature, context and purpose of healthcare relationships, explore models through which these relationships are enacted, developed and critiqued, and provide narratives of health practice relationships in action. These narratives reveal how relationships are experienced and created in real-world situations. The discussions generate a range of implications and recommendations for healthcare practice and systems and for the education of health professionals. This book is addressed to practitioners, educators, clients, members of the community, advocacy and agency groups, regulatory bodies and those with power to shape the future direction of healthcare. There are four sections in the book:

Section 1: Health practice relationships context

Section 2: Understanding professional relationships

Section 3: Health practice relationships narratives

Section 4: Implications for practice, systems and education

Joy Higgs

SECTION 1: HEALTH PRACTICE RELATIONSHIPS CONTEXT

JOY HIGGS

1. HEALTH PRACTICE RELATIONSHIPS

This book, and this chapter, explore health practice relationships. This chapter sets the scene for the book and privileges the humanity and diversity of social and practice relationships that this title evokes. In Chapter 2 we turn to the topic of professional practice, placing this book predominantly in the context of Western orthodox medicine today, and we place the clients, support people and healthcare providers at the centre of our discussion. Here, however, it is valuable to acknowledge the broader interpretation of health as the pursuit of wellbeing, of healthcare as ranging from self-managed healthy living to alternative medicine, traditional healing, and Eastern medical practices, as well as contemporary Western orthodox medicine. Across these frames of reference and practices of healthcare, relationships between people – receivers and agents, clients and providers, health seekers and health practitioners, patients and carers, individuals and service agencies, colleagues, practitioners and clients, with translators, advocates, volunteers, support personnel, religious staff – play a fundamental role in the experience and outcomes of healthcare for those involved and for those concerned about enacting and embodying person-centred care.

PRACTICE

Practice encompasses the doing, knowing, being and becoming of professional practitioners' roles and activities (Higgs, 1999; Higgs & Titchen, 2001); these activities occur within the social relationships of the practice context, the discourse of the practice and the practice system, and the setting (local and wider) that comprise the practice world. Relationships in health practice occur throughout each of these embodied activities. These relationships translate our worldview and our being, or practice ontology, into the way we frame our models or frameworks for practice. They enable the doing or realisation (making real) of the pursuit of wellbeing by practitioners, clients and agencies. They bring self as interactive agent into who we are and what we do as participants in healthcare collaborations. They challenge what we know, what we are learning, how we derive knowledge from practice and what knowledge growth we want to pursue. These things comprise our practice epistemology. They shape how we reflect upon ourselves and grow in practice, communication and engagement; both how we want to practise (our practice model aspirations) and who we want to become, which includes developing a practice model and identity. Doing, knowing, being and becoming in practice are, simply, not solo and self-focused pursuits. Titchen and Higgs (2001, p. 269) emphasised

the inseparability of self and professional role and indeed, the desirability of their integration, both for the enhancement of the service that professionals provide and for the enrichment of their own journeys. … We recognise the importance of understanding and acknowledging self as part of employing a critical social framework for professional practice. Self-knowledge is a precursor to achieving the goal of transforming self and helping others to empower themselves.

CONTEXTUALISING HEALTH PRACTICE RELATIONSHIPS

The context of healthcare and relationships in health practice is shaped by historical, social and cultural influences (see Chapter 2). The particular contexts that were selected for this book and which have emerged through the collaborations with co-authors and clients include the following.

In section one the authors examine the following health practice relationship contexts: professional practice, healthcare systems and spaces, changing directions in healthcare, and the important place and practice of patient-centred care. We see in these chapters that healthcare practice is a complex and dynamic space that requires understanding and making choices about the stances we want to take and the way we want to relate to others. Section two deals with understanding professional relationships. In this section readers are asked to consider the changing face of professionalism and what this means to healthcare practice and relationships and the challenges associated with working in teams and negotiating healthcare relationships. Alongside these challenges, questions are raised about how healthcare participants collaborate and demonstrate caring for others. All these endeavours are overlaid by our own aspirations and the expectations of healthcare consumers and systems in relation to access, agency and quality of care.

A range of narratives is provided in section three, bringing the reader inside the experiences of health practice relationships. Voices in this section include mothers of children with disability, people with chronic illnesses receiving healthcare in their homes, students and educators in clinical education, family members, people with mental health concerns, Indigenous practitioners and communities, patients, educators, practitioners and students. Various settings and relationship modes are explored, including person-centred, care, interprofessional collaboration, rural contexts, situations where people need to make decisions for others, training wards, and long-term patient-student relationships. In the final section the themes of the book are tied together in interpretations around the themes of relationships, systems and professional education. Readers will also have their own realisations and issues to ponder.

