Bringing Leadership to Life in Health: LEADS in a Caring Environment

Putting LEADS to work

Graham Dickson
Bill Tholl
Editors

Second Edition

Springer

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Foreword

If there is one thing Canada does better than any country in the world, it is study the shortcomings of its health system. From the 1961 Royal Commission on Health Services, led by Supreme Court Justice Emmett Hall, through to the 2019 Ontario Premier's Council on Improving Healthcare and Ending Hallway Medicine, headed by Dr. Rueben Devlin, there have been dozens of learned analyses of how medicare could be improved.

There is much to be done, but the recommendations for reform have been remarkably consistent over the decades:

- Bolster primary care to create a strong foundation and a medical home for every Canadian;
- Move health services out of institutions into the community wherever possible;
- Create a coherent human resources plan to ensure care can be delivered when and where it is needed;
- Invest not just in sickness care but in social services that bolster health, things like income supports, affordable housing, and accessible education;
- Expand the services covered by publicly funded insurance beyond hospital and physician services, most notably by providing universal coverage of prescription drugs;
- Place greater emphasis on the quality of care.

These ideas are usually greeted with enthusiasm, but we never quite get around to making the changes, at least not on a large scale. There are excuses, of course, like lack of money, political priorities, fear of public backlash, and the objections of interest groups but, at the end of the day, the failure to move from ideas to implementation and the penchant for short-term thinking are usually blamed on a lack of leadership.

Because of Canada's laggardness, health system reform is more urgent than ever. So it is refreshing to see that we are finally taking healthcare leadership seriously, as evidenced by the embrace of the LEADS framework, which is now the foundation for leadership in 70 per cent of the country's health organizations.

In the first edition of this book, Graham Dickson and Bill Tholl laid out the five domains of the LEADS framework—Lead self, Engage others, Achieve results, Develop coalitions, and Systems transformation—in a manner that made it

compelling and actionable. In this, the second edition, they flesh out what it takes to be a good leader and engage in transformational change, provide some powerful anecdotes of how LEADS can make good leaders better leaders, present a richer evidence base that reflects the increased academic interest in health leadership, and offer some useful comparisons to other jurisdictions. While "patient-centred" and "family-centred" are the buzzwords *du jour*, what those terms mean in practice is brought to life in a series of vignettes peppered throughout the book.

The second edition includes contributions from a number of invited authors, including a powerful chapter on leadership lessons from Indigenous teachings, as well as analysis of how the LEADS philosophy can help promote equity and diversity.

There is a consumer revolution coming to healthcare, along with game-changing technological innovations like artificial intelligence. We can no longer content ourselves with the crisis management approach that has been the norm for so long. In this brave new world, leadership will no longer be about authority and enforcement, but about taking responsibility and having an impact.

Transformational change will require transformational leaders at all levels of the health system, from the bedside to the cabinet table.

The pressures are intense and multifaceted: meeting the ever-growing healthcare needs of an aging population; building and maintaining a health workforce; and bending the cost curve to keep care affordable, individually and collectively. To make matters worse, politicians in Canada have a tendency for micro-managing, instead of getting out of the way and letting professional managers manage.

Yet there continue to be leaders with great potential drawn to public service because they believe in the importance of universal healthcare. The challenges they face—political, social, financial, and practical—cannot be overstated.

One of the invited authors cites the commonly used analogy that Indigenous healthcare transformation is "like driving a bus that's on fire down a road that's in the process of being built." In many ways, that vivid image applies to the health system writ large as well, and the fire will only get more intense as financial constraints increase, and long-overdue structural reforms begin.

Ultimately, healthcare is a people business. The best leaders are those who can communicate and mobilize, and acknowledge that we need the right mix of private and public funding and delivery, and that we obsess too much about the cost and volume of care delivered and too little about value.

We need leaders who can speak those uncomfortable truths to power and who are willing to make the all-important leap from vision to action, and LEADS can help embolden and fortify them.

As Dickson and Tholl state succinctly: "Leadership in health care is about accomplishing three key functions: integrating care for patients and families, creating healthy and productive workplaces and changing the system to respond to environmental pressures and population needs."

And, as the real-life examples presented in the Second Edition attest, good leadership can make an appreciable difference not only to the bottom line but those who ultimately matter most, patients.

André Picard, health columnist, The Globe and Mail.

Preface

Leading healthcare system change is among the most complex, dynamic, and important challenges facing society in 2020. As the co-chairs of two national organizations dedicated to bringing the highest quality of leadership to Canadian health care, we know that the best evidence and knowledge of what good leadership is, and how it works, is a necessary condition for addressing those challenges. Dickson and Tholl demonstrate that a distributed approach or team effort is required, from informal caregivers through front line providers to the C-suite. This book is for everyone who wants to be a better leader and for all of us who are committed to better leadership and followership in the healthcare system.

The 2014 edition of the book introduced us to an easily accessible and memorable common vocabulary of health leadership called LEADS: an acronym for Lead self, Engage others, Achieve results, Develop coalitions, and System transformation. Over the past five years, we have witnessed a growing evolution of health leadership. The 2020 edition chronicles how our knowledge of good leadership has grown and how the LEADS framework, when put into practice, can address modern health leadership challenges. It also explores efforts in other international jurisdictions to use similar frameworks to generate change and purports to learn from their efforts.

The Canadian College of Health Leaders (through LEADS Canada) and the Canadian Health Leadership Network (through its 40+ network partner organizations) have enjoyed a front row seat in this evolution of health leadership. Our two organizations work together to advance leaders and leadership through LEADS. We have been pleased to have been integrally involved in the progression of LEADS and in helping Dickson and Tholl chronicle the many ways that LEADS is being put to work. We believe that the content of this book—and the LEADS framework itself—is vital to the membership of both our organizations. We encourage you to leverage up the LEADS advantage in your leadership practice and strongly endorse the book.

