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RESEARCH ARTICLE

Navigating and understanding organisational complexity in health services: The value of POSH-VRE

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Abstract

This methodological article introduces positive organisational scholarship in healthcare and video reflexive ethnography (POSH-VRE) as a methodology to cut through the challenges of accessing and engaging organisations for research. We demonstrate how POSH-VRE can open space to navigate and better understand organisational complexity and build capacity. Organisational complexity denotes the interrelated components of a system. POSH-VRE can be helpful within complex organisations, such as health services, because it focuses on positive healthcare practices and experiences. We exemplify this with reference to a study on brilliant community-based palliative care. Using fieldnotes and video-recordings, we reveal the value of positive recognition – or celebration; video-cameras; and courtesy, whereby we adapted to different contexts. POSH-VRE can be of scholarly, methodological, and organisational value. It enables researchers to navigate organisational complexity and co-construct findings with nonacademic experts. Furthermore, it can encourage nonacademic experts to improve practice by learning from their own capacities to navigate organisational complexity.

Key words: positive organisational scholarship in healthcare; video reflexive ethnography; knowledge translation; methodology; participatory research

Introduction

In this era of big data, heightened surveillance, and political tensions, it can be difficult for researchers to access, engage with, and examine organisations (Mills, 2017). In public services, such as health services, bureaucracy, risk-aversion, and a constant state of busyness abound. This suggests organisational research, particularly about health services, is likely to require more than the conventional approach of finding-and-fixing issues. This is because find-and-fix research requires scholars to initially find problems and deficits. This in turn can heighten sensitivities among staff members – irrespective of seniority – who often feel they are being surveyed or monitored, and thus become more reticent or secretive. Furthermore, a sole focus on problems and deficits offers limited insight into the 'distinctly human capabilities' found within complex adaptive systems, such as health services (Fraser & Greenhalgh, 2001: 801).

An emphasis on negativity in health service management research is particularly apparent in the care of people who are dying. Despite the seemingly good intention, discourse about people who are dying can be unconstructive. Research, policy, and media reports are replete with references to the poor care of the dying. For example, dying people are described as 'marooned' recipients of 'slow' services that deliver 'suboptimal' care (Cicely Saunders International, Hospice UK, Macmillan, Marie Curie, National Council for Palliative Care, Motor Neuron Disease Association, & Sue Ryder, 2016).

This is not to suggest an absence of positive discourse (Meier, Gallegos, Montross Thomas, Depp, Irwin, & Jeste, 2016). Research suggests palliative care is deemed favourably in particular nations (Jürges, Laferrère, & Lemoine, 2019). Furthermore, a recent systematic review indicated that the 'Core elements' of a good death include 'control of pain and symptoms, clear decision-making, feeling of closure, being seen and perceived as a person, preparation for death, and being still able to give something to others' (Krikorian, Maldonado, & Pastrana, 2019: 1).

However, 'A good death is hard to find' (Ting, 2017); for some, it represents an ideal they are 'Still searching' for (Tenzek & Depner, 2019). This might be partly due to the salience of bad deaths, which can leave 'a negative imprint' on the memories of those involved (Tenzek & Depner, 2019: 10). It might also be partly due to the contested nature of a 'good death', and the potential futility of a dichotomy between that which is 'good' and 'bad' (Meier et al., 2016).

Although understanding bad deaths can help to reduce their likelihood, negative discourse can portray people with a life-limiting illness as vulnerable, rather than as living and wishing to contribute to life. Similarly, it portrays clinicians as inept, rather than as agents of change who are attuned to the nuanced needs and preferences of the patients and families they work with.

Scholars have begun to acknowledge the importance of examining positive healthcare. Some have recognised the role of a strengths-based approach to uncover hidden competencies and build resilience to understand and promote safe healthcare (Mesman, 2011). This distinguishes resilience and capacity-building as important parts of the human endeavour, which should be sufficiently studied, akin to tragedy and failure.

Interweaving positive organisational scholarship in healthcare (POSH) with video reflexive ethnography (VRE), POSH-VRE can cut through the challenges of health service management research. Although positive organisational scholarship (POS) and VRE are established approaches, they are yet to be combined to simultaneously: redress negative-centric scholarship on health service management (Dadich et al., 2015); and encourage nonacademic experts – such as managers, clinicians, patients, and their families – to collect and interpret data.

We argue that POSH-VRE can be used to navigate organisational complexity within health services. This argument is made with reference to a study to understand brilliant palliative care within a community health service. By drawing on ethnographic fieldnotes and video-recordings, we reveal: how this combined methodology can be operationalised; its strengths; the challenges; and how these can be managed.

This methodological article commences by describing POSH and VRE, highlighting common principles. Following this, we portray the study in which we used POSH-VRE to understand brilliant palliative care. We then present what we found to be particularly useful when operationalising this combined methodology. We conclude by explicating implications associated with the thesis of this article – particularly for those interested in messy methodologies.

Positive organisational scholarship in healthcare

POSH extends POS by clearly situating scholarship in healthcare. Before explaining the rationale for this extension, we provide an overview of POS, how it has been used, its strengths, and its challenges. POS is 'the study of that which is positive, flourishing, and lifegiving in organizations' (Cameron & Caza, 2004: 731). Challenging the tendency to concentrate on problems and gaps, it seeks to study triumphs and achievements because of their inherent appeal and allure – furthermore, triumphs and achievements reveal opportunities for capacity-building.

