Chapter 5

Synthesising complexity and creativity – towards a new epistemology.

How I first became influenced by complexity theory.

don't establish the
boundaries
first,
the squares, triangles,
boxes
of preconceived
possibility,
and then
pour
life into them, trimming
off left-over edges,
ending potential:

(Ammons, 1965).

In this chapter I will give an overview of my engagement with writers of complexity theory and how insights from the field of complexity have influenced the development of my creative practice. I will reflect on how by engaging in a process of inquiry in to my practice, the synthesis of complexity and creativity, I was finding alternative ways of making sense of and encouraging an improvement in the daily life of organisations. This chapter is not written with the intention of constructing a critique of complexity theory but is more concerned with the way the writing of some complexity thinkers have enabled me to develop a better understanding of

how organisations work. As a consequence of this I have been able to make better use of my embodied knowledge as a creative practitioner within this context.

Organisations like healthcare organisations are now widely recognised as being complex in their make-up. As I engaged with writers and thinkers of complexity I found myself identifying similarities with what they were saying and with my own experience. I also began to explore systems thinking and in particular whole systems and learning organisations (Senge, 1990) and I was also at this time introduced to the work of Donald Schön in relation to learning systems and found resonance with the following statement.

"A learning system……must be one in which dynamic conservatism operates at such a level and in such a way as to permit change of state without intolerable threat to the essential functions the system fulfils for the self. Our systems need to maintain their identity, and their ability to support the self-identity of those who belong to them, but they must at the same time be capable of transforming themselves." (Schön, 1983, p.57).

My interest in organisational life had a rather slow beginning. I began work at Sandown College of Performing Arts (SCOPA) in 1985, firstly on a very part time basis in between acting jobs for extra income. I was then asked to apply for a full time position. I was unsure about giving up working in the theatre but I wanted to be able to input into the training of actors at the college because I wasn't very impressed with the quality of their education. I worked at SCOPA for almost 5 years and in that time was able to rewrite the diploma course with the result that it became much more student focussed. I was also able to develop my directing skills, which of course included working on group dynamic, an essential part of

devising and creating ensemble theatre. It was here that I first began to use the methodology I had started to develop at Rose Bruford College with others. An actor working with other actors as part of a devising process or as part of the rehearsal process of an ensemble piece use a wide range of skills. In order to take on another role in a truthful and believable or authentic way the actor has to develop an awareness of self, an understanding of their own authentic identity. A crucial part of the development of your authentic self has to include how you relate to other people, how other people perceive you and what effect you and the way you behave or relate has on others in the group. This of course can be a very difficult process requiring exquisite sensitivity, (Scholes-Rhodes. 2002) and it is the role of the director in this context to create and hold a 'safe space' where individuals can challenge, experiment and develop. Actors have to be receptive to receive constructive criticism and to learn to give criticism to others in a constructive way as part of their learning within a devising process. Actors also have to relearn how to play, for it is through play as children that we learn and also begin the development of our creative selves. These are all skills we very often put aside as adults. (This is discussed in greater depth in Chapter 7, "Being creative in practice.")

My time at Sandown was both incredibly challenging and rewarding but I was missing being an actor and although I had enjoyed directing and teaching I wanted to return to the acting profession. Shaun was offered the position of Head of Theatre at a college in the South West and we saw this as an opportunity for me to return to the theatre. Shaun accepted the offer and started almost immediately and I stayed behind in Hoylake with the children to complete the sale of our house. Our children were then aged 6 and 2 and we wanted this move to cause them as little disruption as possible. A friend of mine who is a general practitioner in Liverpool contacted me a couple of days after I had left Sandown and asked me if I

could do him a favour. He told me that his practice had to do a clinical audit and they had been given a very tight deadline in order to complete it. I asked him what a clinical audit was and he replied he wasn't sure but they needed someone with a nursing background to help them to work it out. I pointed out to him that my nursing practice may be a little out of date, but he wouldn't take no for an answer and I found myself agreeing to meet with him and his audit team later on in the week.

The meeting with the "Team" was very interesting; there were 3 General Practitioners from 3 neighbouring practices who were keen to review the services for children with asthma. Together we narrowed this down to children who were in their 1st year at primary school as we felt that this was probably the most vulnerable group. As none of us actually knew what clinical audit was and how we should be undertaking it I set myself the task of finding out and communicating this to the team. As I learnt about the purpose of clinical audit, a multi-professional and reflective activity concerned with improving quality of care, it was apparent to me that 3 GP's did not really constitute a multi-professional team. What about other healthcare professionals, teachers, the parents? I would certainly want to be involved in any development concerning my child especially if they had a condition like asthma. I identified school nurses, health visitors and the school staff as being directly involved in the care of children with asthma. By doing this I was instinctively developing a framework for inclusional practice. It was glaringly obvious to me that if you don't involve all those who will be affected by any changes you make they will not have ownership of those changes. They are also the people who really know what currently happens, they are the people who have the expertise. They all have stories to tell that will influence the way we design the services we provide and without their input all that experience is lost. Many of the people I have worked with on improvement projects, particularly those who are not members of clinical teams, for example

when involving service users and carers, have expressed their surprise at being "allowed" to participate. It is only with this involvement, and it has to be a two way process, that we will begin to take more responsibility for shaping the society we live within. Bernstein (2000) makes this point clearly:

