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

A New Perspective

Graham Dickson
Bill Tholl

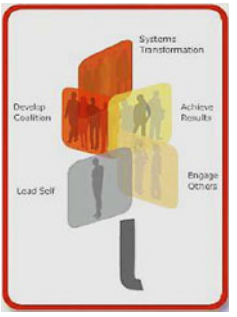
Springer

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

Graham Dickson • Bill Tholl

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

A New Perspective



Springer

Graham Dickson, PhD
Royal Roads University
Victoria
British Columbia
Canada

Bill Tholl, MA, ICDD
Canadian Health Leadership Network
Ottawa
Ontario
Canada

ISBN 978-1-4471-4874-6 ISBN 978-1-4471-4875-3 (eBook)
DOI 10.1007/978-1-4471-4875-3
Springer London Heidelberg New York Dordrecht

Library of Congress Control Number: 2014930009

Printed on acid-free paper

Springer is part of Springer Science+Business Media (www.springer.com)

Leadership

Effective leadership is required in all facets of society. Countries need it. Businesses need it. Public institutions need it. Health care really needs it!

What does it mean to be an effective leader? There is no one-size-fits-all definition, but there are some common elements. These would include intelligence, energy, drive, vision, communication skills, steadiness of purpose and an understanding of context; and in health care, a commitment to universal care. So how does a health leader give voice to these qualities? This book provides an answer.

In government, there is a brutal test of leadership: winning or losing elections. In business, the test over time is the bottom line. But what about the public sector? Leadership is obviously required in the public sector, but what is the test of its effectiveness? And what tools would a leader in the public sector have at his or her disposal to drive change with so many obstacles at every turn?

Seventy per cent of Canada's health-care funds are spent in the public sector, so health-care qualifies as a public program. Moreover, Canadians tell pollster after pollster that it is their most important public program, even to the point of defining who they are as a people. Running a health-care program is hard enough; running an icon is even harder.

Graham Dickson and Bill Tholl bring their wisdom and experience to bear in this book for health-care leaders. It is a welcome book, because they have studied the health-care field in various capacities and therefore understand what it takes to be an effective leader in this field.

As always, it is easier to talk about leadership than do it. For starters, health-care is highly political, as one would expect for a high-profile public service that touches so many people in a given year. Health-care leaders therefore make what they might consider to be straightforward, rational, resource-allocation decisions only to find them contested in the community or, more ominously, on the floor of the provincial legislature. Lurking around the corner from some decisions are newspaper headlines, usually about something gone awry.

Then there are the internal forces at work. Provider groups – doctors associations, nurses and other unions – patient advocacy groups, hospital or regional health authority boards all have their preoccupations and in some cases collective

bargaining agreements. With these agreements come strict rules of work, grievance procedures, legal guarantees, all leading to rigidities that make the health-care system exceptionally hard to change.

And then there is the sheer complexity of the system. A hospital is itself a wondrously complicated institution, but it is only one part of a wider and still more complicated system. Trying to move one part of this complicated system usually means bumping into another part, and another, and so on. Think of a jigsaw puzzle with all its rounded parts. Move one piece and it touches three or four others. So it is with the health-care system.

There is also the matter of accountability. If things go wrong in the health-care system – or if tens of billions of dollars have been spent without corresponding improvements to the system, as has occurred in Canada – who is responsible? Everyone, which means essentially, no one.

It is the job of leadership to address these concerns. Good leadership is foundational. The Health Council of Canada, in one of its last reports, underscored the failure of the health-care system to improve much despite all the billions poured into it. Trying to figure out a better way forward, the Council seized upon something much discussed in the United States: the Triple Aim framework for health-care, with Leadership at the top of the four priorities.

The Council said, in words that echo themes in this book, "We view leadership as the foundation for the other key enablers because it supports and provides momentum to move actions towards attaining health system goals. Leaders recognize and manage change, define roles, encourage collaboration, build consensus, provide vision, align goals and activities, and measure performance. Leadership needs to be continual, dynamic, and responsive to changing needs."

