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Rick Iedema,¹ Eamon Merrick,¹ Donella Piper,¹
Kate Britton,¹ Jane Gray,² Raj Verma,² and
Nicole Manning²

Abstract

This article addresses the issue of how government agencies are increasingly attempting to involve users in the design of public services. The article examines codesign as a method for fostering new and purposeful interaction among service-delivery staff and their customers. Codesign brings together stakeholders who, in the past, have had limited input into the way public services are experienced. By participating in this emerging discourse practice, codesign stakeholders can construct new ways of relating and deliberating. The data presented in this article are drawn from a codesign study initiated by the New South Wales Department of Health in an effort to improve the experience of staff, patients, and caregivers. The article concludes that codesign presents service consumers, professionals, and government officials with new opportunities as well as new challenges. Its opportunities reside in codesign bringing stakeholders together across previously impervious boundaries, producing new understandings, relationships, and engagements. Its challenges reside in these new understandings, relationships, and engagements only becoming possible and only continuing to be relevant if and when stakeholders are prepared to adopt and adapt to the new discourse needed to realize them, implicating them in what has been referred to as the “design competency spiral.”

Keywords

experience-based design, codesign, public service, affective practice, emergency departments, deliberative process

¹University of Technology Sydney, New South Wales, Australia

²New South Wales Department of Health, Australia

Corresponding Author:

Rick Iedema, Professor of Organisational Communication, Director, Centre for Health Communication, University of Technology Sydney, P.O. Box 123, Broadway NSW 2007 Australia
Email: Rick.Iedema@uts.edu.au

In recent years, the practice of consumer involvement in public service decision making has become accepted as an important marker of “open government” (Majone, 1998). Such involvement is believed to play a central role in countervailing the progressive loss in perceived “public value” of government services (Moore, 1995). With regard to health care services, for example, citizens express satisfaction with respect to their personal experiences, but their faith in health care systems is considerably lower (Eurobarometer, 2006). As early as the 1990s, health departments initiated satisfaction surveys and more patient-friendly information provision mechanisms (Garratt, Solheim, & Danielsen, 2008). However, these approaches do not give consumers the opportunity to talk about their experiences, let alone make those experiences count in health care facility structures and processes.

Since then, and drawing on community development initiatives for their theoretical and methodological underpinnings (Skidmore, Bound, & Lownsborough, 2006), governments have begun to initiate “deliberative forums” to strengthen and consolidate public involvement (Phillips & Orsini, 2002). Deliberative forums offer participants the opportunity to articulate concerns but also to engage with issues from different points of view. That is, deliberation is not merely a unidirectional information exchange but affords shared learning (Horner, Lekhi, & Blaug, 2006). Important here too is that these deliberative events are meant to be “issues based”: They are not about debating abstract principles or general standpoints but about addressing and resolving specific issues in a way that has a practical relevance to participant stakeholders.

Practically, deliberative processes can be realized through citizen juries, community panels, planning cells, public hearings, consensus conferences, and deliberative polling (Piper & Dunbar, 2008). In health, such events are rare, but support for them is growing, particularly in Canada and the United Kingdom (Health Canada, 2004; Mansell, Harris, Carthey, & Syed, 2005; Marshall, Haywood, & Fitzpatrick, 2005; National Centre for Involvement, 2008). In those countries, methods are being trialed for sharing experiences among service providers and service users to enable practice improvement and organizational change (Bevan, Bate, & Robert, 2007). One project deployed what the researchers called “experience-based enquiry” (Bate & Robert, 2007). This work involved videotaping patients talking about oncology services and then feeding that data back to clinicians who were enabled to adjust aspects of their ways of working. Another example of this practice is codesign (New South Wales Department of Health [NSW Health], 2008). Codesign was mobilized in New South Wales in 2007 to engender feedback about emergency services and to redesign those services with consumer (and clinician) input.

Being based on a dialogical approach to organizational change, and aiming to countervail approaches that favor imposing changes “from above,” codesign is intended to be dynamic, engaged, creative, and relational (see Marshak & Grant, 2008, for an overview of organizational discourse research into dialogical change). In that regard, codesign is part of a paradigm shift that has involved governments and other representative bodies seeking to create forums of public engagement where dialogue is used to generate new shared meanings and change mindsets and behavior among public

service providers and users (Bunker & Alban, 2005). Consumer service relationships are now considered central to designing service improvements because user involvement is seen to lead to “better and more responsive services,” “tackle people’s disengagement” from public services, and “build social capital” through education about the capabilities and limitations of services (Skidmore et al., 2006, p. 3). These processes are also held to enable confidence building among the public encouraging them to actively contribute to public service improvement.