"First of all, there are the conditions for an effective democracy. I am not going to derive these from high-order principles; I am just going to announce them. The first condition is that people must feel that they have a stake in society. Stake may be a bad metaphor, because by stake I mean that not only are people concerned to receive something but that they are also concerned to give something. This notion of stake has two aspects to it, the receiving and the giving. People must feel that they have a stake in both senses of the term.

Second, people must have confidence that the political arrangements they create will realise this stake, or give grounds if they do not. In a sense it does not matter too much if this stake is not realised, or only partly realised, providing there are good grounds for it not being realised or only partly realised." (Bernstein, 2000. p. xx).

In my later work, particularly with people with dementia and their carers I was often amazed at their generosity of spirit. Quite often we are faced with a limited amount of resources in the health service and this is sometimes perceived as being restrictive to improvement. When service users and carers have been fully included and involved with an improvement process they will come up with wonderfully creative solutions despite restricted budgets.

Although moving back into the health service was neither planned nor anticipated I had thoroughly enjoyed working on this project and

following our move to the South West I saw a clinical audit post advertised in the local hospital. I decided to apply for it thinking that it would tide me over until a theatre job came up, and was very surprised when I received a letter inviting me to an interview.

At my interview in Swindon for the position of clinical audit facilitator at Princess Margaret's hospital, the interview panel expressed the opinion that although the Liverpool asthma project was very interesting, it wasn't really audit, as true audit would only look at the medical input. An excellent example of how a reductionist approach can so easily result in exclusional practice. I was very surprised and a little disappointed with this answer as everything I had read about the purpose of clinical audit placed a great emphasis on the importance of it being a multi-professional and reflective practice. They did however offer me the job stating that I was the only person with any relevant experience. I tried very hard to turn down their offer and requested time to think a little more before committing myself. My thinking time actually lasted for a couple of months and during this period I was contacted by Henry Carr (who was to become my manager). Henry informed me that as part of the movement towards Trust status the locality was separating into an Acute Trust and a Community Trust, he was going to be working in the Community Trust which needed to establish its own clinical audit department and asked me if I would be interested in applying for this position instead. I talked at length with Henry about my insecurities in taking on such a position. I was very worried about moving back into the NHS on a long-term basis, I had invested a lot of time and energy extracting myself from the Health Service, so why on earth would I want to go back. His feelings were that my skills would be much more suited to working in a community setting. Eventually I agreed to apply for the job and following a successful interview. In November 1992 I was appointed as clinical audit facilitator for East Wiltshire Healthcare, a community trust providing a range of

community services, mental health services and services for people with learning difficulties.

My responsibility was to create and lead a clinical audit department within the organisation. The notion of Audit first made an appearance as medical audit in 1989 when it was introduced as part of a package of reforms which also included the creation of NHS Trusts and the development of the internal market. This resulted in greater emphasis on the quality of service.
Medical Audit was defined in Department of Health working paper 6 as:

'The systematic critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources, and the resulting outcome and quality of life for the patient'
(DOH, 1989: 3)

The emphasis in working paper 6 was also on medical ownership of the process and outcome of Audit.

At the same time nursing audit had been developing in a slightly different way. The Griffith's report (1983) an NHS Management Inquiry, led to the appointment of directors of quality assurance who were given the responsibility for all aspects of quality except for medical audit. The effect that this had was to separate audit, which is in effect a quality improvement tool, from quality improvement activity. Audit was perceived to be something that the medical profession engaged in and quality improvement was very much a nursing activity.

Between 1992 and 1994 the Department of Health sought to encourage the move from uni-professional to multi-professional clinical audit. This

change was introduced in order to encourage a whole team approach to the activity of clinical quality improvement.

The expectations from audit have changed over the years along with its definitions. Following the first definition of medical audit in 1989, further guidance was published in 1994 in the document "The Evolution of Clinical Audit". Here we were advised that we should be undertaking multi-professional Clinical Audit and that it should be:

- **Professionally led**
- **Part of an educational process**
- **Form a part of routine clinical practice**
- **Based on the setting of standards**
- **Generate results that can be used to improve the quality of the outcome of care**
- **Involve management in both the process and outcome of audit**
- **Be confidential at the individual patient/clinician level**
- **Be informed by the views of patients/clients**

(Department of Health, 1994)

If you actually examine that list of eight bullet points, as I had to do in my role, and ask how that list should translate in to practice, it demands a change in not only the way audit was being undertaken but also constituted a significant change in the way healthcare providers should be working together. It also indicates what was at the time significant shifting cultures of expectations in public services. The introduction of clinical audit in this way was also indicative of the rise in the accountability agenda and was perceived as the beginning of deprofessionalisation of expertise through enforced managerialism. In my experience the impact of this on the staff I was working with was increased resistance to change and a decrease in moral.

