

Qualities of Personal Interaction: the Promotion of Research Utilisation for Quality Improvement in the US Health Care Sector

James Caldwell Palmer

November 2007

A thesis submitted in partial fulfilment of the requirements of the
University of Hertfordshire for the degree of
Doctor of Management

The programme of research was carried out in the Department of
Human Resources and Strategy: University of Hertfordshire

Acknowledgements

I would like to acknowledge the assistance, support and encouragement of the following persons.

It has been my good fortune to have Drs Donald MacLean and Ralph Stacey as my primary and secondary supervisors. They have provided guidance and advice essential to the success of my endeavour. The quality, depth and rigour of my research and writing could not have been achieved without them.

My learning set colleagues, Sheila Marriott and Cathie Woodward-Palmer, were valued friends along this journey for their advice, support, encouragement and hospitality. I have learned much from our collaboration and hope I contributed to their efforts at least some portion of what they have contributed to mine.

I also wish to acknowledge the important influence of the writings and lectures of other CMC faculty and conversations I have had with them: Douglas Griffin, Patricia Shaw, Farhad Dalal and Eliat Aram. The other members of the third cohort and graduates of previous cohorts of the DMan programme also contributed to my understanding and progress.

The text editing advice of Ms. Alison Terry for the final version was very helpful and timely and is greatly appreciated.

During the several years of the DMan programme I have been encouraged and supported by friends in the UK. I am thankful for our years of friendship and grateful for their welcoming hospitality during my frequent visits in England. They are: the Williams family – Roger, Sara and Florence; Dr Leslie and Katherine Gadman and family; and Dr Alasdair Honeyman.

I am also grateful for the support and encouragement in many important ways from my extended family and my friends in the US.

The past few years have required many trips away from home. Hours of attention went to my research and not to my family. The dining room table often disappeared -- covered by endless thesis drafts, the floor around it carpeted with journal articles and the whole enterprise guarded by walls and watchtowers of books. Fortunately, I have a patient family and it is their enduring support and love I wish to acknowledge most of all – Donna, Claire and Duncan.

Copyright © 2007 James Caldwell Palmer

All rights reserved

Table of Contents

Table of Contents	3
Abstract	7
Nature of the inquiry	7
Relevance	7
Approach.....	7
Findings.....	8
1. Introduction	9
1.1 Extending theory: A complexity theory of emergent learning	9
1.2 Extending methodology: consolidating DMan research strategy	10
1.3 Contributing to the Quality Improvement (QI) literature	10
1.4 Managerial and social relevance and implications	11
1.5 Improving professional practice	12
1.6 Some limits of complexity theory and my research.....	12
2. Theoretical Assumptions: How a complexity perspective functions as a theory of emergent learning	13
2.1 A complexity perspective as a theory of emergent learning.....	13
2.2 What is meant by meaning or knowledge?	14
2.3 What are qualities of interaction of experience	16
2.4 The thought traditions of foundational theories of learning	17
2.5 QI theoretical mixture as revealed preference of theory choice	18
3. Methodology: research strategy, core methods, complementary methods	22
3.1 Research Strategy: mindful reflexivity	22
3.2 Core methods	25
3.2a Week-long residential sessions	25
3.2b Large-group sessions	26
3.2c Small learning groups	27
3.2f Complementary Methods	29
Table 1. Methods and theories complementary to the DMan methodology and my research inquiry.	31
3.3 Generalizability.....	32
4. Research findings: themes, insights, movement of thoughts	33
4.1 Project One: mindful reflexivity and being present to self ~ other.....	33
4.2 Project Two: mindful reflexivity and understanding emotions and interactions	35
4.3 Project Three: reflexive emotionality and understanding perspectives	40
4.3a Limiting conversation to hold meaning unchallenged	40
4.3b Paying attention to the perspective and emotions of others.....	41
4.3c The longitudinal dynamics of qualities of interaction.....	42
4.4 Project Four: reflexive emotionality and understanding perspectives and narratives of the other	43
4.5 Findings summary.....	46
5. Managerial and social policy implications	48
5.1 Setting and pursuing goals for healthcare improvement.....	48
5.2 Allocating and effectively and efficiently using resources	48
5.3 Implications for healthcare policy.....	49
5.4 Learning about changing the qualities of quality improvement	50

6. Changes to professional practice	51
6.1 Improved accounting for human interaction in my consulting	51
6.2 Educational Methods	51
7. Some limits of the theory and my research.....	52
7.1 Some inherent limits of any theory	52
7.2 Particular limits of this new theory	52
7.3 Limits to my research: some qualities of interaction not investigated.....	53
8. Project One: Shadow and Light, Light and Stone	54
8.1 Reflections	54
8.2 Introduction.....	55
8.3 One beginning.....	56
8.4 The route to the Isle of Man.....	58
8.5 The roots of coincidence are nourished by patterns of our participation.....	60
8.6 The influence of a good book along the journey	61
8.7 A conceptual blend	61
8.8 The workshop at ABC Soap Company	63
8.8b Talking emergence, thinking systems.....	63
8.9 The Santa Fe Trail: my early conversations on complexity	64
8.9b Beware of consultants bearing Strange Attractors.....	65
8.9c Theory and practice.....	65
8.9d Adding one more hurdle.....	66
Figure 1.1 Aligning Complex Adaptive Systems and Communities of Practice Terms	65
8.10 What does this village know about raising healthy children?.....	67
8.11 Emotion and the assignment of meaning.....	69
8.12 Along The Santa Fe Trail: Chico Springs.....	70
8.13 The influence of a book series along my journey	71
8.14 Constructing the future of practice.....	72
8.15 Looking back, looking forward.....	74
Figure 1.2: ontological map of Wenger's community of practice.....	75
Figure 1.3 An emerging research question.....	76
9. Project Two: transforming practice in the hurly-burly of life	79
9.1 Reflections	79
9.2 Introduction.....	80
9.3 Context and setting: a Knowledge Transfer Workshop.....	81
9.4 Day one: gesture and response in the hurly-burly of life.....	83
9.5 Inclusion ~ Exclusion: the social dynamics of seating arrangements.....	84
9.6 Pointing out the pale	85
9.7 Discussing the first work plan.....	86
9.8 Analysis: what sense was I making of my experience?	89
9.9 The first afternoon: awareness as a quality of interaction	93
9.10 The unheard colleague	94
9.11 KT elements in the design and conduct the workshop.....	95
9.12 Analysis: what was happening in the afternoon?.....	96
9.13 Day two: finding my voice	97
9.14 Why did I speak as I did?.....	100
9.15 Perspectives and methodologies: KT and complex responsive processes.....	102
9.16 The knowledge transfer view of the individual	102
9.17 How KT approaches research and evaluation.....	104
9.18 How KT views communication and causality	106

9.19 Summary: into the hurly-burly with new eyes.....	108
9.20 Detachment ~ Involvement: why I see now what I did not see before	109
9.21 Another emerging theme.....	111
9.22 Future inquiry.....	111
10. Project Three: ideology, power relating, and inclusion ~ exclusion in strategic episodes.....	111
10.1 Reflections	112
10.2 Introduction.....	113
10.3 Replicating patterns of interaction in strategy meetings	114
10.4 The setting and start of the meeting	114
10.5 A multiplicity of agendas	115
10.6 Allocating and sharing space	117
10.7 Turn-taking, turn-making and the allocation and use of time.....	118
10.8 Power-relating balances in conversations	121
10.9 Unspeakable challenges to unquestionable values.....	123
10.10 An overview and critique of some key quality improvement concepts	126
10.11 Removing variance as the presumed source of quality issues	128
10.12 The strengths-based community meeting	130
10.13 Background	131
10.14 The setting and the start of the meeting	131
10.15 Agendas and preferences	131
10.16 The use of time in the SB meeting.....	132
10.17 Turn-taking, turn-making.....	133
10.18 How quality improvement movements can shut down conversations.....	134
10.19 Power relating and selecting and defining measures	135
10.20 Power relating and choice-making by cardiac surgeons.....	137
10.21 Interdependence in selecting and defining QI measures.....	139
10.22 Ideology in stroke care quality improvement	139
10.23 How measures can hide or avoid power-relating conflicts	140
10.24 A process measure not talked about.....	141
Chart 1 The ability to intervene in ischaemic stroke.....	142
10.25 The Strategy Workshop literature: a possible contribution	144
10.26 Reflections on my professional practice	146
10.27 Conclusion	147
11. Project Four: anxiety and ambiguity, partial narratives and preferred perspectives	149
11.1 Reflections	149
11.2 Introduction.....	150
11.3 Overview: participating in a strategy review workshop	150
11.4 Starting the workshop: narrative monologues	150
11.5 The childhood illness disparities project.....	152
11.6 How my critiquing emerged in the workshop discourse	151
11.7 How emotional qualities of experience shifted the perspective of my critique	154
11.8 Preferred perspectives for evaluating the CID project.....	154
11.9 Did my suggesting a reflexive third-person perspective have an effect?	155
11.10 Ignoring my familiar colleague's perspective.....	155
11.11 How we were trying to make sense of the project	156
11.12 Some discourse analysis: how project summaries were constructed.....	157
11.13 The project summaries as organisational achievement narratives	158
11.14 A hopeful description of hegemony in the project summaries	159

11.15 Why were QI clients voiceless in project accounts and the workshop?	159
11.16 Categorization in discourse: supporting power dynamics and ideology	160
11.17 Creating and discussing partial, preferential discourse about projects	162
11.19 An overlooked ambiguity.....	164
11.20 The pay for performance project.....	166
11.22 I try to take the perspective of the P4P Quality Team	167
11.23 Last-minute clues emerge about ambiguities in project summaries	170
11.24 How project ambiguities relate to public services reform literature	171
11.25 Public service reformers' perspective on organisational ambiguity	171
11.26 Ambiguities in search of certainties.....	172
11.27 Ambiguity about what constitutes organisational performance.....	173
11.28 How narrative structure and content are clues to emotional states	173
11.29 Anxiety and ambiguity as themes patterning interaction.....	174
11.30 Ambiguity in constructing quality measures for acute stroke care	178
11.31 The ambiguous 'Stroke-Four' measure in US stroke care guidelines	178
11.32 Why construct an ambiguous quality improvement measure?	181
11.33 Discussion and a possible limitation.....	182
11.34 A possible limitation	182
11.35 Conclusions	184
11.36 Officially seeking disambiguation	184
11.37 Officially sanctioning ambiguity in QI measures	185
Bibliography	188

Abstract

Nature of the inquiry

My research inquiry investigated how qualities of personal interaction shape and affect the promotion of research utilisation for quality improvement in the US healthcare sector. The research investigated my own professional practice of consulting, teaching, and research regarding the improvement of healthcare practices and outcomes. Efforts to improve the quality of healthcare services are often difficult to realise and sustain. The quality improvement movement in the USA and elsewhere has not conducted much self-examination of its own processes for sources of these perennially problematic results.

Relevance

The quality of healthcare services can be readily understood as having consequences of life or death, wellness or suffering. Healthcare expenditures in the USA are estimated at 16% of GDP and over 9% in the UK. Improving healthcare quality improvement efforts is a matter of profound human and social significance.

Approach

The DMan research methodology is a reflexively aware process conducted as a cohort and as small learning groups of researchers during the three-year programme. The research inquiry used the complex responsive process of relating theory of learning as emergent changes of meaning or, equivalently, knowledge. As a social science of qualities, it uses the qualities of human interaction as the unit of analysis. The research utilised an interdisciplinary approach drawing upon: healthcare quality improvement literature; organizational discourse studies; research on strategy as practice; performance management; communications theories; the theory of mindful learning; interpersonal neurobiology; figurational sociology; and American pragmatist philosophy.

The methodology employs a mindful reflexivity research strategy related to concepts from mindful learning and social neuroscience literature. Central methods included iterative peer and supervisor debriefing and iterative reflexive narrative practice.

Findings

A contribution is made to the healthcare literature by describing how ordinary qualities of social coordination dynamics affect the promoters of healthcare research, not just potential users of research. A contribution is made to professional practice by providing a new perspective from which to analyse the sources of performance challenges prevalent in healthcare quality improvement efforts. The research findings indicate how applications of substantial organisational and social resources to promote research utilisation in the US health sector can be co-opted and dissipated away from ostensive substantive objectives. This occurs by research promoters' organizational discourse efforts to favourably shape power relating and other qualities of interaction of improvement initiatives. These efforts restrict the emergence of learning about the promoted changes.

1. Introduction

In my research journey across the four narrative projects of my inquiry, I have shown various ways in which qualities of human interaction affect and in turn are affected by the efforts of persons to promote the utilisation of research evidence for the improved expression of healthcare practice. My research has proceeded through the use of a complexity perspective to analyse seriously and in micro detail the interactive qualities of my interdependent activities and experiences with others in healthcare promotion and utilisation efforts. Contributions are made to theory, methodology, healthcare improvement literature and professional practice.

1.1 Extending theory: a complexity theory of emergent learning

Stacey, in writing about what knowledge is from a complexity perspective, notes:

Knowledge is, therefore, the thematic patterns organizing the experience of being together. The process of learning is much the same and there does not seem to be much point in trying to distinguish the one from the other.

(Stacey, 2001, p. 189)

The perspective of complex responsive processes of relating sees learning as creating changes of meaning, or knowledge, and as ‘...qualitative processes of power relating that are emotional as well as intellectual, creative as well as destructive, enabling as well as constraining’ (Stacey, 2001, back cover).

My research adds to complexity theory by providing a more extensive treatment of its application as a theory of emergent learning, while situating it in the intellectual context of some relevant learning theory literature and theories. In particular, I differentiate a complexity theory of emergent learning from dominant versions of Quality Improvement Theory considered as a de facto variable mixture of Diffusion of Innovations Theory (Rogers, 2003), Social Cognitive Theory (Bandura, 1977, 1986) and various Systems Theories (which incorporate views of learning). I point to supporting propositional statements and assumptions of two approaches to learning with similarities to a theory of emergent learning and to the mindful reflexivity research strategy of the DMan methodology. First is the work of Ellen Langer (1989, 1997) on Mindful Learning, written from a social psychology

perspective. Second, Siegel (1999, 2007) explains how mindfulness creates changes of learning, behaviour and self, from an interpersonal psychology, interpersonal neurobiology perspective. Siegel is one of the key developers of the emerging new research area of Interpersonal Psychology, or Interpersonal Neurobiology (Cozolino, 2002, 2006; Stern, 1985, 2005; Schore, 2003).

1.2 Extending methodology: consolidating DMan research strategy

My research offers a contribution to DMan methodology by particularizing as ‘mindful reflexivity’ its generalization of research strategy as ‘taking experience seriously’ and distinguishing it from other reflexive research strategies. Mindful reflexivity pays attention to the qualities of interaction among and between persons. It reflects upon not just the perspectives and attitudes of the researcher, but helps the researcher pay attention to and be keenly aware of the co-dependent rising of perspectives and attitudes between and among people – researchers, informants and others. My research findings contribute to qualitative research methodology by describing mindful reflexivity as a strategy for the acceleration, intensification and re-usability of research, or learning. This is done through perceiving and shaping qualities of human interaction, including changes of meaning as learning. Research is a particular name for learning that is pursued in particular ways for particular purposes. The synopsis section on theoretical assumptions indicates how the DMan research methodology in core methods and complementary methods supports a complexity view of learning and the central role of qualities of interaction. The methodology section explains how the DMan methodology is a particularization for research, or learning, purposes of the general theory of complex responsive processes of relating. The general implication of the emergent perspective of learning for a research/learning methodology is that for those methods to be efficient and effective in helping a researcher (learner), they must increase the abilities of the researcher to perceive and shape, evaluate and assess, relate and account for the qualities of human interaction.

1.3 Contributing to the Quality Improvement (QI) literature

My research findings contribute to understanding how quality improvement efforts to promote healthcare research utilisation can be co-opted by the research promoters. I argue that QI projects can be biased and prejudicial in their design and be conducted in a prepossessed and predetermined manner. For example, quality improvers seek hegemonic advantage by using interrelated social categorisations and attributions that position them favourably as the promoters of superior knowledge to the proposed recipient QI clients. QI theory,

complemented with certain discursive techniques I describe in Project Four, serves to justify quality improvers' actions with the assumption of a social science-derived, 'objective' perspective, considered to be statistically validated and reliable. This justification is related in organisational performance reports (Corvellec, 1997; Varra, 2002) that are preferentially constructed and defensively designed and shared. While analysis of QI efforts usually concentrates on the response to changes by the intended recipients, QI discourse is also subject to being favourably spun by the self-interested efforts of QI promoters. This extends the idea of co-opting during project conduct and implementation phases to be understood as interactive gaming by all involved – quality improvers and QI clients, among others. My research indicates how resources applied to QI efforts can be dissipated by interpersonal interactive contests over whose narratives and patterns of practice and preferred qualities of interaction, such as power relations, shall prevail and with what attendant consequences. These discursive struggles generate problematic results for trying to change actual healthcare outcomes that are important to patients, such as death or disability. QI project results can range unpredictably from significant and sustained, to modest and unsustainable, to actually making matters worse for patients (and practitioners).

1.4 Managerial and social relevance and implications

The generation and application of research findings in healthcare is of profound social significance and relevance for two essential reasons. First, new research findings in healthcare have, literally, implications and consequences on a scale of life and death, wellbeing or suffering. This can involve millions of persons, as in the case of stroke, HIV/AIDS, malaria, and other diseases. A second significance is that in many countries' expenditures on healthcare, as research or delivery of services, account for significant portions of social resource utilisation. Direct government expenditures for 2004 in the member states of the European Union, for example, are approximately 9.4% of GDP (gross domestic product) (OECD, 2006). In the US, healthcare expenditures consumed 15.3% of GDP in 2003 (Heffer, 2005, p. w5-74). But studies indicate that an average time to substantial utilisation of healthcare innovations can be as 17 years in the USA (Balas, 2000). It is therefore important, for multiple reasons and from multiple perspectives, to make efficient and effective use of resources applied to healthcare, assisted by the swift but carefully considered use of new research findings.

Improving the value of quality improvement efforts in healthcare is a vital social concern, present internationally across societies and nations. I assert that my research findings indicate that a theory of emergent learning offers a more plausible accounting for how the promotion and utilization of research evidence actually proceeds. The unit of analysis is the nature and qualities of human interaction and is of central importance to my argument. A complexity theory of emergent learning can contribute in an inclusive way to generating profoundly important, fundamentally relevant healthcare improvement conversations with increased potential to transform healthcare practice in substantive ways to make healthcare narrative accountings, as desired and valued by those involved, come true.

1.5 Improving professional practice

My professional practice consists primarily of consulting on healthcare improvement, and postgraduate teaching at universities in the USA and UK has been changed by my research. I have learned how to interact with clients and students differently and account in a new intrinsically inclusive way for the organisation and delivery of healthcare services as emergent self-organising interactions. My methods of teaching at universities incorporate a mindful reflexivity strategy and iterative narrative inquiry approach. The course content increasingly reflects a complexity perspective.

1.6 Some limits of complexity theory and my research

In a section on limits to the general theory and my research, I discuss how some inherent general limits of theorising apply to the theory of complex responsive processes of relating and my research. Those limits relate to how theorising is a mix of partial narratives and partial abstract systemic frameworks, constructed in preferential manners, and related from a particular perspective. I also describe limits of my research, related to considerations of resources – such as time and dissertation length.

2. Theoretical Assumptions: How a complexity perspective functions as a theory of emergent learning

In this section I describe some basic theoretical assumptions of a complexity perspective to: define its particularization as a theory of emergent learning; provide definitions of terms for meaning and for qualities of interaction; and reflexively, in a social sense, locate the theory of emergent learning in the thought traditions of significant or foundational theories of learning.

2.1 A complexity perspective as a theory of emergent learning

Stacey writes the following about learning:

‘Learning is ... understood as the emerging shifts in the patterning of human communicative interaction and power relating. Learning is the activity of interdependent people and can only be understood in terms of self organizing communicative interaction and power relating in which identities are potentially transformed.’

(Stacey, 2003b, p. 1)

And further:

‘Learning occurs as shifts in meaning and it is simultaneously individual and social.’

(Stacey, 2003b, p. 8)

A complexity perspective indicates that we learn as we lean into each emergent step, since each moment, each step, each thought brings changes of experience however slight or significant. Learning occurs continuously during complex responsive processes of relating as the ongoing perception and determination of changes of meaning, or knowledge, which are changes of the pervasive qualities of experience. Learning is not just reacting to the here and now, but is intelligent improvisational response to experience perceived as past, present and anticipated possible futures through the circular awareness of time as the ‘living present’ described by Mead (1934).

We make sense of experience by organising and integrating that experience in narratives. Narrative understandings of internal conversations, or narrative sharing with others in various

ways, organise the thematic patterning that humans perceive. Narratives implicitly or explicitly incorporate the qualities of interaction expressed by the narrative.

Changes of learning occur as changes to thematic patterns of experience as organised and understood in narrative ways. Stacey describes how learning, or knowledge, emerges from those changes of thematic patterns (which are understood in narrative-like ways):

‘Knowledge is, therefore, the thematic patterns organizing the experience of being together. The process of learning is much the same and there does not seem to be much point in trying to distinguish the one from the other.’

(Stacey, 2001, p. 189)

‘Learning is emerging shifts in the thematic patterning of human action. Another way of saying this is to say that learning is the emerging transformation of inseparable individual and collective identities.’

(Stacey, 2003b, p. 8)

This is a way of pointing to how changes of meaning, or knowledge, are learning, and how those changes are qualities of interaction, or experience. The next section considers what is meant by meaning, and changes of meaning.

2.2 What is meant by meaning or knowledge?

If we take learning to occur as ‘shifts in meaning’ (Stacey, 2003b), then what is meant by meaning?

Mead (1934) described how meaning is generated in symbolic interaction.

‘Mead defined a social act as a gesture by one animal that calls forth a response from another, which together constitute meaning for both. Immediately, meaning becomes a property of interaction, or relationship.’

(Stacey, 2003c, p. 60)

Mark Johnson writes of meaning in a manner commensurate with a theory of emergent learning:

‘...meaning is grounded in bodily experience; it arises from our feeling of qualities, sensory patterns, movements, changes, and emotional contours. Meaning is not limited only to those bodily engagements, but it always starts with and leads back to them. Meaning depends on our experiencing and assessing the qualities of situations.’

(Johnson, 2007, p. 70)

Stacey writes in a similar sense to that of Johnson:

‘I would argue that this linking between qualitative aspects of perceived experience and similar qualitative aspects of felt bodily experience is the basis of human knowing.’

(Stacey, 2001, p. 103)

I have found helpful the writing of Dewey on the idea of a pervasive quality of a given experience, considered as a ‘situation’. Mark Johnson (2007, p. 72) notes that by ‘situation’, Dewey means

‘...not just our physical setting, but the whole complex of physical, biological, social and cultural conditions that constitute any given experience – experience taken in its fullest, deepest, richest, broadest sense: “By the term situation in this connection is signified the fact... that it is dominated and characterized throughout by a single quality.” ‘

(Dewey, 1930/1984, p. 246)

I equate what Dewey is calling a ‘situation’ or ‘given experience’ with what Bruner (1990); Siegel (1999, 2007) and Stacey (2003a) refer to as narrative understanding of experience. This offers a way to understand meaning, or knowledge, as an inseparable quality of (inter)action. That is to say, knowledge and action are inseparable aspects of complex responsive processes of human relating.

Meaning is discerned in the narrative organizing experience by the emotional integration and assessment of that narrative understanding (Siegel, 1999). The emotional evaluation of interactions also informs our sense of value of the experience and the motivational direction

indicated by the meaning and value of the experience. Without that inextricable emotional assessment, socially aware and sustainable behaviour – as characterised by emotionally informed, intelligent improvisation into the emerging moment – is not possible (Damasio, 1994).

Meaning (or knowledge) / (inter)action can be considered as an inseparable relational pair describing aspects of the same complex responsive process of relating and learning. We can therefore consider that learning (or changes of meaning) is inextricably, interdependently and interactively related to changes in the qualities of interaction with others and environments, both built and natural.

I will illustrate in the section on research findings how this view of learning as emergent contrasts distinctly with the fundamental proposition of QI theory that the meaning of a QI project is a representational concept, separable from the actions and interactions of both quality improvers and QI clients.

The next section provides a brief definition and overview of qualities of interaction.

2.3 What are qualities of interaction of experience?

I use the term ‘quality’ in the sense that it refers to:

‘the nature, kind, or character (*of* something). Now restricted to cases in which there is comparison (expressed or implied) with other things of the same kind; hence, the degree or grade of excellence, etc. possessed by a thing.’

(OED online, 1989)

Or, from Johnson:

‘...qualities...are about how something shows itself to us, about how something feels to us, and they seem to involve more than can be structurally discriminated by concepts. Qualities are not reducible to the abstractions by which we try to distinguish them.’

(Johnson, 2007, p. 70)

We make sense of our experience of the world through the qualities of our interactions. John Dewey wrote of this:

‘The world in which we immediately live, that in which we strive, succeed, and are defeated, is pre-eminently a qualitative world. What we act for, suffer, and enjoy are things in their qualitative determinations. The world forms the field of characteristic modes of thinking, characteristic in that thought is definitely regulated by qualitative considerations.’

(Dewey, [1930] 1984, p. 243)

As a reminder of the dynamic character of qualities of interaction, I use the format of relational pairs (inclusion ~ exclusion). Here the use of the tilde ~ is to indicate the dynamics and dynamic balances of related qualities whereas the individual words, unlinked, imply a more static nature. Human experience is perpetually dynamic; qualities of experience can be thought of as dynamic interpersonal interactive tendencies versus relatively static autonomous attributes, such as years of education.

The next section will provide a brief overview of several significant foundational theories of learning that have been predominant since the early days of the field at the beginning of the 1900s. The gap in coverage of these theories of learning is that the qualities of human interaction are generally not considered for their influence, or else are regarded in a limited, secondary manner.

2.4 The thought traditions of foundational theories of learning

‘Nothing endures but change.’

Heraclitus

All theories of learning are theories of change. All theories of learning give particular names to learning, and have particular narrative explanations told from a particular perspective of how learning or change occurs. Theories of learning can thus be understood as combining the following: first, the perspective of the theorist towards learning or change, which is expressed and particularized through a set of propositional statements which comprise an explanatory abstract-systemic framework; and second, narrative explications.

For example, the perspective of the behaviourists such as Pavlov, Skinner, Thorndike or J. B. Watson (Hergenhahn, 2005) is that change, understood as learning, may be described as overt, recognizable, measurable changes in behaviour. Social behaviourism was a theory by George Herbert Mead (1934) and a dialectical counter to the behaviourism of his University of Chicago colleague J. B. Watson which pointed to how people change and develop minds, selves and societies as emergent outcomes of interdependent processes of human social interaction. Other theories consider learning as change in cognitive shifts understood as: mental models we use to process information (in a manner similar to computers) (Argyris and Schon, 1996); or framing situations (Goffman, 1990), or scripts (Schank, 1997). Developmental theorists such as Piaget or Rogers (Jarvis, 2006) point to how learning occurs as changes in ability to do certain cognitive tasks as defined in correlation to some aspect of embodied development. How experience can be considered as learning is, in several ways, the perspective on change of John Dewey (Jarvis, 2006), Carl Rogers (Jarvis, 2006), and David Kolb (Baker, 2002). The theory of Transformative Learning (Mezirow, 2000) analyses change in the perspective of adults. Andragogy (Jarvis, 2006) refers to what factors best describe how adult learners change in educational settings. Stacey (2001) has analysed how mainstream thinking in the organisational literature draws upon the works of Argyris and Schön (Schön, 1983, 1987; with Argyris, 1996) and Peter Senge (1990), and takes a systems thinking perspective of learning.

The next section indicates how the work of Rogers and others work on Diffusion of Innovations, and of Albert Bandura on the Social Cognitive Theory of Learning, along with elements of systems theories of organisations, have a significant role in the study of research utilisation in healthcare.

2.5 QI theoretical mixture as revealed preference of theory choice

This section discusses how the Diffusion of Innovations approach, which incorporates Social Cognitive Theory from Bandura (1977, 1986), has been a dominant concept in the healthcare research utilization field, and across other particular lines of inquiry into learning and change in healthcare-related situations (Greenhalgh, 2004).

Estabrooks and colleagues (2006) provide an overview guide to Knowledge Translation Theory. They consider knowledge translation to

‘...generally encompass terms such as *evidence-based decision making, research utilization, innovation diffusion, knowledge transfer, research dissemination, research implementation, and research uptake.*’

(Estabrooks, 2006, p. 28)

They identify five theoretical frameworks in the healthcare literature as particularly useful ‘...to serve research design in the health services’ (Estabrooks, 2006, p. 29). These frameworks are: 1) Diffusion of Innovations Theory (Rogers, 2003); 2) Research Development Dissemination Utilization Framework by Havelock 1969 (following Rogers, 2003); 3) Greenhalgh and colleagues’ systematic review of diffusion of innovations theory in health care (2004); 4) the Promoting Action on Research in Health Services Model by Kitson and colleagues (2002, 2004) (also similar to a diffusion of innovations approach); and 5) the Ottawa Model of Research Use (OMRU) (1998) (also similar to diffusion of innovations) (Estabrooks, 2006, pp. 29-31).

The diffusion of innovations theory was strongly influenced in its development by the social cognitive theory of learning developed by Albert Bandura (1977, 1986). Bandura was in turn influenced by Rogers (Bandura, 1986, chapter 4). Everett Rogers, the dominant figure in the diffusion of innovations field of research, wrote about Bandura’s influence upon his innovations theory:

‘Social learning and the diffusion of innovations have much in common: Both theories seek to explain how individuals change their overt behaviour as a result of communication with other individuals. Both theories stress information exchange as essential to behaviour change and view network links as a main explanation of how individuals alter their behaviour.’

(Rogers, 2003, p. 342)

In the fifth edition of *Diffusions of Innovation*, Rogers defines diffusion as:

‘... a process by which (1) an *innovation*, (2) is *communicated* through certain *channels*, (3) over *time*, (4) among the members of a *social system.*’

(Rogers, 2003, p. 11)

The work of Bandura can be seen then as influential in healthcare literature by way of being incorporated in Rogers' (1995, 2003) work's influence on healthcare quality improvement in the relevant literature. Bandura wrote that his theory,

‘...had always been much broader than the initial descriptive label (Social Learning). It not only addressed how people acquire cognitive, social, emotional and behavioural competences, but also how they motivate and regulate their behaviour and create social systems that organize and structure their lives. In the more fitting appellation as *social cognitive theory*, the *social* portion of the title acknowledges the social origins of much human thought and action; the *cognitive* portion recognizes the influential contribution of cognitive processes to human motivation, affect and action.’

(Bandura, 2007, pp. 8-9)

The dominant learning perspective in quality improvement (QI) discourse also reflects a basic systems theory view of healthcare organizations that is mixed with the theories just described: Rogers' diffusion of innovations theory (2003) and the social cognitive theory of Bandura (1986). Stacey (2001, pp. 29-30) provides the following as key assumptions of systems theories applied to learning and knowledge creation:

- knowledge is representational;
- human communication is send–receive in nature;
- persons are autonomous individuals;
- change occurs from receiving new information, which is processed rationally to change mental models and thereby potentially or actually to change behaviour;
- emotions are separable from intelligent rational behaviour;
- change can be considered from a formative teleology stance (how events unfold within an organisation);
- or change can be considered from a rational teleology stance (promoters of research utilisation can observe healthcare organisations and create interventions that will induce the utilisation of healthcare research).

I will use the term ‘QI theory’ as a generalization to indicate this variably blended and utilised mixture of theories which, it should be noted, is prevalent in QI discourses, but not monolithic in its compilation or applications.

The Methodology section on DMan Research Strategy outlines how two theories of learning and behaviour have similarities to a theory of emergent learning. One is the theory of 'mindful learning' (Langer, 1989, 1997). The other, interpersonal neurobiology, is a new interdisciplinary field of psychology developed by Siegel (1999, 2007) and Cozolino (2002, 2006), inter alia.

3. Methodology: research strategy, core methods, complementary methods

In this section, I analyse the reflexive research methodology of the DMan programme and how the research efforts it informs enhance learning by affecting the qualities of interaction that shape and are shaped by the researcher's interactions.

For my research I used a combination of several qualitative research methods.

Core elements of the DMan approach included the use of: week-long residential sessions; large group sessions at the residential; small learning groups three times a year; and iterative writing of four reflective narrative projects and a synopsis. In all these, we mutually influenced and improved our research through discussion and critique. The general research strategy of the DMan programme is to 'take experience seriously' with a reflexivity approach, particularized as what I have named mindful reflexivity. The next section explains mindful reflexivity.

3.1 Research Strategy: mindful reflexivity

The DMan methodology uses a reflexivity research strategy that can be characterised as 'mindful reflexivity'. The elements of mindful reflexivity assist the DMan researchers in 'taking their experience seriously', and helps them place '...everyday communication at the centre of one's understanding' (Stacey, 2001, p. 173). I am using the word 'mindful' in the sense of Bishop (2004) from the field of clinical psychology, Langer's 'mindful learning theory' (2000b) and Siegel writing on mindful awareness in developing interpersonal neurobiology (1999, 2007).

Bishop and colleagues define mindfulness as:

‘...the self-regulation of attention so that it is maintained on immediate experience, thereby allowing for increased recognition of mental events in the present moment.’

(Bishop, 2004, p. 232)

and

‘...a particular orientation toward one's experience in the present moment, an orientation that is characterized by curiosity, openness and acceptance.’

(Bishop, 2004, p. 232)

Langer writes:

‘Mindfulness, achieved without meditation, is discussed with particular reference to learning. Being mindful is the simple act of drawing novel distinctions. It leads us to greater sensitivity to context and perspective, and ultimately to greater control over our lives.’

(Langer, 2000a, p. 220)

These definitions by Bishop (2004) and Langer (2000a, b) of mindfulness are part of three research fields that have emerged over the past three decades: ‘mindful learning’, the work of Langer originally; the study of the concept of ‘mindfulness’ in clinical psychology; various psychotherapies (Schwarz, 2004; Germer, Siegel and Fulton, 2005); and the emerging field of a new approach to psychology that Siegel (1999, 2007) has termed ‘interpersonal neurobiology’. This new interpersonal interaction approach has many points of resonance with the interpersonal relations element of a complexity perspective. Stacey (2003c) provides an introduction to some of this related research (Stacey, 2003c; Siegel, 1999, 2007; Cozolino, 2006, 2002; Stern 2005, 1985).

Siegel, using Bishop’s psychological definition of mindfulness, writes:

‘Mindfulness heightens the capacity to become filled by the senses of the moment and attuned to our own state of being’

(Siegel, 2007, p. 14)

These core elements of DMan methodology research strategy I will refer to as a ‘mindful, or interpersonal, reflexivity’ support seven key processes attributes that increase the depth, quality and pace of the researcher’s learning. Points of theoretical commensurability with mindfulness as a psychological construct (Bishop et al., 2004), as mindful learning (Langer) and as mindful awareness (Siegel) help to delineate seven important propositional statements supported by DMan methods that are representative of the mindful reflexivity research strategy. Those techniques help the researchers and supervisors to functionalise the generalization of the DMan Programme to ‘take experience seriously’ by increasing the researcher’s ability to:

1. be present to and willing to be changed by others
 - Friis (2006, pp. 89-91), Walker (2006, pp. 106-107): presence as used here is closely equivalent to interpersonal psychology concepts of attunement and social resonance as outlined by Siegel (2007, p. 14)
2. focus on, orientation to, the living present
 - Stacey (2001, p. 173), Walker (2006, p. 106), Bishop (2004, p. 232), Langer (2000a, p. 220)
3. have sensitivity to context
 - Langer (1989, 1997), Siegel (2007)
4. take a detached involvement research stance – self-aware emotionality or affective style
 - Williams (2005, pp. 63-68); see ‘affective style and emotional modulation of experience’ (Siegel, 1999, 2007)
5. be alert to difference, ‘draw novel distinctions’ (Langer, 2000)
 - Stacey (2001, p. 138), Langer (2000a, p. 220)
6. be open to emergent change, themes, or novelty
 - Christensen (2005, pp. 102-103), Stacey (2001, p. 235), Siegel (2007, p. 5), Langer (2000a, p. 220)
7. consider multiple perspectives – those of others and of the self
 - Mead (1934, p. 89), Langer (1997, p. 23)

Stacey and Griffin (2005) writes that ‘taking one’s experience seriously’:

‘... is the activity of articulating and reflecting upon these [narrative] themes [of interaction]. In other words, the method is that of giving an account, telling the story, of what I think and feel that I and others are doing in our interaction with each other in particular contexts over particular periods of time.’

(Stacey and Griffin, 2005, p. 23)

Elements 1–3 above relate to the ability to organise and understand experience in narrative ways: awareness of self ~ other, a sense of time (and concomitantly of space), and of context. Item 4, reflexive emotionality ~ affective style, or detachment ~ involvement dynamics as referred to by Elias (1956) and Williams (2005), refers to how we integrate and assess our

experience with emotions and feelings (Damasio, 1999; Siegel, 1999). Items 5 and 6 are what we typically use narrative to do: to draw distinctions and notice change, or novelty. The seventh item is the ability to take the perspective of the other, which involves understanding how others might interpret our own narratives or situations. Mindful reflexivity helps the researcher to generate and to be aware of how they are generating narrative understandings in interactions with the self ~ other. Those narratives help us perceive, organise and make sense of the qualities of our interactions, our experiences, jointly and severally.

Mindful reflexivity can be distinguished from some other research reflexivity strategies considered as introspection and intersubjective reflection, neither of which call upon interpersonal interaction, but are more self-centred (Finlay, 2003, pp. 6-8). Hermeneutic reflexivity, also described by Finlay (2003, pp. 105-119), has some points in common with mindful reflexivity, such as considering the effects of researcher emotions. But her individualistic research approach lacks the continuity of peer debriefing and iterativity of critique, which is crucial to increasing the opportunities for learning on the part of the researcher. Stacey and Griffin (2005, p. 36) point out the difference of the DMan approach to reflexivity and that of Action Research, which they portray as also taking an individualistic perspective of reflexivity (Stacey and Griffin, 2005, p. 36).

In section four, Research Findings, I relate how I progressed in the use of a mindful reflexivity research strategy to enable and improve my learning as research. In comments on findings from Project Four I also point to how my research use of mindful reflexivity was changing how I conducted my professional practice.

The next section briefly outlines other core elements of the DMan Methodology and relates them to some of my research experiences.

3.2 Core methods

3.2a Week-long residential sessions

Compatible with the view that learning is the activity of interdependent people (Stacey, 2003b), several approaches to providing for interaction were core elements of the programme. Week-long residentials are attended by the complete cohort. These occurred five times in the first year and a half. There are extended opportunities to interact, both at the planned

sessions for the day and at meals and free time otherwise. Each day of the residential weeks began with large group sessions. We created small learning groups of about four, which have carried on throughout the DMan programme.

3.2b Large-group sessions

Each day at the residential sessions began with a large-group session, with all cohort members and faculty, and any guests, participating. The large-group sessions had a particular orientation to the present (see ‘Mindful reflexivity’, below), providing experience of how we are paying attention in the living present, how we are interacting with ourselves and each other in the moment. The conversation would always veer towards what sense we were making, or trying to make, of the overall programme and our related experiences. Or sometimes, someone said something the day before in the large group that we didn’t like!

The setting for the large group was always the same large room at the same time, the same hour and a half, with the 20-plus of us sitting in a circle. The meetings started at 10:30 and ended at noon. At the opening, until someone first spoke, people were typically looking up at some point on the ceiling, or down at some part of their shoes, with me usually scanning the room, curious to see how others were acting in those opening moments.

It is possible to learn from drawing interesting distinctions from micro-details of behaviour in such a setting. For example, where people choose to sit in a meeting can have meaning. I preferred to sit on the east side of the room, facing the west wall of glass and doors, and looking across the big, well-kept meadow sloping down and right to St. Leonard’s Woods. There were five small slender trees that I liked over towards the far right corner. This simple act of choice of chair offered me a repetitive and comforting embodied familiarity of time and place, and favoured view. I think it was probably an unconscious mitigation of my anxiety from uncertainty, albeit not so great an anxiety, about the pending silence and curious emotional swirls of talking in a large group. O’Flynn, a DMan alumnus, writes (following Stacey) that:

‘If anxiety is very great then efforts will be made to reproduce particular patterns of communication with as little variation as possible.’

(O’Flynn, 2005, p. 122)

The large group provided time and attention to basic dynamics of conversational patterns. For example, on one occasion the faculty members in the room engaged in a form of ‘verbal volleyball’, bouncing comments from one to the other, and back again, with the students becoming sideline listeners. A faculty member pointed out what was happening. It offered a lived experience of how dynamics of inclusion ~ exclusion can occur unconsciously in a group, and how that relates to power relations, and the self-organising of conversations, through the turn-taking, turn-making practices of the group involved.

We learned by engaging directly and reflexively as a large group. I found the large group interactions always interesting, sometimes upsetting, and sometimes routine. I have incorporated the method with modifications in workshops that I teach.

3.2c Small learning groups

Early in the programme at one of the residential sessions we formed voluntarily into small learning groups of typically four students, one primary and one secondary supervisor. This was an ongoing iterative form of, and in some way richer than, what is called ‘peer debriefing’ (Spall, 1998). We met three times per year, usually near the home area of one of the group, or a couple of times in conjunction with a residential meeting.

Meeting in person helped to build mutual understanding of each other and our work. Sometimes we learned from discussing theoretical propositions, like our talk about emergent intentions in one of the learning sets. Sometimes we learned from ‘taking seriously’ our own ordinary lived experience, like a small dispute we had once when meeting in a small mountain town near my home.

3.2d Reflective and iterative narrative projects

As we wrote our projects and the synopsis, we read and critiqued each other’s work. This complements the usual doctoral practice of faculty supervisors reading and commenting on the students’ work. We have had a primary supervisor, and secondary supervisor. Both supervisors read and advised on the iterations of our narratives. Having two or three colleagues to read our work over the course of the programme is a strong form of peer debriefing. I have called this particular DMan method ‘iterative peer debriefing’.