PRACTICE RELATIONSHIPS

We typically think of relationships as personal connections, sometimes chosen, sometimes inherited, sometimes successful, sometimes problematic, but they are

where we belong or where we are. What happens when practitioners and clients enter a practice relationship?

Traditionally, practice relationships were "clinical" – objective, dispassionate, regulated. They gained value through service, professionalism and ethical conduct. For our patients healthcare was provided; the patient's role was to comply with the highly educated, professional advice provided.

And what of today? Is the power gap still there – in knowledge, in decision making, in action and agency? What "distance" should practitioners keep? What are their roles in the new era? How do they cope with changing client interests? What choice does the client want? Who else is part of the scene? Are clients – universally – more educated, more informed, more capable of shared decision making, of managing their own healthcare? Can they all speak on their own behalf? Can they take agency in their own care? So, what are today's health practice relationships like? They are multi-hued and multi-faceted; with as many variations and complexities as the people who participate in these professional practice relationships.

PARTICIPANT VOICES AND CHALLENGES

Consider the range of people who participate in healthcare practice. What are their roles, needs, interests and capabilities as agents of participation? What are their voices saying – what do we need to hear? The graphic below includes Haiku poems. This form of a short poem, originally developed by Japanese poets, uses sensory language to capture an image or feeling. Haiku are often inspired by a poignant experience, an element of nature or a moment of beauty. These reflections capture critical aspects of relationships: entry points, human needs, uncertainties, hopes and fears.

This long night whispers.
Generous friendship enters.
Walking into the light.

An old woman wanders.
Unfolding winter stares.
A scream to escape death.

The new girl listens.
Delicate spirit shakes.
A leap into the dawn.

Some poor child shivers.
Captured spirit cries.
A dream for a new life.

A wise leader wonders.
Collapsing barriers disrupt.
A call into new places.

A weak cry pierces.
Unfolding shadows spread.
We step into a new life.

Across these many voices, lives and situations, different people over a wide range are engaged in the spaces and relationships of healthcare. Each person entering into these spaces is caught up in "person-meets-system", "choices-versus-expectations", and "my needs and theirs", mixed up with all the complexities of the pursuit of health and dealing with illnesses and human frailties.

For practitioners, relationships with colleagues and clients are part of their professional responsibilities and thus need to occur broadly in a socially responsible and accountable manner as well as specifically within the code of conduct of their profession (professional ethics) and the expectations of the workplace or organisation (e.g. an organisational charter).

> For over 2,000 years, it was not thought necessary to actively teach professionalism. The ideals and values of the (medical) profession were transmitted by mentors and role models and were important components of the tacit knowledge base of physicians. … (However) the professionalism of yesteryear has difficulty in coping with contemporary funding and regulatory mechanisms and with a society that has also changed profoundly. (Cruess, Cruess, & Steinert, 2008, p. 2)

A key challenge for today's practitioners is learning about the reality of professionalism on the job. They need to learn about issues and practicalities of ethics, codes of conduct, professionalism, risk management, self-preservation, bringing self into practice, litigation, self- and external regulation, institutional cultures and regulations, and working in healthcare teams within and outside the institution. And this learning is complicated by the changing worlds of practice, systems management, community profiles and cultural mixes and clients' expectations. Learning in academic settings is not sufficient to engender these understandings and capabilities. Instead, real-world experiences (or workplace learning) with real-world and real-life consequences are needed to bridge the reality gap for students and best prepare them for practice. Ideally, workplace learning is embedded into the curriculum and blended with other pedagogies including simulated learning, pre- and post-workplace learning preparation and debriefing, and online learning.

Whether pre-entry, continuing, informal or self-directed, education plays an important part in helping practitioners face these challenges. While it is not possible for formal professional education to anticipate every learning need for every person, it is important for education to address the difficult as well as the more straightforward challenges of preparation for professional practice. Courses need to help prospective practitioners to understand professionalism, to develop capabilities to face – or at least to learn how to develop capabilities to face – the demands of practice and practice relationships, and to forge a professional identity that is both a starting point to carve out a career of professional service and accountability and the realisation that this identity will inevitably change across their careers.