But as social process, codesign poses several challenges. Stakeholders need to be committed to improving the relevant service, and they need to be willing to spend time talking about their experiences. This challenge becomes acute when targeting services whose users are not well to start with, such as an emergency department service or an intensive care service. There in particular, bringing service users (patients) together with professionals (clinicians) is a challenge. Patients and their caregivers may live at a considerable distance from the service. For their part, clinicians are busy and may not feel able to participate in extended discussions with peers, patients, and caregivers. Even when all stakeholders can meet and share experiences for the purpose of service improvement, agreement about the most important priorities for codesign or what the improvements should be are not a given. Finally, investments may be needed to realize improvements, putting a strain on organizations’ budgets and on existing resource commitments.

We begin our article with a background to codesign as emerging practice. We anchor our discussion to a view of design that relativizes its goal orientation and emphasizes its impact as a social-organizational process. Following this, we present the details of the codesign projects that were conducted in 2007 and 2008. This section draws on a recent evaluation of a codesign project undertaken in three hospital sites (ledema, Merrick, Piper, & Walsh, 2008). Our analysis of interview data collected for that evaluation reveals the project’s successes but also its challenges resulting from the need to navigate across multiple stakeholders, perspectives, expectations, and cultural practices. Then, in our discussion we consider how our commonsense understanding of codesign as a targeted production of functional solutions can benefit from a theory of design as an intentional exploration of as yet unrealized social and organizational possibilities. That is, design underpins new functions, objects, and processes, as well as generating (and requiring) new competencies on the part of those involved. We conclude by suggesting that at the cost of having to submit themselves to a “competency spiral” that results from intense and focused collaboration, codesign harbors the opportunity for stakeholders to coproduce new discourse with which to mark their new relations, competencies, and design achievements.

Clinical Codesign: Background

We began this article by suggesting that codesign is a strategic response to decreasing levels of faith expressed by citizens in public services. Codesign affords public involvement, ensuring the public gains a sense of ownership over government decision making.

Such accomplishment of a sense of public ownership is now a practical prerequisite. This is not merely because citizens expect it but because the complexity of public demand and sociocultural change make it impossible for governments themselves to exhaustively determine what is appropriate service provision. As Bradwell and Marr (2008) note, "Public services and governments around the world face pressures from a more demanding public, increasing social complexity and diversity, and overstretched resources." Furthermore, these authors observe:

The historical way of dealing with these issues has been a set of reforms offering diminished returns: the restructuring and reorganisation of bureaucracies, the introduction of targets, and varied management initiatives. But the promise of co-design is that it will take reform in a new direction. . . . In the lasting connections and relationships it encourages between individuals and institutions, co-design has the potential to help governments adapt to this new environment. (p. 13)

What is actually meant by *codesign*, beyond describing a process through which stakeholders form an agreement about what is desirable with regard to a resource or a process, is by no means apparent. Admittedly, for several decades now researchers have deployed the notion of design as encompassing, besides reconfiguring, the form–function relations embedded in material objects, shaping social-organizational processes and relations: "Everyone designs who devises courses of action aimed at changing existing situations into preferred ones" (Simon, 1969/1999, p. 111). Paralleling early Tavistock thinking about "work design" (Trist, 1981), Simon's definition of design promoted it as a general approach to "organizational problem solving" (Simon, 1995). A decade later, Schön (1983) insisted that design also include "problem making," by which he referred to processes "by which we define the decision to be made, the ends to be achieved, and the means that may be chosen" (p. 39).

Contemporary approaches to design extend these definitions yet further to include trialing. Interleaving Simon's (1995, 1969/1999) and Schön's (1983) understanding of design, these approaches situate design in a collaborative space where problems are framed and possibilities negotiated, and where ideas are modeled, realized, and trialed (Trullen & Bartunek, 2007). Such design is creative and longitudinal, shaping phenomena and relations, and bringing them into being, piloting them, and iteratively refining their configuration before implementing them on a broad scale, often involving large financial investment (Coughlan, Fulton-Suri, & Canales, 2007).

But these explanations do not yet comprehensively capture what is at issue in contemporary approaches to design. Three further points need to be made to contextualize the "turn to design." First, design is a practice that takes existing kinds of meaning and decision making into new domains, reinventing them in the process. As part of this, design can recursively act on the skills, tools, and resources it mobilizes, potentially innovating these too. This is because the evaluation of design outcomes will also implicate the way the design process itself was structured, populated, and

resourced. In that regard, the design process is reflective and adaptive as much as it is generative (Schön, 1983).

Second, because social and organizational processes and relations are now undergoing rapid change, designers and design stakeholders (“users of designs”) are entering into close, sometimes intense, relationships. Where traditionally designers deployed a more or less discrete kind of expertise whose products were approved (or not) by non-experts, designers now maintain close working relationships with a range of design stakeholders throughout the development process, and sometimes beyond it. This is critical not just to ensure the relevance of designs but also for them to remain responsive (through extended designer–stakeholder dialogue) to the changing discourses and practices that characterize stakeholder domains.