A basic element of method in the DMan programme is the use of narrative inquiry to write four narrative projects. My Projects 2-4 are written in a Realist–confessional hybrid genre, while Project One was a hybrid mix of impressionist and realist genres (Van Maanen, 1988; Bleakley, 2000). The first narrative was an autobiographical assessment of the current state of our thinking on our professional practice and views of complexity and management, and what our research inquiry would be. My next three narratives reflected on my participation in a number of healthcare improvement strategy workshops.

According to Siegel,

‘When we pause and reflect, attending to our intention, we are creating the foundation for internal attunement. When we pause and take the time to become open to another person’s intentional state, we are creating personal attunement.’

(Siegel, 2007, p. 178)

The interactive critiquing of each other’s projects increased my ability of intra-personal and inter-personal attunement, an aspect of mindfulness and presence to self and others.

I retrospectively selected experiences from my professional practice about which to write. These included two strategy review workshops (which were more about tactics than strategy), one strategy development workshop (which was more about validation of tactics), and one strategy-sharing seminar about the basic approach and some particular applications of a strengths-based healthcare intervention method.

I referred to notes I had made regarding the workshops, handout materials from the two strategy review workshops, and materials from the QI strategy development workshop and associated website of that association. I was already acquainted with the strengths-based method discussed in that strategy-sharing seminar.

These meetings were pertinent to my research inquiry about research promotion; they were accessible in the context of my fully engaged participation in them, and did not require expenditure of additional resources to generate them.

My notes, and other available materials, helped make it feasible to write about the meetings retrospectively. Choosing experiences retrospectively helped to avoid ‘Pygmalion effect’ on my participation; that is to say, I avoided some possible distortions from self-consciousness of my participation that may have arisen had I been consciously considering that participation as my research effort in addition to its direct purpose of engaging with others in QI efforts.

To safeguard the interests of others I anonymised my accounts, and avoided use of any conversations I considered to be more confidential in nature, although this sometimes limited my ability to fully describe a situation and the nature of interactions that were occurring. All the narrative experiences selected were relatively public, openly conducted sessions, to help avoid compromise of any confidences.

3.2e Iterativity

Iteration of narrative drafts was an important part of our research. It allocates resources of time and peer critique and debriefing, to increase mindful learning as a ‘process of drawing novel distinctions’ (Langer, 2000, p. 1) and to increase opportunities to generate changes in meaning (learning). Peer and supervisor debriefing helped to make the most of those opportunities to notice differences and possibly amplify them. This creates an intensification of normal everyday processes with repetitive characteristics – for example, revisiting multiple times in the course of a friendship, a familiar topic of conversation with a friend, and learning from changes over time in the discussion of the topic. The DMan differs in that we are allocating substantial time to write and think through our narrative drafts with the continued interaction with learning set colleagues, an intensified version of the technique of peer debriefing (Finlay, 2003). The DMan schedule creates a compressed occurrence of those opportunities to generate, notice and amplify changes in meaning.

The next section reviews methods and elements from other theoretical perspectives that I used to complement the DMan methodology.

3.2f Complementary Methods

Narrative understanding has a central role in a theory of emergent learning, and several approaches to organizational narrative analysis and discourse analysis from the field of communications theory were helpful in my research for understanding QI discourse in particular narratives. The narrative analytics of Vaara (2002) for organizational

success/failure narratives, and the performance narrative analytics of Corvellec (1997), provided key insights into the preferential construction of organizational narratives. Various works on categorization and attribution were also helpful (Georgensen and Solana, 1999).

The work of Eisenberg (1984, 2007) on purposeful ambiguity in communication was of essential help. The work of Babrow (2001) on ‘problematic integration of ambiguity and uncertainty’ also added to my research.

Table 1. Methods and theories complementary to the DMan methodology and my research inquiry.

Topic/Theory	Qualities involved	Topic treatment	Citation
Problematic Integration/ Communications Theory	discourse/ narrative: Ambiguity, uncertainty (as creation/sharing, experience)	How people seek to recursively resolve ambiguity and uncertainty	Babrow 2001
Strategic Ambiguity/ Communications Theory	Discourse/Narrative: Ambiguity of meaning in strategic communications	The purposeful use of ambiguity in communication	Eisenberg 1984, 2007
Strategic Performance /Performance Management	Discourse/Narrative: Strategic Narrative Ambiguity Uncertainty of Outcomes	Management Reform tries to reduce goal ambiguity increase outcome certainty	Chun and Rainey 2005 a, b.
Preferential Construction/ Attribution Theory	Discourse/Narrative: Characterization/Voicing:	Shows narrator preferences bias narrative construction	Georgensen and Solana 1999
Hegemonic Construction/ Organisational Narrative Studies	Discourse/ Narrative: Characterization, Voicing Social Coordination: Power relations	Analyses presence and expression of power relations in narrative	Boje 1999
Accounting for Success/Failure in organisations /Organisational Narrative Studies, Attribution Theory)	Social Coordination: Power relations Qualities of Self ~ Identity Formation of identities Discourse/Narrative: Plot, Characterization	Describes how organisational narratives account for success or failure	Varra 2002
Performance Narrative/ Narrative Studies	Discourse/Narrative Providing for a general accounting of performance to others	How employees seek to justify/ account for performance	Corvellec 1997 Czarniawska 2004
Strategy Workshops/ Strategy as Practice	Social Coordination: Suspension of power relations, hierarchy Discourse/Narrative Reduced politeness levels	Asserts qualities can be suspended in workshops	Schwarz 2004 Jarzabkowski 2005
Mindful Learning, Mindfulness	Qualities of Mindfulness: Awareness, attention, context, attunement, open to perspectives	Cultivating attention and awareness for learning	Langer 1997 Siegel 2007 Bishop 2004

3.3 Generalizability

Here, I briefly outline two ways in which my research findings can be considered as generalizable to other comparable research inquiries or quality improvement settings in the healthcare sector.

1. I have conducted research into the effects of the qualities of human interaction on the promotion and utilization of research in healthcare. My research looks into aspects of human interaction that are already generalized in nature. By contrast, the dominant tendency of QI research and initiatives is to concentrate on either individuals or the group/organisation level with often particular and autonomous attributes such as job role, years of education, or size of organization, etc. (Estabrooks, 2003). This can result in less generalizable results due to the localised or specific nature of the research parameters or specialised units of analysis.

An example of generalization of my research is its influence on my design and delivery of a Patient Adherence workshop, at the Fall Family Medicine Review Week, Continuing Medical Education Department, University of Colorado Denver and Health Sciences Center, in November 2006. I used qualities of interaction and narrative understanding to illustrate patient adherence to therapy in a new way from that of standard continuing medical education approaches.

2. To indicate how my findings can be generalised, I used narrative analysis methods to illustrate how acute stroke care measures seem to be preferentially constructed (Projects 3 and 4). I have used discourse analysis in Project Four to indicate how public performance reporting systems, such as that of New York State in the USA for certain cardiac surgeries, can be constructed in preferential and conversation and learning-blocking manners. Public performance reporting through such 'score cards' is a significant topic within QI discussions in many countries.

The next section discusses the research findings from my projects and how the research methods I used affected achieving those findings.

4. Research findings: themes, insights, movement of thoughts

‘The unapparent connection is more powerful than the apparent one.’

Heraclitus, fragment 54

4.1 Project One: mindful reflexivity and being present to self ~ other

In writing my first Project, a key research insight emerged from a common question among my learning group colleagues and supervisors: where was I in the narrative? I had written about how my thinking regarding complexity and organisations had come to be as it currently was. But I had done so in an anonymous, third-person observer/narrator manner, rather than from a fully engaged, interactive first-person perspective. The DMan research method that helped me to be aware of this was the iterative peer and supervisor debriefing, which raised the question of the degree of my presence in the narrative. This question of my presence as a character in my own narrative helped me in succeeding projects and other experiences to take my experience more seriously, in a mindfully reflexive way, by being:

- present to self ~ others,
- focused on the (living) present,
- sensitive to context.

The following quote by Stern points to the foundational importance of this shift in the quality of interaction/mind of awareness of self ~ other or the intensity of that quality:

‘Even though the nature of the self may forever elude the behavioral sciences, the sense of self stands as an important subjective reality, a reliable, evident phenomenon that the sciences cannot dismiss. How we experience ourselves in relation to others provides a basic organizing perspective for all interpersonal events.’

(Stern, 1985, p. 6)

I was blocking possible learning by missing, at least in intensity, that foundational sense of self and all the awareness it provides of other qualities of interaction. To be aware of the self is to be more aware of the other, or society, because these are all aspects of the same

interdependent processes of relating. This change in awareness and attention changed my ability to make sense of my experience and generate new meanings in Project Two.

One example is that since my self ~ other awareness had changed I could, as can be seen in Project Two, develop more 'rounded' characterizations of myself and others. This meant perceiving and then changing characterizations of myself and others as a quality of narrative understanding. Rounder characterizations describe characters who can 'surprise you' (Forster, [1927] 1954, p. 104) with distinctive, uncertain interactions, or different perspectives, thus adding insights to qualities of social coordination such as dynamics of inclusion ~ exclusion.

Project One also led me to reconsider how I had taught the first workshop I delivered with a colleague about the organizational concept of 'communities of practice' (Wenger, 1998). I was promoting the utilisation in organizations of Wenger's research about the importance to formation of community and identity by the sharing of content and practice among persons mutually engaged in the pursuit of some common or similar purposes (Wenger, 1998, Introduction). Along with Wenger's framework, I had combined some propositions about how qualities and capacities of interaction influence the spread of best practice (Szulanski, 1996, 2003). But in my consulting and educational approach I was not sensitive to the context of the participants in our workshop. They were marketing employees from various cities across Europe, representing geographically drawn divisions of our client company. These persons were already in communities of practice, by Wenger's definition of, and were influenced by qualities of interaction and relationships with the persons with whom they usually worked. At the time, I did not give much attention in my professional practice to such qualities of personal interaction as emotions and feelings (aside from trust), or power relating, or concerns about inclusion ~ exclusion dynamics.

In reflecting upon my interactions in the workshop, my research strategy helped me to make sense of my past experiences in a different way, by being able to:

- be context-sensitive – the client employees already participated in local patterns of interaction that could be considered 'communities of practice';

- draw novel distinctions – my colleague and I were suggesting a possible change to organizational practices as a meaningful and valuable change, without considering the narrative understanding and the derivative qualities of meaning and value that our clients gave to existing organisational patterns of practice;
- be more present to self ~ other – my colleague and I had taught the workshop while paying more attention to teaching the organisational concept, from Wenger’s research, than to what might be the concerns and constraints our client students. We taught without considering, among other qualities of interaction, existing enabling/constraining power relations the workshop participants encountered with colleagues.

As pointed out in the methodology section, these are particular qualities of interaction considered as mindfulness that the reflexive DMan research strategy promotes and intensifies. These qualities of taking our experience seriously in turn help us to organise and account for our experience in narrative ways that help us relate and make sense of the nature and qualities of interactions in our experiences with self and others (Stacey, 2005, p. 23).

The DMan method of beginning my research with a retrospective narrative generated learning, or changes of meaning, with the first project. The research insights of Project One, especially the possibility to be more intensely aware of self ~ other, provided an important contribution to generating the findings of Project Two, described in the next section.

4.2 Project Two: mindful reflexivity and understanding emotions and interactions

‘Without the Other there is no I. Without the I there is no one to perceive.’

Chuang Tsu, 3rd century BCE

In Project Two I described a QI strategy workshop in which I participated and its purpose as follows:

‘We are gathering in a large meeting room of a small, but significant, government agency that supports and funds health research on particular topics. The agency also promotes the translation of that health research into practice and into more widespread use across the country. Eleven persons invited to the workshop as knowledge transfer

experts are here today to advise and consult as independent voices on four projects sponsored, awarded and financed by the agency.’

(Project Two, p. 80)

Some key insights from that experience are described, along with how the DMan research methodology helped me generate those findings. Supporting examples are provided of how research progress, as learning, was being affected by qualities of interaction.

With the help from colleagues’ critique of Project One, I was learning to be more mindfully reflexive in my research, as well as in my ongoing daily experience. An important influence on learning from Project Two was developing a rounder sense of presence to self ~ other. This quality in turn helped me be attentive to other qualities of interaction, such as accepting or marginalizing the potential contributions of QI clients (who were not at the workshop) or of various agency and consulting employees who sat quietly, as expected, along the back rows of seating arrangements in the workshop. Iterative reminders from my secondary supervisor to consider how people were making sense of the workshop helped me remain attentive to how people had been interacting in the present moments of that workshop and with what qualities of interaction.

The workshop sponsors and I were both trying to make sense of the intertwined qualities of ambiguity of meanings and uncertainty of interactions inherent in experience. Babrow (2001) developed the phrase and concept of ‘problematic integration’ to describe this fundamental sense-making challenge and how human efforts seek its resolution. The agency personnel faced challenges of ambiguity and uncertainty in designing their projects; how should they design and conduct the projects, and what would be the meaning and value of them? In my case, I faced ambiguity and uncertainty about my participation in the workshop. My anxieties and concerns were about how I would participate and be regarded in the workshop, and what meaning and value might emerge from participation.

Feelings of ambiguity and uncertainty about meaning and interaction generate anxieties of change of the self, the unknown, and power relations. These anxieties affect other qualities of interaction, and thereby our patterns of conversation. My anxiety about my own participation and degree of acceptance by others in the workshop had shifted the dynamic balance of my attention and awareness towards self in the self ~ other relational pair of qualities. Ironically,

that anxiety about self was causing me to miss out on indicators of acceptance by others in the workshop! Another expert reviewer, Dr Thomas, brought this to my attention:

‘Your words are having an impact. I watch the room when I am at events like this, and a number of people are agreeing with you or being affected by your words. You can see it when they repeat words they hear along with your name.’

(Project Two, p. 92)

Dr Thomas was interacting with a stronger degree of self ~ other awareness than I was, and thus was better able to draw distinctions about how my comments were affecting the interactions of others. My self-absorption had limited the opportunity for me to perceive an important change of meaning in the situation: people were paying attention and responding to my participation in a mostly accepting manner. It could be said that Dr Thomas utilised a mindful reflexivity learning strategy in his workshop participation, which let him increase opportunities for learning by increased awareness and attention for qualities of interaction.

I similarly missed out on paying attention to the comments of two persons I knew at the workshop in two other instances, because at the time they were speaking I was using my attention span to consider either how I had just participated in the workshop, or what to do next. This was also incited by the extent of my anxiety-enhanced quality of self-absorption.

My reflexive learning efforts emerged in the workshop with the help of that other participant, Dr Thomas, in changing some qualities of my interaction with other participants, notably self ~ other awareness. Other learning emerged through interdependent research efforts with my two learning group colleagues as I reflected upon experiences through narrative inquiry. My colleagues and our two supervisors helped me to make sense of my experience from what can seem at times to be unending multiples of multiple drafts of iterative narrative writings. Our interactions about our respective research generated changes of meaning or learning through: considering different perspectives; increasing sensitivity to different contexts; and leveraging differing abilities to draw distinctions about experiences.

There is an important distinction to note here between an emergent learning perspective and the way I experienced research promotion efforts in the strategy workshop, including my own participation as promoting alternative research findings. In the DMan research methodology,

a mindful reflexivity research strategy is combined by DMan researchers with the propositions of complexity to generate multiple changes of meaning through core and supplemental research methods. DMan researchers interact with other students and supervisors to learn which of those changes of meaning are: most congruent with theory or extensive of it; relevant in constitutive way to the inquiry of the researcher(s); most constitutive and relevant to the narrative; and resonant with the researchers' socially co-created values and motivational direction.

In contrast, my experience and findings indicate that the QI promoters in the strategy workshop in Project Two were intent upon promoting a particular, predefined set of meanings that were to be adopted as changes (i.e., to be learned) by the QI clients. The interactions of the QI promoters among themselves and with others seemed to consciously and/or unconsciously seek to limit opportunities for learning by fixing the meaning and value of the projects and minimizing the nature and qualities of interaction about the projects' meanings and value. These efforts had the effect of seeking to minimise variance from the QI promoters' desired and preferential narrative accounting of promoted changes.

One example of this is what the overall director of the projects had to say at the start of the workshop:

'We don't want a rubber stamp on these projects, but we also don't want to throw them out completely either.'

(Project Two, p. 84)

I noted about her comment:

'...she did not want the discussion to go in certain directions by suggesting the projects be thrown out or by discussing if these were even the right four topics to pursue.'

(Project Two, p. 84)

A corollary to wanting to fix the meaning of the projects was the thin descriptions of QI clients in the project narratives, of which (prospective or already recruited) none was invited

to the strategy workshop. Thin characters lack the ability to surprise in narratives (Forster, [1927] 1954, p. 104), and absent, uninvited project clients cannot make contradictory comments in strategy workshops.

I interpret these conscious or unconscious efforts to manage interactions in the workshop and in the project design narratives as being related to what Stacey – and similarly, O’Flynn (2001, p. 122) – write:

‘If the ensuing anxiety [of change] cannot be borne, then great efforts will be undertaken to reproduce particular patterns of communicative interaction with as little variation as possible.’

(Stacey, 2001, p. 158)

Marginalising QI clients in project narratives and other workshop discourse helped keep the meaning and value of the projects unchallenged and fixed. This helped to maintain desired dynamics and balances of power relating and associated consequences, such as attribution of credit for success or liability for failure.

These are examples from my findings of how anxiety contributes to patterns of conversation that become self-referential and ‘stuck’, while associated narratives seek to portray fixity of meaning, value and to predetermine attributions of credit or liability through self advantageous hegemonic construction and the plot-line patterning of intentions.

The anxiety of the QI promoters increased the quality of attached involvement to a particular narrative ~ pattern of participation and the calming feeling of certainty created by designing and conducting easy-to-do information-based QI interventions. Promoter anxieties about the uncertainties of change and power relations were mitigated with biased and preferential worldview accountings.

The next section describes the important insights gained in Project Three about the longitudinal dynamics of qualities of interaction; the importance of being open to multiple perspectives; and how QI efforts can actually block learning.

4.3 Project Three: reflexive emotionality and understanding perspectives

For my third project, I described my experiences with two QI strategy workshops. The first of the two workshops was described as a Quality Improvement Strategy Roundtable. The setting for that workshop I described as follows:

‘The room is filling. Outside it is a splendid blue autumn day. But this is a windowless room, with no views or natural light. I have never been in this room before, but I recognize a familiar pattern. It is a pattern similar to that of a strategy workshop in which I participated in the spring, when I attended my first experts’ gathering. As in the spring workshop, the conference tables with their chairs and the seats along the walls are arranged like two nested squares set within a square room. There are no assigned seats as such, but the invited experts seem to know that their place is at the tables, and not on the chairs by the wall... In the meeting I notice the people in the chairs aren’t introduced and don’t speak in the discussions.’

(Project Three, pp. 113-114)

A large number, about 40, of various notable or energetic participants in the QI discourse of the country were present as invited subject-matter experts.

4.3a Limiting conversation to hold meaning unchallenged

My experience of the QI strategy roundtable I describe in Project Three felt very frustrating, almost to the point of anger. I had understood that the discussion would be about current best approaches to QI, with significant persons in the field participating. However, as the meeting progressed it seemed clear that the facilitators were intent on discussing QI only in terms of how to use publicly reported price measures to encourage lower costs through increased competitive pressures. They were in that sense trying to maintain a particular meaning and value of cost-cutting for the demonstration projects they were designing. This is congruent with the formative teleology proposition of QI theory. This is a theme of meaning as being created separately and held unchallenged, which emerged for me across my experiences in several QI strategy workshops.

Participants could of course still try to challenge this univocal view of meaning of quality, and some – including myself – did try in the workshop. But any questions or comments along lines contrary to the hosts’ narrow interest in costs were limited by their efforts to ignore such

challenges and keep the conversation 'on track'. They had designed and tried to facilitate the meeting in a question-and-answer, directed-interview sort of focus group style, rather than as a genuine 'round table' as that term would generally be understood.

From the standpoint of emergent learning and mindful reflexivity, the facilitators were blocking learning in several ways. First, by seeking to limit conversation to healthcare costs and price transparency, the facilitators were not being open to other perspectives. Second, by fixating on costs and not responding to or asking questions about other aspects of quality (safety, patient-centred, timely, effectiveness, equitableness; IOM, 2001, p. 6) they were not acknowledging or seeking any benefit from the long-standing and significant contributions to a more rounded approach to QI made by the notable persons in the room. This is a way of not being present to others, and not being willing to be changed in interactions with them. Third, by not responding to comments from participants that regarded aspects of quality other than costs, the facilitators were discouraging and not being open to novelty or emerging themes in the conversation. The efforts of the facilitators to direct the conversation were hindering conversations that could have promoted learning.

4.3b Paying attention to the perspective and emotions of others

An important insight into the longitudinal dynamics of qualities of interaction was gained with the help of one of my learning group colleagues on drafts of Project Three.

In critiquing a draft of my project, she remarked on how intense, almost angry, my reaction seemed to participating in a QI strategy round table discussion and the way it had been facilitated. She noted that I did not seem to show much regard for the perspective or emotions of the round table facilitators, nor why they might have acted as they did. My emotionality in response to disappointment and frustration with the narrow interests of the meeting led to highly attached involvement to my particular perspective or narrative of how the meeting could be most productive.

Her question struck me, and caused me to reflect differently about my experience.

Being present to her and her comments meant that I was willing to reconsider my project and try to understand my experience differently. By shifting my thought to consider the perspective of the facilitators, and trying to understand their perspective with empathy or compassion, changed the meaning of the workshop experience for me.

I thought about how the facilitators were employees in a particular organizational context of patterns of participation, characterised by power relations and other dynamic qualities of interaction that would constrain and enable their interactions with others. I considered how anxiety about helping to meet the goals of the association clients would fix the facilitators' attention on what tactics (cost measures) could best help them with their strategic goals (cutting costs for their political clients).

This is an example of the DMan 'mindful reflexivity' research strategy, supporting learning by the researcher. My interaction with my colleague helped me to: be open to other perspectives, moderate my emotionality with detached involvement, and generate changes of meaning as research findings.

4.3c The longitudinal dynamics of qualities of interaction

As a possible contribution to the research field of strategy as practice, I contrasted my experiences in the QI strategy roundtable with strategy workshop literature. This helped me pay attention to the longitudinal aspects of the dynamics of qualities of interaction. Some organizational researchers (Schwarz, 2004; Seidel and Henry, 2003) suggest that strategy workshops, such as off-site strategy planning episodes, can be liminal spaces and times where regular organizational routines and qualities of interaction such as power relations are suspended.

My reflections about my workshop experience contradicted this idea of liminal workshop space and time. As I wrote in Project Three, I began to understand that there were '...relationship histories, preferences, values, beliefs, power issues that we all brought with us to the meeting...our interactions were influenced by that...' (Project Three, p. 113).

Stacey and Griffin describe how interactive processes carry on across time:

'Processes of social and self-formation are path-dependent – they have a history, and this history is both repeated and potentially transformed in each present.'

(Stacey and Griffin, 2005, p. 16)

The workshop I attended was not a liminal space of suspended qualities of interaction, but the usual hurly-burly mix in the living present of past–present–future interpersonal dynamics.

4.3d How Project Three helped with Project Four

The experience of writing Project Three, along with my gains of awareness from Projects One and Two, motivated me to try to direct my professional practice efforts to be more attentive to and mindful of the emotions and perspectives of other participants in the next QI strategy workshop I attended. This turned out to be a follow-on workshop to the one about knowledge transfer projects described in Project Two. My progressively stronger use of mindful reflexivity in Projects One to Three helped me generate some important findings in Project Four. Several of those findings are briefly described next.

4.4 Project Four: reflexive emotionality and understanding perspectives and narratives of the other

In Project Four I analysed my experiences during a strategy review workshop that followed on from the Knowledge Transfer Strategy Review workshop I described in Project Two. At the first workshop, which had occurred a year before, several projects promoting particular QI research and best practice findings were critiqued by invited experts, including me, as to concept and design. These QI projects had now been underway for about a year. The QI promoters convened this second workshop to discuss the progress of the projects and what changes in their conduct might warrant consideration.

The meeting format had been changed somewhat. I described it as follows:

‘The workshop began in the same room as last year, but with some changes. Seating arrangements were different, with clusters of chairs and tables arranged in the middle of the room. I recognised some persons from the last workshop, some I didn’t. Some of the same expert advisors were present again. Two advisors were new to the workshops. We began with less formal introductions than the previous year, by conducting a group narrative exercise.’

(Project Three, pp. 147-148)

This time, rather than all of the invited reviewers speaking about the same project being reviewed, there were one or two reviewers assigned per project. This provided slightly more time for reviewer comments, about ten minutes extra per project critiqued.

My ability to do research using the mindful reflexivity strategy had increased through the year and a half of interactive efforts of creating the first three projects. Project Three had had a strong influence in my reflections upon how I had not, in my participation, been very heedful of the probable perspective of the facilitators. This generated a feeling of determination to be more present to self ~ other, by considering the feelings, emotions and perspectives of the consultants and agency personnel conducting the RP projects. I wanted to be more certain that the next consulting contribution I sought to make would be pragmatically useful and relevant to the quality improvers of my next consulting effort. This turned out to be the QI workshop reflected on in Project Four. My concerns about how the meaning and value of my participation might be interpreted, and a desire to interact so as to create a greater certainty of favourable evaluation by my clients, affected my workshop participation in ways similar to the way I consider that concerns and anxieties may have affected the QI promoters.

4.4a Blocking or promoting learning

My detachment ~ involvement dynamic in the effort to be more compassionate and understanding may have led me to miss drawing the distinctions about the project and its basic design as noted by my co-reviewer, Alasdair. In concentrating on my desired way of trying to participate, I had overlooked what Alasdair noted about the ambiguity of the goals of the project report being discussed. The DMan research methodology helped me consider my participation retrospectively in a more detached, reflexive, emotionally responsive manner. I also became more present, through reflection, to what Alasdair had pointed out about the projects, and more open to the experienced perspective his views represented. Writing iterative drafts and the comments of my learning set colleagues helped me shift my thinking in that way.

Alasdair made a particular point that he had discerned a lack of clarity in the project progress report about its goals. His comment provided me several important insights. Alasdair had asked of the QI team:

‘In reading this summary, I am really wondering, what’s the point of this project?... It’s not clear what your objectives... your goals are here. Is it to help these people learn to make more informed decisions? Or to get them to do something different?’

There was not really a response to his questions, and the QI team seemed somewhat unaware of this ambiguity in their own document and efforts. This indicates to me that the presence of ambiguity was an example of an unconscious, yet purposeful, defensive mechanism in response to the demands of QI evaluators for clarity of agency goals and certainty of programme performance. Stacey points out about anxiety and learning that:

‘It becomes important then to pay particular attention to how people respond to anxiety because defensive ways of dealing with anxiety inevitably close down learning processes.’

(Stacey, 2003b, p. 9)

4.4b The purposeful role of the narrative quality of ambiguity

Paying attention to the theme of ambiguity that emerged from Alasdair’s comments and my recollection of a similar comment about one of the other projects someone made in the first workshop led me to investigate the role for ambiguity in discourse. This led me to the work of Eisenberg (1984, 2007) in communication and Levine (1985) on culture. I also made use of the work of Georgensen and Solano (1999) on how emotions affect narrative constructions. Various anxieties of the QI promoters about change were inducing discursive measures that were intended, consciously or unconsciously, to maintain an ability to portray their efforts as QI success narratives. This was an important shift in my thinking about the qualities of interaction and the promotion of preferred perspectives, narratives and patterns of participation.

In Projects One, Two and Three I had made progress in paying attention to the effects of qualities on interaction on patterns of conversational interaction. From the Project Four research, movement of thought occurred for me as I learned about how the qualities of interaction, such as anxiety, shape the construction and sharing of discourse as narratives.

4.4c Dual plots and organizational success narratives

The ambiguity of plot and its dual patterning of intentions, as noted by reviewers in both the first and second KT workshops, provided ahead of time for the construction of a final evaluation report at some future point which could be a success narrative (Vaara, 2002). Reasoning from the work of Eisenberg (1984, 2007) on the purposeful presence of ambiguity in communication, this project goal, ‘ambiguity’, provided for the plausible affirmation ~

denial of the alternative narrative forms of QI promoter intentions. The QI promoters could either claim that their intentions had been to persuade QI clients to adopt new practice (if they did so), or that their intentions were to provide information for better decision-making by QI clients (in case they did not adopt the new practice). Success could be plausibly claimed, regardless of whether the QI clients adopted the promoted scorecard practice or not.

The creation of such self-preferential accountings understandably serves to try to mitigate the anxieties of the authors, and to assert their preferred view of how healthcare should be conducted. But it blocks qualities of interaction important to learning, such as being open to the perspective of others (e.g. what the QI clients thought about the projects) and noting the possible emergence of contrary themes by open consideration of challenges to the meaning and value of the projects.

4.5 Findings summary

In the Research Findings section, I have shown how the acuity, depth and breadth of my understanding of qualities of interaction changed across the course of my research projects and how the DMan methodology was essential to that change. Project One helped me take the essential step of increasing my awareness of self ~ other. In Project Two, I built upon this cornerstone quality of awareness by paying attention to my interactions with others. I could be aware of the influence of my emotions on how I was interacting in the workshop to promote my own favoured evidence about QI methods and their degree of effectiveness, while others promoted their favoured approaches. Project Three helped me to improve my perception of feelings and emotions by reflexive emotionality, as well as to understand their effect on perspectives and patterns of participation. Project Four built upon emotional reflexivity and my enhanced attention to perspective, to enable a thorough inquiry into the effects of qualities of interaction for the partial and preferential construction of narratives that are understood and promoted from a particular perspective.

I have used these insights into my experience to illustrate the various ways that qualities of interactions were shaping and being shaped by the interactions of QI promoters as they sought to have their particular research promotion efforts prevail. Opportunities for learning were restricted by the efforts of the QI promoters, both conscious and unconscious, to try to fix the

certainty of meaning of their research promotion projects, while minimising the uncertainties of interactions and their outcomes.

The next section describes the managerial and social implications of my research findings and their relevance for the promotion and use of research evidence in healthcare.

5. Managerial and social policy implications

In this section, I consider some managerial and social implications of the effects of the qualities of personal interaction on efforts to design, conduct and implement QI initiatives. The areas of concern include: setting and pursuing goals for healthcare improvement; effective and efficient use of QI resources; implications for healthcare policy; and possibilities for learning about changing the qualities of QI discourse.

5.1 Setting and pursuing goals for healthcare improvement

My research findings indicate that qualities of interpersonal interaction, such as anxiety about evaluations of QI projects and their promoters, hindered or blocked opportunities for learning about those projects. The learning-related qualities of drawing distinctions and noticing emergent themes in experience were shown as being hindered or blocked in Projects Three and Four by efforts to hold meaning, and the value of some QI efforts went unchallenged. The QI project plans discussed in Project Two and project progress reports of Project Four clouded present and future evaluation conversations with project discourse ambiguity about QI promoter intentions with regard to goals and objectives. This narrative quality of ambiguity in those project plans and progress reports provided readily for whatever future construction might be desired of self-similar success performance narratives, regardless of the nature and extent of substantive effects. This understandable discursive defence mechanism, however, makes it more difficult to determine whether significant or strategic QI goals are being met, or whether resources have utilised with efficacy in pursuing those goals, when the success of QI projects is discursively embedded at their beginnings, during their progress, and potentially justified upon their completion, regardless of outcomes as others might interpret them.

5.2 Allocating and effectively and efficiently using resources

As an example, my research findings point to how partial and preferential spinning of QI projects can occur by a singular fixation on particular QI measures as selected by QI promoters. In Project Three, some QI project designers were very interested in hearing about recommended sets of publicly reported price measures to use in their proposed QI projects. The conversation they wanted to generate and guide concerned which price measures are most helpful in reducing costs. The question not asked or discussed was: How might such a

singular fixation of resources on publishing prices to reduce costs negatively affect the other interdependent aspects of quality care? To learn whether resources are being used in an efficacious manner in the interdependencies of healthcare services requires mindful awareness and sensitivity to context, as indicated by a complexity perspective of learning as emergent.

5.3 Implications for healthcare policy

Often in QI efforts, various interested parties agree between and among themselves the design and use of QI measures. The reporting of these measures as objective and accurate depictions of the quality of health services is often intended to inform policymakers in the social sector, and the public in general, as to the state of affairs of various healthcare issues. I argue that a complexity perspective of learning as emergent, as particularized by my research findings, indicates that QI measures can be understood as emergent aspects of self-organizing interactions. This asserts that the qualities of those interdependent interactions, such as QI promoters' anxiety over performance evaluation, can dissipate or divert QI measurement development efforts, just as the concerns and anxieties of QI clients are asserted to game QI measures or to capture QI efforts.

An example of this is the generalization of my research findings to analyse acute stroke care performance measures. That analysis in Projects Three and Four indicates that attention and resources are used in conversations in the US and UK health sectors, which are, respectively, meagrely developed and clearly deflected from discussions that could generate learning about the utilisation rate of the medicine tPA for the reversal of ischaemic stroke. This blocks learning about the general rate of utilization of tPA in either country for acute stroke care and its clinical research-supported ability to reduce mortality and disability.

Such a partial and preferential approach to the emergent co-creation of a set of quality improvement measures can block the learning of healthcare policymakers and the public by limiting the ability to detect differences in care or emergent themes of slow adoption of innovative medicines such as tPA. Inadequate measures of healthcare services can block awareness of and sensitivity to the broader context of particular healthcare services such as acute stroke care. These are foundational aspects of the emergence of learning.

5.4 Learning about changing the qualities of quality improvement

Another implication of my research findings is that while attention is usually concentrated on the response of QI clients to QI efforts, with the clients often characterised as seeking to block improvement, the efforts of QI promoters can also be analysed usefully as to how they may also block or hinder QI efforts.

I argue that interpersonal contests over the power-relating effects of common social coordination dynamics can generate preferentially biased and distorted QI efforts that are ineffectual or irrelevant for the patients, practitioners, and others whom the QI efforts are ostensibly and ultimately supposed to assist. These contests of preferred accountings spin QI efforts away from the substantive changes stated by QI goals and objectives. A mindfully reflexive research, or learning, strategy of inquiry could help persons involved in healthcare sector QI efforts to learn how the qualities and micro-details of their local patterns of experience are the sources and determinants of the emergence of global patterns of QI discourse. This would serve as a foundational step for seeking to shape and improve the qualities of quality improvement efforts and methods.

6. Changes to professional practice

6.1 Improved accounting for human interaction in my consulting

My research findings have provided me with an expanded understanding of qualities of interaction and how they affect quality improvement efforts. Quality improvement efforts, in their various forms in healthcare, are of vital relevance and my consulting now offers a unique perspective on probable sources of problematic results in those efforts and how interdependent learning could help address those issues.

6.2 Educational Methods

6.2a Graduate School of Business Course: In teaching a postgraduate business course on organisational effectiveness for the past three academic years at the University of Colorado Denver and Health Sciences Center, I use a mix of mindful reflexivity inquiry approach, conducted through reflective practice narratives with peer debriefing.

6.2b Continuing Medical Education: I developed and taught a CME (continuing medical education) course for the CME Department of the University Medical School, using a theory of emergent learning perspective to explain the importance of narrative understanding in patient adherence to therapy. I used a narrative-sharing, mindful reflexivity educational approach for teaching the workshops.

6.2c Secondary Education: As a volunteer parent, I taught during two academic school years the basics of a mindful reflexivity approach using reflective narrative practice to interested parents and over 200 students. The students are enrolled in a particular secondary education (years 9–12 of schooling) curriculum called the International Baccalaureate Program. The students use reflective practice and qualities of interaction analysis to intensify their learning and understanding by ‘taking seriously’ the social services experiences in which they engage. This is now a self-sustaining innovation at this particular school, and is probably unique, I believe, across the 200-plus schools in USA that take part in the International Baccalaureate Program.

7. Some limits of the theory and my research

The theory of complex responsive processes of relating and its particularisation as a theory of emergent learning shares some limitations in common with all theories, as well as some limits that are particular to new theories.

7.1 Some inherent limits of any theory

Theorizing is how researchers account to others for what they have been doing or what they think others are doing. They do so in the way of all human theorists: by using partial narratives, of preferential construction, told from a particular perspective. They combine these narratives with abstract systemic frameworks, which are also always partial in some manner. The limits of theories in general can be looked for in what is not talked about and by examining with what other theories, or theorists, they do not connect or have dialectical conversations. Theories find their validation and much of their extension through interaction with other theories, just as narratives find their validation in the context of other narratives.

The partiality or preferential construction aspect of the complexity perspective is that at present it pays attention primarily to negative, or withdrawal, emotions, as my research also did in applying the theory. This leaves a gap in the complexity literature to fill with investigations of positive emotions from a complexity perspective. Theoretical connections could be initiated, for example, with the rapidly growing recent branch of psychology called 'positive psychology', initially developed by Martin Seligman (2002).

7.2 Particular limits of this new theory

Further development of particular elements of the theory is possible, for example with regard to how interaction occurs. The complexity perspective indicates that human interaction as conversational patterns is inherently self-organising, self-patterning, where emergence depends on the micro diversity of the qualities of human interaction and the human ability to make choices. There is more to be analysed and explained regarding how emergence in human interaction occurs as affected by qualities of interaction and narrative understandings.

There could be more interaction with the work on various patterns of attachment response that have been the primary branch of research generated by the landmark works of Bowlby on attachment and separation (Rholes, 2004). How do those patterns of response to formative

childhood attachment ~ separation experiences combine with complexity propositions to provide additional analytics of workplace behaviours?

My research incorporates the limitations described above, as well as having others. For reasons of time, resource and length available in this thesis, I have not connected my research inquiry to other particular research areas of organisational studies, such as the organisational change literature, or emotions in organisations literature.

7.3 Limits to my research: some qualities of interaction not investigated

I have indicated that qualities of interaction shape changes of learning and behaviour, but have not considered how that relates to our qualities of interactions with environments. Not have I inquired into the nature of qualities of patterns of interaction (e.g. stability ~ instability, free-flowing ~ stuck conversations) and how those qualities emerge from local interaction. But for the purposes of my inquiry into promoting the use of research evidence, the three categories of qualities of interaction I did primarily investigate – interpersonal interaction, emotions ~ feelings, and narrative themes/narrative understandings – seemed to be the constitutive elements to consider for my research purposes.

Another limit to my investigations is that I have not had have time or space to consider in equal detail how concerns of self and identity, in addition to other qualities of interaction, were influencing both the promotion and the utilisation of research. My research pointed to a change in my awareness of myself, in the sense of being present in my narratives and to others in my experiences; but it did not venture deeper into the relevant literature on the self. I have described the understandable anxieties that research promoters experience over whether or not their research financing will be continued when their current RP projects conclude. Those same research promoters may also be concerned about their work, its meaning and value to them, and what that means to the emergence of their own sense of self. The same consideration, of course, applies to healthcare practitioners in their response to proposed changes.

8. Project One: Shadow and Light, Light and Stone

8.1 Reflections

Project One was written at the beginning of the DMan Programme as an autobiographical reflection on our current thinking about organizations and complexity, and what had helped to shape our ideas. In it, I wrote about my long-standing interest in the topic of complexity and the influence of the writings of Ralph Stacey and other Complexity and Management Centre faculty on my decision to enrol in the DMan programme. I analysed how I combined my early interest in the qualities of interaction, inspired by the work of Szulanski (1996, 2003), with the organizational concept and social theory of learning called Communities of Practice (Wenger, 1998).

But perhaps the most important thing about Project One is what I did not write and what my colleagues asked me about that. My learning-group colleagues and supervisors had noted how I had written in the narrative voice of a very detached, third-person observer. They asked ‘So where are *you* in the narrative, Jim?’

The question struck me with some force, and caused me to reconsider how I had written the account. Encouraged to reflect upon my sense of self ~ other created learning opportunities by generating changes of meaning about Project One and then Project Two, using a mindful reflexivity research strategy in several ways:

- Present to self ~ other
- Focused on the present in my narrative – what was I doing in those moments
- Changed my affective style towards more involvement, less detachment
- Open to multiple perspectives – of self and others
- Helped me to be open to novelty and distinction in my interactions with others.

Daniel Stern, who writes about the interpersonal nature of psychology and psychotherapy, emphasised the importance of a sense of self:

‘Even though the nature of self may forever elude the behavioral sciences, the sense of self stands as an important subjective reality, a reliable, evident

phenomenon that the sciences cannot dismiss. How we experience ourselves in relation to others provides a basic organizing perspective for all interpersonal events.’

(Stern, 1985, p. 6)

The change in the quality of presence to self ~ other improved my ability to have, and to be open to, that basic organizing perspective, to which Stern refers. This was an essential step forward in my research ability, both in the next project and in the remainder of my research, as will be seen.

8.2 Introduction

‘O body swayed to music, O brightening glance,
How can we know the dancer from the dance?’

William Butler Yeats

This is a story, a narrative, of a certain sort. It has some of the feel of the genre called training tales. This particular training tale is a journey – a story of my thinking and my practice over the past few years. It is a narrative that tells how my practice came to be what it is at present. The narrative will outline what my consulting, research and teaching practice is about, as well as shedding light on why I conduct my practice as my own firm, and why the sort of clients I seek have changed.

Central to my practice for the past six years has been the social theory of learning known as Communities of Practice, and associated ideas of how we make use of knowledge in organizations. The theory of complex responsive processes has been fundamental to my efforts to build a new practice capability over the past three years. Over the past few years, my awareness has increased of how the complexity sciences could be a source of analogies for understanding human behaviour and organizations. My thinking and understanding has evolved incrementally to include these new concepts related to complexity. As I stand today in contemplation of my practice, my attention turns to the question: Why, and how, do the qualities of interaction, understood as complex responsive processes, generate emergent patterns of work and associated outcomes?

This narrative is my invitation to the reader to share in the patterns of participation that have influenced me; the narratives of those patterns as I knew them, then and now; some of the themes that intertwine them; and the research questions I now consider.