Calgary, AB — Feisal Keshavjee
Halifax, NS — Chris Power
Victoria, BC — Kathy MacNeil

Acknowledgments

Not unlike leading health systems change, writing a collaborative book on health leadership is not for the faint of heart. All the challenges of distributed leadership are at play. Resiliency and mutual respect are required. Clear articulation of individual roles is needed. Expect the unexpected and look to others to help when required. And at the end, in keeping with our car pool metaphor in Chap. 8, give credit to all who helped us get to the destination.

We have been inspired and encouraged by many along the way. We want, first and foremost, to thank our publisher Springer for its support and encouragement from the outset. Springer shared our enthusiasm around the timing for a second edition. Specifically, we are indebted to our editors at Springer (Melissa Morton, Krishnan Srinivasan and Vignesh Iyyadurai Suresh) for their invaluable guidance and ongoing support. Our own editor, the intrepid Jane Coutts, was up to the task of bringing LEADS 2.0 to life and to ensuring that we kept the reader in mind throughout the writing and editing process. She was relentless in her quest for error-free editing and we could not have been better served.

In contrast to LEADS 2014, this second edition focuses on how LEADS is being put to work in practice, both as a talent management and leadership development framework and as a change leadership model. Beginning with the Achieve results domain, we were looking to ensure that we met the twin objectives of writing the second edition of *Bringing Leadership to Life in Health*. The first objective was to assess and evaluate the mass of new research and evidence in support of health leadership as a prerequisite to service integration, organizational health and productivity, and health system change. We set as a goal to only use references published or released after the first edition, except where they are truly seminal. The second objective was to effectively chronicle the many ways in which LEADS had been *put to work* in practice across as broad a range of leadership challenges as possible.

Moving to the Engage others domain of the "E" in LEADS, we want to begin with heartfelt thanks to our respective spouses, Sue Dickson and Paula Tholl. Their patience and unflagging support through the many turns and bumps along the path to publishing is appreciated. We also want to thank our LEADS 2nd Edition Advisory Group for helping frame the overall plan for the book and for helping us settle on the five invited chapters. The group of five included: Kelly Grimes, Brenda Lammi, Dr. Ivy Bourgeault, Sharon Bishop, and Dr. Owen Adams. They also helped us identify and reach out to our invited coauthors for each of the invited chapters:

Stewart Dickson, Dr. Don Philippon, Kelly Grimes, Brenda Lammi, Stevie Colvin, Sharon Bishop, Cathy Cole, Heather Thiessen, Brenda Andreas, Dr. Alika Lafontaine, Caroline Lidstone-Jones, Dr. Elizabeth Hartney, Dr. Karen Lawford, and Dr. John(y) Van Aerde.

We were also committed to identifying those who could bear witness to the various ways that LEADS was being put to practice in the real world of health leader-ship. We were able to identify over 30 mini-case studies or stories and want to thank all those who were able to share their stories to the benefit of others. The list of key informants runs the gamut of health leaders, from deputy ministers and CEOs to mid-level, front-line and informal leaders.

We want to specifically acknowledge and thank all of the following Canadian colleagues: Dr. Arun Garg, Suann Laurent, Dr. Susan Drouin, Dr. Suzanne Squires, Alison Connors, Dr. Peter Vaughn, Lorrie Hamilton, Christine Devine, Amy Porteous, Isabelle Bossé, Hugh MacLeod, Phil Cady, Ellen Melis, Sandra Ramelli, Kathryn Adams, Stephanie Donaldson, Terri Potter, Dr. Gillian Kernaghan, Dr. Carolyn Pullen, Julie Sutherland, Brad Dorohoy, Sheila Betker, Peter Martin, Lauren Ettin, Dr. Karen Cohen, Glenn Brimacombe, Gabriele Cuff, Yabome Gilpin-Jackson, Cam Brine, and Jaci Edgeworth. In terms of our international collaborators, we want to thank Stephen Hart (NHS England), Carolyn MacLeod (NHS Scotland); Desmond Gorman (New Zealand), Don Dunoon, David Sweeney, Dr. Neale Fong, and Dr. Elizabeth Shannon (Australia), and Eric de Roodenbeke (International Hospital Federation).

Turning to the Develop coalitions domain, we also want to thank the two organizations that have, more than any others, helped us to learn from the practical application of LEADS over the past five years. The Executive Director of the Canadian Health Leadership Network (Kelly Grimes), the Vice-President of the Canadian College of Health Leaders and leader in charge of LEADS Canada (Brenda Lammi), and the CEO of the Canadian College of Health Leaders (Alain Doucet) have been incredibly supportive of taking on this project and helping us maintain a focus on the practitioners of health leadership.

In terms of System transformation, the "S" in LEADS, we would like to thank the innumerable LEADS champions in health organizations across Canada and abroad, who have taken LEADS to heart and embedded it in their quest for better leadership. Canada's healthcare system has seen dramatic changes in how it is organized and administered, with a continuation in centralization of accountabilities and authorities at a province-wide level. And, of course, Canada is not alone in witnessing transformational change to healthcare planning and administration; our colleagues in the UK, Australia, and New Zealand join us in the goal of better leadership to serve our populations. We have seen an acceleration in the adoption of accountable health organizations and dramatic developments in our understanding of new technologies and what they can do to improve health leadership, health, and health-care outcomes.

Finally, in terms of the Lead self domain, this is our second major undertaking together as coauthors. We continue to learn from one another and build on our respective experiences in bringing LEADS to life both personally and

professionally. Our friendship and our commitment to advancing the cause of better leadership for healthcare have continued to grow through this demanding and rewarding process.