Third, and following from these first two points, design implicates both designers and design stakeholders in innovation that exceeds that of the designed objects. That is, both parties are faced with constantly having to assume and display new skills, discourses, and practices to realize such innovation. The design process should thus be understood, besides leading to the production of new phenomena, as ensnaring participants in what Sloterdijk (2007) terms a “competency spiral.” Designers, stakeholders, and the users of designs, through their increasingly frequent and extensive interaction, are both enabled and obliged to update and revise their competencies. Only by doing so will they be able to maintain their participation in the ongoing reconfiguration of designs, resources, discourses, practices, and approaches.

For its part, codesign is still an emerging social practice. It invites stakeholders to enter deliberative situations where what people can say, how the process is structured, and what practical outcomes are possible and appropriate remain (to a greater or lesser extent) underdetermined. For the cultural theorist Sloterdijk (2007), this is the defining characteristic of design *per se*: It is a process through which individuals enter domains of socioorganizational life that are as yet uncolonized, or not yet subjected to knowledge, technologies, and procedures. Sloterdijk’s definition of design elevates this entry into the not-yet-done and the not-yet-thought to first principle: “Design is nothing but the intentional confrontation of our incapacity” (p. 144).¹ At the same time, Sloterdijk regards design as conduct that we all as contemporary citizens have no choice but to partake in. The world is now so fast changing and complex that we constantly have to look for new ways of being, doing, and saying. This means we need to engender new skills, resources, identities, and discourses to ensure we are capable of producing and populating the world with new conducts. With this as background, let us turn to our analysis of what stakeholders said about the codesign process.

The NSW Health Codesign Project

In 2007, NSW Health in Australia initiated a pilot program to investigate the facility and process design implications of patients’ and caregivers’ experiences of emergency department care. The project stemmed in part from the political imperative to increase customer satisfaction with state health care services. Reinforcing its timely character

is that the project coincided with a coronial inquiry into the preventable death of a girl who was hit in the head with a golf ball (Milovanovich, 2008), and this inquiry in turn led to a statewide commission of inquiry into the state's emergency health services the same year (Garling, 2008). Emergency services in particular, then, were under pressure to reassure the public, media, health department, and politicians that they were both capable and enabled to meet these different stakeholders' expectations.

The codesign project was conceived as a form of experience-based design (Bate & Robert, 2007). Experience-based design involves interviewing patients, caregivers, and staff and allowing each group to share their stories, prioritize issues for improvement, and jointly "codesign" new processes and/or facilities. One benefit of this method is to alert clinicians to patient concerns that they might not otherwise know about and enable clinicians to redesign their clinical care processes in collaboration with patients and their caregivers. Thus, the codesign project intended to engage clinicians and consumers in a *collaborative* identification of issues and resolution of problems. With the support of NSW Health project staff, patients, caregivers, clinicians, and support staff were interviewed about issues important to them. These issues and problems became the focus of an elaborate redesign process targeting facility as well as process issues.

The codesign project engaged staff and consumers from three public emergency departments in New South Wales. The principal objective of the project was "to strongly engage frontline staff, patients and carers in identifying the best and worst aspects of their experience, and to co-design solutions to improve that experience within the Emergency Department" (Hunter New England Area Health Service, 2008, p. 6). Although the codesign approaches differed subtly from site to site, the basic methodological approach was the same. Each site conducted staff and patient interviews and focus groups, patient "tag-alongs," emergency department observation, as well as analysis of complaints, compliments, and root cause analysis data.² The data yielded through these sources were analyzed by project staff, clinicians, and consumers. In this collaborative way, major themes, or "touch points," were extracted that were then used as the basis for the articulation of specific solutions.

Evidence of the success of the project was collected as part of an independent, post hoc evaluation, and it is these evaluation data and their analysis that are presented here. Besides consulting codesign documentation produced by each site about the new designs introduced, the evaluation involved conducting interviews with 15 project staff, 12 clinicians, 3 health department employees, and 10 patients, all of whom were involved in the codesign project (Iedema, Merrick, Piper, and Walsh, 2008).

For the purposes of the present article, an additional discursive analysis was conducted of the evaluation interviews. The purpose of the original evaluation was to establish how effective the codesign *outcomes* were in the eyes of those involved in the project across the three sites. The present analysis focuses on interviewees' views on the codesign *process*. Note, however, that the discourse analytical approach mobilized here does not reduce discourse to textual object (Iedema, 2007). On the contrary, the approach pursued here focuses on and seeks to explain the dynamic properties of discourse as practice. The analysis does not make claims about specific textual patterns

because its principal concern is to respect discourse as a complex socioorganizational and affectively charged process. As such, its analysis and exegesis need to acknowledge that discourse is epiphenomenal (marking and enacting a social dynamic) as much as systemic (displaying and replaying an internal set of patterns or “logic”). We have referred to this kind of explanation of discourse practice as *abduction* (Iedema, Rhodes, & Scheeres, 2006). Here, analysis and explanation are not about either deducing or inducing analytical evidence from language patterns but about “abducting” feasible explanations for apparent regularities (Eco, 1990; Peirce, 1955).