Dickson and Tholl describe how to deliver this leadership. They offer a clever acronym: LEADS. Taking the letters in order, it means Lead Self, Engage Others, Achieve Results, Develop Coalitions and Systems Transformation. Well put, but easier to itemize than accomplish, which is what the rest of this book is about. The authors get the context right: the years of easing leadership choices through injections of large additional amounts of public cash are over. For the foreseeable future, health-care leaders will be operating within what the authors correctly say will be "increasingly strained budgets." The need for better results – improved patient outcomes, more timely access and staff satisfaction – will require outstanding leadership. Good leadership won't cut it; something even better will be required under these trying circumstances. Read on to gain insight into what that outstanding leadership will entail.

Jeffrey Simpson

Preface

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.

This book grew out of our sense there has been a lack of support for developing and supporting health leadership. That's perhaps not surprising; leadership in health is often taken for granted, based on an implicit assumption that the competencies that make good leaders in the for-profit world can be imported wholesale to the complex world of health care. We don't think that assumption holds true.

Health care is one of the most complex social enterprises in society. It is, as we reflect in our title, a caring environment. Its mandate first and foremost is to look after the vulnerable, whether they are patients, or the people who love them, or citizens from every sector of society. To offer that care takes a system of staggering complexity: so many professions, thousands of organizations, myriad treatments, a constant stream of new technology, a political profile, the pull of tradition and the pressure of limited financing. And over it all, health care's place as a social good is to be protected and advanced. Clearly, the standard twentieth century business model of leadership will not do.

There are many ways in which LEADS deviates from that model, but two stand out: we don't think leadership is an inborn gift—rather, it is an ability to be acquired. And, equally important, we don't subscribe to the idea of hero-leader, the one person at the top of a hierarchy who works alone to take his followers to new heights. Leadership is not the sole prerogative of senior executives. Leaders can be and are found everywhere throughout the system, because leadership is a function of time, place and circumstance. LEADS is a framework for learning what's needed to be an effective leader. It can benefit everyone who finds him or herself working toward a goal. Each of us can be a "CEO of self," taking charge of our ability to influence others toward a common, constructive purpose.

The increasing speed and complexity of change in healthcare puts a greater premium on each of us learning the capabilities of what's known as complex adaptive leadership [1]. This conception of leadership, which influenced the development of

LEADS, is decentralized—that is, teams and individuals share responsibility for leadership in different ways at different times. It is suited to health care because it is flexible and responsive to challenges as they emerge and evolve. Many traditional aspects of leadership are part of it, but complex adaptive leadership adds to them, ultimately giving people the ability to adapt their actions to the emerging dynamics of complexity.

This book is about developing the tools to do that. The *LEADS in a Caring Environment Framework* was designed to show both formal and informal leaders the capabilities they need to meet challenges and bring about change for the better in their health care setting—practice, unit, organization or system. You'll read about the five domains of health leadership—how to Lead self, Engage others, Achieve results, Develop Coalitions and bring about Systems transformation.

But this is not a textbook. It tells stories—real stories—of people like you, at various stages of their career, trying hard to serve patients well. The stories are followed by opportunities to reflect on your own experiences—a powerful way to learn. You can do the exercises in the abstract, or apply them day to day as issues arise. You can return to the framework again and again, for a quick refresher or ongoing guidance.

The LEADS framework is a shared effort, developed in a spirit of "leadership without ownership" with the Canadian College of Health Leaders, the Canadian Health Leadership Network, Royal Roads University and many individuals. It was not about getting credit for good ideas, or advancing our own agendas. The goal was to establish that leadership in health is everybody's business. And, just as all of us working in the system have a leadership role within our sphere of influence, we feel no one organization or profession owns leadership. That's why more than 40 health organizations formed the Canadian Health Leadership Network and endorsed LEADS. It's why some aspects of LEADS have been influential in Australia and why we are working with partners in other countries to take LEADS concepts abroad.

We want to conclude by saying we also see this book as a call to action. The evidence is clear: better leadership is the source code for better health. Canada cannot wait for the leadership talent it needs to reform health care and ensure its sustainability for coming generations. It needs leaders now. LEADS can help train them, but we must be open about what the system needs and how to accomplish it. Patients and providers must accept the need for change; governments need to move away from short-term action and develop far-sighted policies. It's time for a national discussion about leading change to create the health system of the future we all want—and the leadership to do so: LEADS.