My role as clinical audit facilitator was very challenging in this environment and often left me feeling frustrated and disempowered. What was being expected of clinical staff was that they come together as a team and critically evaluate their clinical practice. This was a real challenge in the environment at the time for 3 main reasons.
Firstly, although each professional group e.g. nurses, doctors and professions allied to medicine may have an input into the care of an individual, that care was not negotiated from a team perspective. All professional groups were working independently from each other and each had its own hierarchical structure. There was also no evidence that users of the service were being encouraged to contribute to this process.

Secondly, the internal market had created competition between different Trusts and even between different localities within the same Trust. I worked with a team in one locality who really struggled to introduce a change into their service. On its successful implementation I suggested that they work with their colleagues in the other localities and show them how their work had improved services for their clients. This was met with absolute hostility and a delight in the fact that they could watch their colleagues struggle in the same way as they had had to.

Thirdly, reflective practice was not something that all clinicians engaged in. Although the nursing profession had introduced reflective practice into their training it still wasn't something that clinical teams were comfortable to engage in as a team.

I had realised very quickly after taking up this position that in order to engage clinical teams in more meaningful clinical audit I would have to find a way to influence a change in the culture within the organisation. It did however take me some time before I realised that I had skills and

experience that may be useful in this kind of environment. There was also a lot of resistance to clinical audit throughout the organisation with many individuals expressing the feeling that it was just another management fad and if they kept their heads down for long enough, like all the other NHS initiatives, it would disappear. My feeling at the time was that this may very well be the case, but at the same time my organisation, like many other organisations appeared to be struggling to provide adequate services.

Clinical audit, because of the way it was introduced, was generally not perceived as having been particularly successful. It had been very difficult for Trusts to demonstrate any significant change or improvement as a result of this activity and questions were being asked as to whether the huge investment that had gone into it had been worth it. In the Department of Health publication, The Evolution of Clinical Audit. (1994. HMSO. London.) Clinical Audit Co-ordinators were asked if and why this was the case. Their main responses were: -

1. **They were not empowered within their organisations to lead on change.**
2. **They had never been required to measure whether audit activity had led to improvement so even if they felt it had; they had no evidence to support the improvement.**
3. **The medical profession were most resistant to change and if they were not involved in the project they would not support the identified need for improvement. As they were often the sole holders of power the projects would falter at this stage.**
4. **Clinical audit activity was not part of the Trust Board interest and not linked into management issues. This meant that lapses in quality were not being addressed at Board level.**

At the time of reading this report I felt that this list was incredibly vague and little information was given in relation to how clinical audit staff could have any influence in affecting this list. What it speaks volumes of however is the culture in which clinical audit was being implemented, which was one that was on whole devoid of inclusion and or participation by those being singled out for criticism.

Whilst undertaking a master's degree in social research at the University of Bath in 1997 – 1999, I had undertaken a national survey of all clinical audit co-ordinators employed in NHS Trusts in England. My research findings were very similar and reflecting on this I began to ask myself questions about the way in which we were addressing change management issues such as clinical audit within healthcare organisations. I then attended an event that started me on a very different journey. I had heard that some of my colleagues were going to a master class on organisational development. I had seen the flier describing the event but had not been invited to attend. A couple of days before the event I bumped into our chief executive in the corridor and decided to tackle him on my non-invitation. I was more than happy to express my disappointment to him and to point out that he was once again missing an opportunity for joined-up-ness by not involving me in an event that may enable me to place clinical audit very firmly within the quality improvement framework that he wanted to establish within the organisation. Fortunately for us both he agreed to me attending the event!

To be honest I had no idea what the workshop was really about. I had had feedback from our Medical Director who had already been to a previous workshop held for Medical Directors and Chief Executives – but many of them had been struck down with food poisoning, him included, and he had missed most of it. So I turned up along with about 20 others from around

the region who had an interest in improving the quality of healthcare provision. I was, as I expected, the only clinical audit facilitator there!

What I learnt over the following 2 days was that there was the possibility of an explanation for the way my organisation behaved.