That said, this abductive reasoning became possible thanks to an initial thematic analysis of the interview transcripts.³ The transcripts were read by three independent researchers. Their conclusions about the prominence of specific issues (themes) were tabulated, producing the following four discursive domains:

1. Codesign as “deliberative” process that engages patients and caregivers;
2. Codesign as reflexive process that enables frontline staff to appreciate the effect of their practice and the clinical environment on patients and caregivers;
3. Codesign as a research methodological capacity-building process for project staff;
4. Codesign as a dialogic process through which practical solutions can be derived.

These discursive domains are presented in greater detail next.

Codesign as Deliberative Process That Engages Patients and Caregivers

Codesign required project staff to arrange meetings with patients and their caregivers. In several cases, the patients and caregivers who chose to become involved expressed their gratitude for being able to tell their stories to clinicians and project staff:

We were certainly listened to. (Patient 5)

I enjoyed it. . . . We all sat down at a table and everyone sort of discussed how they felt . . . you could say exactly what you felt about things. (Patient 5)

It got down to the nitty-gritty and no one was backward and they just really said it, it didn't matter if the person sitting next to them was a co-worker . . . excellent meetings. (Patient 1)

Patients and caregivers also commented on the forceful effect that the meetings had on the clinicians and administrative staff who attended:

I think this co-design brought a lot of stuff out, stuff that was happening that perhaps the nurses and the people in charge weren't aware of. (Patient 4)

It was interesting to hear all sides, from the patients that come in and their grievances and then, clerical staff and the complaints that they had, it was just listening to, being an ear for them to talk to as someone, as an outsider. (Patient 1)

On the other hand, patients also commented on the codesign process appearing to benefit health professionals more than them. This feeling was attributed to the fact that clinician participants outnumbered patients, rendering clinicians more visible and perhaps also more vocal during the process.

I found it a little bit top heavy . . . there were so many people from health. (Patient 6)

As these comments indicate, patients and caregivers frequently spoke about the interpersonal and interactive dimensions of the codesign process. Thus, comments focus on how contributions made during focus groups were received, how not just project staff but also the clinicians responded to those contributions, and the extent to which patients and caregivers were listened to. On each of these fronts, interviewees indicate themselves to be conscious of the deliberative process at the heart of codesign. What is also taking shape in these responses are the contours of a new discourse that is definitive of codesign: “you could say exactly how you felt about things,” “codesign brought a lot of stuff out,” and “to hear all sides.”

Codesign as Reflexive Process

The clinician participants commented positively on the experience of deliberating with patients and hearing their experiences. A recurrent theme in their interview responses was “we are learning to see our work through the patients’ eyes.”

I think that everybody should go on a meeting with consumers . . . because they actually see what’s on the other side. (Clinician–Registered Nurse)

It [codesign] made us look at things from the patient’s perspective much more. (Clinician–Doctor)

Listening to the patient experiences does open your eyes. You pick up on things. You think . . . oh my God, how did we do that? (Clinician–Director of Nursing)

At the same time, clinician interviewees saw some aspects of the codesign project as challenging. For instance, the process required them to explain emergency department processes “over and over again” to patient and caregiver participants:

They [consumers] didn’t know what was going on. . . . I had to tell them over and over again, I had to tell them more from the beginning to the end, that was the biggest impact. (Clinician–Registered Nurse)

In these responses, too, the characteristics of a new codesign discourse are made apparent: “[codesign] made us look at things from the patient’s perspective much more,” “listening to the patient experiences does open your eyes,” and “I had to tell them over and over again.” This last comment points to the effort involved in bridging clinicians’ and patients’ and caregivers’ understanding, and reveals the potential for conflict. The difference in stakeholders’ knowledge and understanding necessitates not just the giving and receiving of explanations. At issue here is “emotion work” on the part of all participants (Zapf, Seifert, Schmutte, Mertini, & Holz, 2001). This work is needed to keep the conversation going by ensuring that the differences in understanding do not lead to conflict, miscommunication, or noncommunication. In effect, practical solutions are contingent on participants (patients, caregivers, clinicians, and other staff) discursively negotiating common ground, both technically and interpersonally, before an improvement solution becomes apparent and can be coarticulated.