8.3 One beginning

The journey begins in a small college, on an ancient island, in the middle of the Irish Sea. In May of that year, 2004, together with Patrick, a long-time friend and colleague, I taught a workshop at a new college on the Isle of Man. We called it ‘Mindful Leadership and the Improvisational Organization’. It was the lead workshop of a year-long executive education programme. Some six years ago, we had delivered a community of practice, Knowledge Management project together in Belgium, and had remained friends over the years, although our paths had diverged widely in the nature of our work and in our geographical location. Sometimes I visited Patrick and his family on my trips to England or Europe. Patrick was now teaching at a new college on the Isle of Man; he had called to ask if I would like to do a workshop together. Our interests were once again converging, and ‘yes’ was an easy answer.

At the workshop I ventured some of my latest thinking and research concerning what I call the ‘qualities and capacities of interaction’, with an emphasis on the qualities of interaction. Or, more poetically, ‘lights and stones’. Discovering these lights and stones has taken me many years of journeying and acute observation.

In creating my own consulting practice several years ago, what I sought, in part, was the independence to pursue my thinking and practice around communities of practice, and my interest in complexity. I wanted to increase my understanding of how the concept of communities of practice could be used in organizations, especially within the healthcare sector. I also sought to increase my understanding of the qualities of interaction between and among people, and how those qualities affected the generation, sharing, and application of knowledge and information. I aimed to establish a sound theoretical underpinning for the aspect of my communities-of-practice consulting that initially concerned these interactions. The qualities I have developed the most interest in are awareness, trust, relationship, inclusion ~ exclusion, power relating, intention and response. These represent key elements in the current state of my thinking and research about human interaction. My thinking here originates in readings on theories of knowledge and learning, communities of practice, complex responsive processes, and the particular topics of trust and intention. The emerging

interdisciplinary field of interpersonal neurobiology provides a usefully wide intellectual catchment in gathering together traditions of thought that help to map out the psychological and neurobiological basis for the qualities of human interaction that I am researching. The concept of ‘interpersonal neurobiology’ was formulated by Dr Daniel J. Siegel. In his key work on the topic, *The Developing Mind*, Dr Siegel writes that he is:

‘...proposing that the mind develops at the interface of neurophysiological processes and interpersonal relationships... Interpersonal experience thus plays a special organizing role in determining the development of brain structure early in life and the ongoing emergence of brain function throughout the lifespan.’

(Siegel, 1999, p. 21)

Theories and findings on attachment are especially relevant in Siegel’s thinking:

‘One fundamental finding relevant for developing this ‘interpersonal neurobiology’ of the mind comes from numerous studies across a wide variety of cultures: Attachment is based on collaborative communication.’

(Siegel, 1999, p. 21)

These aspects of psychology and the neurobiological basis of human interaction were gaps in the past practice of my consulting. They are at the centre of my current efforts to provide a more solid and comprehensive intellectual foundation for my practice as I seek to expand it into research and teaching.

While completing my work on developing my new consulting practice and research capabilities, the planned workshop with Patrick represented a good initial platform for sharing my new thinking in the context of informing management practice and developing an improvisational organisation. A simplified description of an improvisational organisation can be considered as people’s ability to act in mindful and harmonious participation with each other, and to act with confidence and skill as the organisation emerges through an uncertain future. A jazz band is a common metaphor to convey the concept of improvisation in organisations (Kamoche et al., 2002, chs. 1, 6).

The capacities of interaction that I see as important to consider along with qualities of interaction are: resources (of the economic kind in all its forms – including land, labour, capital, and material); time; space; and the ways we generate and handle information (generation, presentation, diffusion and management). Described simply, we use combinations of capacities of interaction to support and enable our interactions with other persons. For example we use certain resources, along with time and space, to create a meeting space in an organization. My thinking on these proposed capacities of interaction originated in my economics education and career experience and study of the use of information, particularly in organizations. Much of what can be said of the role for the capacities of interaction is describable in terms of the concepts and processes of economics.

8.4 The route to the Isle of Man

I first met Patrick eight years ago at a meeting of the company which we both worked for at the time, Euro-Consulting. We both were doing some work related to knowledge management. Upon meeting Patrick, I sensed that he would be both a good friend and a good work colleague. In my conversations with him, Patrick always is open to new ideas, consulting or teaching approaches, which has always been encouraging to me in our work together.

Two years after that first meeting, we did have the chance to work together. I was putting together a learning strategy for a client, and trying out some new learning of my own around communities of practice as a prime way to implement that strategy. The phrase ‘Communities of Practice’ is the unit of analysis for a social theory of learning. It has its origins in the work of several social science researchers, but is most closely associated with the work of Etienne Wenger. His major work on the topic *Communities of Practice: Learning, Meaning and Identity* merits the description of a classic work (Wenger, 1998). I read Etienne Wenger’s book in the year of its publication. It changed my way of thinking about people, organizations, and society.

The book also changed my career path and my future. The concept of communities of practice has been a core aspect of my practice, and I will outline briefly here how Wenger describes it.

He starts with four premises regarding learning:

‘1) We are social beings. Far from being trivially true, this fact is a central aspect of learning.

2) Knowledge is a matter of competence with respect to valued enterprises – such as singing in tune, discovering scientific facts, fixing machines, writing poetry, being convivial, growing up as a boy or girl, and so forth.

3) Knowing is a matter of participating in the pursuit of such enterprises, that is, of active engagement in the world.

4) Meaning – our ability to experience the world and our engagement with it as meaningful – is ultimately what learning is to produce.’

(Wenger, 1998, p. 4)

Wenger goes on to explain the ‘components necessary to characterise social participation as a process of social learning and of knowing’. Among these components, he includes:

‘1) Meaning: a way of talking about our (changing) ability – individually and collectively – to experience our life and the world as meaningful.

2) Practice: a way of talking about the shared historical and social resources, frameworks, and perspectives that can sustain mutual engagement in action.

3) Community: a way of talking about the social configurations in which our enterprises are defined as worth pursuing and our participation is recognizable as competence.

4) Identity: a way of talking about how learning changes who we are and creates personal histories of becoming in the context of our communities.’

(Wenger, 1998, p. 5)

In the fall and winter of 1998, I had the opportunity – along with Patrick, and persons from our client account – to try putting the concept of communities of practice into practice within an organization.

The opportunity had come about through a chance encounter in Boston with a past client of mine.

8.5 The roots of coincidence are nourished by patterns of our participation

A Boston blue sky day by the water at a three-star seafood restaurant: one star for the crab sandwiches, one star for the local beer, and one star for the lively lunchtime crowd.

It was the summer of 1998 and I had been thinking about and consulting on knowledge for several years. The day before, Luke (my lunchtime companion) and I had bumped into each other at a knowledge management conference around the corner from the restaurant. Tom Davenport was the featured talking head.

Two years earlier I had undertaken a consulting project for the massive company where Luke worked. I led the architectural design for a global intranet to serve over 100,000 employees in about 40 countries. For Luke, the success of the intranet in its design, and then its implementation, helped to lead to a promotion and relocation for him and his family to Brussels. He now had responsibility for IT in Europe, the Middle East and Africa, for the largest division of the company, with divisional sales at the time of about US\$ 12 billion. Now, two years later, our paths had crossed here in Boston, about halfway between Brussels and Dallas. Because we had already worked together, and had some mutual awareness of each other's work and manner, our conversation over lunch proceeded quickly.

As we ate our crab sandwiches, Luke told me his plans: 'So, Jim, I have a project starting around creating a knowledge management strategy, for the division. We're also doing a big SAP [Integrated Accounting and Production Management software] project, where a resource I was counting on won't be there, and perhaps you could help with that also. What do you think – would you like to come do some work for us in Europe?'

The phrase 'Just watch this space' flashed through my thoughts. I had come to the knowledge conference 'on my own nickel' to pursue an interest in which my consulting employer (the US division, at least), showed little interest and even less apparent understanding. It was my

hope, with résumé in pocket, to meet some potential employer at the conference. But now here was an unforeseen opportunity to work again with Luke, someone I trusted and respected highly, and other people I liked, on a subject I had a passion for, in a region of the world that I loved. Work in Europe? On KM? For the ABC global soap firm? *Just watch this space!*

8.6 The influence of a good book along the journey

At just about the same time as I was arriving in Brussels to help create a learning strategy for Luke, I had started reading Wenger's *Communities of Practice* (Wenger, 1998). It seemed to describe the real experiences of real people. A central story in the book depicts how insurance claims processors actually did their work, by contrast to official company process. Etienne described how the processors shared their understanding of 'how things really worked'. Each agent had to go through formal training, but many circumstances were not explained adequately. The agents created their own path through the company's policies and procedures. They were paid by how many claims they processed, and a claim returned to them for more processing was a deduction in pay. They had a mutual interest in, and benefit from, exchanging information and sharing knowledge with each other. Not only did they share tips on how to complete certain company forms, but they talked about their lives, families and friends, their fears and hopes.

It seemed like a pragmatic explanation of ordinary human interaction in generating and sharing knowledge in the workplace, and offered an approach to the use of knowledge that could be described and taught in a replicable way.

8.7 A conceptual blend

In addition to reading Wenger's work on communities of practice, I had come across the work of Gabriel Szulanski. Szulanski had investigated which factors might explain how and why 'best practices', that is to say, knowledge, either succeeded or failed in spreading across organizations.

Using Wenger's concept of community of practice as the context for how people actually shared knowledge and information to accomplish their work and goals, I blended in several of the factors Szulanski had identified as best practice relating to the spread of knowledge and information. Szulanski's study of the importance of relationships and awareness, among other qualities of interaction, filled a gap I had sensed in studying the work of Wenger, who by choice in designing his research did not fully consider the role of the qualitative nature of

relationships in communities of practice. Instead, as I will describe more fully below, he had paid attention to the sharing of content (practice) and the social cohesion (community) and identities it creates. What I had not fully considered at the time was what then were the intellectual traditions and ways of thinking, either implicit or explicit, of the work I was incorporating from Szulanski. Since becoming aware of this gap, it has become a key aspect of the critical awareness I seek to gain in this research effort. Similarly, in delivering my early communities-of-practice consulting, I often used a systems approach in my thinking and actions, while at the same time advocating to my clients a more emergent way of organising and working! This has been a conflict between my thinking and my practice that I seek to understand more fully.

The blend of these two concepts from Wenger and Szulanski seemed to me to offer an explainable, replicable model for people to use in organizations. The blend offered a way to describe some aspect of the work of employees in an organization, such as product marketing and marketers, as a community of practice. By adding in some thinking from Szulanski, we could point to some specific aspects of behaviour in communities of practice that could either facilitate or inhibit the sharing knowledge and information for the purposes of change and improvement. Szulanski had identified four key barriers affecting best practice (knowledge) transfer, as described by Carla O'Dell and Grayson Jackson:

Reason #1: Ignorance. Those who have the “knowledge” don’t realize others may find it useful. At the same time, those who could benefit from that “knowledge” have no idea someone in the company already has it.

Reason #2: No absorptive capacity. Even when employees were not ignorant of the knowledge or best practice, they lacked the money, time and management resources to pursue and study it in enough detail to make it useful.

Reason #3: The lack of preexisting relationships. People absorb knowledge and practice from other people they know, respect, and – often – like. If two managers have no personal bond, no tie or link which preestablishes trust, they’re less likely to incorporate each other’s experiences into their own work.

Reason #4: Lack of motivation. People may not perceive a clear business reason for pursuing the transfer of knowledge and best practices.’

(O’Dell and Jackson, 1998, p.17)

Szulanski’s ideas made a lot of sense to me. He said that best practices are not transferred to others and adopted for general use simply because someone has documented them and told other workers about them. Effective transfer of knowledge and information is affected by several key factors: being aware of the existence of the best practice; the relationships between the people involved (the originator and the adaptor); trust; and the capacity to understand the best practices sufficiently to make use of them oneself (Szulanski, 2003, ch. 2).

8.8 The workshop at ABC Soap Company

The Belgian project for Luke provided me an opportunity to take what I had learned about an academically expressed concept – ‘communities of practice’ – and blend it with some qualities and capacities of interaction into a deliverable consultancy offering, readily understood and useful to my client. Patrick, my colleague, and I, developed and delivered a workshop that was designed to explain the marvels and benefits of communities of practice to marketing personnel drawn from the primary countries (determined by market size) across Europe. ABC Soap wanted to bring their marketing people together in a more collaborative sense, to share ideas and best practices in their field. As part of the broader learning strategy my colleagues and I were helping them build, we thought we would try some things out on the marketing people.

8.8b Talking emergence, thinking systems

Patrick and I delivered the workshop in the spirit of ‘Here is a model that explains behaviours and the use of knowledge and information in the informal community of practice’. By explaining this to workshop participants, we assumed they would see the value of communities of practice for improving the creation and sharing of knowledge and information. The marketers could then take steps to be a consciously self-aware community of practice. They would be able to think of their work as a pan-European community of practice, instead of just being the ‘London Office’ or the ‘Paris Office’.

Looking back at my practice then, I see the elements of a ‘systems approach’ – the observer standing outside the system; the boundaries drawn around the system; the construction of a new ‘blueprint’ (like the pan-European Marketing community of practice). Patrick and I were implicitly using a systems perspective ‘send–receive’ notion of communication.

In retrospect, the irony was that we were talking about communities of practice as though these were something to be created, while ignoring the multiple communities of practice in which each workshop participant was already involved. We were commending a new pattern of participation, and a narrative to explain it, to people who were quite busy and quite happy already living in their own patterns of local interaction, in narratives they knew by heart. Patterns they could do with their eyes closed, improvising their way day by day, into the patterns of the future. Why switch?

I was thinking of communities of practice as having an emergent aspect, for example, that the small changes in sharing knowledge in the marketing community could ultimately result in large changes – a new consumer product that becomes a best-seller worldwide. Yet Patrick and I were both implicitly using systems ways of thinking about organization, and were conducting our communication as if we were sending packages of information to be decoded and applied (Sperber and Wilson, 2003).

During that same fall of 1998, my interest in complexity flared, as I responded to an ad in *The Economist* for a seminar in Santa Fe, New Mexico, on complexity and strategy. This side trip to my main journey had some interesting results, both in the moment and in the longer term.

8.9 The Santa Fe Trail: my early conversations about complexity

It was November 1998 and I was sitting in the former home of the great artist, Georgia O’Keefe, in Santa Fe, New Mexico. Howard Sherman, a former director of such franchise firms as Midas Mufflers (for cars) and a chain of hairdressing salons and a former professor of philosophy, was explaining the Greek roots of the words ‘emergence’ and ‘strategy’ – such that an emergent strategy became ‘weighing in the mind (strategy) that comes from the depth (emergence)’. I was attending a seminar being conducted by the Santa Fe Center for Emergent Strategies.

8.9b Beware of consultants bearing Strange Attractors

I was drawn to Santa Fe by the opportunity to learn in person with others about the fascinating new topic of complexity.

Two science books written for a general audience (Waldrop, 1992 and Lewin, 1992) had brought complexity and the Santa Fe Institute to my attention. I also had read the book, *Open Boundaries*, by Howard Sherman (one of the associates of the Santa Fe Center for Emergent Strategies) and Ron Schultz, a consultant and writer (Sherman and Schultz, 1998). Their book provided examples of what they considered to be complexity as evidenced in organizations.

Three key points stood out from what I had been reading in various sources:

- 1) ‘Leverage points’ – how small inputs in a system, or organization, could drive big change (Holland, 1995).
- 2) Emergence without a central plan – how patterns and order can emerge without a central plan, as in works by Kauffman and by Holland (Kauffman, 1994, Holland, 1995).
- 3) Diversity and change – the heterogeneity of agents interacting provides sources of change (Kauffman, 1994, pp. 296-297).

8.9c Theory and practice

Howard Sherman paced back and forth along one side of the square we were sitting in. Through the windows, you could see the splendid view of Santa Fe and its surrounding beauty and hills, a captivating scene that had attracted the artistic spirit in Georgia O’Keefe. In his congenial, engaging professorial voice, Howard explained how there are different levels of abstraction in the ways an organization thinks about itself, as follows:

Principles: These are the foundational, most abstract ways the firm thinks of itself. Where do principles come from? They may, for example, express the owner’s intentions. They are like axioms: they cannot be expressed in any more fundamental way.

Models: A model is less abstract than a principle: ‘Here’s what we look like, and do.’ ‘Models are where to formulate actionable ideas.’

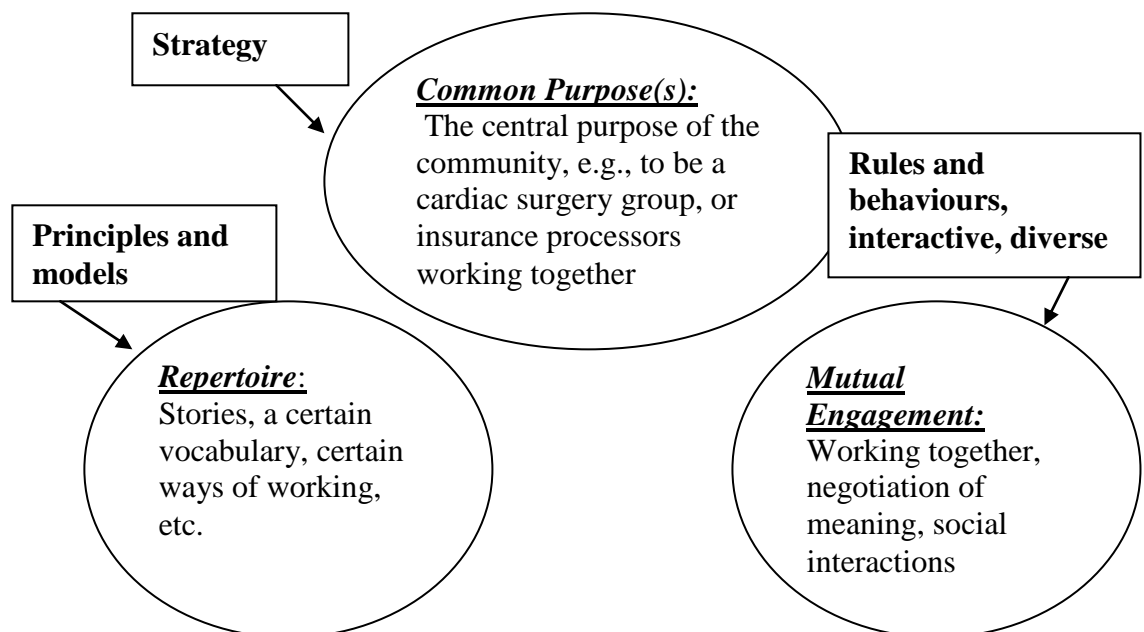
Rules: How to act in certain circumstances. Rules guide our conduct.

Behaviours: behaviours rarely issue straight from principles. The most critical relationship is between models and behaviours.

8.9d Adding one more hurdle

My goal in attending the seminar had been to relate complexity and CAS theorizing, as explained by Howard Sherman and colleagues, to what I was trying to do in knowledge management and communities of practice. I tried to align the key descriptors from the seminar with my understanding of Wenger’s community-of-practice framework (Figure 1.1).

Figure 1.1: How I tried to align words (in boxes) from CAS (complex adaptive systems) with community-of-practice terms (in circles).



I could align the words, to map to one another, but the CAS approach did not seem to add enough explanatory value to justify precluding the community-of-practice terminology and approach. So I returned to Europe and my existing way of describing communities of practice

for the project at ABC Soap. My thinking had been influenced, nonetheless. My efforts along the Santa Fe Trail of Complexity yielded one new word for my practice: ‘adaptive’, construed as the ability to change, which I now added to my repertoire in the following year, 1999, as a fifth hurdle to learn how to leap myself in order to teach others to jump.

Then, three years later, while searching for stories of community of practice like approaches to public health, I serendipitously found something else. I found a way of understanding the emergence of new behaviour, new patterns of participation in a community-of-practice setting. The intellectual Holy Grail I had elusively sought in Santa Fe, a conceptual blend of communities of practice and complex adaptive systems, now found me in the form of a two-page story. It shook my heart, seized my imagination, and changed one after another of my personal narratives.

My Santa Fe Trail to Complexity now moved next through rural Vietnam.

8.10 What does this village know about raising healthy children?

In the winter of 2001, I was searching the Internet for community-centred approaches to healthcare, and came across a story from a back issue of *Fast Company* that I had not read. The article related the work of Jerry and Monique Sternin and colleagues – all of them from Save the Children – regarding malnutrition in Vietnam (Dorsey, 2000, p. 284).

Save the Children, a global NGO, non-profit/social sector organization, had been asked by the Vietnamese government for help with addressing the problem of malnutrition among rural children in their country. In some villages, as much as 80% of the children were malnourished. Thousands were literally dying, in a country with few health care resources.

A small team of five Save the Children volunteers helped a team of village volunteers to assess the health of the children in their villages by examining weight and height relative to age. The charts the villagers learned to make showed that, yes, some children were doing well. Next, they looked at what was different for those children. Their parents, whom the volunteers interviewed, were finding small shrimps in the coastal shallows, and were using a food considered inferior – yam (sweet potato) greens – to add to the rice they cooked in small portions for their children. When their children were sick, even with diarrhoea, in contradiction to community practice they

continued to feed the children. They made sure their children ate their meals, rather than simply cooking a bowl of rice and leaving it out for the children to eat if they wished. Although all families faced the same basic poverty, some families' children were, nonetheless, doing well – their health showed 'positive deviance': they were faring above average, despite having only average means of existence.

The villagers were invited to come to a session to cook meals together and learn how they could all have healthy children. As a price of entry they had to bring some prawns, yam greens and rice. As they cooked together, there also were health messages about vaccinations and parasite hazards provided to parents. Children were weighed throughout the program, to show the benefits of the new meals they were eating. The program was a rapid success and began to spread as villagers then taught other villages in a concerted program sponsored through the regional health offices. Save the Children notes that "In Viet Nam the Hearth Nutrition Program has achieved a reduction of 2nd and 3rd degree malnutrition by 80% among tens of thousands of malnourished children fewer than 3 years of age." In ten years, the program has spread across Viet Nam, and has revitalised the lives of an estimated 50,000 children.

In this story I saw the emergence of a previously unknown solution, through the interaction of diverse agents (the parents, children, and Save the Children volunteers), with a major change in health outcomes from small inputs. I also saw aspects of what I knew from the study of community of practice: the story showed me a way forward in understanding communities of practice together with insights and concepts from the complexity sciences. The mix of ineffable joy and sadness in this story strongly stirred my emotions.

Sometimes we may be watching rain fall on the street, or in a courtyard, and a gust of wind sweeps through, pushing the raindrops across the stones, this way and that, changing the patterns we see. Emotion sweeps through us that way, through the present moment, through the remembered past into the future: changing our view, changing our participation, changing our narratives, all, all in one twinkling of the mind's eye.

A rain of emotions from converging events in the spring and summer of 2001 swept through my life, and played a part in another turning-point in my practice and thinking.

8.11 Emotion and the assignment of meaning

Emotion is used by the mind to assign value and set motivational direction. Our daily practice is not just a matter of coldly rational, emotion-free thought, but is inextricably linked with our emotions. For example, the emotions that swept through me as I read the story of the Vietnamese villagers began resetting values and meaning for me. Those emotions, supplied by my brain and modulated by my mind, gave influence to a newly motivated direction for me in my practice and life. This powerful idea on the role of emotion has come to my professional practice by way of the writings of Antonio Damasio (1999) and Daniel J. Siegel (1999).

The amplification of emotions associated with our participation in life can change the narrative understanding of that participation, and in turn can recursively change the participation itself. We can sometimes recall this most clearly about what we consider to be turning-points in our lives. For me, a significant turning-point in my life and practice occurred in 2001.

Around the time of reading the Vietnam story, a convergence of events brought about a set of significant questions for me. In February of 2001 my father, whom I had loved dearly, died after a long illness. In March a downsizing eliminated my position as a principal at the Balanced Scorecard Collaborative, headed by Drs. Norton and Kaplan, inventors of the Balanced Scorecard. The Balanced Scorecard is a systems approach form of strategic management tool (Kaplan and Norton, 1996). In April, just as another reminder for me of my own impermanence and vulnerability, a careless second while cycling at full speed caused a broken right arm and damaged left shoulder. My emotions related to these events added to the stirring desire to change the course of my practice and life.

With my emotions escalated and my career path paused, after twenty years of business pursuits, that part of my life as well as others, needed some rest and reflection. Emotions and incoming information, as in the story from Vietnam, contributed to a state of mind that led me to create my own private consulting practice as a way of gaining more independence. I turned my primary attention towards health care, in the hope of deriving more meaningful satisfaction from my work by participating in this vital sector.

That year of 2001, the questions flooded me in a torrent: Why not start my own consulting practice? Why not spend time doing research and writing the book I wanted to write? Why not work in healthcare?

Rainer Marie Rilke, a poet, wrote,

‘Be patient toward all that is unsolved in your heart and try to love the questions themselves, like locked rooms and like books that are now written in a very foreign tongue. Do not now seek the answers, which cannot be given you because you would not be able to live them. **And the point is, to live everything. Live the questions now.** Perhaps you will then gradually, without noticing it, live along some distant day into the answer.’

(Rilke, 1903, my emphasis)

To renew my interactions with others around complexity, I began participating in the Plexus Institute events. Plexus concentrates on promoting the understanding of how concepts and principles from the complexity sciences can be applied to human behaviour and organisations.

In March of the personally turbulent winter and spring of 2001, I registered to attend the first annual Plexus summit, at Chico Springs Resort Hotel, in Pray, Montana, at the southern end of Paradise Valley.

8.12 Along The Santa Fe Trail: Chico Springs

It was the middle of June, 2001, with a foot of summer snow falling overnight on Paradise Valley. We were gathered at the Chico Springs Hotel, in the south-western corner of the American state of Montana, to discuss complexity as it might apply to organizations and human behaviour.

Since last attending an in-person gathering about complexity – the ‘Emergent Strategies’ seminar in New Mexico – my own Santa Fe Trail to complexity had somewhat cooled. I had taken a detour through a short-lived consulting venture with some former colleagues in Colorado, aimed at knowledge management, and I had completed a one-year tour of strategic

duty at the Balanced Scorecard Collaborative, the home-base of a well known systems approach to strategic management.

My interest in exploring complexity was rekindled by the opportunity to be among an interesting group of persons, who were also interested in applying concepts from complexity sciences to human behaviour. For me, a highlight of the Chico Springs conference was my first chance to hear Ralph Stacey speak in person, not to mention the chance to speak with him about the DMan program, which I had recently heard about. Before the conference, I had begun reading a book by Dr Stacey and colleagues at the Complexity and Management Centre, University of Hertfordshire, UK.

The book was about complexity and management, and it was about to change the patterns of the unknown future of my life.

8.13 The influence of a book series along my journey

I had been thinking for a long time – indeed, for several years – about how the complexity sciences might have something to say about human behaviour and organisations. But I couldn't work out the transition from a science that described self-organizing rock formations, variably healthy hearts, and swirling chemical patterns, to what this meant for people. Then I read a book. As I read *Complexity and Management: Fad, or Radical Challenge to Systems Thinking?* by Ralph Stacey, Douglas Griffin and Patricia Shaw (Stacey et al., 2000), I felt I had finally come across a relevant and coherent theory on what emergence and complexity might mean for human behaviour. It reminded me how I had felt when I had read *The Knowledge Creating Company* (Nonaka and Takeuchi, 1995) and first became aware of the huge gap between my ideas on the information society and my incomplete understanding of the nature of knowledge itself. There were similarities, too, with my reaction to reading *Communities of Practice* (Wenger, 1998) and first began to grasp how knowledge and information might actually be applied between and among people. Now, continuing my education, this new book by Stacey and colleagues, together with another shortly after – *Complex Responsive Processes in Organizations* (Stacey, 2001) – dramatically changed my level of understanding of what emergence and complexity might mean in the reality of human affairs.

Since discovering those first two books in the Complexity and Management Centre series on complexity, I have read the other books in the series. I am currently concluding a related book by Ralph Stacey, the fourth edition of his work, *Strategic Management and Organisational Dynamics* (Stacey, 2003a).

This series has influenced my thinking in many ways, particularly by expanding the set of qualities of interaction I now include in the consulting capability I have been designing, which addresses the qualities and capacities of interaction and the emergent nature of organizations. For example, from the work of Norbert Elias (Elias and Scotson, 1965/1994) I have added the quality of inclusion ~ exclusion into my thinking and to the teaching and research aspects of my practice. Power relating, as described by Elias, and further expounded by Stacey and colleagues, has been a powerful addition to my thinking on the qualities of interaction. A comment that Ralph Stacey made – at a Plexus Institute seminar, I think – inspired me to rethink the quality I was calling ‘adaptive’, and rename it ‘response’. Ralph’s remark, which is reinforced in various ways in his writing, is that people do not *adapt* in their interactions with one another: they *respond*.

Most importantly, the complex responsive processes approach seems to provide a substantial theoretical underpinning for what I had been talking about in a more simplistic, uncritical way, with regard to the qualities of human interaction, as originally founded in my readings of Szulanski (Szulanski, 2003, 1996).

8.14 Constructing the future of practice

‘...the future is already here. It’s just not very evenly distributed.’

(William Gibson, 1999)

It was in May 2004, with these seven qualities and seven capacities of interaction that I have been studying in mind, that I stepped off the ferry from Dublin onto the quay at Douglas, and into the nearest part of the future of my practice. That part of the future happened to be in the middle of the Irish Sea, where this narrative began.

In the workshop on the Isle of Man, we try to convey what it means to pay attention to the qualities and capacities of interaction in the management of organizations. The workshop

opens by asking participants to write an account of a time when they were involved in an effort at bringing about change within an organization. The participants continue to build on these reflective pieces as the workshop continues. The participants share their narratives with each other, and then the person who has listened shares the narrative verbally with the rest of the workshop. Across three days, we hear each person's story.

Improvisational music is used in an experiential learning way, to help give the flavour of emergence and of what an improvisational organisation might be.

We also teach the principles of improvisational conversation and acting, and have the participants consider how those principles have, or have not, been reflected in their own organizational experience.

This approach was inspired in part by studying the writings of the CMC complexity series, and partly by other studies I had made of reflective practice (Bolton, 2002) and narrative therapy (White and Epston, 1990). Part of what we are doing is encouraging the managers in our course to take their own experience seriously.

Our approach attempts to address, through various experiential and reflective learning approaches, what Ralph Stacey has written of the implications of complex responsive processes for management competencies:

‘They are [management] competencies that do not usually feature in the skill sets prescribed for managers. Examples of the necessary skills are the capacity for self-reflection and owning one's part in what is happening, skill in facilitating free-flowing conversation, ability to articulate what is emerging in conversations and sensitivity to group dynamics. These skills become essential to notions of leadership and the role of top executives because their greater power renders their impact on others all the greater. Furthermore, these skills are not easily taught, perhaps because they cannot be taught, in an abstract way. They are essentially acquired in the experience of exercising them.’

(Stacey, 2003a, p. 422)

At the end of the workshop we discuss as a group what is changing, or has changed, in each manager's thinking about what it means to lead and manage. The comments we have received indicate some significant changes in self-awareness and understanding of others in the thinking that our participants have expressed.

There is, I think, a significant contrast between how Patrick and I have conducted the Mindful Leadership workshop on the Isle of Man and how we were thinking and delivering our Community of Practice workshop in Belgium. I would attribute that to the influence of complex responsive processes on my thinking and to the productive collaboration between Patrick and myself in creating the leadership workshop.

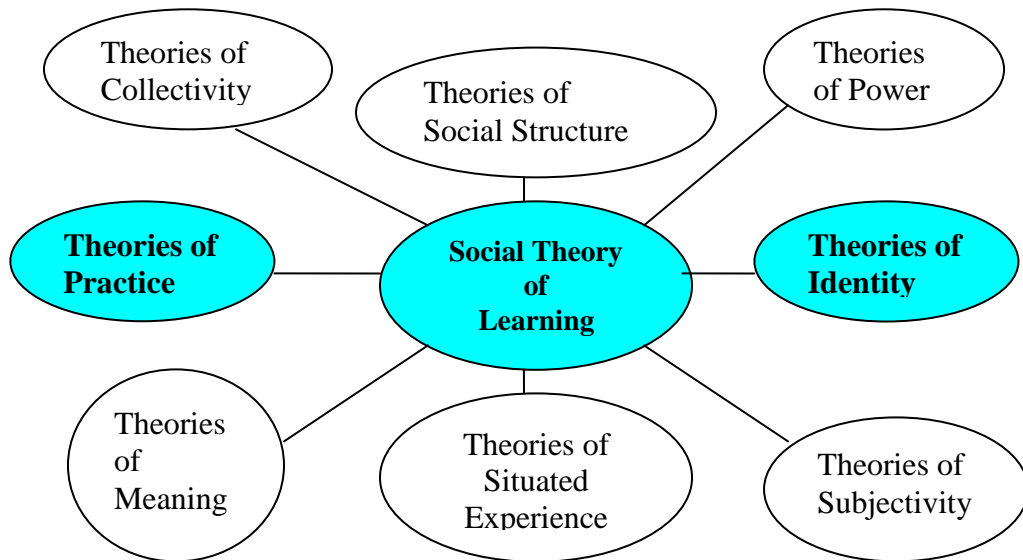
8.15 Looking back, looking forward

As part of constructing my research question, I have reviewed and appreciated anew how Etienne Wenger constructed his social theory of learning. I have re-read portions of his key work, *Communities of Practice* (Wenger, 1998) and discussed the ontology of his work directly with the author, who has become a colleague and friend over the past two years.

In the notes to the introduction of his book, Etienne illustrates the intellectual traditions he was drawing upon (Figure 1.2).

Figure 1.2: Ontological map of Wenger’s community of practice

The shading is Etienne’s emphasis to show his research focus (Wenger, 1998, p. 14).



As he wrote:

‘The purpose of this book is not to propose a grandiose synthesis of these intellectual traditions or a resolution of the debates they reflect; my goal is much more modest. Nonetheless, that each of these traditions has something crucial to contribute to what I call a social theory of learning is in itself interesting. It shows that developing such a theory comes close to developing a learning-based theory of the social order. In other words, learning is so fundamental to the social order we live by that theorizing about one is tantamount to theorizing about the other.’

(Wenger, 1998, p. 15)

In his widely read book, *Communities of Practice*, Etienne Wenger was working to create a social theory of learning. While he drew upon a number of intellectual traditions, as outlined above, and distilled his thinking from many other researchers, he gave his attention primarily to practice and identity. Wenger considered how the sharing of content and practice created social cohesion, and how in turn social cohesion affected sharing and practice.

As Etienne and I talked recently, he explained how he had discerned a space between these traditions of thought, where he could develop a social theory of learning centred on practice and identity – the community of practice. Of his work on this, he wrote:

‘What is of interest to me is not so much the nature of interpersonal relationships through which information flows as the nature of what is shared and learned and becomes a source of cohesion – that is, the structure and content of practice.’

(Wenger, 1998, p. 283)

While Etienne sometimes uses the language of systems approaches, such as in speaking of boundaries, he also has many elements that seem related to the concepts of emergence and complexity. He speaks, for example, of the inseparable duality of the individual and the social. Etienne believes that ‘the primary focus of this theory is on learning as social participation’ (Wenger, 1998, p. 4). In the sources he cites, Etienne is acquainted with Mead’s work, *Mind, Self and Society* (Mead, 1934) and with the work of the Symbolic Interaction theorist, Blumer, who had used Mead’s work as a foundation for Symbolic Interaction.

As Etienne and I have talked over the past three years about both his and my work on communities of practice, we have also discussed what I have been learning about complexity and complex responsive processes, which he has found very interesting, and he has sought out the key works in this field.

Etienne sees communities of practice very much with a view towards local interaction:

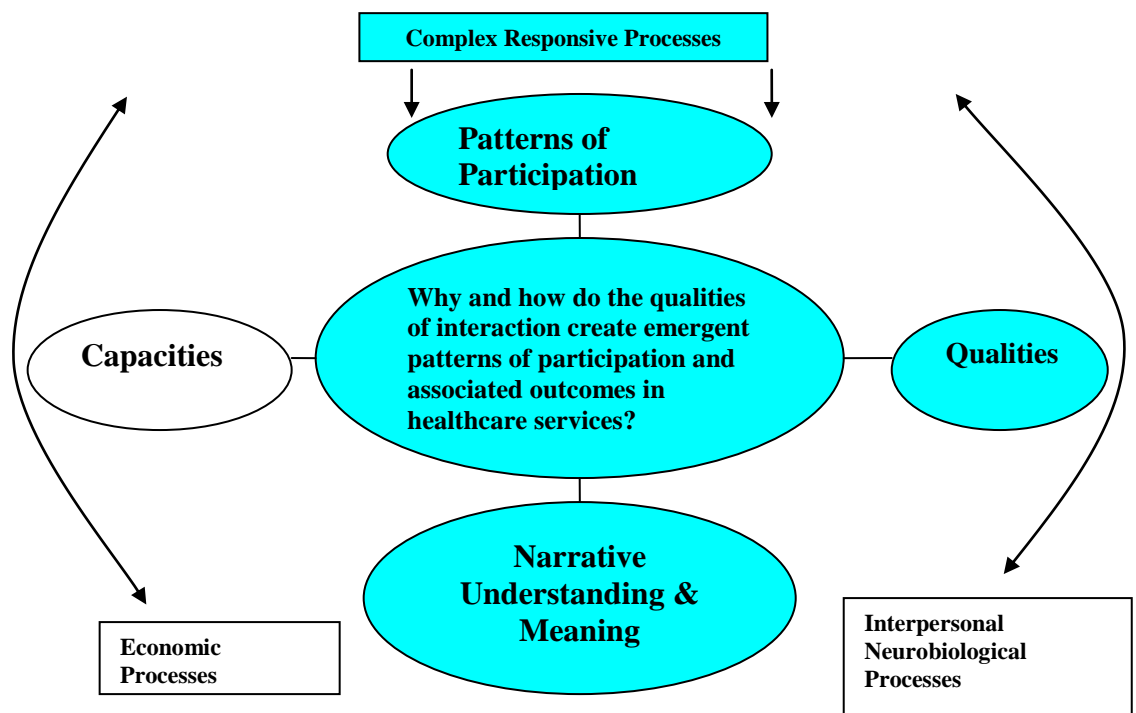
‘Although workers may be contractually employed by a large institution, in day-to-day practice they work with – and, in a sense, for – a much smaller set of people and communities.’

(Wenger, 1998, p. 6)

So when I read Etienne’s book now, and speak with him about it, and take into account other conversations we have had about communities of practice, I sense in his work a mix of some implicit aspects of systems approaches, but also a palpable effort to understand communities

of practice in an emergent, local interaction-driven, pattern of individuals acting in an inextricably social way. What is interesting is the way other practitioners often adopt a rigid systems approach to communities of practice when attempting to design and implement communities of practice within organisations.

Figure 1.3: An emerging research question (shading indicates my research interests).



My emerging research question can be framed as: From the perspective of complex responsive processes, how and why do various qualities of interaction create emergent patterns of participation and associated outcomes in the organization and delivery of healthcare services?

A related question is: Why in my practice have I sometimes been talking about what I considered to be an emergent phenomenon, communities of practice, but doing so from what could be considered a systems perspective?

The unexamined intellectual space Etienne sought to examine in his research concerned the recursively linked sharing of content and the concomitant formation of identity and creation

of social cohesion. I had noticed the space left by Etienne's lack of attention to the interpersonal in his work, and sought to address this by incorporating some of the barriers to best practice transfer identified by Szulanski. But I had incorporated Szulanski's work without critically appraising where those barriers had come from and what they signified (except in a common-sense way, partly justified by the field data Szulanski himself had collected and analyzed). That is one of the oversights that I perceive in my practice, which I am working to redress.

Building upon my experiences in consulting and studying human interaction in work patterns described as communities of practice, my research shifts away from Etienne's focus to look at why and how the qualities of interaction affect and shape human patterns of participation and associated outcomes, including the narrative-like understandings and propositional themes through which we make meaning of our participation in those patterns. An example of this approach would be to look at a set of dedicated stroke units across various healthcare organizations and settings. The capacities of these stroke units will be similar – medicines, imaging machines and medical training – but the qualities of interaction, and outcomes, will be local and particular to each stroke unit.

9. Project Two: transforming practice in the hurly-burly of life

9.1 Reflections

Writing Project Two was improved in a very important way by my experience of writing Project One, as it was influenced strongly by the increase in awareness of self ~ other. I began paying attention to my own role in my experience from a first-person viewpoint, by contrast with the prevalent third-person narrative voice that was prevalent in Project One. That shift of awareness and attention changed the perspective from which I wrote Project Two. I was desirous of trying to draw distinctions about my interactive participation in a strategy workshop.

Like a person new to driving cars, I had to work at paying attention to my interactions and their qualities. Now from the vantage point of an experienced researcher I can reconsider these narratives and have gained additional insights in doing so, as outlined in the synopsis.

I can notice more now about the way the workshop hosts had constructed their project plans and how they were, in various ways, influencing and shaping the conduct of the workshop. As I point out in the synopsis the hosts' interactions were promoting particular QI changes they wished their clients to learn. Their approach to facilitating was blocking the generation of other learning, viewed as changes in meaning. In the project reports the possibilities of additional meanings were blocked by the marginalization and devoicing of the prospective QI Clients. No one among the prospective QI Clients was invited to the workshop to discuss the proposed projects; another way to avoid conversations that might challenge or change the meaning of the projects. A specific and pointed request was made at the start of the workshop to not question if these were the right projects for the right topics. From a complexity theory of emergent learning perspective, behaviour that is seeking to maximise the certainty of meaning requires trying to minimise the uncertainties of interaction. The QI Improvers were consciously seeking to fix the certainty of meaning of their projects. They were consciously, or unconsciously, seeking to minimise challenges to that meaning by trying to control interactions in various ways.

In writing the synopsis I have come to see more clearly in Project Two how the anxieties and concerns, hopes and desires of myself and my hosts about our interactions were shaping our interdependent opportunities for learning.

9.2 Introduction

In this reflective narrative, I describe and analyse my efforts at the expression of my own changing consulting practice. In a socially reflexive way, I situate my experiences as a complex responsive process of participation and interactions with others in a healthcare workshop concerning the transfer of knowledge into new practice in healthcare settings. I portray the messy, unplanned, unpredicted and emergent manner through which I expressed and gave voice to a new way of thinking about my practice. A succession of interactions will be described, modest in significance individually, but having the cumulative effect of creating a surprising shift in the expression of my practice in the final hour of the final day of the workshop. This second project continues my emerging inquiries as to how the qualities of interaction between and among persons involved in healthcare practices affect the translation, or expression, of new learning into changed practice and outcomes.

