

What is a Community of Practice?

A brief excerpt from a paper Wendy Duncan-Hewitt wrote that describes what a community of practice (i.e., a learning community) is.

Although the term "community of practice" is new, communities of practice, per se, are not.

Communities of practice were the first knowledge-based social structures and arose when people realized they could benefit from sharing their knowledge, insights and experiences with others with similar interests or goals.

They exist in families, dispensaries, health practices and professional organizations such as the American Association of Higher Education (whose Web site offers several communities of practice). The American Association of Colleges of Pharmacy is really a network of communities of practice and exemplifies a structure that pharmacy education might emulate.

Examples of successful communities of practice in the educational arena include e-learning communities, continuing education learning groups in medicine, "cooperative education" (i.e., communities of practice) and apprenticeships.

Barab and Duffy described several successful communities of practice. The INSITE program is a collaboration between two universities, eight school districts, local industry and the Indianapolis Children's Museum in which students, supported by the expertise of University faculty and the input from other schools, address issues of concern.

In the EARN project, a K-12 community works on environmental and community projects supported by experts around the world. In the community of teachers program, pre-service teachers negotiate mentorship and membership in a group of learners. Participation in the group involves teaching, being mentored by an expert and revolving leadership in teaching seminars. The student's goal is not to achieve grades, but to demonstrate to the experts' satisfaction that they possess 30 qualities of good teachers. The group is long standing. New pre-service teachers enter, and the more experienced "old hands" leave.

Communities of practice are distinguished from other social groups by five common characteristics:

- 1) Mission
- 2) Practice;
- 3) Communal, practice-centered identity;
- 4) Ways of working together-explicit and implicit roles, procedures and rules, and most importantly;
- 5) Shared knowledge and learning.

Mission

Members of a community of practice share a mission, or a set of goals or objectives. Working together, members are doing something important whether processing prescriptions, solving drug-related problems or advancing disciplinary knowledge. The mission of a community of practice however, is unlike many institutional missions in that it is focused directed to the everyday work and beliefs of its constituents.

Practice

Members of a community of practice have in common their practice, a set of common responsibilities and tasks that define their common work and achieve their common goals. Through their work, members operationalize the ideal processes and theoretical strategies they may have been taught in a didactic environment.

Communal, Practice-Centered Identity

The development of a practice-centered identity (i.e., I am a pharmacist or pharmacotherapy expert) is one of the critical features of a community of practice that distinguishes it from other situated learning environments such as problem-based learning. One cannot develop a practice-centered identity simply by learning about the practice.

While it is true that most of our knowledge is about things (e.g., about football or politics) this superficial learning keeps us at the periphery of a discipline. As long as one remains peripheral, the practice will play little or no role in one's identity. This is the situation in many pharmacy "fundamental" classes, for example biochemistry, where students learn about the topic but never become involved in asking and answering its fundamental questions or being involved in its scholarship.

A practice-centered identity arises when students appropriate the ways in which the members of the practice (or profession) think, feel, and behave; that is, they learn to be. This socialization can become professionalization if the way of being modeled by the practice aligns with the profession's idea of what constitutes professionalism. This assertion is supported by the findings of Burkitt et al. In their study, teams of qualified nurses joined various communities of nursing practice as participating members, shadowing designated nurses and reviewing daily practice in critical incident interviews. They found that the members of these communities of practice developed a strong, mutually held identity centered on the idea of "the good nurse."

Full membership in a community of practice is equivalent to competence and a personal identity entwined with that competence. However not every participant in a community of practice is a full member. Those who are more peripheral to the practice may be learners (apprentices) and/or emissaries from other practices.

It is important to stress that practice cannot exist without its peripheral members. In a community of practice, students play a role that is critical in the community of practice functioning and persistence. Moreover students become more central to the practice as they gradually get entrusted with more complex tasks. This must be contrasted with the current state of affairs in which students are often considered as burdens to the practice consuming resources but not contributing substantively to its aims. Furthermore they enter and leave the practice with the same status that of students, not practitioners.

Ways of Working Together-Explicit and Implicit Roles, Procedures, Rules

Members of a community of practice are interdependent and mutually accountable through implicit (e.g., everyone can count on Mary to come in a bit early and get things started) and explicit (e.g., a policies and procedures manual) roles, rules and procedures. In learning to work together more peripheral participants learn to BECOME more central members of the group. Although practices with shared goals often have much in common, the roles, rules and procedures tend to be unique to their context.

Shared Knowledge and Learning

Knowledge is both explicit (concepts, principles, procedures) and implicit (knowledge that we cannot articulate). Taken together these implicit and explicit forms of the knowledge constitute "competence with respect to the community of practice work." For example, "pharmacy knowledge" is competence with respect to "providing pharmaceutical care." Similar to classroom learning, members of a community of practice often learn by sharing explicit knowledge. But they benefit most from each others' dynamic, implicit knowledge because only in close proximity (and with shared work) can individuals share what they know implicitly by "just-in-time" story-telling, conversation, demonstration, and coaching.

As members of the community of practice work and learn together, mutual understanding is negotiated through the complementary processes of participation and reification. Individuals participate in communities of practice simply by working towards shared goals.

Reification is the process whereby we make explicit that which was previously implicit. It generates increasing focus and clarity by taking amorphous experiences and turning them into concepts, tools, rules, procedures, databases, missions, plans, contracts and stories. Thus, a community of practice is inherently metacognitive.

Participation and reification are complementary. Participation gives community of practice members a common context for understanding and reification is the way in which a common understanding of that meaning is negotiated. As complements, they make up for each other's shortcomings. A reified

documentation method such as a "SOAP note" is more likely to be adopted by an organization through extensive participation in the discussion of its merits and shortcomings. Conversely, the results of a long and complex discussion are more likely to produce concerted actions when they are reified in minutes. Participation and reification must BOTH be present.

When reification dominates there may not be enough mutual understanding of the artifacts to yield a concerted effort towards the enterprise. This is a common problem in the classroom where students, participating as pupil, primarily learn "how to go to school". In this kind of classroom, where full participation is only accessible to teachers, students learn to memorize a host of reified facts * and promptly forget them because they have no meaning outside their role as students.

When participation dominates, as it often does in pharmacy practices, there may be nothing to anchor and direct activities. This is a common problem in pharmacies where work becomes "routine." With little or no documentation of processes or outcomes, without a focus on deepening understanding of practice problems, there is nothing that is mutually understood enough to be improved.

While working in a community of practice, learning comes naturally. In fact, apprenticeship in communities of practice is probably the most epistemologically appropriate way to learn. It is in this kind of environment that we humans demonstrate the (surprising?!) fact that we are all quite proficient learners. That we often come to the opposite conclusion about learners in pharmacy schools is more likely an indictment of our educational system than the individual learners' abilities.