How is Brilliance Enacted in Professional Practices? Insights from the Theory of Practice Architectures

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Abstract

Brilliance has been overlooked in studies of professional work. This study aimed to understand how brilliant practices are made possible and enacted in a multidisciplinary paediatric feeding clinic, where professionals from different disciplines work together and with parents and carers of children. The existing literature has thematically described brilliance but not theorised how it is accomplished and enabled. Using video reflexive ethnographic methods, the study involved the video-recording of 17 appointments and two reflexive discussions with the participating professionals, who selected and reviewed five episodes exemplifying brilliant care. These were analysed through three themes: carer-friendly and carer-oriented practice; ways of working together; and problem-solving in *actu* (in the very act of doing). Using the theory of practice architectures, we explored brilliant practices as complexes of sayings,

doings, and relatings, identifying the arrangements that enabled those practices and the forms of praxis involved.

Keywords

Healthcare, interprofessional, video reflexive ethnography, praxis, practice theory, theory of practice architectures

Introduction

Research into brilliance can enable its spread in practice but has been overlooked in studies of professional work (Dadich et al., 2015). Professional practice demands more than specialist knowledge and technical competence; it involves responsibilities and virtues that cannot be reduced to procedural compliance (Kemmis, 2019; Tyson, 2017). Brilliance in professional practice has been thematically described, yet it remains inadequately theorized. The theory of practice architectures (Kemmis, 2019) recognizes the complex, emergent, and morally imbued nature of professional practices but has not been used to understand how brilliance is enacted or how "architectures" make such enactments possible. In foregrounding brilliance, we take seriously aspirations to excel in professional practices and provide a counter to approaches that highlight problems and shortcomings. Brilliance is not taken up in a competitive spirit or as a pre-defined category, but rather as a novel window into professional practices that highlights aspects of them that are often otherwise overlooked.

We explored practices where professionals from different disciplines work with parents and carers to support children with complex feeding difficulties. In multidisciplinary paediatric feeding clinics, professionals are expected to bring their expertise to bear, work interprofessionally, and coproduce care with families and colleagues. However, little is known about how brilliant practices are accomplished in these or other interprofessional settings.

A focus on brilliance draws on positive organizational scholarship, foregrounding the exceptional, the flourishing and the virtuous (Cameron, Dutton, & Quinn, 2003; Cameron & McNaughtan, 2014; Mesman, Walsh, Kinsman, Ford, & Bywaters, 2019). Excellence depends on practice infused with virtue (Tyson, 2017)—the "good" and moral purpose in practice— and thus raises questions of practical wisdom or praxis (Cameron & McNaughton, 2014; Kemmis, 2019).

Focusing on brilliance counters a deficit perspective in which professionals, practices or organizations are (implicitly) critiqued for what they do not accomplish (Cameron & McNaughtan, 2014; Dadich & Farr-Wharton, 2020), or where outcomes are framed in terms of reduced adverse events (Moraby, Dadich, Elliot, Diamentes, & Hodge, 2018). A positive

perspective instead connects articulations of envisioned practices as in policies with the actual enactment of practices. Assuming that despite complex demands and challenging circumstances there are pockets of brilliance being enacted in practices, we asked:

1.   How are brilliant practices enacted?

2.   What enables these enactments?

Working with both the theory of practice architectures and positive organizational scholarship requires care. The former is rooted in critical theory (Kemmis, 2019), where issues of power and conflict form a central focus. Because such issues are well rehearsed in the interprofessional healthcare practice literature, we deployed the theory of practice architectures to cast light instead on issues of virtue and praxis. This approach has brought new theoretical insights to studies of brilliance in healthcare. We argue that the two approaches are non-competing, without claiming to resolve differences between them, or discounting the relevance of power and conflict in healthcare professional practices.

Brilliance in healthcare

A quest for brilliance is essential to the highest possible quality and safety of health care delivery (Karimi et al., 2017, p 336; NSW Clinical Excellence Commission, 2018; NICE, 2020). Articulations of excellent practice have referred to working interprofessionally, that is, the co-producing of care *with* rather than *for* patients (Dunston, Lee, Boud, Brodie, & Chiarella, 2009; WHO, 2010).

Several studies underpinned by positive organizational scholarship have documented brilliance in healthcare, countering a focus on untoward events by investigating how healthcare professionals envision and enact possibilities (e.g., Dadich & Farr-Wharton, 2020). Key themes in this literature concern relationships, time, and patient-centredness (Kippist et al., 2020). A study of community health services revealed the importance of time with patients, as well as creative ways of investing time in relationships (Dadich et al., 2018). Person-centredness, teamwork and particular qualities of physical spaces were key to professionals' brilliant care for people with cognitive impairment (Collier et al., 2020). Collier et al. (2019) connected brilliance in home-based palliative care with anticipatory action (proactively addressing individualized needs *with* families) and flexible adaptability (balancing building relationships with administrative requirements). Client-centred practices that value the happiness of those in aged care are key to brilliance (Miller, Devlin, Buys, & Donoghue, 2019). Elsewhere, health professionals have foregrounded the concept of "team," invoking brilliance as a collective accomplishment that is not possible without being close and attuning to the patient (Crew & Giradi, 2019; Karimi et al., 2017).

