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# Title

A POSH way to enhance health service management: Inquiry and engagement intertwined

# Abstract

In an era of purported healthcare ‘crises’, an innovative approach to examine, understand, and ultimately improve health service management is one that focuses on brilliance. Revealing pockets of brilliance gives voice to practitioners who might otherwise remain (unfairly) stereotyped as part of a systemic problem. The purpose of this paper is twofold. First, it describes how brilliance emerged and evolved as a research focus and how secondary narrative material was used to shape the process of inquiry. Second, it explicates the philosophy that informed this methodology – namely, positive organisational scholarship in health (POSH) – which promoted and entwined inquiry and engagement. By detailing the process of inquiry and engagement, this paper reveals how POSH engaged the researchers with the data they analysed and with each other, and how it provided a different vista. The paper concludes with a discussion of the implications associated with POSH for researchers and practitioners.

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# Introduction

Reports on the poor or mis- management of health services are relatively common ([Jeffcoate, 2006](#_ENREF_37), [Baines, 2008](#_ENREF_5)). Research that verifies increases in access block and the wait-time to consult with a doctor ([Crilly et al., 2011](#_ENREF_18)) are augmented by media tales of ‘a “weak tone at the top” from… senior leadership… blatant examples of waste’ ([Brodsky, 2009, para. 8-13](#_ENREF_8)) as well as ‘bungled projects and costly financial mismanagement’ ([Hamilton-Smith, 2012, para. 1](#_ENREF_29)). This is compounded by the accessibility of health service information, which purports to ‘inform the community’ ([AIHW, 2012, para. 1](#_ENREF_2)), as well as key performance indicators that largely advocate for patient-throughput ([DHA, 2011](#_ENREF_22)). The seeming negativity that pervades health service management suggests it would be difficult to find, or even expect examples that exceed expectation – that is, examples of brilliance.

This paper argues for positive organisational scholarship in health (POSH). POSH represents one approach to examine, understand, and ultimately enhance health service management – this is because it interweaves inquiry and engagement. POSH is an emerging movement, exhorting researchers to understand human excellence in health services ([Cameron et al., 2003](#_ENREF_11)). Simply defined, it is ‘the study of that which is positive, flourishing and life giving in [health] organisations’ ([Cameron and Caza, 2004, 731](#_ENREF_10)). To demonstrate the potential value of POSH, this paper describes how it was operationalised within the Brilliance Project – a multi-institutional and multi-disciplinary research program that aims to promote brilliant health service management.

The paper commences by reaffirming the need for a different approach to understand and improve health service management; this is achieved by elucidating the potential value of the wicked problem lens ([Rittel and Webber, 1973](#_ENREF_57)) for pursuing brilliance in healthcare. The paper then describes how the Brilliance Project emerged and evolved, and how the analysis of secondary narrative material became a turning point for the group, facilitating a process whereby inquiry and engagement became entwined through both serendipity and energised conversations. Following this, POSH is explicated to clarify how it engaged the researchers with the empirical material and with each other, and how it sharpened their focus when working with narratives of a different kind. The paper then concludes with a discussion of the implications associated with this approach for researchers and practitioners.

## Brilliance Project

Commencing in 2010, the Brilliance Project is an interdisciplinary group of 12 researchers who were not like-minded from the outset. Each had research interests and skills that did not readily align with the theoretical and methodological approaches of the project. The mix of management, marketing, public health, nursing, and computing academics brought multiple ways of knowing ([Miller and Crabtree, 2005](#_ENREF_51)). It also brought tensions that are important to the research process, but also led to the stop-starts that characterised the first few years.

The search for brilliant health service management arose from conversations with Hugh MacLeod, Chief Executive Officer of the Canadian Patient Safety Institute (CPSI), who suggested that ‘pockets of brilliance in healthcare’ merited study. MacLeod ([2009](#_ENREF_45)) highlighted the need to find ‘brilliance in the system’ as exemplars for others and as levers for change. He spoke of how positive narratives can be used to create a ripple-effect in healthcare. He also highlighted that almost everything pertaining to change must start with a focus on relationships, particularly those that have to be built, rekindled, and nurtured to attain and sustain change.

