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Title
Using POSH VRE to examine positive deviance to new public management in healthcare

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Abstract
As part of the wave of new public management (NPM) in comparable contexts, there has been considerable 'regulatory creep' within the Australian health system. Yet this wave was not as spectacular as expected, with the wash-up revealing the dark sides of NPM. Although these dark sides are disappointing and unfortunate, positive organisational scholars have argued that adversity can open opportunity for the extraordinary to emerge. Friction between expected and preferred practices can give rise to positive deviance. Yet as a form of non-compliance, positive deviance can be difficult to examine. This methodological article demonstrates how the combined methodologies of positive organisational scholarship in healthcare (POSH) and video reflexive ethnography (VRE) can help to manage these difficulties. More specifically, it illustrates the methodological utility of POSH VRE to: respectfully study the impact of organisational change on public sector employees; positively reframe how clinicians exercise agency by constructively responding to, and managing obstruction; and reveal the unintended effects of organisational change. As a participatory methodology, premised on mutual respect and meaningful engagement, POSH VRE

promoted trust between the researchers and clinicians, which in turn unveiled instances of positive deviance to new public management in healthcare.

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Conflict of Interest Statement
There are no conflicts of interest to declare.

Keywords
1. Positive organisational scholarship in healthcare
2. Video reflexive ethnography
3. Positive deviance
4. Health service management
5. Palliative care

Summary at a Glance
This article demonstrates the methodological utility of positive organisational scholarship in healthcare (POSH) combined with video reflexive ethnography (VRE) to study: the impact of organisational change on public sector employees; how clinicians can exercise agency by constructively responding to, and managing obstruction; and the unintended effects of organisational change.

Introduction

As part of the wave of new public management (NPM) in comparable contexts, like the United Kingdom, the United States, and New Zealand (Gruening, 2001), there has been considerable 'regulatory creep' (BRTF, 2004) within the Australian health system – this extends beyond conventional settings like hospitals, to community health services (Baum, 1996, Collyer et al., 2015). Underpinned by economic rationalism (Willis et al., 2016a), NPM emphasises managerialism and marketisation (Keisu et al., 2016), promising 'continuous increases in efficiency, the use of ever-more-sophisticated technologies, a labour force disciplined in productivity, clear implementation of the professional management role, [and] managers being given the right to manage' (Walsh, 1995, p. xiii).

The wave of NPM was not as spectacular as expected (Dwyer et al., 2014, Halligan, 2013). Notwithstanding its contributions (Whitcombe, 2008), the wash-up from the NPM wave revealed its dark sides (Simonet, 2013, Diefenbach, 2009). In addition to depreciating personnel within the public sector (Kessler, 2015), these dark sides include: the reframing of relationships as, 'objective phenomena or as market interactions' (Sercombe, 2015, p. 97); the reduced customisation of patient care (Liff and Andersson, 2011); the intensification of clinical work, with limited time to deliver care (Henderson et al., 2016b); the intensification of managerial control over this work (Willis et al., 2016b); as well as job dissatisfaction, psychological strain, and emotional labour among clinicians (Debesay et al., 2014, Teo et al., 2012). Although the post (or, as per its new moniker, transcending) NPM era attempts to address these sequelae by emphasising inter-organisational collaboration and lateral (rather than vertical) governance arrangements (Dunleavy et al., 2005, Addicott et al., 2007, Christensen and Lægreid, 2013), the NPM legacy largely remains, even if sometimes modified (Duncan and Chapman, 2012).

Although the dark sides of NPM are disappointing and unfortunate, positive organisational scholars have argued that adversity can open opportunity for the extraordinary to emerge (Cameron and Spreitzer, 2012, Spreitzer and Sonenshein, 2003). Like tectonic plates, friction between expected and preferred practices can give rise to remarkable, if not brilliant practices and experiences (Dadich et al., 2015a). Consider positive deviants within healthcare who: 'find better solutions and achieve better outcomes than others'; 'follow uncommon or special practises and behaviours'; use 'a 'bottom up' approach'; and/or 'succeed using existing resources' (Baxter et al., 2016, p. 196).

As a form of non-compliance, if not subversiveness, positive deviance can be difficult to examine for at least three reasons. First, any attempt to defy a regime of NPM is likely to be concealed. Second, it can be challenging for researchers to gain the trust of positive deviants to unveil and examine their constructive aberrations. Third, as a socially constructed concept, defining and recognising positive deviance can be problematic (Hunt, 2016, Baxter et al., 2016). For these (and perhaps other) reasons, there is a limited understanding of how individuals positively deviate from organisational change – like that associated with NPM.

The aim of this methodological article is to demonstrate how the combined methodologies of positive organisational scholarship in healthcare (POSH) and video reflexive ethnography (VRE) can help to manage the aforesaid challenges. Towards this aim, this article commences with a brief overview of NPM – its promises and its dark sides. Guided by positive organisational scholarship, it then repositions these dark sides as opportunities for the extraordinary to emerge – that is, positive deviance. Following this, the article describes

the relevance of POSH and VRE to examine these constructive aberrations. Drawing on an Australian study that spans two states, the article then illustrates how POSH VRE can be used to capture, study, and understand helpful forms of non-compliance to organisational change within community-based palliative care. The article concludes with a discussion of key lessons for scholars and practitioners of public administration. More specifically, it illustrates the methodological utility of POSH VRE to: study the impact of organisational change on public sector employees within the Australian health system; exemplify how clinicians can exercise agency by constructively responding to, and managing obstruction; and reveal the unintended effects of organisational change.

New Public Management

For many public sector employees worldwide (van Schingen et al., 2015), particularly Australia and New Zealand (O'Flynn, 2007), organisational change has come in the form of NPM. In the quest for 'fast and frequent change… in organizations delivering public services' (Andrews et al., 2008, p. 309), NPM requires managers to clearly align organisational objectives and processes with that of (their current) government(s) (Doessel et al., 2009), and it requires their subordinates to be accountable for their performance, often via performance-auditing and performance-measurement (Diefenbach, 2007, Guthrie and Parker, 1999).

Theoretically, NPM might be described as a pluralistic reform initiative, drawing from disparate principles (Simonet, 2013). These include public choice theory, principal-agent theory, transaction cost economics, competition theory, the theory of the firm, and modern management theory, among others (O'Flynn, 2007). Such plurality might partly account for the varied euphemisms for, and understandings of NPM, which include managerialism, neo-managerialism, and public management (Gow and Dufour, 2000). Although NPM does not propose a coherent theory, it awards primacy to efficiency and results (O'Flynn, 2007) via three key components – namely, 'the adoption of private sector styles of management and administration; the application of post-Fordist work organisation and design… [and] the retention of a public sector philosophy despite these other innovations' (Lyons and Ingersoll, 2006, p. 83).

Akin to many reforms, the key motive for NPM is improvement. Discontentment with the limitations of traditional bureaucracy, where governments were deemed to be, 'unresponsive, inefficient, monopolistic, and unable to reach formal goals' (O'Flynn, 2007, p. 355), gave way to NPM and the rise of post-bureaucratic, competitive governments. Subsequently, managers pursued performance targets by managing inputs and outputs, and the individual preferences of service-users were aggregated.

The wave of NPM has reached many sectors, including the civil service (Kearney and Hays, 1998), the police service (Butterfield et al., 2005, Butterfield et al., 2004), the criminal justice system (McLaughlin et al., 2001, Raine and Willson, 1995, Mak, 2008, Dadich et al., 2015b), transport infrastructure (Wiesel and Modell, 2013), the youth sector (Sercombe, 2015), and academe (Chandler et al., 2002), among others. In healthcare for instance, NPM has altered the relationship between medicine and management (Kirkpatrick et al., 2016, Simonet, 2013, Willis et al., 2016b) through 'restructuring, performance management, establishment of networks and trusts and new clinical governance structures, as well as changes in the roles and responsibilities' (Byers, 2015, p. 2), particularly for clinicians. Consider the hybrid manager whereby clinicians assume a managerial role to manage, if not moderate resistance

to organisational change among their clinical peers (Spyridonidis and Currie, 2016, Fitzgerald and Dadich, 2009, Kippist et al., 2012).

This is not to suggest that professions have been unassuming in this organisational change. Reflecting on the medical profession, Kirkpatrick and colleagues (2016) observed the complicity of key professional bodies that positioned doctors alongside managers, committed to their health system, as much as they are to their patient. A similar view is found in Australia, whereby the Australian Medical Association (2011) has recognised doctors as, 'uniquely placed to take on leadership roles, including management and leadership of health services, and in the wider management and leadership of the organisations that they work in' (p. 2).