All that said, and with the help of so many, we realize there is a high likelihood that errors of commission and omission remain, for which we take full responsibility.

February, 2020

Graham Dickson, PhD
Bill Tholl OC, MA

Contents

From Concept to Reality: Putting LEADS to Work

1

Graham Dickson and Bill Tholl

The ***LEADS*** *in a Caring Environment* framework defines health leadership through five domains:

Lead self;
Engage others;
Achieve results;
Develop coalitions; and
Systems transformation.

Leadership is the collective capacity of an individual or group to influence people to work together to achieve a common constructive purpose: the health and wellness of the population we serve.

Dickson and Tholl [1]

Introduction

Our LEADS journey began more than 10 years ago, and more than five years have passed since we published the first edition of this book: *Bringing Leadership to Life in Health: LEADS in a Caring Environment.* Over the past five years, the challenges leaders face have changed markedly in Canada and elsewhere and literature on

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health leadership has exploded; yet the fundamentals of LEADS-based leadership have withstood the tests of change and time. And as we show in the ensuing chapters, the five domains and 20 capabilities of the LEADS framework, which we call the DNA of health leadership, have been reaffirmed in the living labs of health organizations, put to use in ways we could not have imagined back in 2014.

So why write a second edition and how does it differ from the original? First and foremost, we believe leadership is an ongoing, life-long learning process. After five years of watching LEADS evolve, it was time for us to reflect on what we've learned about putting LEADS to work and share it with you. In many ways the evolution of LEADS is a live case study, as you will read in the coming pages.

Another reason for this update on LEADS is that the challenges of leading change in health care are even more daunting in 2020 than they were just five years ago. Ideological, technological and demographic pressures create demand for transformational leadership in all sectors, but it's arguable health care is more vulnerable than any other to the vagaries of political processes. For example, since 2014 we have seen provincial regionalization of health care delivery migrate to larger and larger organizations: Saskatchewan, Nova Scotia and Manitoba all went from multiple smaller health regions to one province-wide system. Services were also centralized in Ontario.

This edition was also a response to an important change we see emerging, as governments increasingly shift their focus to the overall experiences and needs of the people they are intended to serve. People-centred care is a priority in every developed country and appears in every health authority's strategic plan.

In Australia, as part of that agenda, the central government has introduced a national electronic health record scheme and activity-based funding, two changes aimed at triggering broader people-centred health system changes [2]. These include promoting greater integration of services, using technology to improve patient care, promoting patient and community involvement, bringing primary care closer to home and improving mental health care [3].

In the NHS England a significant emphasis has been put on changing entrenched, bureaucratic top-down leadership practices to include distributed leadership approaches that are aimed at creating more compassionate, caring health care workplace cultures in hospitals and primary care trusts; which in turn, serve the public better [4–6]. In NHS Scotland, "health and social care…is transforming to meet the needs of patients and communities" [7].

In Canada, similar rhetoric is used to justify a multiplicity of change demands: electronic medical records, new models of funding, physician engagement, etc. All provincial governments seem to be focusing on developing "closer-to-home" care models, engaging patients, families and communities in the provision of care. But as Aesop said, "When all is said and done, more is said than done." We saw a need to leverage LEADS to move beyond words and take concrete action to put patients and their families first. In this edition we have expressly added patients and informal caregivers into the lineup of health leaders (see Chap. 13 and the self-assessments at the end of each of the domain chapters).

Governments' focus on health care is inevitable: it is *the* big-ticket item in public budgets. Health issues can eat up a lot of political capital in a hurry, as you will see in some of the vignettes featured in this book. As Jeffery Simpson pointed out in his

book *Chronic Condition*: "Medicare is the third rail of Canadian politics. Touch it and you die. Every politician knows this truth" [8].

Then, too, the pace of technological change is unrelenting. Our ability to share health information in a digitized world has increased exponentially, straining individual capacity to process information. And yet the information keeps coming: we are witnessing a revolution in the very nature of medical care and struggling to understand how genomics [9, 10], proteomics [11, 12], artificial intelligence [13, 14], and robotics [15, 16] will change how health care is delivered and at what price. According to a 2015 Canadian task force report on health care innovation: "Precision medicine heralds a new era for diagnosing, treating and preventing disease that will move away from a 'one size fits all' strategy to a more individualized approach based on a patient's genetic makeup" [17]. These breakthroughs and other technological advances are already challenging health leaders ethically, economically and legally as never before.

The shift in demographics that Western nations are going through has long been foreseen, but is none the less challenging. The aging of the population is filling an acute care system built in the 1960s with patients suffering complex co-morbidities [18], necessitating transformation of the system into one geared to the needs of older patients. As Monique Bégin, the former federal health minister who led the charge to pass the Canada Health Act (1984) wrote in her memoir: "Today's (health) system has to rethink and accommodate seniors' needs at home and in various types of institutions that are totally different from hospitals. It has to reform its culture from within and it is not first and foremost more funding that will assist" [19].

The impact of this trifecta of turmoil—ideology, technology and demography—on health leaders makes leveraging LEADS more important than ever for individuals and for the whole system. As the scope, breadth and pace of change accelerate, so does the need for effective leaders at *all* levels.

Another reason to update the book is that since 2014 we have seen exponential growth in the use of LEADS in three ways we had not anticipated. It has become *the* common vocabulary of leadership for much of Canada, been adopted as a common learning platform and is increasingly being used as a model for change leadership. At the same time, academic interest in health leadership and its role in overall system and organizational performance [20] has greatly expanded. As a result, we have a much bigger body of research to draw on and better understanding of potential uses for LEADS we want to share.

