

Recognizing the Importance of Materials: Embracing a Sociomaterial Perspective on Interprofessional Collaboration

08.00h: The interprofessional team has just gathered for 'bullet rounds' – a brief 10 minute round designed for reviewing the list of patients who may be discharged each day. Around the table are the physiotherapist, occupational therapist, social worker, charge nurse, attending physician and senior medical resident. The conversation is led by the charge nurse and all members who contribute are listened to thoughtfully. For one of the patients, while the attending physician was intending to discharge them, based on the physiotherapist's voiced concerns, a decision is made to delay discharge and review them again at end of day.

Even in the best of circumstances, achieving effective interprofessional collaboration can be challenging. The above example, by most standards, would however appear to represent a model interaction; there was an effective team leader, meaningful and valued contribution by each participant and team members felt safe to disagree. The problem with it, as it likely is in many less ideal appearing interactions, is not the people. While there certainly can be people problems – such as issues with their attitudes, beliefs and abilities – a growing body of research suggests that the problem is far more complicated and less easily identified. Increasingly, both educators and researchers are turning to sociomaterial theories to trouble our assumptions around complex, real-world problems like interprofessional collaboration.^{1,2}

The term 'sociomaterial' has been taken up in numerous fields including organizational sciences, science and technology, philosophy, education and, most recently, in medicine.³⁻⁷ Rather than a single theory, sociomaterial is being used as an umbrella

term to represent a diverse set of research practices which share a common focus on exploring the ways in which people and materials are "entangled" and together shape practice. Examples of sociomaterial theories used in studies of interprofessional collaboration include complexity theory, actor network theory and cultural historical activity theory.¹

From a sociomaterial perspective, rather than "context" being considered as a backdrop in which collaboration takes place, it is considered to be an essential and inseparable – entangled – component of it. Moreover, the materials that get taken into consideration range from the very tangible (e.g., papers, pencils, rooms, chairs, pagers, cell phones) to the intangible (e.g., the electronic architecture of a medical record, scheduling rules, practice policies). What matters is the practice that takes shape – assembles – as a result of these multiple entanglements. From an interprofessional collaboration perspective, this way of thinking encourages us to think differently about what collaboration is, how it should be done, how it should be measured and the types of things we can do to improve it.

Returning to the example from above, from a sociomaterial perspective, we could ask questions like: What type of practice took shape (assembled)? What elements of the social and material contributed to this assemblage? What other practices – or outcomes – would we hope emerge that do not? In a recent study that asked those very same questions, we found some troubling answers. The practice that assembled was discharging patients. While the expertise for achieving other outcomes, like identifying ways to improve patient wellbeing existed, it was not the focus of any of the interprofessional interactions throughout the

day. Some of the materials that contributed to this particular assemblage included over-crowded emergency rooms, hospital initiatives to address this problem – like bullet rounds, high volumes of patients on the wards and inadequate resources – like too few physiotherapists. Other practices that we would have liked to see emerge, like junior resident learning around interprofessional collaboration and bedside nursing contribution, did not. A deeper exploration of these also revealed contributing materials like rooms too small to include the full team, overlapping scheduled teaching rounds, and nursing assignments such that each nurse looked after patients from multiple different physician teams – on average, a physician team with 28 patients would have to interact with 21 different nurses.

While this paper is necessarily short – another sociomaterial entanglement – it is my hope that it offers a novel perspective that can be taken up in at least three ways. First, I hope it encourages readers to read more about some of these ideas around sociomateriality. The references below include a deliberate mix of papers that are readily available online and books which, while less easily accessed, are highly recommended for those who develop a deeper interest in the topic. Second, I hope it can have an influence on those developing assessment tools for measuring the quality of interprofessional collaboration; using a sociomaterial perspective can strengthen current assessment practices by helping to broaden what is assessed beyond social interactions (e.g., also assess the materials and how they might be contributing to current practices). Third, I hope it can influence those working on quality improvement initiatives to consider materials more broadly, to make small changes with some of the identified materials (i.e., try

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changing the physical space or schedule) and then observe how they impact practice.

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**Remember to Save The Date for
JCIPE's Conference this Fall and
learn more from one of our amazing
keynotes, Dr. Mark Goldszmidt!**

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