Personalized Compassionate Care: An Appreciative Inquiry Exploring
the Positive Core of Canadian Health Care

by

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A thesis submitted in partial fulfillment of
the requirements for the degree of

MASTER OF ARTS

In

PROFESSIONAL COMMUNICATION

June, 2012
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Abstract

This research explores how individuals make sense of their own lived experiences of health through the sharing of their stories and how the collectively shared meaning can be used to identify core values fundamental to sustaining a flourishing Canadian health care system. This study considers health care to be a complex system with inherent unpredictability where ideas for values-based sustainability must be given freedom to emerge. At the Kelowna Dialogue on Health, 29 individuals with diverse health care experiences and perspectives participated in a one-day Appreciative Inquiry (AI) conversation. During the seven-hour dialogue, the affirmative topics of compassion, collaboration, and personal responsibility emerged and a full AI 4-D cycle of discovery, dream, design, and destiny was performed. The delivery of these affirmative topics into actionable ideas that will be communicated in the public sphere through digital media will hopefully empower the participants, both health care providers and recipients, to strive for personalized compassionate health care.

Keywords: appreciative inquiry, health care, complex systems.
Acknowledgements

I would like to thank Sarah Murdoch Black and Dr. Bill Nelems for assistance in the logistical organization of the Dialogue on Health. I would like to thank Dr. Virginia McKendry for her generous guidance as my thesis advisor and specifically for assisting in facilitation of the dialogue.

I would like to express my sincere appreciation and gratitude to each and every one of the 29 participants to the Kelowna Dialogue on Health who embraced the uncertainty of this journey with positivity and passion.

This work is dedicated to my wife Maria and my daughter Patricia for their unwavering love and support.
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The Canada Health Act (CHA), implemented in 1968, provides federal oversight to the provision of health care by individual provinces and aims to enhance the well-being of Canadian residents through facilitating access to health services (http://www.hc-sc.gc.ca/hcs-sss/mediserv/cha-index-eng.php). The federal government exerts influence in the enforcement of the five tenets of the CHA: public administration, comprehensiveness, universality, portability, and accessibility, through the funding agreement with the provinces in the Canada Health Transfer (CHT) Accord (http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2003accord/index-eng.php). Canadian health care is an issue that has been extensively studied over the past 10 years through several national expert-driven problem-based forums: the 2002 Romanow Commission (http://www.hc-sc.gc.ca/hcs-sss/hh-rhs/romanow-eng.php), the 2001 Kirby Report (http://www.hc-sc.gc.ca/hcs-sss/hhr-rhs/strateg/kirby-eng.php), and the 2002 Mazankowski Report (http://www.alberta.ca/acn/200201/11771.html). Despite the fact the issue of Canadian health care is felt by some, including the national public broadcaster the Canadian Broadcasting Corporation (CBC), to have been studied to death, there has been minimal input from individual Canadians on how they would like to see their health care system adapt and evolve in response to the fiscal, demographic, and philosophical challenges facing Canada now and in the immediate future (“Studied to death,” 2005).

Tuohy (2002), a highly regarded authority on Canadian health care, summarized the funding and political considerations around the Canadian health care system up to 2001 in an attempt to determine potential avenues for health care reform. Tuohy (2002) describes the
financing of components of Canadian health care as analogous to a set of concentric circles: the current core circle consists of universal and exclusive public funding (e.g. physician and hospital services); the intermediate circle consists of public programs with copayments and/or eligibility requirements (e.g. home care, prescription drugs); and, the outer ring consists of services with no public coverage. This author suggests that the studies considering reform to the system – Kirby (2001) and Romanow (2002) – have focused primarily on determining what service fits in which ring. Glouberman and Zimmerman (2002) argue that the Romanow – Kirby – Mazankowski manner of examination of Canadian health care has been approached from the view of expert-opinion problem solving and rational planning where health care is assumed to be a linear, predictable complicated system that requires big initiatives to effect change. They contend that Canadian health care is more accurately described as a non-linear, unpredictable complex adaptive system where thinking is divergent, decisions are allowed to emerge, and small inputs can lead to dramatically large responses. Holden (2005) notes that a complex adaptive system framework – a collection of individual agents free to act unpredictably and whose actions are interconnected – is increasingly being utilized for health care research. Health care reform can move from the control of ‘top-down’ expert leaders into the hands of ‘bottom-up’ follower members of society. Similarly, Zoller (2005) suggests that health system change is through health activism where practices, policies, and power relationships are changed through a focus on the issues of power, inequality, and the linkages of the multiple social domains that influence health; it is time for all Canadians to enter into the dialogue.

This research draws from and contributes to literature in the sub-field of health communication (Zoller, 2005), with a specific focus on Canadian health care system and policy
change (Alter, 2011; Blendon, 2002; Tuohy, 2002) and reform (Glouberman & Zimmerman, 2002; Kirby, 2001; Mazankowski, 2002; Romanow, 2002). This research also draws on literature related to the context of Appreciative Inquiry (AI) as a ‘research for change strategy’ (Danielle & Cooperrider, 2008; McNamee, 2003; Patton, 2003; Reed, 2007; Reed, Nilsson, & Holmberg, 2009). The objective of this research is to study how individuals make sense of their own lived experiences of health through the sharing of their stories and how these stories can be used to better understand and guide the future direction of the Canadian health care system. It demonstrates how AI can be used to explore and tell the stories of the typically unheard voices in the Canadian health care debate and how AI can be used to identify core values fundamental to sustaining a flourishing health care system. The theoretical perspective guiding this research relates to the social constructionist and critical theory worldviews that most closely reflect the central tenets of AI as a research framework (Reed, 2007).

My motivation for this research originates from my patients. As a practicing thoracic surgeon, I function primarily as a health advocate assisting my patients in multiple facets, surgical and other, of navigating through their illnesses. Despite, or perhaps because of the fact that many thoracic surgical patients have the very serious condition of lung or esophageal cancer, these patients often project a certain clarity and calmness of thought. The patients wish to question, to communicate, to understand, and to be given realistic hope. The hope of the patient is for the ability to face medical and life situations with knowledge, power, and ultimately, with courage. In this research, my goal is to question, communicate, and understand issues related to the Canadian health care system through applying AI and grounded theory from a critical perspective (Grant & Humpheries, 2006; Kushner & Morrow, 2003). I am positioned in this
research in the other role of my health care provider dialectic, the health activist. As a health care activist, I strive to empower and emancipate individual Canadians to play a role in achieving positive health care system change.

This study is based on my facilitation of an AI process of discovery, dream, design, and destiny in Kelowna, BC with a group of Canadians who undertook this collaborative process to develop actionable ideas on how to improve health care. The goal of this research is to discover core values within the existing system that can be fundamental to sustaining a flourishing and adaptable Canadian health care system and develop values-based innovative ideas that will enable Canadians to enjoy improved health care. The nature and results of the participatory dialogue will enliven and inform the Canadian public sphere. Over the longer term, the goal is to communicate these values-based ideas to the current health care decision makers and, through this avenue, democratize the health care debate so that all Canadians will have the opportunity to influence and ultimately become health care decision makers.

Section Two – Literature Review

Health Care is Complex

A question to consider is whether health care is primarily: a complicated system, a complex system, or perhaps a combination of both in the setting of dialectic tensions. Stacey (2002), by way of The Stacey Matrix (http://www.gp-training.net/training/communication_skills/consultation/equipoise/complexity/stacey.htm), has attempted to categorize simple, complicated, and complex issues based upon the degree of certainty (close to – far from) on the x-axis and the level of agreement (close to – far from) on
the y-axis for the issue in question. He describes *simple* systems as formations of communication that arise when cause and effect linkages can be determined and *rational* decision-making is effective because there is a high degree of certainty and decision-makers are close to agreement. In situations where there is either more disagreement (*political* decisions) or more uncertainty (*judgmental* decisions), the decisions can be described as complicated (Stacey, 2002). Stacey deems extreme situations where there is both high uncertainty and high disagreement to be a form of communicative anarchy where decision-making is *chaotic*. In the area between chaos and complicated decisions lies the *complex* adaptive system, a system characterized by a dynamic of complex decision-making (Stacey, 2002). This zone of complex adaptive systems comprises events with interdependent, constantly changing agents and emergent, non-controllable outcomes (Singhal, Buscell, & Lindberg, 2010). A hallmark of a complex adaptive system (CAS) is that the future outcomes and behaviors cannot be predicted with certainty and the CAS organizes through self-adaptation rather than central control (Singhal et al, 2010; Tan, Wen, & Awad, 2005). This uncertainty can be uncomfortable for organizations with a classical top-down problem-solving culture where improvement is seen as achieving more consistency and more control. Tan et al. (2005) suggest that people seek security through attempting to control situations and predict the future, whereas the unknown creates discomfort. Once it is appreciated, however, that social and human systems are complex in nature then it can be understood that the quality of the interaction in the complex relationship, as expressed through immediate authentic and accurate feedback, is of prime importance in the maintaining a healthy system (A. Singhal, personal communication, November 25, 2011).
Glouberman and Zimmerman (2002) compare and contrast the specific theoretical, causality, evidence, and planning characteristics of complicated and complex systems in health and health care. Complicated systems are linear; tension and fluctuations are suppressed; the solution is external to the system; and, adaptation is to a static environment. In contrast, complex systems are non-linear; tension and fluctuations are seen as opportunity; the solution is part of the system; and, interaction occurs with the rest of a dynamic environment (Glouberman & Zimmerman, 2002). The causality of complicated systems is relatively simple, designed for certain intended predictable outcomes in contrast to the mutual causality of complex systems from which emerge uncertain non-predictable adaptive outcomes (Glouberman & Zimmerman, 2002). The authors describe health care planning from a complicated systems perspective as being focused on convergent thinking with evidence dominated by the averages and ignoring the outliers, as opposed to the complex systems perspective where the focus is on divergent thinking and emergent decisions where outliers, especially the positive deviants, are seen as possible key determinants in the process (Glouberman & Zimmerman, 2002). Boustani et al. (2010) describe the health care delivery system as being composed of a network of semiautonomous constantly interacting individuals functioning not as a machine with replaceable parts and predictable behaviors but “as a CAS with local critical nonlinear relationships that produce unpredictable behavioral patterns” (p. 143).

McDaniel, Lanham, and Anderson (2009) consider the implications of complex adaptive systems theory on health care organization (HCO) research and suggest that we tailor our research design to “learn about what is in front of us rather than being bound by preconceived plans” (p. 191). They suggest that HCO research takes on a fundamentally different character
when approached from a CAS perspective as a dynamic system of inquiry that coevolves during the research (McDaniel et al., 2009). The authors report that effective health care research engages in processes that are designed to anticipate change – expect uncertainty; build in tension – create space for social exchange; capitalize on serendipity – opportunities for study; and, ‘act then look’ – updating beliefs as the study unfolds (McDaniel et al., 2009). Papa, Singhal, and Papa (2006) summarize four main principles of complex social systems: mutual causality – interdependent emergent outcomes; butterfly effect – big change can occur from small interactions; valuing outliers – deviance provides valuable insight; and, celebrating paradoxes – tapping the power of polar opposite ideas. If, as outlined by McDaniel et al. (2009) and Papa et al. (2006), these are key components of complex adaptive systems then methodologies utilized to study health care and to organize for system change must be consistent to these principles.

Appreciative Inquiry (AI) offers one such approach.