Brilliance is not universal across healthcare. Its enactment reflects the aspects of illness and wellness being addressed, and the approach to care being taken. Paediatric feeding care has several noteworthy features: it is shaped by physiological, family, cultural, and mental factors, which means professionals must address the diverse features of children's lives (Bryant-Waugh, Markham, Kreipe, & Walsh, 2010); it impacts on parents and carers (Hopwood, Elliot, Moraby, & Dadich, 2020; Pedersen, Parsons, & Dewey, 2004); and multidisciplinary care is crucial to it (Puntis, 2012). It has also been overlooked and fractured; only in 2019 was a universal definition of a paediatric feeding disorder first proposed (Goday et al., 2019). This makes understanding brilliance in paediatric feeding care practices especially urgent (Hopwood, Moraby et al., 2020).

Theoretical framework

We drew on the theory of practice architectures (Kemmis, 2019) because it took us beyond a thematic description of brilliance to an understanding of what makes it possible and how it is accomplished. This theory is concerned with the architectures that enable and constrain the conduct of practices, which are conceptualized as cultural-discursive, material-economic, and social-political arrangements (Kemmis, Wilkinson, Edwards-Groves, Hardy, Bristol & Grootenboer, 2014). These arrangements form the conditions of possibility that prefigure practices. Practice architectures are not rigid structures that exist outside practices at a particular site; they are "*in* the flow as well as productions of the flow" of the practices (Kemmis, 2019, p. 66, italics in original). For example, (pre-Covid) practices of lecturing in a university are prefigured by discourses of performance, communication, and the specific disciplines (cultural-discursive arrangements), as well as activity space-times where lecturers and students come together with equipment such as seats, projectors and lecterns (material-economic arrangements), and with relations of power and control, including feelings of value in the interactions (social-political arrangements) (Kemmis, 2019). Architectures give practices sufficient stability such that practice traditions can sediment in discourses and materialities, and in both patterned and normed interactions (Kemmis, 2019).

These arrangements are produced through and upheld by concrete enactments in practice—particular sayings, doings, and relatings. These enactments hang or bundle together as complexes of actions in the project of a practice and its ends or purposes. Being dialectically related, such actions shape the architectures that shape them. The theory of practice architectures also emphasizes praxis, that is, acting rightly, wisely, and for a greater good (Kemmis, 2019). According to Kemmis et al. (2014),

> We confront uncertain practical questions more or less constantly, in the form "what should I do now/next?". The kind of action we take in these circumstances is not a

>
> kind of rule-following, or producing an outcome of a kind that is known in advance… This kind of action is "praxis." (p. 26)

Praxis is linked to a disposition to act wisely and prudently (phronēsis). This sits alongside contemplative action (theoria), which is linked to the disposition to seek knowledge (epistēmē), and technical action (poiēsis), which is linked to the disposition to follow rules and techniques (technē). Praxis itself can be expanded into a fourth kind of action, critical praxis, which is acting for the good while interrogating and transforming existing ways of doing things, guided by a critical disposition to free people from untoward consequences (Kemmis, 2019).

Conceived through the theory of practice architectures, brilliance is not just a question of relevant knowledge, technical skill or procedural compliance. It requires judgement amid indeterminate consequences and deliberation over what is good or right to do. Thus, the theory of practice architectures can interrogate aspects of practice that a positive orientation foregrounds, especially the notion of virtue (Cameron & McNaughtan, 2014; Tyson, 2017).

The associated concept of ecologies of practices is relevant given our focus on practices that involve people from different professions working together. Kemmis (2019) notes: "We stumbled upon the idea of ecologies of practices after observing that practices are sometimes dependent on, or interdependent with, other practices" (p. 142). This stresses the interdependence of practices and how the accomplishments of one are necessary for the accomplishments of another. An ecology is distinguished from a practice "landscape," which refers more simply to a site where different practices co-exist, although not necessarily in mutually dependent webs of human activity (Kemmis et al., 2014).

