This piece by Justin Denholm, a leader in the healthcare sector in Australia, illustrates how a brief introduction to ROG and the Self/Other/Situation (SOS) model transformed his approach to the tuberculosis programme during COVID. The key theory maps are SOS and the turn away from a constrained egological approach to a more emergent ecological way of being.

Justin Denholm: The SOS model and tuberculosis programmatic change in the COVID pandemic

By way of background, I am an infectious diseases physician and the Medical Director of the Victorian Tuberculosis Program, based in Melbourne, Australia. I don't have any prior experience as a coach or therapist but was fortunate enough to attend a Relational Organisational Gestalt workshop series in September/October 2020, in which I was introduced to these concepts for the first time. This short piece arose from my reflections on that time, but any awkwardly applied terminology and ROG philosophy are entirely mine!

In recent years, there's been a major global focus for tuberculosis services on moving beyond simply treating people when they become unwell, to expand our programs for early detection and TB prevention. Ultimately these approaches, aimed at community screening to find 'latent' TB (LTBI), are intended to allow treatment to prevent the disease from developing, and eventually support the elimination of TB as a public health problem. In Australia, we have state and national TB strategic plans, both of which have major elements of expanding this type of community-based LTBI testing and treatment. In 2020, the arrival of the COVID pandemic created significant challenges for implementing these plans, though, for reasons that include diversion of funding and human resources to direct COVID responses; public health restrictions on community movement and gatherings; community concerns about visiting healthcare sites; and deprioritising of non-COVID healthcare work. Over the first 9 months of the pandemic, we responded in a variety of ways, including developing a video-conference based model of care, refocusing work priorities and restructuring program activities for staff and community safety[1]. We found, though, that maintaining planned activities was increasingly difficult, particularly given increased social and economic pressures on the communities with which we are engaged, and uncertainty about how long these impacts might persist.

When I was introduced to the SOS model, I immediately recognised my own approach had been essentially egological. I had come into the COVID pandemic with a clear vision for expanding LTBI treatment programs, and my fundamental concern continued to be how to go on accomplishing this under changed conditions. Reflecting on the SOS model, I could see that I'd paid attention to each of the domains from this perspective. I had recognised, for example, my own need for increased self-care to ensure that I retained the energy and capacity for ongoing promotion ("Self"), and the need to support and resource program staff and healthcare workers ("Other") so that they could preserve their capacity to implement change in the environment ("Situation"). This approach had been largely intuitive but being introduced to the SOS model was resonant with me and was a good fit as a conceptual framework for the approach that I'd taken. It also helped me to articulate more clearly what some of the limitations to this strategy had been, including difficulties engaging with stakeholders, and a sense of some growing internal conflict and disengagement that I'd noticed.

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[1] Watts, K., McKeown, A., Denholm, J., & Baker, A. M. (2020). Responding to COVID-19: adjusting TB services in a low-burden setting. *The International Journal of Tuberculosis and Lung Disease: the Official Journal of the International Union Against Tuberculosis and Lung Disease*, *24*(8), 866-869.

While the SOS framework offered me a useful interpretive lens for understanding my approach, what was more impactful was a paradigm shift that arose on being introduced to the possibility of an ecological approach to engagement. I found myself curious about what might emerge if I were to let go of my existing plans, reflect on the situation we found ourselves in, and how we might be shaped by it instead. Rather than seeking to influence others in order to alter our situation, what might emerge from sitting with the reality of our situation, and being open to how we might be changed by it?

Quite soon after encountering the SOS model, there was a striking opportunity to explore it in practice. I met with a key external stakeholder to discuss a budget proposal, intended to be about increasing our funding to support expanding the LTBI program in the context of COVID. Instead, without a clear alternative, I found myself suggesting that we put the proposal aside, and talk instead about the situation that we, and the communities we serve, found ourselves in. What emerged first was an acknowledgment that, however important LTBI programs might be in the long run, they weren't an immediate priority for the communities we needed to engage with at this time. Individuals and communities affected most by TB are often economically vulnerable, and the people we were meeting with were experiencing high rates of unemployment, food and housing insecurity and uncertainty. We acknowledged that these factors were much more pressing, and also that we needed a new approach to listening to community priorities; and suddenly, what emerged from the discussion was a very different proposal – to instead establish a training scheme with these funds, where young women from culturally and linguistically diverse communities impacted by TB and COVID would be employed to train and run peer-support groups for community health. While the program itself would provide employment and training, it would also provide continuous opportunities for better listening to community needs and priorities as they shifted over time, so that public health services like ours could be better tailored and more responsive to change.

It's still very early days for this particular program, and how effective it might be for improving engagement and peer-support remains to be seen. However, I wanted to share this as an example of tangible change in organisational approach that came about directly as a result of being introduced to the SOS model. It's a model that I think public health services in Australia and beyond could benefit from greater awareness of, so I'm keen to also take some opportunities to share it more widely in professional contexts and see how it might influence practice.

Justin Denholm

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