**Appreciative Inquiry is an Appropriate Methodology for Health Care System Research**

Appreciative Inquiry (AI) research, like action research, is firmly grounded in everyday practices and experiences. By being participative, iterative, and through having a whole system perspective, AI leads to positive action and development (Reed, Nilsson, & Holmberg, 2009). AI, first described by Cooperrider and Srivastra (1987), is a strengths-based approach to organizational and system change that explores ideas that people have about what is valuable and tries to work out how these ideas can lead to knowledge creation about the social world (Danielle & Cooperrider, 2008; Reed, 2007). In the AI process, participants address a chosen affirmative topic through a dialogue laden 4-D cycle of *discovery, dreaming, designing*, and *destiny* (Cooperrider, Whitney, & Stavros, 2008; Reed, 2007).
In the discovery process, individuals engage in a positive question based one-on-one dialogue to discover the most vital and alive moments and stories in relation to the affirmative topic (Cooperrider et al., 2008). In the dream stage, participants work together to creatively build on the collective outcomes of the discovery stage to envision new ideas of what might be in a preferred future (Cooperrider et al., 2008; Reed, 2007). In the design stage, participants work together to co-construct an ideal vision through a provocative proposition based on what has worked well in the past and what has been envisioned for the future (Cooperrider et al., 2008; Reed, 2007). The destiny stage directs the energy toward realizing the provocative proposals through thinking and committing to specific tasks and actions (Cooperrider et al., 2008; Reed, 2007). The main assumption of the 4-D AI model is that an organization is not a problem to be solved but is rather a solution to be embraced (Cooperrider, Whitney, & Stavros, 2008; Reed, 2007).

Reed (2007) notes that the social constructionist and critical theory worldviews most closely reflect the central tenets of AI as a research framework. In social constructionism, knowledge is constructed through meanings that are shared between individuals and society (Gubrium & Koro-Ljungberg, 2005). AI and social constructionism share the principle that individuals can shape their view of the world through the way they think and talk about it (Reed, 2007). These worldview thoughts are not developed through simply recording phenomena but rather through interpretation and construction (Reed, 2007). Social constructionist knowledge and worlds are negotiated and co-constructed through dialogue and in critical theory the role of inquiry is to challenge established processes in an attempt to emancipate participants from the restrictions of the established order (Reed, 2007). Critical theory examines ideas in a manner
that is independent from the power structures that perpetuate these ideas (Reed, 2007). In AI, a critical theory perspective can stimulate reflection on the role of power within organizations in determining the social world (Reed, 2007). This critical construction of reality in AI corresponds closely with Paulo Freire’s idea of the necessary role of dialogue and people’s participation in social change development (Papa et al, 2006). In AI, the teacher (facilitator expert) is learner and the learner (participant) is teacher in a collective iterative transformative process that enables people to be engaged in their own welfare (Papa et al, 2006). AI remains true to the four main principles of complexity science as outlined by Papa et al. (2006). There is mutual causality in AI as the outcomes of the process are truly emergent, uncertain, and non-predictable. AI encourages the provocative proposition that celebrates the paradox and embraces the tension of the dialectics. The bottom-up participatory nature of AI allows small positive changes to have the potential to create large effects and the positive deviant outliers in AI have the stories which are discovered and ultimately processed into destiny where this action leads to a new way of thinking.

AI, through its critical and social constructionist worldview and the close alignment of it principles to complex adaptive systems, is an ideal methodology to be utilized to study health care through participatory dialogue with the goal of creating positive system change within Canadian health care. Glouberman and Zimmerman (2002) have attempted to refine the questions asked of the Canadian health care system by reframing health care as a complex (as opposed to a complicated) system. My study takes their analysis one step further, arguing that the questions that could lead to real positive change should be allowed to emerge, when they are ready, from a holistic interdependent relationship involving a broad spectrum of Canadians. We
have had many outside-expert derived studies of Canadian health care, but we have yet to hear from the real inside-experts, the Canadian public. That said, I remain mindful of the fact that health care remains a social system that can at any time or in any circumstance be functioning anywhere within Stacey’s certainty-agreement matrix and where complex, complicated, simple, and chaotic systems can all co-exist. This dialectic tension gives life to human systems such as health care.

It is true that AI’s innovative approach to change makes it challenging to place in existing research frameworks. When AI is used as an organizational development tool, practitioners may focus on the outcome and when AI is used as a research method, practitioners may focus on the processes of the inquiry (Reed, 2007). Here, I would like to focus my discussion on the process of collaborative data collection and analysis and the role of the researcher in adding a second level of data analysis. As noted above, Reed (2007) argues that the research paradigms of social constructionist and critical theory most closely reflect the central tenets of AI as a research framework. AI also has strong methodological links to Action Research (AR) through a shared focus of exploring current practices to create knowledge and application of this knowledge for social innovation by informing strategies for the future (Danielle & Cooperrider, 2008; Reed, Nilsson, & Holmberg, 2009). Reed et al. (2009) describe this participatory worldview, shared by both AR and AI, as balancing action with reflection, and theory with practical solutions. AI looks at the positive forces in an attempt to refine and strengthen the organization while AR focuses on a particular problem and seeks to assist in understanding and addressing the identified problem (Egan & Lancaster, 2010). AI also has relationships with other research methodologies including narrative methodology, ethnography, and case studies (Reed, 2007). Narrative and AI
methodologies share an interest in hearing personal stories and how they reflect people’s interests and goals (Reed, 2007). Ethnography and AI share a focus on sense making through dialogue to gain an understanding of a diverse and complex social world (Reed, 2007). Case studies and AI are focused on researching a phenomenon in the context in which it occurs (Reed, 2007).

As such, AI as a research methodology takes a social constructionist and critical theory worldview and can be considered to be a form of AR with influences from narrative methodology, ethnography, and case studies. The basic intention of AI is to have conversations with people about what matters (Whitney & Trosten-Bloom, 2010). These conversations illuminate what gives life to a human system and, with AI, the researcher is invited to fully engage with the complex, messy, and emergent nature of organizational and social life in an attempt to enable organizational and social change (Danielle & Cooperrider, 2008). The conversations, interviews, and group deliberations are the data that emerged from the Kelowna Dialogue on Health.

**Section Three – Research Method**

**The Participants**

The research employed the strategy of AI in order to explore and tell the health care stories of typical Canadians in an attempt to identify core values essential to sustaining the Canadian health care system. The form of AI engagement chosen for the dialogue was *core group inquiry* to create a *positive change network* and discover *what works well* in Canadian health care. A core group inquiry is a small-scale (fewer than 50 people) process that can be rapidly created to generate a base of enthusiasm and early successes (Whitney & Trosten-Bloom,
In the formation of any positive change network, there is a systematic introduction of AI and a critical mass of change agents are created in an attempt to stimulate improvisational positive change and enhance strategic organizational learning (Whitney & Trosten-Bloom, 2010). My hope here was to get the dialogue process off the ground in a straightforward and timely manner. Individuals interested in participating in an AI core group inquiry and positive change network at the Kelowna Dialogue on Health were recruited through my networks and through a public radio appeal. An explanation of the purpose, objectives, and methodology of this research was posted on the website that I specifically created for this research: www.dialogueforchange.ca (Humer, 2012).

The invitees, chosen to represent as far as possible a wide and diverse spectrum of Canadian society, were selected from a community appeal to both targeted specific outlier groups and interested Canadian individuals in the inlier group. The outlier group of potential participants included individuals at both poles of the extreme range of voice and influence – those with much and those with little. The invitees from the powerful voice group included individuals holding leadership positions with significant influence – politicians, health care providers, and health administrators. The potential participant pool from the low influence group included the marginalized ‘voiceless’ members of society typically reliant on the provision of health care services in a predetermined manner. The spectrum of potential invitees was completed by members of the inlier group of individuals who are typical consumers of standardized health care. The appeal for participation to the specific outlier groups was made by appeal to the representatives of the often marginalized groups including: disabled, mental health, addictions, homeless, shelters, single-parent families, elderly, youth, immigrant, First Nations,
and other groups identified through the appeal process. Direct requests were made to the voices of leadership: government (community, regional, provincial, and federal), health authority and hospital administration, medical and nursing staff, other health care support staff, university and business representatives, service and religious organization representatives, and other leadership groups identified through this appeal. The goal was for each of these targeted groups to represent roughly one-third of the participants with the other one-third to come from the general interest inlier group. The general interest group was to be accessed through public service event notification through the local radio stations.

The formal written invitation to the Kelowna Dialogue on Health, whether originally communicated through direct appeals, interviews, or the website www.dialogueforchange.ca, explained the positive AI focused lens through which this health care dialogue would proceed (Appendix A). Potential participants were informed of the opportunity to express their voice in the Canadian health care conversation through participating in a dialogue exploring Canadian health care from the unique perspective of using open-ended interviews to shift the focus of health care change from a typical problem solving discussion to a solution generating dialogue. Potential participants were informed that I am a thoracic surgeon practicing in Kelowna performing this thesis research in meeting the requirements for a Master of Arts in Professional Communication at Royal Roads University (RRU) and this study had been ethically reviewed by RRU as research involving humans (Appendix A).

The Dialogue

There were 29 participants (registrants 1-27 & 30-31) and two facilitators (28 & 29) for the Kelowna Dialogue on Health, April 21, 2012, at the Clinical Academic Campus (CAC)
building on the Kelowna General Hospital site and all participants signed the consent for participation (Appendix B). The overall plan of this AI-based dialogue was based on the practical application of AI, as outlined by Whitney and Trosten-Bloom in *The Power of Appreciative Inquiry: A Practical Guide to Positive Change* (2010). The agenda for the entire day of dialogue was posted on the walls of the meeting room CAC1 (Appendix C). I began the 25-minute introduction with the proposal to ‘let us take a vacation from problems’ as a lead into the idea of spending our day of dialogue focusing on generating possibilities as opposed to our more typical focus on solving problems. After a brief overview of AI and the 4-D cycle, the idea of the positive core and affirmative topic choice was reviewed with a focus on the question: *What is it you want more of in Canadian Health and Health Care?* This led into the affirmative topic one-on-one interviews (two one-on-one interviews each of 15 minutes duration) where improbable pairs partnered-up to share and record each other’s peak experience stories with respect to health care (Whitney & Trosten-Bloom) (Appendix C:14).

For the affirmative topic interviews, there were 27 interviews completed (1-27) in paired groups with the remaining lone participant interviewed by the co-facilitator (Appendix D). Following the affirmative topic interviews, the participants then formed into six affirmative-topic small groups and they gave their teams names (Appendix E). Each interviewer shared, within their small group, the stories around peak experiences with health obtained from their interviewee partner. From this information, the small groups identified themes, threads, and factors leading to high point experiences (Appendices C:15 & F). A spokesperson from each small group then shared one or two stories with the entire large group through high point experience quotes, with the goal of developing a master list of themes (Appendices C:16 & G).
During the mid-morning refreshment break, the participants discussed the themes with the understanding of the importance of the choice of topics as systems and organizations move and grow in the direction of what they study (Whitney & Trosten-Bloom, 2010). The small groups reconvened and identified potential topics from the stories and master list of themes (Appendices C:18 & H). The small groups shared potential topics with the large group with an onus on explaining why these were meaningful with respect to health care (Appendix C:19). Participants were then given three stickers with their registration number and could vote for preferred topics to study; three votes could be used as desired, all for one topic or spread among multiple topics (Appendices C:20 & I). From this list of potential topics, the voting suggested three preferred topics of health care to study in the subsequent AI 4-D process: collaboration (30 votes), compassion (28 votes), and personal responsibility (22 votes) (Appendices C:20 & J). These became the discovery interview affirmative topics of focus and the participants could now choose which of these three topics they wished to focus on for the remainder of the dialogue.

The discovery interviews were conducted in a similar fashion to the previous affirmative topic interviews and 26 discovery interviews were completed (1-14, 16-23, 25-27, & 30) in paired groups, with each pair having the same topic of focus (Appendices C:22 & K). Participants 14 and 24 had left and participant 30 had joined the dialogue by this point (in each case due to previous conflicting commitments). The discovery interview data sheet for participant 19 was never found; however, participant 19 did participate in the entire dialogue. The participants then formed into small groups around the topics of study: compassion (6), collaboration (8), and personal responsibility (12). Due to its large size, the personal responsibility group was divided into two separate small groups. These small groups gave their
teams names (Appendices C:21 & L). Each interviewer shared, within their small group, the stories, quotes, and inspirational highlights around the topic of inquiry obtained from their interviewee partner. From this information the small groups made meaning of this data and shared high point stories with the large group (Appendices C:23 & M).