Empirical setting and methods

This study was conducted in a multidisciplinary paediatric feeding clinic in Sydney, Australia. At the time of the study, the clinic was staffed by two speech pathologists (SPs), a clinical dietician, a physiotherapist, an occupational therapist (OT), a paediatric team leader, and a paediatric registrar (all female). The clinic ran once a week from 8.30am to 2.00pm. Appointments lasted approximately 60 minutes and were attended by two or more team members, with two appointments held in parallel, in nearby rooms. Patients were children affected by feeding difficulties, accompanied by parents, carers, grandparents, or others involved in their everyday care. Beyond these times, the professionals worked separately, sometimes at the same site and sometimes at other physical locations.

The methodology adopted was video reflexive ethnography. This is an established approach that invites participants who feature in video-recordings of their practices to interpret those practices jointly with researchers through reflection, thus seeking to understand the

practices as they unfold (Iedema et al., 2018). The collection and analysis of data were collaborative and recursive: data were collected first by video-recording practices, and again while practitioners analysed and interpreted selected recordings.

The participating professionals at the clinic gave informed consent for their appointments to be video recorded over six weeks. The families gave prior consent by phone and signed consent forms prior to their appointments. A total of 17 appointments were videoed. One camera was placed across the room and to the side, so it was neither pointing directly at any family member nor within the line of sight as people interacted (see Moraby et al., 2018 for further methodological details).

A dietician and a speech pathologist reviewed the recordings with the third author (also a speech pathologist) to identify moments that epitomized brilliant feeding care (see Table 1). Transcripts were produced. In making this selection, the clinicians looked for explicit or implicit demonstrations of appreciation by family members; experiences of a "feel-good factor' when reviewing the footage; respectful dialogue, especially when it might not have been expected; and demonstrations of a safe space where a disagreement could be voiced or a vulnerability disclosed.

Table 1: *Practice episodes identified by professionals as brilliant care*

Episode	Chosen by	Professionals in clinic	Reason for selection
A	Dietician	Dietician, Speech Pathologist 1	Engagement between professional and mother around educational materials
B	Speech Pathologist 2	Dietician, Speech Pathologist 2, Physiotherapist, Occupational Therapist	Problem-solving that develops solutions aligned with carer's needs
C	Speech Pathologist (Moraby)	Dietician, Speech Pathologist 2, Physiotherapist	Long parent report – listening to the mother 'download'
D	Dietician	Dietician, Speech Pathologist 1	Parent showing trust in sharing non-feeding related concerns
E	Speech Pathologist 2	Dietician, Speech Pathologist 2, Occupational Therapist	Attending to the child when she became unsettled

Two reflexive sessions were facilitated by the second author. The physiotherapist, the dietician, both speech pathologists (SPs), and the occupational therapist (OT) were present. Episodes A and B were analysed in the first session and the other episodes in the second. The interview protocol followed a loose structure: the researchers (Dadich) asked the professional who had chosen the episode to give some clinical background and summarize why she had chosen it, and then asked what everyone present found themselves attending to or noticing as they watched each video. The ensuing discussions were relatively free flowing, with the researcher asking probing questions (e.g., "Why is that important?"). These sessions were video-recorded and transcribed.

The authors coded the transcripts using a grounded approach that organized the participants' reflections into concrete themes and sub-themes. These were then interpreted through the theory of practice architectures. Following Srivastava and Hopwood's (2009) approach, the researchers held a priori theoretical interests in an iterative interplay with the emerging grounded insights, thus focusing on how the sayings, doings, and relatings were bundled into complexes of actions, and on the cultural-discursive, material-economic, and social-political arrangements that made these actions possible.

Findings

We have summarized each episode using pseudonyms to protect privacy. The findings highlight aspects of brilliance that the professionals reflected on during the reflexive sessions. The discussion then theorizes these findings through the theory of practice architectures.

Episode A

This episode involved speech pathologist (SP1) discussing snack foods with Ira, the mother of Maya. Maya had been tube-fed due to very premature birth, and now the focus was on expanding her oral nutrition. Ira, who had limited literacy skills and complex health issues related to methadone use, reported always giving her daughter crisps (chips) as snacks. SP1 showed a "finger foods" guide:

> SP: You can give her things like grapes, grated vegetables, I love grated cheese for children this age because it gives them a dairy element.

> Ira: [Leaning forward to look at the guide] Oh right!

They discussed family meals and then came back to the guide:

> SP: All of these things, just gives some ideas.

> Ira: [Leaning in] Yeah.

> SP: Something like, for example, grated cheese.
>
> Ira: [Pointing to the guide] Sliced up fruit, I'd never thought of that!
>
> SP: That's what I mean! With grated cheese you could put in those plastic containers and just grab one when you're going out. [Ira looks SP in the eye and nods]

In the reflexive session, the dietician explained why she had chosen this episode:

> I think it is good person-centred care. Mum is really engaged and actively listening, and I think [SP1] was very good in choosing education that was pictorial and appropriate… She [Ira] was really looking at you; if you watch her, she's nodding and really engaged.