As a 'powerful transformative device' (Bolton, 2004, p. 326), consumer rhetoric has furthered the NPM cause (Owens, 2015). Repositioning, or seeming to reposition patients (past, present, and future) *and* their carers as customers implies they have agency, choice, and a considerable responsibility to manage their own (limited) wellbeing and/or that of the care recipient (Health Consumers NSW, 2016, Williams and Dickinson, 2015). Although patients and carers might welcome this recognition of personal agency, consumer rhetoric has also challenged health services and the clinicians therein, which are required to accommodate seemingly judicious consumers. As PricewaterhouseCoopers (2016) recently warned:

> President-elect Trump's healthcare mission will sound familiar to anyone working in healthcare today… These goals – patient-centrism, consumer choice, quality, affordability – are hallmarks of the pivot toward value-based care, one of the most powerful forces reshaping the industry. 2017 will be a year dominated by this shift toward value, which has been underway for years… The pursuit of value is laced into partnerships between traditional health organizations and new entrants, and in efforts by healthcare providers to modernize payment systems as consumers finance more of their care (p. 1).

These challenges reveal the dark side of NPM. As the height of the NPM wave has receded, the mismatch between its ideals and 'public service', as pursued by some public sector agencies, has become increasingly apparent (Bradley and Parker, 2006, Thomas and Davies, 2005, Simonet, 2011). The superimposition of commercial values onto social values has impelled a critique of whether NPM can ensure effective and efficient public services (Brunton and Matheny, 2009, Noblet et al., 2006). As Brown and colleagues have argued, 'private sector practices have not always been demonstrated to suit the public sector environment' (2003, p. 232). This echoes recent observations regarding the deleterious effects of NPM on nursing, including the compassion required in palliative care (Henderson et al., 2016a, Crawford et al., 2014).

Despite the challenges associated with NPM, particularly for health services (Braithwaite, 1997, Fisher, 2006), some clinicians have sought to benefit from this organisational change. For instance, following her six-year study on nurse responses to NPM, Bolton (2004) found the paradox of cost-cutting *and* service-quality profoundly affected nursing. Yet from this paradox emerged another paradox. Although the NPM ethos encouraged the nurses to quantify patient care, design the 'one best way' to conduct their duties, and 'ache with the effort of maintaining a 'smiley face'' (p. 327), some harnessed the way that NPM curtailed

medical dominance to raise the profile of the nursing profession within the clinical pecking order. Similarly, Leicht and colleagues (2009) found that, in the context of palliative care, which prizes 'time with a patient… [and] time with their family' (p. 591), temping (or temporary positions) enabled some clinicians to embark on selective nursing, working when they wanted, where they wanted, and undertaking 'proper' (p. 592) nursing, largely devoid of the distractions associated with institutional change. Although a raised nursing profile and temping might merely represent 'powerful transformative device[s]' (p. 326) to co-opt nurses into NPM objectives, these examples demonstrate the value of a different understanding of healthcare – one that purposefully examines, understands, and promotes constructive aberrations. Building from the work of Mesman Braithwaite and colleagues (2015) have argued:

> We must learn to pay attention to how clinicians successfully adjust what they do to match the conditions… We must understand how front-line staff facilitate and manage their work flexibly and safely, instead of insisting on blind compliance or the standardization of their work… Healthcare is already far more resilient than we credit it. The crucial task is to help make it more so… It is therefore essential to learn from the far more frequent cases where things go right and develop ways to support, augment and encourage these (pp. 419-420).

Heeding this call, the following section presents a brief overview of positive deviance to consider and understand constructive aberrations.

Positive Deviance

As part of a positive approach to organisational scholarship – which focuses on 'that which is positive, flourishing, and lifegiving in organizations' (Cameron and Caza, 2004, p. 731) – positive deviance is a 'collection of behaviours that depart from the norms of a referent group, in honourable ways' (Spreitzer and Sonenshein, 2003, p. 209). These behaviours are honourable because of the associated effects, enabling organisations (broadly defined) to flourish. As such, positive deviants depart from expected practices to invigorate, strengthen, or galvanise a group of individuals who pursue a common goal (Mertens et al., 2016). As Gary (2013) has summarised, positive deviance: is 'honorable; departs or differs from an established norm; contains elements of innovation, creativity, adaptability, or a combination of these; [and] involves risk for the person deviating' (p. 29). Although she also described positive deviance as intentional, the value of the behaviour might only become apparent when positive outcomes and/or experiences emerge. For this reason, positive deviance might encompass both intentional and unintentional behaviour.

Conceptually, positive deviance is asset- (rather than deficit-) based; it recognises the value of local or indigenous (rather than external) expertise to address intractable issues (Spreitzer and Sonenshein, 2003, Luft, 2010); and it is socially-driven and sustainable, whereby positivity begets positivity (Marsh et al., 2004). For two key reasons, these represent points of difference from quality improvement exercises and (participatory) action research (Bradley et al., 2009). First, the preferred or best practices are assumed to already exist – they are not introduced via, for instance, an intervention, even if co-developed by researchers and participants. Second, variation is expected – rather than examine phenomena through experimentation and/or feedback mechanisms, positive deviance prizes learning from exceptional exemplars. As Tarantino (2005) explained, 'The statement becomes, "This is how

we can do what we want to do," rather than the question "How can we get them to do what we want them to do?"' (p. 63).

Since its introduction to address public health issues like childhood malnutrition (Wishik and Vynckt, 1976), poor infant development (Guldan et al., 1993), and limited condom use among young people (Babalola et al., 2002), positive deviance has gained traction within organisational and public administration scholarship. Used as a noun or a process (Gary, 2013), positive deviance has been used to examine constructive deviations from organisational norms (Spreitzer and Sonenshein, 2003). For instance, in an examination of 'diamonds in the rough', Clancy (2009) found that clinicians with managerial responsibilities did not necessarily value nurses who blindly complied with organisational standards and policies – but rather, they valued the nurse who, '"always finds a way to get the job done," "is the glue that holds us all together," and "is extremely resourceful, knowledgeable, and adaptable"' (p. 54). These individuals used effective workarounds to realise an organisational aim. Similarly, Melnyk and Davidson (2009) reported that positive deviance is one of the 'key ingredients for success' (p. 294) when creating a culture of innovation. This is not to suggest that positive deviance is the panacea for all organisational or administrative woes by discounting or, worse still, ignoring organisational challenges – but rather, it can help to redress the attraction to problems, gaps, and issues among scholars (Sharma and Gadenne, 2011, Healy and Walton, 2016, Bryant et al., 2014, Gkeredakis et al., 2011).

Much of the guidance on how to examine positive deviance suggests a linear approach, comprised of seemingly discrete and predetermined activities (Klaiman, 2011). Bradley and colleagues (2009) for instance, described the following four 'steps':

> identify 'positive deviants,'… study the organizations in-depth using qualitative methods to generate hypotheses about practices that enable organizations to achieve top performance; test hypotheses statistically in larger, representative samples of organizations; and work in partnership with key stakeholders, including potential adopters, to disseminate the evidence about newly characterized best practices (p. 422).

Furthermore, the identification of positive deviants often entails a statistical approach or a normative approach. The former assumes behaviours and outcomes are normally distributed, and it involves the determination of confidence intervals by which deviance is identified (Spreitzer and Sonenshein, 2004, Heckert, 1998). As Klaiman (2011) noted, 'Methodologies for identifying positive deviants must include a valid outcome measure, reliable measurement, and the ability to adjust for covariates among different agencies' (p. 422). The normative approach focuses on the phenomenon of positive deviance, the contexts in which it emerges, and the factors that shape it (Spreitzer and Sonenshein, 2003, Warren, 2003).

Although this guidance can be helpful, how might positive deviance be studied in contexts that shun it, explicitly or implicitly? Consider for instance, 'today's highly regulated health system environment' (Clancy, 2010, p. 55), where directives and decrees dominate – be they in the form of government policies, organisational protocols, clinical guidelines, or the mandates of professional bodies. A culture that prizes conformity and compliance can mask deviance in all its forms – including that which is positive. For instance, following their study on disciplinary processes and the management of poor performance among nurses, Traynor and colleagues (2014) revealed a 'lack of systematic recording and reporting… and…

examples of deliberate concealment' (p. 57) – and according to the authors, this demonstrated 'increased managerial power'. These observations are noteworthy because, as Gary (2013) has noted, 'when nurses don't report the exact care provided, the outcomes of positive deviance are lost' (p. 31). Given that positive deviance research requires the identification of positive deviants and promulgating their practices (Lawton et al., 2014), it is important to consider methodologies that are conducive to the examination of this concept in complex contexts (Lindberg and Clancy, 2010), like health services. And given the low status and relatedly, vulnerability of nurses relative to their clinical and managerial colleagues, perhaps nowhere is this more important, than in the context of nursing. To address this void, the following sections introduce POSH VRE.

Positive Organisational Scholarship in Healthcare

POSH is 'the study of that which is positive, flourishing, and lifegiving in [healthcare] organizations' (Cameron and Caza, 2004, p. 731). Challenging the tendency to concentrate on all that is negative, it seeks to study triumphs and achievements because of their inherent appeal and allure (Cameron and Spreitzer, 2012) – furthermore, triumphs and achievements help to reveal opportunities for capacity-building (Dadich et al., 2015a).