The narrative describes my experiences in and around a two-day workshop that evaluated four new projects and their proposed work plans, all involving the use of ‘knowledge transfer strategies’. ‘Knowledge transfer’ (KT) is one of the multiple names, descriptions, or ‘meta-narratives’ deployed in the healthcare sector to represent various, often quite similar, ways of thinking and talking about the promotion and encouragement of use in practice of new learning or research (Greenhalgh, 2004). I was one of eleven ‘knowledge transfer experts’, out of a total fifteen originally invited, present to offer their thoughts and advice regarding the four projects.

My narrative describes how the complex, responsive process perspective (Stacey 2003c) has influenced the way I thought about my participation, both prior to and during the workshop. I will outline what I consider to be the perspective on human action and learning that seemed present in the organisation and conduct of the workshop itself.

My reflections and analysis then build from the details of my narrative to outline how ‘knowledge transfer’ can be conceived of as a way of thinking about human action and a methodology for pursuing the use of research in health practice.

In a section below I will distinguish and contrast several salient aspects of a knowledge transfer approach to the complex responsive processes perspective (Stacey 2003b, c) that increasingly informs my own practice. This section will include a brief comparison of KT as a methodology by contrast to the approach of the DMan Programme. I comment briefly also on the canonical consideration in research of what it means for results to be generalizable, and what can generalizable mean in terms of the complex responsive process I am using.

Finally, I summarise the emerging differences in my understanding of what the workshop meant to me and how my reflexive inquiry has affected that understanding. I point briefly to some newly emerging themes in my research around the following questions: what is the role for awareness in our interactions; does a narrative-like understanding have qualities and what are they?; what is the role for emotions in the derivation of meaning, the assignment of value, and the discernment of motivational direction in our narrative understandings?

9.3 Context and setting: a Knowledge Transfer Workshop

‘All action and all love are haunted by the expectation of an account which will transform them into their truth.’

(Merleau-Ponty, 1964, p. 75)

Through the windows I could see tall and slender, grey, bare trees and a small pond, reminders of the farmland this once was. I know these trees, that pond – I have been here and seen them, twice before, but in winter. Outside spring is coming. Inside, the room is filling. Around the perimeter of the room tables are draped in a meeting style. About thirty people are finding their seats at the tables. Another thirty or so attendees are sitting in chairs along three walls of the room. Colleagues are chatting, and the guests are being welcomed.

We are gathering in a large meeting room of a small, but significant, government agency that supports and funds health research on particular topics. The agency also promotes the translation of that health research into practice and into more widespread use across the country. Eleven persons invited to the workshop as knowledge transfer experts are here today to advise and consult as independent voices on four projects sponsored, awarded and financed by the agency. These projects are just getting underway, each managed by one of four

different consulting and research groups contracted by the agency. The four projects each have to do with KT strategies the agency wishes to use for improvements to four healthcare topics: synergies in the pursuit of quality and value for money between large organizational purchasers of healthcare and the healthcare providers they interact with; more efficient care management programs that provide assistance to the indigent; decreasing social disparities in childhood asthma; and making hospitals high-reliability organizations. The agency has explained to those of us it invited to the workshop as experts, which included me, that agency personnel and their consultants were seeking advice and suggestions on how to expand and strengthen these four knowledge transfer projects over the next few years. Each of the experts was sent a packet containing the basic work plans about the four projects to review ahead of the workshop. All four projects being critiqued in the workshop were supposed to make use of KT strategies to communicate and promote knowledge about their respective healthcare topics. The assumption and goal of the overall programme supporting the four projects was that the successful use of knowledge transfer can lead to a desired change of direction in behaviours and in associated healthcare outcomes.

My previous visits to the agency were as a participant paying to be involved in seminars related to complexity and healthcare that they had sponsored. Now as an identified individual, being paid to be a contributor, I sense in myself a mix of excitement and anxiety at the prospect of sharing in the pending discussions. The sense of excitement probably had several parts to it. In one sense I simply looked forward to participating as an invited peer in a discussion about the use of knowledge for the improvement of healthcare services and outcomes. The anxiety related to the fact that it also was the first occasion for me, after several years of part-time development, to have a paying client for my emerging consulting practice in the healthcare sector. The narrative will indicate how both that excitement and my anxiety affected my participation in the workshop, as well as my narrative-like understanding of what was occurring.

The invitation to the workshop had come by way of an acquaintance with another consultant, who would also be at the workshop as a KT expert. We had met three years before through our mutual interest in the topic of communities of practice. But I had also been building my contact and acquaintance with one of the health agency managers, Allan, who had helped host the two complexity seminars I attended. So prior to the workshop I had already been in the process of creating a link with people at the agency to seek advice on financing a research

project and to network with persons involved in aspects of healthcare about which I was also interested. I did not know if Allan would be at the workshop or not, but sent him an email indicating I would be visiting the agency and hoped to see him in person while at the workshop. I view my new consulting offering as blending my earlier practice around communities of practice with my studies regarding complexity and management. ‘Communities-of-practice’ is a social theory of learning developed by Etienne Wenger (1998). It has been widely incorporated into organizational design and change efforts. Interestingly, the unexpected workshop invitation created a vortex of interactions with persons I knew both from my communities of practice interests and from complexity. This had a striking parallel to the convergence of my thoughts about these two theoretical perspectives.

9.4 Day one: gesture and response in the hurly-burly of life

‘Not what one man is doing now, but the whole hurly-burly, is the background against which we see an action, and it determines our judgment, our concepts, and our reactions.’

(Wittgenstein, 1980, vol. II, §629)

The workshop agenda, on paper at least, looked like an orderly exchange of information regarding the four projects and the views about those projects of the invited ‘experts’. But my experience of the workshop felt more like the ‘hurly-burly’ of life that Wittgenstein refers to above (Wittgenstein, 1980, vol. II, §629). The following sections describe how my participation in the workshop emerged in the various unplanned, local interactions which I and others were having in and around the workshop. I have reflected upon those various local interactions through many iterations of this project. An important distinction I make about my workshop experience is that the most significant statement I made about the projects under discussion during the workshop occurred only in the final hour of the final day. Part of my analysis explains why the timing of my comment occurred as it did.

9.5 Inclusion ~ Exclusion: the social dynamics of seating arrangements

Laura, the director of the division involved with the projects, is speaking and giving a welcome and an introduction about the workshop, to those assembled. She is sitting on the side of the room to the left when entering by the main door. From her chair she has a clear view of the main door, the overall room, and the secondary door to the room, directly opposite her. To her immediate left she introduces an agency employee, Henry, who will be the facilitator of the discussion. To his immediate left in turn is the person that Laura reports to in the agency hierarchy.

The room has filled with people, many sitting in chairs along the walls, others standing. The project consultants and their agency counterparts, the KT experts and agency managers have assigned seating at the tables. There are about as many people sitting along the walls as are sitting at the tables. During the course of the workshop these persons along the walls do not, for the most part, actively speak in the discussions; they apparently have come just to listen. As I reflect upon the workshop, I have considered with more attention now than at that moment, how the size of attendance indicated that these projects, and the pending discussions about them, are significant to a lot of people at the agency. A sizable crowd wants to be present to hear the discussion and present to be seen perhaps, even if not to speak in the discussion. Persons sitting along the walls did not seem to have, in essence, ‘turn-taking privileges’ in the discussions of the projects. I wonder how that understanding of who could talk and who should not had been communicated or perceived. The social dynamics of inclusion ~ exclusion written about by Elias and Scotson ([1964] 1995) becomes expressed through such simple matters as who sits by whom. As Dalal writes, drawing upon Elias,

‘Power is the (contested) capacity to say who belongs and who does not, where, and on what grounds.’

(Dalal, p. 15)

I will point again later to the influence of the social dynamic of the small act of inclusion and exclusion of seating assignments upon my interactions with others. It is an example of how small differentials in social interaction can lead to larger effects (Stacey, 2003c).

9.6 Pointing out the pale

‘Pale – An area (as of conduct) or the limits (as of speech) within which one is privileged or protected esp. by custom (as from censure or retaliation) <conduct that was beyond the ~>...’

(Webster’s Third New International Dictionary, 1966)

Laura is still providing the introductory overview of the workshop as my attention re-directs, pulled back to Laura’s words. I hear her saying:

‘We don’t want a rubber stamp on these projects, but we also don’t want to throw them out completely either.’

She explains how this workshop is a checkpoint of sorts, a means to have some extra discussion and expert comment on the four projects under review. But she did not want the discussion to go in certain directions by suggesting the projects be thrown out or by discussing if these were even the right four topics to pursue. And yet she did not want the discussion to lack authenticity either, by seeming in any way to be a ‘rubber stamp’ approval of the agency plans. She is indirectly pointing to and making visible the sort of power relations-based enabling constraints described by Elias (1970). Laura is acknowledging implicitly the interdependence of the workshop participants by outlining the desired and undesired topics of conversation and what comments would be considered beyond the pale.

The four consulting firms will each have a turn to explain what their project is and how they are approaching it. After each presentation there will be time for facilitated discussion, with comments from the consultants. Upon reflection, the workshop had a bit of the feel of an organisational ritual; a ceremony designed to address anxiety around the uncertainty of embarking upon long term projects in the very challenging field of healthcare improvement.

Laura explained further,

‘These projects are part of our effort at disseminating research. Our agency did not do much with knowledge transfer the past two years. So we want to listen to others who have an interest in these topics. We are looking for observations on process, on mechanisms, so as to be successful in capturing why end users will or will not use research. In this workshop we want to focus on KT methods, versus content.’

‘We want to do more than put information from the agency into the hands of people. We want to understand how to change outcomes. Our goals are to enable and encourage them [users of research] to change.’

The excitement of being included in the workshop made me feel determined to be one of the group. One way I addressed that desire was to review some possible stories to use in illustrating points of view I might want to convey in the workshop. I can see retrospectively that I was careful to use only stories that were specifically healthcare related. So, in effect, I set a constraint for myself around what I would say, or not say, by the stories I chose to tell. The anxiety about moving my practice into a new field appears to have helped fuel a desire to concentrate on how my participation might go in the workshop, the effort of selecting good healthcare stories to share and participating in a manner that would be perceived as collegial in tone and spirit. As a result these thoughts were crowding out the distracting worry about being new to the field.

9.7 Discussing the first work plan

The first work plan to be discussed involved how to bring together some large health providers with healthcare purchasing organizations [in the nation-wide context of companies, insurance firms, etc. being the significant groups in paying for healthcare services on behalf of their employees or customers] create some standard best approaches to the construction and use of guidelines, policies, and associated practices for defining and paying for high quality, effective performance in the provision of the healthcare services.

During my turn to speak, I referred to preparatory notes I had made in reviewing the project plans prior to the workshop. The work plans were all laid out in a common fold-out page format, with columns A – H for: targeted goals; available information and resources; activities; activity rationale; rationale for outcome; initial outcome; rationale for long term outcome and long term outcome. I had read through the work plans with my point of view

influenced by complex responsive processes theory. I read from the perspective of my practice as distinguishing between what gives us the capacity to interact (for example, information as a printed report) and what are the qualities of our interaction (who is being included or excluded from a discussion about a patient).

With a confident tone, I was offering one of my favourite stories from healthcare. I was sharing to point to an example that I think illustrates the emergence of practice from the self organised interactions of those persons involved, and not just from steps and tasks described in a medical procedures guideline. With the time limitations of the workshop format I offered an abbreviated version of the story:

‘There is a hospital in Kansas City, which happens to apparently be the best in the world at intervening in ischemic stroke. The medical director was here last fall in fact, and gave a presentation. Dr Rymer. They can intervene at a rate fifteen times, *fifteen* times that of other stroke centres in the US...’

From across the room, in a challenging tone, Lisa, the agency employee managing one of the four projects, interrupts:

‘I was there and I heard that story, and what needs to be done is to promote awareness of it.’

Paused by her interruption, I listen. As she finishes I respond with calm reassurance in my voice, looking first at her, then around the room,

‘But *that’s* exactly what *has* been done – there are approximately 240 Dedicated Stroke Units in the US. They all have access to the same well written guidelines. And a lot of time and money is being spent now with ‘JayCo’ [JCAHO – Joint Commission for Accreditation of Hospitals] to be certified to those standards. But their performance is still a fraction of Saint Luke’s.’

A noticeable fermata of silence followed this last note. My practiced Saint Luke’s riff had been played into the conversation with an improvisational twist and the confident delivery had sounded sweet to me. I was pleased to feel that I had held my ground in the exchange.

The facilitator smoothly concluded this first discussion. It was time for the coffee break. As I stood, my acquaintance at the agency, Allan, approached me, smiling. With a confidential tilt of the head, his slightly lowered voice aimed directly to me, he gave an encouraging, ‘good on you’ sort of movement with the tablet in his hand, and said,

‘Jim way to go, you said exactly the right thing, at the right time. I was so glad you said what you did.’

Somewhat surprised, but really pleased, by the generous comment, I only had time to reply, before he dashed away, ‘Well, glad to be here Allan, and to see you here in the workshop as well. I didn’t know if you would be here or not.’

It was the welcome back stage encouragement of a friend, between scenes on opening night, telling you that you’ve said those first few lines just right. Just the one sentence, but it was emotional fuel to the fire nonetheless. Allan’s words encouraged in me a rising tide of confidence and a good feeling that this workshop just might turn out to be a really good experience. In a deeper, longer term sense, it sounded an encouraging note as well about the long term prospects for my consulting in healthcare.

During the break I had a cup of tea (as the coffee was really poor quality), then chatted with some people and returned to my seat. The second discussion, which regarded efficiency level among the states of the country in managing certain central government financed health programmes for indigent youth and elderly persons, was already beginning. I became aware of someone crouching down just to my left side and just behind the agency deputy director sitting on that side of me. I did not know who he was, but my visitor was tugging at my left sleeve. In a low, somewhat intense sort of tone, he was asking about the Saint Luke’s story:

‘So what did they do? How did they get them to do that? Did they get extra pay? A special incentive? *What did they do?*’

Caught between his questions and the workshop proceeding on around me and with an agency director sitting right next to me, I was reluctant to seem disregarding of the other participants by engaging in this distracting interruption. I replied – whispering:

‘They didn’t get anything special. Well, they got paid their usual pay I suppose. They worked out of care for each other. And the patient. They have a passion for what they do. I would be glad to talk more at a break, or afterwards if you would like...’

My questioner, still crouching, hand on the back of my chair, looked down, thoughtfully puzzled, then went back to his seat. I turned back slowly towards the main discussion. I realised later that day that he was a Vice President of one of the consulting firms. Clearly, some people were responding in very engaged ways to what I was saying. I returned my attention, with confidence, to the conversation in the room. As the morning and afternoon went on, I had the growing sense that I could sit at the table and be regarded as a useful contributor to the day’s discussions. I was mindful of being in the company of others who I thought would demonstrate more claim than I to the title given us of ‘expert’, and the additional meaning and value, that gave to me of being included in the workshop.

9.8 Analysis: what sense was I making of my experience?

The unplanned, self-organised nature of the interactions I had in the first hours of the first day were a great boost to my confidence. I felt the change physically in my level of energy and mood. Elias speaks of how:

‘...plans and actions, the emotional and rational impulses of individual people, constantly interweave in a friendly or hostile way. This basic tissue resulting from many single plans and actions of people can give rise to changes and patterns that no individual person has planned or created.’

(Elias [1939] 2000, p. 366)

Allan’s greatly encouraging words at the start of the coffee break were not planned by him nor anticipated by me. I was not even sure prior to the workshop if Allan, whose office was in the same building, would be there or not. I appreciated Allan’s presence as a like-minded acquaintance, his early words of encouragement and his supportive agreement with and additions to my comments at other points in the workshop; it felt very enabling to me in my comments and responses at the workshop. His expression of congratulatory agreement gave validation to my enacted intention of pointing to relationship related gaps in the work plans, with my comments supplemented by some powerful and relevant narratives. In just the one sentence from Allan at the coffee break, I felt some relief from the newcomer anxiety I have

had in moving my consulting to healthcare. Here was someone from this distinguished agency, whose first words to me of the workshop were invoking feelings of inclusion and mutual respect.

Even the peremptory, somewhat confrontational, challenge of Lisa's comment that the Saint Luke's story just needed to be better publicised, perhaps provided a part of the weaving of impulses in that first morning session which strengthened my resolve to speak to what I saw as disregard for the importance of human relationships and interactions and what a looming gap that made in the work plans.

Lisa's comment that the Saint Luke's story just needed to be publicised was like a one sentence encapsulation of the essence of the knowledge transfer point of view. And my reply in a sense encapsulated part of my perspective that sharing information alone is not enough to change behaviour. So when I read the following thoughts by Shotter, I recalled my exchange with Lisa:

'The 'essential references' of 'this' and 'that' in the moment of acting:
Relying on the directionality inherent in the temporal unfolding of living activities, we are able at certain crucial moments in our exchanges with others to use such expressions as 'Look at *that*'. 'Listen to *this*'. Do like *this*. *This* is what I meant, and so on. The crucial nature of the *moment of utterance* cannot be overemphasised: in coming at a particular moment in the already ongoing flow of contingently intertwined activity occurring between them and us, in pointing in their gestural expressiveness from '*this* past' toward '*that* kind of future', people's activities allow us to intervene at that moment...'

(Shotter, 2005)

When we do this, Shotter says we can point people towards 'another kind of future', and to see connections of a 'previously unnoticed kind' (Shotter, 2005).

Lisa's comment provided perfect staging for what I then felt I could say, in the manner and with the emphasis that felt right to use at that instant. So in the nature of what Shotter is pointing to here, my reply to Lisa was, 'But *that* is exactly what has been done....'

The perception of the hue, the intensity of a colour depends on the colours around it. My words of response to Lisa took on the possibility for a different shade of meaning, through the sharp contrast to Lisa's comment. Her words of challenge before my response, and her pause of silence after the response, with my words and their delivery in between, were the ready-made ingredients for the sense making bricolage of those listening to our exchange. Orr (1985) speaks of how we create new stories from the stories we hear others tell. He calls this creative process *bricolage*, after the manner of Lévi-Strauss, in referring to people using what is at hand to solve a problem (Lévi-Strauss, 1962).

Before I had studied complex responsive processes, and before entering the DMan programme, I would have considered the Saint Luke's Hospital story to be a form of information. As indeed I still do. However, I would have thought that the person hearing the information in the story could use that information to create their own knowledge, as something distinct from the information itself. But as my thinking has changed through trying to incorporate the complex responsive processes perspective into my practice, I would be inclined to say now, that when someone hears the story of Saint Luke's, that meaning, or knowledge are continually recreated in relationships. As Stacey writes:

‘In the complex responsive process perspective, individual minds and the more repetitive themes organizing social experience arise together in the interaction between people. Knowledge or meaning is in the interaction, not in people's heads. Meaning or knowledge emerges in the public interaction between people and simultaneously in the private role play each individual conducts with himself or herself...Whatever it is that is embodied in tools and artefacts such as procedural manuals, it is not knowledge until someone uses the tools and artefacts.’

(Stacey, 2001, p. 197)

Another significant learning for me in my study of the complex responsive process perspective is the concept that persons have a narrative-like understanding of their patterns of participation. As Stacey describes:

‘The turn-taking responsive relating of people may be thought of as forming narrative at the same time as that narrative patterns moral responsibility and turn-taking. In

other words, the experience of the living present, like the past, is structured in narrative-like ways.’

(Stacey, 2003c p. 76)

He states further that:

‘Narrative achieves its meaning by identifying deviations from the ordinary in a comprehensible form.’

(Stacey, 2003c, p. 77)

From this perspective then, my narrative understanding of what might happen in the workshop, the expected future of my experience, was being modified by these unplanned, locally organised interactions with others in the workshop. I came to the workshop with a background concern and anxiety about the newness of my practice. What would prospective clients in healthcare think of me as a newcomer to the health sector? Allan’s comments were a differential in the narrative I had been telling myself prior to the workshop about how my shift to healthcare might occur. It was an early and highly encouraging signal from Allan as to what direction the responses of people in the workshop might take. It gave me an initial indicator of what attitudinal stance to my comments other participants might take, particularly the agency employees with whom I hoped for a longer term relationship.

Why is being new a concern, even after I have had the often repeated experience of being at the newer edges of various business activities throughout my career? Eliat Aram’s work provides some insight for me into that, when she writes:

‘Shame is an affect that is related to not knowing. It is an affect related to feelings of inferiority, of being less than...It is the fear of being ridiculed for being less, for not knowing what is supposedly known to everybody else, or ‘should’ be known by one’s role definition, that gives rise to shame...’

(Aram, 2001, ch. 6, p. 11)

My anxiety prior to the workshop, and during my developmental efforts to create a new consulting capability, related to a fear of feeling ashamed, of ‘being less than’ what my new clients expected I would be. Various unplanned interactions, like those I have described with

Allan, Lisa, and the curious Vice President, had the soothing affect regulation effect of assuaging my fear and enabling my courage to continue to speak as I had been doing. And indeed, by the end of the second day, the courage was there to speak even more bluntly regarding the work plans.

9.9 The first afternoon: awareness as a quality of interaction

‘I wake to sleep,
and take my waking slow.
I feel my fate in
what I cannot fear.
I learn by going
where I have to go.’

(Theodore Roethke, *The Waking*)

On the afternoon of the first day of the workshop my co-participant to my right, Dr Thomas, said to me,

‘Your words are having an impact. I watch the room when I am at events like this, and a number of people are agreeing with you or being affected by your words. You can see it when they repeat words they hear along with your name.’

Sometimes awareness comes at a leisurely speed, as for the poet above, who takes his ‘waking slow’. Sometimes awareness comes suddenly in a bolt of illumination. Dr Thomas’s comment to me caused the latter. Language lets humans transcend our embodied temporal and spatial limitations in various ways, including insight about the perspectives of others.

His words redirected my attention, so that I was mindful of others in a different way in the workshop. I think my awareness of others had been constrained by giving most of my attention to how I was presenting myself rather than to my interacting with others. I also was trying to be attentive both to what the consultants were saying about their projects and to how I was responding to each work plan. After Dr Thomas’s comment, I noticed subsequently during that day and the next that sometimes people did what he had pointed to – they repeated the words of other, which were resonant to them, whether they did so with my words or those

of others. His comment made it possible for me to respond to some interactions I had perceived in a different way previously. Now I could make sense of those interactions with feelings of encouragement and added meaning from those previously heard, but not fully understood words.

Dr Thomas happened to be sitting by me because of the prearranged seating locations, which had our names by them. If someone else had been sitting there to my right I would not have had that unplanned interaction with him. If the person to my left, one of the agency directors, had shown any inclination to conversation, I might have talked less with Dr Thomas than I did. If Dr Thomas had not been hindered by the use of a wheelchair for a temporary foot ailment, he likely would have moved around more at coffee breaks and we would have had less time to talk with each other.

9.10 The unheard colleague

In the afternoon of the first day, we talked about the state programmes for managing certain healthcare payments for indigent children and elderly adults. Now Ned, the acquaintance who had invited me to the meeting, was talking: ‘What I have noticed about the use of change agents is this....’

My attention turned to the work plan in front of me and away from Nick’s words. I concentrated on what I might say about the next work plan. I thought silently, my eyes towards the paper in front of me. Which story could I use as relevant to this work plan? If I point to two changes that could be made in the work plan what are they? As I looked up, Ned was finishing – ‘...so, that’s some of what my experience around change has been.’

The sound of his voice had certainly reached both of my ears physically, but nothing of what he had said registered between them! Whatever Ned had said between starting and stopping had not influenced my understanding of the workshop, since I had allocated no awareness to it and instead deployed my awareness elsewhere. Somehow I made a decision unconsciously, shifting my participation into those moments to one of not listening to what Ned was saying. One emerging theme of this narrative regards awareness and attention, and how and why we seem to tailor them. In what sense is awareness and attention co-created?

At the end of the day Ned came over to me and asked,

‘So, what did you think of what I was saying about change management? My idea about change agents?’

I felt frozen by a sudden rush of embarrassment. I was mortified to realise I had not been listening to Ned at that point, especially since I like Ned and he had been the person to call and invite me to the workshop. Too embarrassed to admit to my inattention, and to the unintended disrespect which that implied, I mumbled some generalization in response to his question. Wasn't this like an act of inclusion ~ exclusion implemented by my use of awareness and attention? I had excluded myself from interaction with Ned, in order to have a silent conversation of interaction with myself about the next work plan.

I suspect that I tuned out his words, because I thought I would hear something already familiar to me. And if that were the case, I should use those few extra minutes to review and update my thoughts about the next work plan or to consider if there were anything else to say about the one under discussion. I had participated in online discussions with Ned. I had talked with him and listened to him at a communities of practice convention, and so that familiarity may have bred disregard for the usefulness to me of listening with attentiveness to him.

9.11 KT elements in the design and conduct the workshop

Upon reflection I have become aware that as those of us in the workshop were participating together during two days, I did not notice, and no one else pointed out, that the design and conduct of the workshop included elements of what knowledge transfer strategies usually prescribe. Knowledge transfer suggests paying attention to how and in what format or medium, information or knowledge (the words are used interchangeably in the KT literature) is sent to an intended audience. The invited experts had all been sent a clearly outlined agenda for the two days, and a packet of the work plans, all of which used a similar format. The physical format of the meeting gave the workshop the feel of a conference panel session. The number of experts, eleven, provided, as implied by the agenda time line, for only brief comments per expert of about 4-5 minutes per work plan. This created a pattern during the workshop of speak and reply without discussion. This limited interacting reflected the KT concept of meaning or knowledge being transferred in a transmittable packet – and if

members of the group can hear and speak well enough, and read the work plans, then knowledge has been shared. In an emergent, unplanned way, however, each expert had apparently talked a bit longer than expected, so their comments had overrun the time allotted for discussing the possible changes as indicated by persons' comments. No one questioned whether it would diminish the usefulness of the workshop, to not have that summary discussion as the agenda prescribed. As in the KT literature in the health sector, there was no effort at the workshop to define the fundamental topic being discussed – knowledge transfer.

9.12 Analysis: what was happening in the afternoon?

Why did we proceed in the way we did in the workshop? It seems as though there was a silent agreement about several matters: to hold constant the meaning of the projects (that KT strategies were the right strategies to use for the right projects); their value (these are the right topics to use resources for); and the right motivational direction (our energies and efforts are headed the right way). The experts typically spoke in brief, high-level terms, of how they consult or teach about: knowledge management; change management; and communities of practice. They did not do much evaluating of the work plans. As for the agency personnel and the consultants, they wanted to talk mainly about how to go *forward* with these substantial commitments of resource which they were jointly undertaking and jointly concerned about. They feared, I think, the emergence of some account, to paraphrase the words of Merleau-Ponty in the epigraph, which would render their unvoiced anxieties into openly known truth. For the experts, including me, perhaps it was part of the desire to be included, to carry on without conflict of any sort that might jeopardise inclusion, that led us to leave unexamined how we were actually participating with each other.

Why do I pay attention now as I write this, and as I reflected upon the workshop over the past few weeks? What has helped create noticeable differentials in my narrative understanding of the workshop, and what it meant to me? One reason for that shift might be simply spending more time to consider the experience, which means I can pay attention to aspects of the experience that would have been crowded out of my attention when participating in the moment. During the workshop, as a newcomer to most people in the workshop, I was concerned about and attending closely to how I was presenting myself: was I remembering to tell relevant stories; was I acting in a collegial, non-sales manner. So I did not observe what Dr Thomas saw in the behaviour of the workshop participants, as to the agreement of several of them with my words. Dr Thomas had a different degree of involvement in the situation.

He had a habit, he said, of checking for such agreement, or disagreement I presume also, in such situations. His habit led him to pay attention to and be aware of, what I had overlooked.

In knowledge transfer, as will be discussed more in a section below, such considerations of interpersonal awareness or other qualities of personal interaction do not seem to come into play. It is as if it is assumed that there is a clear line of sight between the knowledge object being transferred, and the person targeted by the KT initiative.

My occasionally self-absorbed participation at times in the workshop reminds me of and is in contrast to, the stance of a complex responsive process researcher as described by Stacey and Griffin. For such a researcher, investigating an organization from the perspective of complex responsive processes, they say:

‘...the insights/findings of the research must arise in the researcher’s **reflection** on the micro detail of his or her own *experience* of interaction with others. It follows that the research method is subjective, or rather, a paradox of *detached involvement*.’

(Stacey and Griffin, 2005, p. 9)

Because of my anxiety about performance, which was related to anxiety about being a relative newcomer in healthcare, I did not have the detachment to observe how others were commenting favourably on my words, ironically enough of course, since that was exactly an outcome I was hoping for! An emerging interest for me involves the effect of emotion on what sense we make of our narrative understandings. Siegel (1999) indicates a central role for emotion:

‘The appraisal of stimuli and the creation of meaning are central functions of the mind that occur with the arousal process of emotion.’ [Siegel’s use of italics]

(Siegel, 1999, p. 139)

9.13 Day two: finding my voice

A surprising twist occurred in my participation in the final two hours of the workshop on the second day. Bruner calls this a *peripeteia* (from the *Poetics* of Aristotle), which is a sudden reversal in circumstances (Bruner, 2002, p. 5).

I had not spoken so specifically on the first day, but on the second day while discussing the second project, I purposely declare and speak to what my intentions are, trying to influence the clarity and accuracy of the perception of them, by saying,

‘I am not here to walk on your work, but to share with you some of my thoughts on these work plans.’

Perhaps I am saying this because I know nonconsciously, before I sense it consciously in my attention and working memory, that on this final work plan I am going to speak in a bit more direct and blunt manner than I have in the workshop until this point.

Henry the facilitator recognizes my turn to speak. I speak the lines above about my intentions, pause, and then dive to the topic:

‘The implicit model in this work plan is very much like that of the other work plans. It proposes to bring people together, provide them with information and reports, which the agency is, and properly so, well known for. It brings them together and there is the implied and hopeful assumption that people will then go back and change the organisations they are part of.’

‘Also implicit in this work plan is an idea of people having the power as leaders to come to these meetings and conferences you would hold, and then go back to their organizations and change them. But when they get back, they are one of many persons, and what happens is not just up to them.’

‘This project speaks of connecting system to system – but there is no such thing as the system. It is a word used a lot in healthcare these days, but systems are made up of people, of individuals.’

‘When we talk about learning networks, [the phrase all the work plans used in some form] as if there is a network that is reification. There is of course not actually a network, but we talk as if there were.’

I cite the CME (Continuing Medical Education) challenge. I point out that a lot of money and time is spent each year, with increasing dissatisfaction and a growing consensus that not much is achieved in the way of actual changes in behaviours and medical practice.

As Dave Davis, an internationally known researcher on medical education, and his colleagues, have said:

‘The effects of CME and CPD [Continuing Professional Development] have been extensively studied. Although it is an unstable and imperfect database, the literature shows that most passive educational activities are poor at changing physicians’ behaviour.’

(Davis, 2003, p. 33)

I notice that the consultant, sitting across from me, who has been describing his firm’s work plan, is taking notes as others and I speak to his project. Now as I speak he is looking straight across at me, a bit wide-eyed, as if he sees an oncoming train. I notice his look, but it is not my intention to intimidate, or to trash their work plan, but to speak clearly and authentically. My intention to speak forthrightly strengthens and I go on with my comments. Enabling my determination to speak this way is the courage that is the root word of the encouragement that I took in the unplanned, but welcome, interactions of the day before: with words of respect and praise from Allan; the acknowledgement and intrigued puzzlement of the curious consulting Vice President; the reassuring observation of Dr Thomas that people were agreeing with me; and my confident response to Lisa’s peremptory comments.

I am still speaking into the silent attention of the room. Intuitively, I slow my voice down for effect and place myself verbally in the mutual generalized-other role of a consultant. I try to speak with a tone of certainty, but the certainty of a concerned colleague, seeking to help:

‘As consultants we have to ask the tough question of what are we doing for the client? How am I adding value here? Am I helping them to do something they couldn’t do by themselves?’

‘There are already forums where a quality officer could go and hear discussions of these topics. There are articles they could read. CEOs of hospitals know each other and talk. They network with each other.’

‘There is good material regarding information, but information is not enough, it is the interactions between people that count.’

‘You may spend a lot of time and money on this and what results will you have at the end? There is a lot that is useful and important here. You need that base of information. But the question is, what can you add to that, that will be value added for the client?’

Like a seabird speeding across waves, my words strafe, but do not dive below, the affording surface of what is at issue here. I am not saying to throw this project out, but I am pointing out to the room, by way of specific citations and stories now and during the two days, that the work plan needs a lot more consideration and change to take it in a direction truly useful to the agency. Here on this final project work plan, in the final hour of the final day, my words feel the most direct and the strongest to me. I am mindful how close my words are to flying beyond the pale created by Laura’s effort to set conversational constraints.

But this one sentence which I improvised into the conversation, which I had not planned to say, or even contemplated saying that I can recall, felt consistent with the values I hold regarding my consulting practice and interactions with others in general. Was it from trying to be true to those values in the emergent creativity of my speaking a warning that a sense of integrity, of authenticity of self arose?

9.14 Why did I speak as I did?

Ogawa and colleagues, cited by Siegel (1999) say the following about the integrity of the self:

‘ “Integration is not a function of the self, it is what the self is...Therefore, the failure to integrate salient experience represents profound distortion in the self system. When salient experience must go unnoticed, disallowed, unacknowledged, or forgotten, the result is incoherence in the self structure. Interconnections among experiences cannot be made, and the resulting gaps in personal history compromise both the complexity and the integrity of the self.” ‘

(Siegel, 1999, p. 315)

If I had not vocalised my concern about where the projects seemed to be headed, unless amended in significant ways, I would not have felt I had been as useful in my contribution to the conversation of the workshop as was possible. The fact that it took until the final hour of the final discussion for me to speak a warning that strong, reminds me of the departing patient with their hand on the door of the surgery, who says what is most important just before the end of their appointment with the doctor.

It seems to me that the feeling of being authentic to myself somehow involves speaking clearly of what my narrative understanding is of the relevant pattern of participation. What I had said was just one strong sentence as I recall – that if the project continued on as designed, a lot of time and money might be spent with few results. In contrast to the one sentence from Allan on the first morning which encouraged me and cheered me, that single sentence spoke about a future scenario of disappointment. It evoked in me what I hoped it would evoke in others; a sense of the feelings to be felt about a failed project. Mead describes this as follows:

‘We are, especially through the use of the vocal gestures, continually arousing in ourselves those responses which we call out in other persons, so that we are taking the attitudes of the other persons into our own conduct. The critical importance of language in the development of human experience lies in this fact that the stimulus is one that can react upon the speaking individual as it reacts upon the other.’

(Mead, 1934, p. 69)

What I think my words probably invoked was a general sense of anxiety around what would be the consequences of a failed project or set of four failed projects. I did not consciously craft my words to do that. But did the intention to speak as I did, nonetheless emerge from a mix of my conscious and unconscious processes? Stacey writes of how we cannot be:

‘...fully aware of...all the narrative themes that are patterning public interaction...In this sense many of the themes are tacit or unconscious.’

(Stacey, 2001, p. 208)

He adds to this that:

‘Those participating are not always likely to be aware of their own, or others’, changing body/feeling rhythms. Since much of their responsive relating to each other

is very rapid and spontaneous, they are likely to be unaware of its patterning. A great many themes organizing the experience are thus inevitably unconscious.’

(Stacey, 2001, p. 208)

Indeed, the body is organised to react at high speed in an unconscious way, for example, to avoid or to catch a falling object. It was at one of the slower moments of the workshop that I reacted swiftly to circumstances by becoming unaware of what my colleague Ned was saying about change agents. What is it that is happening when my attention and awareness shift as they did in various ways during the workshop, such as not listening to Ned? How are awareness and attention co-altered or shaped in interactions with others? And how is that related to the involvement and detachment Elias wrote about (1956)? Or to the detached involvement of the qualitative research strategy of the DMan programme? My narrative inquiry has given me a clearer view of the self-organised aspects, conscious and unconscious, of our interactions with each other by the considering the strong role for that self-organisation in the emergence of my pattern of workshop participation.

Two particular areas of interest have emerged from my inquiry regarding awareness as just mentioned above, and the recursive role for emotions in our patterns of participation and our narrative understandings. I consider these questions in the following section.

9.15 Perspectives and methodologies: KT and complex responsive processes

This section contrasts some key aspects of my experiences in the workshop with corresponding aspects of KT as described in the literature and relates the KT view of new or transformed practice and its connection to new knowledge or learning, to the complex responsive processes perspective. Some brief remarks on how the KT perspective and complex responsive process perspectives are expressed as methodologies are included.

9.16 The knowledge transfer view of the individual

The dominant view of the individual in KT is that of the autonomous individual. This can be seen in how the methodology for investigating the transfer of knowledge is designed and discussed. For example, the work of Estabrooks and colleagues (2004) in conducting a systematic review of 95 studies of research utilization in nursing yielded the following conclusion:

‘Researchers have focused on the individual determinants of research utilization since the beginning of this field [research utilization] in nursing (1972).’

(Estabrooks, 2004, p. 256)

The emphasis of KT, as this quote indicates, is on the characteristics of individuals and not on how they interacting with and influencing each other. My experience of the workshop was in sharp contrast to that individual-centred perspective. My experience of the workshop as outlined above, and as I have come to understand it in general, was that my expression of my practice was being clearly affected by my interactions with others. My encouraging interactions on the first day became the figurational history of the second day from which I drew encouragement to speak forthrightly regarding the projects being evaluated. The socially intertwined nature of my experience contrasts with the knowledge transfer perspective, which consider persons as autonomous individuals who can be categorised in average sets or aggregates (by role, age, organisation, etc.) and modelled as having average encounters.

KT Researchers have investigated various individual and organizational characteristics. Individual characteristics that have been examined with research utilization as the dependent variable include, according to Estabrooks (2004); level of education (the most common attribute examined, Estabrooks, 2003); professional characteristics – e.g. years as a nurse (Estabrooks, 2003); research beliefs; attitudes towards research; problem-solving ability; involvement in research activities; and reading practices. The design and implementation of KT research follow the abstract theoretical frameworks which explicitly and implicitly inform the KT literature. In a study of 95 KT studies – the literature for the KT discourse in healthcare is still sparse – Estabrooks and colleagues found that most of the time – 71.5% in fact – studies did not specify their theoretical grounding. The Diffusion of Innovations model of Rogers (2003) was used 18% of the time. The 10.5% of remaining studies referred to various research utilization models developed in healthcare. In addition to theoretical models KT relies upon, such as that of Rogers (2003), the implicit theoretical bases for KT (also called Knowledge Exchange at times) can be seen in various definitions of knowledge transfer, as represented by the following quote:

‘Knowledge exchange [another phrasing of knowledge transfer] refers to the two-way dialogue and exchange of information between those who generate and those who receive and use knowledge, and is also operational throughout the project or research study. Together, these two elements [KBT and KBE] serve to facilitate the use of research in practice.’

(Barwick, 2005, p. 8)

My perception is that KT, as portrayed in the literature, can be considered to have the following assumptions and views: persons are autonomous individuals; human action is seen from a systems-oriented, rational causality view; a representational view of knowledge; and a strongly cognitive ‘single skull’ psychology perspective about learning, behaviour and self. The implicit view here seems to be of persons as autonomous individuals, separable in their learning, identifiable by particular attributes and not by relations and interaction with other. Knowledge transfer considers decisions and actions to change practice and adopt new research findings as being made independently by those autonomous individuals. The next section shows how these assumptions are present in typical KT research.

9.17 How KT approaches research and evaluation

A common assessment tool in KT studies in nursing is called BARRIERS (Estabrooks, 2004). It is derived from the Diffusion of Innovations Model (Rogers, 2003) and looks at attributes of individuals and organisations. It has so dominated studies in the particular health field of nursing that Estabrooks and colleagues suggested further studies based upon it would probably be redundant in their contributions (Estabrooks, 2004).

The contrasting view of complex responsive processes is that of the socially inextricable individual, where ‘individual’ is the singular and ‘social’ is the plural of the same process (Elias, 1970; Stacey 2001, 2003). We do not act alone, but co-create social reality and the future, in an unpredictable, emergent manner. So in the workshop when I offered my thoughts and comments on the projects I could not predict precisely how other workshop participants would actually react or how I would react to their reaction, and so forth. How I was making sense of my participation in the workshop seems to be related to qualities of the interactions I was experiencing with others, and not the sort of individual attributes – age, years of work, etc. – which a BARRIERS methodology, or Rogers perspective (2003) would understand to be important influencers of behaviours in expressing new practice. An example

of this is the way, as noted in the narrative, in which sometimes I was attentive to and aware of, how others were reacting to my story about Saint Luke's – some favourably (for example, Allan) and others, in a challenging way (as from Lisa). That awareness of others, and my response to them, seems to have certainly influenced my succeeding comments in the workshop. In another example of awareness as a quality of my interactions with others, Dr Thomas brought to my attention that my words and stories seemed to be evoking responses of agreement among other workshop participants. While I had noticed that to some degree, his separate observation reinforced my perception of what sense others might be making of my comments. His comment had the spirit of the words of Stacey and Griffin on the stance of a complexity researcher. As Stacey and Griffin write, if organisations are understood as emergent global patterns arising in local interactions, then:

‘This means that the insights/findings of the research must arise in the researcher’s *reflection* on the micro detail of his or her own *experience* of interaction with others. It follows that the research method is subjective, or rather, a paradox of *detached involvement*.’

(Stacey and Griffin, 2005, p. 9)

By contrast, KT takes more of a standard positivist approach, where the observer is considered to be a rational objective observer that is working from the traditionally described detachment of a ‘God’s-eye view’. It further regards people as objective, rational decision makers when their emotions are properly managed and not allowed to cloud judgment. This emotional management is either guided by the persons managing the knowledge transfer process or the persons receiving the transferred knowledge. Emotions seem to be referred to rarely in the KT literature except as being the source of resistance and attachment to the old ways of doing things (Barwick, 2005).