The OT commented how SP1 was "responding to her [Ira], the way you're showing her the pictures, explaining… she seemed relaxed, smiley."

The repeated reference to grated cheese was discussed, the physiotherapist explaining that she also often says things many times because "They're taking so much in, they are hearing lots of stuff thrown out there." SP1 added that repetition was helpful because Ira had a lot to deal with in terms of her own appointments, as well as some memory difficulties associated with methadone use. Neither Maya's feeding difficulties nor the professionals' practices involving repetition were uncommon in this clinic, although Ira's circumstances required SP1 to take a tailored approach to enacting brilliance by engaging in parent-friendly ways, taking circumstances into account, and creating a relaxed atmosphere.

Episode B

This episode involved a dietician and the second speech pathologist (SP2) working with Sally, the guardian of her nephew Brock who fed using a tube and for whom sufficient nutritional intake was a concern. Sally started by saying, "I feel I'm tied to home with this big pump that I can't take out." She also reported that Brock vomited and coughed a lot during feeds, which were taking a very long time to complete. After some discussion of weight gain, the dietician said:

> Dietician: I wonder if we get you a mobile pump it will give you more mobility, so you're not stuck at home and having to stick to certain timeframes. We could try slowing the pump down to see if that gives him more time to digest [the food].

Sally agreed, and it emerged that she had assumed that a number mentioned in other appointments referred to the minutes of feed duration, rather than millilitres of liquid per hour. The dietician proposed dropping the feeding rate from 140 to 120 (mls/hour) to reduce vomiting but also using a mobile pump, which might extend the feeding time. Sally

commented, "That sounds so much better. I don't mind if it's slower, as long as he's putting on the weight."

SP2 chose this episode because of how the dietician had "put it forward that we can do some problem solving. That's exactly what you need to do." The physiotherapist commented that it was important to incorporate the suggestion to slow the feed into the solving of Sally's problem:

> Not just "You have to do this." That's going to be life changing for her because at the moment she's totally tied down to being at home for these feeds and she's got four other kids.

The physiotherapist and dietician mentioned that the realization of Sally's misunderstanding was a crucial step that might not have emerged in a more rushed situation.

Frequent vomiting and the use of pumps are familiar to the professionals at the clinic, and the idea that enacting brilliance required time to solve problems together was not unique to their work with Sally. However, they regarded this episode as a good example of these practices because its particular combination of challenges and solution were unique.

Episode C

This episode involved Emily reporting on the timing and volumes of milk feeds, vomits, and medications of her daughter Cassie. The physiotherapist and SP2 said little, seeking occasional clarification, for example, "You tried adding thickener for the reflux? Did it take her a long time?" The dietician responded to the clinicians' behaviours seen in the video:

> [Emily] is downloading, she has come in and saved up all this information she wants to share, and it is all coming up in a big gush. You did a really good job of letting her talk but then piping in with a few short bits to clarify.

The physiotherapist agreed, noting that the short, concrete comments made the interaction feel more relaxed and "Not so much of a medical bam bam!" and the OT noticed the mother relaxing and slowing her speech after these clarifications. The team discussed how parents of infants like Cassie, who was born prematurely, can become medicalized: "You wonder whether they lose their role as mums because they take on all this other responsibility." This was connected to the importance of listening, clarifying, confirming, and helping the parent relax:

> OT: It can feel like [Emily has] to be that medical professional, but you can see her not just downloading, she's checking, "Am I doing the right thing?" and she just needs that reassurance … "Actually, yes you are."

> Physiotherapist: And we see [parents] at their most medical because when they come to see us, they're like, "I need to tell you how I've been doing everything like this." The kids are probably not like that all the time, and that's why it's so important that we get them to relax because you can't actually see how they're really feeding at home.

Premature births are a common reason for attending the feeding clinic. This episode thus exemplifies the relatively common brilliant care practices of allowing parents to offload and of using short interjections to help them relax. This can provide parents with a much needed outlet and lead to fuller reports from them of feeding patterns for professionals to work with.

Episode D

The dietician and SP1 met Jade, the mother of Abbie and Ivy, who was attending the clinic due to Ivy's low weight gains. During a pause late in the appointment, Jade said, "I was at the chemist getting some stuff for her and Ivy sometimes blanks out, she won't respond, she stares blank. The lady asked me if she was having seizures." She added that this often happens when shopping or in the car. Without changing her spoken manner or posture, SP1 asked for more details about this, which Jade provided. Meanwhile, Ivy crawled over to the dietician, who picked her up.