Victoria, BC, Canada — Graham Dickson, PhD
Ottawa, ON, Canada — Bill Tholl, MA, ICDD

Reference

LaRue S. Adaptive leadership theory: leading and following as a complex adaptive process. Res Organisational Behav. 2011:31:125–50; And Obolensky, Nick. (© 2010). *Complex adaptive leadership: embracing paradox and uncertainty*. [Books24x7 version] Available from http://common.books24x7.com.ezproxy.royalroads.ca/toc.aspx?bookid=3745.

Appreciation and Acknowledgements

The development of *Bringing Leadership to Life in Health*: *A LEADS Perspective* has been a work both of passion and science. It has been a ten year journey of research, reading, analysis, and dialogue with hundreds of Canadian and international health leaders.It builds on more than 35 years of experience in senior health leadership positions. We have been inspired and encouraged by many along the way.In many ways, this book reflects an application of LEADS itself.

It required, first and foremost, an unrelenting focus on *Achieving results*: pulling a manuscript together to take advantage of the opportunity presented by Springer Publishing.We needed to stay focussed on producing a reliable and readable book for you, the reader. We want to sincerely thank our publishers and, in particular, our editorsT. Dudley, J.Megginson and S.Suganya for all their efforts to bring LEADS to life.

The *Engage others* domain reminds us that relationships are key to a leader's success. Particularly, we would like to thank our wives, Sue Dickson and Paula Tholl, who have provided invaluable advice and support along the publishing pathway.

Other relationships contributed to ensuring that the LEADS leadership lessons were as clear, concise and compelling as they could be.Leadership in health is an expansive and growing area of interest. It would be impossible for any two individuals to capture the watershed of wisdom.

The inner circle, acore team that became even more engaged than we could have hoped for, included: Lynda Becker, Nikki Lineham, Paul and Lou Douillard, Stu Dickson, and Kelly Grimes.Our own intrepid editor, Jane Coutts, deserves particular thanks.She demonstrated immense patience and perseverance in helping us stay on point; to speak with one voice; and to keep the concept of shared leadership as a driving force of the book.

We benefitted from an extended team of wise Canadians who took the time to carefully read and comment on early versions of chapters or sections of the book. We also want to thank the original research teamand other co-authors of the original LEADS booklets (LEADS 1.0);: Shauna Fenwick, Zoe MacLeod, Guy Naismyth, Lorna Romilly, Don Briscoe, Paul Mohapel; Debbie Payne, Monique Cikaliuk; and

Ron Lindstrom. Other LEADS champions from Canada who were instrumental in giving encouragement and support for this book, include:Peter Norman, Leo-Paul Landry, Judith Oulton, SholomGlouberman, Sharon Sholtzberg-Gray, Owen Adams, Joe Chouinard, Jim Niningerand Lynda Becker.

Internationally, from the United Kingdom our collaborators included:Chris Ham, John Clark and VijayaNath.They helped us to take a snapshot of the rapidly changing leadership landscape in England. From Australia, we want to thank Andi Sebastian and Etienne Scheepers for their insights into the exiting, fast moving achievements of Health Workforce Australia; and Heather Gray, Gaynor Heading, Don Dunoon, David Sweeney and Sheree Patterson from the Health Education and Training Institute in New South Wales.

Turning to the *Develop coalitions* domain, LEADS would not have been possible had it not been for carpooling or the sharing of organizational support, both financial and in-kind.In terms of organizational support and encouragement, the LEADS journey began and continues to take us back to Royal Roads University; a university with a difference and a deep commitment to a better understanding of the discipline of leadership as it applies to health and other arenas of building a better Canada.