Bate and colleagues ([2008](#_ENREF_6)) also impelled this scholarly focus on brilliant health service management. They argued that, relative to others, their research on quality healthcare moved the spotlight from the science of quality improvement to the social science of improvement. They stated, ‘we see quality as not just method, technique, discipline or skill, but as a human and organizational accomplishment as a social process’ ([13](#_ENREF_61)). They described how hard, left-brain, technical, and operating-system factors – like those depicted in scorecards, metrics, measurement systems and technology, clinical pathways, and evidence-based medicine – have dominated quality improvement research, while their in-depth, ethnographic research revealed the importance of the right-brain – the sociology, psychology, aesthetics, and organisation of improvement. It was not that one was more important than the other; but rather, the right-brain aspects were largely neglected.

There is a growing swell of interest in the dialogic of healthcare ([Carter, 2006](#_ENREF_12)). Consider the *real* evidence-based medicine movement, which calls attention to the dark-side of conventional understandings of evidence-based medicine, and repositions the scholarly gaze to evidence-*informed*, *patient*-centred, *compassionate* care. According to Greenhalgh and colleagues ([2014](#_ENREF_28)), *real* evidence-based medicine: ‘Makes the ethical care of the patient its top priority; Demands individualised evidence in a format that clinicians and patients can understand; Is characterised by expert judgment rather than mechanical rule following; Shares decisions with patients through meaningful conversations; Builds on a strong clinician-patient relationship and the human aspects of care; [and] Applies these principles at community level for evidence based public health’ ([4](#_ENREF_28)). Fostering these practices within an organisation requires an appreciation for relational dynamics that connect individuals, elicit emotion, give rise to meaningful interaction, and generate shared understandings ([Greenhalgh, 2013](#_ENREF_27)).

The aforesaid authors do not espouse a particular approach to understand and promote brilliant health services; but rather, they reinforce the need for multiplism ([Bate et al., 2008](#_ENREF_6), [MacLeod et al., 2009](#_ENREF_46), [Greenhalgh, 2013](#_ENREF_27), [Greenhalgh et al., 2014](#_ENREF_28)). The challenge for the Brilliance Group was to find an approach that reached the soft and seldom-described aspects of brilliant health service management, address the hard, left-brain aspects, as well as all that might lie in between. Miller and Crabtree ([2005](#_ENREF_51)) exhort researchers to always assume a both/and approach, to recognise the strengths of all approaches, and to highlight what is missing, silent, invisible, or routinely ignored – such as brilliance in health service management.

**Brilliance Agenda**

Two developments were critical to shaping the Brilliance agenda. The first was the connection between brilliance and POSH; this provided a theoretical grounding and clearly resonated with the subject matter as well as the researchers’ interests in appreciative inquiry (AI). The second was the discovery of secondary narrative material that no group member had compiled. These serendipitous finds changed the researchers’ conversations and, as discussed later, framed a mode of engaged inquiry.

AI became the methodological linchpin well before the connection with POSH was established. In essence, AI is a ‘cooperative co-evolutionary search for the best in people, their organizations, and the world around them’ ([Cooperrider et al., 2008, 3](#_ENREF_17)). It assumes the way an organisation changes reflects the way it inquires; if an organisation continues to focus solely on problems and challenges, it will continue to find them. Conversely, an organisation that attempts to identify its strengths will uncover even more goodness. As an epistemological orientation, AI privileges particular types of knowledge and thus, the types of questions asked from the outset. AI requires sensemaking, involving multiple, complex, and competing interpretations and understandings on the part of researchers as they engage with others. AI is described as a relational mode of inquiry and practice that is always ‘other’ oriented ([Cunliffe, 2008](#_ENREF_19), [Hosking, 2011](#_ENREF_36)). Several researchers were relationally-oriented and this became an important part of the researchers’ common understanding.