In contrast, the DMan Programme approach to methodology uses reflective narrative inquiry as an approach compatible with the methodological implications of the complex responsive process perspective. Additionally in the DMan Programme, the narrative as a means of assessment is extended by the sharing and critiquing of students’ narrative projects among themselves, while convening in small ongoing learning sets, and with primary and secondary supervisors. Sense-making in a large group, which relates to the narrative-like understanding of experience that complex responsive process perspective proposes, is also used as part of the

methodology. The dynamics of the large group setting provide insights into one's own behaviour and that of others, and offer parallels to experiences in organisations. In this way the research and evaluation approach of the DMan Programme parallels a complex responsive process perspective, similarly to the way KT research practices follow a KT perspective in its view on what is important to consider in the sharing of knowledge and its application.

In reflecting upon my experiences in the workshop from a complex responsive process perspective, and through the other narrative-sharing and critiquing that characterises the DMan Programme of research in which I am engaged, I have come to different insights as to what it meant for me to try and express my consulting practice in the context of the workshop. By trying to shift my way of thinking towards a complex responsive process perspective I was paying attention – that is to say. I had a new awareness of – different aspects of my participation with others in the workshop than I would have done earlier in my consulting career. A KT perspective points the researcher's attention in a different direction: towards content and away from personal interaction; towards the individual or group and away from inter-personal experience in the group; towards the view of thinking as a rational, cognitive exercise and away from its emotional elements. In my experience of the workshop, and then in my reflection upon that experience, emotions seemed to played a key role, and indeed a very useful and enabling role, for how I came to express my practice. A KT perspective on participation would have lead me to overlook such considerations of emotion and the importance of the several personal interactions that fuelled the emotional energy that helped me improvise into the moment on the second day and speak as strongly about the proposed work plans as described.

9.18 How KT views communication and causality

In my intensive sampling of the KT literature, the general view of communication appears to be the send-receive model, where knowledge (without being clearly defined) is something that can be sent, or transferred, translated or exchanged. The transfer of knowledge is viewed either as done by dyadic communication between individuals (researcher to research user) or the dyadic exchange of one organization (or system) to another. The rational assessment of the new knowledge then leads to action by the recipient. A sample description of this view of communications is as follows:

‘...the research literature strongly suggests that research organizations should transfer actionable messages from a body of research knowledge, not simply a single research report or the results of a single study. A message can, however, profile and place in context a particular study when relevant.’

(Barwick, 2005, p. 8)

Another example comes from the work plans for the projects reviewed in the workshop, which appeared to have exactly this unproblematic conception of it being sufficient to induce changes in practice by sharing content with the intended recipient of the ‘knowledge’ being transferred. Each of four work plans spoke of assembling various information sources: reports; research results; presentations (printed or delivered) by subject matter experts to give to the participants in a learning network. It was a general statement of the plans that it was important to recruit the ‘right people’ as participants. For the project that was promoting high reliability performance among hospitals, the ‘right people’ were considered to be patient safety officers and chief executives of a selected group of hospitals – in other words, persons chosen by personal attributes rather than how they relate to and interact with others.

My experience of learning the story of Saint Luke’s stroke team is in contrast to the KT view of learning as simply the sending and receiving of information. For me to be able to discern the meaning of what the Saint Luke’s stroke team accomplish and to understand how to share that story with others, took place over time and through many interactions. The attempt to share that story during the first KT workshop generated a variety of experiences: how it felt and what it meant when Allan congratulated me on sharing the story; how it felt to justify the story in view of Lisa’s challenge; and the interesting response to the story by the puzzled consulting vice-president, who had knelt by my side, tugging at my sleeve right in the middle of the workshop.

The various ways my understanding of the Saint Luke’s story has grown and changed illustrates that my view of how we go about communicating and making meaning is much more involved than the simple and much reduced view of communication as the sending and receiving of messages between persons, as though they were simply autonomous information-processing machines. Meaning, or knowledge, is not in the ‘actionable messages’ mentioned above, but arises in our gestures and responses with others, and by way of how our emotions integrate and assess the experience of those gestures and responses (Siegel, 1999). This way

of thinking draws upon Mead (1934) and Stacey (2001, 2003b, c), where meaning is not in the gesture alone, but in the gesture and response combined. As Stacey (2001) describes communication:

‘Humans communicate with each other in the medium of symbols, where these symbols are meaning and knowledge. Knowledge therefore is not an “it” but a process of action.’

(Stacey, 2001, p. 116)

9.19 Summary: into the hurly-burly with new eyes

‘To live is so startling, it leaves but little room for other occupations...’

(Emily Dickinson, 1872)

‘The real voyage of discovery consists not in seeking new landscapes, but in having new eyes.’

(Proust, *A La Recherche du Temps Perdu*)

My reflective narrative inquiry has placed in sharp contrast for me how a KT perspective would describe human efforts to generate and share knowledge, or meaning, and the way I now understand and could describe what I experienced in the KT workshop and why. I would say that the tension for me of the workshop, along with the sense of excitement and simply happiness, generated a mixture in my participation and my narrative understanding during the workshop, reflecting elements of older narrative understandings and habits, along with an emergent self-awareness around complex responsive processes arising in my interactions with others and myself in the course of my studies, consulting efforts, and participation in the DMan Programme and its methodological approach.

KT seems to be a thin narrative (from narrative therapy as developed by White and Epston, 1990), with flat characters, who lead solitary lives, other than in the context of tasks to be done. It provides a fairly emotionless description of human behaviour and motivation. By contrast, a complex responsive process perspective seems to provide me a much richer

narrative understanding of what I experienced in the workshop. By looking at my experience with a complex responsive process perspective, and the DMan methodology that is the corollary to that perspective, it made a difference for me I think, in the sense in which Stacey and Griffin have written:

‘It matters what methodology one chooses because the choice affects one’s sense of self and what one does.’

(Stacey and Griffin, 2005, p. 42)

If I had described my efforts to create new consulting practice related to healthcare from a KT perspective, what could I have said then about my participation in the KT workshop? What I would have paid attention to, and become aware of, in my consideration of the workshop would have been different, with different findings of course as a result, reflecting the words of Stacy and Griffin, that:

‘It is in our narrative accounts that knowledge of ourselves arises as we filter out what we pay attention to.’

(Stacey and Griffin, 2005, p. 41)

9.20 Detachment ~ Involvement: why I see now what I did not see before

As I have written this project I have wondered – what is it that happens when I am reflecting upon my experience in a narrative inquiry manner, and participating in the other aspects of the DMan programme? How, and why, does it result in reaching a different narrative understanding of, and perspective on, my experience in the workshop? Why did it take the repeated hammering of multiple iterations on the changing anvil of my awareness, to finally arrive at a narrative understanding that felt truly resonant with my lived experience? In early iterations I was trying to take my experience seriously, but for some reason my attention and awareness were allocated elsewhere, away from the insights that finally, in this iteration, has seemed the most useful in understanding my experience. Several factors seem involved: the emotionally different context of writing about and discussing my experience by contrast with living it at that moment; the reflections and comments of fellow students and supervisors upon my experience; the added time allocated to understanding my experience; and how my awareness and attention regarding elements of my experience shifted and changed as a result in various ways of all the preceding factors. There is room here to point briefly to two of

these aspects of the complexity perspective on researching organizations: 1) the different emotional context of reflective inquiry, and 2) the effects of reflections and comments of fellow students and supervisors.

The different emotional context of reflecting upon experience from a different point in time let me see and understand that experience in a different way. Stacey and Griffin refer to this in a particular way as ‘detached involvement’ (Stacey and Griffin, 2005, p. 9). Siegel (1999, 2007) explains this ability to affect our narrative understanding as being due to the integration and assessment role for emotion in understanding our experience. It is, he explains, how we determine meaning, assign value and determine motivational direction from experience. While reflecting upon my experiences in the workshop through multiple iterations, I was able to consider, in the manner of detached involvement, various emotional and informational aspects of those experiences. In doing so, I was modulating, as I understand from the work of Siegel (1999, 2007), the mix of emotion, information, and energy that is our embodied experience and generating thereby a new narrative understanding. This aspect of how we form our narrative understandings is related to the emerging theme in my inquiries regarding the role for emotion, as discussed below.

I have also considered how the formation and conduct of my narrative inquiry, and what I could consider to be my current narrative understanding of my workshop experiences, were shaped by the awareness and attention of others, as expressed in the comments and advice of my fellow students and supervisors regarding my narrative research project.

In the course of the workshop my attention waxed and waned, drifted or focused, depending on various factors and my interactions with others. For example, Dr Thomas brought to my awareness the manner in which my words were affecting others in the workshop. In a similar manner, the comments on my research Project Three by my colleagues in my researcher’s community also shifted and changed what I paid attention to and wrote about in my narrative. I can understand now that what holds others’ attention and occupies their awareness affects the placement of my attention and the creation of my own awareness. As a result, my own narrative understanding of what the workshop had meant to me, both then and in the present moment of writing this narrative has changed.

9.21 Another emerging theme

My narrative inquiry indicates to me that, as in the KT literature, I too have neglected the role of emotions. Did I put emotions aside in the development of my consulting practice and its implementation out of lack of awareness of the subject? Or did I move my attention and awareness away from emotions in my practice development and its expression, because it was too difficult for me in some way or (somewhat paradoxically, of course) because of my own emotional response? The role for emotions seems more important to me now, and their exclusion from my previous interests and understanding is a noticeable gap. Was part of that gap attributable to a concern about how I might usefully share an appreciation for the role of emotions with my clients who are interested in organizational change?

9.22 Future inquiry

In this project I have paid attention to the qualities of interaction in the expression of practice. Awareness and the role for emotions have emerged as salient points to examine further. As adumbrated in my first project, the role for qualities of interaction in the sharing of knowledge and information and the generation of outcomes was a deliberate gap in the work of Wenger on communities of practice (Wenger, 1998). He examined instead the generation of social cohesion, i.e., the community; the negotiation of meaning and construction of identity; and how they all emerge in the mutual engagement of sharing information and resources in the pursuit of common, or similar, goals. Here I see an emerging point of inquiry that can advance my research. This emerging point involves the question: how do awareness, attention and emotions relate to the discernment of meaning and assignment of value in narrative understandings of patterns of participation? What is the affect upon motivational direction of these qualities of meaning and value? How is this connected to the sense of self and identity? I sense that to direct my inquiries towards these points in contrast to the communities of practice tradition of thought as begun by Wenger (1998), should prove to be a productive line of inquiry.

10. Project Three: ideology, power relating, and inclusion ~ exclusion in strategic episodes

10.1 Reflections

Project Three built upon my efforts in Project Two to pay attention to self ~ other and the qualities and nature of my interactions with others, especially with regard to emotions and feelings. Again peer debriefing, combined with the iterative writing of narrative drafts, helped me to perceive more acutely the qualities of my experience in two QI strategy workshops. A learning group colleague asked me why I seemed so frustrated, almost angry, in my narrative about a workshop I had attended. She noted that I did not seem to give much attention to the perspectives of the workshop facilitators or why they might have acted as they did. This led me to extend my consideration of qualities of interaction by reflecting upon the differences between my perspective of a strategy round table session and the perspective of the host facilitators. I also considered the effect of the dynamics across time and contexts of emotions and relations. My colleagues' critique, combined with the DMan research strategy of detached involvement, helped me change my emotional response to the workshop that had so frustrated me. Changing the emotional assessment of an experience changes the meaning we can discern from that experience (Siegel, 1999, 2007). This helped me consider how the facilitators' anxieties about undertaking some new quality improvement projects was locking their attention onto the topic of how to use public reporting of healthcare prices to generate cost savings (for example, through competitive awareness of prices).

These findings helped me generate insights in the synopsis about how anxieties about possible changes in power relations, inclusion ~ exclusion dynamics or self can contribute to the desire to create preferentially and partially constructed self-advantageous organizational narratives. An example would be the desire of the strategy round table facilitators to create some QI project plans, with a view to having those narratives and their interests as QI promoters prevail in guiding interactions with others.

Insight from this project into the longitudinal dynamics of qualities of interactions and how our emotions or feelings shape our perception of the perspective of others helped me participate differently and write differently about the strategy workshop described in Project Four.

10.2 Introduction

In this project, I examine some interactions during two strategic meetings or workshops in which I participated, and describe ways that ideology, power relating and inclusion ~ exclusion seemed to affect opportunities for learning.

The first meeting I describe was convened as a round table of experts for the discussion of current quality improvement approaches in healthcare. The purpose was described to me as being to help an organisation set strategy for designing some quality improvement projects. The second meeting was intended to be a strategic discussion of two pioneering implementations of an internationally known public health promotion method and to generate ideas about future applications in my country.

I relate my questions and concerns raised from investigating my practice to literature regarding: power relating (Stacey, 2003c); social inclusion ~ exclusion (Elias and Scotson, 1965/1994, Stacey, 2001; Dalal, 1998); and the concepts of cult values and ideology (Stacey, 2003c). As a test of my inquiries regarding the nature of organisational episodes, I situate my narrative in the context of some related writings in recent literature about strategic workshops (Seidl and Hendry, 2003; Schwarz, 2004; Jarzabkowski, 2005). I also combine insights from my inquiries about my professional practice with the complex responsive processes perspective to analyse healthcare literature regarding quality improvement efforts in cardiac surgery and stroke care. In all of these – the meetings I attended, and the quality improvement initiatives I considered from healthcare – an essential aspect of my inquiries involves the categorization and/or measurement of experience by individuals and groups. This aspect of my inquiries draws upon the work of Dalal (1998), Elias (1970) and Stacey (2001).

An emerging conclusion, or insight, relates to the prevailing QI concepts currently in vogue across a number of countries. My examination of two meetings in this narrative leads me to consider how the currently favoured methods of QI, might be viewed as making the pursuit of quality and its methods unquestionable. If that is indeed happening, opportunities to engage in conversations of transformative potential (Stacey, 2003b) may be diminished. Paradoxically, then, QI movements may be blocking transformative opportunities in healthcare by rendering them closed to discussion.

Another insight is that a complex responsive process perspective seems to lead to a more useful explanation of strategic episodes than the theoretical models currently used in the emerging literature on organisational strategy workshops or episodes (Schwarz, 2004; Seidl, 2003; Jarzabkowski, 2005). This literature, still sparse, makes use of a systems-like perspective. The approach seems more descriptive than interpretive, with a view of causality in workshops as being so dogmatically certain as to be implausible relative to lived experiences. The work of Schwarz (2004) seems to do this by ascribing to reified strategy workshops an ability to create desired organisational outcomes, such as a successful new marketing approach, with a very strong certainty. Her examples, considered as narrating, or telling stories of organisational practice, seem to lack the idea of the unexpected reversals and twists of fortune of life, which the ancient Greek dramatists called *peripeteia*. This awareness of the unexpected is an element that Bruner describes as being central to believable narratives about life (Bruner, 1990). I describe how a complex responsive processes perspective could provide an insightful way of thinking about the fundamental omnipresence of those very sorts of transformative uncertainties as being intrinsic to human interaction.

10.3 Replicating patterns of interaction in strategy meetings

In the following section of narrative about my experiences in the QI meeting, I relate how I have come to see the intertwining influences and effects of ideology, power relating, and dynamics of inclusion ~ exclusion in human interactions. I also examine the role for categorization of experience. I consider their effects upon the nature of meeting agendas; facilitation; the allocation and use of time and space; turn-taking/turn-making; and conversations, in terms of their length and topics.

10.4 The setting and start of the meeting

I walked out of the beautifully restored train station and into a blue autumn day in my nation's capital city. It is often described as a city whose reasons for existence are all about questions of power. I was there to take part in an Experts Round Table on Quality Improvement in Healthcare.

The room is filling. Outside, it is a splendid blue autumn day. But this is a windowless room, with no views or natural light. I have never been in this room before, but I recognize a familiar pattern. It is a pattern similar to that of a strategy workshop in which I participated in the spring, when I attended my first experts' gathering. As in the spring workshop, the conference tables with their chairs and the seats along the walls are arranged like two nested

squares set within a square room. There are no assigned seats as such, but the invited experts seem to know that their place is at the tables, and not on the chairs by the wall. Other persons, like supernumeraries in an opera entering stage left, have found their places in the chairs along two walls. In the meeting I notice the people in the chairs aren't introduced and don't speak in the discussions. The two facilitators have their jackets off and are sitting in shirt-sleeves – perhaps, I feel, to demonstrate that they are working very intently today. They are sitting at the far side of the room, a good vantage-point from which to watch the door and the audience. Behind them is a large woman at a small table. She has a large truncated funnel held to her face by an elastic band, and a keyboard on her small table. She will make a meeting transcript in a way that strikes me as rather odd and anachronistic-looking. People are taking coffee or tea from a small shelf just to the right of the double door. Old acquaintances are chatting. New introductions are made. I have just enough time to quickly find attendees I had especially planned on meeting.

10.5 A multiplicity of agendas

As I had heard the QI meeting initially described, it was to be a round table discussion. My agenda for participating originated in the agenda of my immediate client's interests, who arranged my invitation through his contacts. My client and many of his colleagues were concerned that QI projects in healthcare often did not seem to generate significant or lasting results. I had been advising them on how QI efforts in healthcare might be understood from a complex responsive processes perspective. My client had said that some very well-known healthcare leaders would be there and we would discuss the state of the art in QI. To be included in such a distinguished assembly of persons, so relatively early in my work in healthcare, was a point of personal pride, as was my consulting for Allan and his agency. I shared my delight about this with some friends and colleagues.

My personal agenda for participating included the fact that I had made a strong commitment several years before to move my professional practice into the healthcare sector. I wanted to share in the efforts to improve the effectiveness of organising and delivering healthcare services. This has become a point of great passion and resolve for me. I brought with me to the meeting those feelings of passion and eager commitment.

The basic meaning of a round table originates with the famous one used by King Arthur and his knights. At a round table, peers come together to exchange views and deliberate upon

some topic. As it happened, however, the agenda, which arrived just one business day before the round table, had a very structured set of questions, all regarding the one particular topic of QI measurements. The agenda called for three and a half hours of questions and answers. There were no breaks indicated; nor, apparently was any lunch to be provided, although the meeting would last from 10:30 until 14:00. I thought this showed either inexperience with organizing meetings or a disregard for the comfort and preferences of guests. I pointed it out to the person who had arranged for my invitation. He forwarded my observation to his meeting contacts.

This directive agenda indicated a reduced opportunity for me to meet others and a conversation that would be narrowly trained on the use of QI measures. The questions I had hoped to ask, the conversations I had hoped to participate in, the introductions to interesting people, might not happen within such a restricted agenda. For example, I wanted to meet, among other persons, one particular doctor who had developed an approach to chronic healthcare that had gained international attention. I also hoped to speak with a woman whom I had heard of before, but had only met that day as she came into the room. She was leading a very interesting and high-profile new programme on superior performance in healthcare, a topic of keen interest to me. But the agenda had a tight focus on just talking in certain preferred ways about measures and why they were important: it was not just a timeline of events, but also a signalling of the preferences of the hosts. These included: how we would be talking (fairly brief comments and sound-bite responses); what we would be talking about (QI measures); and who had preferential speaking rights (all the persons at the inner table). The signalling of the agenda about these preferences is a form of what can be called categorization of experience.

Categorizing, as Stacey points out, by its nature involves dynamics of inclusion ~ exclusion:

‘The processes of categorizing, which sustain ideologically based patterns of power relations, immediately create the dynamics of inclusion and exclusion through particular ways of talking.’

(Stacey, 2001, p. 156)

My somewhat naïve response of surprise at the agenda's construction is explained by Stacey's further comments on change and accompanying shifts in power dynamics and inclusion ~ exclusion:

‘When one ignores the shifts in power relations and insider/outsider dynamics generating and generated by change, one is taken by surprise at the unexpected turns that change takes. When one expects the unexpected generated by these processes, it all makes more sense and anxiety levels drop as one accepts that change cannot be controlled by anyone.’

(Stacey, 2001, p. 156)

The change that had occurred was that the meeting hosts were to receive financing to pursue some healthcare QI projects. For the hosts, this new contract may have had some special significance or political importance that was generating anxiety. Perhaps the facilitators sought to mitigate their anxiety through the controlling approach to the QI meeting, to ensure that they obtained from the meeting what they felt they needed. Also, what I did not consider until later was that perhaps the lead facilitator also had to follow the agenda because it had been decided by his boss.

As have I reflected upon my participation in this meeting, I have thought more about the relationship histories, preferences, values, beliefs and power issues that we all brought with us to the meeting, and how our interactions in the meeting were influenced by all of that. So, in that sense, the interactions that took place were a replication to some degree of patterns that were occurring prior to the meeting in all our respective paths, and were related to patterns we might be expecting to occur after this QI meeting.

10.6 Allocating and sharing space

The agenda, as announced that morning at the meeting, had been altered to include a working lunch (to keep discussing issues while eating) and a break or two. So maybe the comment about their initial absence, forwarded by my client, had been responded to. But the list of predetermined questions, and the restrictive focus on measures, remained the same.

Like the first penguin from his group at the edge of some pack ice, I tested the waters for possible change and dove in:

‘Could we perhaps split into small groups? There are enough people here to cover the usual key topics in quality improvement.’

I think I asked partly in a fantasised sense that perhaps by suggesting a different approach it might be seriously considered, or perhaps partly in the hope that others in the room might second the idea. What the lead facilitator actually said in response is blurred in my reconstruction of the moment, but my sense of his response was, ‘Well we have an agenda already, and need to follow that’. Nobody spoke to second my idea; next, someone said something about a different matter and the conversation moved along.

The seating arrangements and the agenda’s categorizing of how the meeting was expected to run reflected the ideology of the facilitators and perhaps most of the participants.

The seating arrangements were privileging in a physically demonstrative way the participation of the experts, in addition to their being privileged socially by being called ‘experts’. Elias and Scotson ([1965]/1994) point to similar acts of exclusion of certain members of a community from certain pubs in town:

‘One of the two public houses, “The Eagle”, was almost exclusively frequented by “villagers”, the other “The Hare and Hounds”, by people from the Estate.’

(Elias and Scotson, [1965]/1994, p. 75)

When residents from the Estate had tried to visit The Eagle pub, they:

‘Found the attitude of the other guests in the pub unfriendly and had been “frozen out”.’

(Elias and Scotson, [1965] 1994, p. 75)

Another example of ideology privileging the use of social spaces is in racist environments, when people designated as being the different colour, race, and so on are discriminated against and are expected (for example) to sit at the rear of a public transit bus, while the privileged class or race may sit in forward seats.

The categorisations made by ideology become perceptions held as self-evident truths, as Dalal says, about social attitudes between rich and poor, master and servant. Most of the persons in the QI meeting apparently had an expectation of a general tendency as to where and how to properly sit and converse for those next few hours. As a newcomer, I was probably making myself look like an outsider by asking what I did. I was challenging what Eagleton, cited by Dalal (1998, p. 116) calls ideology ‘a particular way of viewing the world – a way that is defined by the more powerful’.

As Dalal further points out:

‘Now, ideology is always invisible to the conscious mind. Much like elements of the Freudian unconscious, ideology too drives and determines behaviour in invisible ways; Ideology is a means of preserving the current order by making it seem natural, unquestionable, by convincing all the participants that it is so.’

(Dalal, 1998, p. 116)

As mentioned, the facilitators had preferences that could be seen in the agenda and meeting physical format of the meeting: how they thought the conversations should be conducted, how the seating should be arranged, who should sit where, and so forth. Had I been designing and running the meeting, then the agenda and room layout would have been in accord with the preferences and values of my colleagues and me, as influenced by our social context. Over the years of my professional practice my preferences have become my view of the world, my ideology, shared with those of similar predilections. After my narrative inquiries, my insight is that my unhappiness in the QI meeting was a power-relating issue around ideologies.

10.7 Turn-taking, turn-making and the allocation and use of time

Stacey writes about a personal experience in the NHS (National Health Service of the UK) that seemed to echo some of my experience in the QI meeting. He had been asked to take part in a planning meeting that would decide on the topics for discussion by some focus groups that were to be conducted, and was invited to help facilitate one of those groups. He writes of his experience:

‘There were two people at this meeting who expressed some scepticism, and wondered what the proposed focus groups could hope to achieve. However, they were not being

taken seriously. There was clearly a particular pattern of talking structured by and structuring the particular themes [of what the focus groups should do once convened] I have just mentioned. Those who talked in this way were the “in” group and those who did not were clearly being excluded.’

(Stacey, 2001, p. 157)

It seemed that whenever attendees asked questions that might lead to discussion, or added sense-making conversation, the facilitator would basically ignore the question and move on to his own next question. Other attendees generally did not respond directly to, or question, other attendees, but – in resonance with the behaviours of the hosts – tended to interact only with the facilitator. This is a pattern similar to most market research focus groups (for example); it is contrary to the usual understanding of what is meant by a round table.

The following is an example of how these qualities of power relating and inclusion ~ exclusion were intertwined. One person to my left at the meeting had heard a couple of comments about measures of healthcare prices for various services, and how a) those measures can illuminate wide variance in prices in a given geographic area and b) the public availability of such measures would presumably help healthcare consumers to make different and more efficient choices.

The exchange occurred in a manner like this:

One participant said: ‘In our area we found a 400% variance on the cost of just one procedure.’

The facilitator perked up and the transcriber typed faster.

Facilitator: ‘Really? [Rising vocal note, more alert stance] Which shows the importance of transparency in pricing...’

Dr Kelly: ‘And I think when you publish that information, then people have to start justifying themselves; it could get some action, I think...’

A public health practitioner at my left side said:

‘But if we emphasise pricing of a certain procedure in a certain area, unless we also talk about the quality of care received, aren’t we, perhaps, driving, or pushing the customer toward an inferior solution just based on price?’

The question seemed relevant, and is a standard one asked around the issue of balancing quality and cost in the US healthcare sector. The facilitator basically ignored the question and moved on. The questioner did not press her point, but let it go, which was in line with the general pattern of behaviour in the workshop. The pace and pattern for the questions and answers resulted not only from the facilitator’s efforts but also from the acquiescence of the audience, like the partnership of persons dancing. To press one’s question could have been seen as poor form. There was also the risk, given all the pre-existing interdependent relations among participants, of upsetting someone by making a wrong comment. This behaviour on the part of the facilitator and questioners was repeated a number of times. What it did, it seems to me, was to close off possible paths the conversation could have taken. Paths which, had they been followed, might have led to exploring in a more contextual and useful way the disconnected sound-bite responses to the facilitator’s questions.

10.8 Power-relating balances in conversations

The form of the meeting discussion was set as though communication were thought of as ‘send–receive’ by the meeting designers. The facilitator would send his question to be received by the group, and then some persons would send a brief message back. Meaning, in the ‘send–receive’ model of language, is in the message (Sperber Wilson, 1985, pp. 2-21). This implies that the time needed to ‘send’, i.e. create, meaning is basically the time required to send and receive the message. The functionalisation of that belief is indicated in the relatively small amount of time allocated in the meeting for comments to made and noted. Many exchanges were very brief, with limited contextual information. An example of this is the following exchange:

Facilitator to group: ‘What are some sets of measures you found useful?’

1st expert: ‘Well, I like the set of population health measures of the WHO [World Health Organisation]. It’s very comprehensive.’

2nd expert: ‘Those were tried in a lot of countries and they all pushed back.’

1st expert: ‘Oh, I didn’t know that’.

Facilitator to group: ‘And what else are good sets of measures?’

This view of communications assumes the meaning to be located in the message, as sent and received. In healthcare literature about organisational changes such as QI or KT, it is often said that the information should be sent as an actionable message (Barwick, 2005, p. 8).

The agenda, as mentioned above, provides a way to signal planned categorizations of the meeting experiences. For example, the first session on the agenda listed very basic questions about why and for what purposes we measure quality in healthcare. By choosing those questions to ask, others are not asked. The listed questions are the preferred in topics of conversation; anything else is out of topic. Categorizations made from ideological views are a form of power relating (Dalal, 1998).

So, although the experts being assembled from across the country at substantial cost in time and money were people with years of experience, the questions for the first 45 minutes of the agenda were of a surprisingly basic nature: Why do we measure quality? – For cost? For effectiveness? They were important and complex questions, being asked in a simplistic way.

I felt frustrated by the nature of the questions. They seemed the equivalent of assembling some well-known architects to advise on some new buildings, and then asking: why do we have buildings? as protection against weather? as a status symbol?. So as conversational momentum shifted towards beginning the first set of those introductory questions, I felt I should speak again, with a willingness to question the agenda:

‘Excuse me, but I have another question about the agenda. You have a lot of very bright, well-known persons here, who have published and thought about these issues and are known in their field. These seem like very basic questions you are asking. It is a lot of time... and it’s mostly the time... and expense, you know... to gather everyone here and it seems you are asking about things that could be read in their articles, or... or sent in an email perhaps...’

Again, the facilitator’s actual reply is vague in my recollection. He side-stepped my questions. However, perhaps sensing a lack of enthusiasm for his questions, he ended the first session a little early by saying, ‘well, we do want to be mindful of your time, and let’s move

on the next section of the agenda.’ So the implementation of the agenda as planned became the co-creative effort of facilitator and audience.

In the context of the QI meeting, it could be that the purpose was indeed for the hosts to learn what an assembled group of well-known and highly regarded healthcare professionals would say about measures. This might give the facilitators more assurance of speaking in an ‘in’ way, with a certainty and in knowledgeable-sounding way, with those clients, by linking their referencing of various QI measures to experts as a social validation of the worthiness of the measures.

So with regard to my proposition that QI approaches can shut down learning, it might be more specifically said of this QI meeting that learning was shut down in some ways for some participants, so that the learning goals of the facilitators were more likely to be achieved.

10.9 Unspeakable challenges to unquestionable values

When someone seeks to shift the topics of conversation in a meeting in an off-agenda direction, it can be disconcerting, even anxiety-inducing, for facilitators and others interested in pursuing the agenda as planned. The anxiety-creating aspects of shifting a conversation relate to the changes implied for power and related inclusion ~ exclusion dynamics. Stacey explains these points in his experience of an NHS meeting about focus groups:

‘I joined the ‘out’ group in their scepticism and began to suggest other ways we might proceed, perhaps, by focusing attention on what was going on now and what the next step might be, as an alternative to some abstract exercise about a future about which none of us knew much.’

‘This caused great irritation for some and a debate ensued. Why the irritation? The person most irritated was a member representing senior management and in charge of Organizational Development. The themes structuring the talk and making it “in” were themes from the language of OD professionals. Any attempt to shift the language and talk about self-organizing processes and emergence would clearly shift the figuration of who was “in” and who was “out”. The ideology of OD, therefore, had to be defended because it was the basis of the current power structure, certainly at that meeting and, I am sure, more widely.’

(Stacey, 2001, p. 157)

This explanation of figurations of power and inclusion ~ exclusion has helped me understand the details of the following experience I had at the QI meeting.

The facilitator was questioning the assembled experts, in the way an experienced market research person might conduct a focus group. He wanted to know what would be some good sets of measures to take to their association members, whom they planned to help design and implement QI projects.

I was sitting directly across the room from the facilitator, Tom. I still felt determined, even obliged, at this point to try to make some contribution to the expressed goal of discussing how to strategically plan QI projects. I spoke without the nearby microphone.

‘Excuse me if I seem naïve, but how can we... in this room... pick out measures for certain groups of people in Colorado, where I live, or some other area, without asking what their concerns are? It seems like such a vast topic, with so much to measure; how can we, in this room, pick out what measures to tell them to look at?’

Tom threw his hands up, saying ‘well how ever many measures...,’ apparently misunderstanding my comment.

I quickly, but calmly, said:

‘No, I don’t mean how many, I don’t care how many measures, I am just wondering how you would pick out the measures... Some set of measures... That is, out of all the things that can be measured in healthcare, it is such a huge field... and with all the various issues in different local regions, and then to suggest that is what they should look at. I just wonder how we can do that here?’

The conversation moved on with no real reply from the facilitator. I was looking down at my notes. A small strip of paper fluttered down in front of me. I sensed that an acquaintance of mine from the agency, who happened also to be at the meeting, had just walked behind me.

‘You need to back down’, the note read.

My sense of energetic engagement, which had kept me involved in the meeting, albeit with feelings of frustration, suddenly disappeared in a chilling sensation rushing down my neck and back. I felt that freezing sense of being caught out in a way. It was a feeling of being called to heel in one set of relating and interactions in the workshop, by being reminded of the power relating of another figurational relation. Remorse followed instantly with the thought that I might have agitated my client sponsors, who were also at the meeting, and that maybe my energetic questions and comments were even in some sense imperilling my consulting engagement. Just how agitated had I made some of the agency people? The room and conversations faded into the background, and my thoughts and feelings absorbed my attention and awareness fully. My view became self-directed.

I thought, with head down, looking ruefully to the left at my notes. I did not regret my words, spoken directly and honestly in an effort to understand the workshop and the purposes of the facilitators. I wanted to reconcile my understanding that QI topics besides measurement were important to quality performance in healthcare. Instead, I felt remorse that my actions could have inadvertently made some of my clients and acquaintances uneasy or anxious about reactions of colleagues to my questions or comments during the workshop.

I folded the small paper note, and literally chewed on it thoughtfully, while listening in a distant way to the facilitator. He was talking about how to bring all this together, and create a draft consensus document for circulation and comment. I sat mute. I wondered about what I had asked the facilitator prior to my sudden silencing: how can a meaningful consensus document on such a complex topic as quality in healthcare be assembled from just the brief questions and sound-bite conversations of the meeting?

But, then again, as the small note was in effect reminding me, it wasn't really my turn that day, at that particular meeting, to be like a parrhesiast of ancient Greece, challenging normative practices, whether the crowd cares to hear or not. Bleakley defines this word:

‘The parrhesiast purposefully seeks to challenge habitual patterns of thought and action especially in situations of ‘danger’, as in pointing out the unworthiness of established or normative practices that are unethical, hypocritical, unreflexive, congealing, or sloppy.’

(Bleakley, 2000, p. 14)

On reflection, I can now see that a parrhesiast perhaps simply privileges his own ideology and idealised values, as he criticises those of others – just as, it now seems to me, I was doing in the meeting.

Some key concepts of QI in healthcare, in addition to measurements, are briefly described in the following section.

10.10 An overview and critique of some key quality improvement concepts

In this section I provide some brief context about concepts prevalent in the QI programmes, and the QI literature, as currently in vogue across various countries. This will provide some background for situating both the meetings I describe and the QI initiatives described above.

The following seem to be some prevalent aspects in the QI literature: a systems view of healthcare; an emphasis on performance measurement; and the use of those measurements and other tactics to eliminate performance variance. Quality in healthcare is often discussed with respect to either structure (e.g. hospital beds), process (e.g. clinical procedures), or outcomes (e.g. mortality rates).

A very influential, and representative, QI publication in the USA has been the book *Crossing the Quality Chasm: A New Health System for the 21st Century* (Institute of Medicine, 2001). The title points to two prevalent aspects of Quality Improvement programmes – a particular interest in variance from standards (the ‘Quality Chasm’), and a view of healthcare services as provided by systems.

The preface states:

‘This second report focuses more broadly on how the healthcare delivery system can be designed to innovate and improve care.’

(Institute of Medicine, 2001, p. ix)

This draws upon a mechanical view of organisations as systems that can be analysed from outside. Initiatives for a systems improvement can be rationally designed and implemented.

The report also states:

‘The healthcare system of the United States consists of various parts e.g. clinics, hospitals, pharmacies, laboratories) that are interconnected (via flows of patients and information) to fulfil a purpose e.g. maintaining and improving health). Similarly, a thermostat and a fan are a “system”. Both parts can be understood independently, but when they are interconnected, they fulfill the purpose of maintaining a comfortable temperature in a given space.’

(Institute of Medicine, 2001, p. 309)

Plsek (2001), author of the passages cited, combines this systems description with the idea that complex adaptive systems can be described with simple rules that govern the systems. He describes ten such rules for improving healthcare delivery. All the rules are stated in the injunctive – what information patients *should be* provided; what healthcare professionals *should be* doing.

Additionally, the *Crossing the Quality Chasm* report (2001) lists six major aims the report’s authors think healthcare services should exhibit:

‘All healthcare organizations, professional groups, and private and public purchasers should pursue six major aims; specifically, healthcare should be safe, effective, patient-centered; timely, efficient, and equitable.’

(Institute of Medicine, 2001, p. 6)

These six aims might be understood as cult values, in the sense of Griffin’s writings:

‘...idealized values emerge in the historical evolution of any institution and these are ascribed to the institution itself. These idealized cult values become functional values in the everyday interactions between members of the institution.’

(Griffin, 2002, p. 116)

It is when those values are negotiated and actually realised in the interactions of particular persons in particular circumstances that conflict inevitably occurs over how to proceed. Interestingly, we can think about how the functionalizing of cult values about the minimizing

and elimination of variance will in their own functionalization in the daily interactions of life also create difference and variance.

As Dalal explains, differences, or variances, are omnipresent in experience:

‘Take *any* two objects and we will *always* be able to find at least one shared attribute that will make for a similarity between the two objects. We will also always be able to find at least one attribute that is not shared, so making a differentiation between the two objects. This is another way of stating...that things are always similar to each other in some respects *and* simultaneously different to each other in other respects. In other words it is always possible to find a category that any and every combination of objects will be able to ‘belong’ to, and another category that they will not mutually ‘belong’ to.’

(Dalal, 1998, pp. 161-162)

In all our interactions, then, Dalal seems to indicate, we are continually co-creating (or re-creating) differences – or similarities. The categorization of experiences and people in terms of those differences or similarities involves naming those experiences or people. A variance-eliminating methodology, such as typical QI efforts as implemented in healthcare, involves power relating in deciding who will choose the categories of compliance and variance with regard to performance – their construction and calculation. Such a methodology will require decisions on who will conduct the processes of defining and eliminating variance and any assignable attendant consequences. Next, we consider several QI examples of the naming of differences and similarities.

10.11 Removing variance as the presumed source of quality issues

Much emphasis on measuring and explaining variance is present in the QI literature. The following passage by Berwick (2002) illustrates how quality issues are viewed, with a very interesting subtext:

‘The Roundtable had provided a helpful nosology of such problems, contributing the labels "overuse," "underuse," and "misuse" as now-familiar classifications of quality defects. "Misuse" was the Roundtable's term for failures to execute clinical care plans

and procedures properly... "Overuse" was its term for the use of healthcare resources and procedures in the absence of evidence that they could help the patients subjected to them... "Underuse" denoted failures to employ healthcare practices of proven benefit... The Quality Chasm report grappled with all three of these quality-of-care issues flagged by the Roundtable, as well as other performance gaps that the Roundtable did not address...'

(Berwick, 2002, p. 82)

It is interesting to note the original meaning of the word above, nosology. Nosology refers to the classifying of diseases. So if your work is categorised by a nosology of quality defects, it is being categorised in a way that is linked to the classification of diseases. Nosological categorizing might understandably amplify the anxiety about being measured and perhaps adding to any resulting sense of opprobrium.

The variance of structure, process or outcomes from some defined optimum of healthcare practice is often referred to as a gap in quality. Minding this gap generally involves viewing variance as a defect, not as a beneficial occurrence. So the report of McGlynn et al. (2003), as cited by Berwick and Joshi (2005), indicates that

'...research findings indicating the gap between current practice and optimal practice have proliferated... The many studies range from evidence of specific processes falling short of the standard e.g. children not getting all their immunizations by the age of two) to overall performance gaps e.g. risk-adjusted mortality rates in hospitals varying fivefold.)'

(Berwick and Joshi, 2005, p. 4)

This intense interest in the measurement and the elimination of variance seems related to categorizing experience, as well as to how persons maximise differences at the boundaries of those categories, and minimise the differences within categories. There is a saying from China that the beginning of wisdom is to know the right names of things. This implies that there must already have been a naming of things before that beginning. In the work of Dalal and Elias, we can view the naming of names, and the generation of wisdom or knowledge, as social processes in groups.

Dalal wrote about this as follows:

‘...knowledge is always the property of the group. ‘People...learn or forget as groups’ (Elias 1991, p73). This gives rise to the intriguing idea that what is constructed to be objective and true at any moment in time is the outcome of a sociological process. This process might be an enlightened democratic one, or it might be a more dictatorial one.’

(Dalal, 1998, p. 109)

The names from QI we have so far reviewed – variance, current practice, optimal practice – might be seen, then, as examples of power relating in a sociological process of categorizing and naming. We can view the validation of wisdom, or knowledge (that is, what QI should be understood to be, by whom and how) as an example of the dynamics of power relating in interdependent relations. Categorizations, the naming of people and experiences, are examples of what Dalal refers to as:

‘...the structures and mechanisms that are used to maintain the advantage of the power differential.’

(Dalal, 1998, p. 115)

In the next section, we can see how the categorization of experience and the social inclusion ~ exclusion dynamics of groups can be present quite subtly, even among persons striving not to make such judgments.

Then, in the section below on **How Quality Improvement movements can shut down conversations**, we shall consider how such categorizations and naming in performance reporting in healthcare involve the sustaining of ideological positions, and the associated dynamics of power relating and inclusion ~ exclusion.

10.12 The strengths-based community meeting

In the following section I relate how the effects and dynamics of ideology, power relating and inclusion ~ exclusion were present in a ‘strengths-based’ meeting I participated in, and their affects on the agenda; the allocation and use of time; and turn-taking/turn-making. Strengths-based (SB) improvement approaches seek what resources and useful practices already exist in

social groups for addressing the issue at hand, but which until then have not been widely utilised group-wide.

10.13 Background

My client, Allan, invited me to be a participant at an SB meeting he was hosting. In my consulting for Allan, I was sharing my evolving understanding of a complexity perspective and what that might offer for understanding and conducting QI projects differently. Allan and I both saw this particular SB approach as a pragmatic, low-cost, effective public health improvement method that was potentially well suited to quality improvement in healthcare organisational settings.

10.14 The setting and the start of the meeting

We convened in a sunny room, with a large window and a high ceiling. There were only about ten of us, and our visiting convenor encouraged us to ‘skooch closer’ so we could sit nearer to one another. We all sat in a semi-circle towards the end of a large conference table. There were no microphones, as there had been at the QI round table meeting. This had been described as a meeting to have conversations and to make connections about the SB approach to community health. By contrast with the QI meeting, where experts had not spoken much to each other, this meeting seemed more like colleagues conversing about a topic as equals – a round table discussion in the true sense of the term.