Given that POS and appreciative inquiry both recognise positive phenomena, it is worth clarifying their differences, lest they be misconstrued as equivalent. Appreciative inquiry 'creates the conditions for generativity in organization life… [by exploring] questions such as "What gives life to an organization when it is functioning at its highest level?"' (Bright & Miller, 2013: 321). In effect, it involves an expressed effort to *change* a context. As Head (2013) noted, 'Appreciative Inquiry is a process for diagnosing an organization's need for change… it establish[es] interventions that will make the peak experience factors the norm, rather than the exception' (p. 576). As such, although there might be exceptional practices within a research setting, these are not the expressed focus of appreciative inquiry. POS however, is distinct in that it, 'seeks to understand extraordinary human organizing' (Bright & Miller, 2013: 321–322). Through theoretically-based research, it considers the dimensions that give rise to the extraordinary or brilliant.

POS helps to respond to organisational scholarship that is awash with reports of failure. Many scholars are drawn to organisational flops and fiascos. Nowhere is this more apparent than in health service management research, where reports of 'adverse events' (Rafter et al., 2014) and 'dismissive and aggressive' behaviours (Bradley et al., 2015) can be readily sourced. Yet, POS topics include strength, resilience, organisational virtuousness, positive deviance, extraordinariness, and capacity-building.

Harnessing and purposefully extending POS, POSH attempts to redress the current imbalance towards health service *mis*management. Against the wave of pessimism, POSH (like POS) recognises that the way a scholar frames their questions shapes how they engage with a healthcare space; what they primarily attend to; how they perceive and make sense of that space; what they find; and the possibilities they envision. Although critiqued for being ignorantly blissful and lacking critical analysis (DeMatteo & Reeves, 2011), these concerns can be addressed by drawing on critical theory to encourage scholars to question tendencies, assumptions, as well as understandings of the positive and the organisation (Barker Caza & Caza, 2008). This helps to avoid simply ego-stroking participants, collecting their 'best of' anecdotes, and turning these into change objectives.

Video reflexive ethnography

VRE involves inviting participants to: feature in and/or gather visual data (V); interpret the data pensively and openly (R); and suspend and understand organisational practices and experiences *in situ* (E). VRE actively involves 'participants' recognising and appreciating both practice-based and lived knowledge. Thus, the VRE researcher attempts to be an 'alongsider' with participants to coproduce representations of what is sensed, perceived, and experienced (Carroll, 2009). This contrasts with participant surveillance and scrutiny, which risks leaving them feeling, 'quantified, measured… defined to the last detail… predetermined and finished off' (Bakhtin, 1984: 58).

VRE can impact organisational practices by revealing taken-for-granted routines. It has been used with clinicians to: identify risks to, and opportunities for patient safety; and design tailored solutions (Iedema, Merrick, Rajbhandari, Gardo, Stirling, & Herkes, 2009). Given its transformational quality, VRE has been used to understand and change diverse organisational contexts (Iedema, Mesman, & Carroll, 2013).

There is growing international interest in, and scholarship about VRE (Collier et al., 2019; Dadich, Collier, Hodgins, & Crawford, 2018; Mesman, Walsh, Kinsman, Ford, & Bywaters, 2019). Consider, for instance, the VRE International Association – 'an international collective of like-spirited scholars and practitioners with an interest in… VRE as a transformative methodology' (n.d., para. 1) – as well as a recent publication, demonstrating how VRE 'turns existing paradigms on their head [by recognising]… that front-line professionals and patients and their families know everyday care by living it every day' (Iedema, Carroll, Collier, Hor, Mesman, & Wyer, 2018: 6). This can be achieved when guided by the four principles of VRE – namely: exnovation – that is, 'the accomplishment and complexity of everyday and taken-as-given care practices unfolding in the here and now' (p. 12); collaboration; reflexivity; and care.

Although VRE can help to appreciate the complexities of clinicians' everyday work, it also presents challenges that warrant consideration. The mere presence of a video-camera can provoke vulnerabilities, as people can fear seeing themselves on film. The video-camera can unflatteringly expose the gap between the way individuals see themselves and the way the world sees them, producing a vulnerability of being on film. Indeed, VRE works on this very assumption – by seeing ourselves in a different way, we can become attuned to the aspects of ourselves and others, as well as our autopilot practices. Additionally, like ethnography, VRE prioritises participant perspectives. This is moderated by an analytical commitment to understanding actions as context-sensitive and context-renewing, whereby the sense and significance of an activity are embedded within the situation and circumstances in which it is produced.

POSH-VRE

These descriptions of POSH and VRE suggest they share two principles. The first is a recognition of local expertise. Rather than assume the importance of external knowledge and the value of superimposed interventions to fix issues, POSH and VRE award primacy to context and the individuals therein. Second, both foreground the taken-for-granted. As De Wilde (2000) noted, 'things or practices are not less valuable simply because they already exist' (p. 13). POSH and VRE redirect the scholarly-gaze to accepted, if not tacit practices. Although this reflects exnovation, POSH-VRE does not have 'the explicit aim to *improve* practices' (Mesman, 2011: 76, emphasis added). Those who use POSH-VRE do not necessarily intend to change others – that occurs if participants want and have the opportunity to change.