POSH is not ignorantly blissful. Its link with critical theory suggests it encourages scholars to question tendencies, assumptions, as well as understandings of the positive and the organisation (Dadich and Olson, 2014, Ryff and Singer, 2003, Oliver, 2005). POSH represents 'an alteration in focus' (Cameron and Caza, 2004, p. 732) – a deliberate attempt to redress the scholarly preoccupation with the non-positive, if not the negative. This approach recognises that a scholar's starting point – the way they frame their questions – shapes how they engage with a research space; what they primarily attend to; how they perceive and make sense of that space; what they find; and the possibilities they envision. Nowhere is this perhaps more apparent than in health service management research, where reports of 'failure' (Edmondson, 2004), 'poor care' (Dixon-Woods et al., 2014), 'adverse events' (Rafter et al., 2014), 'healthcare disasters' (Macrae, 2014), as well as 'rude, dismissive and aggressive' behaviours (Bradley et al., 2015) – among other calamities – can be readily sourced (Radnor et al., 2012). POSH is gaining considerable traction, largely because of the Brilliance Group and its research program dedicated to promoting brilliant health service management (Dadich et al., 2015a, Dadich et al., 2014, Fulop et al., 2013, Fulop et al., 2011).

Video Reflexive Ethnography

As an interventional methodology, VRE invites individuals to: feature in and/or gather visual data (V); interpret the data pensively and openly (R); and suspend and understand practices and experiences *in situ* (E). VRE is a collaborative methodology comprised of participant observation and other traditional ethnographic methods. It involves the negotiated filming of practice and/or participant accounts of practices supplemented by reflexive viewing to co-analyse the footage (Iedema et al., 2013). It has been used in a range of hospital contexts including emergency departments (Iedema et al., 2012), intensive care units (Carroll et al., 2008), and infection control (Hor et al., 2014).

VRE is interventional in nature. It encourages the co-construction of new meanings by challenging the assumptions of all parties – be they researchers, managers, clinicians, patients, or carers (Collier and Wyer, 2015, Iedema et al., 2015). By actively disrupting the *status quo*, VRE is inherently complex and produces a number of challenges as well as opportunities (Mesman, 2007). It requires researchers to embark on a journey with

participants in directions that are uncertain to: capture what are often contested perspectives; and produce footage that might have different meanings to different people at different times and in different settings (Collier and Wyer, 2015).

Method

Following clearance from the relevant research ethics committees, generalist and specialist clinicians who delivered community-based palliative care in one of two community health services were invited to participate in a study as co-researchers using VRE. To preserve anonymity, the teams in New South Wales and South Australia were collectively comprised of: specialist palliative care nurses, palliative medicine staff specialists, junior medical staff, generalist registered nurses and allied health staff and administrative staff Over approximately 15 months (September 2015 to December 2016, inclusive), and following informed consent, members of the research team – many of whom were clinicians – recorded routine, as well as atypical practices. These practices included: weekly case review meetings; daily clinical huddles; team discussions; the delivery of palliative care within patient homes; conversations between clinicians, with patients, and/or with carers, be it in person or via telephone; as well as the documentation of clinical notes, be it in the service, the patient homes, or the clinicians' vehicles-*cum*-office spaces. Despite the expressed focus on brilliant palliative care, an array of practices was captured, given the exploratory nature of this study. More specifically, because there was limited understanding of when and how brilliance might manifest, close to 75 hours of digital video files were recorded at the two sites during this period, some of which might not have captured brilliant palliative care.

The research team at each site then invited their clinical colleagues to analyse selected exemplars of video footage that epitomised brilliant palliative care. During six reflexive sessions across the two sites, this involved asking the clinicians to describe: what they observed; how they felt while viewing the footage; whether and why the exemplar epitomised brilliant palliative care; and the factors that influenced this moment. Framed by POSH, this collaborative approach encouraged reflective practice – it enabled the researchers to critically reflect on their role as a clinician and/or researcher, and isolate edifying, teachable moments that epitomised brilliance. Footage containing moments of brilliance were edited when appropriate, in a way that did not sever the exemplar from its context. Further detail on how the study was operationalised is published elsewhere (withheld for blind review).

To determine how the combined methodologies of POSH and VRE helped to study positive deviance in the context of organisational change, footage of the reflexive sessions were analysed, with a particular focus on discussions of positive deviance. This involved reviewing the footage and documenting instances when workarounds were noted by the clinicians as they discussed community-based palliative care. To determine the accuracy of the emerging findings, the footage of the reflexive sessions was supplemented with additional ethnographic data – namely, fieldwork ? footage of brilliant palliative care, fieldwork notes, and opportunistic interviewing with members of the clinical team. The use of these additional data helped to situate positive deviance in context.

Results

Footage of the reflexive sessions and the supplementary ethnographic data were replete with instances where clinicians employed workarounds to meet the needs and preferences of patients and their carers at poignant moments. As demonstrated in this section, POSH VRE

helped to highlight positive aberrations, and reveal the ways the clinicians used their tacit knowledge and networks to exercise agency in response to organisational demands.

By purposefully focusing on 'enablers, motivations, and effects associated with positive phenomena' (Barker Caza and Caza, 2008, pp. 21-33), this study unveiled instances where clinicians operated outside organisational boundaries with positive intentions and/or effects. When invited to reflect on their own brilliant practices during reflexive sessions, the clinicians often discussed instances when they acted in a way that was contrary to what was implicitly or explicitly expected of them. This seemed to be prompted by the term, brilliance, which was collectively defined as exceeding expectation. For instance, the clinicians discussed having close, personable relationships – if not friendships – with patients who received palliative care, despite recognising this as 'wrong', according to organisational protocols or 'management'. One clinician for instance, attended the wedding of a patient's daughter to offer support, although this role was fulfilled in a voluntary capacity. They spoke of the tensions associated with 'doing what's right', as opposed to what is professionally acceptable:

> We've got all these professional boundaries. But I always think, you've got to do what's in your heart, what's right for you… When you go the professional boundary courses, I probably did everything wrong. But at the end of the day, it's like, what I said, it's in my heart… I wasn't hurting anybody and they were appreciative [*Clinical Nurse Specialist*].

Another example of defying expectation was described in reference to thinking and/or acting unconventionally, from a new perspective. While observing footage, and discussing the elements of brilliant palliative care, impelled by POSH, thinking and acting 'outside of the box' was considered to be vital:

> she won't have seen the patient and she'll ask this question that you go, 'I can't answer that. I don't know. I need to find that out. But why haven't I thought to ask that question?'… She will come out with things that none of us have thought of… I try to nurture in myself what I see is good in [that clinician] [*Medical Staff Specialist*].

The positive focus required by POSH also helped to unveil the investment of time often associated with brilliant palliative care, which was often perceived as being at odds with the expectations of 'management'. The clinicians regularly articulated the need to 'invest time' into palliative care, which defied the implicit expectations of the organisation to complete home visits quickly. A clinician demonstrated this while *en route* from a patient's home:

> I think it (seeing the footage back) goes to show how much goes into a visit… it's half an hour or one hour or more with a patient. You know there is so much to contemplate on the way back [from a home visit] [*Junior doctor*].

An SA clinician conveys how her involvement in the project affirms her use of time despite the expectations of her allied health line managers that she should respond to functional tasks alone:

> Again, this project makes me feel like the people who don't get it, [the purpose of the palliative care team and the need for blurring of disciplinary roles] who don't understand 'why is it you spend time

> counselling and having a conversation? We've got social workers who do counselling' I am there at that time, it is appropriate and I feel like, in the context of what's happening I have the skills to manage that situation and I've also got the nous to know when I can't and when I need to refer on. So don't tell me a (names discipline) can't do counselling in a palliative setting. Otherwise why are you employing (names discipline)? We are so holistic. We have to be. These people (patients and families)are not in a clinic or a hospital. They are at home. They are an hour and a half away sometimes, so you have to do what you have to do. [*Allied health staff member*].

This purposeful focus on theses clinician's brilliant practices and the respectful use of VRE to capture these created a situation that was conducive to this finding. This was further demonstrated by the seeming contrast between palliative care and general community healthcare. The responsibilities of the generalist registered nurses included both palliative care and general community healthcare – notably, wound dressing and the administration of antibiotics. Relative to palliative care, general community healthcare was perceived as task-driven with clear duties to be completed during a home visit, each with an allotted time. For instance, a 'wound 2' visit was expected to be completed within thirty minutes during which a wound dressing was removed, and the wound, cleaned, examined, and redressed. Notwithstanding slight variation between 'wound 2' visits, they were largely deemed to involve defined tasks with clear expectations. This was juxtaposed by the greater fluidity of brilliant palliative care, whereby the length and use of clinician time was determined by the situated dynamic between the clinician, the patient, and their carers:

> I suppose it's time… sometimes people can take a couple of hours to visit when they're dying. So, if you're going to do that brilliant work, you can't just, 'Oh it's an hour now; I'm gonna go' [laughs]. You might need to spend that two hours with them and… if you're keeping them at home, they're not going to bounce into hospital, so you are saving the government money in the long run but I don't think they measure that *[Specialist Palliative Care Nurse*].

During the reflexive sessions, clinicians at both sites would regularly discuss the need to invest time into their relationships with patients and carers. As part of a push towards value-based care, they recognised the need to develop a personal, if not close relationship to enable the patient and carer to trust the clinician and disclose their concerns, however sensitive. This in turn was conducive to preventative healthcare, potentially averting the need for unnecessary hospitalisation:

> It's an investment to spend that time, because in the end, you're going to get compliant patients who are going to have less problems, less likely to go into hospital. So really, when you look at cost and time, you're saving a lot [*Generalist Registered Nurse*].