Without the support, both financial and otherwise from the Government of British Columbia, channelled to RRU and the Centre for Health Leadership and Research, LEADS would not have received the jump start it needed.Two people deserve specific credit in this regard:Dr. Penny Ballem, the then Deputy Minister of Health and Mr. Geoff Rowlands a former Assistant Deputy Minister and subsequently the Chief Executive of Health Care Leaders British Columbia. Their vision, leadership and commitment, backed up by action, wascritical to launching the LEADS journey.

In the latter stages of writing the book, we have benefitted from the ongoing support and encouragement of both the Canadian College or Health Leaders and the Canadian Health Leadership Network, of which the College is a founding partner. Specifically, we want to thank Mr. Ray Racette, the CEO of CCHL and the co-chairs of CHLNet:Dr. Don Philippon and Elma Heidemann (founding) and Dr. Brian O'Rourke and Hugh McLeod (current).They could not have been more encouraging.All read earlier parts of the book and continued to give us the time and the opportunity to chronicle the LEADS story.

We conclude that leadership is the key enabler or "source code" for successful *System transformation*, a fourth LEADS domain.As this book demonstrates, health systems are among the most important, challenging and complex systems. The writing of this book is akin to changing tires on not just any car...but a race car.Canada's health system is undergoing many transformational changes within our unique political, social and economic imperatives of 2013.Both the National Health Service (England) and Health Workforce Australia are also engaged in large scale leadership change.Indeed, it was extraordinarily difficult to decide exactly when to put the book "to bed", as each day presented new insights and developments into the world of leadership in health.But, as they say there is nothing that concentrates the mind better than the prospect of a publication deadline!

Finally, the *Lead self* domain. This is the first major publication work for both of us and we have learned a great deal about ourselves, especially our own leadership strengths and limitations. We have also witnessed the challenges and benefits of a binocular view of the world. Our friendship and commitment to leadership have only grown as a result.

Despite all the insights and encouragementfrom so many, we are only too aware that there may be remaining errors of both commission and omission, for which we take all responsibility.

December, 2013

Graham Dickson, PhD
Bill Tholl, MA, ICDD

Contents

Chapter 1
LEADS: A New Perspective on Leadership in Health

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

Lead Self;
Engage Others;
Achieve Results;
Develop Coalitions; and
Systems Transformation.

Health leaders of the 21st century will need to have the capacity to see the future faster, to manage and mentor talent better, and to service growing health needs within increasingly restrained budgets.

–Ray Racette

Introduction

Never have the challenges of leading change in health and health care been more daunting. The need for change creates demand for transformational leadership and therefore LEADS.

Health care, which has undergone great upheavals in recent decades, is headed for yet more change. We live in a faster, flatter society [1] where our ability to share health information in a digitized world has increased by approximately *ten million times* since the late 1960s, with a commensurate demand on our individual capacity to process this information [2]. The tectonic forces of technology and demography, combined with the emergence of a consumerist attitude in patients are changing the landscape for the practice of leadership. As the scope, breadth and pace of change accelerate, so does the need for effective leaders at *all* levels of the system.

G. Dickson, B. Tholl, *Bringing Leadership to Life in Health: LEADS in a Caring Environment*, DOI 10.1007/978-1-4471-4875-3_1, © Springer-Verlag London 2014

We define leadership as "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." See leadership as a process, not a position. It can therefore come from anyone at any time. In health care, it could be from patients, providers at every level, politicians, or the public. What makes a person a leader is the ability to combine a commitment to improve with the knowledge of how to exercise influence and engage support.

This book is about developing the tools to be a better leader. The *LEADS in a Caring Environment Framework* was designed to show both formal and informal leaders the capabilities they need to meet challenges and bring about change for the better in their health care setting—practice, unit, organization or system. You'll read about the five domains of health leadership—how to Lead self, Engage others, Achieve results, Develop Coalitions and bring about Systems transformation (the source of our acronym, LEADS).

We don't think leadership is an inborn gift. We believe very strongly that it is an ability to be acquired. We see LEADS as a whetstone that can be used to hone what you have gained by instinct, education and experience into truly effective leadership. And that honing is important: better leadership is increasingly seen as critical for improving system performance and dealing with twenty-first century health care. Randal Ford, director of organizational development for Spartanburg Regional Healthcare in South Carolina, says "future leaders in health care will require different competencies than in the past" [3].