Codesign as a Research Methodological Capacity-Building Process for Project Staff

Project staff interviewees made clear that they carried the biggest burden of ensuring the codesign process gained and maintained momentum. Balancing the competing interests of the different stakeholders and maintaining adherence to the deliberative principle of codesign clearly strained the resources and patience of some project team members. Project staff interviewees regarded skilled facilitation of meetings with clinical and patient/caregiver stakeholders as central to ensuring that codesign maintained its focus and was able to produce tangible outcomes. This became particularly important when the meetings had to navigate through difficulties such as disagreements.

There’s much more intensity in dealing with [difficult] issues. You need the right people, again you need the right project management around [codesign]. (Codesign Project Manager 2)

In some instances, instead of being able to move toward new designs, project staff were obliged to confront existing grievances about staffing, workload, and interpersonal relationships. This points to codesign meetings potentially “opening up cans of worms.” Moreover, discussions about such grievances were experienced as negatively affecting the morale of those participating in the codesign:

Asking staff general questions can open up a can of worms . . . there may be an expectation that something would be done about [staff grievances]. (Project Officer 1)

The project negatively affected staff morale, led to factions between staff [and it] created a morale problem that the hospital was trying to fix. (Project Manager)

Despite having to manage such tensions, project staff talked enthusiastically and positively about their experiences of codesign and about the achievements of their respective sites.

As much as I've had ups and downs with the project, it's been good, it's been a very good learning experience and it's introduced me to another part of health care. (Project Officer/Clinical Nurse Specialist)

I would say go for it, do it . . . it changes our approach to emergency medicine. (Project Officer 2)

Interviewees were clear, however, that project planning was critical and that project staffing needed to be stable. Such planning and staffing stability were seen as essential to building and maintaining trust relationships with all participants.

Make sure you organise regular meetings. From a implementation point of view work out what's doable [and] what is not doable, and organise the tasks, [then] divy up the tasks. (Project Officer 3)

For me the key thing [is] that things are actually happening—they might be still slow . . . but I think the key thing is that the patients were able to say their piece and that work started where it was. (Project Officer 4)

Besides making sure the codesign process was well organized, project staff interviewees also regarded as important that local clinicians took an active role in the codesign process. Clinicians taking on codesign roles created a direct connection with the workplace itself and led to other colleagues taking an interest, while also taking some of the weight off codesign project staff.

It appeared to me that [staff] had really picked up the baton and were running with it . . . and they were conversant, so they really picked up a lot of concepts around codesign and they'd set up some managerial structure around it . . . [they] had done a lot of things around the solutions and were following up on a lot of things . . . they seemed to have spread it from one person to three or four, which I thought was really good. (Project Leader)

A final theme that emerged from interviews with both clinicians and project team members concerned the difficulties that were associated with maintaining patient and caregiver involvement. Although this was not seen to be a problem in Bate and Robert's (2007) original study (sited in a oncology department where [chronically ill] patients' experiences were recorded so that clinicians could redesign their practices (Bate & Robert, 2007), doing codesign in an emergency department with an ambulant (short-stay) patient population came up against the problem of maintaining patients' participation.

The difficulty of running this project in ED [Emergency Department] is the short turn-around of patients and the lack of continued involvement of patients in the service. (Project Officer 1)

Therefore, project time and resources needed to be spent on encouraging as well as maintaining patient and caregiver involvement, ranging from contacting numerous people and groups for names of potential participants to arranging parking spaces and providing morning tea. Despite these difficulties, here too interviewees' responses remained positive.

As interviewees elaborated these issues, they staked out the contours of the new codesign discourse. Recurrent characteristics were the unpredictable nature of the discussions ("much more intensity," "open a can of worms"), the concern with shared meaning making ("patients were able to say their piece"), and the evident learning that was taking place ("[clinicians] were conversant, they picked up a lot of concepts of codesign"). We address these characteristics and their role in the codesign process next.

Codesign as Dialogic Process Through Which Practical Solutions Can Be Derived

The fourth overarching theme that emerged targeted the general purpose of codesign: producing better services. Several interviewees commented on the project's impressive achievements across all sites:

It did get a lot of things done physically I suppose because the physical layout was just terrible. (Senior Project Officer)

The solutions—I think they were positive and I think that they've helped to definitely improve patient flow . . . [and] patient experience. (Project Manager)

Specific codesign solutions that were suggested included improvements to triage arrival and registration, such as more frequent contact with patients in the waiting room. Facility improvements tended to focus on the redesign and remodeling of clerical areas, triage offices, and waiting rooms. Thus, counters were altered to allow better surveillance, signage was improved to provide better guidance for visitors, and desk space was arranged for a second triage nurse. At the same time, however, it was evident to interviewees that some of the codesigned solutions came to pose a burden on the health service. That is, these solutions required resource funding investments, putting them in direct competition with existing budget items.