> I'm not producing a huge amount of work, but for the people we're seeing, the sort of outcomes that we're wanting to achieve, that's just what time it takes to actually get it done. So I don't see that the executive would understand [*Palliative Medicine Staff Specialist*].

To ensure the clinicians had opportunity to invest into these relationships, they surreptitiously carved out time from their competing responsibilities. When shadowed by the researchers, they were sometimes observed to: rush administrative tasks – sometimes with ill effects; carefully plan their route between patient homes to optimise efficiency; and hasten more task-oriented healthcare, like wound dressing. Although palliative care visits did not always require the maximum limit permitted of 60 minutes (excluding travel time), the clinicians were keen to ensure that the importance of time investment was duly recognised within 'the system' – for this reason, and in the interests of perception management (Elsbach, 2013), they sometimes avoided a premature return to the service, lest palliative care be perceived as ephemeral. Again, the trusting relationship between the clinicians and the researchers, buoyed by POSH, helped these workarounds to be empirically observed.

While POSH anchored the study in positivity, VRE – particularly its ethnographic component – enabled the clinicians to disclose their positive aberrations to the researchers. By shadowing clinicians across the two sites to witness and understand their brilliant practices, the researchers became increasingly sympathetic to the challenges they faced while delivering palliative care. The positive dialogue between the researchers and the clinicians typically occurred in intimate spaces, like: a café that offered internet access, while the clinician electronically documented clinical notes; the funeral of a deceased patient; or a fleet vehicle while *en route* to a home visit:

> You guys ask a lot of questions of us when we're driving along… You ask a lot of questions and I wonder whether that's why we're reflecting a little bit more than we would normally do. But we're debriefing to you… You could say to us, 'That was really shit and I'm really angry or I'm happy' or whatever, but you never say that; you usually say, 'So, how do you feel?' [*Specialist Palliative Care Nurse*].

> I enjoy it… I went out with [the researcher] the other day; she was saying, 'That was amazing' and she asked me something like, 'What do you think about the project?' And I kind of said, 'Well, you only ever tell me the good things I do. You never tell me when I do anything bad'. And she goes, 'Well, that's not what we're about' and I'm like, 'That makes sense'. It's not a performance appraisal – the focus is brilliance. And I said to her, 'I understand now exactly what you're talking about'… Not many times do you have someone that witnessed exactly what you'd like to talk about. For example, I can't go home to my husband and explain to him the way someone who witnessed it can understand… They just saw it and you can talk about it; I really enjoy talking about what we've done [*Generalist Registered Nurse*].

These close interactions encouraged mutual respect and trust. This in turn allowed the researchers to peer into the unintended effects of organisational change and the ways the clinicians coped with these effects. In New South Wales for instance, the researchers witnessed how the clinicians gave the appearance of compliance with point-of-care documentation protocols. During (rather than after) home visits, the specialist and generalist nurses were required to use an internet-connected electronic tablet to document clinical notes with the patient and their carers. This was to be completed before or after clinical tasks were performed, like refilling a syringe driver or (re)dressing a wound. Many clinicians deemed

the electronic tablet as problematic due to: the complicated software; the screen, which was not always sensitive to the stylus pen or clinician-touch; limited connectivity to the internet; and the perceived appearance of disregard for the patient and relatedly, disrespect. While they were shadowed by the researchers, these clinicians described the point-of-care documentation protocols as distracting and (negatively) disruptive. Materially, the electronic tablet was said to create a barrier between the clinician and the patient; psychologically, it diverted their attention; while socially, it disturbed their rapport with the patient and their carers:

> [I] hated using the tablets in front of the patients [*Generalist Registered Nurse*].

Given their concerns, these specialist and generalist nurses typically documented clinical notes after home visits, creatively finding ways to carve out time in an otherwise chaotic work-day. To optimise recall, some used their electronic tablet immediately upon returning to their vehicle, balancing the device on the boot or the steering wheel. Others would complete several home visits and then frequent a public space known to be clean and comfortable – like a public library, a café, or (like many other travelling employees) a McDonald's outlet – to document clinical notes for all patients while resting for a tea-break or lunch. The latter approach was particularly helpful, enabling the nurses to telephone relevant colleagues – be they a general practitioner (GP) about a status of a shared patient; a hospital employee about an impending admission or equipment required by a patient; or an interpreter service re a subsequent home visit to a patient of a linguistically different background.

The value of VRE and the close interactions that it encouraged between the researchers and the clinicians, was paralleled in South Australia. Anchored by POSH, the researchers became privy to moments of positive deviance – they observed and learnt how some of the clinicians resourcefully manipulated the vehicle booking system to ensure they could travel to a patient's home, as scheduled. VRE revealed the complex operation and performative elements of brilliant palliative care. Such care required the clinicians to negotiate organisational protocols – like a booking system – that aimed to streamline processes; manage resources, like vehicles; and monitor clinician whereabouts.

Secure in their close positive relationship with the researchers, some clinicians used the study to further their own cause(s). They harnessed the opportunity to give voice to their concerns, describing some of the collective frustrations that thwarted brilliant palliative care – like limited workforce capacity, poor leadership, and documentation templates that were hospital-, rather than patient-centric:

> Nowadays, we have to do the PCOC [Palliative Care Outcomes Collaboration – 'a national program that utilises standardised clinical assessment tools to measure and benchmark patient outcomes in palliative care' (Palliative Care Outcomes Collaboration, 2016, para. 1)] and the data and the letters to the GPs, and I ask myself, do the doctors even read these letters that we write?... all this paperwork that we fill out, that's all normal and we've always collected that… We see a patient and… We check whether they've got allergies, what their drugs are, if they've got ambulance cover, all of that, the really important stuff – the psychosocial, the spiritual. All that is so important… [Yet] there's a… bit of paper that tells us that we have to do this and that's part of our initial assessment and we've gotta have

> this, it's gotta be here, because some person has to find it when we are being accredited [*Specialist Palliative Care Nurse*.
>
> It's not personalised, its hospitalised [*Specialist Palliative Care Nurse]*

Furthermore, the opportunity to respectfully shadow the clinicians with a video camera helped to capture the subtle ways they constructively skirted standardised practices for the benefit of their patients. For instance, they formed alliances with select hospital-based clinicians to ease patient transition to and from the hospital; they discerningly drew on their networks when influence was required; and – as demonstrated by the following exchange between two clinicians – they used language intelligently to ensure patient referrals to complementary services were readily accepted:

> [The patient] wants to stay home as long as he can [*Specialist Palliative Care Nurse]*
>
> It's really difficult because he's not showering himself. I think we've asked… [another service]… for some hygiene [assistance], because he's not getting up and showering himself [and the] ex-wife doesn't feel comfortable to do that [*Specialist Palliative Care Nurse]*
>
> Well, as long as you don't just call it hygiene [*Palliative Medicine Staff Specialist*].

Having recently received an email emphasising referral criteria to another service, the staff specialist quoted above prompts a colleague in what to say with the knowledge that requiring assistance with hygiene is unlikely to result in acceptance of the referral. By traversing the 'rules' of their service, as well as those of complementary services, these clinicians knew how to navigate the health system to provide patients and their carers with what they needed and wanted in a timely way.

The positive focus of POSH coupled with the collaborative nature of VRE impelled some clinicians to encourage positive deviance within the team. Following a heightened push for value-for-money within the service, which serves to quantify care, they recognised the footage as a way to capture the attention of senior managerial staff – notably, the chief executive officer (CEO) and chief financial officer (CFO) – and verify the resources required for brilliant palliative care, including time. During a reflexive session, five clinicians deliberated on the most effective ways to politicise the research to positively further their agenda. Recognising the study as a means to an end, they considered how the data – particularly that which included patients and carers – might be used to advocate for brilliant palliative care in the context of NPM, even if this required the shrewd editing of the footage:

> If you show that back to CEO or CFO, would they think you were providing value for money? [*Palliative Medicine Staff Specialist*].
>
> I wonder if it's the way you cut [the footage] [*Specialist Palliative Care Nurse]*
>
> Yes, there's a risk in showing the garden first [[*Specialist Palliative Care Nurse]*
>
> But isn't that what we do – the humane bit? [*Specialist Palliative Care Nurse]*

> But there's no complexity shown there at all! [*Specialist Palliative Care Nurse]*

Despite the methodological value of POSH VRE in this study, its use was sometimes challenged. In a context impacted by NPM (Kirkpatrick et al., 2016, Simonet, 2013, Willis et al., 2016b, Byers, 2015), which prizes accountability (Diefenbach, 2007, Guthrie and Parker, 1999), some clinicians – many of whom visited patients independently and unaccompanied – were dubious about the motives for the study, and that of the researchers. Concerned they were to be surveyed, they deemed the ethnographic element of VRE to be invasive:

> [Some of the others thought you were] spies sent by management to liaise back and inform management of our practices [*Specialist Palliative Care Nurse]*

Although some of these concerns were mitigated in time (for further detail, see - withheld for blind review), it is likely that some of these clinicians were (and perhaps remained) less forthcoming about whether and how they demonstrated positive deviance in response to organisational demands, lest they be reprimanded by 'management'.