Finally, since 2014, we have seen increased evidence, albeit still limited, of the value for money in investing in better leadership development programs and ways to better measure its impact on organizational performance [21–23]. We see, for example, that NHS England has continued to invest significantly in leadership development [24] and NHS Scotland has developed a unique national approach to grow leadership in that country [25]. In Canada an estimated 80% of Canadian health institutions now have a leadership framework in place and 69% of those health care institutions have adopted LEADS as their preferred leadership learning platform [26]. This further attests to the value for money in investing in health leadership. So we see this book as establishing a baseline against which to measure progress over the next five years. We say more about international efforts in Chap. 11.

Bringing Leadership to Life in Health: A Primer on LEADS

The *LEADS in a Caring Environment* capabilities framework defines high-quality, modern health leadership. As we explain in Chap. 3, LEADS is a leadership framework by health, for health. The acronym represents the five domains of leadership:

- **L**ead self;
- **E**ngage others;
- **A**chieve results;
- **D**evelop coalitions; and
- **Sys**tems transformation.

Each of the domains comprises four measurable, observable capabilities of exemplary leadership. We explain each of the five domains in detail in Chaps. 5–9, along with some of the approaches, techniques and tools supporting use of the framework. In this edition we also feature more case studies, stories and vignettes in each of these domain chapters to help you better understand how LEADS capabilities are being put to work in Canada, Australia and the United Kingdom. So, if you're practice-oriented and want to skip the theoretical foundations for leadership and LEADS, we encourage you to jump directly to Chap. 5: Lead self.

If you want to better understand the challenges of leadership in complex systems like health care, how to grow your leadership capacity, and better understand the changing policy environment shaping how LEADS is being deployed, move on with us through Chaps. 1–4.

Putting LEADS to Work: A Retrospective on a New Perspective

When we wrote the first edition, we used the tag line: "A New Perspective." This was because LEADS was a novel concept and was still in the early stages of the standard "introduction, adoption and diffusion" process of change [27]. As we will explain, we are now well into the adoption upswing and, we believe, entering the rapid diffusion phase of putting LEADS to work as a by health, for health framework.

Back in 2014, the health sector in Canada was largely importing leadership concepts and tools from the leadership articles written by business, for business, with few references relative to health care leadership. LEADS was a new and untested concept. The goal was to integrate relevant constructs of business leadership with health care organizations' competency frameworks and describe leadership in the context and language of health care. The initial efforts to create a toolbox to support development of the LEADS capabilities were quite limited and LEADS support systems were only beginning to take shape (see Chaps. 3 and 11).

Use of LEADS and of the tools in its toolbox has grown significantly over the past five years. LEADS has been put to work in all 10 provinces in Canada, is in use in New South Wales and in other parts of Australia and has influenced leadership development in Israel, Belgium and India.

Importantly, LEADS is not only being used for purposes such as self-assessments and 360 assessments or to help focus teams with a common vocabulary of leadership, or to help in developing personal learning plans. Now it's also helping leaders build bridges with boards, as a basis for developing graduate school curricula, as a foundation for engagement surveys in health workplaces, to shape interviews and as a guide to enhancing workplace health. These and other uses are described in the book. There is even, as we detail in Chap. 11, an infrastructure overseen by LEADS Canada to certify LEADS consultants and facilitators who help build LEADS-based leadership capacity across Canada and globally.

This emphasis on LEADS is not to suggest that other countries like England and Scotland should use LEADS; they have national frameworks and leadership talent management initiatives of their own. Certainly, Canada can learn from them as we outline in Chap. 11, and they from Canada. However, for a country beginning that trek, the LEADS journey has important lessons that can help shape its approach.

What has Changed: Key Ideas

This second edition is built around five cross-cutting ideas, outlined here to help you work through the book. They are:

1. The Centrality of Lifelong Learning for Self, Organization and Systems

LEADS is all about lifelong learning. You will never graduate with a LEADS degree as a fully developed leader because getting better is a continuous process. At the same time, the LEADS framework works for people no matter where they are on the ladder of leadership. It encourages you to lead from who you are and where you are. LEADS is not limited to individuals. We see organizational and systems learning as an analogue to personal learning. Peter Senge's work on systems thinking and the learning organization, begun in the 1990s [28, 29], has been widely embraced and the notion of organizations as learning systems has also been applied to health systems. The theme of learning permeates all chapters in this book.

2. Sharing How LEADS has Been Put to Work in Practice

One of the basic differences between this book and the earlier edition is captured by the title of this chapter, "From Concept to Reality." There are over 30 case studies and vignettes in this edition, each with its own set of insights into *Putting LEADS to Work* (our subtitle). They come from leaders throughout health care—patients, providers, policy makers and administrators. This variety of perspectives helps drive home how LEADS has become more than just a useful leadership framework or learning platform and is now also seen as a way to stay grounded professionally and personally. Many people we interviewed for the book referred to "living LEADS" and spoke of trying to model LEADS in the community as well as in the workplace.

Based on the case studies presented here, when LEADS is put to work—as a way of thinking, acting and developing leadership—it enhances people-centred

care and improves overall system performance. We know that without active leadership in turbulent times, complexity can devolve into chaos. It's the job of health care leaders to ensure complex change does not become chaotic but remains focused on improving health and health care for all. In Chaps. 9 and 10 we discuss the limits of linear, reductionist principles of leadership and how we can put LEADS to work to lead change in a sector increasingly characterized by volatility, uncertainty, complexity and ambiguity (known as a VUCA environment). LEADS could almost have been purpose built for the VUCA world of the twenty-first century.

3. Sharing Our Deeper Understanding of Contextual Leadership

All leadership is a function of time, place and circumstance [30]—that's not new. But, as we discuss in depth in the following chapters, every leader works in a different context that demands customized action. We discuss the environmental, structural and personal contexts that shape leadership as they relate to each of the five LEADS domains.