Kemmis (2010) wrote about the complexity of professional practice and recognised the importance of patients in professional practice. He contended that

patients were "not merely 'objects' operated on or influenced by practitioners, but persons-in-themselves who are, to a greater or lesser degree, knowing subjects who are co-participants in practice" (p. 145).

What challenges face patients or clients in practice relationships? In part, this depends upon the state of their health. Ill health in acute and in long-term situations can diminish agency and place people at the mercy of empowered systems and practitioners. Sometime the pursuit of better health and the courage to take responsibility and initiatives can bring about self-empowerment. However, this is often a double battle, both for inner strength and for resilience to stand up against system controls that may serve to diminish that strength.

A MODEL FOR HEALTH PRACTICE RELATIONSHIPS

A model for health practice relationships starts with the key players, operating within their individual frames of reference, cultures and communities of practice and forming relationships that bring these frames of reference into dialogue.
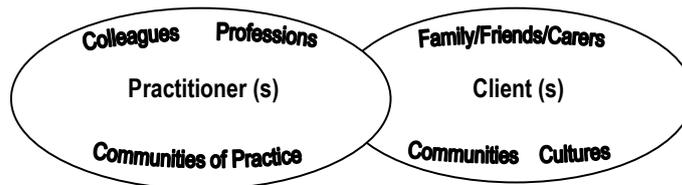
Next, consider how these relationships overlap and each person becomes part of multiple relationships. People take their perspectives and personal relationships into these health practice relationships.
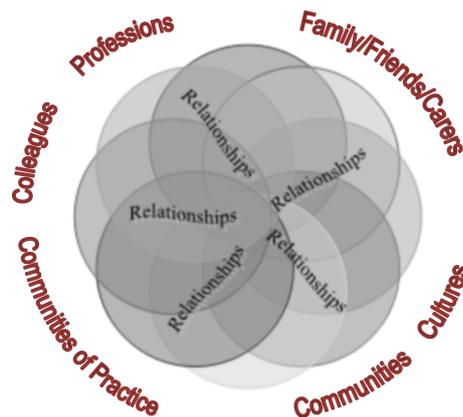
Next, we need to recognise the multiple contextual factors (the outer ring below) that influence our many health practice relationships.

7
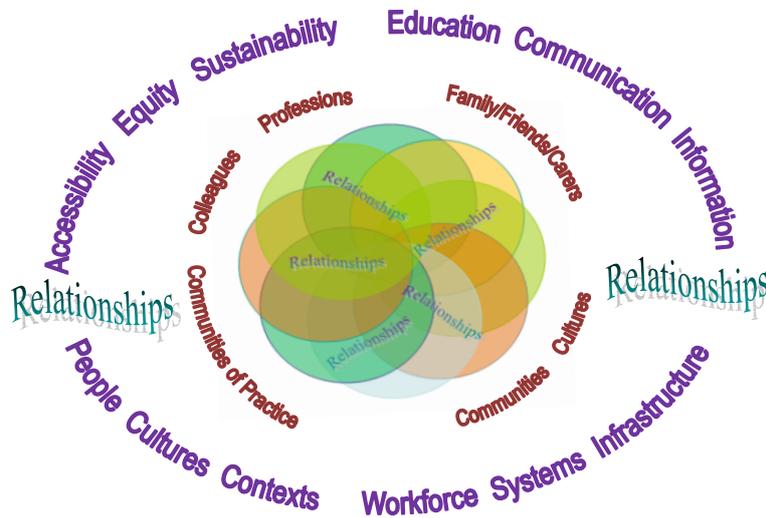
CONCLUSION

All around the participants in healthcare, the world of practice is changing at an unprecedented rate. Within practice, relationships form the core. This is not in question. Rather, in this book we question how these relationships can and should develop, and we consider links between "healthy" practice relationships and sustainable practice futures for healthcare practitioners.

REFERENCES

Cruess, R., & Cruess, S., & Steinert, Y. (2008). Introduction. In R. Cruess, S. Cruess & Y. Steinert (Eds.), *Teaching medical professionalism* (pp. 1-4). Cambridge: Cambridge University Press.

Higgs, J. (1999). Doing, knowing, being and becoming in professional practice. In *Proceedings of the Master of Teaching Post Internship Conference*, The University of Sydney, September. Retrieved (1999) from: http://alex.edfac.usyd.edu.au/conference99/Keynotes/higgs.htm

Higgs, J., & Titchen, A. (2001). Preface. In J. Higgs & A. Titchen (Eds.), *Professional practice in health, education and the creative arts* (pp. x–xii). Oxford: Blackwell Science.