POSH-VRE focuses on what organisations and the people therein do exceptionally well, if not brilliantly. It involves filming organisational practices and reflexively determining the conditions that enable brilliance. This focus can be of scholarly, methodological, and organisational value. POSH-VRE can promote critical dialogue, insight, and theorising. Given its focus on brilliance, it can represent a key to employees, particularly in senior positions, who permit external researchers to unlock and enter a contentious and complex space. Finally, POSH-VRE can build organisational capability by encouraging nonacademic experts to reflect, generate new knowledge, and improve performance, should they wish to and have the opportunity. To demonstrate these strengths, the challenges, and how they can be managed, the following section presents an exemplary study on brilliant palliative care in which we used POSH-VRE. As such, the purpose is not to present empirical findings from this study, but rather, to illustrate how POSH-VRE can help to cut through the challenges of health service management research – empirical findings associated with this study can be sourced elsewhere (Collier et al., 2018).

Methodology

Following ethics approvals (reference numbers: HREC/15/LPOOL/73 and HREC/15/TQEH/240), generalist and specialist clinicians who were affiliated with one community health centre in New South Wales, Australia and delivered palliative care were invited to participate in a study to better understand their brilliant practices, as defined by established criteria (Dadich et al., 2015). This followed discussions with senior managers within the health district who spoke highly of their reputation with reference to the care and compassion they extended to patients and their families. Furthermore, the clinical team was relatively stable and had an effective relationship with the major tertiary referral hospital. This occurred despite resource shortages, including staff and time; reforms within the health system to avert hospital admissions by encouraging community healthcare; and increasing patient demand for community-based palliative care.

The clinical team included specialist palliative care clinicians and nonspecialist clinicians and encompassed a Nurse Unit Manager (NUM), a Clinical Nurse Educator (CNE), Clinical Nurse Consultants (CNCs, $n = 2$), Clinical Nurse Specialists (CNSs, $n = 4$), Registered Nurses (RNs, $n = 7$), Enrolled Nurses ($n = 2$), and Medical Specialists ($n = 3$). Over approximately 24 months (October 2015 to September 2017, inclusive), and following informed consent, two of us captured routine and atypical practices using a video-camera. These included weekly case review meetings;

the delivery of palliative care within patient homes; conversations between clinicians, with patients, and/or with families, in person or via telephone; as well as the documentation of clinical notes at the service, in patient homes, or in the clinicians' vehicles-*cum*-office spaces. While each of these represented routine practices, they were also enacted in disparate, and sometimes atypical ways. Consider, for instance, the different ways that clinicians would time and broach a conversation about end-of-life care with distressed family members; the distinctive ways that nurses would deferentially challenge, if not disagree with the array of '-ologists' they worked with, who did not hold expertise in palliative care; or the unique connection that clinicians would share with a particular patient and their pets.

Despite the expressed focus on brilliant community-based palliative care, myriad practices were captured, given the exploratory nature of this study. Because the study commenced with limited understanding of when brilliance might manifest, how, and who (or what) might be involved, approximately 50 hours of everyday practices were captured via video-files, some of which might not have captured brilliance.

In addition to institutional ethics, we were guided by situated ethics (Perez, 2017). Situated ethics, 'acknowledges the uniqueness and complexity of each situation and any ethical decision needs to take cognisance of the precise way in which many… factors are played out in the specific socio-political context' (Piper & Simons, 2005: 58). This does not suggest the futility of ethical guidelines and policies – but rather, 'any such statements or principles will be mediated by the local and specific – by, in other words, the situatedness which constitutes that practice' (Simons & Usher, 2000: 2). As such, decisions about what and when to film and with whom were made 'in the context of time and place as well as who is involved, rather than according to a set of prescriptive rigid rules or regulations to be adhered to or wholly adopted' (Clark, 2012: 25). Accordingly, and following a participant's formal consent, an ethically-conservative approach was used to film and subsequently view the footage (Iedema et al., 2018). For example, participants were recontacted to seek their permission to show footage for specific audiences and occasions.

Given the ethnographic component of POSH-VRE, data came in different forms, from different sources throughout the study. They included our paper-based and audio fieldnotes; audio and video-recordings of interviews with clinicians, patients, and family members; video-recordings of routine and atypical practices; as well as video-recordings of the reflexive sessions. Anchored by POSH-VRE, these data were analysed to understand brilliant palliative care and determine the conditions that enabled it. As reported elsewhere (Collier et al., 2018), this largely involved four levels of analysis to align: POSH-VRE; its participatory, interpretive, and transformative tenets; as well as the methods used to operationalise these tenets. Specifically, we collaborated with interested clinicians to: first, identify exemplars of brilliant palliative care, as per the established criteria (Dadich et al., 2015), and construct themes associated with these exemplars (Braun & Clarke, 2006, 2011); second, edit the video-recordings to create video-clips that portrayed the themes, in a way that did not sever the exemplar from its context (average length = 3.50 minutes); third, co-facilitate four reflexive sessions at intervals and times that were convenient for the clinical team (average length = 90 minutes) to analyse and critique the video-clips by inviting the clinicians to describe: what they observed; how they felt while viewing the video-clips; whether and why the exemplar epitomised brilliant palliative care; and the factors that influenced these exemplars; and fourth, analyse and critique video-recordings of the reflexive sessions to determine the characteristics that contribute to brilliant palliative care.

To integrate the two methodologies, we grounded the study in POSH, while delicately balancing the use of video, reflexivity, and ethnography. As demonstrated in the following section, this was achieved through positive recognition – or celebration; the negotiated use of video cameras; and courtesy, whereby we adapted to different contexts, guided by what the situation required, and what participants preferred.