The second dimension of our discussion on context is to compare the use of LEADS in Canada to other countries' leadership frameworks and talent management strategies to explore approaches Canada might learn from. Each country we profile—Australia, the UK (NHS Scotland and NHS England) and New Zealand—has dedicated significant resources to managing leadership talent. They, like Canada, believe their priorities for reform—integrating services, creating healthy workplaces and making structural reforms—will not be realized without better, more sophisticated and distributed leadership.

4. Sharing Different Perspectives on the Caring Ethos of LEADS

Over the past five years, as the challenges of leading in health care have become more complex, LEADS has helped health leaders stay focused on why they chose to work in a caring environment. We have numerous stories in this book about the importance of caring to individual health leaders, and five invited chapters that focus on the topic.

Another aspect of caring is working to ensure equity, diversity and inclusiveness for everyone in the health care system: providers, patients, families and our diverse communities as a whole. The goal is to have enough leaders of different backgrounds in the health system to understand and reflect the broad range of people it serves. LEADS can help with that by enabling leadership that is attentive to equity, diversity and inclusiveness. To guide us in that effort, we invited Dr. Ivy Bourgeault to offer her insights on linking equity, diversity and inclusiveness to the LEADS domains and capabilities [31]. Ivy's perspective is highlighted in each of the five domain chapters.

5. Sharing and Updating Our Curation of Health Leadership Literature

When we began this journey, there was only limited literature on leadership in the social sector overall and virtually none specifically about health care. Today, there is much more peer-reviewed and grey literature [18, 32–35]. Virtually all of

the sources we quote in this edition were published in the past five years, a testament to how our understanding is growing of the critical role leadership plays in health care.

What Hasn't Changed: Enduring Ideas

While much has changed, the core values and beliefs of the LEADS framework remain. This edition, like the original, is still about helping all leaders better themselves and achieve better results by understanding the growing evidence in support of LEADS-based leadership development and talent management. It's based on the premise each of us is a leader and we are all CEOs of self. The book is intended to help you be a better leader, whatever age or stage you're at in your leadership journey and in whatever role you find yourself in health care.

What else remains unchanged? LEADS is still predicated on the belief leaders are both born and made. Everyone is born with some predisposition toward being able to lead and given the opportunity, can develop those innate talents through hard work, learning from experience and reflecting on what they learn. Both books show how through LEADS, you too can become the leader you want to be (Chaps. 4 and 5 are devoted to this theme).

Another returning idea is the fundamental belief that leadership is less a function of the power or authority (what's called hard power) you may have by virtue of your position, and far more a function of your influence inside and outside the formal hierarchy (soft power). In our view, those functions in modern health organizations and systems are threefold: one, to integrate service for patients and families; two, to create healthy and productive workplaces so people can deliver optimal service; and three, to successfully implement desired health reform policies and practices. These functions are, of course, interdependent but it is important to recognize them also as distinct.

Many prevailing ideas of leadership are artifacts from a bygone era when hierarchy, privilege, gender and restricted access to information determined who had power and who did not. To us, someone who uses authority without showing respectful, enabling behaviour may be less powerful than someone in an informal role who treats people with respect and supports their efforts. Barbara Kellerman makes this point eloquently in her book, *The End of Leadership* [36]. In this edition of our book, we recommend the use of self-directed learning tools to help you leverage your influence (see Chap. 4). For on line access to new LEADS-based tools please visit our website at: http://www.leadsglobal.ca/.

One of the most frequently asked questions over the past five years when we were speaking about LEADS was where's the leadership going to come from to transition health care into the twenty-first century? The answer is clear to us: it has to come from all of us. LEADS is designed to help you develop the capabilities you need to do your part to transform health care. Our hope—and the hope for the system—is this edition of LEADS will help you become the best leader you can be, developing your full potential to meet ever-changing leadership challenges.

Summary

Health leadership is vital for achieving the health care we need. Ensuring services are people-centred, creating healthy workplaces where providers can thrive and give their best care and reforming the systems that deliver that care are the job of leadership. All of us—formal and informal leaders, from diverse backgrounds and in different roles—must work together to get that job done. The LEADS framework is a guide to the leadership needed to do it.

Let's now look a little more closely at the inspiration behind LEADS and the phenomenon we call leadership, in Chap. 2.

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Illuminating Leadership and LEADS

2

Graham Dickson, Stewart Dickson, and Bill Tholl

Many people spend time studying the properties of animals, or herbs; how more important it would be to study those of people, with whom we must live or die.

Baltasar Gracian

The Foundations of Modern Leadership

Ancient Greece and Rome are famous for their leaders [1]; Chinese philosophers Lao Tzu, Confucius and Mencius all had thoughts on leadership [2]. Chanakya, an ancient Indian philosopher mused on leadership. Machiavelli's masterpiece of political philosophy *The Prince* is often quoted (rarely flatteringly) [3].[1] Shakespeare's

[1] In an interview with the *New York Times*, Pulitzer Prize–winning author Jared Diamond was asked which book he would require President Obama to read if he could. His answer? Niccoló Machiavelli's *The Prince*, written 500 years ago. He argued that while Machiavelli "is frequently dismissed today as an amoral cynic who supposedly considered the end to justify the means," he is, in fact, "a crystal-clear realist who understands the limits and uses of power."

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plays examine power through the examples of individuals who strive for it [4]. The seventeenth century [5] Spanish philosopher Baltasar Gracián, who wrote this chapter's opening quote, was yet another writer on leadership.