POSH VRE also demands a continued ability to negotiate tensions – this is particularly the case when there is a healthy power dynamic among the participants, be it for professional and/or personal reasons. For instance, sensitivities arose when the workarounds of junior or less assertive clinicians became apparent to those who held a managerial or supervisory role. This requires sound facilitation skills whereby tensions are suspended, considered, critiqued, and interpreted. Distributed facilitation among the researchers and participants alike can help to ensure a steadfast focus on the research aim that is framed by the methodology of POSH VRE, rather than remaining focused on an isolated person:

> that first scene [in that footage of a home visit]… captured [the patient] quite well in that she has a very strong personality which I like, but it doesn't always make her easy to get along with and I think that would present challenges for any community nurse… I think people with strong personalities like her are often difficult to assess, difficult to get to the root of what the problems are, difficult to connect with… and difficult to get them to trust you and I could immediately see that in that scene where she wasn't happy about being contacted when she was expecting to, and [the clinician] trying to deescalate that and I feel that in our job, it's difficult enough to make connections with some people anyway, and that's starting from a good place… but I now had a lot of sympathy for [that clinician] cause she's now not just… got to come in [to the patient's home] and make the connection to get the work done, but… she was upset with us before [that clinician] had even walked in the door. I think [the clinician] did a beautiful job of allowing her to speak and acknowledging her, so I think that was a great snapshot of the difficulties of connecting with someone like her and I think the next scene was in her garden and on the step [of the back door]. I thought it was funny because… [the clinician] was almost hollering at her, 'What you doing? What's that there? Is that spinach?'… I think it's interesting cause we went from this very serious scene of sitting…

> and probably a more traditional scene of what is assumed we do as community nurses in their role… but you know, it sort of flipped to this and of course my managerial hat – 'What on Earth is she doing?! Get back in the lounge room! Sit back on the couch and sort out the problems!... Scrambling around in someone's vegetable garden… when you are meant to be working!'… But… I've been in that situation, so I also know there is a lot more going on than that… if the… first shot had been shown [in the garden]… people would be thinking, 'What the hell? Who is this woman? Is she actually a nurse?'… I think the important thing is that it's those two things combined [*Specialist Palliative Care Nurse]*

In the context of NPM and the associated 'application of post-Fordist work organisation and design' (Lyons and Ingersoll, 2006, p. 83), the POSH component of POSH VRE might need to be amplified to moderate perceptions that the methodology purely aims to further the 'regulatory creep' (BRTF, 2004).

Discussion

This article has demonstrated how the combined methodologies of POSH and VRE can help to study positive deviance in the context of organisational change within community-based palliative care. The Australian health system, akin to others within the Organisation for Economic Co-operation and Development (OECD), is facing increasing demands without the resources required to meet these demands (Robinson et al., 2012). While people are living longer with chronic illnesses, hospital stays have become shorter and outpatient care has become increasingly complex, involving a mix of public, private, and not-for-profit agencies (Jenerette and Mayer, 2016). The response, in part, has been the adoption of NPM, which strives for efficiency, regulation, and accountability. Simultaneously, health services are under growing pressure to deliver high-quality, patient-centred care. The acuteness of these challenges is aptly demonstrated within community-based palliative care, where patients requiring end-of-life care, their carers, and the clinicians who work with them, often grapple with post-Fordist healthcare – healthcare delivered by: different sectors, some of which are contracted by the public sector; different services, each with their own protocols and regulations; as well as different disciplines, including palliative care, oncology, nursing, social work, and occupational therapy, among others (Housego and O'Brien, 2012). Furthermore, although the final phase of life can be poignant and emotionally-charged, palliative care in Australia is becoming increasingly objectified and quantified, as evidenced by the adoption of a national program of performance indicators (Palliative Care Outcomes Collaboration, 2016).

According to positive organisational scholars, organisational demands create opportunities for the extraordinary to emerge. To meet the needs and preferences of patients and their carers, some clinicians have become increasingly innovative in how they practice their profession, creatively bypassing organisational expectations and conventions (Vadera et al., 2013). Given that healthcare is 'quintessentially institutionally complex' (Martin et al., 2016, p. 5), this context can provide fertile ground for positive deviance (Rowley, 2011).

Positive deviance is premised on the assumption that transformative potential and power reside within the people and practices of a system. Research indicates that palliative care teams are particularly adroit at working flexibly and adaptively, improvising effectively to meet the needs of patients and their carers, whatever the disciplinary role (Crawford and

Price, 2003, Davison and Hyland, 2003). This capacity to work together with such an interwoven commitment suggests that palliative care teams might be especially likely to demonstrate positive deviance. However, understanding how teams and the individuals therein, constructively negotiate, if not flout NPM-inspired change has been difficult to investigate.

The positive and collaborative methodology of POSH VRE impelled the researchers to draw attention to the clinicians' strengths and how they creatively trounced conventions that seemed to hamper brilliant palliative care. This in turn facilitated and sustained trust between the two parties, enabling the researchers at both sites to: witness what *really* happened *in situ*; capture these practices via video recordings; and interpret the footage *with* the clinicians. This demonstrates the utility of POSH VRE. As a methodology, it can be used to examine: the impact of organisational change; how helpful responses unfold in sensitive, emotionally-charged contexts marked (if not obstructed) by NPM; as well as the unintended consequences of organisational change. This is in contrast to merely reflecting retrospectively, on what clinicians did and how they did it (Iedema, 2011).

In the context of the study presented in this article, the benefits of POSH VRE were twofold. First, it helped the researchers and clinicians – some of whom held a managerial or supervisory role – to recognise and examine positive deviance – those subversive practices that defied organisational requirements and enabled brilliant palliative care. Like a torch, the methodology illuminated those helpful workarounds that were otherwise obscured, intentionally or unintentionally. For example, the findings demonstrate how POSH VRE unveiled the creative ways used to engage different professions, internally or externally, as well as agencies that represented a different sector, to ultimately address the needs and preferences of patients and carers. POSH VRE thus revealed how these clinicians exercised personal agency and made use of their tacit knowledge to manage and overcome organisational protocols.

Second, as a capacity-building methodology (Iedema et al., 2013), POSH VRE offered the clinicians a political tool to bring attention to their plight and further their cause(s). Clinicians in both states sought to harness the study to advocate for their service and the needs of those they work with. Consider for instance, how some clinicians recognised the way the video footage might be purposefully used to convey a persuasive message – one that demonstrates alternative interpretations of the phrase, value-for-money.

Despite the methodological contribution this article makes to extant literature, two cautions warrant mention. First, the use of POSH VRE is largely contingent on context. There is no claim that it is the methodological panacea to definitively understand all instances of positive deviance to NPM. In a context where reform is now routine (Brunsson, 2009), where clinicians face greater scrutiny (Walshe et al., 2016, Flynn, 2017), and where services increasingly vie for limited resources (Boxall, 2011), POSH VRE might not be for the fainthearted. It requires researchers to be comfortable with, and patiently manage tension – tension that emerges from: interpersonal and/or interagency rivalry; relatedly, self-interest and a reluctance to share brilliant practices with colleagues; miscommunication, whether intentional or inadvertent; as well as the perceived irrelevance of brilliant practices (Lawton et al., 2014). As Bradley and colleagues (2009) explained:

> Barriers to its use may include competition between units within a single organization or between organizations such that secrets of

> success are not readily shared, structural separation of units so that information does not flow easily, or workforce issues in that employees do not see others' experience as adequately relevant to their own (p. 9).

Second, an invitation to expose positive deviance, no matter how well intended, risks distortion and censure for individuals and services alike. Evidence that a clinician or their service was 'working against the system' might result in disciplinary action. Similarly, those who hold a managerial or supervisory role might feel obliged to exercise their managerial muscle and reprimand the deviant. At a time when NPM is strong and health systems universally are being re-engineered, there is a risk that evidence of deviance – even if positive – could be politically sensitive and distorted to purposefully diminish public trust in clinicians and the health services they represent.

Despite these cautions, the thesis of this article – namely, the methodological utility of POSH VRE to examine positive deviance to NPM in healthcare – offers notable lessons for scholars and practitioners of public administration. For scholars, the article demonstrates that a methodology premised on positivity and collaboration – like POSH VRE – can open an empirical window into otherwise obscured practices. Although it requires sound facilitation skills, a comfortability with tension, as well as patience, POSH VRE can ease a scholar's journey into the complex, and politically-charged context of healthcare. For practitioners, the article suggests that POSH VRE can offer insight into the unintended effects of organisational change. By creating a safe space, clinicians have opportunity to share their workarounds in response to reforms. Furthermore, as a powerful transformative device, POSH VRE can encourage clinicians to exercise agency by raising the profile of matters they are passionate about – like the needs and preferences of patients requiring palliative care and their carers.

References

ADDICOTT, R., MCGIVERN, G. & FERLIE, E. 2007. The distortion of a managerial technique? The case of clinical networks in UK health care. *British Journal of Management,* 18**,** 93-105.