To operationalise POSH, rigorous, theoretically-informed methodologies were required that were both appropriate and edifying ([Luthans and Avolio, 2009](#_ENREF_44)). Although its focus is inherently positive, POSH does not ignore or denigrate non-positive phenomena that are the focus of critical inquiry – to do so would be naive and limiting ([Grant and Humphries, 2006](#_ENREF_26), [DeMatteo and Reeves, 2011](#_ENREF_21)). POSH seeks to study success because success and its associated phenomena are inherently attractive ([Bernstein, 2003](#_ENREF_7)). Furthermore, success helps to reveal resilience and capacity-building, which are as much a part of human endeavour as tragedy and failure ([Roberts, 2006](#_ENREF_58)). By taking this different slant on health service management, the researchers sought to discover, preserve, and celebrate anomaly – that is, the elements and processes that are typically beyond the purview of traditional approaches. Furthermore, the project sought to use research findings as levers for new conversations for change ([Miller and Crabtree, 2005](#_ENREF_51)).

For two key reasons, POSH is particularly useful in the context of management. First, its tools, including AI, relational coordination ([Gittell, 2002](#_ENREF_25)), and positive deviance ([Spreitzer and Sonenshein, 2003](#_ENREF_66)), can promote positive outcomes and shape health services that flourish in the face of adversity ([Havens, 2011](#_ENREF_32), [Cameron and Lavine, 2006](#_ENREF_9), [Karp, 2004](#_ENREF_38)). This is because these tools can facilitate transformation. They recognise knowledge, cognition, and experience as inextricably entwined and shaped by context, collectively generating action. As ‘groundless’ awareness ([Varela et al., 1991](#_ENREF_70)), this collective action represents ‘an exciting “space” where possibility arises for how we think about knowledge, cognition, and experience’ ([Haskell et al., 2002, para. 7](#_ENREF_30)).

Second, POSH draws attention to process – that is, ‘how and why things [notably, those that are virtuous] emerge, develop, grow, or terminate over time’ ([Langley et al., 2013, 1](#_ENREF_40)). Consider Lee and colleagues ([2003](#_ENREF_41)) who used POS to examine processes of knowledge creation; similarly, Luthans and Avolio ([2003](#_ENREF_43)) investigated the positive processes that create leadership patterns. Akin to process studies generally, POSH recognises the ‘importance and inescapability of time and timing in human affairs in general and in the lives of organizations in particular’ ([Langley et al., 2013, 4](#_ENREF_40)); the importance of interactional expertise ([Collins, 2004](#_ENREF_15)), which requires ‘immersion in the discourse of the community’ ([Collins et al., 2006, 658](#_ENREF_16)); and the value of the narrative, which helps to coherently convey complex tales of a lived experience.

In addition to optimising conceptual clarity, cogent methodologies – particularly within emerging movements as this – can guide the neophyte, encourage experimentation among veteran scholars, and contribute to a growing research toolbox.

The discovery of the publication, ‘What’s right in health care: 365 stories of purpose, worthwhile work, and making a difference’ ([Studer Group, 2007](#_ENREF_68)), allowed the Brilliance Group to explore, albeit at arm’s-length, how consumers and practitioners recognised healthcare that was ‘right’. The published narratives provided the group with a shared syntax for exploring different interpretations of what could be thought of as good, great, excellent, and even brilliant health service management. It became a boundary object ([MacPherson and Jones, 2008](#_ENREF_47)). The narratives were the platform on which to co-create new conversations around a shared goal, and they helped the researchers to shape the subject matter of their empirical focus. The narratives energised the researchers – they became meaning-creating and practice-generating, fostering reflective practice. The lack of familiarity with the narratives and the method of analysis diminished the collective expertise of the researchers and allowed different perspectives and understandings to emerge. No longer in familiar territory, they had a ‘groundless’ awareness ([Varela et al., 1991](#_ENREF_70)), enabling them to experience ‘freefall pedagogy’, focusing on ‘the possible, not the grounding of experience... open to mindful participation and passion for continued learning or perceptual yearning’ ([Haskell, 2000, 120](#_ENREF_31)).

## Inquiry and Engagement Intertwined

This pedagogical journey required the Brilliance Group to work and think together as a community of practice. Building and engaging this community required the researchers to generate rich information and understandings, develop knowledge of each other and mutual trust, set and manage expectations, and supportively hold each other accountable. They were thus required to: dialogue, discuss, work with defensive routines, and (perhaps most importantly) question. These four elements are addressed in turn.