The lunch break followed and participant 31 joined the dialogue at this time as a member of the collaboration group. The plan immediately following lunch was that the small groups would map the positive core, the root causes of success and the essence of the organization at its best (Appendices C:26 & C:27). However, the group appeared to require some degree of refocusing and this led into a large group discussion of the dream phase. To bring us back on schedule, the small group meaning making data (Appendix M) was used as the basis for the positive core from which the dream phase resulted and lifted up the positive core through ‘the dream for the better’ (Whitney & Trosten-Bloom, 2010) (Appendix C:28). Each small group developed their specific topic collective dream data (Appendix O). The dream data was shared with the large group to create a collective map of common themes and opportunities (Whitney & Trosten-Bloom, 2010) (Appendix C:29 & P). The subsequent design and destiny stages of the 4-D cycle were performed in a large group for each of the three chosen topics (Appendices C:30, C:31, C:32 & Q). This decision to move to a large group format was taken in order to keep the energy and creativity levels high so that provocative propositions and the opportunities for inspired action and improvisation could result.

To end the research session, the large group collaborated to develop a plan on how to continue forward in the post dialogue phase with small group meetings focused on developing
and implementing actionable plans related to the three dialogue topics of collaboration, compassion, and personal responsibility.

**Data Analysis: A Grounded Theory Method**

_Meaning making_ is the ultimate goal of data analysis and the Kelowna Dialogue on Health data was generated through interviews – one-on-one, small group, and large group. These data were analyzed by way of description, explanation, and interpretation.

**Description.**

Each participant generated individual data from both the affirmative topic and the discovery interviews (Appendices D & K). Each original small group generated data through the processes of theme identification, sharing themes and stories with the large group, potential topic identification, and sharing potential topics with the large group (Appendices F, G, H, & I). Each discovery-topic small group generated data through the processes of meaning making, dreaming, and sharing the dream with the large group (Appendices M, O, & P). The large group generated data by voting on a final dream topic, and designing a plan to deliver the dream through actionable ideas (destiny) (Appendices J & Q).

**Explanation.**

The raw small group and large group data were the result of analysis and meaning making by the small and large groups respectively. The results of the participant analysis and their meaning were analyzed in a similar manner to the individual affirmative topic and discovery interviews as outlined in the interpretation section below.

**Interpretation.**
The data analysis uses a grounded theory (GT) method that flows from data management, to data reduction, to conceptual development, and to theoretical rendering. The essential data I analyzed were the individual affirmative topic and discovery interviews. As these were qualitative interviews, the goal was to derive interpretations, not facts or laws, from these guided conversations (Warren, 2001). Interpretation of data creates new principles that can be taken from one frame of meaning and applied to another (Lindlof & Taylor, 2011).

I would like to comment here on the appropriateness of a GT approach for meaningful analysis of the Kelowna Dialogue on Health interview and group generated data. GT was developed by Glaser and Strauss (1967) as a method “to make theoretical insight in an area of research, and the ability to make something useful of the insight” as they collaborated on studying patients dying in hospital (p. 46). Stern (a student of Glaser and Strauss) and Porr (2011) describe GT as a “systematic, inductive means to generate parsimonious theory that is grounded in relevant empirical data” (Stern & Porr, 2011, p. 37). GT allows the researcher conducting qualitative research to generate theoretical explanations for people’s concerns and problems and for how they achieve resolution of these situations (Stern & Porr, 2011). Stern and Porr (2011) explain that classic Glaserian GT has four principles that must be adhered to: 

\textit{discovery never verification, explanation never description, emergence never forcing, and the matrix operation.}

The GT principle of ‘discovery never verification’ compels the researcher to have the courage and curiosity to take a voyage with the participant on an inductive generational pathway (Stern & Porr, 2011). The principle of discovery is also deeply embedded in AI, as through the exploration of people’s most \textit{vital and alive} moments and stories people determine what is
valuable (Cooperrider et al., 2008). The ‘explanation never description’ principle in GT describes a quest for understanding, interpretation, and explanation that moves beyond simple accurate description (Stern & Porr, 2011). In GT, concepts are identified and propositional statements that connect the concepts are created, similar to the *provocative propositions* that result from the design phase of the AI process (Stern & Porr, 2011; Whitney & Trosten-Bloom, 2010). The GT principle of ‘emergence never forcing’ focuses on *trusting* the data to generate thoughts and conceptual sense-making (Stern & Porr, 2010). AI trusts people’s collective wisdom about a system’s strengths to inform the data generated from their stories and dialogue (Whitney & Trosten-Bloom, 2010). While GT focuses on the importance of identifying the core concern and strategies implemented in response to that concern, the positive-lens view of AI aims to *discover* the positive core and magnify it through *dream* to imagine it to be even better (Stern & Poor, 2010; Whitney & Trosten-Bloom, 2010).

Whitney and Trosten-Bloom (2010) describe the interview to be an essential “non-negotiable” aspect of the AI process (p. 144). As the interview is a social encounter, it must be analyzed as a social encounter (Fontana, 2001). Both the GT and AI perspectives position the researcher as a *curious being* who is co-researching with the participants to develop a better understanding. In this sense, the interview is about *self* as well as *other* as the interviewer is no longer objectified but becomes a co-member of the communicative relationship (Warren, 2001; Fontana, 2001). As noted by Stern and Poor (2011), the interview is not about pre-conceived ideas of what one is looking for in the data but rather about what has evoked curiosity as one looks at and analyzes the interview data.
AI does not attempt to ignore or deny the problem but rather asks the researcher and the participants to focus on strengths, so as to maximize AI’s power to transform a system or organization (Whitney & Trosten-Bloom, 2010). In AI, all are expected to participate in a fully appreciative manner, similarly, GT is not only a way of doing but more completely a way of thinking (Stern & Poor, 2011). With GT and AI having complementary perspectives, the final principle to consider in Stern and Poor’s (2011) GT researcher checklist is the researcher’s ability to tolerate the “unpredictable and sometimes chaotic iterative pattern of grounded theory analysis” in the matrix operation. The iterative nature of the GT ‘matrix operation’ stage (data collection, analysis, and more collection based on the analysis) is echoed in the AI dialogue, as exemplified by affirmative topic interviews that are followed by the small group theme and topic identification, leading to the discovery interviews, and resulting in small group meaning making (Stern & Porr, 2010; Appendix C). As Singhal et al. (2010) note, the fact that the future outcomes and behaviors cannot be predicted or controlled is the hallmark of complex systems and the AI Kelowna Dialogue on Health research data can be most appropriately analyzed through the complexity sensitive perspective of the GT method.

Now that I have outlined the appropriateness of a grounded theory (GT) method of analysis of the AI generated dialogue data, it is equally important to speak to the differences in the GT and AI approaches in order to further highlight the liberating possibilities of AI. The GT method assists the researcher in determining what is important and problematic to people and identifies how people manage to resolve the problem (Stern & Porr, 2011). The AI approach utilized in the Dialogue for Health moves the focus from problems to possibilities and the human adaptation shifts from resolving a problem to uncovering and amplifying identified strengths.
In AI, the motivation for the generation of the observed data has at its central core the liberation of power (Whitney & Trosten-Bloom, 2010). AI liberates the power of *the best in people* through cooperation and innovation by allowing people to be known in relationship rather than roles, to be heard, to dream in community, to choose how to contribute, to act with support, and to be positive (Whitney & Trosten-Bloom, 2010). My analysis of the participant data focuses on both the positive possibilities and the liberating power generated by the data.

**Section Four – Results**

The interview data and the raw small and large group data were analyzed using a grounded theory model of substantive and theoretical coding, constant comparison, and memoing as a conceptual framework to generate theory (Stern & Poor, 2011, p. 61). The raw data were analyzed through line by line coding and themes and an overall storyline were developed. I analyzed the individual interview data from both the affirmative topic and discovery interviews. The small group and large group data were analyzed in a two-step process of participant self-analysis and my own analysis. The analysis is presented in the same chronological order that data was collected during the dialogue. In an attempt to give an *unedited* voice to all participants, the results section contains a large number of direct quotes. My choice of which specific individual quotes to present is a step in the analysis pathway from interview coding to conceptual framework development. Just as the entire interview and dialogue process is conducted in the spirit of AI and CAS, the description, explanation, and interpretation of the data must be *allowed* to *positively* emerge by valuing the contributions of all participants.
Description and Explanation: What Happened, What Emerged, and What it Means

Affirmative topic interviews (8:25 a.m. - 8:55 a.m.).

The participant and group self-analysis generated the topics of compassion, collaboration and personal responsibility and I analyzed the individual affirmative topic interview data in an attempt to explain how these three topics were chosen by the large group for further study at the Kelowna Dialogue on Health.

Participant #1 introduces the idea that care *is* compassion and compassion *is* care by noting that the doctor “left a huge impact as a compassionate physician”, describing this as “most memorable – care and compassion”. Participant #17 describes compassionate care as “equality when sick all treated the same…with respect and compassion…to preserve dignity when receiving health care”. The description is extended by participant #18 such that compassionate care includes “gentle approach, trust, respect, open dialogue, importance of relationship”. Participant #16 reminds us of the humanity in health care: “we are so much more than mechanics of care, we use the word care, have the courage to do that…get rid of silos: open up communication, connect, care.” Participant #21 describes a system of “compassion, gratitude, responsibility, accessibility” where both *caregivers* and *care-recipients* realize their “individual responsibility for health”. Participant #23 speaks of a desire for an intimate system of health care that “got me feeling that we were the only ones [that mattered]” and for “practitioners to recognize they have the power to make a positive difference in people’s lives…if you decide to stay 15 minutes later, you could change someone’s life”. Health care providers must listen and respond to the call of the patient and the family for compassion in the delivery of care.
Health care delivery requires collaboration through a “multi-disciplinary approach”, in order to “respect where people are in life”, with health care providers having “the understanding that patients and communities are our employers” (#26). Participant #7 expands on the idea of collaboration where there is “more ‘we’ for all health care professionals”, and there is a “primary care team-patient life long relationship”. Through “increased collaboration – interdisciplinary [practice]”, participant #19 describes a “continuation of care” where the “health care provider becomes manager” of the patients’ health over time. The collaboration in the “doctor patient relationship”, where “trust is the foundation”, requires “the open ear”; “it isn’t time, it’s about being personable” (#20). Participants #4 and #5 note that when the members of the health care team collaborate “the system worked!” and “everyone was on top of their job”. They observe that “the patient comes first, not the paperwork”, “I was fully informed”, “people [were] listening / hearing”, and care givers provided “respect & listening to family and patient”.

Collaboration is about much more than systems and structures. Collaboration in health care is about people talking, listening, and forming effective relationships.

Collaboration in decisions regarding health care is empowering and leads to the theme of personal responsibility for both providers and consumers of health care; “patients – be involved in your own care” (#8). Participant #9 expands on this idea of personal control with the example of “I take total responsibility in seeking out the best qualified practitioner” and “supporting patients in self-responsibility mode”. The health care provider has a responsibility to be creative and open-minded; “young doctor with new ideas brought new therapy” with a focus on “patient centered care – informed patient involved with decision making (#13). Personal control is further supported by “more empathy”, “general knowledge”, and when “ER staff took seriously”
and patients “feel validated as a human being” (#10). The patient is firstly a human being and investments in empathy and knowledge-sharing reap good returns in individual empowerment. Participant #11 describes how the patient and family receive further control of health care through “very honest open dialogue – all in the communication” so that the “[f]amily felt they were involved in the care – team effort – they had a voice”. As noted by participants #11 and #12, “community-based family resource centres”, “teams with advocates, health coaches, patient navigators, stress counselors, volunteers to provide support”, and “multi-disciplinary team to provide home-based support” shift the responsibility for care from the domain of a solitary health care provider to the patients, their families, their teams, and their community. We are all responsible for ourselves and for each other.