With the use of a game called the glass bead game Paul Plsek, the workshop leader, introduced us to complexity theory and the basics of life in a complex adaptive system. The name of the game is taken from the novel of the same name written by Herman Hesse and for which he won the Nobel Peace Prize in 1946. This was his final novel and it is a tale of the complexity of modern life. (Hesse. 2002). We took part in a simulation game in which we experienced being part of a system that was flawed and how activity in one part of the system can have a profound affect on the rest of the system. I was finding much resonance with Paul's ideas and my experience of my own organisation. We often look back at the past and remember things appeared to be much simpler then than they are now. This is in fact now recognised as being the case. The rapid advances in science and technology have created a much more complex world. Healthcare has become more and more complex as are healthcare organisations. If we take the mental health model as an example and look at how this service has changed over recent years we can see this. Not so long ago if I was feeling depressed I would probably make an appointment with my general practitioner. Here my GP would either treat me within primary care or refer me to a consultant psychiatrist. Now I may use the services of a counsellor, I would probably be supervised by a community psychiatric nurse who in turn may advise some occupational therapy. I may also consider the services of a psychologist or psychotherapist. Also with the recent developments from the social exclusion work you can also include gym membership or yoga. So what was once a simple care package delivered by a couple of individual practitioners has now grown

and developed into a wide and diverse team and as a result has become far more complex. It is then not surprising that managers in organisations like healthcare are finding that the traditional ways of managing appear to be no longer always applicable.
The way that we manage healthcare organisations, and many other organisations has been developed using the Newton and Cartesian notion of the Clockwork Universe.

"The nearly 400 year old Newtonian-Cartesian legacy encourages us to see the world as a deterministic machine, which once wound up, operates efficiently and predictably in terms of its moving parts, held together by processes of cause and effect." (McNiff, 2000. p. 42).

This works on the assumption that organisations are machine-like and the way to solve large organisational problems is to break them down into small manageable problems that can be solved. Quite often this can cause even greater problems than the one you started with. Jean McNiff (2000) describes the impact of this mechanistic view of the world in the following way.
"….'the' scientific method helps us to understand the world so that we can predict what will happen and ultimately control it. The system of control lies in assumptions of cause and effect: if x then y. Reality is fragmented, existing as separate structures, and experience is linear. It is possible to manipulate both reality and experience as variables, so that particular outcomes will be assured; these outcomes constitute data which may be validated through analysis, usually statistical, and then applied to other like events. The validity of the research lies in its capacity for replicability and generalisability; what works in one system will work in another; there is one set of cognitive principles and models appropriate to understanding all realities. *(*McNiff, 2000. p. 43).

My meeting with Paul Plsek was somewhat of a light bulb moment and I began the process of using my emerging insights from complexity theory to make sense of the daily life in an organisation such as the National Health Service. It was also a turning point in my own learning as I began to develop a greater interest and a better understanding of this new theory of complexity. What was exciting for me was that this notion of organisations being complex and adaptive fitted more comfortably, from my background in theatre, with my way of working with people. The management style in the NHS, like many other large organisations, has developed using the paradigm of the machine and much of our traditional management theory was developed in the 1940's by Frederick Taylor using this model. Managing an organisation in this way becomes very command and control, it requires stability and predictability but most organisations are neither of these things, which results in the kind of problems being experienced by myself and others working within a change agenda. Our organisations have become very complex and leading a complex organisation through a programme of change can be incredibly difficult with many people seeming to resist change.

Complex adaptive systems are also unpredictable as the individuals within the system have the freedom to act in many different ways. Lewin and Regine, (2000) described complex adaptive systems in their book "The Soul at Work" in the following way.

"Complex adaptive systems are composed of a diversity of agents that interact with each other, and in so doing generate novel behaviour for the system as a whole, such as in evolution, ecosystems and the human mind. But the pattern of behaviour we see in these systems is not constant, because when a system's environment changes, so does the behaviour of its agents and, as a result, so does the behaviour of the system as a whole. In other words, the system is constantly adapting to

the conditions around it. Over time, the system evolves through ceaseless adaptation." (Lewin & Regine, 2000. p. 44.)

The differences between mechanical systems and complex systems are often expressed in the following way.

Mechanical Systems	**Complex Systems**
Rigid Boundaries	Fuzzy Boundaries
Well-defined membership	Changing membership
Regularity and control	Agents are adaptive

If you apply these two lists to any healthcare team and certainly those I have worked with they fall very firmly into the "complex" category. Each member may belong to several different teams at the same time. Teams are often not only multi-professional in their make-up but also cross several boundaries e.g. social care and/or education, thus making any boundary a very fuzzy boundary.

Margaret Wheatley explains the difference between mechanical systems and complex systems in the following way.

"One of the first differences between new science and Newtonianism is a focus on holism rather that parts. Systems are understood as whole systems, and attention is given to relationships within those networks. Donella Meadows, an ecologist and author, quotes an ancient Sufi teaching that captures this shift in focus: "You think because you understand one you must understand two, because one and one makes two. But you must also understand and" (1982, 23.) When we view systems from this perspective, we enter an entirely new landscape of connections, of phenomena that cannot be reduced to simple cause and

effect, or explained by studying the parts as isolated contributors. We move into a land where it becomes critical to sense the constant workings of dynamic processes, and then to notice how these processes materialize as visible behaviours and forms."(Wheatley, 1999. p. 10).