Dialogue is the free and creative exploration of complex issues. It requires deep listening and the suspension of personal views – not abandonment, but suspension. Its purpose is to go beyond individual understanding. This requires collegiality, a respect for diverse views, and as such, recognition that conflict is central to, and necessary for *bona fide* dialogue. By managing dialogue, views are gently held, enabling individuals to inquire into others’ views with a collective view to learn, not determine or judge.

Discussion involves the presentation and defence of different views to find and/or co-create the best view and course of action. This element is important in problem-solving – it casts a spotlight on the views that emerge from dialogue to inform decision-making. While complex issues are explored during dialogue, decisions are made in discussion; while dialogue diverges, discussion converges; while dialogue draws on skills of inquiry, discussion draws on skills of advocacy ([Senge, 1994](#_ENREF_63)). Discussion therefore builds on, and refocuses dialogue – it helps to confirm collective decisions and strategies. The challenge however, is to balance the two elements, lest discussion be premature and decisions, ill-informed.

The ability to work with defensive routines marks an effective team. Defensive routines are path-dependant attempts to maintain a mental model ([Argyris and Schön, 1978](#_ENREF_4), [Argyris, 1985](#_ENREF_3), [Sterman, 1994](#_ENREF_67)). The ability to work with these entrenched habits involves conflict management, rather than resolution. It requires a sensitivity that does not inflame resistance, but understands the reason(s) for, and thus respects and works with the resistance. This in turn converts the ‘un-discussable’ into the ‘discussable’.

Questions are central to active listening – they foster engagement, presence, recognition, and inquiry. Questions invite and help individuals to find and create meaning and answers, enabling them solve problems or become more receptive to assistance. Questions communicate intent to focus on, and understand others’ concerns to achieve good outcomes. As such, they afford the ‘inquiree’ a larger speech bubble to respond to the ‘inquirer’ and facilitate understanding; the inquirer-inquiree exchange therefore requires time and patience.

Questions can be used to support dialogue and discussion. The former can be aided by inquiry questions, while the latter can be aided by problem-solving questions. Examples of inquiry questions include, what possibilities are there, that have not yet been considered; what is the smallest change that could make the largest impact; which solutions result in mutual benefit; and what makes a question inspiring, energising, and mobilising? Examples of problem-solving questions include, what is the largest problem; why are there always unreasonable demands; why do errors regularly occur; and how might additional resources be acquired? The two types of questions differ in tone and orientation, and can elicit different emotional responses from both the inquirer and the inquiree. Given these differences, the two types serve distinct, yet equally important roles. As such, they need to be consciously used for purpose – inquiry questions to enable dialogue and problem-solving questions to support discussion.

The Brilliance Group performed a complex and an unpredictable dance as they analysed the Studer Group ([2007](#_ENREF_68)) narratives. Drawing on Miller and Crabtree ([2005](#_ENREF_51)), the researchers’ mode of inquiry included three key processes, which might be referred to as reflexivity, interpretive, and analytical. This mode of inquiry was particularly useful for POSH, as it served to integrate narrative analysis within the context of healthcare. The reflexive process is not always easy to foster, nor is it easy to demonstrate expertise with ([see Fulop and Mark, 2013](#_ENREF_24)). In practice, reflexivity is both inherently relational as well as personally hierarchical. Reflecting in action with others means, ‘drawing on cumulative personal and organizational knowledge and engaging in a reflective conversation with the situation’ ([Cole et al., 2011, 144](#_ENREF_14)). It is relational to the extent that the, ‘research process is simultaneously participatory and cognizant of the power imbalances inherent in relationships in the greater health care system’ ([Miller and Crabtree, 2005, 621](#_ENREF_51)). The mode of inquiry used by the Brilliance Group demonstrated multiple forms of intensive reflection ([Dadich et al., in press](#_ENREF_20)).

Using an interpretive lens ([Holstein and Gubrium, 1994](#_ENREF_35), [Rabinow and Sullivan, 1979](#_ENREF_55)), group members each analysed twenty narratives. Although thematic analysis was suggested, the researchers were given no guide, thus encouraging a flow of ideas. Whilesharing and reflecting on each others’ analyses, the researchers used AI, emphasising the positive accounts first and foremost, and deliberately foreclosing negative accounts. They also emphasised disciplined listening as interruption was not permitted during the presentation of findings (only to stop reference to negative themes). However, critical reflection crept into the discussion. Each researcher produced positive observations of the narratives; some even described the experience as more uplifting than expected.