Results

The value of celebration

Ethnography within a health service, particularly with a video, can present quandaries for senior staff, concerned about how their organisation will be represented. Senior staff who participated in this study initially struggled to recognise the potential value of VRE in general. Familiar with conventional research, like surveys, they questioned the purpose, what might be gained, and how 'real' outcomes might be produced and measured. They raised concerns about social desirability bias and halo effects. To discuss and manage these concerns, we held several meetings with staff of all levels – specifically, separate meetings were held with senior managers within the health district; senior clinicians at the research site; and the aforesaid clinical team. Furthermore, regular meetings were held (for the duration of the study) with the senior clinicians and the clinical team at the research site, to better understand their (changing) expectations, their interests, their concerns, and how we might address and accommodate these within the study. Given the authority afforded by their positions, senior staff within the health district were involved in the development of the research design to clarify how POSH-VRE might be operationalised, complete with contingency plans. This was a clear acknowledgement of their expertise.

Following this, we met with the specialist palliative care team before beginning fieldwork, helping to seed a positive relationship. The specialists found the study appealing, offering an opportunity to showcase the brilliance they recognised within community-based healthcare, yet was seldom appreciated:

> I thought… if it was going to be captured, to show other people that [*sic*] weren't involved in palliative care how good we were doing within the community; I thought that was really… good. In other words, exposure… to the community or to people in the hospital, the hierarchy, other nurses, etcetera, doctors (*CNS*).

The specialists' favourable response shaped the way the wider (nonspecialist) team perceived the study. During a subsequent meeting with the NUM, CNE, and the clinicians who did not specialise in palliative care, we introduced POSH-VRE and described how it *might* be used to highlight their brilliant practices. We emphasised *might* because we indicated that POSH-VRE has the elasticity to be shaped for different contexts. This point resonated with the clinicians – they appreciated the invitation to share the research reigns with us to steer the study in codetermined directions:

> [At our weekly research meetings], everyone could give their input and ideas. I think it kind of expanded what the project could do because it wasn't just one or two people thinking about it, but there seemed to be a lot of people giving their input (*RN*).

Another factor that resonated with the clinicians was our interest and enthusiasm. Perhaps to test our genuineness, immediately after the aforesaid meetings, we were invited to shadow the clinicians during their chaotic days – and we jumped at the chance. Rather than formalise, systematise, and bureaucratise POSH-VRE, we were directed by the clinicians, within the parameters of what the ethics committees had approved. What we observed, how we observed it, and when we observed it, was directed by these experts. This helped to frame the scholarship, 'not as an act of accumulation but of participation (through role) in a process of identity construction such as movement not as an act of to "expert" status' (Bleakley, 2006: 152).

First impressions count. Although we were (and remain) genuinely focused on brilliant healthcare, we were keen to ensure our words and actions would be construed as appreciative, given the political sensitivities of healthcare (Moll, 2012). We regularly vocalised our observations of what we deemed brilliant to the clinicians we shadowed; we commended their perseverance, particularly in the face of adversity; and we extolled their self-control. Consider a home visit to a man who was terminally ill with cancer, and his wife, who together resided on a large acreage. This was the first time the attending CNC and RN had met this couple. With compassion, they attentively listened to the couple's story – a laborious story that involved contact with several clinicians; a litany of tests and tablets; and complaints about extensive waiting times, particularly before specialist appointments. As we sat around the dining table, the patient's wife attempted to narrate a seemingly bewildering experience. She described what she and her husband had assumed would be an appointment with the oncologist. Given the patient's 'boney mets' (or bone metastasis), the long commute to the hospital-based appointment was painful for both the patient, and for his wife who bore witness to her husband's pain. They arrived early to ensure they were not late, only to sit on 'uncomfortable' chairs for a considerable time, exacerbating the patient's pain. As they 'waited and waited and waited', the patient writhed in pain; and when he and his wife were summoned into the clinic, they were disappointingly afforded '5 min' with a registrar:

> We waited all that time; he was in so much pain. And we only saw [the registrar]. You would think [the oncologist] would come and see us, even for five minutes; I mean, she was definitely there – I saw her walk past (*patient's wife*).

Overwhelmed with emotion and information, most of which was in medical-speak, the patient and his wife learnt the cancer had progressed and the patient was to be referred to yet another health service whose clinicians would visit the patient at home.

Over the next few days, the patient and his wife were unsure about his medication regime – they were no longer clear on how to use the myriad bottles and boxes of tablets, and when to use them. Telephoning the registrar for clarification, the wife was advised that the patient no longer needed to continue the medications, for there was nothing more that could be done. The patient had therefore been referred to the palliative care team:

> He said there wasn't any-more that he could do, and he didn't want to see him anymore (*patient's wife*).

The patient and his wife were visibly dazed and distraught by this news, and the experiences that preceded it at the hospital-based appointment. She spoke in a hushed tone while she watched tears roll down her husband's checks. Needing to be alone, the patient rose to his feet, left the dining table, and took a short stroll around his property.

We cannot verify what transpired at the hospital-based appointment – we do know whether or how the registrar informed the patient and his wife that palliative care clinicians would be requested to consult with the patient. All we can verify is that the subsequent telephone conversation between the registrar and the patient's wife is when she first internalised this information.

The CNC and RN acknowledged the couple's pain and expressed remorse for their situation. There was no blame or hostility in their words – just heartfelt empathy. They respectfully decoded the medical-speak and explained how they could support the patient and his wife, pending their preferences.