The increased speed and turbulent nature of change puts a greater premium on learning the capabilities of what's known as complex adaptive leadership [4, 5]. This form of leadership is patient-centred, decentralized and shared by both teams and individuals in different roles. It's also flexible and responsive to emerging challenges. Many traditional approaches to exercising leadership are part of it, but complex adaptive leadership adds to them.

Bringing Leadership to Life: A Primer on LEADS

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

Lead Self;
Engage Others;
Achieve Results;
Develop Coalitions; and
Systems Transformation.

Each of the domains is composed of four measurable, observable capabilities of exemplary leadership. We explain each of the five domains in Chaps. 5, 6, 7, 8, and 9, along with some of the approaches, techniques and tools that support use of the framework. 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 explore the issue of leadership more fully, move on with us through Chap. 1 as we focus on the dramatic changes that have created the need for a shared leadership operating system. In Chap. 2, we provide an in-depth exploration of the concept of leadership, in particular as a social good. Chapter 3 provides information about the validity of LEADS, its research foundation, and its evolution as a learning platform for individuals and organizations in health care. Chapter 4 outlines how to learn leadership over your lifetime. We conclude by explaining how LEADS can also serve as a model of change adding to, rather than competing with, existing models (Chap. 10), and finally where we think LEADS and leadership development are going in the next few years (Chap. 11).

Better Leadership, Better Health: The LEADS Approach

What's required to nurture better leaders? What do we know about leadership and learning that can be used to ensure individuals who try LEADS can grow and develop its capabilities? The answer to those questions and the driving force behind the LEADS framework lies in the emerging discipline of leadership and leadership development.

The discipline of leadership in a health context needs to be acknowledged as distinct from other sectors. It also needs to be better understood. What are the core capabilities that make for better health leaders, and how do they stack up against the core competencies of good management? What distinguishes competencies from capabilities when it comes to leadership? How does leadership have to adapt for the increasingly complex world of health care as a social enterprise?

The discipline of leadership development also needs to be well understood. How can I become a better leader or how can I be a better mentor for emerging leaders? Do I have to take a leadership course, or can I learn on the job? What tools, techniques and approaches will help me grow and develop? We address these questions in Chap. 4 and in Chaps. 5, 6, 7, 8, 9, and 10 with "Learning Moments," designed to stimulate your own growth with regard to LEADS.

The literature on leadership tells us, better leaders and better leadership go together, but they are not the same thing. All leadership is a function of time, place and circumstance [6] so a leadership framework must be adaptable to different situations and responsive to the uniqueness of your needs. It also must allow for customization to reflect the unique qualities that distinguish us as individuals.

As you will see in Chap. 4, and in subsequent chapters, LEADS acts as a common language for leadership; but how that language plays out in the unique

behaviour of each individual depends on their individual strengths, and how each brings forward the behaviour needed in a particular situation and circumstance. At the end of each of the core chapter (Chaps. 5, 6, 7, 8, and 9) you will find a self-assessment tool to allow you to personalize your learning needs.

LEADS is designed to suit the context of social good and a caring culture that is the Canadian health care system. That context is described in the next section.

Leadership Challenges in Canadian Health Care: Adjusting to a New World

To underscore how much the world of health has changed, let's look at one response to the increased organizational complexity of health care systems: regionalization. Canada, like many other countries (United Kingdom, Sweden, Australia), continues to try to improve performance in health care by better aligning operational authorities and accountabilities at the national, provincial and regional levels. Because our ten provinces and three territories have primary responsibility for delivering health care, Canada is ranked "the most decentralized federation in the Organization for Economic Cooperation and Development" [7]. That said, we continue to experiment with various forms of decentralization or regionalization within provinces. The leadership challenge is to strike the right balance between the need to be responsive to patient needs by making decisions close to home, while at the same time, ensuring the national objectives for access, quality, equity and efficiency are met.

It is interesting that a new focus on patient or people-centred care is emerging as systems are becoming regionalized. Does structural complexity distance system leaders from the patient? After all, complex adaptive leadership suggests decentralized patient-centred approaches. Structural complexity can create serious leadership challenges as leaders try to create a highly functioning health care system.