This SB gathering, by contrast to the QI meeting, seemed lighter in mood, with more open interaction. We were sharing and discussing complete stories instead of the more disconnected sound-bite comments of the QI meeting. We thought, questioned and conversed about those particular elements of those stories that held our attention. When people asked questions of the speakers, responses were offered not only by the person telling the immediate story, but also by others of the group who wished to contribute.

10.15 Agendas and preferences

Through multiple iterations of this project with the feedback of two supervisors and my two learning set colleagues, I have come to a better understanding of why I enjoyed this SB meeting so much more than the QI meeting, and why my participation in it was different.

Some similarities with the SB approach include that I enjoy using stories in my professional practice, whether consulting or teaching. I find smaller group settings easier for myself and

others to participate in discussion. The conversation in such groups seems more inclusive and deeper than in a room of 40 people.

One difference of my participation in the SB meeting, compared with the QI meeting, is that I did not challenge the SB agenda, because I already favoured the proposed meeting approach. I also had more favourable interchanges with the primary guest speaker, whose work I admired and had influenced me. This was by contrast with the facilitator in the QI round table, whose controlling approach and narrow topic interests frustrated me. I was predisposed to enjoy the SB meeting, because it resonated in several ways with my existing values and norms as I came to the meeting.

10.16 The use of time in the SB meeting

The SB meeting, in parallel to the inclusive SB methodology, provided a larger amount of potential talk time per participant than the QI meeting (24 minutes versus 7). This could be considered the planned attempt to functionalise a cult value that might be expressed as ‘we always are inclusive and appreciative of each other’s experiences by providing generous amounts of time to talk in meetings’. I will describe two ways in which the functionalising of this value did seem to encourage more conversation and opportunities to meet others. I will also describe, in the turn-taking/turn-making section, how that idealized value was not always realised during the meeting.

Another aspect of the SB meeting I noticed was that in our introductions, we had enough time to say more than just our name and organisational affiliation. Introductions in the QI meeting seemed minimal, and felt rushed.

Another example of the effect of a larger allocation of time, combined with a lighter mood and tone of conversation, was the opportunity for a casually sociable lunch versus the ‘working lunch’ of the QI meeting. This made it possible for me to talk longer over lunch with Joe, a doctor who had sat next to me in the meeting. We shared in his very interesting story about using a similar approach to SB in improving patient safety at his hospital.

Joe was talking:

‘What you said about the team at Saint Luke’s... We tried also to have a multi-disciplinary team, but in orthopaedics, and that went nowhere. Outside the team there just weren’t any relationships...’

‘Well,’ I said, ‘one thing I have been looking at is that, with regard to integrated clinical pathways – and Saint Luke’s wrote one of the first in this country – the pathway is about the things, the tasks and procedures, you have to do. And, that’s necessary and good, but... it doesn’t refer to the interactions going on around that pathway. That’s what I think is driving the outcomes.’

‘Yeah, I was thinking about some of what you said,’ shaking his head a little, ‘and it rang a bell about a peri-operative [before surgical operation] fasting guideline we tried by committee and it just fell apart, just... fell... apart... [with a mild chuckle of the ‘I just don’t know’ sort] when we tried to implement, and it was, you know... I think there again there just weren’t relationships outside the committee.’

The extra time that Joe and I had to talk and learn some about each other’s thoughts on these issues has contributed since to our continuing discussion on possible collaborative patient safety efforts. The tight timeline of the QI meeting had not provided for such conversational time, and so far no new contacts have emerged from it for me.

10.17 Turn-taking, turn-making

Although an SB approach to improving health describes itself in inclusive terms, the dynamics of power relating and inclusion ~ exclusion are nonetheless always present in human interaction.

As it so happened, the facilitator was loosely watching the agenda timeline. The conversation overran the designated time for a person on the speaker phone, Glenda, to present. Glenda did not speak out to claim her turn. I seem to recall thinking briefly that she might not have her time to talk. But then I turned my attention back to the conversation among those of us in the room. We were all ignoring her, and in a way excluding her from the conversation, albeit not (it seemed to me) in a consciously deliberate way. Was there an unconscious categorization going on – ‘we in the room’, those ‘others on the speaker phone’ – and then a privileging of the ‘in the room’ group’s turn-taking?

The overlooked participant co-created the oversight by not speaking out about the matter. Perhaps she felt constrained in turn-taking, because of the physical difficulty of being able to detect an appropriate chance to speak. So, in either the more closely controlling facilitation of the QI meeting, or the inclusion-promoting SB meeting, persons were alternately either included or excluded in various and shifting ways.

The next section uses two well-known examples of QI efforts in healthcare to illustrate the application and generalizability of my narrative experience insights.

10.18 How quality improvement movements can shut down conversations

In this section I illustrate some ways to think about and analyse, from a complexity perspective, two examples of the measurement of quality in healthcare. In the first example, I consider how the ideology and dynamics of power relating probably affect choice-making and patient outcomes in certain cardiac surgery QI efforts. In the second example, I analyse the probable effects of anxiety on developing acute stroke care performance measures.

In this narrative I have pointed to how a QI view can be understood as an ideology. I use the term ‘ideology’ in the sense proposed by Stacey and Griffin:

‘Ideology is the basis on which people choose desires and actions, and it unconsciously sustains power relations by making a particular figuration of power feel natural. We can see, then, that complex responsive processes of human relating form and are formed by values, norms, and ideologies as integral aspects of self/identity formation in its simultaneously individual and collective form.’

(Stacey and Griffin, 2005, p. 6)

With that description in mind, it can be said that in 1989 the New York State Department of Health employees made a choice to create a Cardiac Surgery Reporting System (CSRS) to use measurements to motivate quality improvements in cardiac surgery, in accordance with certain values and norms typical of QI programmes.

One Commissioner of the Department described the system and its purpose in the following way:

‘New York has taken a leadership role in setting standards for cardiac surgery, and in monitoring outcomes and sharing performance data with patients, hospitals and physicians. Using a risk adjustment formula crafted with the Cardiac Advisory Committee, the Department of Health is able to compile and compare the performance of New York’s surgeons and cardiac surgery centers... This process allows for comparison and, more importantly, has identified opportunities for quality improvement which have been effectively utilized by hospitals. The data have prompted some hospitals to re-evaluate their processes of care and to make changes that have significantly improved their patient outcomes. Results have been dramatic since the inception of the program, and mortality rates continued to decline in 1994.’

(New York State Department of Health, 1996, p. 1)

10.19 Power relating and selecting and defining measures

Just as creating the CSRS was a choice, so too the measures to be used in the reporting system represent choices that emerge in temporal processes of interactive power relating and communicating. These power-relating dynamics of choice-making around CABS (coronary artery bypass surgery) involved primarily certain members of two groups, the New York State Department of Health and their Cardiac Advisory Group, apparently without much interaction with the general community of surgeons, who were the measured group.

Power-relating dynamics are an ever-present aspect of human interactions. As Stacey and Griffin point out:

‘As soon as we enter into relationships we constrain and are constrained by others and, of course, we also enable and are enabled by others. Power is this enabling-constraining relationship where the power balance is tilted in favour of some and against others depending on the relative need they have for each other.’

(Stacey and Griffin, 2005, p. 5)

We can illustrate the effect of power relating on the selection of measures with the work of Johnson et al. (2002) who examined the effect of making choices about which definition of post-surgery deaths to use in calculating and categorizing post-surgery outcomes for CABS,

the particular surgery being assessed in the CSRS in New York State. Such considerations of defining mortality rates can include how considerations such as: how long after surgery can deaths be attributed to the surgery?

What the study uncovered is quite interesting:

‘Hospital performance as assessed by the two different definitions of death varied substantially. The rankings of hospitals differed for 86% (37/43) of hospitals. Twenty-one percent (9/43) changed their quartile of rank, and five hospitals changed their outlier status.’

(Johnson, 2002, p. 1)

In this QI relationship, choices made by the primary designer and constructor of measures, the role which the New York State Department of Health was performing, can have the following effect, according to Johnson:

‘Judgments regarding the quality of a hospital's performance of coronary artery bypass surgery vary depending on the definition of postoperative mortality that is used. Further research is needed to assess what definition is most appropriate to identify quality of care problems.’

(Johnson, 2002, p. 1)

These assessments and evaluations of cardiac surgery performance are downstream examples of the possible measurement selection approaches that were talked about in the QI round table. An example is that a suggestion was made at the round table that publishing the prices of healthcare procedures in a region for public comparison could be a good QI tactic. Another participant responded by asking what might be the effects upon patient healthcare choices of that act of publishing prices, if related quality measures are not also included at the same time? But her question was not responded to by the facilitator or by others in the conversation, and so was not discussed. Thus, any follow-on comments that might otherwise have occurred did not happen, and so did not make their way into the transcript and its summarization for the QI meeting. The QI meeting hosts were thereby, in the context of power relating, deciding which preferred sets, or types, of measurements, would ultimately be presented to their clients to consider for use in the future QI projects.

We consider next the public reporting of surgeons' performance by the New York CSRS. I describe how one consequence may be the shutting down of some possible interactions between surgeon and patients, including denial of potentially life-saving surgery.

10.20 Power relating and choice-making by cardiac surgeons

Craig Narins and colleagues wondered what cardiologists would say had been the actual effects of New York State's CSRS upon the conduct of their cardiology practice and making choices regarding patients. Narins and colleagues surveyed all 186 interventional cardiologists in New York who were included in a CSRS report in January 2003. To encourage responses of a forthright and authentic quality, the survey assured the anonymity of participating surgeons.

Narins says:

‘While these reports attempt to provide the public with objective information about physician quality, they can in some instances create a conflict for the physician that may actually worsen patient care.’

(Gaffney, 2005)

As one example from Narins' research, on one of the questions of the survey, 83% of the doctors answered that they agreed, or strongly agreed, that risky angioplasties with life-saving potential for patients needing such might be avoided out of concern for the effect upon the patient mortality rate on their physician report card (Narins et al., 2005).

These decisions made by the surgeons represent Griffin's point that in the functionalization of a cult value such as ‘Public performance reporting will help improve CABS patient outcomes’:

‘...conflict arises and it is this conflict that must be negotiated by people in their practical interaction with each other. This is how they are continuously constructing the future.’

(Griffin, 2002, p. 117)

Matters of power relations affect negotiations of public performance reporting. For example the New York State Health Department is the agency that decides on and issues surgeons their license to practice and issues hospitals the certificate of necessity which permits them to offer cardiac surgery services. The Department also runs the CSRS. The work by Narins et al. (2005) indicates how conversations about possible shortcomings of the CSRS were being shut down by these power relations.

In the QI round table I described how power relating stopped interactions as conversations in various ways, including a neck-chilling note from my acquaintance. My questions and those of others in the QI meeting, if discussed fully, could have challenged the apparent strategic direction the facilitators seemed intent on pursuing – measurement with a particular purpose of reducing or shifting costs of healthcare. Thus one person I spoke to, Ms Troy, expressed to me a desire to keep the group on target, and my acquaintance delivered a more direct suggestion with a written note. These are examples of how power-relating dynamics channel or stop conversations.

Chassin notes about starting the New York CSRS that it:

‘... was born in a state that heavily regulates its health care delivery system. The broad regulatory power of the health commissioner in 1989, more than any other factor, explains why no hospital refused when he asked them to provide the clinical data on risk factors, without any compensation for the cost of the activity. The active engagement of the health department continues to be a primary force for improvement.’

(Chassin, 2002, p. 49)

Such considerations of power relating are strong incentives not to ‘tweak the beard of the lion in his den’.

The next example investigates additional aspects of the power balancing between measurers and the persons measured, as well as between the resulting measures chosen and their possible effects.

10.21 Interdependence in selecting and defining QI measures

In the example about stroke care measures that follows, we can see an instance where the power balancing seems to provide for more influence by the measured healthcare practitioners over how measures are selected and constructed.

I describe a way to analyse the selecting of stroke care process measures in the UK NHS as an aspect of interdependent interactions the members of two groups. This interacting occurs between various members of the NHS QI management groups, like the NAO (National Audit Office) and other healthcare practitioners, persons whose performance is ostensibly being measured and assessed. The understandable desire of people in both groups is to seek to control or mitigate the interdependent effects of measuring and being measured.

10.22 Ideology in stroke care quality improvement

In the UK, stroke care services performance measures are published annually by the National Sentinel Stroke Clinical Audit. The audit calls attention to ‘12 key indicators for stroke care’. Publishing these indicators publicly is intended to spur improvement in stroke care processes.

The Executive Summary begins by noting:

‘This audit will inform stroke clinicians and those involved in organising care how they perform against predetermined standards (National Clinical Guidelines and the National Service Framework). Individual site results are benchmarked against the other participants in the audit. The first three cycles of the audit in 1998, 1999 and 2001 showed there were significant areas of stroke care that needed improvement, with considerable variations in the standards of care between different Trusts.’

(National Stroke Sentinel Audit, 2004)

In this statement we can see some common features of QI movements: the generation of standards; using those standards to measure variance; and use of information to reduce variance as a presumed indicator of a quality of care gap.

The audit has key measures for attention and improvement:

‘The 12 Key Indicators for Stroke Care

Results of the National Sentinel Stroke Clinical Audit 2004

1. Patients treated in a stroke unit
2. Patients treated for >50% of stay on a stroke unit
3. Screening for swallowing disorders <24 hours after admission
4. Emergency brain scan within 24 hours of stroke
5. Aspirin by 48 hours after stroke
6. Physiotherapist assessment within 72 hours of admission
7. OT assessment within 7 days of admission
8. Patient weighed during admission
9. Patient’s mood assessed by discharge
10. Patient on antithrombotic therapy by discharge
11. Rehabilitation goals agreed by the multidisciplinary team
12. Home visit performed before discharge.’

(Royal College of Physicians, National Sentinel Stroke Clinical Audit report 2004, section 7, p. 48)

I suggest two ways to understand how these particular measures may have been chosen. First, they satisfy understandable desires to make the QI process more manageable, achievable and less anxious for both the QI managers and the stroke practitioners. Second, they help to avoid tougher conversations by hiding struggles among practitioners over what constitutes the effective provision of acute stroke care services in terms of actually helping to reverse or ameliorate the effects of stroke.

Through self-motivated, competitive and collaborative interaction of management and practitioners, two healthcare groups can interact in a way which, while not necessarily being collusive, nonetheless results in mutually beneficial, non-controversial, readily achieved and improved measures of care processes.

10.23 How measures can hide or avoid power-relating conflicts

Categorizations such as the ‘12 indicators’ above point to a certain similarity, or homogeneity, of professional practice, that can be illusory. Here, the supposed similarity being created is

‘we are all working in common to improve stroke care quality and achieve full compliance with these performance measures’.

However, as Dalal points out, instead of such efforts at categorization illustrating an actual commonality in a group, something else may be happening:

‘With Elias, I would give another answer, which is that the similarity is there for a reason. The reason is to hide something, and the thing being hidden is material, physical, psychological power.’

(Dalal, 1998, p. 204)

The consensus document of the QI round table may have been intended to accomplish a similar surface homogeneity of approach. A surface homogeneity also occurred in the workshop, when various questions and comments about the workshop’s concentration on measures and particular interest in costs and prices were ignored or not responded to by the facilitator and thus were not discussed.

10.24 A process measure not talked about

There is a medicine called tPA, available in the UK and globally, that is generally considered proven to be safe and effective for the treatment of ischaemic stroke and can help to reverse its effects. Ischaemic strokes are the most common type of stroke. Such strokes result from a blood clot blocking the flow of blood and thereby oxygen to the brain. When properly administered, tPA can destroy such clots and save the lives of stroke patients, or keep them from being permanently disabled (Power, 2004, p. 36).

But this unique medicine is seldom used in the UK. The Executive Summary of the 2004 stroke audit report provides a one-sentence description of the use of thrombolysis for stroke care, referring essentially to the use of tPA:

‘Thrombolysis was probably given to at most 27 patients (<1%) from 17 sites (<10%).’

(National Sentinel Audit of Stroke 2004 Clinical Audit Report, p. 8)

By comparison, Saint Luke's Healthcare System (of Kansas City, Missouri, USA), the hospital with the leading intervention rate in Chart One below, will in a typical year treat more than 200 patients with this medicine, or about 28–30% of their ischemic stroke patients.

It is challenging to achieve the swift and accurate coordination of people and resources required to administer tPA. The conversations about tPA in the literature and media, in the UK and other countries, have at times been contentious. In the UK, comments often refer primarily to the organisational challenges and hazardous aspects of using tPA, while not discussing the significant benefits.

The National Clinical Guidelines for Stroke in the UK note:

‘Thrombolysis [an action accomplished by the medicine tPA] has the potential to improve outcome of patients with cerebral ischaemia, however it is a high-risk treatment and should only be administered by personnel trained in its use, in a centre equipped to investigate and monitor patients appropriately. Evidence...has shown that unless the protocols for treatment are strictly adhered to outcomes are worse. The evidence for the benefits of intra-arterial thrombolysis remains limited.’

(National Clinical Guidelines for Stroke, p. 34)

And a nursing protocol for tPA states:

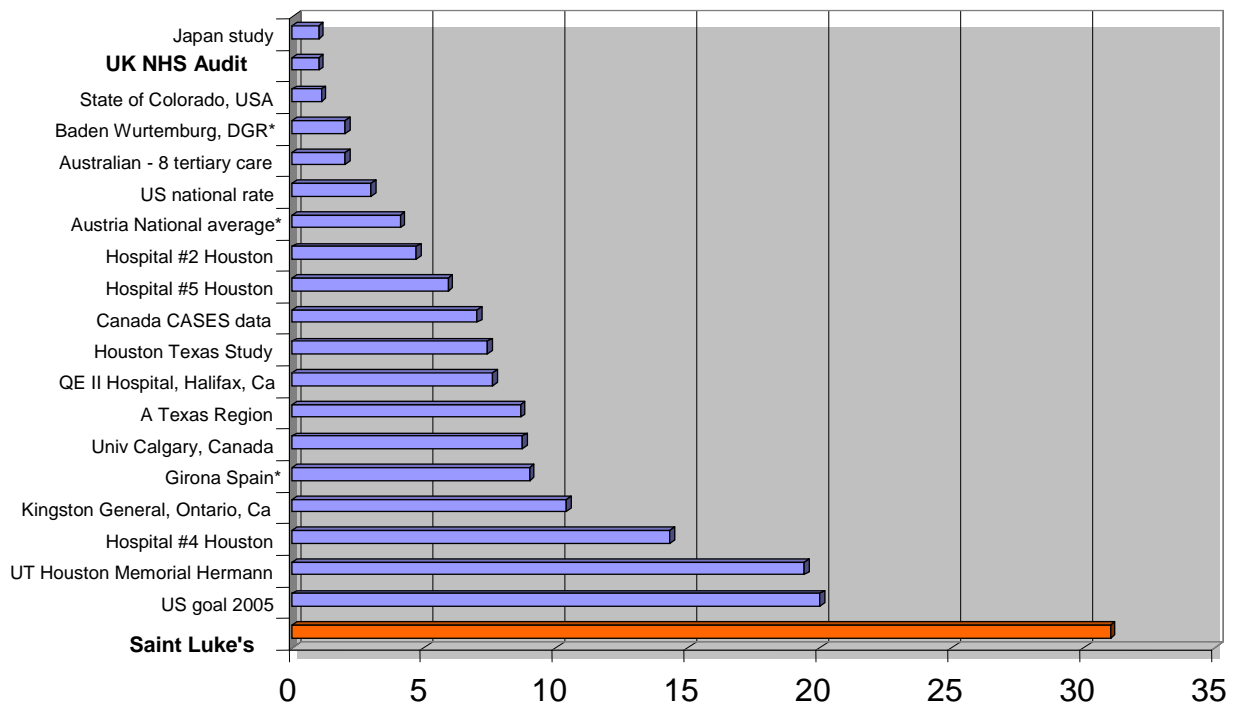
‘Fear of side effects and medico-legal protection for nursing staff. Both doctors and nurses fear the haemorrhagic [bleeding in the brain or elsewhere] complications of thrombolytic treatment...’

(IST-3 Stroke Nurse Collaborative Group, 2003, p. 6)

Low utilization of tPA in the UK might be linked to anxieties regarding the professional consequences of its use. Even when correctly administered, there is a possibility of possible adverse outcomes for patients and thereby for practitioners. As part of the interdependent selection of stroke care measures in the UK, both doctors and QI managers, for their own respective reasons, may prefer not to discuss or measure tPA utilization.

What I am trying to provide, then, is a plausible explanation of emergent competitive/collaborative patternings of interdependencies among people in their daily interactions. That self-organizing interaction might, as in this case, lead to the emergence of mutually agreeable measures, helpful in general to both groups. Alternatively, as in the CSRS example, a more competitive, even adversarial and threatening, set of QI measures might be the outcome.

Chart One: The ability to intervene in ischaemic stroke with thrombolytics (expressed as percentage of ischemic stroke patients receiving the thrombolytic, tPA)



Source: James C Palmer

* Source data was expressed as percentage of total strokes.

10.25 The Strategy Workshop literature: a possible contribution

This project has discussed two central themes: sociological processes, such as power relating and inclusion ~ exclusion; and the categorization of experiences and people, and the related effects of both on conversation and learning. The two meetings are examples of strategy workshops or meetings, which represent a specific topic of inquiry and field of literature within the broader area of study known as ‘strategy as practice’.

In this section, I briefly discuss a line of inquiry and possible contribution related to that literature on strategy workshops (Schwarz, 2004; Seidl and Hendry, 2003) and the wider research field of strategy as practice (Johnson et al., 2003; Jarzabkowski, 2005). Research insights from this reflexive project, along with my efforts to generalize them as explanations of QI activity, suggest that a complex responsive processes perspective could provide a useful alternative to the systems thinking-related views of that literature on strategy workshops. As Schwarz indicates regarding the study of strategy workshops, there is a theoretical gap in the strategy literature to which contributions can be made (Schwarz, 2004, p. 2).

Johnson, Melin, and Whittington describe the strategy-as-practice field by saying:

‘This paper argues for a shift in the strategy debate towards a micro perspective on strategy and strategizing. More specifically we are calling for an emphasis on the detailed processes and practices which constitute the day-to-day activities of organizational life *and* which relate to strategic outcomes. Our focus therefore is on micro-activities that, while often invisible to traditional strategy research, nevertheless can have significant consequences for organizations and those who work in them.’

(Johnson, 2003, p. 3)

They say additionally:

‘It is time to shift the strategy research agenda towards the micro; to start not from organizations as wholes – corporations, business units and so on – but from the activities of individuals, groups and networks of people upon which key processes and practices depend.’

(Johnson, 2003, p. 14)

Seidl and Henry (2003) posit that strategy workshops can be deliberately designed and managed through such factors as a change of location, ambience, informality of social discourse and interaction, to induce a higher level of strategic thinking and discourse. This would be in contrast to the day-to-day routine and operational or hierarchical aspects of organisations. This is a systems-related way of thinking, as indicated in the comments of Seidl and Hendry that such strategy meetings can:

‘...provide a mechanism by which a system can suspend its routine structures and so initiate a reflection on and change of these structures.’

(Seidl, 2003, p. 175)

This implies that, in a sense, it is possible for an individual to step out of the regular organisation and into the specially designed strategy workshop, where they will act and think differently, so as to generate strategic concepts and plans.

Schwarz (2004) writes along similar lines to Seidl and Hendry, stating for example:

‘...strategy workshops play a central role in firms’ strategic management processes – in particular strategy making. This [Schwarz’s] research suggests that strategy workshops present institutionalised strategy practices which take over the following roles within a firms’ strategic management: creation of context for strategy making and strategic decision – making, an informal forum for strategic discourse, social and political interaction, a mechanism for knowledge sharing, organisational learning and a possible source for innovation.’

(Schwarz, 2004, p. 28)

I would challenge the view put forward by these authors. I would conclude, from insights from my research inquiries into my own experience in such meetings, that they are not (like systems) distinctly separate from the groups that initiated them. Considered from a complex responsive processes perspective, my experiences of the QI and SB meetings was that they seemed to involve in various ways the replication of prior existing patterns of participation. They seemed to reinforce, rather than suspend, the ‘routine structures’ of the groups and organisations involved. I propose a different perspective from that of Seidl and Hendry, and suggest that there is an inertial aspect to the existing dynamics of social processes, such as

categorizing experiences and people, with a momentum that carries on beyond the time-constrained and/or topic-delimited organisational episodes called ‘strategy workshops’. In the SB meeting, despite an effort to be inclusive in sharing, and to not be hierarchical in facilitating style, it still seemed that dynamics of power relating and inclusion ~ exclusion occurred. In the QI meeting, I could see how my own actions and responses were not set aside for the meeting. Pre-existing relations seem to carry forward in time through the meeting, as shown in the support of Ms Troy for keeping the conversation and participants focused and on target.

I think there is a resonant line of further inquiry to be explored, comparing the strategy-as-practice approach, and its micro-focus on the details of strategy processes of development and implementation, with a complex responsive processes perspective. Such further inquiry holds the promise of making a useful contribution to the field of strategy as practice and to the particular topic within it of strategy workshops. Such an inquiry might also contribute to the investigation of contrasts between and possible resonances with other organisational areas of study and the complex responsive processes perspective.

10.26 Reflections on my professional practice

Plato is quoted as saying ‘The man of recent authority is always very stern’. What I have seen in myself through narrative inquiry is a person learning a new perspective on organisations, very enthusiastic and eager to point out differences from other perspectives. In doing this, am I practising the sort of categorization that Dalal refers to (1998)? Is categorization of my own experience heightened in my awareness by the enthusiasm of studying a new and interesting perspective on organisations?

I would note further that the KT workshop I wrote about in Project Two is coming around again, and I will participate in the next one. I have suggested to my client Allan that we make use of some small group breakout sessions to improve the quality of discourse and increase the opportunities for creative conversations. After proposing that to him over the phone, I considered how my having made that suggestion could be compared to Schwarz (2004) writing about how strategy workshops can be designed. Did I mean anything different by my strategy workshop suggestions for Allan?

I find myself wondering how I will talk about matters such as this with clients; does a complexity perspective increasingly become a core ideology for me? Can I avoid cult values that unrealistically idealise my professional practice? How do I avoid the trap of considering and presenting a complex responsive processes perspective as just another management tool?

10.27 Conclusion

One understanding I have deepened is that power dynamics and inclusion ~ exclusion are omnipresent qualitative aspects of interaction. They are related to the expression of the ideology and values of the participants. Inquiring reflexively in minute detail about my experiences in two strategy meetings is shifting my understanding of my professional practice and changing my potential conversations with clients.

An implication I draw from this replicating of patterns of interaction in these meetings is that factors such as power dynamics cannot be designed away by strategy workshop planners, nor acted away by their participants, as suggested in the strategy workshop literature. An example of the omnipresent aspect of power relating and inclusion ~ exclusion dynamics was evident even in the SB meeting, which purposively sought to be inclusive, yet unintentionally excluded someone from the conversation.

Another insight gained is the possible effects of idealized cult values in healthcare improvement on QI measurement. An example might be the value that public reporting guarantees improvement, as expressed by Loewenson:

‘Quality can be measured. What gets measured gets improved; and
What gets measured and publicly reported gets improved even more.’

(Loewenson, 2005, p. 4)

But couldn't such idealized values have unintended consequences in the process of their functionalization in daily interactions of healthcare practitioners, their patients, regulators and others involved? Those consequences might actually worsen the quality of outcomes or else shut down discussion and opportunities for conversations with transformative potential. The former seems to be happening in cardiac surgery in the CSRS example from the US. It also seems to have happened in the stroke measures selection example from the UK. The need to conduct anonymously the survey of cardiologists in New York indicates that conversations,

other than perhaps between trusted colleagues, about the true influence and its possible rectification of the surgical measures in preventing treatment for some patients, were being shut down. The stroke measures in the UK direct attention and resources towards indicators that do not seem to hold the same potential for improving stroke care in the UK as might discussions of why the utilization of tPA for ischaemic stroke reversal in the UK is so low.

Regarding insight about my professional practice, I conclude that one of the most useful concepts I can share from a complexity perspective is the value of learning to consider how people are actually interacting, rather than how they should be, or are alleged to be, interacting. Doing so would enhance the opportunities for me to engage with my clients in conversations with transformative potential.

One emerging inquiry is to investigate further the relationship to my professional practice and my research of the topic of strategy as practice, and strategy workshops, as part of that field of study. I also intend to examine more closely how a complexity perspective compares with current thinking in that field, and what contribution might be made to the literature of either.

Another emerging line of inquiry is the role of categorization and the tendency, cited by Dalal (1998, p.116), for people to create binary oppositions such as 'us ~ them'. How do these affect the way learning or innovations are expressed as new practice in healthcare?

11. Project Four: anxiety and ambiguity, partial narratives and preferred perspectives

11.1 Reflections

Project Four built upon insights from Project Three and continued the expansion and deepening of my learning. My experience of the frustrating strategy round table I described in Project Three, and reflective consideration of it, had an effect on the way I approached the next quality improvement workshop. In Project Four, I wrote about participating in a second strategy workshop, subsequent to the one described in Project Two. As I participated in the workshop described in Project Four, I made a particular effort to seek to understand with empathy, or at least compassion, the perspective of the agency and consulting persons directly involved with conducting the QI projects. When I decided retrospectively to write about this workshop, the additional attention I had given to the perspective and emotions of the quality improvers helped me generate insights about how QI narratives are shaped by qualities of interaction. My perception was that the quality improvers had strong anxieties about the changing mission of their agency, about the challenge of QI projects in general, and the evaluation and future financing of their project efforts. Paying attention to the mix of perspective and emotions afforded me strong insights into how QI narratives are partially and preferentially constructed from a particular perspective. Project Four indicates how that shaping of the QI narratives affects the possibilities for learning.

Understanding how anxieties of change in power relations, self and other qualities of interaction could shape the preferential construction of QI organisational narratives was an important step forward in my research findings. By considering how narratives are connected over time, just as the relational dynamics of Project Three continued through time, I was able in the synopsis to consider how the narratives of quality improvers – project plans, progress and evaluation reports – are foreshadowed in the generalized narrative of QI discourse and theoretical mix.

11.2 Introduction

This project describes my experience of a one-day strategy review workshop, the purpose of which was to evaluate the conduct and progress of several ongoing healthcare improvement projects. It was the second of a series of three planned annual workshops in which I am participating as an expert advisor. In this project I consider the effects of anxiety and ambiguity as qualities of interaction upon the presentation of research evidence in care improvement initiatives. I will describe the manner in which narratives about the improvement projects were shared during the workshop and how participants' perspectives affected their interpretations of the narratives. I explore how themes of anxiety and ambiguity were affecting the qualities and construction of quality improvement project narratives. In doing so, I point to an alternative explanation of the sources and effects of ambiguity in the goals, directives and evaluative approaches of governmental and other public sector organisations (Hood, 1995; Chun and Rainey, 2005a, b; Ackroyd, 2001).

My research findings are related to the presence of ambiguity in quality improvement measures in acute stroke care processes.

11.3 Overview: participating in a strategy review workshop

The second of three strategy workshops was convening. These strategy workshops bring together expert advisors with personnel of a government agency and the consultants helping them to deliver four projects. The workshop purpose is to critique those projects. The agency personnel were not confident they had the experience to conduct the projects themselves, and so selected three consultancies to assist in designing and implementing the projects. I had participated in the first workshop a year before, as one of the invited experts. Now I had been invited back again for the second workshop.

For this second knowledge transfer strategy workshop, I had the opportunity to critique two projects. Knowledge transfer (KT) is a term used in healthcare research to indicate efforts to have research evidence used by healthcare practitioners (Barwick, 2005, p. 8). The agency invited eight expert advisors to this second workshop, compared with 15 at the first workshop. We were assigned, either singly or in pairs, to review two projects. First I assisted in the critiquing of a project aimed at efforts to reduce disparities in access to care and outcomes for children of minority status with a particular childhood illness. The second project I critiqued involved coaching a group of ten healthcare providers and healthcare purchasers

(organisations such as companies or government entities) on collaborating in the use of performance standards to achieve ‘pay for performance’.

In the next section, I relate my experience with critiquing the first project.

11.4 Starting the workshop: narrative monologues

In the following sections, I relate how anxiety about identity and power relations among QI team members (agency employees and the contracting consultants) for the Childhood Illness Project (hereafter CID) affected the discourse about the project.

The workshop began in the same room as the year past, but with some changes. Seating arrangements were different, with clusters of chairs and tables arranged in the middle of the room. Some persons from the last workshop I recognised, some I didn’t. Some of the same expert advisors were present again. Two advisors were new to the workshop.

We began with less formal introductions than the previous year, by conducting a group narrative exercise. The same congenial facilitator, Henry, was helping us to start:

‘So welcome again, to the second Knowledge Transfer Expert Workshop. To get started we are going to take seats in the arrangements of chairs here in the centre. Rather than do individual introductions, we’re going to do some quick rounds of story sharing to get to know each other a bit. And Rose will explain what we are going to do.’

Rose, a KT expert, explained how we would, in groups of four or five, each tell a two-minute story about our current projects or work. We would then change groups to hear new stories. Everyone seemed very animated, and engaged readily in these good-natured introductions.

Two rounds went by. Then we carried our chairs back to our pre-arranged places at the tables. The brevity of this exercise, just two minutes to speak, gave only enough time to tell a partial account of projects from the perspective of the narrators, with no time for questions.

Interestingly, these partial narratives and particular perspectives foreshadowed our workshop interactions.

Each expert advisor had received brief project summaries prior to the workshop. The summaries were about one and a third typed pages, each outlined in similar language and format: the goals; target audience; activities/accomplishments in the first year; and future activities.

With project summaries in hand and the group exercise completed, we began the project critiques.

11.5 The childhood illness disparities project

In this section I consider how the discourses of the workshop – project summary documents, and the conversations in the workshop – were affected in creation, content, and sharing, by various qualities of interaction, such as power relating and emotional qualities such as anxiety.

11.6 How my critiquing emerged in the workshop discourse

As I sat down at my group's table, I felt my intentions changing rapidly about how to critique the project. In this current workshop I was sitting at a small table, eye to eye with the others. This made it feel somehow more aggressive than the year before to deliver a strong critique, when everyone had been sitting in a large room set in an impersonal square conference style. Some persons then had been 50 feet away from me.

Our discussion had not yet begun, but the stern admonitions I had privately voiced pre-meeting now felt wrong for this live, close-up context. My practiced phrases fell in silent disarray. As I had thought about the project summary before the workshop, and mentally rehearsed my assessment, my internal voice had had a sharp tone to it. That tone now suddenly felt out of place, as I looked upon the others and began to reconsider how the discussion might actually proceed.

There were six of us. We made rudimentary introductions before beginning. I noticed how young the two consultants across from me looked. They were the consultancy persons on the project helping the agency. They were, I guessed, two decades my junior in age and business experience. This perceived experience gap affected my concern to correctly calibrate my project assessment with the proper mitigation, i.e. the 'level of politeness' strategy (Linde, 1988, p. 380). The consultancy managing director, sitting to my left, looked about my age.

Adrian, a repeat advisor and a friend of mine, sat next to me. A young male agency employee, who joined late, sat silent throughout most of the discussion.

While thinking ahead about the meeting, I had not known much about the QI team members for this discussion, except their names, titles and organisations. Mead describes the process of thinking as being carried on with a generalized other:

‘We have seen that the process or activity of thinking is a conversation carried on by the individual between himself and the generalized other; and that the general form and subject matter of this conversation is given and determined by the appearance in experience of some sort of problem to be solved.’

(Mead, 1934, fn. 7, p. 254)

Those few seconds of sitting down and nodding ‘hello’ had caused a cascade of shifts in my thinking: my perception changed of the particular context, the combination of persons, and my initial impressions of them.

Mead writes:

‘The essential characteristic of intelligent behavior is delayed responses – a halt in behavior while thinking is going on; this delayed response and the thinking for the purposes of which it is delayed (including the final selection, as the result of thinking...’

(Mead, 1934, fn. 7, p. 254)

My concerns about how best to proceed in the current workshop were affected by my participation in another organisation’s QI strategy workshop the previous autumn (described in Project Three). The same agency, which I now was advising, had sponsored that meeting. Feedback to me post-workshop indicated that some of my comments had come across as too strong or critical of the approach the hosts of that workshop were using to design their QI projects. I had felt regret about that; the experience caused me to want to avoid the same perceptions or feedback at the conclusion of this second KT strategy workshop. As a result, my desire now was to provide a strong and pragmatically useful critique, but one that would be perceived as collegially shared and mindful of the perspectives of others involved. In

trying to adjust my behaviour this way, I was experiencing what Mead refers to as ‘social control’:

‘...thus it is that social control, as operating in terms of self-criticism, exerts itself so intimately and extensively over individual behavior or conduct, serving to integrate the individual and his actions with reference to the organized social process of experience and behavior in which he is implicated.’

(Mead, 1934, p. 255)

11.7 Emotional qualities of experience shifted the perspective of my critique

Despite the unexpected shift in my planned critique, I felt keen to talk. We had about 45 minutes in total. Adrian deferred to my request to begin. I improvised around my original evaluation plans. I carried on with a preconceived topic, suggesting that QI projects should themselves be analysed with QI methods. I spoke with mitigation:

‘May I say, I think this is a very worthwhile project. But I would suggest you have to be willing to apply the principles of Quality Improvement to your own effort – for example, what is the evidence supporting your approach... what is the efficacy of it?’

‘A good bit of what is being done here is providing information. That’s useful and good, but just sharing information is not enough and I would refer you to the work of Dave Davis or Nick Freemantle, which points to the ineffectiveness of this approach alone... [Davis, 1995, Freemantle, 2002]’

‘What you could also look at this way is your effectiveness, your efficiency, as in quality improvement literature. It seems to be taking a lot of effort to generate the amount of talk, of interaction that is occurring. So what is it costing to do that?’

I was seeking to have my perspective be a persuasive view for evaluating the project.

11.18 Preferred perspectives for evaluating the CID project

In critiquing the CID project, I wanted to promote my own assessment, but not without regard to the consultants' workshop expectations. In the first KT workshop the year before, Laura, the agency manager of the projects, had said her group did not want to question whether these were the right projects. Instead, the QI teams wanted to know of any better tactics for their implementation.

I felt concerned to help the agency employees in the way they wanted, while still providing, within prescribed bounds, some useful advice. In a larger context I was learning the nuances of working as a consultant in the healthcare sector. I felt concern about my inclusion in the current and related future groups. This motivated me to pay attention to evaluating the project in a collegially perceived manner, albeit a challenging one (Stacey, 2001, 2003b, c; Dalal, 1998). My emotional qualities of concern and anxiety were affecting how I shared my perspective of the projects, shifting it from first person to third person.

Instead of stating my evaluation, as originally planned, from my perspective, or trying to take the general perspective of the team members, I encouraged the team to take on the generalized perspective of a quality improvement evaluator. I was asking the QI team members to 'take the perspective of the other', in the sense of Mead (1934) as to how a QI practitioner, of a standardised characterization, might evaluate QI projects.

I could not, and did not, expect the QI team to arrive at exactly the same points of critique as I had in preparing my comments pre-workshop. My indirect, third-person perspective of critique was an effort to favourably influence the QI teams' thoughts towards my own perspective.

Adrian and I were making sense of the discussion by analysing the project summary and the discussion from our preferred perspectives. For Adrian, that was his perspective about the importance of the sense of community and social cohesion among people with a common practice. For myself, I wanted to encourage the team to look at the project from a standardised QI perspective.

11.9 Did my suggesting a reflexive third-person perspective have an effect?

How my rhetorical strategy may have affected the consultants came to light at the end of the day. The facilitator asked the group what they had learned today. One of the two young consultants on the disparities project answered, while turning in her chair to look back over her left shoulder at me, and said,

‘We should take a look at our own project from a quality improvement point of view.’

I smiled at her. Perhaps my perspective had been taken in for consideration.

11.10 Ignoring my colleague’s familiar perspective

As the project review continued, and I elaborated on my evaluation points, I realised I was starting to labour the point:

‘Well, I realise now I am starting to sound like a professor... which I am as it happens...I sound as if I’m lecturing... which I don’t mean to do.’

Adrian asked,

‘Perhaps at this point I should offer some thoughts?’

He spoke,

‘How are you going about bringing these people together? What is going to create a sense of cohesion in these groups?’

‘What is the, you know, the *aboutness* of this group, and what creates that?’

My attention began to wander in and out of the conversation, with no disrespect intended to my colleague. Adrian and I have known each other for about five years. Familiarity characterised my awareness of his emerging comments. My attention shifted towards my own interests. I reflected upon what I had just finished saying. I thought about whether my comments had been useful and pragmatic rather than just polemical points delivered from my perspective. Could I add anything before the discussion ended?

The two young women, who were the main consultants on the project, had listened mostly, answering Adrian's questions and engaging some with me. They had explained something of the current state of the project. To my right, the young team member from the agency had been mostly silent. To my left, the consultancy managing director had listened in an engaged, reflective way. The group interaction was not so much a discussion of the project summary, but more about Adrian and myself seeking to have our particular perspectives used to analyse the project.

A chime rang. Time for coffee. We continued talking for a minute or two, engaged in discussion. Then we all stood, each with his or her perspective about the project; perhaps altered, perhaps unchanged. The expert advisors rotated on to their next assigned discussion.

11.11 How we were trying to make sense of the project

As mentioned above, Adrian and I had basically accepted the narrative summary of the CID project as offered. Deeper reflection upon my experience led me to wonder why these summaries had all been written similarly with a one-and-a-third page format. Why had the particular project team I was interacting with written and shared the project summary the way they did? Why did Adrian and I take the project summary as it was, without question? After reflexive inquiry, I feel that the project summary narratives were written in a particular and partial way, from a preferred perspective, for reasons I put forward in the next few sections. In the next several sections I call upon organisational narrative discourse analysis to assess the project summaries and their discussion.