After leaving the patient's home, the author who observed this home visit discussed the consultation with the two clinicians. Like the researcher, the clinicians were disheartened and 'pissed off'. They were angry to know the couple had left the hospital-based appointment without clearly understanding the registrar. Yet, the clinicians restrained their emotions – they did not slander fellow clinicians who seemed to 'work differently'; instead, they channelled this emotion into demonstrations of empathy. Placing themselves in the position of the patient and his wife, they acted in ways they would find helpful, if receiving palliative care. Inspired by, and in awe of these clinicians, the researcher lauded the perceived brilliance and spoke with them throughout the day, and thereafter, to better understand how these practices came to be.

Continuing to shadow the clinicians, when permitted, helped us to familiarise with: organisational discourses, as they manifested through slogans, creeds, jokes, and stories, which were shared socially to reflect the organisational culture; what they deemed to be mundane and brilliant; and how they acknowledged brilliance. Correspondingly, our presence and our expressed purpose of celebrating palliative care helped to remind the clinicians that our primary interest was their brilliant practices.

Our focus on brilliance was helpful for three reasons. First, it helped to clearly anchor the study in, and operationalise POSH. Second, as a term that is open to interpretation, brilliance optimised inclusiveness. The term encouraged manifold interpretations of the phenomena under investigation, while maintaining a focus on that which demonstrates remarkable excellence. This focus recognises that, although health services contain 'bright spots' (Dixon-Woods et al., 2014: 110), these are visible to different people at different times, under different conditions – thus, brilliance is polysemous. Although brilliance can be difficult to define, recognise, capture, and measure, these tasks become easier when guided by the overarching purpose of a health service – in New South Wales, that is to 'Keep… people healthy and out of hospital while still providing timely, quality care when and where it's needed' (NSW Health, 2014: 8). Accordingly, this study commenced with, and adhered to fundamental questions that attuned the researchers, the clinicians, and those they supported to brilliant palliative care. Together, we considered: what constitutes such brilliance in community settings; how it affects individuals, teams, and organisations; and the factors that contribute to, and shape it.

The third reason our focus on brilliance was helpful, was because the language of brilliance helped us to access and engage with the research site, and the clinicians therein. Given the highly-politicised, neoliberal nature of many Western health systems, where political tensions, strong professional identities, and rigid accountability mechanisms reign, it was important that we dissociated ourselves from conventional problem-finding exercises that pathologise and reprimand well-intended, if not brilliant clinicians. The research site was challenged by limited resources, and the clinicians were regularly held to account for their use of equipment and time. For many of the clinicians, this suggested their inefficiencies were of primary interest to the organisation, rather than their acts of perceived brilliance. Consider the use of a paper-based travel log in which the clinicians were expected to manually record each kilometre travelled using a fleet vehicle, or the impromptu 'boot audits' to reclaim and reallocate yet-to-be-used supplies like syringes, dressings, and saline water vials. It was therefore essential to distance ourselves from these mechanisms to quantify and measure healthcare, to avert the perception that we were an ally of, and/or accountable to 'management' (Bakhtin, 1984). This was achieved by explicitly and regularly acknowledging the clinicians' brilliant practices. Our admiration reminded all who were in earshot of our focus. Furthermore, our compliments made the research more appealing, encouraging clinicians to consider themselves and their organisation in a new light:

> When you guys came in, we didn't know what to expect. But because you were so supportive of what we were doing and constantly gave us positive reinforcement saying, 'You're brilliant, you're brilliant', it made me happy to have you come out on the road with me. It made me think, 'Oh, maybe what we do is brilliant' (*CNS*).

Although the framing of brilliance enabled us to navigate organisational complexity, we and the participants were concerned by our fluid understandings of what was and was not 'brilliant'. Brilliance – by our definition – was subjective. For instance, a point of early contention was the difference between the ordinary and the *extra*ordinary. Some came to understand brilliance as synonymous with standing out from the everyday; others sought to uncover the everyday practices involved in successfully caring for patients and their families, where success meant accommodating their needs and preferences in a timely way. Although this understanding reflected organisational expectations and government policy, it was difficult to achieve. This is because it required a delicate blend of sophisticated clinical and social skills; and discerning intuition. Consider how an RN paid heed to and respected a family's reluctance to have their loved one admitted to a hospice, despite the patient's critical situation. Given their steadfast perceptions of a hospice as 'a place to die', the family members could not be readily convinced that a temporary admission was possible – thus, as the patient's clinical situation deteriorated, the RN demonstrated her relational prowess as she patiently explained the many functions of a hospice, how they differ from hospitals, and how hospice-based clinicians can temporarily monitor patients; titrate their medication regime, as appropriate; and inform their community-based counterparts, accordingly. Although it was difficult to develop a shared understanding of brilliance, as evidenced by frequent animated debate, interrogation of our scholarly focus helped us to collectively establish a wide, reflexive view of the context. By drawing attention to what was and was not brilliant, we forced our perspectives into a critical analysis of brilliance in the context of palliative care, thereby strengthening our scholarship.