AMA (AUSTRALIAN MEDICAL ASSOCIATION) 2011. Position statement: Role of the doctor. Barton, ACT: AMA (Australian Medical Association).

ANDREWS, J., CAMERON, H. & HARRIS, M. 2008. All change? Managers' experience of organizational change in theory and practice. *Journal of Organizational Change Management,* 21**,** 300-314.

BABALOLA, S., AWASUM, D. & QUENUM-RENAUD, B. 2002. The correlates of safe sex practices among Rwandan youth: A positive deviance approach. *African Journal of AIDS Research,* 1**,** 11-21.

BARKER CAZA, B. & CAZA, A. 2008. Positive organizational scholarship: A critical theory perspective. *Journal of Management Inquiry,* 17**,** 21-33.

BAUM, F. 1996. Community health services and managerialism. *Australian Journal of Primary Health,* 2**,** 31-41.

BAXTER, R., TAYLOR, N., KELLAR, I. & LAWTON, R. 2016. What methods are used to apply positive deviance within healthcare organisations? A systematic review. *BMJ Quality & Safety,* 25**,** 190-201.

BETTER REGULATION TASK FORCE (BRTF) 2004. *Avoiding regulatory creep,* London, Cabinet Office.

BOLTON, S. C. 2004. A simple matter of control? NHS hospital nurses and new management. *Journal of Management Studies,* 41**,** 317-333.

BOXALL, A.-M. 2011. What are we doing to ensure the sustainability of the health system? Canberra, ACT: Parliamentary Library, Parliament of Australia.

BRADLEY, E. H., CURRY, L. A., RAMANADHAN, S., ROWE, L., NEMBHARD, I. M. & KRUMHOLZ, H. M. 2009. Research in action: Using positive deviance to improve quality of health care. *Implementation Science,* 4**,** 1-11.

BRADLEY, L. & PARKER, R. 2006. Do Australian public sector employees have the type of culture they want in the era of new public management? *Australian Journal of Public Administration,* 65**,** 89-99.

BRADLEY, V., LIDDLE, S., SHAW, R., SAVAGE, E., RABBITTS, R., TRIM, C., LASOYE, T. A. & WHITELAW, B. C. 2015. Sticks and stones: Investigating rude, dismissive and aggressive communication between doctors. *Clinical Medicine,* 15**,** 541-545.

BRAITHWAITE, J. 1997. Competition, productivity and the cult of 'more is good' in the Australian health care sector. *Australian Journal of Public Administration,* 56**,** 37-44.

BRAITHWAITE, J., WEARS, R. L. & HOLLNAGEL, E. 2015. Resilient health care: Turning patient safety on its head. *International Journal for Quality in Health Care,* 27**,** 418-420.

BROWN, K., WATERHOUSE, J. & FLYNN, C. 2003. Change management practices: Is a hybrid model a better alternative for public sector agencies? *International Journal of Public Sector Management,* 16**,** 230-241.

BRUNSSON, N. 2009. *Reform as routine: Organizational change and stability in the modern world,* Oxford, Oxford University Press.

BRUNTON, M. & MATHENY, J. 2009. Divergent acceptance of change in a public health organization. *Journal of Organizational Change Management,* 22**,** 600-619.

BRYANT, J., BOYES, A., JONES, K., SANSON-FISHER, R., CAREY, R. & FRY, R. 2014. Examining and addressing evidence-practice gaps in cancer care: A systematic review. *Implementation Science,* 9**,** 1-17.

BUTTERFIELD, R., EDWARDS, C. & WOODALL, J. 2004. The new public management and the UK police service. *Public Management Review,* 6**,** 395-415.

BUTTERFIELD, R., EDWARDS, C. & WOODALL, J. 2005. The new public management and managerial roles: The case of the police sergeant. *British Journal of Management,* 16**,** 329-341.

BYERS, V. 2015. The challenges of leading change in health-care delivery from the front-line. *Journal of Nursing Management,* Epub-ahead-of-print.

CAMERON, K. S. & CAZA, A. 2004. Contributions to the discipline of positive organizational scholarship. *American Behavioral Scientist,* 47**,** 731-739.

CAMERON, K. S. & SPREITZER, G. M. (eds.) 2012. *Oxford handbook of positive organizational scholarship,* New York, NY: Oxford University Press.

CARROLL, K., IEDEMA, R. & KERRIDGE, R. 2008. Reshaping ICU ward round practices using video-reflexive ethnography. *Qualitative Health Research,* 18**,** 380-390.

CHANDLER, J., BARRY, J. & CLARK, H. 2002. Stressing academe: The wear and tear of the new public management. *Human Relations,* 55**,** 1051-1069.

CHRISTENSEN, T. & LÆGREID, P. (eds.) 2013. *Transcending new public management: The transformation of public sector reforms,* Hampshire: Ashgate.

CLANCY, T. R. 2009. In search of elegance: Making the complex simple. *Journal of Nursing Administration,* 39**,** 507-510.

CLANCY, T. R. 2010. Diamonds in the rough: Positive deviance and complexity. *Journal of Nursing Administration,* 40**,** 53-56.

COLLIER, A. & WYER, M. 2015. Researching reflexively with patients and families: Two studies using video-reflexive ethnography to collaborate with patients and families in patient safety research. *Qualitative Health Research,* Epub-ahead-of-print.

COLLYER, F., HARLEY, K. & SHORT, S. 2015. Money and markets in Australia's healthcare system. *In:* MEAGHER, G. & GOODWIN, S. (eds.) *Markets, rights and power in Australian social policy.* Sydney, NSW: Sydney University Press.

CRAWFORD, G. B. & PRICE, S. D. 2003. Team working: Palliative care as a model of interdisciplinary practice. *Medical Journal of Australia,* 179**,** S32-S34.

CRAWFORD, P., BROWN, B., KVANGARSNES, M. & GILBERT, P. 2014. The design of compassionate care. *Journal of Clinical Nursing,* 23**,** 3589-3599.

DADICH, A., FULOP, L., DITTON, M., CAMPBELL, S., CURRY, J., ELJIZ, K., FITZGERALD, A., HAYES, K. J., HERINGTON, C., ISOUARD, G., KARIMI, L. & SMYTH, A. 2015a. Finding brilliance using positive organizational scholarship in healthcare. *Journal of Health Organization and Management,* 29**,** 750-777.

DADICH, A., FULOP, L., SMYTH, A. & DITTON, M. A POSH way to enhance health service management: Inquiry and engagement intertwined. ACSPRI (Australian Consortium for Social and Political Research Incorporated) Social Science Methodology Conference, 7th-10th Dec. 2014 Sydney, NSW.

DADICH, A., HODGINS, M. & COLLIER, A. 2016. Video reflexive ethnography: A creative approach to understand and promote brilliant organisational experiences. *ACSPRI (Australian Consortium for Social and Political Research Incorporated) Social Science Methodology Conference.* Sydney, NSW.

DADICH, A. & OLSON, R. Interprofessional socialisation in healthcare – A POSH approach. ACSPRI (Australian Consortium for Social and Political Research

Incorporated) Social Science Methodology Conference, 7th-10th Dec. 2014 Sydney, NSW.
DADICH, A., STOUT, B. & HOSSEINZADEH, H. 2015b. Reacting to and managing change within juvenile justice. *Journal of Organizational Change Management,* 28**,** 315-328.
DAVISON, G. & HYLAND, P. 2003. Palliative care: An environment that promotes continuous improvement, learning and innovation. *In:* GEISLER, E., KRABBENDAM, K. & SCHURING, R. (eds.) *Technology, healthcare and management in the hospital of the future.* Westport: Praeger Publishers.
DEBESAY, J., HARSLØF, I., RECHEL, B. & VIKE, H. 2014. Dispensing emotions: Norwegian community nurses' handling of diversity in a changing organizational context. *Social Science & Medicine,* 119**,** 74-80.
DIEFENBACH, T. 2007. The managerialistic ideology of organisational change management. *Journal of Organizational Change Management,* 20**,** 126-144.
DIEFENBACH, T. 2009. New public management in public sector organizations: The dark sides of managerialistic 'enlightenment'. *Public Administration,* 87**,** 892-909.
DIXON-WOODS, M., MINION, J. T., MCKEE, L., WILLARS, J. & MARTIN, G. 2014. The friends and family test: A qualitative study of concerns that influence the willingness of English national health service staff to recommend their organisation. *Journal of the Royal Society of Medicine,* 107**,** 318-325.
DOESSEL, D. P., WILLIAMS, R. F. G. & WHITEFORD, H. 2009. Deinstitutionalisation and managerialism in Queensland's public psychiatric institutions: Challenging 'rhetoric' with empirical results. *Australian Journal of Public Administration,* 68**,** 459-483.
DUNCAN, G. & CHAPMAN, J. 2012. Better public services?: Public management and the New Zealand model. *Public Policy,* 7**,** 151-166.
DUNLEAVY, P., MARGETTS, H., BASTOW, S. & TINKLER, J. 2005. New public management is dead - Long live digital-era governance. *Journal of Public Administration Research and Theory,* 16**,** 467-494.
DWYER, J., BOULTON, A., LAVOIE, J. G., TENBENSEL, T. & CUMMING, J. 2014. Indigenous peoples' health care: New approaches to contracting and accountability at the public administration frontier. *Public Management Review,* 16**,** 1091-1112.
EDMONDSON, A. C. 2004. Learning from failure in health care: Frequent opportunities, pervasive barriers. *Quality and Safety in Health Care,* 13**,** ii3-ii9.
ELSBACH, K. D. 2013. *Organizational perception management,* New York, NY, Routledge.
FISHER, J. A. 2006. Indoor positioning and digital management. *In:* MONAHAN, T. (ed.) *Surveillance and security: Technological politics and power in everyday life.* New York, NY: Routledge.
FITZGERALD, A. & DADICH, A. 2009. Organizational-professional conflict in medicine. *In:* BRAITHWAITE, J., HYDE, P. & POPE, C. (eds.) *Culture and climate in health care organizations.* Hampshire, UK: Palgrave.
FLYNN, J. M. 2017. Towards revalidation in Australia: a discussion. *Medical Journal of Australia,* 206**,** 7-8.
FULOP, L., DADICH, A., DITTON, M., CAMPBELL, S., CURRY, J., ELJIZ, K., FITZGERALD, A., HAYES, K., ISOUARD, G., HERINGTON, C., KARIMI, L. & SMYTH, A. 2013. Working on the edge: Positive organisational scholarship in healthcare (POSH) and looking for what's good in healthcare. *In:* GRIMMER, M. & HECKER, R., eds. ANZAM (Australian and New Zealand Academy of Management)