This for me was describing a very different way of looking at organisations such as healthcare and it was also a way of thinking that I was finding great resonance with in my day to day work. I was experiencing many of these issues and in particular the importance of focussing on the way we relate to each other within the system. I was also beginning to understand that the tension and conflict within the teams was a natural phenomenon. This was again something that I was more than happy to deal with in a creative setting, conflict and tension are always an expected part of a devising process, particularly when devising as a team. My experience of this environment had prepared me to work within that creative tension and to feel comfortable with uncertainty. Traditional organisational management encourages uncertainty out of the system; complexity theory on the other hand encourages individuals to live happily within uncertainty.

***"Tension and paradox are natural. Interaction leads to continually emerging novel behaviour**."* (Stacey, Griffin and Shaw, 1999).

Capra also refers to tension particularly that experienced by those engaged in creative activity.

"The experience of tension and crisis before the emergence of novelty is well known to artists, who often find the process of creation overwhelming and yet persevere in it with discipline and passion." He goes on to say that of course there are degrees of crisis and not all of them are as extreme but what they have in common is uncertainty. ***"Artists and***

other creative people know how to embrace this uncertainty and loss of control………After prolonged immersion in uncertainty, confusion and doubt, the sudden emergence of novelty is easily experienced as a magical moment." (Capra, 2002. p. 118).

Having been educated as a "conscious, devising actor" these references to tension and paradox in relation to the creative process have been my lived experience. What I now began to understand following Paul's workshop was that I had been using the methodology I had learnt and developed whilst working as an actor in my current role.

As I began to explore complexity theory and widen my reading to include an enormous range of complexity writers, I began to understand that it is the relationships between individuals as well as the individuals themselves that are critical to a successful organisation. As I reflected on the projects I had been involved in I was able to identify that those that had been most successful in leading to improvement in practice, were those that had involved teams who had developed better relationships, this enabled them to create an environment where they could study their own patterns of behaviour and if necessary, try to change them. I began to ask myself questions about other teams who were finding improvement more difficult. Would I be able to use what I was learning about complexity and my understanding and experience of creative processes to work with them to encourage them to develop better relationships? If I did this would it result in an improvement in services? Was this a more realistic way of improving services? This inquiry into my own practice was a way of beginning to address these issues.

I was also aware that it was at the boundaries of services where things were most likely to go wrong for the patients and we in the health service were very good at creating boundaries. Boundaries not only exist between

different professional groups, but we have also created additional boundaries between primary and secondary care as well as between health and social care and education. In healthcare this is often referred to as a "silo mentality". At this particular time all improvement processes were limited to the point of the boundary and didn't cross either from primary to community or to secondary care or across professional boundaries like health and social care. I believe that this was contributing to the sustaining of "silo mentalities." Truly effective clinical audit, that leads to an improvement in the services provided for patients, should place the service user at the centre and all activity should then relate to them. If we were restricting ourselves by erecting even more barriers as the internal market was certainly doing it was going to be a challenge. Having engaged with the work of Alan Rayner, (Rayner, 2004), I have been able to further develop my understanding of the importance of boundaries as places of flexibility and dynamism rather than places of severance and separation. This understanding of boundaries is crucial in creating a more inclusional way of working.

"At the heart of inclusionality, then, is a simple shift in the way we frame reality, from absolutely fixed to relationally dynamic. This shift arises from perceiving space and boundaries as connective, reflective and co-creative, rather than severing, in their vital role of producing heterogeneous form and local identity within a featured rather than featureless, dynamic rather than static, Universe. We move from perceiving space as 'an absence of presence' – an emptiness that we exclude from our focus on material things – to appreciating space as a 'presence of absence', an inductive 'attractor' whose ever-transforming shape provides both the coherence and creative potential for evolutionary processes of all kinds to occur. "(Rayner, 2004).

This understanding is also crucial in my facilitation work as I try to find a way to engage people at the point of boundary be they professional boundaries or organisational boundaries or both.

Many management theorists have drawn on the work of complexity theorists in the recent years in order to better understand organisational behaviour. As I too became involved and engaged in the debate about complexity theory I began to be aware of differences of opinion as to how the insights into the complexity sciences were being applied to human organisations. There appears to be a number of different strands to complexity theory and Stacey, Griffin and Shaw, (1999), identify three of these strands as being ***"chaos theory, dissipative structure theory, and the theory of complex adaptive systems."*** What they all seem to have in common and as a central core to their thinking is that complexity theory requires management to acknowledge the self organising and emergent properties of complex systems rather than managing organisations in a mechanistic way. Stacey, Griffin and Shaw in their writing argue that many of the management complexity writers are still not paying attention to the limitations of systems thinking and do not draw distinctions between the different strands of complexity theory. ***"in not paying attention to the fundamental differences in notions of causality in the three perspectives and in not attending to the limitations in systems thinking, they run the risk of simplification that subtly undermines the proclaimed challenge and merely reproduces the dominant discourse in new jargon."*** (Stacey, Griffin & Shaw, 1999.p.128.)