Our collective societal responsibility for quality health care can be expressed as the “quality of civilization defined by the care given to the most vulnerable in society” (#14). The societal responsibility for health care is highlighted by recognition that “we aren’t always good stewards of ourselves”, and that we need “better allocation of resources…more effectively efficiently”, and “focus on outcomes...could we do this better?” (#15 & 16). **Best care**, as described by participants #2 and #3, is enacted through “respect, passion, caring, love, passion, and listening” which develops “patient confidence”. Participants articulated that the health of the health care system can be enhanced by “unconditional positive regard to co-workers, patients, everyone to be treated with care and dignity” (#24). The provision of quality health care is expanded upon by participant #14 through “people listening and hearing” with “better means of communication in an era of exploding technology”. Participant #27 describes the ideal health care system where “access is the biggest thing” and “[there is] more compassion in
practice”. Access to health care must be “easy” with “time for patients to tell story” and “when it’s at its best, [provide] seamless accessibility” (#22). A healthy system requires access and the “ability for people who have responsibility to have authority”, “to act independently, let them use judgment”; it is this opening of the lines of communication and mobilization of creativity that allows for “compassion” and “human connection” (#25) 

Finally, the appreciative topic interviews revealed that, while the complex problems in and of health care require the extra-creative efforts of the health care team, these efforts do not necessarily have to be more costly to the system. For example, participant #6 highlights their “gratitude” that a physician demonstrated “tenacity with complex problems” and noted the need for “more creative approaches – not more money” and “more collaboration and less competition”. The “focus on positive” in ways that “don’t cost, but [give] tangible value” results in “care that is more fulfilling for caregivers and more fulfilling for patients” (#25). “We have to get away from the disease model” and “think about the human being where they came from” (#21). In health care, we need to get to know the patient’s story (not simply their disease) as the disease often defines what the patient cannot do while the patient’s story and history defines what they can do.

These findings from the participant appreciative topic interviews laid out the pathway to topic choice and the AI 4-D cycle, beginning, in effect, the first layer of discovery data analysis. The concepts developed include: compassion is care; collaboration is people and relationships not systems and structures; we are all responsible to ourselves and to each other; we are all a part of quality care; and, get to know the patient’s can do story rather than the can’t do illness.

Small group analysis of themes to define topics of study (8:55 a.m. - 10:50 a.m.).
The next stage of the AI process entailed an exercise in which the small and large groups subsequently identified themes and generated topics to study. First, through sharing the affirmative topic data, the small groups determined factors contributing to high point experiences and generated themes (Appendix F). Team *Gourmet of Ideas* (GOI) reported that “I was reassured that he was treated as a person and called by his name rather than a bed number or a diagnosis” and identified the value of “humanized treatment as opposed to depersonalization”. The *Mostowy's medical marvels* (MMM) team noted the importance of “collaboration and communication” and “compassion and connection” in achieving “what everyone deserves” to “put the care in health care”. Team *We are one* (WAO) reported that “he made a human connection” and described care as “intimate compassion, and the courage to do that”. The *Multi-disciplinary team* (MDT) noted that “he was a person first, not just a disease” and “he was treated as a person not just a number”. The *Vacationers* (VAC) team noted the value of “care based on need not ability to pay” and the “respect for personal wishes and values”. Team *Empathetic voice* (EV) highlighted “empathy / respect in dealing with patient...[o]ne touch from doctor made the difference that day – non-judgmental...[m]ade me feel like a human being”. 

There is a striking similarity regarding the energy of all six small group teams around themes of personalized, compassionate care where the individual is treated as a human being and with respect. This is reflected in the high point experience quotes (Appendix G).

Then, the small groups identified potential topics through highlighted focused short descriptors: “personalization is paramount” (GOI), 3-Cs of “communication, compassion, collaboration” (MMM), “courageous intimate compassion” (WAO), *care* is “relational, interdisciplinary, continuity” (MDT), “role of personal responsibility” (VAC), and “family,
team, and interdisciplinary approach” (EV). These summarized ideas for potential topics of focus all had a positive focus and energy and again focused on personalized compassionate care. From this group of ideas, the topics of collaboration (30 votes), compassion (28 votes), and personal responsibility (22 votes) in health care garnered the most support and became the areas of further focus in the discovery interviews (Appendices I and J).

**Discovery interviews (10:50 a.m. - 11:20 a.m.).**

Here, I analyze the individual discovery interview data in a manner similar to the affirmative topic interview data in an attempt to develop a conceptual framework in relation to the chosen topics of collaboration, compassion, and personal responsibility. Acronyms that represent the conceptual categories are generated (Appendix Q).

**Collaboration: “when it was needed – the system – all parts were playing their part”**.

Eight participants performed discovery interviews focusing on the topic of collaboration in health care and I developed conceptual categories from analysis of this data (#2, 4, 5, 10, 11, 12, 19, & 30). Participant #20 notes that “We need to stop thinking this is my problem and this is your problem” and aim at “preventing patient from falling through the cracks” through collaborating in the provision of health care (#10). Participant #10 also identifies the need for “collaboration between 2 branches: long term care and mental health/urban outreach”, such that “non-physician medical professionals could do referrals without going through a doctor”, and “health care workers would have the time to meet together to work out a collaborative care plan”. The data from participant #2 identifies collaboration being enacted through “the communication between all health care providers and family”, “continuity of services”, “build[ing] on connections between GP & hospital community”, and “improv[ing] the transition
process from acute to chronic / long term care.” This pathway or flow of communication is labeled with the conceptual category of the care continuum network (CCN). CCN is built by “community based family resource centres”, “day hospital drop-in services for problems which community services can not address”, and a “step-up / step-down facility”; it is strengthened by “making connections”, “facilitat[ing] awareness – education”, and “increased community dialogue – as we are doing today” (#11). The care continuum network is one potential framework for collaboration in health care.

CCN has at its core the concept of respect (RES). RES has been identified by participant #2 as “respectful listening”, “sincere care”, “feeling of control & empowerment”, and “dignity”. Participant #11 notes: “[they] listened to what I had to say”, “[I] had a voice”, “they acted on my concerns”, and “felt part of team – an equal, felt secure”. One of the ways that RES is demonstrated is when “non-clinical personnel...[and] non-physician health care workers [are] taken seriously” (#10). RES in the CCN is important because “family members have a huge contribution to make” and “all patients need an advocate” (#11). Tips from participant #4 as relates to RES include the need to offer “empathy to the patient”, and “put the needs of the patient first”. A definition of collaboration arises out of the confluence of RESP and CCN, where health care is delivered with a continual flow of respect through interrelated care continuum networks. Participant #4 likens the flow of respectful care from “improved communication between acute and family and health care” to the concept of a well-tuned orchestra (WTO) where care is provided “when it was needed...all parts [of the system] were playing their part, and if they weren’t I don’t know what would have happened”. The ‘well-
tuned orchestra’ of collaboration in health care is a combination of respect and care continuum networks that are “working together to put the needs of the patient first” (#4).

The WTO is greater than the sum of its parts (CCN + RES) and the question is how to sustain (SUST) this degree of powerful collaboration. Methods for sustaining the CCN are “improved record keeping from hospital setting to chronic/family setting” and “improved communication between acute and family health care” (#4). Participant #4 notes “more resources” are a key to SUST and #5 extends this idea to “balanced budgets”, and an “only collaborative model” of health care delivery. Ideas for the concept of SUST include a focus on “outcomes – see direct benefit of collaborative program” with the “responsibility for health and accountability from all members of community”. Change through the sustainable care continuum networks will require, as reported by participant #12, “thinking outside the box” through “more focus on family physicians and collaborative interdisciplinary care” and “comprehensive care which is patient and family focused”. Examples include “reduction in ER visits and elimination of walk-in clinics” and “looking for efficiencies not just ‘old’ way[s] of providing care – all ‘team’ members [must be] involved” (#12).

The hope is that we can move the focus of health care from current old way of an acute/intensive care unit (ICU) model to the new way of a patient and family included care unit (PFICU) model, where “family structure could operate as an included unit in care” (#19). Participant #19 suggests it will require “some form of improved patient education which includes family unit”, “more access to information between acute and chronic care facilities”, and “more collaboration between health care providers and services they bring to the table”. The concept of PFICU can be realized through “health education – ongoing”, where “patients have basic
knowledge and understanding of biology”, and where need to feel that they “could make suggestions to [the] Dr.” (#30). The ‘patient and family included care unit’ will bring a depth and breadth to the previous health care provider/patient relationship such that “all health care providers and family members [are] informed and [providers] let family members participate to the best of their ability (#19).

The conceptual categories that I developed with the data segments from the collaboration interviews were: care continuum network (CCN), respect (RES), well-tuned orchestra (WTO), sustainability (SUST), and patient and family included care unit (PFICU). Together, these conceptual categories express the principles that would allow health care to be delivered in a sustainable and respectful manner to a ‘patient and family included care unit’ through the collaboration of a care continuum network. A key factor in achieving a collaborative health care system that performs with the quality of a well-tuned orchestra is through “improved communication between acute and family health care” (#4) facilitated by “skilled compassionate communicators – health care providers” with a “desire to look for solutions” (#10).

Compassion: “treated him as a person; he was not a cancer, he was a man who had cancer”.

Six participants performed discovery interviews focusing on the topic of compassion in health care (#13, 14, 16, 18, 25, & 27). The conceptual categories developed from the data segments are compassion-in-action (CIA), treat as a person (TAP), and to be present (TBP).

Acts of compassion-in-action (CIA) are identified as inspired examples that “embed compassion in the health care organization thinking” (#14). Participant #14 describes CIA as occurring when a “surgeon insists residents [surgical trainees] go from Operating Room to
patient’s parent [or family] for post-op discussion meeting”. Other examples of modeling CIA “through part of the educational process” are generated from participant #25 who describes examples of “personal empathy” where the health care provider “hold [s] patient’s hand” and is “allowed access to family members”. These acts can “change patterns of human behavior” through “daily practice of compassion” which “starts with the people in the room [the Dialogue]” (#25). Compassion is nurtured through “sensitivity training for all staff to demonstrate the opportunities to deliver compassion” and to “include ‘compassionate caring’ in the curriculum” (#16). The power of CIA is expressed by participant #27 in a story about how compassion from a homecare nurse “enable[s] the discussion…[which] is motivational for family, [creating a] ripple system beyond the immediate moment” and can have “system effects”. The idea here is that “people need to reach out – from all levels of organization, including those who don’t see their job description as including compassion” and change the message from “you are socially ineffective” to “I will help you” (#14).

Strategies are required to move the individual from isolation to integration and this can be achieved through inspired CIA and bringing the individual into the care decisions. Participant #13 highlights the importance of “knowing people are not alone in their health-care” as “disease produces isolation”. *Treating the patient as a person* (TAP) is a conceptual category for facilitating CIA and participant #13 describes TAP as a time when a patient was “treated as a person; he was not a cancer, he was a man who had cancer”. With TAP as a factor in CIA, “everyone is a good listener” with a “recognition of others who are part of a person’s health care, including family not just practitioners” (#13). Treating the individual with compassion and as a person brings the focus of care to the individual.
CIA is extended to the concept of to be present (TBP), to place the needs of the individual at the centre of the relationship with the health care team, including clinical and non-clinical health care providers, family members and friends, and the community and society as a whole. Participant #18 describes the TBP concept as a way to “background the medical voice and foreground the affective relational voice” through describing the example of a nurse who “extended herself to be relational – have the courage to make yourself vulnerable”. We health care practitioners are reminded that “it’s why we’re here, to effect patient care positively...to make a difference” (#18). TBP applies to all parties in the health care relationship: the patient who wishes to be informed, respected, and treated with dignity; the family that wishes to be informed and listened to; and, the health care providers who want to be able to function fully and most effectively.