The positive focus enlivened the researchers – it raised their engagement with, and appreciation for others’ experiences and interpretation of the narratives. It was the point at which the researchers started to develop a different conversation about brilliance that was rich in anecdotes. The reflections revealed a visible change in the researchers’ mindsets and a sense that brilliance was worth pursuing. However, to give a sense of coherence to their interpretations, each researcher was invited to reflect on the discussion at which they presented and discussed their inductive analyses. This involved a consideration of: (1) the content of the narratives, as identified and discussed by the group as a whole; (2) content that was largely absent from the narratives, as identified and discussed by the group as a whole; (3) the approaches used to source, solicit, select, assemble, and present the narratives; and (4) connections between the personal experiences depicted in the narratives and the organisational context in which they occurred. Reflections were prepared in prose and were quite diverse.

It was also at this point that critical AI (CAI) ([Oliver, 2005](#_ENREF_53)) entered the researcher discussions. Despite the positivity that permeated the narratives, the researchers were critical of the approaches that may have been used to present them. They were dubious about the ways in which storytellers were selected, key characters were portrayed, and reliability was ascertained. At best, the publication is a collection of spontaneous narratives from individuals wanting to express gratitude to exemplary staff members, or have their deeds recognised. At worst, it is a contrived arrangement of fictitious experiences to aid the promotion of individual staff members or the marketing of health services.

Nevertheless, AI yielded new insights that may not have emerged, had the researchers commenced this process from a negative viewpoint. What outweighed the researchers’ misgivings was recognition that the narratives were part of a process of inquiry – they did not definitively delimit good, excellent, or brilliant healthcare. Furthermore, there is a level at which all secondary data requires recognition of what they represent at face-value. Lessons from others who have travelled a similar path suggest value in the researchers’ use and management of secondary qualitative material ([Cheshire, 2010](#_ENREF_13), [ADA, 2012](#_ENREF_1), [Ryan, 2005](#_ENREF_59), [Ratcliff, 1995](#_ENREF_56), [Sandelowski, 1986](#_ENREF_62), [Maxwell, 1992](#_ENREF_50), [Whittemore et al., 2001](#_ENREF_71), [Kirk and Miller, 1986](#_ENREF_39)). However, AI requires a critical lens, if critically reflexivity is part of the research plan.

Following their analysis of the narratives (see [Dadich et al., in press](#_ENREF_20), [Fulop et al., 2013](#_ENREF_23)), the researchers extended POSH by collecting primary material. For instance, they have invited Australian healthcare professionals to share experiences with, and perceptions of brilliant health service management; describe its associated effects; as well as identify and exemplify the factors that shape it. However, eliciting these reflections can take time – given the negativity that pervades some health services, it can be difficult to recognise, let alone describe brilliant health service management. However, given the transformative quality of POSH, it is an endeavour worth pursuing.

# Discussion

This paper demonstrates how POSH can be used to examine and understand brilliant health service management. It described a dialogical process that emerged through an analysis of secondary narrative material, engendering inquiry and engagement – not as discrete (or even interrelated) stages, but as intertwined elements. The contributions of this paper are twofold. First, it starts to reveal how brilliance in the context of healthcare is understood. Second, it uses POSH to reveal the brilliance seldom theorised in health service management literature. These contributions are explicated as follows.

Through this methodological journey, the Brilliance Group has (and continues to develop) an enhanced understanding of POSH and AI. Before embarking on this project, the researchers had variable comprehensions of, and experiences with either approach. Despite familiarity with, and appreciation for seminal works in the field ([Cameron and Caza, 2004](#_ENREF_10), [Cooperrider et al., 2008](#_ENREF_17), [Lewis et al., 2008](#_ENREF_42)), healthy debate ensued, which did not necessarily culminate with unanimous or common understandings. There was also limited emersion in their philosophical underpinnings, so at times the researchers floundered through this novel approach, progressively tweaking the process. As their explorations advanced, they gradually walked-the-talk of left- and right-brain engagement, confronting the challenge of developing a multi-ontological lens to examine brilliance ([Mark and Snowden, 2006](#_ENREF_49), [Mark, 2006](#_ENREF_48), [Rycroft-Malone et al., 2004](#_ENREF_60), [Fulop and Mark, 2013](#_ENREF_24), [Miller and Crabtree, 2005](#_ENREF_51)).