The dietician chose this episode to review because "It was holistic care in how the families trust us to open up about other things and how we are receptive to that." Her colleagues confirmed that they often find parents raising things "quite outside the remit of feeding." The dietician commented:

> I think generally it is about the rapport that we develop with the families. It's something about the clinic as well, which feeds into your [SP1's] point about them having that long opportunity to talk to us, and us being patient.

SP1 added:

> We do make them feel comfortable; they start talking about things outside the remit of feeding, and actually our sessions are so long because this is the first time they've had the opportunity to offload all the information about something that's so emotional for them.

SP1 drew attention to the dietician's interaction with Ivy:

> I liked the way you did a little check on the side—how does she feel?—having a hold of them you realize a lot more than just watching a baby being held by someone else.

The OT linked this back to the issue of rapport, explaining the importance of families feeling comfortable with such interactions, and that professionals can help parents and carers concentrate, rather than worry their child might be disruptive. Although Jade's particular concerns were highly unusual, this episode exemplifies a form of brilliance relating to patterns in these professionals' practices concerning strong relationships of trust and taking time to listen to parents.

Episode E

In this episode, Zaina was feeding her daughter Rajani as she reported on her feeding habits. When Rajani finished feeding, she became unsettled. As the dietician continued speaking to Zaina, SP2 asked Zaina if she could offer a rice stick to Rajani. With Zaina's permission, SP2 knelt on the floor and placed one on the high-chair tray, and Rajani ate it.

SP2 explained that it was important to have gained Zaina's permission. The OT and physiotherapist agreed, given Zaina's possible cultural considerations around food. The dietician highlighted the way the team had carried on calmly, despite Rajani being unsettled: "We should endeavour to stay really relaxed." This was about showing that it is acceptable if the child is a bit noisy or wriggly, in contrast to ignoring the child or saying "Are you going to be quiet? We're trying to talk here!"

This episode highlights the brilliance enacted by maintaining calm and normalcy when children "play up"—which happens often in the clinic—and when parents might worry this is disrupting the appointment. It also points to the importance of the professionals consulting parents about any food they might offer during the appointment.

Discussion

We now theorize the findings and draw in additional data that show how the participants connected each episode to patterns in their practices. These are considered through three themes: carer-friendly and carer-oriented practices; particular ways of working together; and problem-solving in *actu* (in the very act of doing). We explore the enactment of brilliant practices through complexes of sayings, doings, and relatings, the arrangements that enabled those practices, and the forms of praxis involved (Kemmis, 2019).

Carer-friendly and carer-oriented practices

This theme is related to the idea of patient-centred care and reflects specific features of paediatric feeding care. While the child is formally the patient in the clinic, brilliance was often invoked in terms of carer-friendly and carer-oriented practices that were enacted through four connected complexes of actions.

The first complex of actions concerned tailoring care to individual circumstances. This manifested in episode A as sayings (a repeated message), doings (sharing a pictorial guide),

and relatings (the high engagement of the mother) that hung together in a project and interacted in ways that were appropriate for the mother. In episode B, tailoring was enacted through a bundle where the answer to the question 'What should I do?'—the guiding point for praxis—was attuned to Sally's *saying* that she felt tied down to home, hence leading to future doings with the mobile pump. Here, the project was to jointly find a solution to what mattered to the mother, namely, feeling stuck at home.

The architectures making this complex of actions of tailoring possible included the discourses shared across the clinicians that enabled them to repeat similar messages (cultural-discursive); the collection of resources in different formats (material-economic); and the arrangements that maintained some asymmetry between families and clinicians but clearly framed practice in terms of mutual contributions and negotiation, not something determined by professionals alone (social-political).

The second complex of actions hung together in projects to engage parents and carers as people with responsibilities to themselves and others, rather than as pseudo-medical professionals. Many carers of children with feeding difficulties struggle with the medicalization of parenting, but little is known about how to counter this (Tong, Loew, Sainsbury, & Craig, 2010). Episode C foregrounded listening accompanied by sayings to show interest, clarify, and confirm. The physiotherapist explained that she often looked for opportunities to "take them back to being a mum," and she described a different appointment that morning where she had said of a daughter, "She looks so comfortable just snuggling with her mummy." This addressed a disconnect between the professional biomedical concerns (often weight gain) and parents' concern that their child feels loved (Hurt et al., 2015). Discourses of parenting and motherhood made it possible to counter otherwise prevailing discourses of medicalization. Physical arrangements of parents and children attending together, while not unusual, contributed to the conditions of possibility by creating an environment in which the "doings" of parenting could be noticed and commented on.

The third complex of actions involved taking time to listen to parents, where sayings, doings and relatings hung together in a project to let parents talk freely and feel heard. With episode C as a catalyst, the professionals associated brilliance with listening to parents with minimal interruption, thus allowing them to "download." This was linked to enabling carers to feel relieved as 'there's someone who is actually listening and validating their concerns, their wishes'. SP2 expanded:

> That shows why our sessions are so long. You couldn't have that discussion in 10 minutes; you need to build that rapport; you need to hear the whole story. You said being patient-focused; you actually need to be *patient* as well.