The positive core of health care is defined by this group as the compassionate embracing of human beings by the whole system through acting with and modeling compassion, treating the patient as a person, and being present in our health relationships.

Personal responsibility: “rejoice in knowing that the choices I make about how I live my life affects my health”.

Twelve participants performed discovery interviews focusing on the topic of personal responsibility (PR) in health care (#1, 3, 6, 7, 8, 9, 17, 20, 21, 22, 23, & 26). The conceptual categories developed from the data segments are: mastery of self (MOS), channel for dialogue (CFD), independent self (IS), interdependent self (RS), the relationship between independent and interdependent self (RIR), and, from me to we (MTW).
Participant #1 data leads directly to the concept of *mastery of self* (MOS), where the individual is “given skills to make positive changes to lifestyle” and is “for health problem, life changing, took upon self to find answers.” Participants #1, 2, 20, & 23 identify the role of positive attitude in developing a MOS. Participant #22 notes how important it is to “rejoice in knowing that the choices I make about how I live my live affects my health”. The need is for “promotion of healthy behaviors in our society” through the “importance of healthy role models” and “financial incentives for healthy living” (#22). “Greater societal emphasis on prevention and healthy living” with “support for health care providers to encourage living” and “healthy living as part of the school and health curriculum” will “foster intrinsic motivation for transformative change” (#22). This mastery of self, where “people need to take charge of themselves”, requires an avenue for access to communication and information through a *channel for dialogue* (CFD) (#23).

The channel for dialogue leads to “improved access, increased communication, and increased compassion” with a resulting increase in MOS through “educating self, increased understanding of well-being, and coping skills acquisition” (#1). Participant #2 reports that the knowledge obtained from following a “list of instructions, [to] understand [illness], within capabilities” enables one to proceed [independently] as “you have to work toward your own recovery”; in other words, the channel for dialogue enables mastery of self. With “open heart surgery – once you left hospital, if you don’t do what you were asked to do, no one else can do that for you” (#2). Personal responsibility requires the commitment described by participant #20: “when I needed hip surgery...[my] buying into the pre-post-op program for physio [therapy] and strengthening [was important to my recovery]”. PR is reinforced in the CFD through
“knowledge, motivation to make change, support healthy lifestyle, and positive reinforcement” to “engage all to think ‘health’” (#20). The concept of personal responsibility becomes defined as mastery of self aided by a channel for dialogue.

Participant #6 “lives his life as if the health care system doesn’t exist” through “exercise, non-smoking, and diet enhancement”. This suggests a role for the independent self (IS) in the MOS. Participant #6 notes the importance of “tolerance, patience, [and] role models” and the need for “more bottom-up leadership”. Participant #23 relates a story of “trying to improve lifestyle choices to avoid the need for the system” so as to enable us to “save compassion for those who need it”. These characteristics suggest a role for an interdependent self (RS), the relationship between self and society, that is informed and informs the channel for dialogue and, together with the independent self, contributes to the mastery of self. Participant #7 reports on a daughter who “plays rugby – gets injured – concussion...Ramifications – [the daughter] cannot study & falls behind in school work”. This speaks to the role of the independent self but #7 also describes the need for “education – getting [the] message heard through peer groups”, which highlights the role for CFD and RS in relation to IS. Through incentives such as “free tools to quit smoking” and disincentives such as “increased taxes for sugar drinks”, the relationship between the independent self and the interdependent self (RIR) allows for the opportunity to “direct resources appropriately and provide compassion” (#7).

The role of RIR is expanded upon by the participant #8 data as it moves from an independent self that “make[s] your health a priority” to an interdependent self that “make[s] health a priority so you can be a more effective mother, worker, etc.” This RIR between the independent self and the interdependent self speaks to the responsibility to be a participating
member of society. The societal responsibility becomes “health promotion should be the standard, not a choice” and the provision of “meaningful ways to educate” (#8). There becomes a shared responsibility for the independent self through “personal responsibility in eating habits, exercise”, for the interdependent self through “availability for children to have accessible sports/ activity”, and for the relationship between independent and interdependent self to “motivate and make change” (#8).

PR is a choice described by participant #9 as a “decision to proceed with personal responsibility for health”. This recalls the principle of channel for dialogue, where health organizations and governments become facilitators of client choice, such that there is “more government recognition to embrace alternate therapies” and the facilitation of “more harmony within the health care system” (#9). This would result in the opportunity for independent and interdependent choice as well as moving the focus of health care “From Me to We” (MTW) (#9). PR and MTW is strengthened by CFD through “more education & communication” and the “chance to ask questions & understand & be able to complete self-care instructions before he was expected to be personally responsible” (#17). Participant #21 strives to “study mechanisms to improve personal responsibility / accountability” with an idea to “create financial incentives within universal health insurance program to foster healthy behaviors”.

The resulting mastery of self is personal empowerment where the independent and the interdependent self sit in a dialectical tension that is the relationship between the individual’s choice for self and for society. An interesting point raised by participant #21 is that “health care providers understand they have a large influence on health care expenditures and waste”. This highlights the concept of MTW where we all must appreciate and be accountable for our
responsibility to ourselves and to others. Our collective responsibility for a me to we perspective, through the relationship between the independent and the interdependent self, is to “assist individuals in helping them find their highest level of health” (#26). Personal responsibility is achieved through a mastery of the independent and the interdependent self to “provide compassion to others” (#26).

Dream, design, and destiny phases of the 4-D cycle (11:20 a.m.-15:00 p.m.).

The final stages of the AI process involve exercises in which the positive core possibilities identified by the discovery topic groups are amplified and expanded upon through the 4-D cycle. The collaboration, compassion, and personal responsibility groups took their health care topic and through a 4-D cycle imagined how to positively imagine, innovate and deliver better Canadian health care (Appendix M) (Whitney & Trosten-Bloom, 2010, p. 6). The overall message generated from affirmative topic small group themes may best be stated as the desire for personalized compassionate care (Appendix F).

The message of personalized compassionate care is applied to the topic of collaboration – a sustainable well-orchestrated delivery of respectful care. Collaboration requires creative thinking and is achieved through care continuum networks and engaging family included units of care. We transform how we provide care to the patient. We move from “some things get lost in translation” and “my client would have fallen through the cracks” to “orchestrate long term solutions and deal with the big picture” (Appendix M). We achieve collaboration through an understanding that “we are all coming from a different viewpoint with different strengths” and “it’s the different strengths working together that allows us to solve problems that may have seemed impossible on our own” (Appendix M). The dream ideal is that illness, wellness, and the
delivery of care are all “a continuum, where we see various stages of care” (Appendix O). How this is designed is through more integration – in training and in practice, and more diversity – extending the notion of health care “beyond health care professionals” to the people who use the system (the “public needs to get involved”) (Appendix P). The empowerment opportunity from this vision of collaboration is that people are free to choose how they contribute and health care moves from being about individuals and roles to being about teams and relationships.

Applying the desire for personalized compassionate care to the topic of compassion addresses the hope of both care providers and recipients to be present in order for the care provided and received to be of the best quality through compassion-in-action; we “embed compassion in health care organization” as compassion “supports, trumps, and transcends” (Appendix M). In this positive image of the future of health care, “being vulnerable is a professional strength” and professionals are “working in an environment where compassion embodies health care”. It is a system focused on human beings, not roles, one in which “people are never alone”, whether they are providers or recipients of care, and compassion “looks/sounds/feels like family” (Appendix O). The physician/patient relationship “is now person/person relationship” delivered in a relationship of equals between the health care delivery team and the health care recipient team (Appendix P). Through embracing the opportunity to be “vulnerable, fallible, and open”, the physician and the health care system can be human and caring (Appendix P). The empowerment opportunity from this vision of compassion is that all people are given discretion and are supported to act. We are known in relationship as “compassion trumps roles and defines roles” (Appendix Q). We are all given voice, heard, and
emancipated from the constraints of the existing health care system and given the opportunity to create the next system.

The first step on our collective societal journey toward a new system of personalized compassionate health care begins with each individual’s personal responsibility – a conceptualized mastery of self in the context of an appreciation of our influence and impact on our society. We receive “equal opportunities” for the “personal discovery” of “voice”...with opportunity and voice, I “rejoice in knowing that the choices I make about how I live my life affects my health” while understanding my “individual responsibility to whole society” as “we must go from me to we” (Appendix M). The mastery of self is “never too early to learn” so “we can all start from a level playing field” through “public education” and “resources to permit healthy choices” (Appendix O). It means that we “teach our children to be independent” through a society that is interdependent (Appendix O). The “freedom for informed choice” through personal responsibility “will involve people...setting expectations for themselves...expectations of excellence” (Appendix Q). The empowerment of personal responsibility is “the power of personal control” and the opportunity to dream, share the dream, and to be supported to act on the dream (Appendix M). This opportunity for excellence gives the individual both personal freedom and a responsibility to society; an opportunity to be heard and an opportunity to listen.

Section Five - Discussion of Process and Findings

This research uses an AI approach to explore how a group of individuals makes sense of their own lived experiences of health and through the sharing of their stories the group collectively identified the core values of compassion, collaboration, and personal responsibility as being fundamental to sustaining a flourishing Canadian health care system. My independent
GT analysis of the affirmative topic interviews revealed: compassion is care; collaboration is people and relationships not systems and structures; we are all responsible to ourselves and to each other; we are all a part of quality care; and, we need to get to know the patient’s can do story rather than the can’t do illness. My analysis of the discovery interviews performed for the topics of collaboration, compassion, and personal responsibility resulted in conceptual categories from the data segments (Appendix Q). The overall concept emerging from the analysis of all the interviews is the hope of the participants, both health care providers and recipients, to be involved in a process of personalized compassionate care.

My analysis of the group-generated data from the dream, design, and destiny phases of the dialogue considered the empowerment opportunities unearthed by the data (Appendices O & P). Empowerment is considered to be the underlying motivating factor that influences the results of an AI process (Whitney & Trosten Bloom, 2010). The AI focus for every component of the Dialogue on Health focused the perspective on liberating power and the participants were liberated and empowered through encouraging and enabling them to be positive (Whitney & Trosten-Bloom, 2010). The empowerment opportunity emerging from the collaboration data is that people are free to choose how they contribute and health care moves from being about individuals and roles to being about teams and relationships. The empowerment opportunity from the compassion data is that all people are given discretion and are supported to act. We are known in relationship as we welcome a state where “compassion trumps roles and defines roles” (#11). We are all given voice, heard, and emancipated from the constraints of the existing health care system and given the opportunity to create the next system. The empowerment opportunities emerging from analysis of the personal responsibility data is “the power of
personal control” and the opportunity to dream, share the dream, and to be supported to act on the dream (Appendix M). This opportunity for excellence gives the individual both personal freedom and a responsibility to society; an opportunity to be heard and an opportunity to listen. These empowerment opportunities generated from my analysis of this data remind us all that we have choice, voice, and the power to act in influencing decisions related to Canadian health care as the physician/patient relationship is now a person-to-person relationship of equals.