The value of a camera

The vulnerabilities provoked by filming proved to be an inherent challenge of POSH-VRE in this context. Clinicians were concerned about how we – with video-camera in tow – might intrude, especially in the intimate space of a person's home while they were dying. Combined with existing clinical and organisational demands, VRE was initially viewed as another demand – and our access into patient homes relied on whether the clinicians deemed it appropriate. Given these concerns, it is important to note the video-camera did not leave its camera-case when fieldwork commenced – instead, the video-camera appeared (and disappeared) at the direction of the clinicians, the patients, and their families. For instance, some clinicians were particularly averse to the video-camera and remained so throughout the study. Thus, it was not used while these clinicians were shadowed. When shared spaces were filmed, seating arrangements attempted to ensure they remained out of the camera's eye. However, akin to other fluid workspaces where employees are not confined to particular areas, sometimes these clinicians would enter a room in which the video-camera was used. This was managed by ensuring the clinician was aware of the video-camera's presence, asking whether they would prefer recording to cease, and if not, approaching them later to determine whether they would prefer the footage to be deleted.

Our own reluctance to intrude on sensitive moments was also challenging. To manage this, we used several approaches to introduce and sustain the use of a video-camera. For instance, as a relatively less intrusive way to capture conversations and moments, we used an audio-recorder as an entrée to filming. We interviewed clinicians to familiarise them with the study and filmed some of these interviews using a video-camera. We also filmed shared spaces, like the weekly case review meetings where clinicians convened to discuss patient progress, as well as the clinicians' shared office-space. Additionally, we regularly kindled impromptu reflexive discussions with the clinicians, questioning our decisions and the motives behind them; and we analysed and edited video-files onsite, encouraging the clinicians to observe and question how the recordings were used, and reflect on what they observed in those recordings. These approaches accustomed the clinicians to the video-camera, to seeing it in our hands, and to VRE.

We sought ways to increase the appeal of the video-camera among the clinicians and the patients and families they worked with. We suggested the clinicians could use the recordings to aid the subsequent documentation of clinical notes. However, in most cases, these suggestions were employed to appease our own discomfort. For example, carrying the video-camera when not in use helped to legitimatise our presence during home visits. Although we would have certainly obliged any request, the clinicians did not accept the offer to review footage for clinical use, following a home visit.

The footage offered three unanticipated benefits. The first was the affirmation. This was demonstrated by a CNS who was unusually affected by a patient's death. Confiding in the CNC, she doubted her competencies and questioned what else she might have done to facilitate a 'good death'. Although the CNC was confident in her colleague's knowledge and skills, she was unable to allay her colleague's concerns. Recalling the patient had been discussed during a case review meeting, the CNC combed through the footage of this meeting and invited her colleague to view it with her. Together they watched the CNS provide a comprehensive, coherent, and heartfelt summary of the patient's situation and how she had aimed to ensure their needs and preferences were accommodated. In addition to the patient's clinical situation, she spoke at length of their social situation, and her quest to develop a rapport with the family:

> She's got [cancer of the] brain, liver, lung… She lives with her husband [and]… two young boys… [Her husband]'s left everything to the mother… The mother wants to know about every[thing]… She just told me now that they're seeing some scientific nutritionist. I said, 'Look, I understand, *I would do the same if it was my daughter*'… I said, 'Can we get some personal care… Considering all the work that everybody here is doing for you, would you consider somebody coming in and just assisting your mother?' [The patient]… looked up at her mother… and her mother goes… 'No… I'll be alright'… She calls me practically every-day… to be reassured… [The patient]… said to her mother the other day… 'You know mum, I'm dying of cancer'. That was very confrontational for her… [The mother's] very angry because she says she's only recently diagnosed – 'The doctors must have missed it… How can it be that my daughter was working in November last year and now [in March] she's bedbound?'… She's very cranky, *as you can imagine*… If I can build a rapport, then she might let me walk through those doors (*CNS, emphasis added*).

Viewing herself utter these words reminded the CNS of her brilliant care, allaying her doubts.

The second benefit was vicarious learning. The clinicians, some of who were uncomfortable with palliative care, had the opportunity to 'see' a different vista of palliative care and how it was enacted. Rather than declare their clinical limitations (perceived or otherwise) to their senior colleagues, they could revisit their own patient visits, as well as respectfully peer into their colleagues' visits, to shape what they did and how they did it:

> It's a rare opportunity… to… see what your interaction was like, your bedside manner, what you could have done differently… Looking at yourself… on video, it's like… you don't even recognise your own voice and there's little things… you don't realise you do… You just say to yourself, 'I'm not going to do that next time'; or by looking at other nurses' videos, you say – 'You know what, I really like how they did that and I'm going to do the same' (*RN*).

The third unanticipated benefit afforded by the footage was a legacy. Having established friendships with some patients and families during this study, we would contact bereaved family members to convey their condolences, following the death of their loved one who had contributed to this study. Following consultation with the ethics committee, these families were offered a copy of the footage in which they and/or their loved one was depicted. The families who accepted this offer relished the opportunity to see and hear their loved one again:

> I just needed to hear his voice again. I have these photos, but I don't have his voice (*widow*).