Kemmis, S. (2010). What is professional practice? Recognizing and respecting diversity in understandings of practice. In C. Kanes (Ed.), *Elaborating professionalism: Studies in practice and theory* (pp. 139-166). New York: Springer.

Joy Higgs AM PhD
The Education For Practice Institute
Charles Sturt University, Australia

JOY HIGGS AND NARELLE PATTON

2. PROFESSIONAL PRACTICE

Professional practice is a social phenomenon in essence and in realisation. How we view professional practice in any era is influenced by the sociocultural and historical influences on that era. "There is no single, ahistorical set of professional practices" (Broadbent, Dietrich, & Roberts, 2005, p. 1). Contextual change is dynamic rather than linear, embedded rather than objective, conditional rather than predictable, and is amenable to influence rather than inevitable.

Social constructionists hold that the way we experience everything is shaped by personal, historical and cultural influences (Gergen, 2009). The term *social constructionism* was introduced by Berger and Luckmann (1966), building on the work of Schütz. Schütz (1964, 1967, 1970) was concerned with the social world, specifically the social nature of knowledge. He argued that, within the "life world", people create social reality and are also constrained by the existing social and cultural factors and structures they inherit from previous generations.

Social constructionism refers to a theory of knowledge in sociology and communication theory; it proposes that knowledge is not individually generated but is created collectively as a result of the fluid, subjective and relative nature of our interpersonal processes (Schwandt, 2001). In this theory, people interacting in social systems co-create meaning and knowledge. This meaning-making process involves people using language as the core system of constructing reality, and creating a model of the social world to make sense of their experiences (Leeds-Hurwitz, 2009). Through shared understandings, members of society develop habitual, reciprocal roles that embed meaning in society and construct social reality.

ORIGINS AND EVOLUTION

In essence, the word *profession* refers to the idea of professing or declaring publicly, which was linked to taking solemn vows on entering a religious order (c.1200, Middle English) and went on to be associated with an occupation one professes to be skilled in, and a body of people engaged in an occupation. The word is derived from Latin *professio* from *profitēri* (declare publicly).[i]

In medieval times three professions, the "learned professions", were recognised by society: medicine, law and divinity. Of interest is the evolution from society's need (e.g. for law), to practices (e.g. in using laws), to recognised practitioners, then to occupations which through professionalisation emerged into professions. Brundage (2008) examined the history of Roman law in antiquity and identified the development of a legal profession in the last two centuries of the Roman republic. This was preceded by laws existing in many civilisations including Ancient Egypt

(3000BC). Medicine, including the use of herbal remedies, existed in prehistory and was practised in an advanced form by the ancient Egyptians and ancient Greeks and in both India and China (Metcalfe, 2007). Religious leadership was born in prehistory and the study of theology was part of ancient academies as far back as the Platonic Academy founded in Athens in the 4th century BC (Morgan, 2010).

Hamilton (1951, p. 141) described two important developments occurring in medicine in the 1700s: a revolution in science and training, and "a growth of professional feeling, which led to a struggle for improved status and for reform of the profession". She contended that these two movements, along with the significant expansion of the middle classes, meant that "by 1800 the professional scene of a hundred years before had been completely transformed: the apothecaries, once mere tradesmen and the "servants of the physician", had become practising doctors; the surgeons had dissociated themselves from the barbers, and the "pure" or hospital surgeon had become a specialist of high reputation (p. 141). What emerged was a professional class replacing the distinction between gentleman physicians and the craftsmen apothecaries and surgeons. As a result of these changes, "professional honour, etiquette and status were now matters of the liveliest debate" (p. 141). We discuss issues of ethics and professional conduct below.

From these earlier days the rise of professions as occupational groups has escalated, particularly from the 20th century, in terms of the number of professions, the percentage of professions in the workforce, and the influence of the professions in society leadership and governments (Saks, 2013). Today, society recognises many professions across a range of fields including education (academics and teachers), commerce (accountants, actuaries, economists), healthcare (doctors, dentists, allied health professionals, nurses), the social and justice services (lawyers, psychologists, social workers), the construction industries (urban planners, surveyors, engineers) and religion (clergymen).