[It] takes money . . . training, resources. . . . The things they're grappling with down there is great solutions, absolutely fabulous stuff, but how do we as a health service pay for it and then backfill those solutions? (Project Leader)

This added another layer of complexity to an already challenging process. Project staff needed to interest stakeholders in participating in the codesign project without being able to promise that everyone's wishes would be realized, and without being able to exaggerate its likely outcomes.

Discussion: Codesign as a Space of Deliberation

Analysis of the codesign project interviews indicates that the process harbored successes as well as challenges. Challenges included recruiting patients and maintaining the project's momentum. Other challenges were managing difficult issues that surfaced as a result of staff and patients being given the opportunity to share their personal experiences, some of which were grievances. Excellent project facilitation was clearly critical to channeling the intensity of the meetings and to ensuring that the deliberative process did not denigrate into dissent. Special resources for codesign are critical, too, to enable projects to realize the solutions that are codesigned.

Successes included gratitude on the part of patients, statements from the clinicians about having learned to see their work through the eyes of others, and project staff satisfaction thanks to a well-received project. Successes further included the in situ improvements that the project was able to design and implement. Judging by the attention given to it by interviewees, the biggest success was the creation of a deliberative space involving people from very different spheres of life. Despite difficulties and challenges, project staff, clinicians, and patients managed to come together to discuss service issues and personal experiences, and to think about how the practical design of processes and spaces could be altered to ameliorate those experiences.

Our point is that besides being defined by the effects of a renovated waiting area or a new triage process, codesign deliberation has the potential to register as successful collaboration and shared creativity. In that sense, codesign operates as a "large group intervention" that mobilizes not change authorized from above, but dialogical innovation through "deliberative democracy" (Lukensmeyer & Brigham, 2005). Interviewees commented frequently on this deliberative dimension of the codesign process, referring particularly to the dynamics that were unleashed for them by being given the opportunity to meet other stakeholders, narrate their experiences to them, and take note of their very different experiences and understandings. These dynamics manifested as a new codesign discourse whose principal markers are intensity (due to the need to negotiate different viewpoints), uncertainty (due to entering an interactive space where conducts are as yet not sedimented), and learning (due to coming into contact with new perspectives on care).

This last point brings us back to the theme with which this article started. There, we began to frame ("abduct") codesign as not just a technical accomplishment but also as an interpersonal dynamic incurring affect (Iedema & Scheeres, 2009). Drawing on Sloterdijk's (2007) insights, we acknowledged that codesign could involve participants in venturing into a discursive space where few of them had ventured before. Having presented our more formal analysis earlier, we can now specify the contours of that discursive space and elaborate in greater depth what participants confront when engaging in codesign.

To prepare the ground for our discussion, we need to clarify two points. First, although commercial business has for some time transacted new kinds of relationships across the producer–user boundary, particularly those involving product and service feedback (Thrift, 2006), this trend is only just beginning to make itself felt in public service administration, and health services in particular (National Centre for Involvement, 2008). This lag is understandable: Shared design practices targeting specialized software, telecommunications technologies, or computer games attract views and complaints that tend to be limited to an object’s usability (Nielsen, 1994). In the context of a government health service, we deal with life domains that reach beyond the practical and technical into the existential and the emotional. In health, users’ experiences are colored by illness, fear, and suffering. The expectations of these latter users are in that regard qualitatively different from those of users of specific kinds of hardware or software.

Second, the standard reasons for which people have hitherto gathered from across professional, governmental, and public spheres include celebration (e.g., a new public service or a new medical technology), representation (a vote), or failure (an error or “adverse event” requiring investigation and perhaps mediation). Against this backdrop, codesign presents a radically new form of congregation. Governments of postindustrial countries have recently begun to congregate with service providers and users in ways that go beyond regulating service provision, negotiating resource or representative matters, and facilitating information dissemination. Emerging research reveals that innovative government-initiated gatherings such as health forums and citizen juries are becoming less functionally constrained and processually predetermined, and more allowed to be contingent on the people that attend, the issues they raise, the sociocultural and organizational differences they embody, and the dynamics they coenact to accommodate those differences (Iedema, Sorensen, Jorm, & Piper, 2008; Mooney, 2008).

Having made these two points, we are now in a position to outline the main contribution of the present article. We describe codesign as an organizational decision-making process in search of functional outcomes *and* as a sociocultural development that entwines people in having to develop new competencies and selves. This is because as an emerging (innovative) and emergent (unpredetermined) social process, codesign presents participants with an inevitable unpredictability. This unpredictability springs from two sources: The first is to do with the challenge for people to collaborate in circumstances where few social and discursive rules as yet exist (viz., “they didn’t know what was going on”), and the second is to do with the challenge of being asked to participate in a creative process targeting innovation (viz., “you pick up on things”)—a process traditionally regarded to be the domain of the sole individual professional expert or innovator. In that regard, codesign acknowledges that patients as service users bring unique kinds of insight and “experiential expertise.”