Here is how one seasoned Canadian expert in governance described the complexity of leading a large regional health authority in Canada:

> *"I want you to imagine one of the busiest airports in the country, which in Canada's case is the Pearson International airport in Toronto handling millions of passengers and thousands of takeoffs and landing each year.*[1] *This is not unlike the millions of patient visits and thousands of handoffs in any given year for some of our larger regional health authorities in Canada.*
>
> *"In a smoothly functioning airport, the airport authority sets down policies and establishes standard operating practices to ensure, first and foremost, the safety of the passengers, the wellbeing of their staff and the effective use of the capital and operating resources at their disposal. Well trained, and well rested air traffic controllers are there to ensure that planes take off and land safely and on time. And, of course, there are well trained and well rested pilots to respond to timely, carefully communicated instructions of the air traffic*

[1] According to Wikipedia, in 2012 Toronto International airport handled almost 35 million passengers and almost 500,000 planes.

control tower. The pilots also are responsible for the safe operations of each of their planes and for the safety of each individual passenger."

"Now, I want you to imagine an airport where the pilots are left on their own on the tarmac, because of a breakdown in communications from the control tower. The cause of the breakdown is not known, but it is suspected that part of the reason is that the air traffic controllers can't make up their mind about who is responsible for which plane. This lack of communications and /or breakdown in decision-making means that every pilot is on their own to make individual decisions based on the best available information to ensure that planes take off and land as safely as they can. In this metaphorical world, the airport authority is completely unaware of the breakdown within the control tower and the lack of communications between the control tower and the pilots. The airport authority is oblivious, preoccupied with trying to respond to the most recent report of the transportation safety board about the most recent near miss" [8].

In some ways, this story reflects the regionalized health care system in Canada. The airport authority—the federal or provincial ministries—is often caught up in dealing with the most recent, and always the most urgent, crisis of the day or policy imperative. Senior ministry officials and leaders of regional authorities, the air traffic controllers of the system, are not clear on their collective or individual responsibilities. As a consequence, the pilots (the CEOs of institutions, clinic managers and clinicians) do their best to ensure planes take off and land in a timely and safe way—that is, that their patients receive timely, high quality care when they need it. The passengers, or patients are generally pleased with the service and are usually unaware of the challenges around them until tragedy strikes. When it does, it can create storm systems where taking off and landing are even more treacherous.

Happily, based on our research, this metaphor only applies in some cases. But it does show the challenges of change and the importance of good leadership. In particular, it emphasizes the importance of shared leadership aligned with changing needs across the entire system.

Leadership, Change, and Transformation

Leading change effectively is increasingly identified as a critical success factor for improved system and organizational performance. The 2002 Royal Commission on the Future of Health Care in Canada flagged the need for stronger leadership to sustain our universal, prepaid hospital and medical insurance programs. Since then, that plea has been repeated many times, and in many jurisdictions other than Canada.[2] A decade later, the head of the Royal Commission, Roy Romanow was giving a synopsis of progress since the unveiling of his report and restated the need

[2] The Health Council of Canada (2012) recommends more "supportive leadership" if we are to meet the targets set by First Ministers in 2004 coming out of the Royal Commission; and the recent report from Canada's premiers', entitled *From Innovation to Action* identified "present leadership" as one of four critical factors for better system performance (2012). The King's Fund report in the UK, and the Health Workforce Australia leadership initiative are all aimed at improving the quality of patient-centred leadership.

for stronger leadership. When an audience member asked him where that leadership was to come from, after a long pause, he answered "It's not altogether clear to me where the leadership will come from."

It is, however, clear to us. It has to come from those of us who believe in universal health care; who want the system to make a difference for our children and grandchildren. LEADS can assist you to develop the capabilities of doing so. Our hope—and the hope for the system—is that you will become CEO of yourself, developing your full leadership potential in response to ever-changing, consistently demanding new circumstances in pursuit of high-quality, people-centred health care.