The value of courtesy

POSH-VRE was also aided by our courtesy – our respect and consideration for the context through our actions and words. Akin to community-based palliative care clinicians, who are required to adapt their practices to suit different individuals and the different contexts they enter, we adapted our practices to suit the needs and preferences of clinicians, patients, and families. This required us to leave our agenda(s) at the door, including our study-timetable; harness serendipitous opportunities to fraternise with the clinicians to understand the organisational culture; and situate POSH-VRE within this culture. For instance, heated debates on medicinal marijuana, while both interesting and entertaining to discuss, offered a glimpse into clinician sentiments and values, and how these shaped their practices. Likewise, quietly observing clinicians' skilful use and completion of (seemingly duplicative and tedious) online clinical data systems at the end of a long day enabled us to witness their diligence and dedication. We watched the clinicians systematically (or at least attempt to) recall varied conversations throughout the chaotic day with patients, families, fellow team members, general practitioners, allied health professions, and hospital staff who, for instance, managed hospital admissions or the hiring of hospital beds. We observed how they honoured promises to patients, families, or colleagues by, for instance, diplomatically reminding a general practitioner of a much-needed prescription; rescheduling the next home visit to accommodate a patient's conflicting medical appointment; ensuring a patient's filled sharps-bin was replaced during the next visit; and sourcing additional syringes or oral swabs impregnated with sodium bicarbonate to help the patient manage oral thrush. We viewed how they pieced together different artefacts collected throughout the day, like printed discharge summaries and blood pressure readings they had scrawled on the back of their hand to save time; make sense of these fragments of data and information; and convert them into coherent, legally-binding clinical notes via an online data system for the immediate benefit of fellow clinicians. By interacting with, and observing the clinicians, we discretely discovered the ethical and practical dimensions of palliative care:

> [The researchers] have done such an amazing job with [this study]… not just with the way they interacted with the patients so… sensitively, but also the way that they… really held our hands… asking us how we felt after an interaction; I think it was really… well done (*RN*).

This situated study was not, 'a sequence of research-driven abstract decisions'. Instead, it commenced and evolved from the brilliance of, '[real] individual[s]… real organizations and [real] systems… in their real contexts' (Wieringa, Engebretsen, Heggen, & Greenhalgh, 2017: 964–969). Such situatedness was necessary for two reasons. First, palliative care occurred in multiple ways and places – it occurred at the service, as the clinicians shared their tribulations and triumphs; it occurred in patient homes, as the clinicians refilled syringe drivers and developed end-of-life care plans with patients and families; and it occurred within the confines of clinicians' fleet vehicles, as they used their hands-free mobile telephones to contact general practitioners or source hospital equipment. Second, palliative care was sometimes tumultuous – it involved emotional uncertainties as the researchers, clinicians, patients, and families considered the impacts of dying, death, and grief.

Enacting this situated study required a relational and plasticine-like self-shaping to adapt to the context. Consider how we bonded with the clinicians who also found cathartic value in the (appropriate) use of expletives. When beyond the earshot of patients and families, profanities were humorously exchanged when sharing and lamenting work-related woes. This served to oil the relationship and demonstrate authenticity:

> I was a bit worried about these researchers… talking down to us. But when… she swore, I thought to myself, 'These guys are okay' (*CNC*).

Our situatedness also reshaped how the clinicians perceived us and academe. Accustomed to externally-driven research, they had not previously encountered 'subjective, messy and nonlinear' methodologies (Doyle & Buckley, 2017: 97), like POSH-VRE. Rather than dictate the course of the study, we deferred to their judgement. Rather than collect data and hastily retreat to academe, we collected and interpreted data *with* the clinicians. Although this initially involved those with an expressed interest in palliative care, we found ways to involve nonspecialist clinicians by, for instance, facilitating weekly research meetings within the clinicians' shared office-space, affording everyone opportunity to contribute to the study, if and when they wished:

> I know for the nurses I have spoken to, co-research has largely been a positive experience. I like that the project has helped to engage the team in palliative care (*CNS*).

Furthermore, rather than solely communicate findings via refereed journals, we encouraged the clinicians to pursue their own opportunities – like the hospital grand rounds programme to help hospital-based, 'single organ' colleagues better understand community-based palliative care. This programme represents an important educational activity (Tarala & Vickery, 2005). For those who deliver palliative care, they offer 'an opportunity to promote the discipline, support institutional culture change, and favorably influence the attitudes, knowledge, skills, and performance of colleagues' (Morrison & Portenoy, 2010: 1477). This might partly explain the clinicians' interest in this programme, and the opportunity to deliver a presentation to colleagues from different specialties. This demonstrates reciprocity within this research and our relationship with the clinicians.

POSH-VRE is premised on *bona fide* participation, requiring participants to govern the research. Rapport development with the clinicians during fieldwork gently encouraged them to assume greater research control. The participatory nature of POSH-VRE enabled them to consider the 'unseen' brilliance in the context of their palliative care practices:

> That's what we see is our normal, everyday work. But… it's… taken-for-granted… because it's my job (*NUM*).

The reflexivity inherent to VRE opened space for the clinicians to appreciate the complexity of their organisation. During reflexive moments, they deliberated on recent experiences – both the trivial and nontrivial – and discussed their reactions; these included reactions that were spoken, enacted, and felt. These moments did not demand othering – instead, the researchers and clinicians awarded primacy to the self, becoming observers of their own practices and interpreting their interpretations. During reflexive moments – most of which did not involve viewing video-footage – they exposed and questioned their reactions, thereby disrupting and transforming themselves. These moments 'demand[ed]… both an other and some self-conscious awareness of the process of self-scrutiny'.