RECENT CHALLENGES TO THE PROFESSIONS

In recent years, questioning of the future of the professions has become a regular occurrence. Broadbent et al. (2005, p. 1) observed, "we are all facing and coping with … the stresses and contradictions of changing work and organisational practices. … and we are in the course of developing new understandings of what is meant by the term professionalism". They cautioned that we need to understand the dynamics of change rather than assume we can deal with the messiness and uncertainties of our changing world using intuition and common sense. The authors in their edited volume argue that the restructuring of professional work encompasses:

- adopting a fundamental rationale for professionalism that means the professional organisation might evolve and blur but that it cannot be viewed as an optional extra in society

- seeing professionalism as a diverse set of practices grounded in the contexts of different professions and informal norms grounded in society norms as well as explicit rules; professionalism is subtle and complex and should not be oversimplified
- recognising both the common roots and the diversity in professionalism in order to understand the current change era
- recognising the dynamism of the current era and the historical location of the set of institutional practices that requires change agents.

Within today's economic, technological and organisational trends (Fournier, 2000), developments such as market liberalism and commercialism challenge the foundations and legitimacy of the professions. The impact of these changes is evident in blurring boundaries between different professions, for instance, through multi-functional teamwork in the search of the flexibility deemed requisite for the turbulent environments of work and the commodification of professional labour. Similarly, boundaries between managers and professionals are becoming blurred in the pursuit of entrepreneurial opportunities. Increasing external and institutional demands for accountability have resulted in less attention to individual accountability and personal responsibility for quality of care and professional conduct. With the increasing availability of Internet information, clients are becoming empowered consumers and, at the same time, they face escalating costs for professional services. This has led to clients questioning professional advice and decisions and seeking value for money. The authority, mystery and monopolies of the professions have been challenged, and professions face declining respect and status. Professionals have been challenged for their increasing self-interest over public interest (Saks, 2013). The present context of the professions is one of contradictions and paradoxes, and their future robustness remains to be seen. We await the next phase of the confrontation of market-economy and expert-disseminated knowledge.

Key questions raised in this challenge to the professions are, "Why should there be occupational groups controlling expert knowledge?" and "Will professionalism spread throughout the occupational world?" In answering such questions, Abbott (1988) conducted a historical comparative study of the system of professions as a whole. He identified the important concept of jurisdiction, or the link between an occupation and its work, and the way professions are interdependent and occupy a space of contested jurisdictions. He argued that the division of labour in society creates the need for an expert division.

Beck and Young (2005) drew on Bernstein's (2000) interpretation of how particular knowledge structurings may be related to the formation of occupational identities through what Bernstein referred to as "inner dedication" and "inwardness". Challenges to these identities come from genericism and the regionalisation of knowledge. Beck and Young contended that, beyond "mere criticism", the recent challenges facing the professions have resulted in the radical restructuring of professional practice by governments and by marketisation. They reflected on the profound consequence of these changes and influence for

professionals, particularly in terms of their relationship to knowledge, clients and organisational structures.

PROFESSIONS AND THEIR CHARACTERISTICS

In general usage the term *profession* has many connotations, ranging from a highly specialised and skilled occupation to any full-time paid job (Freidson, 1986). In the context of this book we refer to professions that are recognised as such by society. Interpretations and definitions of established professions as a social construct vary considerably. A profession is:

> an occupation that regulates itself through systematic, required training and collegial discipline; that has a base technical specialized knowledge; and that has a service rather than profit orientation, enshrined in its code of ethics. (Star, 1982, cited in Cruess & Cruess, 2008, p. 1)

> an occupation whose core element is work based upon the mastery of a complex body of knowledge and skills. It is a vocation in which knowledge of some department of science or learning or the practice of an art founded upon it is used in the service of others. Its members are governed by codes of ethics and profess a commitment to competence, integrity and morality, altruism, and the promotion of the public good within their domain. These commitments form the basis of a social contract between a profession and society, which in return grants the profession a monopoly over the use of its knowledge base, the right to considerable autonomy in practice, and the privilege of self-regulation. Professions and their members are accountable to those served, to the profession, and to society. (Oxford English Dictionary, 1989)

> a self-regulated occupational group having a body of knowledge, an inherent culture and a recognised role in serving society. Professions operate under continual scrutiny and development, and are self-regulated, accountable, and guided by a code of ethical conduct in practice decisions and actions. Membership of a profession requires completion of an appropriate (commonly degree-based) intensive educational program. (Higgs, Hummell, & Roe-Shaw, 2008, p. 58)

Most definitions of professions refer to the following characteristics: a specific knowledge base, a service orientation, formal education and a code of ethics. More complex definitions also include advanced features such as culture, professional evolution and professional status being a social contract with society.