I would like to offer some further discussion about the overall value of a strengths-based inquiry approach to health care, including how other researchers might learn from the lessons I experienced while conducting this study. First, let me underscore the value of using an AI dialogue model to provoke positive, if uncertain, change in the Canadian health care system and the power of viewing health care, not as a problem to be solved, but rather an opportunity to be explored. May et al. (2011) has noted the power of the positive question approach of AI in bringing out the best in health care. Glouberman and Zimmerman (2002) suggest that we need to move from defining and responding to current health care issues as if they were merely complicated problems toward answering more complex questions in an attempt to begin the process of revitalizing the Canadian health care system. My research studied how individual Canadians make sense of their health care experiences through the sharing of their stories and how these stories become the data that are analyzed to better understand and guide the future direction of the Canadian health care system. It is obviously a very significant undertaking to study the Canadian health care system and several large-scale problem-solving studies have been performed over the past ten years (Kirby, 2001; Mazankowski, 2002; Romanow, 2002). For example, the problem-solving perspective has identified that, in Canada: despite universal access
lower socioeconomic status is related to poorer health; and, individuals feel that access to specialty care is a serious concern; (Alter et al, 2011; Blendon et al., 2002). My research used a strategy of Appreciative Inquiry to explore the existing Canadian health care system from a positive-based perspective. AI is an affirmative, inquiry based, improvisational process that works because it redirects the focus of analysis and it treats people like people, not like machines (Whitney & Trosten-Bloom, 2010). AI shifts the focus of inquiry from deficit-based change with: selected inclusion; feedback to decision makers; and, a best solution to resolve the problem to positive-based change with: whole system inclusion; widespread and creative dissemination of feedback; and, a capacity for ongoing positive change (Whitney & Trosten-Bloom, 2010).

Second, I would like to comment on the challenge of participant selection when working from a perspective that takes health care to be a complex system. In the case of dialogues aimed at engaging a public, it simply is not possible to ensure the engagement of ‘the system’ as a whole, but it is possible to initiate the mobilization of the positive energy of the system. The first step in this dialogue process was to consider the mode of recruitment of participants such that the system of health care would be sufficiently represented. The core group inquiry and positive change network form of AI engagement were chosen for the Kelowna Dialogue on Health because these forms aim to get the inquiry process started as quickly and as easily as possible and allows the dialogue to be an emergent, unpredictable complex process. The small (fewer than 50) number of participants in a core group inquiry means that all voices will not ‘be in the room’; however, the participants to the dialogue are both targeted through direct appeal and invited through public appeal to come with ‘something to positive to say and to share’. The 29 dialogue participants who took advantage of the opportunity and registered on the
dialogueforchange.ca website become the critical mass of agents in the *positive deviant* change network. Positive deviance is an approach to social change that focuses on discovering and acting on local wisdom with the belief that knowledge and ability to solve a problem lies inside the community (Singal et al., 2011, pp. 25 & 29). As Glouberman and Zimmerman (2002) suggest, Canadian health care is a complex system where positive deviants play a key role in the emergent solutions that originate from within the existing system (p. 10). The participants came to the Kelowna dialogue as local ‘experts’ and they brought with them a breadth of experiences and perspectives that ensured for a lively exploration of Canadian health care.

Third, I would like to offer that acknowledging the issue of participant time constraints and the challenges of maintaining a positive perspective count as important considerations for any researcher employing an AI approach. The Kelowna Dialogue on Health was a one-day seven-hour process on a Saturday. Typically, AI approaches to whole-system study are a minimum duration of four days and often significantly longer (Whitney & Trosten-Bloom, 2010, pp. 31-41). However, the participants for the Kelowna Dialogue on Health volunteered their time and a majority of the individuals could not participate during the workweek. Finegold et al. (2002) describe the value of an AI approach in stimulating the co-creation of a new plane of understanding where individual passion and collective commitment join forces in pursuit of a “bold and expanded” ideal (p. 251). In all likelihood, the necessity of a condensed schedule turned out to be a positive factor in the emergence of an extremely energetic, enthusiastic, and creative day of dialogue. Two other factors extremely important in the success of the dialogue were the idea of ‘taking a vacation from problems’ and a highly visible, tightly scripted schedule. These two factors had been identified as potential problems – or *opportunities* when viewed from
an AI perspective – during an eight-member, four-hour, pre-dialogue workshop. At that workshop, AI and positive-based change was reviewed in moderate detail. The workshop group had lengthy a discussion about the relative merits of the positive-focused approach versus the more familiar problem-solving approaches to health care change. I had a strong desire for the Kelowna Dialogue on Health to attempt to complete an entire 4-D cycle and the participants had only seven hours to both choose the topics of inquiry and to perform the complete AI process on these topics. The first principle outlined at the beginning of the Kelowna dialogue was ‘let us take a vacation from problems’ (Appendix C:1). This idea transformed the tone of the dialogue and kept the AI positive focus alive; “you can solve problems at work on Monday, but for today, you are on vacation” became the message for the entire day. The other concept that enabled successful completion of the entire 4-D cycle was the tightly scripted agenda (Appendix C). The minute-by-minute agenda was displayed on the walls of the meeting room and in my 25-minute introduction I referred to the tight schedule for the day and adhered to it. I believe that the ideas of ‘take a vacation from problems’ and a well-scripted agenda had an empowering effect on the dialogue participants because they were free to put aside questions about the conduct of the dialogue process and participated enthusiastically and unreservedly. The dialogue participants fully embraced the inherent uncertainty of the study of the complex system of Canadian health care as is reflected in the rich data that they generated from this AI-driven process.

Finally, I would like to address issue of the significant volume of data presented. The data presented in the results section are both rich and dense because I have attempted to bring the voice of all participants forward and each individual participant has an important story to share. These are the participants’ data and I honor the participants by both describing and attempting to
make meaning and sense of the data. Before I can attempt to take a complicated perspective of controlling the data through analysis I must take the complex perspective of allowing the data to emerge through presentation. Therefore, for the reader the data may be challenging to absorb and assimilate, yet this uncertainty and emergence is a hallmark of research into complex adaptive systems such as health care.

A future issue for the Canadian public to consider is their role and responsibility in influencing and disseminating decisions related to Canadian health care. Bate, Robert, and Bevan (2004) suggest that the next phase of health care improvement involves mobilizing people’s own internal energies to create a bottom up movement for change that originates from a locally led grass roots level. Zoller (2005) argues that health activism – challenging existing orders and power relationships that are perceived to negativity influence some aspects of health and health care – is an important and often overlooked concept in health communication because activists help to construct the discursive contexts of the key research foci in health communication. Brown and Zavestoski (2004) contrast health activism with health advocacy – a focus on education working within the existing system and medical model. Health advocacy relies on expert knowledge and, in contrast, health activism challenges the medical paradigm by insisting on democratic participation in medical knowledge production (Zoller, 2005). Brown and Zavestoski (2004) extend the concept of public participation in health care policy decisions to include health social movements (HSMs) – collective challenges to health and health care policy and practice through a wide array of supporters, organizations, networks of cooperation and media. Tuohy (2002) questions whether health care reforms can be implemented within the distinctive Canadian model of publicly financing the costs of health care. The CBC notes that “a
lot of dollars and a lot of ink have been devoted to finding a cure for what ails Canada’s health care system” (“Studied to death”, 2005). In a recent interview, Jim Clifton, Chief Executive Officer of the public policy group Gallup, stated that “high healthcare costs are dooming job creation, badly needed hope, and employee engagement” (Robinson, 2012). The results from the Kelowna Dialogue on Health suggest otherwise as health care costs received very little attention at the dialogue and participants are very engaged and remain hopeful, as demonstrated by the recent formation of a compassion group to develop plans to value and measure compassion in health care providers.

The research of the Kelowna Dialogue on Health has demonstrated that the Canadian conversation around health care can evolve from being a discussion that is static, event-based, and expert-led to becoming dialogues that are dynamic, ongoing, web-based, and whole-system led. In that spirit, I offer the following recommendations for moving forward the energy, ideas and commitment that emerged from the Dialogue on Health, as follows:

1) The data and results of the Kelowna Dialogue on Health should be presented in a public domain at the website www.dialogueforchange.ca in an attempt to inform the public and to encourage respectful and positively focused conversation.

2) The identified topics of collaboration, compassion, and personal responsibility should be more fully developed into actionable ideas through further AI-based study groups.

3) The Dialogue on Health offers a successful format to study Canadian health care through “increased community dialogue – as we are doing today” (#11) and “more meetings like this” (#10) should be repeated at different Canadian locations so that
more voices may be added to the conversation and region-specific results may be compared.

**Section Six – Conclusions**

When I asked my wife Maria for the ‘okay’, prior to embarking on the journey of completing a master’s degree while continuing to practice fulltime thoracic surgery, she gave her blessing for me to go to Royal Roads University as long as “I solved that health care problem while I was there”. I appreciate now that health care is not a problem to be solved. From this AI-based research, Canadian health care is seen to be a complex system with identified core values of collaboration, compassion, and personal responsibility and the overarching goal of personalized compassionate care is a desire of both health care providers and recipients.

There has been minimal input from individual Canadians on how they would like to see their health care system adapt and evolve in response to the fiscal, demographic, and philosophical challenges facing Canada now and in the immediate future. The AI focus for every component of the *Kelowna Dialogue on Health* focused the perspective on *liberating power* and it is now the time for more Canadians to participate by adding their empowered positive voice into the health care conversation and the website www.dialogueforchange.ca is one avenue for continuing the ongoing dialogue.

if we collaborate as one voice to collectively develop actionable plans to help realize this positive future together.
References


Would you like the have the opportunity to express your voice in the Canadian health care conversation? I would like to invite you to participate in a dialogue exploring Canadian health care from a unique perspective. We will discover *what works well* in Canadian health care by exploring the positive experiences and stories of the participants. The *Kelowna Dialogue on Health* will use Appreciative Inquiry (AI) and open-ended interviews to shift the focus of health care change from a typical problem solving discussion to a solution generating dialogue. This event will utilize a strengths-based focus aiming to discover, dream, and design new ways to improve the delivery of health care to Canadians. The Kelowna dialogue on Health will take place on Saturday April 21st at the Clinical Academic Campus (CAC) building on the Kelowna General Hospital site from 8 a.m. to 3 p.m. with lunch and refreshments provided.

I am a Thoracic surgeon practicing in Kelowna currently completing a M.A. in Professional Communication at Royal Roads University (RRU). My thesis project strives to add new voices from a wide range of perspectives into the health care conversation. The goal of this research is that core values fundamental to sustaining a flourishing and adaptable Canadian health care system will be discovered and developed into innovative ideas that will enable Canadians to enjoy improved health care. This research has been ethically reviewed through RRU and consent for use of the data generated and protection and privacy considerations will be formalized in the dialogue workbook.

If you have an interest in participating in this dialogue or have any questions please contact me ([dialogueforchange.ca](mailto:dialogueforchange.ca)). I hope you can join us on April 21st to share stories and ideas to better inform the conversation regarding Canadian health care.

Your voice is needed.

Sincerely, Michael Humer
Appendix B

Consent for participation: *Kelowna Dialogue on Health*

Appreciating Canadian Health Care: Canadians Participating in a Positive Dialogue

*Kelowna Dialogue on Health – Consent for Participation*

I would like to invite you to participate in this research project where we will examine Canadian health care from the unique perspective of exploring the positive experiences and stories of the participants in order that we may discover together *what works well* in Canadian health care. The *Kelowna Dialogue on Health: April 21* will use Appreciative Inquiry (AI) and open-ended interviews to shift the focus of health care change from a typical problem solving discussion to a solution generating dialogue. This two-day event will utilize a strengths-based focus aiming to discover, dream, and design new ways to improve the delivery of health care to Canadians.

I am a Thoracic surgeon practicing in Kelowna currently completing a M.A. in Professional Communication at Royal Roads University (RRU) under the faculty supervision of Dr. Virginia McKendry. My thesis project strives to add new voices from a wide range of perspectives into the health care conversation. The goal of this research is that core values fundamental to sustaining a flourishing and adaptable Canadian health care system will be discovered and developed into innovative ideas that will enable Canadians to enjoy improved health care. This research has been ethically reviewed through RRU and consent for use of the data generated and protection and privacy considerations will be formalized in the dialogue workbook.