In a rich tradition going back some 2500 years, the leadership styles of people ranging from Roman emperors to Vladimir Lenin, from Mahatma Gandhi to Margaret Thatcher, have been dissected at length. Much of this literature focuses on the "great man" model of leadership, where character is destiny [6].

However, such accounts fail to recognize the collective leadership of the many. In *War and Peace* Leo Tolstoy argued leadership from the unnamed masses was the engine of success, pointing out that historians give Napoleon credit for the success of the French army in Russia, but in reality, it was commanders and front-line soldiers who exercised the leadership needed to defeat the Russian army. Tolstoy captured that in this amusing vignette of the morning of a great battle:

> *Napoleon wakes up early on a misty summer morning and stands outside his tent, surveying the placement of his armies in the valley below. To his surprise, he sees a Russian regiment moving to flank a division of French troops. He immediately calls a senior general to his side, telling him to get on his horse and ride out to alert the French commander in the field of this maneuver. The general snaps a salute, saying "Of course, my emperor," and runs off to his horse. He quickly realizes the risks of carrying out the order: he could easily be shot delivering the message. So he grabs a bottle of wine and some baguettes, and heads out into the forest for a picnic. Two hours later, having rubbed dust and grime into his uniform, he rides his horse back into camp and says to Napoleon, "Message delivered, Sir!" In the meantime, the French commander in the field, having received intelligence from his sentries, responds to the Russian threat and defeats them as per Napoleon's plans* [7].

After thousands of years of contemplation and writing, there are numerous theories to explain leadership and how it works (see Appendix). Dinh and colleagues [8] described a number of these, including these traditional approaches:

- Trait theory seeks to identify the character traits of a successful leader.
- Behavioural theory posits that it's a leader's behaviour that allows him or her to be successful.
- Situational theory suggests the effectiveness of a leadership style depends on the goals of the organization at the time as well as the nature of the task presented to the leader.

Contextual leadership theories are similar to situational, describing leadership effectiveness as a function of how a leader's behaviour interacts with context. Some newer ideas academics are exploring include: authentic leadership, servant leadership, substitutes for leadership, spirituality and leadership, cross-cultural leadership, complexity leadership, abusive/toxic leadership, change leadership and e-leadership.

Work on LEADS has been informed by an awareness of all these theories and it's perhaps not surprising that since the first edition was released, we've often been told there's nothing fundamentally new about the LEADS framework: "I've heard this all before." Our response has been relief—we'd be concerned if something fundamental was missing. How those multiple theories of leadership come together in a

modern, public service-oriented health system has been our first concern as we researched and defined how leadership is understood and put to work in practice through the LEADS framework.

This chapter reviews the understanding of leadership that underpins the LEADS framework and explores various contexts that shape our concept and definition of leadership and generate some of the philosophy behind the LEADS framework. We also use those concepts to define modern health leadership, the definition that gave rise to LEADS.

The Foundations of Leadership

Leadership has been likened to a fog: you can see it and feel it, but you can't grab hold of it. But if we can see it and feel it, why can't we define it? And if we can't define it, how can we possibly develop it?

Simpson and Jackson in their book *Teacher as Philosopher* [9] suggest one way of understanding the implicit meaning of a word is to examine its use in conventional talk, the day-to-day discourse of society. By looking at references to leaders and leadership in advertising slogans we get a sense of its meaning in private-sector discourse. Table 2.1 gives some examples:

Table 2.1 References to leaders and leadership in advertising slogans

Advertiser	Statement	Implied meaning
Cadillac	*The Penalty of Leadership; The Mark of Leadership* (one of the most famous print ads of all time, written in 1915)	Cadillac is the finest vehicle in the automotive world. As a consequence, Cadillac must deal with the pressure of expectations and the potential mean-spirited whispers from those who cannot measure up.
ESPN	*The World-Wide Leader in Sports*	ESPN is the most comprehensive, most polished, and most knowledgeable sports entertainment company. They are the experts.
Seiko Watch Company	*At the Leading Edge of Time*	Seiko is first in the field; its advancements are unequalled. The ad plays on the split-second requirements of competitive sport.
Toshiba	*Leading Innovation*	Toshiba is in the forefront of innovation, and sets standards others should aspire to.
SpecGrade LED	*Sustainable lighting leading the way in the fight against global poverty*	SpecGrade is helping community residents to reverse the cycles of poverty by providing low-cost sustainable lighting products. It sees what other manufacturers have not seen: the potential for using lighting to solve social issues.
Mercedes Benz	*Mercedes Benz Leadership goes beyond just staying ahead*	Mercedes Benz is visionary; not complacent. It's pushing boundaries.
Shell Ultra Helix	*Shell Ultra Helix is leading the way for a new standard in motor oil protection*	Hard working company at the cutting edge is producing new products meeting the highest standards of safety.

The ads are trading on several conventional beliefs about leaders and leadership:

1. *Leaders go first:* People who lead enter new territory—sometimes of thought, sometimes of action. They face challenges or uncertainties and take the initiative to address them.
2. *Leaders face uncertainty and danger:* Exercising initiative means taking risks; leaders have the courage to face them, and confidence in their ability to overcome them.
3. *Leaders have vision and can communicate it compellingly:* Leaders see things others don't, have information or understanding others lack and can engage people in sharing a vision.
4. *Leaders are capable and credible:* Leaders have substance and focus; they know their business and personify quality.
5. *Leaders innovate to provide service to clients:* Leaders are creative and find new solutions to old problems.
6. *Leaders have followers:* Leaders differentiate themselves from others and attract followers who share a willingness to shoulder the risk, initiate action or find a solution.

Learning Moment

Sometimes taking a risk is as simple as risking discomfort in changing one's own behaviour.