Listening to the parent can build relationships, but it requires the virtue of patience as well as practice arrangements that allow sufficient time. The carers' comfort in offloading was contrasted with other settings where similar information was not shared, for example:

> Physiotherapist: They did see a paediatrician, but they didn't say anything [to them]. They just told us.

The architectures making these enactments of brilliance possible hinged on the material-economic arrangements of the clinic's long appointment times, and the social-political arrangements of continuing, stable relationships between clinicians and families that created comfort and trust beyond what was evident in other settings. These enabled the clinic to establish arrangements where parent-led discourses were legitimized. Given that such openness and trust were not present in other settings, this suggests critical disposition and action: the professionals in this clinic had not simply accepted the existing ways of doing things, they had taken emancipatory steps to do things differently.

Within the theme carer-friendly and care-oriented practices, the fourth complex of actions concerned a purpose to create a relaxed, non-medical atmosphere. The physiotherapist explained that they tried to counter a medical feel by introducing themselves in more human ways. Her colleagues added:

> SP2: I love that we all sit on different-sized chairs. I've always loved that. Because it makes us seem less like a panel.

> Dietician: More relatable.

> SP2: Like when she [the OT] sits on the floor, or that little chair, it makes us a bit normal, like we're people.

Here we see relaxedness enacted through a bundle of sayings (introductions) and doings (sitting) associated with relatings that reduced social distance between professionals and families. This arose in episode E in terms of remaining calm when children become disruptive. Interactions with the child (evident in episodes A, D, and E) were bundles of sayings, doings, and relatings that further helped to de-medicalize the appointments. The dietician explained how this establishes "relatability" as a person who cares about the child, not as a professional who "doesn't want to engage or connect, just filling in assessments.' The OT contrasted Ira's smiles, relaxed posture, and leaning in with what she sees in more traditional medical clinics.

Here the material-economic arrangements, including non-standardized furniture, were complemented by shared patterns of doings—arrangements that went beyond any one

individual performance—such as practices of sitting on the floor, showing interest in children, and not following an assessment script.

These complexes of action highlight new aspects of patient-centredness as a feature of brilliance. Other studies have foregrounded happiness in those being cared for (e.g., Miller et al., 2020), a notion indirectly echoed here through ideas of helping parents and carers be in loving moments with their children when medicalized responsibilities can otherwise dominate. Nurturing positive connections (Crew & Giradi, 2019) was accomplished in the multidisciplinary paediatric feeding clinic through relationships where parents felt comfortable offloading, partly because professionals took time to listen. Close attunement to patients (Karimi et al., 2017) was enacted through patiently listening and adapting sayings, doings, and relatings to the particularities of the carers' circumstances.

Particular ways of working together

Interprofessional practice is widely recognized as important in healthcare (WHO, 2020). In this study, professionals articulated a project to work together in supportive, mutually enabling ways that respected distinctive expertise and practice traditions without being precious about boundaries. Ways of working together that contributed to brilliance included asking "each other's questions," and being secure in the limits of and differences between their disciplinary expertise and judgements, including in front of families. Collier et al. (2019) found understanding and appreciating roles across disciplines were keys to brilliance. What follows elucidates and theorizes this concept in new detail.

The asking of questions that might conventionally sit within another's disciplinary practice tradition was discussed in relation to episode B, where much of the talk was between Sally and the dietician, despite the presence of four other professionals (see Table 1). This was then related to episode D, where SP1 asked Jade questions and the dietician was quieter, picking up the child, and to episode E, where the dietician spoke with Zaina and the SP2 interacted with the child. The complex of actions included sayings (asking questions across disciplinary boundaries), doings (listening to colleagues' questions, perhaps focusing on the child), and relatings (open boundaries between professionals' roles, which enabled focused relationships between one professional and the parent or carer):

> SP2: We ask each other's questions. I find that I'm asking questions, maybe I've covered some of [dietician's] bits and vice versa… We're not precious about that.

> Physiotherapist: There are no egos. I wouldn't get worried if I hear someone asking something that is more physio, or if [the OT] hears me saying something that is more OT-related, we're like "Good for you for mentioning that." I think it all comes back to being family-focused because if you're talking, it's better for you to keep talking,

> because the mother is engaged with you, it doesn't matter whose mouth it comes out of.

> OT: And they open up more to that person.

SP2 added, "That doesn't happen everywhere. I've worked in environments where people are precious about their designation." When reflecting on how they were able to work this way, she said, "It's experience of working with each other. If it was our first session together, I don't think you would have seen the same thing." A social-political arrangement of stable interprofessional relationships was an enabler here.