Recognised, established professions arise when an occupation transforms itself through "the development of formal qualifications based upon education, apprenticeship, and examinations, the emergence of regulatory bodies with powers to admit and discipline members, and some degree of monopoly rights" (Bullock &

Trombley, 1999, p. 689). According to Perks (1993), the major milestones that may mark the identification of an occupation as a profession include:

1. an occupation becomes a full-time occupation
2. the establishment of a training school
3. the establishment of a university school
4. the establishment of a local association
5. the establishment of a national association
6. the introduction of codes of professional ethics
7. the establishment of state licensing laws.

PROFESSIONAL PRACTICE

Building on the above discussion, we now turn to a reflection on professional practice. According to practice theory, "practice is [seen as] an organised constellation of different people's activities. A practice is a social phenomenon in the sense that it embraces multiple people. The activities that compose it, moreover, are organised" (Schatzki, 2012, p. 13). Activity "is the idea that important features of human life must be understood as forms of, or as rooted in, human activity – not the activity of individuals, but in practices, that is, in the organised activities of multiple people" (Schatzki, 2012, p. 13). Practices prefigure individual actions (Schatzki, 2002).

> The term practice can refer broadly to social practice, and more precisely, it frequently denotes professional practice. Practice is inherently situated and temporally located in local settings, lifeworlds and systems; it is embodied, agential, socially-historically constructed and it is grounded and released in metaphor, interpretation and narrative. Practice models come in many shapes and forms: technical-rational, empirico-analytical, evidence-based, interpretive, and critical emancipatory models, for example. In action, practice, can be collective (e.g. a profession's practice) and individual (such as an individual practitioner's practice). A (collective) practice comprises ritual, social interactions, language, discourse, thinking and decision making, technical skills, identity, knowledge, and practice wisdom, framed and contested by interests, practice philosophy, regulations, practice cultures, ethical standards, codes of conduct and societal expectations. An individual's practice model and enacted practice are framed by the views of the practice community as well as the practitioner's interests, preferences, experiences, perspectives, meaning making, presuppositions and practice philosophy. (Higgs, 2012, p. 75)

Enacted Professional Practice

Professional practice can be interpreted as "the enactment of the role of a profession or occupational group in serving or contributing to society" (Higgs,

13

McAllister, & Whiteford, 2009, p. 108). The term *practices* refers to customary activities associated with a profession, and to the chosen ways individual practitioners implement their practice/profession. Examples of practices are ethical conduct, professional decision making, client-practitioner communication, consultation and referral, and interdisciplinary teamwork (Higgs, 2012). As we explore this book on relationships in health practices, an important lens to facilitate the reflection on challenges faced by those enacting and embodying professional practice is to see how these practice expectations are addressed and how they are re-created in the changing context portrayed above.

Communities of Practice

Consistent with the previous discussion that highlighted the inherent social nature of both professions and professional practice, we now focus on the central role of practice communities to the development of practice capabilities and practice identity. In their landmark work on situated learning, Lave and Wenger (1991) articulated a model of workplace learning in which development of practice capabilities unfolds in opportunities for practice. In this model, practice capabilities are developed through the process of becoming a full participant within a community of practice. Communities of practice have been defined broadly as groups of people who share a concern, a set of problems, and a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis (Wenger, McDermott, & Snyder, 2002). This model highlights participation, social interaction, and consequently relationships as key features contributing to the successful development of practice capabilities and practice communities in workplace contexts.

Health practitioners are active participants in social (professional) communities, constructing their identities in relation to those communities, with participation shaping not only what they do but also who they are and also how they interpret what they do (Wenger, 1998). A community of practice shares existing knowledge and provides an arena for the development of new knowledge and transformation both of practitioners (Candy & Mathews, 1998) and communities (Ranse & Grealish, 2007). Effective participation in supportive communities of practice supports the development of health practitioners as effective team players capable of forming meaningful professional relationships and engaging in collaborative problem solving (see Baldry Currens & Coyle, 2013).

Development of practice capabilities can thus be understood as both an embodied process (through action) and an embedded process (in practice communities), with transformative potential for both learners and communities. This is important because it highlights the importance of social interaction to transformation of the practice(s) of both individual practitioners and practice communities. In this way, health practice relationships play a central role in the formation of individual practitioners and practice communities capable of meeting the complex and fluid demands of 21st century health practitioner practice.