Participating in this research dialogue will require a time commitment of up to 7 hours on April 21. The questions to be asked, through open-ended interviews, will focus on the stories relating positives experiences that you and your family have had in relation to Canadian health care. The individual information will be recorded in written form in the *Kelowna Dialogue on Health Workbook* and this workbook will become the data of the research and will be stored securely to ensure privacy, confidentiality, and anonymity. The individual participants name will not appear on any documentation and a secure code number will be used for identification and to insure anonymity. Only Dr. McKendry and I will have access to the raw data and
individual identification information and this data will be stored securely for 20 years and then destroyed. The collective group information will be available publically at the website dialogueforchange.ca. The completed thesis document will be available to participants at their request. Participants have the right to not participate in this research and have the right to withdraw at any time without prejudice.

Other than the consideration that the collective Kelowna Dialogue information may be published in some form in the future, I have no disclosure of any conflict of interest. Both Dr. McKendry and I are available throughout and following this dialogue to answer any questions. Sincerely, Michael Humer

I have read this document and agree to participate in this research and also to treat as confidential any personal information shared by my fellow participants.

Signed___________________________, Date__________________
Appendix C

Agenda: Kelowna Dialogue on Health

1) 8:00 a.m. - 8:05 a.m.
   • Let us imagine…
   • Let us take a ‘vacation from problems’

2) 8:05 a.m. - 8:10 a.m.
   • From “What is wrong here?” to…
   • “Who are we when we are at our best?”

3) 8:05 a.m. - 8:10 a.m.
   • From deficit-based to positive-based change
   • From problems…to possibilities

4) 8:10 a.m. - 8:15 a.m.
   • Appreciative Inquiry (AI)
   • What works well?

5) 8:10 a.m. - 8:15 a.m.
   • AI is “the study of what gives life to human systems when they function at their best”

6) 8:10 a.m. - 8:15 a.m.
   • Appreciation
   • Recognition
   • Valuing
   • Gratitude

7) 8:10 a.m. - 8:15 a.m.
   • Inquiry
   • Exploration
   • Discovery
   • Receptivity

8) 8:15 a.m. - 8:20 a.m.
   • AI: The 4-D cycle
   • Focuses on the affirmative topic
   • Revolves around the positive core

9) 8:15 a.m. - 8:20 a.m.
   • Discovery is appreciating
   • “What gives life?”
10: 8:15 a.m. - 8:20 a.m.
- Dream is imagining
- “What could be?”

11: 8:15 a.m. - 8:20 a.m.
- Design is innovating
- “What should be?”

12: 8:15 a.m. - 8:20 a.m.
- Destiny is delivering
- “What will we do?”

13: 8:20 a.m. - 8:25 a.m.
- Affirmative topic choice
- “What is it you want more of in Canadian health and health care?

14: 8:25 a.m. - 8:55 a.m.
- Affirmative topic interviews
- Improbable pairs
- Share stories
- Peak experience

15: 8:55 a.m. - 9:25 a.m.
- Small group theme identification
- Themes and threads
- Factors contributing to high-point experiences

16: 9:25 a.m. - 9:45 a.m.
- Share themes and stories with large group
- One or two stories
- Master list of themes

17: 9:45 a.m. - 10:00 a.m.
- Refreshment break
- “Systems move in the direction of what they study”
- Choice is fateful

18: 10:00 a.m. - 10:15 a.m.
- Small group identifies potential topics
- Three to five potential topics from stories and master list of themes

19: 10:15 a.m. - 10:35 a.m.
- Share potential topics with large group
• With logic
  • Why meaningful...for health and health care…

20: 10:35 a.m. - 10:45 a.m.
  • Cluster, select, and finalize topics with large group
  • Vote
  • Spirit, essence, and intent of positive stories

21: 10:45 a.m. - 10:50 a.m.
  • Choose new small group related to an affirmative topic
  • Transform affirmative topics into positive questions

22: 10:50 a.m. - 11:20 a.m.
  • Discovery interviews
  • Imagination and play
  • Personal human stories
  • Direct quotations

23: 11:20 a.m. - 11:45 a.m.
  • Make meaning in small groups
  • Interview data, stories, quotes, and inspirational highlights are shared and made sense of in total

24: 11:45 a.m. - 12:15 p.m.
  • Large group narrative analysis
  • High point stories shared

25: 12:15 p.m. - 12:45 p.m.
  • Lunch
  • Disseminate stories and best practices through the power of videotape

26: 12:45 p.m. - 1:15 p.m.
  • Small groups map the positive core
  • Essence of the organization at its best
  • Root causes of organizational success
  • Create positive core map

27: 12:45 p.m. - 1:15 p.m.
  • Small groups create positive core map
  • Metaphor for the organization
  • Incorporated positive core into the entire 4-D process
PERSONALIZED COMPASSIONATE CARE

28: 1:15 p.m. - 1:45 p.m.
- Small groups dream
- Lift up the best of “what is” and imagine it even better
- Extend the context for excellence
- Pragmatic idealism
- The dream for a better…

29: 1:45 p.m. - 2:00 p.m.
- Share dream with large group
- Create a collective opportunity map of common themes and opportunities
- Make the map of opportunities

30: 2:00 p.m. - 2:30 p.m.
- Design in small and large group (10 min per group)
- Give form to an opportunity
- Match a design element to an opportunity
- Craft a ‘provocative proposition’ through the lens of one design element

31: 2:30 p.m. - 3:00 p.m.
- Destiny in small and large group (10 min per group)
- Present the provocative
- Be big, bold, and brief

32: 2:30 p.m. - 3:00 p.m.
- Destiny in small and large group
- What are we proposing?
- What commitment will I/we make?
- What do we need to make this happen?
- Inspired action and improvisation

33: 2:30 p.m. - 3:00 p.m.
- Destiny in small and large group
- Plan for how to proceed

34: 2:30 p.m. - 3:00 p.m.
- Large group deliberation
- Small groups present their most inspired action and improvisation

35: 3:00 p.m.
- Review of the Kelowna Dialogue on Health
- Getting started, affirmative topic choice, discovery, dream, design, and destiny
Appendix D

Affirmative topic interview questions

Q1) Tell me about an experience when you or our family needed health care and you received exceptional care, when someone or something made a positive difference: *a time when the care felt right.*

Q2) What do *we need more* of in health and health care to enable what you experienced to become *the standard of care*?

Q3) What *core factors give life* to Canadian health and health care when it is at its best?

Q4) If you had a magic wand and could have any *three wishes* granted to heighten the health and vitality of Canadian health and health care, *what would they be?*
Appendix E

Affirmative topic small groups

Gourmet of ideas (GOI): #1, 2, 5, and 21

Mostowy’s medical marvels (MMM): #14, 22, and 23

We are one (WAO): #8, 12, 17, 20, and 27

Multi-disciplinary team (MDT): #13, 16, 18, 19, and 25

The Vacationers (VAC): #7, 9, 15, 24, and 26

Empathetic voice (EV): #3, 4, 6, 10, and 11
Appendix F

Small groups identify themes

Note: Any bold, underlined, or capitalized text was taken directly from the participant generated data sheets. Any italics were added by the researcher (MH) to clarify the text according to the participant’s intended meaning.

Team: Gourmet of ideas
- High point: with private U.S. experience: accessibility, lack of bureaucracy, timeliness re cardiac CT “couple of phone calls and it was done!”
- “I was pregnant and very sick, went to Emergency and nurse said” “don’t worry, we’re going to look after you.” “I felt cared about.”
- Respect for and listening to patient and family. “I felt reassured by their caring and competence”. “As a health care professional I was reassured.”
- “I was reassured that he was treated as a person and called by his name rather than a bed #or a diagnosis”.
- HUMANIZED TREATMENT AS OPPOSED TO DEPERSONALIZATION.

Team: Mostowy’s medical marvels
- COLLABORATION and COMMUNICATION. COMPASSION and CONNECTION
- COORDINATION and EFFICIENCY of care when ACUTE / DURESS
- Two and one-half year old male: collapsed at home, ambulance 4 min, intubated 5 min, OR 30 min > rapid care.
- Husband having MI and being looked after – wife comfortable enough to have root canal that afternoon.
- Patient comes first, not the paperwork.
- “Recognized what I was going to” : new baby born, yet already had 3 children – supportive care provided – let her discharge from hospital at night, when other kids asleep.
- -Acute > Chronic Care Transition.
- -“Put the care in health care.”
- -Quality of civilization is defined by the care given to the most vulnerable in society: time of vulnerability – no bill seen! i.e. illness of child.

Team: We are one
- Access to health care: Organized within 3 hours, we had CT, instructions and meds.
- Personality is legitimate and must be respected. Consideration should be given to patients and colleagues.
- Nurse gave personal commitment – “sat with me during her break to make me drink.”
“The doctor ‘advocated on my behalf’ , what was best for me was not what the system recommended. He made a human connection.”
Nurse knew my mom over 4 years of care. She talked as mom passed, and “we use the word ‘care’ but it is so much more than the mechanics of care – it is intimate compassion, and the courage to do that.”

**Team: Multi-disciplinary team**
- “He was treated as a person not just a number.”
- “My family was part of my brother’s care when he was critically ill.”
- “The open Ear. It isn’t about time, it is about being personable.”
- “People want to feel heard.”
- “He was a person first, not just a disease.”

**Team: The Vacationers**
- “When you don’t have problems you don’t need solutions.”
- Timely care: “Care based on need not ability to pay.”
- Information Services.
- Respect for personal wishes / values.
- Equal access.
- Primary Care Teams: “Life long relationships.”
- “It’s never fast enough when it’s a loved one.”
- “Good listening”.
- “Unconditional positive regard in a mental health environment.”
- “There are good deaths and there are bad deaths – my grandmother had a good death.”
- “I was amazed at my age ‘87’ that they rushed me so quickly – for open heart surgery.”
- “I have lived in countries where seniors are expendable.”

**Team: Empathetic voice**
- “Imaginary Sirens, imaginary help, it wasn’t supposed to be this way”. (*Poem from 12-year-old patient/daughter*)
- Whole family care with respect to any illness.
- Recognition and understanding about addictions. Empathy/respect in dealing with patient. One touch from doctor made the difference that day – non-judgmental. Made me feel like a human being.” Empathy.
- Support to provide seniors with dignity – help to remain in their homes – team approach.
- “Five years later, every day I continue to get better.” Ten years of chronic illness and eventual simple treatment.
- “Can you feel the pain?” When system listens to the person with illness, it helps with sense of loss of isolation.
Appendix G

Share themes and stories with large group

High point experience quotes:

Gourmet of ideas
- “I felt reassured by their caring and competence. As a health care provider, I was reassured.”
- “I was reassured that he was treated as a person and called by his name and not his bed #or diagnosis.

Mostowy’s medical marvels
- “When my husband was having an MI and being looked after expertly, I felt so comfortable that went out and had a root canal that afternoon.”
- “The quality of a civilization is determined by the care it gives to its most vulnerable members.”

We are one
- “The doctor advocated on my behalf. What was best for me is not what the system recommended. He made a human connection.”
- “We use the word ‘care’, but it is so much more than the mechanics of care. It is intimate compassion and the courage to do that.”

Multi-disciplinary team
- “The open ear – it isn’t about time. It is about being personable.”
- “He was a person first, not just a disease.”

The Vacationers
- “It gave het the information she needed at the time she needed it and reduced her anxiety in a medical crisis” re nursing hotline.
- “I was amazed at my age they would rush me so quickly. I’ve lived in countries where seniors are expendable. Because I am not any special person… I am just an ordinary person.”
- “It affects your mind as much as your body.” Mentioned that this helped for recovery from surgery because team wanted.
- “There are good deaths and there are bad deaths. My grandmother had a good death.”