At one point one of your co-authors, Graham, was asked by a senior official of British Columbia's Ministry of Education to be its official representative to the BC Federation of Labour, the BC Business Council, and the BC Chamber of Commerce. I was flattered as the government of the time was promoting workplace learning and I was to facilitate their support for a new skills policy for Kindergarten—Grade 12 education.

I went back to my office and did my usual: read papers, researched what each of these organizations did, and planned what I would say when they approached me. I worked out strategies for engagement. However, after 2 weeks, no one from any of the organizations had contacted me or even acknowledged my new role.

"Sam," I said to the man who appointed me, "I don't think this is going to work. It's two weeks since you appointed me to this role and not one person has bothered to pick up the phone and call me." Sam looked at me over his glasses, took them off his head and waggled them at me. "Graham," he said, "Leaders cross the street first."

That was a blinding glimpse of the obvious: rather than reaching out to them I had waited for them to come to me. Given I am an introvert at heart I simply indulged my comfort zone. Taking a risk—in this case—was simply reaching out to make contact.

Reflective Questions
- Do you have default attitudes and behaviour? What are they?
- How do they limit your ability to respond to some leadership challenges?
- Can you think of some current situations where changing an aspect of your habitual behaviour might lead to a resolution?

Looking at how words are used in private-sector advertising doesn't capture every aspect of leadership and leaders; there are some different expectations and realities in public-sector leadership. Because Canada and other developed countries are multi-cultural societies, we looked at the use of the word *leadership* as it pertains to public service in a variety of cultures [10].

There are few accessible records of Canada's Indigenous peoples using the term leadership (in a literal translation), but the concept of leadership is well established. Popularly the notion of a leader is closely tied to that of an elder, someone whose wisdom about spirituality, culture and life is recognized and affirmed by the community [11]. Not all elders are old; sometimes the Creator chooses to imbue a young person with the wisdom of an elder. First Nations communities will normally seek the advice and assistance of elders on a wide range of issues. (We explore Indigenous health leadership in detail in Chap. 14.)

On the west coast of British Columbia, home to the Nisga'a peoples, formal leadership was traditionally held by a hereditary chief, or *Sim'oogit*. This position was passed on through matrilineal succession. From birth, future hereditary chiefs were taught leadership qualities, which were honour (personal integrity), respect (esteem for, or a sense of the worth or excellence of something), and compassion (tenderness, a desire to alleviate suffering). A *Sim'oogit* would also wear a headdress during sacred ceremonies as a reminder to "move with caution and purpose as [they] are a leader" [12]. It is interesting to note that in Nisga'a, the word to lead or chair an event is *diyee*, which captures the idea of guiding, or giving direction.

In Australia, Aboriginal and Torres Strait Islander peoples have different values and criteria for leadership than wider Australian society [13]. There are no words in the native language directly translatable to the English word, but their notions of governance speak to it: a leader is someone to whom other people listen, a person who can create consensus. Leadership is only conferred conditionally and has to be constantly earned. Leadership is also seen *as a process* rather than a position, with the leader on the same plane as those who confer authority on him or her through consensus.

In Hindi, the word for leadership is *netrtva*, pronounced *neh-tu*. It means to guide and exercise initiative. In Punjabi, the word leadership itself is used, direct from English. However, *pardhaan* is the word for leader in a temple. A *pardhaan* leads people in prayer and performs temple duties. Also, in Punjabi, a leader can be called a *surpanch*, which is an elected leader of a village. In traditional Chinese the

characters for leadership are: 領導 [pronounced *ling dao*] meaning to direct, to shepherd and to guide. By putting a scroll with this word on the wall of your home, or office you are suggesting you are deliberately honing your leadership skills or hold a position of leadership.

In German, the word for leader is *fuhrer,* synonymous with guide, operator and pilot. In Italian, the word for leader is *capo* (from the Latin word *capit*, meaning head, also the root of the English word captain). The Italian word for leadership, *direzione*, is synonymous with giving direction and guidance, as well as management. In France, the word for leader is *chef*—meaning boss, overseer or superintendent.

It's notable that these multicultural examples capture the importance of guiding and offering wisdom—harkening to the type of leadership people want in a public-service context. They suggest a widespread foundation for Richard Lewis's contention "each society breeds the type of leader it wants, and expects him or her to keep to the path their age-old cultural habits have chosen" [14].

Other key ideas of leadership found in various cultures are:

1. *Service to the people:* In Nisga'a heritage, leaders alleviate suffering. In the indigenous cultures of Australia, leaders listen to the people. Captains and pilots guide others safely on journeys. Implicit in all is the ideal of compassionate, just, and fair service on behalf of others.
2. *Leaders are expected to have moral character:* Leadership qualities are described in terms of honour, respect, compassion, righteous self-esteem and a hard-working character.
3. *Leadership can be developed:* Young Nisga'a future leaders are taught leadership qualities from birth.
4. *Leaders have wisdom:* Implicit in the culture of First Nations is the belief in leading from a place of wisdom: that is, depth of understanding and humanness based on spirituality, culture and life, as affirmed by the community.
5. *Leaders are resilient:* Successful public-service leaders experience sudden shifts in political ideology. Having the inner strength to snap back from inevitable setbacks in advancing service to the public is essential.

Comparing public-service and private-sector concepts of leadership shows they share some attributes but differ on others. Both public- and private-sector leadership link to notions of initiative, foresight, excellence and professionalism, but the public sector definition of leadership does not include the element of risk that characterizes entrepreneurship valued in the private sector.

One other trend is obvious as well: in public-service leadership, the assumption that leadership qualities are genetic and passed on from one generation to the next has faded. For the most part, leaders must establish their own

credentials, are elected to (or selected for) positions based on their ability to lead effectively and are held accountable—formally and informally. In today's world of instant social media judgment and feedback, leaders can be constantly under attack for perceived flaws—while people who are not in positions of power but possess natural leadership talent can exert enormous influence, enough sometimes that if a leader is ineffective, someone else will quickly be identified to do the job.