11.12 Some discourse analysis: how project summaries were constructed

In this section, I combine tenets of a complexity perspective with organisational narrative analysis (Hansen, 2006; Boje, 1999; Vaara, 2002; Corvellec, 1997; Czarniawska, 2004) to analyse the project summary of the CID project. I also make use of narrative construction motivation theory from the research field of communication theory (Georgensen and Solano, 1999). The analysis will show how the project summaries can be understood as organisational performance, or achievement, narratives (Corvellec, 1997) written in a hegemonic style (Boje, 1999). Further analysis will show the summaries are constructed in the manner of a preferentially motivated account (Georgensen and Solano, 1999) and imbued with a strategic ambiguity (Eisenberg, 1984) as defensive rhetorical moves to create plausible and favourable interpretations of the projects as a success (Vaara, 2002).

Keenoy and colleagues point out that organisational discourse analysis is an umbrella term without clearly defined scope or definition:

‘Discourse analysis, like organization theory, is emerging from an amalgam of different disciplines which include sociology, psychology, philosophy, linguistics and literary studies.’

(Keenoy et al., 1997, p. 148)

and that it is:

‘...possible to identify two overarching analytical positions or ‘meta-discourses’ within the literature. First, for some, discourse analysis is merely a methodological device for making linguistic sense of organizations and organizational phenomena...Second, in contrast, the study of discourse is also pursued as a means of revealing the ambiguities of social construction and the indeterminacy of organizational experience.’

(Keenoy et al., 1997, p. 148)

In my research I used the second stance described to point to the ambiguities and uncertainties of the various discourses of the QI teams, their management, external evaluators and financing sources of the agency. The next section considers the project summaries as organisational achievement narratives (Corvellec, 1997).

11.13 The project summaries as organisational achievement narratives

Corvellec (1997, 2002) provides an insightful description of organisational performance accounts as achievement narratives. He contends that we only know organisational performance through accounts created and shared in various ways:

‘...rather than denoting, as the management literature claims, some form of organisational achievement *per se*, organisational performance denotes *an account* made of organisational action...More specifically, from regarding an organisational performance as something that one has achieved within the organisation, we are led to regard it as being the naming of this achievement.’

(Corvellec, 2002, p. 9)

The project summaries written for the KT strategy review are performance or achievement narratives, as understood in the perspective of Corvellec, which:

‘...confirm the organisation’s well-ordered instances of production, contribute to providing a sense of purposefulness to managerial actions, and participate in the making and holding together of organisation.’

(Corvellec, 2002, pp. 24–25)

11.14 A hopeful description of hegemony in the project summaries

The project summaries, written as achievement accounts (Corvellec, 1997, 2002) that are favourable to the purposes and preferences of the QI team, as opposed to those of the QI clients, are also written with a hegemonic style.

Boje describes the concept of hegemony in organisational narrative discourse this way:

‘The term hegemony...in critical and poststructural theories usually stems from its use by Gramsci (1971) to refer to forms of domination that gain power from being cleverly masked, taken for granted, and otherwise invisible. Hegemony, according to Clegg (1989), “involves the successful mobilization and reproduction of the active consent of dominated groups” (p.160) ‘

(Boje, 1999, p. 341)

The QI teams, I argue, wrote the initial project plans and summaries in a hegemonic style, as though the projects would happen and conclude in a manner preferred by the QI team, with the active cooperation of the QI clients in the project. By writing as if a hegemonic situation prevailed, the QI teams (they all wrote their project summaries this way) can portray that they are engaging in ‘well-ordered instances of production’ (Corvellec, 2002) that will end successfully.

In writing an organisational narrative, vocalization is selectively managed. Vocalization refers to the voices that are heard in the narration: is it univocal or multivocal? Are some voices absent? The characterizations of actors in it, along with their degree of voicing, are preferential categorizations of power relations in the events and circumstances being

described. Rhodes and Brown refer to the concern of narrative researchers such as David Boje, et al. (1999):

‘...with the way that narrative is used to reflexively reproduce power relations and the way that researchers too are embedded in those relationships.’

(Rhodes and Brown, 2005, p. 182)

Barry and Elmes provide additional narrative analytic insights to understand strategy accounts:

‘...a narrative approach can make the political economies of strategy more visible (cf. Boje 1996): “Who gets to write and read strategy? How are reading and writing linked to power? Who is marginalized in the writing/reading process?”

(Barry and Elmes, 1997, p. 430)

11.15 Why were QI clients voiceless in project accounts and the workshop?

In neither the first workshop, nor the second, were any QI clients present in person. In the project summaries, the narration is third-person. The actual QI clients have no audible voice, and their actions are minimally described.

Interestingly, to my knowledge, no one, including me, ever asked why the clients were so diminished? In the project summaries, such as the one for CID, the QI clients were not referred to by name as individuals. They are referred to as participants in Learning Networks or Learning Partnerships (the QI team names for these joint efforts), or by the states of the country they are from, or by the types of organisation in which they work. Using terms from literary theorist E. M. Forster ([1927] 1954), the clients are flat or thin characters in the project summaries. Flat characters, he writes, ‘never surprise’ us. Forster notes that:

‘The really flat character can express in one sentence...’

(Forster, [1927] 1954, p. 104)

These QI clients, thinly described, cannot act in an independent or contrary way to what the QI team hopes and prefers will happen. There is no voicing in the project plans or summaries of why non-adoption by clients might occur. This marginalised depiction of the QI clients

supports the projected portrayal of the QI team as being hegemonically successful conductors of their projects. The next section will describe how narrative techniques of hegemonic discourse and ‘flattened’ client characters supported preferential categorizations for ideological and power-relating purposes.

11.16 Categorization: supporting power-relating dynamics and ideology

The discussion of hegemonic discourse style and marginalised QI clients relates to power-relating dynamics in the KT projects. These dynamics involve QI teams considering themselves as possessing validated research evidence that is of higher value than current healthcare knowledge. The portrayal of the projects and their progress to date in a hegemonic style can be seen as the projection of the preferred narratives of the QI team, as a particular view of the world – in other words, as an ideology (Dalal, 1998; Eagleton, [1983] 1996). The uncontested ideological assertion in the project plans and progress summaries is that the QI teams will help reduce childhood illness disparities by transferring this superior research evidence to their ‘target audience’, the QI clients.

Recently, this agency, and others that initiate government-funded healthcare research, had faced increasing political demands from elsewhere in government to demonstrate that the research findings generated were actually utilised and making a difference (some public management reform movements related to this are discussed in more detail in the section on public services reform literature, below). The hegemonic narrative style of the project accounts plausibly relates to a desire to show successful KT strategies to senior management at the agency and to evaluators of the agency (whose evaluations affect financing). The voicelessness of the QI clients helps postpone, or deflect, uncomfortable conversations about how many of them will actually adopt the research evidence offered them.

The work of Phillips and Jorgensen adds insight to this discussion about discourse and ideology. Following Weatherell and Potter (1992), they define ideology as:

‘discourses that categorize the world in ways that legitimate and maintain social patterns...[where ideology is understood]...as a practice and its power as diffuse and discursively organized.’

(Phillips and Jorgensen, 2002, p. 108)

Boje and colleagues speak further of hegemonic qualities and ideology in organisational narratives:

‘People tell stories to enact an account, or ideology of themselves and their community (Browning, 1991).’

(Boje, 1999, p. 341)

The categorization of the QI clients as receiving a transmitted message of superior evidence enacts an account that portrays their role as choosing rationally to improve performance by utilizing the evidence provided. The QI team is categorised as transmitting the superior evidence.

We can add to these considerations the notion that categorizing, as Stacey notes, by its very nature involves dynamics of inclusion ~ exclusion:

‘The processes of categorizing, which sustain ideologically based patterns of power relations, immediately create the dynamics of inclusion and exclusion through particular ways of talking.’

(Stacey, 2001, p. 156)

From the above propositions, we can see categorization and hegemonic presentation as related ideological aspects of what the project summaries portray.

The QI teams would not want to be evaluated as having failed in their KT strategy projects. The agency employees would not want the agency to be categorised as not meeting its declared strategic objectives. To be categorised that way risks being put in the position of programmes or agencies that are refused financing, or have their financing cut or not increased.

An understandable uncertainty involved how many QI clients would or would not use the offered research findings; this was a source of anxiety generated for the QI teams by their external evaluation concerns. As the next section explains, this uncertainty relates also to existential anxiety about the changing mission of the agency and the research identities of its

employees. In the next two sections, I will show how these concerns influenced the particular and partial way of shaping and sharing the project summaries.

11.17 Creating partial, preferential discourse about projects

Stacey describes how the narratives we share with others recount our experience, but only partially:

‘...the interactive communication between people forms narrative-like sequences...Experience is narrative-like in its formation and patterning in the living present and afterwards that experience may also be recounted in the form of the narrative “told”, but only ever partially. And such “narratives told” feature prominently, as a tool, in the ongoing process of communicative negotiation between people in the living present.’

(Stacey, 2001, p. 139)

The narratives we tell are partial, not only due to human limitations of memory or time to share, but also to the preferential limits and methods that we employ in co-creating narratives. In the next section I consider what was partial about the project summaries of the QI teams. Using the CID project as an example, I will explain what plausibly affected the emergent creation, content and structure of the project summary.

11.18 How a preference motive shapes organisational narratives

One aspect explaining why the narratives of experience are only partially told is that we can choose what to include or exclude, whether events or persons, from a narrative. The same sort of power relating and inclusion ~ exclusion dynamics, and emotions that shape the patterns of our participation with others in narrative-like ways and themes, should logically also shape how we construct and tell narratives about our interactions:

‘ The narrative structure of participants in the self-interest condition [preference motive] focused more on their own cognitions and goal-directed actions than did the narrative structure of participants in the other two conditions.’

(Georgensen and Solano, 1999, p. 189)

The two project summaries I helped to evaluate primarily described the QI team’s activities as though done on behalf of the passively and marginally portrayed clients. These activities

centred on information: disseminating information (teleconferences and workshops), creating opportunities to disseminate information e.g., establishing a website). These activities were listed without indicated outcomes, except to acknowledge that the QI clients received the information in the various ways listed.

Georgensen and Solano note about this type of narrative construction that:

‘Furthermore, the narratives of self-interest-motivated participants focused less on consequences than did the narratives of accuracy-motivated participants.’

(Georgensen and Solano, 1999, p. 189)

This can be seen also in the six achievements listed for the second project I reviewed (described below) with the ‘Pay for Performance’ (P4P) team. The P4P achievements also involved forms of giving information to others (for example, workshop presentations, a teleconference presentation of a case study, establishing a website for the project).

Ten future activities were also listed, again centred on providing information in various ways – teleconferences, conducting workshops, hosting a website. Project purposes were listed as being to provide opportunities to give information to the clients or to help them share information with each other. Again, no consequences for healthcare quality or process changes were indicated or predicted.

Both the project summaries I reviewed and the project summaries I read paid more attention to the goals and activities of the QI team and gave less attention to either the actions of the QI clients or the consequences of the project activities. As Georgensen and Solano note, this structural characteristic of preference-motivated narrators:

‘...is likely the result of self-interested participants focusing the story on their own role rather than on the actions of the other group members in order to emphasise their own contributions and minimise the contributions of the others.’

Georgensen and Solano cite research that:

‘...threat, in the form of negative feedback, motivated participants to reconstruct their narratives.’

(Georgensen and Solano, 1999, p. 177)

The project summaries were not just documents for the workshop, but can also be viewed as rehearsals of ‘achievement narratives’ (Corvellec, 2002) to be used later for future conversations with agency senior management, agency evaluators, or agency financiers.

11.19 An overlooked ambiguity

In the KT workshop of the prior year, a participant commented that the CID project objectives seemed ambiguous. She asked: ‘The goal is to reduce disparities of exactly what? Access to care? Treatment received? Or actual patient outcomes?’. At the time, I did not analyse the point being made. In the second workshop, neither Adrian nor I mentioned this point of goal ambiguity in the CID project.

Chun and Rainey define this sort of ambiguity, which they term ‘organisational goal ambiguity’, as:

‘...the extent to which an organizational goal or set of goals allows leeway for interpretation, when the organizational goal represents the desired future state of the organization.’

(Chun and Rainey, 2005a, p. 2)

They use Feldman’s (1989, p. 5) definition of ambiguity from her work on decision-making in government agencies as:

‘the state of having many ways of thinking about the same circumstances or phenomena.’

(Feldman, 1989, p. 5)

This goal ambiguity present in the CID project objectives was also present in the next project I reviewed in the workshop.

In the section just ended, organisational discourse analysis indicated how organisational narratives can be constructed and told in partial ways and interpreted from preferred perspectives for the purposes of the narrative authors. This does not guarantee how the narratives will actually be responded to, but provides a discursive point of view or negotiation for the authors. The use of hegemonic and preferential styles of construction in the CID project plans and summaries were influenced by power-relating dynamics and identity anxiety regarding the role of the agency employees.

In the next section, the concept of organisational goal ambiguity is analysed for its presence in the QI project plans and summaries. The relationship of ambiguity to social categorizations (Dalal, 1998; Stacey, 2001) is also investigated.

11.20 The pay for performance project

In this section, I consider how ambiguity can have a purposeful role in strategic narratives such as the project summaries and in the interactions regarding those narratives. I also consider the entwined effects of narrative, perspective, categorization and ideology.

The advisors had rotated to our next assignment. Adrian now had a different group to talk to, while I met with the performance measures team.

The P4P project involved the QI team assisting and encouraging QI clients to use agency-provided evidence and an associated evaluation tool. The QI team were ‘hoping’ (their word) for the adoption of the use of performance quality measures in agreements between major purchasers (e.g., companies for employees) and providers (doctors, hospitals).

Six of us were at a small table discussing the P4P project. There were two advisors, myself and Alasdair. Alasdair is a well-regarded senior healthcare researcher. Two agency employees were there, one of whom, Laura, was a senior manager at the agency for these projects. I knew her from the first workshop. There were two consultants from the firm conducting the project for the agency. Sitting to my right was Connie, the lead consultant on this performance measures project. Connie also managed overall client relations with the sponsoring agency for her firm. To my left, Michael, the consultancy managing director, was her manager. None of the healthcare practitioners who were the ultimate QI clients was at the workshop for this or any of the project discussions. No one commented on their absence.

Alasdair took the lead:

‘In reading this summary, I am really wondering – what’s the point of this project? Is it to encourage more use of performance scorecards? Or is it to encourage better thinking about whether to use them?’

If one participant uses a new approach, is that success for the project? What is “success” here?

It’s not clear what your objectives... your goals are here. Is it to help these people learn to make more informed decisions? Or to get them to do something different?’

All were silent. Michael, Connie and Laura looked thoughtful and concerned – not distressed, but concerned. It was harder to read Wanda, the agency project lead. Then some comments sallied back and forth, with speakers allowing that Alasdair’s comment on goal ambiguity was probably a valid project issue.

Alasdair was taking a clear, blunt-feeling approach to analyzing the project. It seemed similar to my own approach at the first expert review workshop.

Alasdair said,

‘What you seemed to have done here is bring some people together, who aren’t really interested in being together. I don’t think there is learning going on here, or that you have a network here.’

Alasdair was referring to a phrase common across all the four projects – ‘learning networks.’ Each project sought to generate ‘learning networks’ that would enable and encourage project participants to engage with each other and the topics in a collaborative, productive manner. Alasdair spoke about another point that of seeking to measure value for money for expenditures on healthcare by using performance scorecards:

‘The evidence is not there for scorecards,’ he said.

The agency team member on the project was protesting back to Alasdair about scorecards. (Scorecards are usually simple matrices of performance measures, such as the well-known ‘Balanced Scorecards’ of Kaplan and Norton, 1996). I knew that the other agency person at the table had been an early promoter of health scorecards. I felt some compassion for her for the challenge these comments gave to her management role regarding this project and her support of healthcare scorecards. I looked across at her: she was looking down and to the right, not responding.

The agency team member had protested:

‘But performance cards do help...’

Alasdair was firm, and he spoke with the gravitas and authority of 20 years’ distinguished experience in healthcare research.

‘Sorry, but the evidence is just not there on performance scorecards.’

11.21 How Alasdair and I made sense of the project and discussion

In reflecting upon Alasdair’s perspective, and what I know of his background in healthcare research, he would be quite used to having to justify his own projects, or to analysing projects presented to him for financing. So a natural perspective for him to take was that of a project evaluator or financial sponsor. Alasdair had not taken the offered project summary just as is, but challenged key elements, and had, it seemed, done so from his customary perspective.

11.22 I try to take the perspective of the P4P QI Team

Alasdair’s comments addressed fundamental project design and implementation challenges in a manner similar to what I myself might have said. So I thought I would turn my comments to other aspects of the project. I wanted to ask the QI team what they desired to achieve, from their view, in the remaining months of the project:

‘Should I call you Connie or Constanza?’ I had turned to my right and was looking eye to eye with her.

‘Connie.’

‘Connie, would a possibility here be to put the attention to the one [client] organization, or two, that at this point seem the most interested in taking up some performance measures, and pay-for-performance sort of agreements, and focus your efforts there? Building on what Alasdair has said about what are the objectives, if you could help those two [organisations] change, is that enough for the project?’

As the discussion had been going on, I had sensed anxiety, or concern, in Connie’s expression, words and movements. This agency was an important client, both for herself and for her firm. Michael and Laura also seemed very absorbed in their thoughts about the discussion, and engaged by the discussion. I was still unable to read much into the participation of the agency project lead, Wanda, who was unfamiliar to me.

We talked a bit about whether to concentrate efforts on the one or two QI client organisations that seemed more inclined to use the ‘pay for performance’ concept of the project.

I explored another angle:

‘Success doesn’t come all at once, and I would suggest it doesn’t have to. We know the studies about how innovations get taken up over time across groups.’

I continued:

‘We know the familiar S-shaped curve [marking an S in the air], but then expect projects to have results like a vertical line on Monday morning when everyone starts doing the same new thing. But it doesn’t happen that way. So isn’t it a success even if you encourage just two or three of these groups to adopt a new process?’

‘Depending on what it is you want to accomplish by the end of the project [ten months away], what you might consider would be to focus your effort on this one particular client that is more interested in change. I don’t think you have to feel as if you need to change everyone at once... Change and success take longer than that. It can be a while for things to change.’

Laura, with a pensive or rueful look, glanced briefly across at me from the other end of the small table, then said, looking down to her left:

‘But unfortunately not everyone thinks that way, and some people... some management... want results faster than that...’

All again sat silent. Our discussion was running out of time.

I spoke again:

‘Well, in the months left for the project I would suggest considering how to gain the most you can toward what you can agree is the objective for the project.’

A few more general comments were made, and then it was time for a brief break before reconvening as the larger group.

My comment, I can see now, missed the mark because I was responding to a partially described situation I did not fully understand. I did not know the context then as well as I do now after reflection and research. I was trying to take the perspective of the P4P QI team, with sympathy for persons similar to me in comparable circumstances to some of my own past experiences. But this in itself did not suffice for me to gain a clear understanding of the broader situation the QI team faced, but were apparently reluctant to openly share until some unplanned conversations at the end of the day.

11.23 Last-minute clues emerge about ambiguities in project summaries

Sometimes a key element for a doctor–patient interview emerges when the patient is just at the point of leaving, hand on the door of the doctor’s surgery, the examination room; the patient says, ‘Doctor, I’ve just been wondering about something...’ An analogous hand-on-the-door discussion occurred in the final session of the workshop. It was mentioned by Dr Thomas, one of the expert advisors, that he had noticed a lot of anxiety during the day about the future financing of these projects and the implications for the projects, the clients and the QI teams.

Dr Thomas spoke:

‘I have a suggestion to make about how you are putting forward the case for the really good work the agency is doing. And that is – stories.

‘You have some engaging, very gripping stories that come out in our discussions of the projects. But your formal descriptions are like: “We held two teleconferences – we had this many meetings – handed out this set of documents”. It is stories that will get people’s attention on those committees you have to deal with.’

‘I know that there is a lot of concern here about funding going forward, and I just think you have a great story to tell about your work.’

So, that’s my suggestion – more stories.’

Dr Thomas could be understood as making his suggestions from the perspective and accustomed role of a long-time and very successful seeker of grant and project financing. His comments, useful in their basic sense, overlooked a deeper issue of why financial anxiety was present. Similarly, in discussing the P4P project, Alasdair and I had not pursued the reason for the presence of the ambiguity that Alasdair had noted. The chief concerns of the agency were not how to be more persuasive in the presentation manner of their financial requests. They were more concerned, I argue, with the prospect of having to explain why they were unable to set clear objectives and goals and then achieve them with predetermined certainty. It is commonly referenced in QI literature how uncertain or unsustainable healthcare QI efforts and results often are.

Some agency persons and consultants added to the conversation about financing concerns by discussing openly, if guardedly, how certain politicians and evaluators had been making pointed inquiries and demands as to the efficiency and effectiveness of such healthcare research agencies.

Someone added a comment about how that approach to evaluation seemed to be strengthening. I sensed the tension in others in the room and noticed some looks of concern. There were some distracted turnings of heads – the sort that signal people wondering to themselves, *just what is going to happen next?*

11.24 How project ambiguities relate to public services reforms

The connections I am pointing to in this project are between and among the presence of ambiguity as a quality of the project summaries and plans and: emotional qualities of experience, like anxiety; interpersonal qualities of interaction, such as power relating; evaluation and financial uncertainties; and agency employee identity concerns related to uncertainties about their agency's mission and purpose.

By contrast, Chun and Rainey (2005a, b) describe the relationship of organisational goal ambiguity and performance of US government agencies in their analysis of four aspects of organisational goal ambiguity: mission comprehension; directive goal ambiguity; evaluative goal ambiguity; and priority goal ambiguity. My inquiry seeks to find recursively linked sources of organisational goal ambiguity and performance in the experience of persons involved with the QI projects I researched. I use a perspective of complex responsive processes of interpersonal relating, linked with several organisational discourse analytic concepts and techniques. By contrast, Chun and Rainey (2005a, b) seek to relate the sources of ambiguity as antecedent research variables to organisational attributes of federal agencies such as: agency age, size, sources of financing, etc.

11.25 Public service reformers' perspectives on organisational ambiguity

Public services performance management improvement efforts, such as NPM (New Public Management; Hood, 1995) in Europe and elsewhere, and the GPRA (Government Performance Reporting Act; see GAO, 2004) and PART (Program Assessment Rating Tool; Rudin, 1998) in the USA, illustrate the effort to move public services management towards 'accountingization' (Hood, 1995). A central aspect of these reform initiatives is a call for clarity of objectives and accountability for performance. Chun and Rainey have written:

'...the assumption that goal clarification will improve organizational performance underlies recent administrative reforms, including the Government Performance and Results Act (GPRA) in the United States and initiatives based on the New Public Management in other nations.'

(Chun and Rainey, 2005b, p. 530)

The type of organisational goal ambiguity examined in my research can be classified in two forms: directive and goal ambiguity. These are defined by Chun and Rainey:

‘Directive goal ambiguity refers to the amount of interpretive leeway available in translating an organization’s mission or general goals into directives and guidelines for specific actions to be taken to accomplish the mission.’

(Chun and Rainey, 2005b, p. 532)

In addition to the directive ambiguity present in the KT project plans and summaries is the possibility embedded in their manner of construction and content for generating alternative interpretations of the projects as a success. This type of ambiguity relates to evaluative goal ambiguity, as defined by Chun and Rainey:

‘Evaluative goal ambiguity refers to the level of interpretive leeway that a statement of organizational goals allows in evaluating the progress toward the achievement of the mission... Some organizations can express their performance targets in an objective and measurable manner that allows a minimum level of interpretive leeway. Other organizations have difficulty specifying objective, quantitative and outcome-focused performance indicators and may use workload or process indicators rather than results or outcome indicators in performance evaluation.’

(Chun and Rainey, 2005b, p. 533)

11.26 Ambiguities in search of certainties

A curious aspect of this is that various evaluators have pointed to the ambiguity that exists in accounting approaches to performance assessment (McSweeney, 1997; Peursem, 2005; Hines, 1991). McSweeney writes:

‘...neither current, nor reformed, accounting can make unambiguous representations...’

(McSweeney, 1997, p. 691)

Public management reformers can be seen as requiring strong certainty and clear accountability from public services providers for organisational performance concepts that are

usually ambiguously defined (Corvellec, 1997, ch. 2) through the mandated use of inherently ambiguous accounting methods.

11.27 Ambiguity about what organisational performance is

In addition to recommended ambiguous accounting methods of performance measurement, even the Performance Management directives or initiatives can be seen as ambiguous in their own regard. An evaluation by the US Government Accounting Office, for example, of a US evaluation method known as PART (Program Assessment Rating Tool), notes that:

‘Many PART questions contain subjective terms that are open to interpretation. Examples include terminology such as ‘ambitious’ in describing sought-after performance measures. Because the appropriateness of a performance measure depends on the program’s purpose, and because program purposes can vary immensely, an ambitious goal for one program might be unrealistic for a similar but more narrowly defined program.’

(Government Accounting Office, 2004, p. 20)

That multiple interpretation of meaning in the PART approach represents ambiguity in the very evaluation tool used to assess clarity and certainty in the programme efforts of national government agencies. I propose that this indicates power-relating dynamics and competing ideologies are at play, rather than the pursuit of accuracy in assessing agency effectiveness.

11.28 How narrative structure and content are clues to emotionality

Emotional and motivational clues in narratives and their narration are also described in research from the field of language and social psychology, which considers how emotions and motivations shape the construction of narrative. Georgensen and Solano (1999, p. 175) describe how ‘motivation influences not just the content of a story but also how a story is connected.’

Their research is useful in considering the presence of the emotional clue Alasdair and I had overlooked. It relates to the ambiguous objectives in the construction of the P4P project. Alasdair had noted the lack of clarity regarding the objectives of the project; were they seeking to help the clients be *better informed in decisions* about using scorecards, or did the project team seek to have the clients *adopt and make use* of scorecards?

What could be the emotions or concerns regarding the projects and the mission of the agency I was assisting, that would contribute to ambiguous construction and declaration of the project objectives and goals? In the next section, complex responsive processes of relating theory will offer some clues as to why a theme of ambiguity was present in the two projects I helped review, as well as in the other project narratives.

11.29 Anxiety and ambiguity as themes patterning interaction

In the theory of complex responsive processes, anxiety can be described in terms of its relation to the inclusion ~ exclusion dynamics of human interaction. Stacey writes:

‘For a being for which the social is essential to life itself, the deepest existential anxiety must be aroused by any threat of separation or exclusion, since it means the potential loss or fragmentation of identity, even death. Also, categorizing people into this or that kind, with this or that kind of view, may be experienced as threatening. This is because it creates potential misrepresentation of identity and potential exclusion.’

(Stacey, 2003c, p. 130)

The anxiety that agency personnel had been experiencing had several sources. First, there was an ongoing theme of what the central purpose of the agency should be. There were conversations in the first workshop as to whether the agency employees should change, or were able to change, from generating research and publishing research findings towards a more active role encouraging the actual use of research evidence. From my interactions with agency personnel, I have seen that this is an ongoing matter of identity anxiety for them. Secondly, the anxiety of identity change was heightened by agency evaluators and financiers insisting that this identity change be a clear and swift transition from evidence generators to involved surrogate implementers. The role of the surrogate implementer is to coax or somehow persuade potential evidence users, researchers or healthcare practitioners to rapidly and thoroughly adopt the latest preferred innovations, be they evidence, medicines, guidelines, or something else. These discussions are what Stacey describes as:

‘...conversations with transformative potential [that] inevitably arouse anxiety at a deep existential level. Such anxiety provokes defences such as denial. In other words, themes emerge in conversations that counter themes with transformative potential and

so shut down further exploratory conversation. The questions of how people deal with anxiety, almost always unconsciously, and how they might find ways of living with it, are central.’

(Stacey, 2003c, p. 80)

The anxiety of being exhorted to change their identities from healthcare researchers to healthcare evidence promoters, I argue, generates a defence tactic of ambiguity in the discourse of the agency. Such ambiguity can be seen in the KT project summaries. The theme of ambiguity in the KT projects can be seen as arising as a counter theme to conversational themes with agency evaluators and financiers about research utilization rates not being as high or as rapidly and certainly achieved as desired. Ambiguity in strategic communication, as noted by Eisenberg (1984), provides plausible denial and affirmation. Eisenberg offers this:

‘In organizations, the deniability of ambiguous communication is a key element in the maintenance of privileged positions and has both task and interpersonal implications.’

(Eisenberg, 1984, p. 235)

If research utilization rates are low and practice changes are few, then the agency QI teams can plausibly deny that it was possible for the KT projects ever to have counted on strong rates of adoption. Instead, the QI team can assert that the agency and consulting employees had always given their best efforts to encourage clients to change, as evidenced by using expert outside advice and well-validated research findings. QI teams can point out that this interpretation was always present – however ambiguously – in the project plans and evaluation reports, from beginning to end. These options for interpretation can be understood as the QI team responding in a sensible way to the possibility of negative evaluations of their project. The defensive response of ambiguity may also have been from general psychological defences against anxiety, which Stacey (2003, p80) notes are almost always unconscious processes. My analysis points to what purposes the organisational goal ambiguities of the QI teams might serve. The analysis does not depend on whether the discourse defences originated as conscious or unconscious processes, or a mix of the two.

Related to communication behaviour similar to this narrative discourse patterning by the QI teams, Eisenberg writes:

‘Strategic ambiguity in task-related communication can preserve future options. Disclosure of information in unequivocal terms limits options and may prematurely endanger plans.’

(Eisenberg, 1984, p. 235)

He notes further:

‘...ambiguous communication is not a kind of fudging, but rather a rational method used by communicators to orient toward multiple goals.’

(Eisenberg, 1984, p. 239)

The mix of directive and evaluative ambiguity behaviour that Alasdair had noted in the project can be seen as emotionally competent, rational conduct (Damasio, 1999, 2000; Siegel, 1999) by the QI team in generating plausible and flexible discursive defences against anxieties of identity and power relations.

Stacey writes of the defensive behaviours such as those just mentioned, which people may deploy to avoid anxiety:

‘...people may prepare forecasts of future states that are impossible to predict and develop strategic plans on the basis of these forecasts. Such plans may then have little impact on what is actually done but by creating a sense of certainty defend people against the anxiety of feeling uncertain.’

(Stacey, 2003a, p. 379)

I propose that this is what is occurring in the KT projects. The QI P4P team indicated in the workshop the difficulty of persuading even one or two of the limited group of QI client organisations on the project to adopt the suggested QI approach. The workshop discussion indicated that only one or two organisations might do so, while even that seemed uncertain. That reality notwithstanding, the project summary for the workshop had been written as an organisational achievement narrative (Corvellec, 2002) in a hegemonic style (Boje et al., 1999), with a preferential form (Georgensen and Solano, 1999); all in order to point to the project as well-conducted and an anticipated success. Should the project be evaluated in the

future as a failure, this preconceived social distancing of the QI clients as a distinct group of 'others' by the hegemonic and marginalizing style of the project plans and summaries could enable improvisational scapegoating of the clients as culprits responsible for the sources of failure of the project (Vaara, 2002). This would provide another line of defence for the quality improvers.

In this section, it has been shown how identity-related anxiety and social dynamics of power relating, inclusion ~ exclusion and competing ideologies (understood as expressed through competing narratives), can be understood to result in defensive behaviours expressed in organisational goal ambiguities, both directive and evaluative, in the organisational discourses of the KT projects.

In the next section I indicate the relevance and transferability of these insights about the QI projects for the analysis of how some stroke care process quality measures have been developed in the USA.

11.30 Ambiguity in constructing quality measures for acute stroke care

This section tests the transferability of my findings regarding the qualitative sources of ambiguity and its discursive uses for the dynamics of power relations. I do so by examining the presence of ambiguity in the construction of a key process measure in a standardised national set of acute stroke care performance measures in the USA. I analyze how, in a fashion parallel to the discussion of ambiguity in the QI projects of this narrative, it is plausible that anxiety as an emotional quality of relational interactions in the community of stroke care practice is a plausible motivator for the presence of that ambiguity. The ambiguity of the stroke care measure provides a means by which distinctly different modes of stroke practice can all be described as successfully improving their care process quality.

11.31 The ambiguous Stroke-Four measure in US stroke care guidelines

A set of stroke care performance measures have been agreed to in the United States by a committee of doctors and professors of medicine and health services, and published and promoted by the originating regulatory organisation, the Joint Commission (formerly known as JCAHO, or the Joint Commission for the Accreditation of Healthcare Organizations). The Joint Commission is an important US regulatory body that sets various standards and guidelines in healthcare. The ten primary stroke care measures they publish were developed as part of a strategic effort to measure and improve quality in acute stroke care

(<http://www.jointcommission.org/>). A comparable set of UK stroke care measures are discussed in my Project Three.

The US measure to be analysed for ambiguity, ‘Stroke-Four’, also has another name: ‘Tissue Plasminogen Activator (t-PA) Considered’. Tissue Plasminogen Activator, or tPA, can be briefly described in lay language as a natural substance produced by the human body that can be manufactured by pharmaceutical firms for use in treatment to reverse strokes caused by a clot that is blocking the flow of blood to the brain (Mosby, 1996, p. 761)

The Stroke-Four measure states:

‘All patients who present at a hospital with symptoms of an ischemic stroke with symptom onset of 3 hours or less should be *considered* [emphasis in the original] to receive intravenous (IV) t-PA.’

(JCAHO, 2004, pp. 4-19)

This measure has a primary rate with three elements:

‘I) Primary Rate

The number of patients who were **considered** for IV t-PA administration. This includes:

1. Patients who were considered but determined to be ineligible to receive IV t-PA
2. Patients who were offered IV t-PA
3. Patients who received IV t-PA’

and a secondary rate:

‘II) Secondary Rate

The number of patients who **received** IV t-PA’

(JCAHO, 2004, pp. 4-20)

The Stroke-Four process quality measure notes improvement as an increase in rate (JCAHO, 2006, p 4-19). Ambiguity is present in that a stroke team could either concentrate on

reporting progress towards considering the use of tPA for patients or they could pay attention to the number of patients actually receiving the medicine. There already exists an approximately ten-to-one gap between the average rate for tPA usage and the best usage rate among US hospitals [see Chart One in Project Three].

11.32 Why construct an ambiguous QI measure?

In this section I use insights from my research to connect the ambiguity of the Stroke-Four measure to ambiguity arising from anxieties and concerns of a directive (how to express practice) and evaluative (how will our stroke practice be assessed and evaluated) nature. The categorization of experience and/or persons, as a quality of the construction of stroke care quality narratives, provides for two primary and distinct views of practice, either of which can show that quality is improving. This ambiguity provides leeway in the categorization by stroke practitioners of their administration of tPA to stroke patients. This narrative leeway helps practitioners avoid professional disagreements and power-relating dynamics in their communities of stroke practice. The use of tPA still stirs contention and anxiety regarding its use, in the USA and the UK, 11 years after its approval by the US Food and Drug Administration (FDA) for safe and effective use in ischaemic stroke (American Heart Association, 2007) and three years after its approval for similar use in the UK. Part of the understandable anxiety of practitioners regarding tPA is that, even with proper administration, it can in a small percentage of cases cause damaging or fatal bleeding in the brain (SICH – symptomatic intracranial haemorrhaging) as an adverse side effect.

This association with contention is referred to by the Joint Commission in its guidelines for implementing the stroke care measures:

‘While controversy still exists among some specialists, most practice guidelines developed in the United States advocate the consideration or use of IV t-PA for eligible patients within strictly defined criteria, and when administered by experienced physicians in healthcare centers with appropriate expertise.’

(JCAHO, 2004 pp. 4-19)

Given the strong tone often present, and the persistence of contention, I argue that the evaluative ambiguity (Chun and Rainey, 2005a) of Stroke-Four functions as a defensive tactic to counter the anxiety of US practitioners and regulators with regard to their concerns about

performance evaluation around the utilization of tPA. The corollary to the evaluative ambiguity is the acceptable cover that it provides for directive ambiguity (Chun and Rainey, 2005a) by legitimizing distinctly varying and different modes of acute stroke care practice.

It can be understood then, that the suggested stroke care process quality measures in either country can provide the constitutive elements (Abbott, 2002) for constructing organisational achievement narratives (Corvellec, 2002) regarding the quality of stroke care being provided locally (in the USA and UK) or nationally (in the UK). Although tPA is used in stroke care in distinctly different ways, with differing results, in reversing ischemic strokes (standardised for comparability), nevertheless each team can provide an achievement narrative featuring quality improvement with regard to the Stroke-Four measure.

Practitioners can create a partial narrative, from their preferred perspective, that accords with their point of view on how stroke care practice should be conducted. They can still show they meet medical community norms of behaviour as ambiguously provided for by the stroke guidelines. For example, stroke teams that do not use tPA can often strive to achieve a 100% mark by *considering* giving the medicine to patients. An increase in the rate of consideration is rated as improvement.

For stroke teams capable of administering this medicine to a substantial, or increasing, number of patients, this can point to improvements in both *considering administering* the medicine, and in the secondary rate of how many patients *actually received* tPA. The ambiguity of the measure accommodates the achievement narratives (Corvellec, 2002) of two distinct approaches to utilising evidence in expressing stroke care practice.

A follow-on note to the discussion of the Stroke-Four set of US stroke care measures is that the second edition was released in August 2007. Stroke-Four now measures the rate of tPA utilisation, not consideration of its use. There is no discussion in the measures guidelines of why this measure now has more clarity (JCAHO, 2007).

This section provided a validation check of my findings by testing their transferability. The presence of ambiguity in a key stroke care performance measure can be plausibly explained by motivations to manage evaluation stress and other associated anxieties. Those other

anxieties relate to possible changes to identity or practice, and are managed by the use of evaluative ambiguity to maintain and cover existing power relations and practice modes.

11.33 Discussion and a possible limitation

In my analysis I have described how emotional qualities of experience such as anxiety relate to the existential concerns of the QI teams and QI managers about identities as healthcare researchers and their agency's mission. Further, I have shown a connection between those anxieties about agency performance evaluations with personal career or agency financing consequences, and qualities of interpersonal interaction such as power relations or inclusion ~ exclusion dynamics. Qualities of feelings/emotions e.g. anxiety) and social coordination e.g. power relations) in turn were analysed as plausible sources for the types of goal ambiguity seen in the QI project discourses. Ambiguities noted included two forms: directive (what the projects were seeking to do and how) and evaluative (how to evaluate the projects). These ambiguities provide flexibility in how the projects' success or failure can be interpreted. These ambiguities are identified as central aspects of an ideological contest of selectively partial narratives and preferential perspectives, where categorization enables attempts to maintain or hide, extend or preserve existing dynamics of power relations and inclusion ~ exclusion dynamics. Here ideology is understood as a particular view, or perspective, of the world (Dalal, 1998; Eagleton, [1983] 1996).

These assertions find support in the research of Chun and Rainey, which connects organisational goal ambiguity to organisational performance. The entwined influence of financial concerns with anxiety and ambiguity among the QI teams relates to what Chun and Rainey found in their research on organisational goal ambiguity. They calculated a statistically significant connection between an antecedent variable, termed 'financial publicness' (which measures the proportion of funding from governmental sources of an agency), and three aspects of organisational goal ambiguity:

'Financial publicness was negatively related to directive, evaluative, and priority goal ambiguity, indicating that those agencies receiving higher levels of funding through government allocations (as opposed to sales or user fees) have higher levels of goal ambiguity (as contrasted with more "businesslike" agencies that rely less on government allocations, and that the results showed to have lower goal ambiguity).'

(Chun and Rainey, 2005b, p. 536)

The agency in my narrative has a high degree of financial publicness.

11.34 A possible limitation

In considering limitations to my research, a methodological question is: what are the implications for my research of methodological oscillations between and among the discourse analytic techniques deployed?

My analysis uses what Barry et al. (2006) call endotextual, exotextual, and text-context methods, without reconciling possible contradictions to these distinct approaches. Barry et al. describe the challenges and advantages to such mixed methods. They offer the following definitions:

‘The endotextual approach works within the text (and its relations with other texts) and typically uses techniques from literary theory. The exotextual seeks to place the text within its context(s) and typically works with ethnographic, production/reception, and/or socio-cultural-political readings. Multi-method approaches try to do both by embedding a detailed textual reading within an exploration of contextual influences.’

(Barry, 2006, p. 1091)

From communication theory, I used an endotextual technique from Georgensen and Solano (1999) to analyse the construction of one of the project summaries. This technique investigates effects of motive of the narrative constructors, analysed as predominantly either a preferential or an accuracy motive. I used literary theory from the work of E. M. Forster (1927/1954) regarding flat characters.

I also used an exotextual method of considering the project summaries as being written partly in the context of, and in response to, texts of public management reformers and evaluator/financers. I referenced various texts and analysis of them in the organisational literature, to include GPRA and PART reform initiatives in the USA, and NPM in Europe (Hood, 1995; Rudin, 1998). I also examined from a complexity perspective how the project summaries were partially and selectively created and told narratives (Stacey, 2001, 2003). My approach uses some aspects of ethnography (describing my experience of the workshops) along with the aforementioned narrative analysis techniques. This resembles the

ethnonarrative method described by Hansen (2006) as a hybrid mix of research methods that would offer methodological advantages. What I have not had the time to do is the sort of analysis conducted by Barry et al. (2006) of the implications of conducting qualitative research with the ethnonarrative (Hansen, 2006) or diatextual (Barry et al., 2006) methods. This might have implications, so far unexamined, for my findings and conclusions.

It could be said that my mixed-method approach exhibits what Barry and colleagues describe as:

‘A tendency in multi-method approaches to either neglect one of the approaches, or blithely jump from one approach to the other, has also raised questions and concerns in the organizational literature.(Alvesson and Karreman, 2000a, 2000b, Hardy 2001)’
(Barry, 2006, p. 1092)

A point in favour of the multi-method approach I used is that it offers a triangulation check of research quality by investigating research materials from more than one theoretical perspective (Creswell, 1998, p. 202). The possible weakness of my approach resides in not adequately considering the differences between the research methods used and the implications of those methodological differences and/or similarities for the research being conducted.

11.35 Conclusions

If a man will begin with certainties, he will end up with doubts; but if he will be content to begin with doubts, he shall end in certainties.