Conference, 7th-10th Dec. 2013 Hobart, TAS. Deakin West, ACT: ANZAM (Australian and New Zealand Academy of Management).
FULOP, L., FITZGERALD, J. A., CAMPBELL, S., CARTER, J., CHAPMAN, G., DADICH, A., DITTON, M., EDWARDS, I., ELJIZ, K., FAWKES, S., HAYES, K. J., HERINGTON, C., ISOUARD, G., KARIMI, L., KEWLEY, C. & SMYTH, A. The Brilliance Project in healthcare: An exploratory study. ANZAM (Australian and New Zealand Academy of Management) Conference, 7th-9th Dec. 2011 Wellington, NZ.
GARY, J. C. 2013. Exploring the concept and use of positive deviance in nursing: 'Responsible subversion' and why accurate documentation matters. *American Journal of Nursing,* 113**,** 26-34.
GKEREDAKIS, E., SWAN, J., POWELL, J., NICOLINI, D., SCARBROUGH, H., ROGINSKI, C., TAYLOR-PHILLIPS, S. & CLARKE, A. 2011. Mind the gap: Understanding utilisation of evidence and policy in health care management practice. *Journal of Health Organization and Management,* 25**,** 298-314.
GOW, J. I. & DUFOUR, C. 2000. Is the new public management a paradigm? Does it matter? *International Review of Administrative Sciences,* 66**,** 573-597.
GRUENING, G. 2001. Origin and theoretical basis of new public management. *International Public Management Journal,* 4**,** 1-25.
GULDAN, G. S., ZHANG, M. Y., ZHANG, Y. P., HONG, J. R., ZHANG, H. X., FU, S. Y. & FU, N. S. 1993. Weaning practices and growth in rural Sichuan infants: A positive deviance study. *Journal of Tropical Pediatrics,* 39**,** 168-175.
GUTHRIE, J. E. & PARKER, L. D. 1999. A quarter of a century of performance auditing in the Australian federal public sector: A malleable masque. *Abacus,* 35**,** 302-332.
HALLIGAN, J. 2013. Reform design and performance in Australian and New Zealand. *In:* LÆGREID, P. & CHRISTENSEN, T. (eds.) *Transcending new public management: The transformation of public sector reforms.* Hampshire: Ashgate.
HEALTH CONSUMERS NSW. 2016. *Who is a health consumer? and other definitions* [Online]. Sydney, NSW: Health Consumers NSW. Available: http://www.hcnsw.org.au/pages/who-is-a-health-consumer-and-other-definitions.html.
HEALY, J. & WALTON, M. 2016. Health ombudsmen in polycentric regulatory fields: England, New Zealand, and Australia. *Australian Journal of Public Administration,* Epub-ahead-of-print**,** 1-14.
HECKERT, D. M. 1998. Positive deviance: A classificatory model. *Free Inquiry in Creative Sociology,* 26**,** 23-30.
HENDERSON, J., WILLIS, E., BLACKMAN, I., TOFFOLI, L. & VERRALL, C. 2016a. Causes of missed nursing care: Qualitative responses to a survey of Australian nurses. *Labour & Industry,* 26**,** 281-297.
HENDERSON, J., WILLIS, E., TOFFOLI, L., HAMILTON, P. & BLACKMAN, I. 2016b. The impact of rationing of health resources on capacity of Australian public sector nurses to deliver nursing care after-hours: A qualitative study. *Nursing Inquiry,* Epub-ahead-of-print.
HODGINS, M., DADICH, A. & COLLIER, A. 2016. Negotiating access and undertaking video reflexive ethnography in community-based palliative care. *ACSPRI (Australian Consortium for Social and Political Research Incorporated) Social Science Methodology Conference.* Sydney, NSW.
HOR, S. Y., IEDEMA, R. & MANIAS, E. 2014. Creating spaces in intensive care for safe communication: A video-reflexive ethnographic study. *BMJ Quality & Safety,* 23**,** 1007-1013.

HOUSEGO, A. & O'BRIEN, T. 2012. Delivery of public services by non-government organisations. *Australian Journal of Public Administration,* 71**,** 211-220.
HUNT, P. 2016. Positive deviance. *In:* FORSYTH, C. J. & COPES, H. (eds.) *Encyclopedia of social deviance.* Thousand Oaks, CA: Sage Publications.
IEDEMA, R. 2011. Creating safety by strengthening clinicians' capacity for reflexivity. *BMJ Quality & Safety,* 20**,** i83-i86.
IEDEMA, R., BALL, C., DALY, B., YOUNG, J., GREEN, T., MIDDLETON, P. M., FOSTER-CURRY, C., JONES, M., HOY, S. & COMERFORD, D. 2012. Design and trial of a new ambulance-to-emergency department handover protocol: 'IMIST-AMBO'. *BMJ Quality & Safety,* 21**,** 627-633.
IEDEMA, R., HOR, S.-Y., WYER, M., GILBERT, G. L., JORM, C., HOOKER, C. & O'SULLIVAN, M. V. N. 2015. An innovative approach to strengthening health professionals' infection control and limiting hospital-acquired infection: Video-reflexive ethnography. *BMJ Innovations,* 1**,** 157-162.
IEDEMA, R., MESMAN, J. & CARROLL, K. 2013. *Visualising health care practice improvement: Innovation from within,* London, Radcliffe Publishing.
JENERETTE, C. M. & MAYER, D. K. 2016. Patient-provider communication: The rise of patient engagement. *Seminars in Oncology Nursing,* 32**,** 134-143.
KEARNEY, R. C. & HAYS, S. W. 1998. Reinventing government, the new public management and civil service systems in international perspective: The danger of throwing the baby out with the bathwater. *Review of Public Personnel Administration,* 18**,** 38-54.
KEISU, B.-I., ÖHMAN, A. & ENBERG, B. 2016. What is a good workplace? Tracing the logics of NPM among managers and professionals in Swedish elderly care. *Nordic Journal of Working Life Studies,* 6**,** 27-46.
KESSLER, I. 2015. *Exploring the relationship between human resource management and organizational performance in the healthcare sector* [Online]. New York, NY: Oxford University Press. Available: www.oxfordhandbooks.com [Accessed 22nd Jun. 2016].
KIPPIST, L., HAYES, K. J. & FITZGERALD, A. 2012. Professional and managerial language in hybrid industry-research organizations and within the hybrid clinician manager role. *In:* JEMIELNIAK, D. & MARKS, A. (eds.) *Managing dynamic technology-oriented business: High-tech organizations and workplaces.* Hershey, PA: IGI Global.
KIRKPATRICK, I., KUHLMANN, E., HARTLEY, K., DENT, M. & LEGA, F. 2016. Medicine and management in European hospitals: A comparative overview. *BMC Health Services Research,* 16**,** 7-14.
KLAIMAN, T. 2011. Learning from top performers using a positive deviance approach. *American Journal of Medical Quality,* 26**,** 422.
LAWTON, R., TAYLOR, N., CLAY-WILLIAMS, R. & BRAITHWAITE, J. 2014. Positive deviance: A different approach to achieving patient safety. *BMJ Quality & Safety,* 23**,** 880-883.
LEICHT, K. T., WALTER, T., SAINSAULIEU, I. & DAVIES, S. 2009. New public management and new professionalism across nations and contexts. *Current Sociology,* 57**,** 581-605.
LIFF, R. & ANDERSSON, T. 2011. Integrating or disintegrating effects of customised care: The role of professions beyond NPM. *Journal of Health Organization and Management,* 25**,** 658-676.