The participants noted the importance of being secure with the limits of their knowledge and with differences of opinion within the team—especially in front of families. Although this was not directly captured in the five episodes, it was a recurring feature of their practices. SP1 recounted having recently said to a mother, "Hang on a sec, there's a dietician in the other room, let me just ask her for advice." She expanded:

> A while ago, I said to the patient, "I think we should give overnight feeds so she's hungry in the day" and [the dietician] said, "Oh I don't really like giving overnight feeds because…," and the patient was right there. Because we didn't feel insecure, it wasn't a problem, it was just "This is why I wouldn't do this." In the end we made a decision together, and the parent actually saw that whole process.

Such complexes of sayings, doings, and relatings enacted *praxis* through a collective and open approach to answering "What should I do?" (Kemmis et al., 2014, p. 26). This reflects the enabling of cultural-discursive arrangements in which verbalizing uncertainty and disagreement is culturally acceptable in the clinic; material-economic arrangements in which the doing of decision-making happens during appointments; and social-political arrangements in which hierarchies and boundaries are blurred in favour of the open and inclusive working through of ideas.

In these practices, the clinicians did not replace one another's specialist modes of thinking (theoria) or technical doings (poiēsis); they remained respectful of the unique contributions all could make as representatives of the distinctive practice traditions of their particular fields. However, a phronētic disposition to act for a wider good appears as each clinician accepts permeable boundaries. Through reciprocal deliberations and decisions, and the visibilizing of uncertainty and disagreement among the team, the clinic operates not as a landscape where different professional practices co-exist, but as an ecology where practices are mutually interdependent, feeding off one another. In contrasting the work practices at this feeding clinic with the "egos" and insecurities the clinicians experienced elsewhere, there are suggestions of critical praxis and a critical disposition where norms from other sites have been interrogated, deemed untoward, and transformed.

Problem-solving in actu

The participants referred to problem-solving "online"—meaning "as the clinic happens." Brilliant practices were framed in terms of a purpose to figure things out together as practice unfolded, rather than to follow pre-existing rules, procedures or expectations. This was not just in *situ*, but in *actu*—not just at the clinic, but in the very act of providing care. Problem-solving was done as the interactions with families unfolded, not between appointments. Offering suggestions and possibilities, rather than recommendations and directives, are indicative of the sayings of problem-solving. These were linked to being sensitive to what mattered to parents or carers (doings) and establishing a shared platform for problem-solving (relatings) so that they contributed to the process. The clinicians noted:

> Physiotherapist: I think that something that all of you are great at, part of the culture is that we *are* very patient-focused. We make our recommendations about the patient and the family... That's the nature of a feeding clinic is that you have to solve problems…

> OT: Even just the way you delivered it [episode E] was nice. I've seen at a lot of our clinics where you kind of let the family join in and in this case, she came in at the beginning and said this is my problem; but you let her digest the problem, normalize the problem and the solution… it felt like it was with her.

Key to this was a readiness to suspend judgements they might reach early in the appointments. When the physiotherapist described how they might be tempted to leap ahead when they see, for example, a fussy feeder, they all agreed: "We have to go through the process of listening, getting all the details, and sometimes you're wrong."

While the opportunity to see children "play up", especially around feeding, was deemed helpful when problem-solving in *actu*, the clinicians needed to show they trusted the parents' accounts:

> Physiotherapist: It's hard when the child doesn't do what they wanted to show you. Today, this mum wanted to show us that her baby was taking the bottle quite well and it would not work! We let them know that it's okay, we don't need to see it; actually, we can problem-solve without seeing everything.

Although "live" doings can be helpful, brilliant care involved making sense of these by bundling them with verbal artefacts through relationships of joint problem-solving.

The architectures making these bundles possible included discourses (ways of talking involving suggestion rather than instruction) and social-political arrangements where parents and carers were positioned alongside clinicians when working out solutions and had their knowledge about their own children trusted and legitimized. Here we also see

dispositions among the clinicians to seek new knowledge (epistēmē) and to act prudently rather than on the basis of initial assumptions (phronēsis).

This theme links to co-producing care (Dunston et al., 2009) through its suggestion that answers are seldom known in advance or arrived at through mechanistic or diagnostic processes. Praxis is evident here, where rule-following is insufficient, uncertainty abounds, and answers to "What to do?" emerge through each appointment. This resonates with the "flexible adaptability" highlighted as part of brilliant palliative care (Collier et al., 2019, p. 91) and the "responsive, personalised" approach to brilliant renal care discussed by Kippist et al. (2020, p. 355). As well as finding parallels in different professional contexts, this study adds new knowledge about how these features of brilliance are actually achieved.