Complexity management writers such as Wheatley (1992) and Lewin and Regine (2000) place a lot of emphasis in their writing on the importance of the development of caring relationship in complex systems. I also felt a sense in their writing of them indicating that there was something deeper and bigger and more meaningful and if we work together in harmony we

can tap into a greater something. Although much of their writing resonates with my own work I was finding it difficult to accept this sense of what was coming across to me as almost mystical. They also place great emphasis on harmony and I know from my own experience in the creative world just how important conflict is in the creative process and how it is conflict and diversity and not harmony that so often contributes to new and novel behaviour.

I was also interested in the ideas of paradox emerging from complexity. The idea that systems could be both ordered and disordered, organised and disorganised at the same time. Stacey, Griffin & Shaw (2000) and Stacey (2001) have developed what they refer to as "Complex processes of human relating". This is described by Patricia Shaw (2002) as using insights from the complexity sciences to develop a more participative practice.

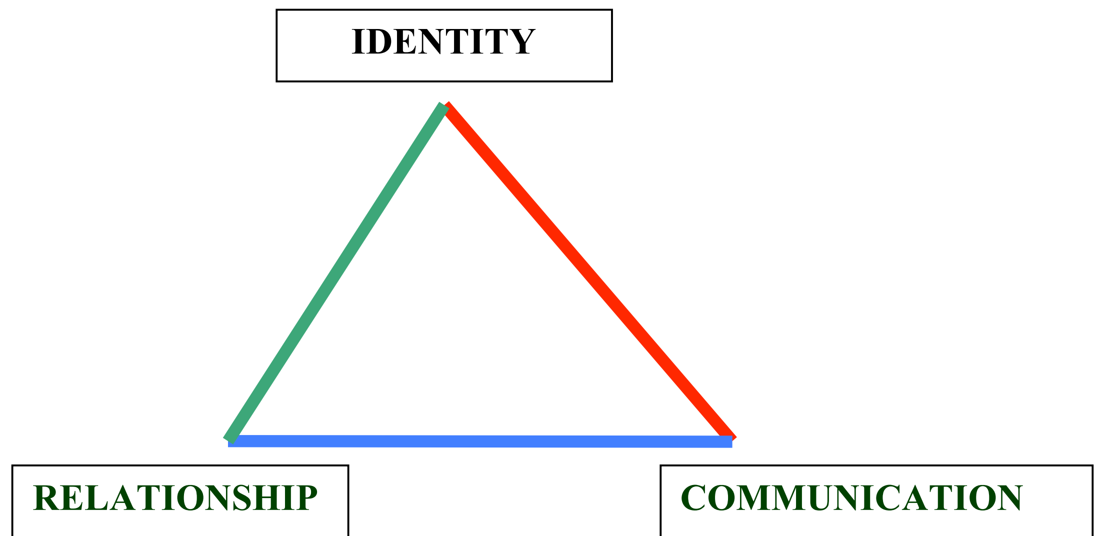
"*It is a way of thinking that invites us to stay in the movement of communicating, learning and organizing, to think from within our living participation in the evolution of forms of identity. Our blindness to the way we participate in fabricating the conversational realities of organizing is compounded by the difficulty we have in thinking from within, in thinking as participants, in thinking in process terms, above all, in thinking paradoxically."* (Shaw, 2002. p. 20).

As part of the process of developing my own theory/thesis of my life/learning, I have been focusing on the development of my own living dialectic in relation to the account of dialectics and complex responsive processes described in Ralph Stacey's, (2003), latest book, ***Complexity and Group Processes: A Radically Social Understanding of Individuals.*** In this work Stacey presents his fullest account to date of his theory of complex processes of relating. He describes this as a human-centred,

complexity inspired perspective on life in groups and organisations. In the forward to this book he identifies the key questions it is addressing as:

- ***Who am I and how have I come to be who I am?***
- ***Who are we and how have we come to be who we are?***
- ***How are we all changing, evolving and learning?***

I found this list of questions were very similar to the paradigm I am using and developing in my thesis – A living theory of responsive practice, as shown below:-



The questions "who am I" and "How have I come to be who I am?" are represented in my diagram by the box "Identity". In the work I have been engaged in these questions have been addressed by myself about myself through a process of developing an understanding of my embodied values and in what way I am able to live these values in my practice. As I have

been looking at my own learning in order to improve my practice these values have been able to influence the standards by which I am able to judge my practice. This process has been informed by encouraging the individuals I have been working with to engage in a similar process. This process has been enabled by the use of a methodology rooted in Theatre for Development as together we engage in a relationship focusing on the sense-making of life in healthcare organisations. The relational nature of this process for me is crucial. Stacey has placed emphasis on the importance of relating in his second question ***"How have we become to be who we are?"*** He addresses this question through his theory of complex responsive processes. Stacey places the development of complex responsive process for the reader in the historical perspective of two contrasting streams of Western thought, these are:-

Firstly, that of Descartes, Kant, Leibniz, Freud and modern psychoanalysis all of whom claim that the mind is inside a person and the social system is outside, and,
Secondly, and in contrast, Mead, Hegel and Elias who hold the view that both mind and society are essentially identical patterning activities of humans - two aspects of the same process.