With regard to the first, our interviewees were clear about the interpersonal burden of speaking across sociocultural and organizational boundaries. These comments were explained previously by pointing to how codesign brings people together from very different walks of life. These people gather thanks to their goodwill and willingness to put sociocultural and organizational differences aside. But the first task such a group

faces is that they need to prove their sociability: “Such a group gathering—unlike a religious or cult gathering—first must produce evidence of its own togetherness” (Sloterdijk, 2007, p. 167).⁴ Producing such evidence in the group and for the group is necessary to reassure participants that they are trusted and that their experiences are treated with sincerity. This qualifies and extends our comments earlier about emotion work and affect: Besides requiring participants to manage their own and others’ feelings in the interest of process continuity, codesign creates opportunities for participants to put sincerity, and therefore their own identity, into play.

The second task faced by codesign participants consists of exploiting a social gathering for the purpose of redesigning their physical and functional environment. Here, what participants confront is yet another anomaly. Instead of the professional expert applying his or her specialist knowledge to a problem, a social grouping of people whose expertise is not the design of hospital facilities or processes gathers to do just that. The challenge here is translating such confluence of lay knowledge, individual opinions, and personal experiences into practical and functional solutions that will then structure the work and experiences of others. For Sloterdijk (2007), the principal question here is “whether the social bond can—even if momentarily—be forged in serious thinking, a process normally associated with needing to be alone, distant and isolated” (p. 169).⁵ Here, too, codesign poses itself as a sociointeractive challenge, requiring participants to negotiate personal and practical understanding at the expense of perspectival differences.

Critical to making this process succeed is that stakeholders engender a discourse to which they do not just subscribe, but *into which they become inscribed*. The principal parameters of this new discourse were outlined previously: unpredictability (of the codesign process), (the challenge of) shared meaning making, and (the importance of) learning. Taken together, these parameters reveal the profoundly interpersonal character of the process that is at issue here. Codesign is not simply an “objective” process producing evidence for best practice, but an intersubjective process engendering locally validated and valued ways of structuring reality.

Given the interactive nature of its main two task components and the interpersonal character of its discourse, codesign must be defined as in the first instance an *affect-based* process. That is, codesign is about people coming together, negotiating deliberative dynamics, and forging new sociocultural engagements. These processes harbor a new way of speaking—a new discourse—that traverses people’s sociocultural, professional, and personal boundaries. This new way of speaking interleaves realities that until recently would have been the unique preserve of the architect, the manager, the bureaucrat, the clinical professional, or the patient. Framed thus, codesign is an affective accomplishment insofar as it generates cross-boundary deliberation. Equally, it entwines people in a “competency spiral” as it is contingent on stakeholders reconfiguring material resources, professional habits, and personal identities marking everyone’s ability to communicate, collaborate, and cocreate.

To be sure, the dystopian view of codesign would see it as harnessing what Courpasson (2000) terms *soft power*. Being given the impression that their opinions matter, stakeholder participants could be convinced that governments, bureaucrats,

and professionals have their interests at heart when deciding on how to allocate resources and structure services. On such a reading, consumers are “allowed” to participate in a process initiated and “designed” by others in power. In this article, however, we have not elaborated this perspective, although a dystopian critique would be appropriate and effective for addressing the limits of multistakeholder engagement processes. By the same token, we did not want to present codesign as an ideal solution. Its challenges and difficulties were more than evident from what was said during the interviews. It was clear that codesign could embrace and thereby neutralize concerns, but it was also apparent that it could act as a form of “reconstitutive power” extending to consumers opportunities they had not previously had.

Ultimately, our analysis sought to target the indeterminacy of codesign as a volatile interactive space. In codesign, the locus of power is not necessarily pre-given. It needs to be construed, achieved. Our conclusion therefore does not attribute a specific value or impact to codesign. We do suggest that postindustrial governments have little choice but to involve practitioners and citizens in the cocreation of “public value” (Moore, 1995) to countervail the growing “democratic deficit” that is undermining people’s perception of their services and processes (Majone, 1998). Whether a good thing or a bad thing, the principal means through which public value is currently being retrieved is multistakeholder involvement. And codesign represents an increasingly prominent instantiation of this trend.

Conclusion

[Since the project] a couple of consumers have been admitted to the Emergency Department [and] they have been on the alert . . . looking for things. (Patient 5)

This article has presented an analysis of the discursive features of interviews given by participants in a recent codesign project. This analysis and its findings provided anchorage for the article’s overarching argument: Besides potentially producing improved work processes and workplace facilities, codesign brings stakeholders from very different social spheres together and charges them with new interpersonal and practical tasks. Codesign invites patients, their caregivers, clinicians, and administrators to speak about their health care views and experiences, and to explore the implications of these views and experiences for how to redesign health care work.