Conclusions

The quest for brilliance is essential for delivering the highest possible standards of practice (Karimi et al., 2017). This paper has extended this agenda by using the theory of practice architectures to conceptualize how brilliant practices are enacted and what makes them possible. In this study the determination of "brilliance" was in the hands of the participating clinicians. They chose five episodes from 17 recorded appointments. While each episode had particular characteristics, the clinicians discussed them as exemplars of the practices they recognized in their work with families more generally. Those making the selections were not asked to draw a hard line between "brilliant" and "good" practices; the aim of investigating how aspirational practices become possible, rather than focusing on problems and conflicts, does not require such a distinction.

Little is known about how brilliant practices are enacted and how such enactments become possible. Recent research highlights professional relationships, time, and individualized, patient-centred care as features of brilliance. Our study has elaborated on these, revealing previously undocumented and under-theorized aspects of their enactment and enabling. We have shown how understanding and appreciating roles, regardless of discipline (Collier et al., 2019), can be enacted through practices such as asking questions on another's behalf and being comfortable in open discussion and disagreement when complex decisions are made. We found time to be key: the amount of time to enact brilliance and how much time was invested in relationships and positive connections (Crew & Giradi, 2019; Dadich et al., 2018). Specifically, brilliance can be enacted by being patient, listening fully to what carers say, and using appointments to problem-solve in *actu*, rather than by rushing to make decisions. This enabled brilliance with regard to individualization and the respectful enrolment of families into care. Thus, anticipatory action (Collier et al., 2019)—a form of co-production (Dunston et al., 2009)—was enacted by engaging carers in ways that countered their medicalized roles and foregrounded the loving connections with their children.

How is Brilliance Enacted in Professional Practices?

In all the episodes, brilliance emerged as a collective accomplishment. This extends Karimi et al.'s (2017) stress on the team-ness of brilliance by including the patient. The theory of practice architectures (Kemmis, 2019) is especially valuable in this regard, as it enables brilliance to be conceptualised in a way that preserves its collective nature (as opposed to individual flair), without erasing the contribution of individual actions. Theorized this way, brilliance is a matter of how specific doings, sayings, and relatings coalesce as complexes of action in ecologies of interdependent practices shaped by collective projects. Ecologies may involve one professional's careful utterances, another's listening, another's attuning to a child; or one professional's staying "in" a dialogue of trust and comfort with a client, while others step back. Each enactment is an individual and joint affair, not as pieces in a jigsaw puzzle but as a dynamic mutualism that allows all involved to feed and nurture each other.

Such practices are accomplished through complexes of actions and enabled by particular architectures. Brilliance depends on individual and collective performances, but these are not sufficient. Brilliance has also been attributed to physical spaces, personal capacities and teamworking (Collier et al., 2020), but these are yet to be theoretically integrated in ways the theory of practice architectures makes possible. Humanizing and personalizing discourses of parenting counter those that medicalize parents and carers. Physical arrangements that reduce distance between clinicians and families, along with appointment duration and stability of relationships, make crucial complexes of action possible in the moment. Relationships in which parents and carers are enrolled into joint problem-solving and in which health practitioners remain respectful of their specializations without being confined within rigid, impermeable boundaries are also important. This understanding presents professionals as contributing significantly to the conditions of brilliance—not as merely acting within conditions determined by others.

The theory of practice architectures addresses the complexity of and responsibility imbued in professional practices through its focus on praxis, that is, action that goes beyond rule-following with known consequences, and where moral questions of the "good" emerge (Kemmis et al., 2014). This must be accounted for in understanding brilliance within professional contexts. The participants in this study found their way through morally charged uncertainties, deliberating on what was "right" to do in terms of being carer-friendly and carer-oriented; being comfortable and not precious in transcending professional boundaries; and resourcing joint problem-solving in *actu*. We found traces of phronētic and critical dispositions, where formal knowledge and technical skill were not displaced but instead were invigorated through prudence and humility around knowledge, a collective searching for the "good" for each family, and a readiness to interrogate existing ways of working and doing things differently.

Promoting the spread of brilliance in professional practices requires robust empirical and theoretical platforms. In this article, we have extended the emergent body of work

documenting brilliance in actual practice—rather than as an aspiration—by countering a focus on problems and challenges and trends to understate what is possible despite challenging circumstances. We have argued that the theory of practice architectures, with its dialectical connection between actions and what enables them, as well as its orientation to praxis, offers a valuable basis for theorizing brilliance. A focus on brilliance need not frame professional practices in a competitive way or depend on exclusionary, pre-defined categories; rather, it can serve as an invitation to explore practices, with practitioners, in novel and revealing ways by shedding light on aspects of professional work that are valued and valuable but otherwise potentially overlooked.

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Article history

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