Empathetic voice
- “He made me feel like a human being…”
- “Imaginary sirens, imaginary help… it wasn’t supposed to be this way.”
- “As a family unit, when you’re listened to and you have a voice, anything is possible.”
Appendix H

Small group identifies potential topics

Note: Any bold, underlined, or capitalized text was taken directly from the participant generated data sheets. Any italics were added by the researcher (MH) to clarify the text according to the participant’s intended meaning

Gourmet of ideas
- Appreciation of humanized treatment: communication, empathy, respect, and compassion.
- Personalization is Paramount.

Mostowy’s medical marvels
- Compassion: connection with patient when system struggling to provide needed care. Patient oriented NOT system oriented.
- Collaboration: acute > chronic transition. Widen the scope and long-term view.

We are one
- Courageous Intimate Compassion.
- The Open Ear: Communication.
- Respect: Collaboration – staff-staff-patients.

Multi-disciplinary team
- Relational Care: Compassionate, empathetic, evidence-based, patient centered, and family voice.
- Interdisciplinary Care: Communication between all players – not just health care members.
- Continuity of Care: Linking the acute care scenario to the chronic health maintenance.

The Vacationers
- End of Life Care: service provision, advance directives, and individualized senior care.
- Multi Disciplinary Care: right person seeing right patient at right time, finding efficiencies in the system.
- Role of Personal Responsibility.

Empathetic voice
- Proposed Affirmative Topics: whole family care, client centered, team approach, needs based care, human dignity / empathy – interdisciplinary including family and advocates.
- Family – Team:
- Family care delivered with humanity, empathy, [and] dignity.
• Team-based approach interdisciplinary care including: family, patient, advocates.
• Individualized affordable care for all.
Appendix I

Small groups share potential topics with large group and individuals vote

*(Three votes per participant, 79 votes cast). Listed in the order presented to large group.*

A - Courageous, intimate *compassion* – *(WAO)*
(#16, 17, 25, 26) = 4

B - We believe in the 3-Cs: Communication, *collaboration*, and *compassion* – *(MMM)*
(#1, 4, 5, 6, 14, 16, 17, 19, 22, 23, 25) = 14

C - Family and team-based care – *(EV)*
(#1, 3, 5, 11, 11, 11, 12) = 7

D - Relational care is *compassionate*, empathetic, evidence-based, patient-centered, and family voice – *(MDT)*
(#2, 6, 9, 10, 12, 13, 18, 20, 27) = 9

E - Interdisciplinary care: communication between all players – *(MDT)*
(#2, 5, 8, 12, 18, 19, 26, 26, 30) = 9

F - End of life care – *(VAC)*
(#3, 7) = 2

G - Role of *personal* responsibility – *(VAC)*
(#1, 2, 3, 6, 7, 8, 9, 9, 13, 13, 14, 16, 18, 20, 21, 21, 21, 22, 23, 25, 26) = 21

H - The ‘open ear’ – *(WAO)*
(#27) = 1

I - Respect – *(WA0)*
= 0

J - Universal access – *(Large group)*
(#1, 4, 8, 10, 19, 20, 30) = 7

K - Empowerment of the client – *(Large group)*
(30) = 1

L - Continuity of care – *(Large Group)*
(4, 22) = 2

M - Long-term perspective – *(Large Group)*
(7,10) = 2
Appendix J

Small groups cluster, select, and finalize topics with large group

- **Collaboration** in health care: $B+C+E = 7+14+9 = 30$
- **Compassion** in health care: $A+B+D+H = 28$
- **Personal responsibility** in health care: $G+K = 22$
Appendix K

Discovery interview questions

Q1) Tell me about a high point experience when you or your family experienced ...(fill in with affirmative topic of study) as being most alive and most present. What conditions contributed to this?

Q2) What do we need more of in health and health care to enable what you experienced in this high point experience to become the standard of care?

Q3) If you had a magic wand and could have any three wishes granted to heighten the health and vitality of Canadian health and health care in relation to this affirmative topic, what would they be?

Q4) Can you suggest some first steps along the pathway from the current reality toward the imagined best possible future?
Appendix L

Discovery interview topic small groups

**Collaboration:** The A team (AT): #2, 4, 5, 10, 11, 12, 19, 30, 31 (at 12:45 p.m.)

**Compassion:** The warm fuzzies (WF): #13, 14, 16, 18, 25, 27

**Personal Responsibility:** Personal best (PB): #1, 3, 6, 9, 17, 26

**Personal Responsibility:** Rejoice (RJ): #7, 8, 20, 21, 22, 23
Appendix M

Small groups make meaning

Note: Any bold, underlined, or capitalized text was taken directly from the participant generated data sheets. Any italics were added by the researcher (MH) to clarify the text according to the participant’s intended meaning.

Team: A-team (Collaboration)
- “Without collaboration, my client would have fallen through the cracks.”
- “Without collaboration, some things get lost in translation.”
- “Outcomes see the direct benefit of collaborative programs.”
- “Collaboration between professions helps to orchestrate long term solutions and deal with the big picture.”
- “Family collaboration allowed the family to know where they could help.”
- “It’s okay to ask for help.”
- “We are all coming from a different viewpoint with different strengths. It’s the different strengths working together that allows us to solve problems that may have seemed impossible on our own.”
- “As a team we are all equal.”

Team: warm fuzzies (Compassion)
- “We came to hospital in need of support, and we got it.”
- “People need to reach out – from all levels of organization, including those who don’t see their job description as including compassion. Embed compassion in health care organization.”
- “Modeling. “Seeing compassion in others made me comfortable seeking the care I needed.”
- “My dad was part of the interdisciplinary team. It was compassion in action.”
- “It takes courage to be compassionate. “It took courage for the nurse to stay during my grief and to embrace it.”
- “We need to have tea.”
- “The job isn’t done until we talk to the family.”

OTHER MINOR NOTES
- “Job – evaluation of compassion, letters of commendation to show gratitude, research.”
- “Evaluated and shared, outcomes measurable, looks like family.”
- “Supports, trumps, and transcends.”
- “Third space – dichotomies transcended e.g. practitioners-patient relationship. How we get there = through utilization and promotion of existing supports”
- “This evaluated and shared for the purpose of celebration.”

Team: Personal best (Personal responsibility)
• “There was a gift in it” – life changing event that inspired new way of life. “Went from all-consuming, to second nature to who I am”. Now have collaborative relationship with GP because they know I am responsible.”
• “Exercise, exercise, exercise!”
• “Personal Discovery – NOT Responsibility – All people can find personal discovery to be healthiest they can be!”
• “Tolerance – Success can be measured differently for different people.”
• “Equal opportunities – baby steps then individual choice.”

Team: Rejoice (Personal responsibility)
• “I rejoice in knowing that the choices I make about how I live my life affects my health.”
• “When it comes to healthcare, we must go from ‘me’ to ‘we’ – individual responsibility to whole society.”
• “I need help in understanding how my actions/decisions affect my long-term health” – power of personal control.
• “My voice – when applying for pension, have advanced directives clearly outlayed.”
Appendix N

Small groups dream data

Team: A-team (Collaboration)

What could be
- Detailed electronic records – one only – accessible throughout health care network.
- Everyone has a health advocate.
- Valuing communication.
- Interdisciplinary education and training is part of the job.
- System that treats ill health as a continuum, where we see various stages of care.
- Different health care professionals are accessible, they trust each other’s opinions and are open to solving problems together.

Team: Warm fuzzies (Compassion)

The warm fuzzies give you compassion
- People are never alone.
- Working in an environment where compassion embodies health care.
- Compassion is an element of every relationship.
- Compassion –looks/sounds/feels like family.
- Where being vulnerable is a professional strength.
- That it is a part of job description and so is evaluated with the purpose of celebration, sharing, and improvement.
- Where outcome measures include: - perception of compassion – other possible benefits -?
  Decreased post-op stay.
- Compassion is rewarded and rewarding.
- Compassion in health care extends and reaches into larger community.
- Compassion trumps and supports roles.
- Parking (for patients and families) is free.
- People are more important than records.

Team: Personal best (Personal responsibility)

Personal Best – Personal Discovery: 5 years from now
- Able to care for yourself – independent = freedom.
- “I want to be independent and independence means freedom.”
- “No more elder apartheid.”
- Within a community where children – younger adults + seniors live together. Community support systems in home.
• “It’s never too early to learn”. From early ages: 1) Teach basics of knowledge and skills in – nutrition, fitness, responsible living, health literacy, 2) Early childhood education, 3) Preparing children – personal responsibility and independence.
• “We can all start from a level playing field.”
• “Let’s teach our children to be independent.”
• For adults – integrated affordable housing.
• Allow self to be vulnerable > “I need help.”

**Team: Rejoice (Personal responsibility)**

**Freedom for Informed Choice**

• Physicians choose to die differently than general public.
• Public education.
• Resources to permit healthy choices.
• Fewer chronic conditions.
• Carrots and sticks.
• Healthy behaviors are the norm.
Appendix O

Small groups share dream with large group

COLLABORATION
- Care is continual
- Integration of e-health records
- Integrated training – university, wards
- Health advocate

COMPASSION
- Compassion trumps roles and defines roles
- Physician/people (patient) relationship is now person/person relationship
- Physician can be vulnerable, fallible, and open

PERSONAL RESPONSIBILITY
- “Freedom for informed choice”
- “To get there, where healthy behavior is the norm”
Appendix P

Design and destiny in large group

COLLABORATION

Opportunities
- Care is continual
- Integration of e-health records
- Inter-disciplinary training: university, wards etc.

Provocative Propositions
- Health advocate
- 80% that GP doesn’t see
- Change financial incentives

Ideas
- Public needs to get involved
- More diversity – beyond health care professionals

Destiny
- [Not commented on by group]

COMPASSION

Opportunities
- Compassion trumps roles and defines roles
- Physician/people [patient] relationship is now person/person relationship

Provocative Propositions
- Physician can be vulnerable, fallible, and open
- [Compassion] becomes part of professional role and enhances it
- Compassion training from day 1 – nursing, porters, dieticians, physicians. This reaches into larger community. We are leaders all of us. Random acts of compassion as a positive contagion.

Ideas
- Lay public determining who gets into medical school
- Reward compassion
- Allow for health care providers to be optimally functioning
- Allow people to be present
- When one health professional sees an act of compassion, that gets noted and recorded
• Decide whom to report to

Destiny
• Credentials Project? Can we determine this? Valid measurement?
• “How did you show compassion this year?” Health care compassionate people of the month
• Research in compassion at centre of outcomes (ICU), (Sarah on Lit. Search)
• Initiative for patients to write “compassion satisfaction letters”
• Gross Compassion Product –“GCP” (*Compassion Index*)
• Alaska model. (*Nuka model - integrated, customers-owners are partners in their own health care, Indian self-determination*)

PERSONAL RESPONSIBILITY

Opportunities
• “Freedom for informed choice”
• Great public education
• Resourcing personal responsibility and informed consent

Provocative Propositions
• To get there, where healthy behavior is the norm – carrots and sticks
• People dying like doctors choose to die
• Expectations of excellence

Ideas
• “You need to know what’s possible to be able to live your best life”
• “People only aspire to what you expect of them”
• Start early
• Involve people in setting expectations for themselves.
• “Everyone has already passed the course. Now, where do we go from here?”
• Leaves room for vulnerability, “mistakes”, learning in which students are totally committed to their own learning

Destiny
• [Not commented on by group]
Appendix Q

Acronyms for discovery interview conceptual categories

Collaboration
- Care continuum network (CCN)
- Respect (RES)
- Well-tuned orchestra (WTO)
- Sustain (SUST)
- Patient and family included care unit (PFICU)

Compassion
- Compassion-in-action (CIA)
- Treat as a person (TAP)
- To be present (TBP)

Personal responsibility
- Mastery of self (MOS)
- Channel for dialogue (CFD)
- Independent self (IS)
- Interdependent self (RS)
- Relationship between independent and interdependent self (RIR)
- From me to we (MTW)