We proceeded to frame codesign as being more than a functional exercise that aims to produce tangible solutions to practical problems as well as being more than simply a calculative strategy to restore public faith in government. Thanks to the processes it sets in motion, codesign is an underdetermined or emergent communicative process. This underdetermination places two kinds of expectations on stakeholder participants. First, participants are to produce evidence of their shared trust and mutual understanding: They must first articulate their experiences and views and then respond respectfully and productively to others. Second, and conditional on the trust and understanding thus brought into being, participants need to engage one another in speculation about and articulation of new social-organizational realities. Both expectations are met and

made manifest when stakeholders become capable of coproducing the new discourse that instantiates them.

We also suggested, drawing on Sloterdijk's (2007) recent work, that design, and therefore codesign, is increasingly inevitable as social and organizational practice. This part of our argument focused on design as the means through which contemporary citizens and employees create and re-create relevancies—discursively, practically, and personally. Here, design acts as the dialogic interstice that mediates evolving practices, multiple realities, and emergent collaborations. Design cranks up the functional efficacy of skills, knowledge, and capacities in our effort to accommodate the intensification of feedback from an increasingly complex world. Likewise, codesign answers to this dialogic feedback imperative, enabling not just more public participation in public service decision making leading to more information, but *better* public participation producing affective and more meaningful (or more feelingful?) relationships. Better participation means more intense and focused communication about issues that really matter to individual people. As underdetermined social-organizational process, codesign asks people to renegotiate and strengthen user-provider-funder relationships. As activity that crosses such boundaries, and its challenges notwithstanding, codesign may represent the means par excellence for eliciting new ways of shaping and inhabiting the world.

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Notes

1. This is translated from the original German by the authors: "Denn Design ist—von einem kompetenzökologischen Ansatz her gesehen—nicht anderes als die gekonnte Abwicklung des Nichtgekonnten" (Sloterdijk, 2007, p. 144).
2. Root cause analysis is an incident investigation technique used in many health organizations to determine in what respects services can learn from errors (Iedema, Jorm, Braithwaite, Travaglia, & Lum, 2006).
3. The transcripts were verbatim and at a low level of delicacy; that is, although utterances were captured with great precision, no paralinguistic features (such as pauses, soundings of words or sentence parts, etc.) were included in the transcripts.
4. The original German reads: "Eine solche gesellschaftliche Versammlung muss sich—anders als eine Glaubens- oder Kultgemeinschaft—ihre Zusammenhörigkeit erst beweisen."
5. The original German reads: "Ich stelle die Frage, ob das soziale Band für einige Momente auch im Nachdenken geknüpft werden kann, das im allgemeinen unser einsamster, verlorester, gesellschaftsfernster Zustand ist."

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Bios

Rick Iedema is director of the Centre for Health Communication at the University of Technology Sydney. His work targets how clinicians, patients, and managers communicate, and how such communication organizes health care services. He has published three books (two edited) and more than 150 research papers and book chapters.

Eamon Merrick is research fellow on an Australian Research Council Discovery Project investigating organizational complexity, clinical risk, and spatial design. Eamon is a registered nurse with expertise in critical care. He has completed a masters of health services management and is currently completing his doctoral studies.

Donella Piper holds a law degree and has just submitted a PhD thesis titled "The Role of Legislation in Facilitating Community Participation in Healthcare Governance: NSW Health—a Case-study." Donella was a Director of New England Area Health Service (NEAHS) from July 2002-July 2004.

Kate Britton is a researcher with the Centre for Health Communication, University of Technology Sydney. She works on the "100 Patient Stories Project" on Open Disclosure and on "Komuniti Tok Piksa," a video project on Papua New Guinean experiences of HIV/AIDS. Her research interests span communications, visual ethnography, and arts-informed research.

Jane Gray is a senior manager with the Health Services Performance Improvement Branch of NSW Health. She leads the Patient and Carer Experience Program, which involves measuring and improving the experience of NSW public health patients. Jane oversees the annual state-wide survey of patients and supports "experience-based codesign" projects in selected New South Wales hospitals.

Raj Verma has been the director of the Health Services Performance Improvement Branch and Clinical Services Redesign Program at NSW Health since April 2008. Raj is responsible for managing systemwide performance improvement across the entire NSW Health sector and leading the drive for major structural reform in the provision of clinical services.

Nicole Manning works for the Health Services Performance Improvement Branch within NSW Health as part of a team responsible for improving the patient, caregiver, and staff experience with NSW Health. She specialized in emergency nursing before taking up health service management and health policy roles.