Reflecting on this mode of inquiry, the group’s enhanced understanding of POSH and AI was facilitated by reflexivity and relational dynamics – this was demonstrated in three key ways. First, the researchers needed to remind each other of previous discussions, the content of which was sometimes at odds with AI. Others started analyses, which they latterly curtailed after realising they were at odds with AI. The researchers’ collective reflexive position on why this occurred attributed blame to their original training, their predominant experience with left-brain thinking, and their focus on discrete elements of a complex system. Even the notion of left- and right-brain thinking – often described as left-brain / right-brain mythology ([Hines, 1987](#_ENREF_34), [Nielsen et al., 2013](#_ENREF_52)) – does not adequately capture the complexity of this challenge. As Miller and Crabtree ([2005](#_ENREF_51)) argue, the integration of all involved in healthcare is required, where the forces that drive prioritisation and pressurise the health system are integrated with the relational side that involves both clinical practice and the collective side described in this paper. This integration opens opportunities to promote elements of social justice within health services, like diversity, equity, and fairness ([Tomlinson and Schwabenland, 2010](#_ENREF_69)).

Second, the group brought together researchers steeped in different paradigms for addressing health service management. Through reflexive engagement and the process of inquiry chosen, members began to contextualise the research and build a community of practice of like-inspired, rather than like-minded researchers ([Hayes et al., 2012](#_ENREF_33)).

Third, in developing the methodology presented in this paper, the value of protocols and tools became increasingly apparent. During moments of uncertainty or stagnation, questions that prompted critical appreciation helped to ensure the research promoted POSH. At times, these questions were confronting as they required the researchers to spend time in a murky methodological mess – furthermore, the questions often revealed perceptual differences among the researchers. Yet, the questions also encouraged the researchers to work with and through the messiness and the divergences. Discussing and journaling the process helped to inform decision-making at difficult junctures and opened up possibilities for intuitive thinking.

The methodology presented in this paper has implications for both researchers and practitioners. For researchers, the methodology requires further testing. For conceptual clarity, this could be conducted in contexts with relatively more discrete boundaries and/or with different analytical methods ([Smith and Humphreys, 2006](#_ENREF_64), [Pentland and Feldman, 2007](#_ENREF_54)). For comparative value, future research could be conducted with different groups, particularly at an international level.

For practitioners, integration with others involved in healthcare might be aided by recognising brilliance as a process worthy of consideration. Despite the seeming inflexibility of health services, the narratives analysed by the researchers suggest it is still possible to deliver *brilliant* or ‘right’ ([Studer Group, 2007](#_ENREF_68)) healthcare. Even in the most adverse situation, glimpses of light can be found.

In addition to these implications, this methodology offers a nexus between researchers and practitioners. It can facilitate health service management research that maintains focus on, ‘relevance, usefulness, resonance and data that support informed, evidence-based decision-making’ ([Smyth and Holian, 2008, 36](#_ENREF_65)), *while* embracing multiplism. The examination of brilliant health service management is an opportunity for innovation and creative thinking about ways to change a health service. This novel approach encourages individuals and teams to focus on *bona fide* engagement that seeks to develop what is best in, and for healthcare. This approach shifts from the traditional, one-size-fits-all model used to optimise healthcare efficiencies. It also distances itself from the failed strategies that target, blame, and penalise practitioners for their behaviour. Although further research is required to identify the drivers that energise and sustain brilliant health service management, POSH adds another perspective to that from which healthcare is currently delivered. As such, the key questions now are, how do researchers of POSH and brilliance in healthcare engage with others, including (but not limited to) health service managers, clinicians, consumers, carers, and policymakers; and how might the lessons garnered through such scholarship be translated into practice? These questions suggest there is considerable opportunity for further research.

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