LINDBERG, C. & CLANCY, T. R. 2010. Positive deviance: An elegant solution to a complex problem. *Journal of Nursing Administration,* 40**,** 150-153.
LUFT, H. S. 2010. Data and methods to facilitate delivery system reform: Harnessing collective intelligence to learn from positive deviance. *Health Services Research,* 45**,** 1570-1580.
LYONS, M. & INGERSOLL, L. 2006. New public management and 'photocopy' bargaining in the Australian public service. *Australian Journal of Public Administration,* 65**,** 83-94.
MACRAE, C. 2014. Early warnings, weak signals and learning from healthcare disasters. *BMJ Quality & Safety,* 23**,** 440-445.
MAK, E. 2008. The European judicial organisation in a new paradigm: The influence of principles of 'new public management' on the organisation of the European courts. *European Law Journal,* 14**,** 718-734.
MARSH, D. R., SCHROEDER, D. G., DEARDEN, K. A., STERNIN, J. & STERNIN, M. 2004. The power of positive deviance. *British Medical Journal,* 329**,** 1177-1179.
MARTIN, G., CURRIE, G., WEAVER, S., FINN, R. & MCDONALD, R. 2016. Institutional complexity and individual responses: Delineating the boundaries of partial autonomy. *Organization Studies,* Epub-ahead-of-print**,** 1-25.
MCLAUGHLIN, E., MUNCIE, J. & HUGHES, G. 2001. The permanent revolution: New labour, new public management and the modernization of criminal justice. *Criminology & Criminal Justice,* 1**,** 301-318.
MELNYK, B. M. & DAVIDSON, S. 2009. Creating a culture of innovation in nursing education through shared vision, leadership, interdisciplinary partnerships, and positive deviance. *Nursing Administration Quarterly,* 33**,** 288-295.
MERTENS, W., RECKER, J., KOHLBORN, T. & KUMMER, T.-F. 2016. A framework for the study of positive deviance in organizations. *Deviant Behavior,* 37**,** 1288-1307.
MESMAN, J. 2007. Disturbing observations as a basis for collaborative research. *Science as Culture***,** 281-295.
NOBLET, A., RODWELL, J. & MCWILLIAMS, J. 2006. Organizational change in the public sector: Augmenting the demand control model to predict employee outcomes under new public management. *Work & Stress,* 20**,** 335-352.
O'FLYNN, J. 2007. From new public management to public value: Paradigmatic change and managerial implications. *Australian Journal of Public Administration,* 66**,** 353-366.
OLIVER, C. 2005. Critical appreciative inquiry as intervention in organisational discourse. *In:* PECK, E. (ed.) *Organisational development in healthcare: Approaches, innovations, achievements.* Oxon: Radcliffe Publishing.
OWENS, J. 2015. Creating an impersonal NHS? Personalization, choice and the erosion of intimacy. *Health Expectations,* 18**,** 22-31.
PALLIATIVE CARE OUTCOMES COLLABORATION. 2016. *About the palliative care outcomes collaboration* [Online]. University of Wollongong: Wollongong NSW
PRICEWATERHOUSECOOPERS HEALTH RESEARCH INSTITUTE 2016. Top health industry issues of 2017: A year of uncertainty and opportunity. Dallas-Fort Worth, AR: PricewaterhouseCoopers.
RADNOR, Z. J., HOLWEG, M. & WARING, J. 2012. Lean in healthcare: The unfilled promise? *Social Science & Medicine,* 74**,** 364-371.
RAFTER, N., HICKEY, A., CONDELL, S., CONROY, R., O'CONNOR, P., VAUGHAN, D. & WILLIAMS, D. 2014. Adverse events in healthcare: Learning from mistakes. *QJM: An International Journal of Medicine,* 108**,** 273-277.

RAINE, J. W. & WILLSON, M. J. 1995. New public management and criminal justice. *Public Money & Management,* 15**,** 35-40.
ROBINSON, S., WILLIAMS, I., DICKINSON, D., FREEMAN, T. & RUMBOLD, B. 2012. Priority setting and rationing in healthcare: Evidence from the English experience. *Social Science and Medicine,* 75**,** 2386-2393.
ROWLEY, E. 2011. Deviantly innovative: When risking patient safety is the right thing to do. *In:* ROWLEY, E. & WARING, J. (eds.) *A socio-cultural perspective on patient safety.* Farnham: Ashgate Publishing.
RYFF, C. D. & SINGER, B. 2003. Ironies of the human condition:Well-being and health on the way to mortality. *In:* ASPINWALL, L. G. & STRAUDINGER, U. M. (eds.) *A psychology of human strengths.* Washington, DC: APA (American Psychological Association).
SERCOMBE, H. 2015. The watchmaker's chainsaw: Why new public management is the wrong tool for youth work (and most of the professions). *Journal of Applied Youth Studies,* 1**,** 97-121.
SHARMA, B. & GADENNE, D. 2011. Balanced scorecard implementation in a local government authority: Issues and challenges. *International Journal of Health Care Quality Assurance,* 70**,** 167-184.
SIMONET, D. 2011. The new public management theory and the reform of European health care systems: An international comparative perspective. *International Journal of Public Administration,* 34**,** 815-826.
SIMONET, D. 2013. The new public management theory in the British health care system: A critical review. *Administration & Society,* 47**,** 802-826.
SPREITZER, G. M. & SONENSHEIN, S. 2003. Positive deviance and extraordinary organizing. *In:* CAMERON, K., DUTTON, J. & QUINN, R. (eds.) *Positive organizational scholarship: Foundations of a new discipline.* San Francisco: Berrett-Koehler.
SPREITZER, G. M. & SONENSHEIN, S. 2004. Toward the construct definition of positive deviance. *American Behavioral Scientist,* 47**,** 828-847.
SPYRIDONIDIS, D. & CURRIE, G. 2016. The translational role of hybrid nurse middle managers in implementing clinical guidelines: Effect of, and upon, professional and managerial hierarchies. *British Journal of Management,* 27**,** 760-777.
TARANTINO, D. P. 2005. Positive deviance as a tool for organizational change. *Physician Executive,* 31**,** 62-63.
TEO, S. T. T., YEUNG, M. & CHANG, E. 2012. Administrative stressors and nursing job outcomes in Australian public and non-profit health care organisations. *Journal of Clinical Nursing,* 21**,** 1443-1452.
THOMAS, R. & DAVIES, A. 2005. Theorizing the micro-politics of resistance: New public management and managerial identities in the UK public services. *Organization Studies,* 26**,** 683-706.
TRAYNOR, M., STONE, K., COOK, H., GOULD, D. & MABEN, J. 2014. Disciplinary processes and the management of poor performance among UK nurses: Bad apple or systemic failure? A scoping study. *Nursing Inquiry,* 21**,** 51-58.
VADERA, A. K., PRATT, M. G. & MISHRA, P. 2013. Constructive deviance in organizations: Integrating and moving forward. *Journal of Management,* 39**,** 1221-1276.
VAN SCHINGEN, E., DARIEL, O., LEFEBVRE, H., CHALLIER, M. P. & ROTHAN-TONDEUR, M. 2015. Mandatory internal mobility in French hospitals: The results of

imposed management practices. *Journal of Nursing Management,* Epub-ahead-of-print**,** 1-9.
WALSH, K. 1995. *Public services and market mechanisms - Competition, contracting, and the new public management,* Basingstoke, Macmillan Education.
WALSHE, K., BOYD, A., BRYCE, M., LUSCOMBE, K., TAZZYMAN, A., TREDINNICK-ROWE, J. & ARCHER, J. 2016. Implementing medical revalidation in the United Kingdom: Findings about organisational changes and impacts from a survey of responsible officers. *Journal of the Royal Society of Medicine,* Epub-ahead-of-print**,** 1-8.
WARREN, D. 2003. Constructive and destructive deviance in organizations. *Academy of Management Review,* 28**,** 622-632.
WHITCOMBE, J. 2008. Contributions and challenges of "new public management": New Zealand since 1984. *Policy Quarterly,* 4**,** 7-13.
WIESEL, F. & MODELL, S. 2013. From new public management to new public governance? Hybridization and implications for public sector consumerism. *Financial Accountability & Management,* 30**,** 175-205.
WILLIAMS, I. & DICKINSON, H. 2015. Going it alone or playing to the crowd? A critique of individual budgets and the personalisation of health care in the English national health service. *Australian Journal of Public Administration,* 75**,** 149-158.
WILLIS, E., KELEHER, H. & REYNOLDS, L. 2016a. Introduction to understanding the Australian health care system. *In:* WILLIS, E., REYNOLDS, L. & KELEHER, H. (eds.) *Understanding the Australian health care system.* Third ed. Chatswood, NSW: Elsevier.
WILLIS, E., TOFFOLI, L., HENDERSON, J., COUZNER, L., HAMILTON, P., VERRALL, C. & BLACKMAN, I. 2016b. Rounding, work intensification and new public management. *Nursing Inquiry,* 23**,** 158-168.
WISHIK, S. M. & VYNCKT, S. 1976. The use of nutritional 'positive deviants' to identify approaches for modification of dietary practices. *American Journal of Public Health,* 66**,** 38-42.