Stacey's theory of complex responsive processes has been developed from his insight into the resonance between the second school of thought and of complexity science. He argues that the separation of the mind from society forms the basis of the systems theory developed by Kant which then became the foundation of systems thinking. With all systems theory there remains an element of control and predictability. The work on complexity science began in the Santa Fe Institute in America and is now widespread. Examples of complex adaptive systems are often given as the immune system, a colony of termites or the weather. What these systems have in common is that they are comprised of a large number of individual

agents who interact locally. They also have the ability to be both chaotic and stable at the same time and can demonstrate novelty and emergence. The science of complex adaptive systems is now being used widely as an analogy for understanding complex organisations – like the health service. I have found the analogies from the complexity sciences useful in my work and my learning but have also been very aware that these analogies have their limitations. For Stacey the usefulness is in the understanding that agents can interact and that this interaction can pattern itself without intervention or control. He also, in his introduction, makes a plea for practitioners to describe their practice. ***"If we are not doing what we are writing, the scope for confusion is immense. I suggest that we need to write about what we are doing"*** (Stacey, 2003. p. 14).
This is what I did not find in this book, Stacey does not write about what he is doing. I wanted to know how these theories were influencing his practice and in what way his practice was developing as a consequence of his new insights. What he does do in the book is to theorise and to demonstrate the thinking behind the development of the theory of complex responsive processes which has been influenced by the thinking of Elias and Mead.
"The theory of complex responsive processes draws together Elias' process sociology and Mead's symbolic interactionism as ways of translating analogies from the complexity sciences into a theory of human action." (Stacey, 2003. p. 17).

I have also found Stacey's insights into the work of Mead very useful and have found Mead's work to have many similarities with the work I have been engaged in when focusing on "relationship". Mead is well known for his work which focused on demonstrating how mind and society have evolved together. Much of this is explained by what he calls gesture-response, here meaning is not communicated from one individual to another but it is in the interaction that meaning happens.

"Here meaning is emerging in the action of the living present in which the immediate future (response) acts back on the past (gesture) to change its meaning. Meaning is not simply located in the past (gesture) or the future (response) but in the circular interaction between the two in the living present." (Stacey, 2003. p. 61).

This can be explored further with improvisation. I have found improvisation to be a crucial part of developing an understanding of "I" and "I" in relation to/with "you". It is also through the process of facilitating this exploration that I have also been able to learn and develop my own practice. If you consider a very simple improvisation that I have used which involves 4 people. The room is arranged to resemble a sitting room, using whatever is available. The four people are asked to enter the space and the brief is that 3 are always to exclude 1. What happens in this exercise is very interesting as each individual will enter the space already forming their own agenda, trying to direct the conversation in order to not be the person to be excluded by the others. The participants will very quickly experience how unpredictable their relationships are and how they are meaning making in the action of the living present. Knowledge, I believe, is created in this way, through our conversation, interacting with each other. This creates a constant moving forward of ideas, of understanding, creating knowledge in relationship with each other in a truly emergent and authentic way. In this example in the unfolding scenario of the improvisation but also just as importantly in the improvisational nature of the facilitator, in this case - me, bringing forth my embodied knowledge which I respond with, which in turn is being created in the moment. This I believe to be a living dialect, living in the sense that the theory of my practice is continually emerging in the pedagogical and paradoxical relationships I/we form are forming in this joint action of improving practice.

So in what way does this differ from the dialectic offered in this book? Stacey describes how the dialectic of Kant differs from that of Hegel in that Kant calls for a synthesis of opposites while Hegel's dialectic is one of paradox.

"For Kant the dialectic is the hypothesizing of the autonomous individual about an object…….Hegel's dialectic, in purely technical terms, is a way of thinking, a particular kind of logic to do with the paradoxical movement of thought. It is a logic in which there is the unity of opposites in their dissolution and transition, that is, Aufhebung means negating opposites and preserving them, so raising or transforming them, all at the same time. In this paradoxical movement a unity of thought emerges. The new unity of thought not only preserves the opposites but also abolishes them because while they are preserved, their original meanings are modified and the distinctions between them are negated." (Stacey, 2003. p. 212).

Stacey is also clear that he is a follower of the dialectics of Hegel. For me as a reader I cannot find within the chapters of this book the evidence to support this in his practice. Although he does give some examples of group sessions they give the reader no insight into his learning and in what way the people he is working with in groups where he uses complex responsive processes of relating are influencing his practice. This is where I believe there is a difference in my own thesis in that I am demonstrating, by showing how my practice is influenced by those I am working with in a facilitator role in a continuous spiral of emerging knowledge/practice.