This reflexivity reflects a meta-process – 'a movement amongst and between… four… modes' (Hibbert, Coupland, & MacIntosh, 2010: 57). The first is repetition, 'in which an individual is reflecting in a relatively closed, self-focussed manner and recursivity operates passively' (p. 52). In this study, repeated, focused reflexivity formed part of the regular reflexive sessions, providing a supportive environment, with familiarity in the process developing over time. The second is an extension, which involves 'some building of new principles or understandings that connect with well-known principles but is not subsumed within them' (p. 53). Within the reflexive sessions, brilliant themes were developed over time. Initial reflexive sessions were analysed to seed concepts germane to brilliant palliative care. These themes related to aspects of brilliance, such as perceptiveness; connections; and humour, among others. Theme development was ongoing, with initial themes presented and discussed at each subsequent session, providing opportunity to extend collective understandings of brilliant practice. The third mode is disruption, where 'the intimate or personal [segregates]… from the public and collective, or the everyday life from the occasional "political" act' (Gouldner, 1970: 504). Disruption was demonstrated when, for example, we intentionally positioned ourselves as a provocateur, confident that our probing questions would not be misconstrued as a nuisance; and un- (or at least, less) conscious reflexivity was apparent, *ex post facto*; for instance, when healthy debate helped us to grasp the emotional sequelae associated with seemingly trivial events, like the lack of an email-reply from senior managers regarding a request for much-needed syringe drivers. The fourth mode – participation – occurs when 'the organizational researcher is changed in the process by giving up (at least partly) the notion of independently directing the process of reflexivity and is open to the insights and challenges of others' (Hibbert, Coupland, & MacIntosh, 2010: 50). This was inherent to the practice of courtesy, as we encouraged the coresearchers and participants to shape the research focus. As the research progressed, clinicians were increasingly invited to engage with the study in a hands-on fashion and identify data they perceived to be related to brilliant practice. For instance, they were asked to review and edit footage for reflexive sessions, capture video-recordings, and present the findings to audiences they deemed suitable.

Although difficult to empirically-verify, these opportunities for reflection and reflexivity were possible because of the trusted relationships between the clinicians and us. By sharing ourselves, revealing our vulnerabilities, assuming different roles – the reflector, the confidant, the advocate, or the agitator – and being open to personal change, we collectively became able to comfortably question each other, knowing these challenges were well-intended and not disrespectful.

Discussion

Health services are complex, with political tensions, rigid accountability mechanisms, and limited resources necessitating a need to move from the prominent deficit model of scholarship to focus on what promotes flourishing healthcare. Despite the challenges that pervade many health services, this article demonstrated that POSH-VRE can encourage nonacademic experts to generate new knowledge. Furthermore, it can encourage these experts to continually improve performance through positively-framed reflexivity, enabling appreciation of organisational complexity. Balancing video, reflexivity, and ethnography to focus on brilliant palliative care reinforced and promoted such care, partly by bolstering clinician confidence. The clinicians observed themselves to 'view… the broader system of practice… the systemic space within which it operates… [and] the opportunities for change that this systemic perspective brings into view' (Iedema et al., 2009: 299). Importantly, they were able to observe when and how they enacted brilliant palliative care. These observations helped to crystallise brilliant practices; and promote the self-efficacy required for such brilliance, perceived or otherwise.

VRE and POSH can (but are not required to) be agents for change. By enabling reflexivity, VRE can encourage participants to question practices and underlying assumptions. VRE can also empower participants to lead positive change, promoted through structured reflexivity (Carroll, 2009). Similarly, POS(H) is dedicated to recognising and highlighting positive processes and states (Barker Caza & Caza, 2008). By using POSH-VRE, the scholarly agenda becomes much more positive, with an agenda invariably focused on empowerment to dismantle interprofessional hierarchies and promote wellbeing.

Researcher positioning in VRE has received attention given how it shapes results. Carroll (2009) discussed physical positioning and how different vantage points are shaped by, and shape how the researcher conducts the study. The presence of the video-camera in participants' lives can make new subject positions available to participants and researchers, offering an important reflexive tool. Similarly, when deciding what is filmed, edited, and collated for reflexive sessions, the researcher defines and determines the experiences worthy of study. This echoes the metaphor of zooming in and zooming out, whereby switching theoretical lenses and repositioning the field allow certain aspects of practice to be foregrounded (or bracketed), contrasting wider organisational realities with microcosms of participant experiences. However, POSH-VRE advances this by zooming *with* participants, inviting them to interpret their reality; enhance the research findings; and construct new insights into organisational complexity.

Integrating VRE and POSH to move from finding-and-fixing to a positive focus was not straightforward. It revealed (and created) methodological tensions, requiring us to be continuously and situatedly reflexive. VRE and POSH do not discount challenges, risk, and vulnerabilities. Negotiating when, where, and how the light might be shined, by who, and with who can be fraught, particularly when the subject matter is less than positive. Inherent in VRE is the control given to participants to shape how the research unfolds – this becomes a source of trust between the researcher and participants. Yet it is impossible for the researchers to completely mitigate their own agendas and 'outsider' perspectives. Knowledges of what is and is not brilliant can be contested and might be privileged at a particular time and context. What is regarded as brilliant and by who, and when is never fixed. Perhaps this unfixed characteristic of brilliance promotes further brilliance.

Our study illustrates how POSH-VRE can help researchers to circumnavigate organisational complexity to capture and celebrate what makes an organisation and its members brilliant. By reflexing on positive practices, our approach nurtured a space to build capacity and better understand organisational complexity, giving this space over to clinicians. Scholarship is now required to explore whether and how POSH-VRE might be used to navigate complexity within other organisations. Within health service management research, this might involve interrogating contested and privileged perspectives of brilliance by expanding research boundaries to include patients, family members, allied health professionals, and diverse specialisations. Beyond this field, this might involve considering highly-networked and/or bureaucratic sectors, such as biotechnology or the public sector. Given the increasing complexity of many organisations and the sectors they represent, many opportunities abound to determine the potential of POSH-VRE.

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