Let's look at how context can affect leadership.

Leadership and Context

Regardless of who a leader is, what will work is not only a function of their leadership behaviour, but also of situation, time, and circumstance. A leader's choice of self-, interpersonal or strategic leadership is not just a function of how he or she acts, but also the degree to which s/he interacts with the context in which the action is done. Recent theories of leadership increasingly focus on context as an important factor in leader effectiveness [15, 16].

Formal health leaders work in large, multi-level organizations or in some cases, larger systems (nation-wide, state-wide, or region-wide amalgams of organizations working together to create health and wellness). Different contexts demand a suite of different leadership actions and styles, customized to the unique situation and particular organization.

Context has two dimensions. The first is the structural context—the organization's design, size, scope, the leader's breadth of responsibility and role, time constraints. Barak Oc states "…characteristics of the task, team, organization, and social network as well as physical distance and time pressure play an important role in shaping the leadership outcomes, more so than the leadership process itself" [15, 16]. Health care leaders, then, must strive to know the multiple contexts in which a decision is made, and its potential impact on both individual contexts and the organization as a whole.

The second dimension of context is people—their emotion, energy, politics, team chemistry and organizational culture and climate. To address this dynamic Tse and colleagues [17] attempted to integrate how feelings and emotions of leaders and followers interact with people factors at five levels: self; between persons; interpersonal; team; and organizational levels. In our research [18], we learned health care leaders should constantly assess their own feelings and emotions, their impact on people with similar levels of responsibility, and on those with different levels of responsibility, on teams and on the organizational climate overall. Better strategic decisions result when leaders are armed with that information.

Let's look now at multiple aspects of context that will shape our definition of modern health leadership.

The Democratic Context

The context of modern democracy demands leadership that is exercised in a different way than it was thousands or even dozens of years ago. Below are some aspects of modern democracy that influence what kind of leadership is most likely to succeed:

- *A highly educated population:* Canada, the United Kingdom and Australia—like most developed nations—have the most educated populace they have ever had. Educated people want to exercise critical thinking, debate issues and use knowledge and evidence to make decisions.
- *The knowledge explosion:* Knowledge is growing at an exponential rate. Leaders don't need to search for knowledge, their task is to assess its truth, relevance and meaning.
- *Professionalism and expertise:* Leaders need to recognize the challenge of professionalism, which gives preferential credibility to a group's expertise and inclines members to be more influenced by their peers than their leaders.
- *Gender and cultural equity:* Women, as the #MeToo movement shows, are demanding the patriarchal power traditionally wielded by males be dismantled and replaced by leadership that is more caring. Indeed, we are now seeing a stepped-up effort initiated by the United Nations to engage more actively with the #HeForShe movement, enjoining men to not just be better mentors for women but also sponsors. Similarly, societies that might earlier have been ethnically monochrome are benefitting from a multiplicity of different cultures and traditions. The involvement of people from all cultures in leadership is vital to modern societies.
- *The revolution in communication technology:* In 2014, we wrote that we live in what Thomas Friedman calls a flatter, faster world, where information is almost universally available [19]. That's even more true today, as the explosion in social media use and the advent of bots sends information travelling at warp speed. Evidence suggests "when you are exposed to a given piece of information multiple times, your chances of adopting this information increase every time" [20].
- *Choice, customization and increased expectations:* There has been a dramatic growth in the choice of treatments in health care. Technological advancements and artificial or augmented intelligence (AI) make it possible to customize care, while public demand has complicated the choices health care leaders face and makes their decisions staggeringly more complex.

- *Economic capacity:* Since 2013, governments in Canada and abroad have been much more preoccupied with "bending the cost curve" of health care spending. Even though economic capacity has been marked by the longest bull market in decades and sustained growth from 2011 to time of publishing, stringent controls on health care expenditures have been maintained [21].
- *Politics of approval:* For two decades, reality shows have dominated prime-time television. One pundit has said we're so good at portraying reality on TV that audiences are hungering for "authentic" reality from their leaders.

These and other factors are why leadership is as stimulating as it is challenging, and different every day. Just as we explored tenets of leadership from a macro perspective to better understand the impact of culture and context, it's important to consider the micro level as well: the organization you work in.

The Organizational Context: Leadership and Culture

Do our large and growing health delivery organizations have cultures that de-emphasize leadership and accept compliance? Max Shkud and Bill Veltrop, change architects and authors, contend that a major problem that organizations face today "is the widening gap between their existing leadership capacity and the exploding demands of our increasingly complex and rapidly changing world. To return to the computer metaphor, the 'old leadership operating system' is no longer able to keep up—to respond with sufficient agility and intelligence to the growing barrage of challenges and opportunities in the environment" [22].

Shkud and Veltrop have classified organizational culture based on the degree to which leaders and others distribute the qualities of leadership throughout the organization's culture (see Fig. 2.1). The resilience scale on the right hand of Fig. 2.1 suggests that as you move from toxic organizational cultures to generative cultures, your resilience as individuals and organizations increases. In a volatile, uncertain, complex and ambiguous (VUCA) environment, the need for high levels of resilience is heightened.

Edgar Schein, an organizational development guru from MIT, defines culture as "a pattern of basic assumptions invented, discovered, or developed by a given group as it learns to cope with its problems of external adaptation and internal integration…," or more simply, culture is "the way we do things around here" [23].

The primary determinant of an organization's culture is the formal leader's influence on it [24]. A recent study found evidence that autocratic leadership at high levels in organizations makes it more likely managers further down in the hierarchy will behave similarly [25].