I have come to realise and to understand over the past few years since my return to the Health Service, how introducing a creative way of working would be difficult to achieve. I am now seeing things change a little and I

believe that I have been able to influence and contribute to this change. The same could be said of complexity theory as so much of what is happening under the heading of complexity theory is actually, I believe, just more of the same. That 'same' being management by command and control but hidden slightly within a change agenda. If, as Ralph Stacey states, (2003), when self-organising interaction is ***"richly connected enough"*** it has ***"the capacity to spontaneously produce coherent pattern in itself, without any blueprint or program."*** I believe we must focus on making sure that those connections are enriched. I also believe that it is through a process of creative engagement that this may be achieved. In the creation of this thesis of my living theory I am showing what creative engagement, for me, actually means in practice. Researching my own practice in this way ensures that I am making a contribution to the development of organisation theory. It is also important here to bring in the work of Jean McNiff, who in writing about Action Research in Organisations (2000) has enabled me to make connections for myself between action research and complexity theory with statements such as:

"The most important thing to remember about organisations is that they are not structures; they are people. Take away the structures and you still have organisations. Take away the people and you have none. Theories of organisation are theories of people's lives. Traditional theories of organisation are theories about places. New theories of organisation are story-theories by people for people."(McNiff, 2000. p. 243).

Peter Senge, a well known author of organisational development has also drawn on concepts from systems thinking to promote the idea of organisational learning. The following is a quote from "Emergence", a journal of complexity delivered to me electronically on the Thursday of each week from the Plexus Institute. This was from June - July 2004.

"In the past, Senge's systems approach has suggested that one could describe the boundaries of a whole organizational system, and work to identify key leverage opportunities for change. This implies a clearly spatial metaphor and understanding. More important, it implies a top-down or whole-system approach to the dynamics of organizational change. ……….Peter Senge had just published a new book with several colleagues called "Presence," it is a significant departure in understanding and prescription. In this new book Senge and colleagues talk about learning from the ancient traditions of Buddhism, Hinduism, Christianity and even shamanistic practice. Instead of the spatial notion of a system and its boundaries, they refer to the slowing of the individual's internal dialogue. They speak of being "present in the moment" and learning to pause before responding to communication input. In other words, they have adopted a temporal metaphor for change. It is also a very personal method, in which the key drivers of organizational change become the understanding that every moment presents choice, and that all options need to be heard equally."
(Waltuck, 2004. p.1).

I share a similar understanding of the way in which we need to approach organisational change and move away from the more traditional ways of organisational change and learning. By developing a synthesis of creativity and complexity in my practice and researching the improvement in my practice I have been developing a living theory of inclusional and responsive practice. Engaging in an inclusional and responsive relationship with the people I am working with, encouraging them to engage creatively, to tell their stories, to explore context through mediums such as improvisation makes a contribution to the creation of new knowledge, knowledge that emerges as part of a process of relating. Stacey describes a similar way of knowledge creation.

"Knowledge, or meaning is the interaction, not in people's heads. Meaning, or knowledge, emerges in the public interaction between people and simultaneously in the private role play each individual conducts with himself or herself". (Stacey, 2001. p.197).

Aram, (2000), also stresses the importance of the relational aspect of learning and knowledge creation.

"A fundamental challenge to ones way of understanding the concepts of power, control and intention is embedded in the relational approach to learning. Also embedded is a different understanding of the concepts of expert knowledge and the transmission of knowledge. This means that there is a challenge to ones way of understanding ones role and function, in fact a challenge to one's identity."(Aram. 2000).

Stacey also states that knowledge is created in the interaction between people.

"Meaning, or knowledge, emerges in the public interaction between people and simultaneously in the private role play each individual conducts with himself or herself." (Stacey, 2001. p. 197.)

This does not represent current thinking within healthcare where the dominant change models being used still speak of the transfer of knowledge from one individual to another. Change agendas talk about and promote the "spread of good practice." This assumes that one person has the knowledge or the skills or expertise which they can then pass on to another individual, this individual receives this knowledge which they can then pass on and so forth. What is missing for me in this traditional method of learning is the individual and the relationships that each

individual has with each other. In my practice I believe I have developed an understanding of how I can encourage those I am working with to experience and consider alternative ways of improving our practice together. I have developed this understanding by my engagement with complexity theory and my knowledge and experience of the creative process.

In the next chapter I will reflect on how I have begun to expand my use of creativity in my practice in synthesis with an understanding of the day to day life within a complex system and how this was applied to a specific project.

My continuing passion is to part a curtain,
that invisible shadow that falls between people,
the veil of indifference to each other's presence,
each other's wonder, each other's human plight.
(Eudora Welty)

(Cited in Wheatley. 1999. p.v.)