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Off the peg or made to measure: how does this theory fit?

Medical education research is generally concerned with change. Changes in knowledge, skills, practices, environments, curricula, clinical teams, training, organisations and so on – arguably learning always encompasses change and change encompasses learning. Previously much medical education research into aspects of change and learning adopted an instrumental, atheoretical approach; more recently there has been increased interest in, and appreciation of, a range of theoretical approachesⁱ. These more theorised approaches and studies are very encouraging for everyone who is interested in developing good quality, robust research about matters of learning and change.

However, there so many possible and potentially useful approaches to researching such learning,(for example Hager et al 2012ⁱⁱ) that interested researchers can be faced with the questions ‘what does a good theory look like’ or ‘does my theory fit’? There is no right answer to this but I think it can be helpful to consider broad groupings of theories and how and what they explain. A very useful distinction is that between theories of behaviour and theories of practice. The former group focus on individuals, their learning and actions in different settings; the latter group focus on “relations among the everyday actions, routines and material arrangements in particular environments and forms of knowledge generated from these” (p.3 Hager et al). These two orientations or lenses, of behaviour and practice, lead to different understanding about actions and their basis, processes of change, the position of policy and transfer of lessons about change from one situation to another. Essentially theories of behaviour conceptualise actions as a matter of individual choice, change as causal and policy as an external influence on individual behaviour. In contrast, practice theories emphasise the social and emergent nature of action and change and understand policy as embedded in the practices at which it is directed. One important consequence of these different approaches is that they lead to different understandings about how outcomes from one setting can be transferred to another; theories of behaviour present this relatively unproblematically whilst practice theories emphasise that any attempts to transfer outcomes from one setting to another will be limited by their historical and cultural specificity. ⁱⁱⁱ

Hopefully, this brief summary of these two major theoretical orientations suggests some of the ways in which one’s orientation can influence research questions asked as well as data gathering and data analysis and explanations. Theoretical lenses and perspectives are used in a different way by Lara Varpio and colleagues in their paper (REF). They have used a sort of post hoc approach to consider how different theoretical approaches might inform specific questions and analyses around interprofessional education (IPE). They argue that the understandings offered by the different theorists they consider can suggest different solutions to some of the difficulties in delivering IPE. IPE is a really good choice for such an interrogative approach, it is a complex and messy idea – there is general agreement that it is a good thing, we need more of it but it is difficult to develop, implement, deliver, sustain and evaluate. So much so, sometimes I am uncertain whether much of the rhetoric and policy directives around IPE has ever been submitted to a logic test, never mind a theoretical one.. Readers will be interested to follow the arguments presented and maybe to try out the authors’

explanations on other problems they face – do any of these theories offer a good fit? Can you take a theory off the shelf or does it need some alterations? And how do you know?

In part, the answers to these questions depend on ontology – understandings about the nature of being. As far as developing medical education research goes, it is important to consider our assumptions about the nature of professional practice, professional knowledge, organisations and learning, especially learning in clinical settings. For my own decisions about what fits I have found some of the work on practice theories very useful. This is especially because they suggest helpful ways of understanding clinical settings, learning and work and offer possibilities for new approaches. Such approaches conceptualise practice and learning as distributed and relational, emerging from interactions between people and between people and things. Perhaps a more simple, straightforward way to illustrate this is to consider prescribing ‘errors’. One analysis of errors in prescriptions found error rates of around 10-12% but most of these errors did not reach the patient—because, for example, the error on the prescription is noticed by the pharmacist or nurse. When clinical learning and practice is understood as distributed and relational both the questions and the explanations change. Practice theory perspectives can provide ways of understanding how practice is maintained and how new practices emerge. They move us away from simplistic notions of cause and effect and start to unravel the messy complex nature of clinical practice and learning. But, whichever theory you select – check the fit!

References

ⁱ Varpio et al this issue

ⁱⁱ Hager P, Lee A and Reich A. (eds) 2012 Practice learning and change. Practice-theory perspectives on professional learning. Springer: Dordrecht

ⁱⁱⁱ Shove et al 2012 The dynamics of social practice Sage;London

5 ‘pull out’ points

1. “arguably learning always encompasses change and change encompasses learning” (p.1 line 3)
2. “‘what does a good theory look like’ or ‘does my theory fit?’” (p.1 line 11)
3. “different approaches ... lead to different understandings about how outcomes from one setting can be transferred to another” (p.1 line 24)
4. “Can you take a theory off the shelf or does it need some alterations? And how do you know?” (p.2 line 1)
5. “When clinical learning and practice is understood as distributed and relational both the questions and the explanations change” (p.2. line 14)