(Francis Bacon, 1605)

11.36 Officially seeking disambiguation

In a section above I analysed the public management reform efforts of evaluators and financers who claim to seek clarity in strategic planning and operational performance, in relation to the organisational goal ambiguities of the KT project summaries and other discourse. These reform efforts may, ironically, actually cause or increase ambiguity in the responses of the QI participants. I conclude that the unwillingness of evaluators of QI efforts (and perhaps of senior QI management as well) to begin with, or admit to, uncertainties in

their project plans or summaries about the changes possible from QI interventions, increased the goal ambiguities in the organisational discourses of the QI teams.

The ambiguity in the KT project plans and workshop summaries can be understood not necessarily as signs of poor project design or missing management skills, but rather as serving pragmatic purposes for the QI teams. These ambiguities result from a fundamental existential angst over self and group inclusion ~ exclusion dynamics; that existential angst affects qualities of feelings/emotions, tailoring our participation with others. As a consequence, a defensive ambiguity emerges as a quality of our narrative accountings to each other of our interactions. The evaluative and directive ambiguity used in narratives and other discourse provides psychological defences for anxiety about identity and power relations. Ambiguity of communication supports rhetorical methods for negotiations in the portrayal and interpretation of acceptable organisational performance accounts to share with their evaluators and financiers.

Ironically then, the ambiguity of the QI teams' discourse can be seen as a rational response to the recursive generation of anxiety in relations between and among themselves and the evaluators and financiers, who are seeking the mandated disambiguation of public services strategies and their implementation through preferred accounting tools and organisational performance concepts.

I conclude that the efforts of the QI teams to promote the utilisation of healthcare research findings and evidence by QI clients were being affected by the following: emotional qualities of experience (such as anxiety about identity); qualities of interpersonal interaction (such as power relations); and qualities of narrative telling or narrative patterning of interaction (such as ambiguity).

11.37 Officially sanctioning ambiguity in QI measures

From my analysis in the sections above analysing ambiguity in constructing QI measures for acute stroke care, I conclude that the evaluative and directive ambiguity present in the construction of the US stroke quality measures in effect officially sanctions the creation and sharing of partially constructed organisational achievement narratives about stroke care practice, told from a preferential perspective. These stroke practice achievement narratives can use the evaluative ambiguity of the Stroke-Four measure, in particular to optionally

portray movement towards quality stroke care as being accomplished either by an increase in *considering administering* the ischemic stroke medicine, tPA (the primary rate of the measure) or through *actually administering* tPA to patients (the secondary rate). The Stroke-Four measure provides a constitutive, albeit ambiguous, narrative element (Abbot, 2002) for the construction of successful performance accounts of stroke care practice. These two forms of performance accounts may, after analysis, have very different meanings for patients, yet both can be declared compliant with standards for improving stroke care.

A committee of healthcare practitioners, professors and regulators worked together to create the stroke care quality measures. Their work provides, in effect, an official sanctioning of organisational goal ambiguities, expressed as evaluative and directive ambiguities. This may provide both stroke practitioners and regulators with discursive defences against anxieties that are related to the prospect of changes to identity and the renegotiation of meaning, or knowledge, in the context of stroke communities of practice (in the sense of Wenger, 1998). Such renegotiation and identity changes would come with changing stroke care practice (for example, by moving from not utilizing tPA very often, to providing it to a substantial percentage of patients). Of relevance here are reports that the average utilization rate of tPA for stroke in the US is estimated to be about 3% of ischemic stroke patients (Colorado Department of Public Health and Environment, 2003), while in the UK it is less than 1% (Royal College of Physicians, 2005). For regulators, with anxieties of their own about accountability and evaluation, ambiguous stroke care measures support the greater certainty of the possibility of creating organisational achievement narratives that can show improvement regarding tPA, regardless of whether this means that practitioners are merely considering its use, or actually using it in reality.

This official US sanctioning of organisational goal ambiguity for a key measure of stroke care performance in the first edition of the JCAHO guidelines provided for the preservation by providers of existing preferred modes of practice. The initial ambiguity of the Stroke-4 measure, which was changed to measure actual usage in the second guidelines edition (JCAHO 2007), provided a socially validated statistic that can show progress in *considering* the administration of tPA, while its actual utilisation rate is still low 11 years after its approval by the US FDA for use in the care of ischaemic stroke patients.

This project has supplied additional findings to my research inquiry into how the qualities of interaction affect the utilisation of research evidence and learning for the expression of new practice. This has been accomplished by analysis of how existential anxieties (such as emotional qualities), qualities of interaction (such as dynamics of power relations and inclusion ~ exclusion), and qualities of ambiguity in narrative patterning or narrative discourse, all intertwine recursively in affecting research utilisation efforts and their progress in various ways.

Bibliography

Abbott, H. Porter (2002) *The Cambridge Introduction to Narrative*, Cambridge: Cambridge Press.

Ackroyd, Stephen, Hughes, John A., Soothill, Keith (2001) Public Sector Services and their Management, *Journal of Management Studies*, 26, 6, 603-619.

Alvesson, Mats, and Dan Karreman (2000a) Taking the linguistic turn in organizational research: Challenges, responses, consequences, *Journal of Applied Behavioral Science* 36, 2, pp 136–159.

Alvesson, Mats, and Dan Karreman (2000b) Varieties of discourse: On the study of organizations through discourse analysis, *Human Relations* 53, 9, pp 1125–1149.

American Heart Association (2007) Tissue Plasminogen Activator (tPA). Downloaded from <http://www.americanheart.org/presenter.jhtml?identifier=4751>

Aram, Eliat, Chapter 5 The Responses to not Knowing: anxiety and panic in learning processes, unpublished thesis, University of Hertfordshire: Hatfield, UK.

Argyris, Chris and Schön, Donald (1996) *Organizational Learning II*, Reading, Massachusetts: Addison-Wesley.

Babrow, Austin (2001) Uncertainty, Value, Communication, and Problematic Integration, *Journal of Communication*, September, 2001.

Backer, T. E. (2000) The failure of success: challenges of disseminating effective substance abuse prevention programs, *Journal of Community Psychology*, 28, pp 363-373.

Bacon, Francis (1605/1998) quote from *The Advancement of Learning*, Book I, section V, paragraph 8. Copyright 1998 Dr Hartmut Krech, Bremen, Germany (kr538@zfn.uni-bremen.de). Downloaded from: <http://www.uoregon.edu/~rbear/adv1.htm>

Baker, Ann C., Jensen Patricia J., Kolb, David A. (2002) *Conversational Learning: An Experiential Approach to Knowledge Creation*, Westport, Conn.: Greenwood Publishing Group, Inc.

Balas and Boren (2000) Managing clinical knowledge for healthcare improvement, *Yearbook of Medical Informatics* (2000), pp 65-70, Center for Health Care Quality, Jefferson City, Mo.: University of Missouri.

Bandura, Albert, *Albert Bandura Autobiographical Sketch*, p 9. Downloaded from <http://www.des.emory.edu/mfp/bandurabio.html>, verified April 25, 2007.

Bandura, Albert (1986) *Social Foundations of Thought and Action: A Social Cognitive Theory*, Englewood Cliffs, New Jersey: Prentice-Hall.

Bandura, Albert (1977) *Social Learning Theory*, New York: General Learning Press.

- Barry, David, Elmes, Michael (1997) Strategy Retold: Toward a Narrative View of Strategic Discourse, *The Academy of Management Review*, 22, 22, pp 429-452.
- Barry, David, Carroll, Brigid, and Hansen, Hans (2006) To Text or Context? Endotextual, Exotextual, and Multi-textual Approaches to Narrative and Discursive Organizational Studies, *Organization Studies*, 27, 8, pp 1091-1110.
- Barwick, M.A., Boydell, K.M., Stasiulis, E., Ferguson, H. B., Blase, K., & Fixsen, Dean (2005) *Knowledge Transfer and Implementation of Evidence-Based Practices in Children's Mental Health*, Children's Mental Health Ontario, Toronto, ON.
- Ben-Ze' ev, Aaron (2000) *The Subtlety of Emotions*, Cambridge: The MIT Press.
- Berwick, Donald M. and Joshi, Maulik S. (2005) Healthcare Quality and the Patient, in Ransom, S, Joshi, M. and Nash, D. (eds.) (2005) *The Healthcare Quality Book: Vision, Strategy and Tools*, Washington, D.C.: Health Administration Press.
- Berwick, Donald M. (2002) A User's Manual for the IOM's 'Quality Chasm' Report, *Health Affairs* 21, 3, pp 80-90.
- Bishop, S. R., Lau, M., Shapiro, S., Carlson, L., Anderson, N.D., and Carmody, (2004) Mindfulness: A proposed operational definition, *Clinical Psychology: Science and Practice*, 11, 3, pp 230-241.
- Bleakley, Alan (2000) Writing with Invisible Ink: narrative, confessionality and reflective practice, *Reflective Practice*, 1, 1, pp11-24.
- Boje, David, Luhman J.T., and Baack, D.E. (1999) Hegemonic stories and encounters between story-telling organizations, *Journal of Management Inquiry*, 8, 4, pp 340-360.
- Boje, David (1995) Stories of Story Telling Organizations: A postmodern analysis of Disney as "Tamara-Land", *Academy of Management Journal*, 38, 4, pp 997-1035.
- Boje, David (1991) The storytelling organization: A study of story performance in an office-supply firm, *Administrative Science Quarterly*, 36, 1, pp 106-126.
- Bolton, Gillie (2002) *Reflective Practice: Writing and Professional Development*, London, UK: Paul Chapman Publishing.
- Bruner, Jerome (2002) *Making Stories: Law, Literature, Life*, New York: Farrar, Straus, and Giroux.
- Bruner, Jerome (1990) *Acts of Meaning*, Cambridge: Harvard University Press.
- Chassin, Mark (2002) Achieving and Sustaining Improved Quality: Lessons from New York State and Cardiac Surgery, *Health Affairs*, 21, 4, pp 40 – 51.
- Chuang Tsu (3rd century BCE/2000) *Chuang Tsu: Inner Chapters*, Gia-Fu Feng and English, Jane, New York: Vintage Books.

- Christensen, Bjørner (2005) Emerging participative exploration: consultation as research, in Stacey, Ralph D, and Griffin, Douglas (2005) *A Complexity Perspective on Researching Organizations*: London and New York: Routledge.
- Chun Young Han, Rainey, Hal G. (2005a) Goal Ambiguity in U.S. Federal Agencies, *Journal of Public Administration Research and Theory*, 15, pp 1-30.
- Chun Young Han, Rainey, Hal G. (2005b) Goal Ambiguity and Organizational Performance in U.S. Federal Agencies, *Journal of Public Administration Research and Theory*, 15, pp 529-557.
- Colorado Department of Public Health and Environment (2003) *Survivors of the fight: Stroke in Colorado*, 2nd ed., Denver, Colorado: State of Colorado.
- Corvellec, Hervé (2002) Narratives of Organisational Performances, Working Paper Series 2002:4, Kristianstad University College. Downloaded from: http://www.hkr.se/upload/E/Working%20papers/wp2002_4.pdf
- Corvellec, Hervé (1997) *Stories of Achievement: Narrative Features of Organizational Performance*, New Brunswick, USA and London: U.K. Transaction Publishers.
- Cozolino, Lou (2006) *The Neuroscience of Human Relationships: Attachment and the Developing Social Brain*, New York and London: W.W. Norton and Company.
- Cozolino, Lou (2002) *The Neuroscience of Psychotherapy: Building and Rebuilding the Human Brain*, New York and London: W.W. Norton and Company.
- Creswell, John W. (1998) *Qualitative Inquiry and Research Design: Choosing among Five Traditions*, Thousand Oaks, California: Sage Publications.
- Cunliffe, Ann (2003) Reflexive Inquiry in organizational research: Questions and possibilities, *Human Relations*, 56, 8, pp 983-1003.
- Czarniawska, Barbara (2004) *Narratives in Social Science Research*, Thousand Oaks: Sage Publications.
- Dalal, Farhad (1998) *Taking the Group Seriously Towards a Post-Foulkesian Group Analytic Theory*, London: Jessica Kingsley Publishers.
- Dalal, Farhad, Power, Shame and Belonging: Radical Group Analytic Theory, unpublished paper.
- Damasio, Antonio R. (1999) *The Feeling of What Happens: Body and Emotion in the Making of Consciousness*, New York City: Harcourt Brace & Company.
- Damasio, Antonio R. (1994) *Descartes' Error: Emotion, Reason and the Human Brain*, London: Picador.

- Davis, Dave, Evans, Mike, Jadad, Alex, Perrier, Laure, Rath, Darlyne, Ryan, David, Sibbald, Gary, Straus, Sharon, Rappolt, Susan, Wowk & Zwarenstein, Maria, (2003) The case for knowledge translation: shortening the journey from evidence to effect, *British Medical Journal*, 327, 5.
- Davis, D., Thomson O'Brien, M.A., Freemantle, N., et al. (1999) Impact of formal continuing education: do conferences, workshops, rounds and other traditional continuing education activities change physician behavior or health care outcomes, *Journal of the American Medical Association*, 282, pp 867-74.
- Davis, D.A., Thompson, M.A., Oxman, A.D. & Haynes, R. B. (1995) Changing Physician Performance: A systematic review of the effects of continuing medical education strategies, *Journal of the American Medical Association*, 274, pp 700-5.
- Dewey, John ([1930] 1984) Qualitative Thought, in *John Dewey The Later Works, 1925-1953, Vol. 5: 1929-1930*, ed. Boydston, Jo Ann, Carbondale, Illinois: Southern University Illinois Press.
- Dickinson, Emily ([1872] 2004) Dickinson/Higginson correspondence: Late 1872. Dickinson Search, *Dickinson Electronic Archives*. Online Institute for Advanced Technology in the Humanities (IATH), University of Virginia (original work published 1872).
- Donabedian, Avedis (1980) *The Definition of Quality and Approaches to its Assessment*, Ann Arbor, Michigan: Health Administration Press.
- Dorsey, David (2000) *Positive Deviant* in Fast Company magazine, issue 41, page 284, photographs by Jana Leon.
- Eagleton, Terry ([1983] 1996) *Literary Theory: An Introduction*, Minneapolis, Minnesota: University of Minnesota.
- Eisenberg, Eric (2007) *Strategic Ambiguities: Essays on Communication, Organization, and Identity*, Thousand Oaks, California: Sage Publications, Inc.
- Eisenberg, Eric (1984) Ambiguity as Strategy in Organizational Communication, *Communication Monographs*, 51, pp 227-252.
- Elias, Norbert (1991) *The Society of Individuals*, Oxford: Basil Blackwell.
- Elias, Norbert (1987) *Involvement and Detachment*, Oxford: Basil Blackwell.
- Elias, Norbert (1970) *What is Sociology*, New York: Columbia University Press.
- Elias, Norbert & Scotson, John ([1965] 1994) *The Established and the Outsider*, London: Sage Publications.
- Elias, Norbert (1956) Problems of involvement and detachment, *British Journal of Sociology*, 7, 3, pp 226-52.

- Elias, Norbert ([1939] 2000) *The Civilizing Process: Sociogenetic and Psychogenetic Investigations*, Oxford: Blackwell Publishers.
- Epston, D. & White, M. (1990) *Narrative Means to Therapeutic Ends*, New York: W.W. Norton and Company.
- Estabrooks, Carole, Thompson, David S., Lovely, J. Jacque E., Hofmeyer, Anne (2006) A Guide to Knowledge Translation Theory, *The Journal of Continuing Education in the Health Professions*, 26, 1, pp 25-36.
- Estabrooks, Carole A, (2004) A Nursing and Allied Health Sciences Perspective on Knowledge Utilization, in Lemieux-Charles, Louise & Champagne, Françoise (eds.) *Using Knowledge and Evidence in Health Care: Multi-disciplinary Perspectives*, Toronto, Ontario: University of Toronto Press.
- Estabrooks, Carole A., Floyd Judith & Scott-Findlay Shannon, O'Leary, Katherine, Gushta, M. (2003) Individual Determinants of research utilization: A systematic review, *Journal of Advanced Nursing*, 43, 5, pp 506-520.
- Feldman, M. (1989) *Order Without Design: Information production and policy making*, Stanford, Ca.: Stanford University Press.
- Finlay, Linda and Gough, Brendan (2003) *Reflexivity: A Practical Guide for Researchers in Health and Social Sciences*, Oxford: Blackwell Publishing.
- Fonseca, Jose, (2002) *Complexity and Innovation in Organizations*, London: Routledge.
- Forster, E. M. ([1927] 1954) *Aspects of the Novel*, New York: Harcourt Brace and World.
- Freemantle, Nick (2002) Optimizing Clinical Performance, in McKee, Martin & Healy, Judith, (eds.) *Hospitals in a Changing Europe*, Buckingham: Open University Press.
- Friis, Preben (2006) Presence and spontaneity in improvisational work, in Shaw, Patricia and Stacey, Ralph (2006) *Experiencing Risk, Spontaneity and Improvisation in Organisational Change: Working live*, London and New York: Routledge.
- Gaffney, Karin (2005) Many interventional cardiologists opt out of treating patients if chance of death is high, press release, University of Rochester Medical Center, 10, Jan., 2005.
- GAO (United States Government Accounting Office) (2004) PERFORMANCE BUDGETING: Observations on the Use of OMB's Program Assessment Rating Tool for the Fiscal Year 2004 Budget, Report GAO-04-174, January 2004.
- Germer, Christopher K., Siegel, Ronald D., Fulton, Paul R. (eds.) (2005) *Mindfulness and Psychotherapy*, New York: Guilford Press.
- Georgensen, John C, and Solano, Cecilia H. (1999) The Effects of Motivation on Narrative Content and Structure, *Journal of Language and Social Psychology*, 18, 2, pp 175-195.

- Gibson, William (1999) NPR Talk of the Nation, 30 November, 1999 show. Downloaded from: www.npr.org
- Ginger, Clare (1998) Interpreting Roads in Roadless Areas: Organizational Culture, Ambiguity, and Change in Agency Responses to Policy Mandates, *Administration & Society*, 29, 6, pp 723-57.
- Goffman, Irving (1990) *The Presentation of Self in Everyday Life*, London: Penguin Group.
- Golden-Biddle, Karen and Locke, Karen (1993) Appealing Work: An Investigation of How Ethnographic Texts Convince, *Organization Science*, 4, 4, pp 595-616.
- Gooding, Richard Z. and Kinicki, Angelo J. (1995) Interpreting Event Causes: The Complementary Role of Categorization and Attribution Processes, *Journal of Management Studies*, January, 32, 1.
- Goodwin, Brian (2004) *How the Leopard Changed its Spots: The Evolution of Complexity*, Princeton, New Jersey: Princeton University Press.
- Griffin, Douglas (2002) *The Emergence of Leadership: Linking Self-Organization and Ethics*, London: Routledge.
- Greenhalgh, Trisha, Kyriakidou, Olympia, Peacock, Richard, (2004) How to Spread Good Ideas: A systematic review of the literature on diffusion, dissemination and sustainability of innovations in health service delivery and organization, *Report for the National Coordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO)*. Downloaded from http://www.sdo.lshtm.ac.uk/pdf/changemanagement_greenhalgh_report.pdf.
- Greenhalgh, Trisha, Robert, Glenn, Macfarlane, Fraser, Bate, Paul, Kyriakidou, Olympia, Peacock, Richard (2005) Storylines of research in diffusion of innovation: a meta-narrative approach to systematic review, *Social Science & Medicine* 61, pp 417-30.
- Hannan EL, Kilburn H Jr., Racz M, Shields E, Chassin MR (1994) Improving the outcomes of coronary artery bypass surgery in New York State, *Journal of the American Medical Association*, 9, 271(10), pp 761-6.
- Hansen, Hans (2006) The ethnonarrative approach, *Human Relations*, 59, 8, pp 1049-1075.
- Hardy, Cynthia (2001) Researching organizational discourse, *International Studies of Management and Organization*, 31, 3, pp 25–47.
- Heffer, Stephen, Smith, Sheila, Keehan, Sean, Borger, Christine, Clemens, M. Kent, Truffer, C. (2005) US Health Spending Projections for 2004 – 2014, *Health Affairs*, pp w5-74 – w5 – 85.
- Hendry, John and Seidl, David (2003) The Structure and Significance of Strategic Episodes: Social Systems Theory and the Routine Practices of Strategic Change, *Journal of Management Studies* January 2003, 40, 1.

Heraclitus, quote on connections, Fragment 54, cited by Hippolytus, *Refutations*.

Heraclitus, quote on change, from Diogenes Laertius, *Lives of Eminent Philosophers*.

Hergenhahn, B.R., Olson, Matthew (2005) 7th Ed., *An Introduction to Theories of Learning*, Upper Saddle River, New Jersey: Pearson Prentice Hall.

Hines, R. D. (1991) The FASB'S conceptual framework, financial accounting and the maintenance of the social world, *Accounting, Organizations and Society*, 16, pp 313-331.

Holland, John, (1995) *Hidden Order: How Adaptation Builds Complexity*, New York: Helix Books, Addison-Wesley.

Hood, Christopher (1995) The "New Public Management" in the 1980s: Variations on a Theme, *Accounting, Organizations and Society*, 20, 2/3, pp 93-109.

Houchin, K. and MacLean, D. (2005) Complexity Theory and Strategic Change: an Empirically Informed Critique, *British Journal of Management*, 16, 149-166 (2005).

Institute of Medicine (2001) *Crossing the Quality Chasm: a new health system for the 21st Century*, Washington D.C.: National Academy Press.

IST-3 Stroke Nurse Collaborative Group (2003) Thrombolysis for acute ischaemic stroke: the development of a nurse protocol in the United Kingdom, University of Edinburgh and the Scottish National Health Service. Downloaded from:
http://www.dcn.ed.ac.uk/newist3/nurse_protocol_article.htm .

Jamieson, Kieren and Hyland, Paul (2006) Good Intuition or Fear and Uncertainty: The Effects of Bias on Information Systems Selection Decisions, *Informing Science Journal*, 9, pp 1-24.

Jarvis, Peter (2005) *Towards a Comprehensive Theory of Human Learning, vol. 1, Lifelong Learning and the Learning Society*, London: Routledge.

Jarvis, Peter (2006) *Sociological Perspectives vol. II, Lifelong Learning and the Learning Society*, London: Routledge.

Jarzabkowski, Paula (2005) *Strategy as Practice An Activity-based Approach*, London: Sage Publications.

JCAHO (2007) Stroke Performance Measurement Implementation Guideline, 2nd Edition, downloadable from:
http://www.jointcommission.org/CertificationPrograms/PrimaryStrokeCenters/stroke_pm_education_2.htm

JCAHO (2006) Standard Stroke Measures, downloadable from
http://www.jointcommission.org/CertificationPrograms/PrimaryStrokeCenters/stroke_measure_set.htm

JCAHO (Joint Commission for the Accreditation of Hospital Organizations) (2004) Stroke Performance Measurement Implementation Guideline, downloadable from: http://www.jointcommission.org/CertificationPrograms/PrimaryStrokeCenters/guide_table_contents.htm

Joas, Hans (1997) *G.H.Mead, a contemporary re-examination of his thought*, Cambridge, Massachusetts: The MIT Press.

Johnson, Gerry, Leif Melin and Richard Whittington (2003) Guest Editors²² Introduction: Micro Strategy and Strategizing: Towards an Activity-Based View *Journal of Management Studies* 40, 1, pp 3-22.

Johnson, Mark (2007) *The Meaning of the Body Aesthetics of Human Understanding*, Chicago and London: University of Chicago Press.

Johnson, Michael L. PhD *; Gordon, Howard S. MD *; Petersen, Nancy J. PhD *; Wray, Nelda P. MD, MPH *; Laurie Shroyer, A. PhD +; Grover, Frederick L. MD + and; Geraci, Jane M. MD, MPH ++ (2002) Effect of Definition of Mortality on Hospital Profiles, *Medical Care*, 40, 1, pp 7-16.

Kamoche, Ken, Pina e Cunha, Miguel, and Vieira Da Cunha, João (eds.) (2002) *Organizational Improvisation*, London and New York: Routledge.

Kaplan, Robert S. and Norton, David P. (1996) *The balanced scorecard: translating strategy into action*, Boston, Massachusetts: Harvard Business School Press.

Kauffman, Stuart (1994) *At Home in the Universe: The Search for the Laws of Self-Organization and Complexity*, Oxford: Oxford University Press.

Keenoy, Tom, Oswick, Cliff and Grant, David (1997) Organizational Discourses: Text and Context, *Organization special issue discourse and organization*, 4, 2, pp 147-157.

Keenoy, Tom, Marshak, Robert J., Oswick, Cliff, Grant, David (2000) The Discourses of Organizing, *The Journal of Applied Behavioral Science*, 36, 2, pp 133-135.

Kelemen, Mihaela (2000) Too Much or Too Little Ambiguity: The Language of Total Quality Management, *Journal of Management Studies*, Oxford, 37, 4, pp 483-498.

Kelso, S.A.J. and Engström, David (2005) *Complementary Nature*, Cambridge, Mass.: MIT Press.

Langer, Ellen (2000) Mindful Learning, *Current Directions in Psychological Science*, 9, 6, pp 220-223.

Langer, Ellen J, and Moldoveanu (2000) The Construct of Mindfulness, *Journal of Social Issues*, special issue on mindfulness, 56, 1, pp 1-9.

Langer, Ellen J., and Moldoveanu (2000) Mindfulness Research and the Future, *Journal of Social Issues*, special issue on mindfulness, 56, 1, pp 129-139.

- Langer, Ellen J. (1997) *Mindful Learning*, Cambridge, Mass.: Da Capo Press.
- Langer, Ellen J. (1989) *Mindfulness*, Cambridge, Mass.: Da Capo Press:
- Langley, Ann (1989) In Search of Rationality: The Purposes behind the Use of Formal Analysis in Organizations, *Administrative Science Quarterly*, 34, pp 598 – 631.
- Lavis, John N., Robertson, Dave, Woodside, Jennifer M., McLeod, Christopher B., Abelson, Julia, and the Knowledge Transfer Group, (2003) How Can Research Organizations More Effectively Transfer Research Knowledge to Decision Makers? (2003) *The Milbank Quarterly*, 81, 2, pp 221-248.
- Le Guin, Ursula K. (1980) It Was a Dark and Stormy Night; or Why are We Huddling about the Campfire?, *Critical Inquiry*, 7, 1, pp 191-199.
- Lemieux-Charles, Louise, Champagne, Françoise, (2004) *Using Knowledge and Evidence in Health Care: Multidisciplinary Perspectives*, Toronto, Ontario: University of Toronto Press.
- Levi-Strauss, Claude ([1962] 1966) *The Savage Mind*, Chicago: University of Chicago Press.
- Levine, Donald (1985) *The Flight from Ambiguity: Essays in Social and Cultural Theory*, Chicago: University of Chicago Press.
- Lewin, Roger, (1992) *Complexity: Life at the Edge of Chaos*, New York: Collier Books, Macmillan Publishing Company.
- Linde, Charlotte (1988) The quantitative study of communicative success: Politeness and accidents in aviation discourse, *Language and Society*, 17, pp 375-399.
- Lines, R., Stensaker, I.G., Langley, A. (eds.) (2006) *New Perspectives on Organizational Change and Learning*, Bergen, Norway: Fagbokforlaget.
- Loewenson, Jane (2005) Testimony of Jane Loewenson, Director of Health Policy National Partnership for Women & Families. U.S. House of Representatives Energy & Commerce Subcommittee on Health Hearing on “Patient Safety and Quality Initiatives” June, 9, 2005. Downloaded from:
<http://www.nationalpartnership.org/site/DocServer/PatientSafetyTestimonyJune05.pdf>
- Loyal, Steven and Quilley, Stephen (2004) *The Sociology of Norbert Elias*, Cambridge: Cambridge University Press.
- Lozeau, D., Langley, A. and Denis, J. (2002) The corruption of managerial techniques by organizations, *Human Relations*, 55, 5, pp 537-64.
- Lynch, Michael (2000) Against Reflexivity as an Academic Virtue and Source of Privileged Knowledge, *Theory, Culture and Society*, 2000, 17, 3, pp 26-54.
- MacLean, D. and MacIntosh, R., unpublished paper, Strategic Change as Creative Action.

- McCleary, Lynn & Brown, G. Ted (2002) Barriers to paediatric nurses' research utilization, *Journal of Advanced Nursing*, 42, 4, pp 364-72.
- McGlynn, E.A., S.M. Asch, J. Adams, J. Keeseey, J. Hicks, A. DeCristofaro, E.A. Kerr, 2003. The Quality of Health Care Delivered to Adults in the United States, *New England Journal of Medicine*, 348 (26), pp 2635-45.
- McPhee, Robert D., Zaug, Pamela (2001) Organizational Theory, Organizational Communication, Organizational Knowledge, and Problematic Integration, *The Journal of Communication*, 51, 3, pp 574-591.
- McSweeney, Brian (1997) The Unbearable Ambiguity of Accounting, *Accounting, Organizations, and Society*, 22, 7, pp 691-712.
- Mead, G.H. (1934) *The Mind, Self and Society: From the Standpoint of a Social Behaviorist*, Chicago: The University of Chicago Press.
- Mead, George Herbert (1925) The Genesis of the Self and Social Control, *International Journal of Ethics*, (1925), 35, pp 251-277.
- Mead, George Herbert (1913) The Social Self, *Journal of Philosophy, Psychology and Scientific Methods*, (1913), 10, pp 374- 380.
- Merleau-Ponty, Maurice (1964) *Signs*, translator Richard C. McCleary, Evanston, Illinois: Northwestern University Press.
- Mennell, Stephen (1998) *Norbert Elias, An Introduction*, reprint, Dublin, University College Press, (first published 1989 as *Norbert Elias: Civilization and the Human Self-Image*), UK: Blackwell Publishing.
- Mezirow, Jack and Associates (2000) *Learning as Transformation: Critical Perspectives on a Theory in Progress*, San Francisco: Jossey-Bass.
- Mosby Medical Encyclopedia (1996) Revised Edition, New York: A Signet book, Penguin Putnam.
- Munro, Roland (1995) Managing by Ambiguity: An Archaeology of the Social in the Absence of Management Accounting, *Critical Perspectives on Accounting*, 6: 433-482
- Narins, Craig R., Dozier Ann M., Ling, Frederick S., Zareba, Wojciech (2005) The Influence of Public Reporting of Outcome Data on Medical Decision Making by Physicians, *Archives of Internal Medicine*, 165, 1, pp 83-87.
- New York State Department of Health (1996) Coronary Artery Bypass Surgery in New York State 1992-1994, New York State Department of Public Health Report, 1996.
- Nightingale, Florence (1863) 3rd edition *Notes on hospitals*, London: Longman.
- Nonaka, Ikujiro, and Takeuchi, Hirotaka (1995) *The Knowledge Creating Company: How Japanese Companies Create the Dynamics of Innovation*, Oxford: Oxford University Press.

O'Dell, Carla, and Grayson, Jr. C Jackson and Esaides, Nilly (1998) *If Only We Knew What We Know*, New York: The Free Press, division of Simon Schuster.

O'Flynn, Mary (2005) Letting go, keeping connected and change at the Phoenix Project, in Stacey, Ralph D, and Griffin, Douglas (2005) *A Complexity Perspective on Researching Organizations*: London and New York: Routledge.

OECD (2006) OECD Health Data Organisation for Economic Cooperation and Development, June 2006. Downloaded from: <http://www.oecd.org/health/healthdata>

Orr, Julian (1985) Sharing Knowledge, Celebrating Identity Community Memory in a Service Culture, chapter in Middleton, David & Edwards, Derek, *Collective Remembering*, London: Sage Publications.

Phillips, Louise and Jørgensen, Marianne W. (2002) *Discourse Analysis as Theory and Method*, Thousand Oaks, California: Sage Publications.

Potter, Jonathan and Wetherell, Margaret (1987) *Discourse and Social Psychology: Beyond Attitudes and Behaviour*, London: Sage Publications.

Power, Michael (2004) An Update on Thrombolysis for Acute Ischaemic Stroke, *ACNR*, 4, 3, pp 36-37.

Profetto-McGrath, Joanne (2004) Knowledge Transfer: What it is and what it takes to do it best!, Presentation, Centre for Knowledge Transfer/Centre Sur Le Transfert Des Connaissances. Downloaded from www.ckt-ctc.ca.

Proust, Marcel (2003) *In Search of Lost Time* (ed.) Prendergast, Christopher, London: Penguin Classics.

Ransom, Scott B., Joshi, Maulik S., and Nash, David B. (2005) *The Healthcare Quality Book: Vision, Strategy, and Tools*, Chicago: Press Health Administration.

Rhodes, Carl, Brown, Andrew (2005) Narrative, organizations and research, *International Journal of Management Reviews*, 7, 3, pp 167-188.

Rholes, W.S. and Simpson, Jeffrey (eds.) (2004) *Adult Attachment: Theory, Research and Clinical Implications*, New York: Guilford Press.

Rilke, Rainer Marie (1903) Letter Four (July 16, 1903), *Letters to a Young Poet*, Novato, California: New World Library.

Roethke, Theodore (1975) The Waking, in *The Collected Poems of Theodore Roethke*, New York: Anchor Books.

Rogers, Everett (2003) *Diffusion of Innovations*, fifth edition, New York: Free Press.

Rogers, Everett (1995) *Diffusion of Innovations*, fourth edition, New York: Free Press.

Royal College of Physicians, Clinical Effectiveness and Evaluation Unit, Prepared by the Intercollegiate Stroke Working Party (2004) *National clinical guidelines for stroke*, Second edition, June 2004, London: Royal College of Physicians. Downloaded from: <http://www.rcplondon.ac.uk>

Royal College of Physicians, Clinical Effectiveness and Evaluation Unit (2005) *National Sentinel Stroke Audit Report 2004*: London: Royal College of Physicians. Verified 7 October, 2007: <http://www.rcplondon.ac.uk/pubs/books/strokeaudit/strokeaudit2004.pdf>

Rudin, Beryl A. (1998) The Government Performance and Results Act (GPRA): Hydra-Headed Monster or Flexible Management Tool?, *Public Administration Review*, 58, 4, pp 307-316.

Rycroft-Malone J., Kitson A, G Harvey, B McCormack, Seers, K, Titichen, A & Estabrooks, C (2002) Ingredients for change: revisiting a conceptual framework, *Quality and Safety in Health Care*, 11, pp 174-180.

Rymer, Marilyn, MD Duane Thurtchley, RN; Deborah Summers, RN, MSN; for the Mid America Brain and Stroke Institute Stroke Team Expanded Modes of Tissue Plasminogen Activator Delivery in a Comprehensive Stroke Center Increases Regional Acute Stroke Interventions (2003) *Stroke*, 34, pp e58-e60.

Sackett, D., Richardson, W.S., Rosenberg, W., Haynes, R. & Strauss, S. (1997) *Evidence Based medicine: How to practice and teach EBM*, Edinburgh: Churchill Livingstone.

Schank, Roger (1997) *Virtual Learning: A Revolutionary Approach to Building a Highly Skilled Workforce*, New York: McGraw-Hill.

Schön, Donald (1983) *The Reflective Practitioner: How Professionals Think in Action*, New York: Basic Books.

Schön, Donald (1987) *Educating the Reflective Practitioner: Toward a New Design for Teaching and Learning in the Professions*, San Francisco: Jossey-Bass.

Schore, Allan (2003) *Affect Regulation and the Repair of the Self*, New York: W.W. Norton and Company.

Schwartz, Jeffrey and Begley, Sharon (2002) *The Mind and the Brain*, New York: Harper Collins Publishers.

Schwarz, Mirela (2004) Strategy Workshops for Strategic Reviews: Components, Practices and Roles of Actors, presented at EGOS Summer 2004 workshop.

Scott-Findlay, Shannon & Pollock, Carolee (2004) Evidence, Research, Knowledge: A Call for Conceptual Clarity, *Worldviews on Evidence-Based Nursing*, 1, 1, pp 92-97.

Seidl, David and Hendry, John (2003) The Structure and Significance of Strategic Episodes: Social Systems Theory and the Routine Practices of Strategic Change, *Journal of Management Studies*, 40, 1, pp 175-196.

- Seligman, Martin E.P. (2002) *Authentic Happiness: Using the New Positive Psychology to Realize Your Potential for Lasting Fulfillment*, New York: Free Press, division of Simon Schuster.
- Senge, Peter (1990) *The Fifth Discipline: The Art and Practice of the Learning Organization*, New York: Currency Doubleday.
- Shaw, Patricia (2002) *Changing Conversations in Organizations: A complexity approach to change*, London and New York: Routledge.
- Shaw, Patricia and Stacey, Ralph (2006) *Experiencing Risk, Spontaneity and Improvisation in Organisational Life: Working Live*, London: Routledge.
- Sherman, Howard and Schultz, Ron (1998) *Open Boundaries: Creating Business Innovation through Complexity*, Reading, Massachusetts: Perseus Books.
- Shotter, John (2005) Inside the Moment of Managing: Wittgenstein and the Everyday Dynamics of Expressive-Responsive Activities, *Organization Studies*, 26, 1, pp 113-115.
- Siegel, Daniel J. (2007) *The Mindful Brain: Reflection and Attunement in the Cultivation of Well-Being*, New York: W.W. Norton.
- Siegel, Daniel J. (1999) *The Developing Mind: How Relationships and the Brain Interact to Shape who we are*, New York and London: The Guilford Press.
- Solomon, Nicky, Boud David and Rooney Donna (2006) The in-between: exposing everyday learning at work, *International Journal of Lifelong Education*, (Jan-Feb 2006), 25, 1, pp 3–13.
- Spall, Sharon (1998) Peer debriefing in qualitative research: emerging operational models, *Qualitative Inquiry*, 4, 2, 280.
- Sperber, Dan and Wilson, Deirdre (1995) *Relevance: Communication and Cognition*, 2nd Ed, London: Blackwell Publishing.
- Stacey, Ralph and Griffin, Douglas (2006) *Complexity and the Experience of Managing in the Public Sector*, London and New York: Routledge.
- Stacey, Ralph, Griffin, Douglas (2005) *A Complexity Perspective on Researching Organizations: taking experience seriously*, London: Routledge.
- Stacey, Ralph, Griffin, Douglas, and Shaw, Patricia (2000) *Complexity and Management: Fad or radical challenge to systems thinking?*, London and New York: Routledge.
- Stacey, Ralph (2005) *Experiencing Emergence in Organizations: Local interaction and the emergence of global pattern*, London and New York: Routledge.
- Stacey, Ralph D. (2003a) *Strategic Management and Organisational Dynamics: the Challenge of Complexity*, Harlow, England: Pearson Education, Prentice Hall Financial Times.

- Stacey, Ralph (2003b) Learning as an activity of interdependent people, *The Learning Organization*, 10, 6.
- Stacey, Ralph D. (2003c) *Complexity and Group Processes: A radically social understanding of individuals*, Hove and New York: Brunner-Routledge, Taylor & Francis Group.
- Stacey, Ralph (2002) Organizations as Complex Responsive Processes of Relating, *Journal of Innovative Management*, Winter 2002-2003, 8, 2.
- Stacey, Ralph D. (2001) *Complex Responsive Processes in Organizations: Learning and Knowledge Creation*, London: Routledge.
- Standard Five, National Service Framework for Older People, (2003). Downloaded from <http://www.dh.gov.uk/PolicyAndGuidance/HealthandSocialCareTopics/OlderPeoplesServices/OlderPeopl...>
- Stern, Daniel (2005) *The Present Moment*, New York and London: W.W. Norton & Company.
- Stern, Daniel (1985) *The Interpersonal World of the Infant*, New York: Basic Books.
- Stewart, T. Harmata L., and Bzdel L. (2005) *Researcher – Decision-maker Resource Guide*, Health Organization Studies, Alberta, Canada: University of Alberta.
- Streatfield, Philip J. (2001) *The Paradox of Control in Organizations*, London: Routledge.
- Szulanski, Gabriel (2003) *Sticky Knowledge: Barriers to Knowing in the Firm*, London, Thousand Oaks, New Delhi: Sage Publications.
- Szulanski, Gabriel (1996) Exploring Internal Stickiness: Impediments to the Transfer of Best Practices within the Firm, *Strategic Management Journal*, (Winter Special Issue), 17, pp 27-43.
- Trice, H.M. (1970) Outsider's Role in Field Study, in *Qualitative Methodology: Firsthand Involvement with the Social World*, ed. W.J. Filstead, 77-82, Chicago: Markham.
- Turi, Zoltan G., MD (2005) The Big Chill The Deleterious Effects of Public Reporting on Access to Health Care for the Sickest Patients, MD, *FACC Journal of the American College of Cardiology*, 45, pp 1766-1768.
- Vaara, Eero (2002) On the Discursive Construction of Success/Failure in Narratives of Post-merger Integration, *Organization Studies*, 23, 2, pp 211-248.
- Van Mannen, John (1988) *Tales of the Field: On Writing Ethnography*, Chicago and London: The University of Chicago Press.
- Van Peurse, K. A. (2005) Conversations with internal auditors: the power of ambiguity, *Managerial Auditing Journal*, 20, 5, pp 489-512.

Waldrop, M. Mitchell (1992) *Complexity: The Emerging Science at the Edge of Order and Chaos*, New York: a Touchstone Book, Simon and Schuster.

Walker, David (2006) Leading in the moment: taking risks and living with anxiety, in Shaw, Patricia and Stacey, Ralph (2006) *Experiencing Risk, Spontaneity and Improvisation in Organisational Change: Working live*, London and New York: Routledge.

Webster's Third New International Dictionary (1966) Chicago: Rand McNally and Company.

Wenger, Etienne (1998) *Communities of Practice: Learning, Meaning and Identity*, Cambridge: Cambridge University Press.

White, Michael and Epston, David (1990) *Narrative Means to Therapeutic Ends*, New York: W. W. Norton.

Wittgenstein, Ludwig (1980) *Remarks on the Philosophy of Psychology*, §629, Oxford: Blackwell.

Yeats, William Butler (1996) *Among School Children*, in *The Tower, The Collected Poems of W.B. Yeats*, ed. Finneran, Richard J., second revised edition, p. 215, New York: Scribner Paperback Poetry.