The primary reason leadership today is different than before is the pace and complexity of change. Leadership has no meaning without change. If the world were static, management would have it tightly organized, planned and humming along in a highly ordered way. Leaders seek the opportunity to change, for change means improvement and growth. Leaders provide direction and purpose to change. Today, leading change often involves substituting one set of challenges for another, hoping the new ones will prove more manageable than the old. In our turbulent, complex world, real change—transformative change—may be the only way health care can continue. There are no magic solutions, but LEADS at the least provides a map to guide you through that journey.

We think the process of change in modern society has itself changed. It is characterized by speed, variety and an abundance of choice that is a quantum leap from before. The old conceit that leaders can unfreeze a situation, change it, and then freeze it again into an ongoing pattern of predictable action is gone [9]. As author Peter Vaill writes: "Permanent white water puts organizations and their members in the position of continually doing things they have little experience with or have never done before at all. The feeling of 'playing a whole new ball game' thoroughly pervades organizational life" [10].

The pace and unpredictability of change creates the potential for either chaos or transformational change. Transformation results in new forms of being that bear little resemblance to what was before—a true paradigm shift. Paradigm shifts are movements from one primary world view and way of operating to a radically different one—which will redesign the distribution of power, influence and privilege. Those whose self-interests were being served well in the old paradigm may well lose out in the new one [11]. Does the pace and turbulence of change in health care portend such a shift? Is the demand for complexity leadership a reflection of that impending reality, and maybe a way to forestall a move from complexity to chaos? Modern leaders have a responsibility to create the conditions for a 'safe' transformation, rather than devolution into unsafe chaos.

It would be easy for us as writers—and for the reader—to see change as an enemy to be avoided or managed. That's not our intention. We incline toward the old saying "a change is as good as a rest." Change can bring energy, innovation, creativity and insight, all of which are assets to health leaders in the twenty-first century. Today's health leaders may well be those who see both the downside and the upside of change, and still embrace the latter.

The Context for LEADS: Reversing the Trend

In 2006, Tommy Douglas, former premier of Saskatchewan, was the winner of a television contest called "The Greatest Canadian." Viewers made the choice, based on his reputation as the father of Medicare in Canada: the universal health insurance system he helped to create. Since 1984 medicare has been a prized part of the Canadian identity. More recently, in a 2012 best-selling book called *Chronic Condition*, author and journalist Jeffrey Simpson argued that our cherished medicare system may no longer deserve that iconic status. He acknowledges Canadians "embrace their public health-care system, medicare, more passionately than any other public program" but he also believes their reverence for it is out of touch with the reality of its performance [12]. He provides data to show Canada's performance on most international indicators of health performance have slipped significantly over the past 10 years.

Indeed, the rosy view of Canada's pre-eminence in health care is slowly eroding. International comparisons, news stories and personal experience tarnish its image [12]. That leads to calls for the health system to change and to sometimes scrambling responses. The system appears to lurch from change to change, chaotically seeking solutions. Rarely, however, do these efforts lead to sustainable improvements. As the former minister who shepherded the passage of the Canada Health Act (1984), the Honourable Monique Begin said:

> When it comes to moving health care practices forward efficiently, Canada is a country of perpetual pilot projects. We seldom move proven projects into stable, funded programs, and we rarely transfer the outcomes of pilot projects across jurisdictions. This approach is not serving our health care system well [13].

Canadian health care is often described as a series of silos: services originally conceived in isolation and often delivered independent of each other. As services evolved they were bolted together in programs and linked across regions. Sometimes providers interact together to address the full range of health and social needs of Canadians, more often they don't. They are not trained to and the model was not designed to encourage it.

As prescient as Tommy Douglas was, he was not clairvoyant. He didn't sit down in 1962 and draw a working model of a whole embracing all the components of health and wellness that would work in 2014. His concept was designed to address sickness. Certainly, the advances in medicine, in communication, in technology, and the changes in lifestyle that are happening today were not envisaged in the original Canada Health Act's design. We won't have a health system until we think in terms of a system—which will require leaders who see health care as a whole.

For most administrators, providers, politicians and citizens, the leadership challenge is to convert a fragmented set of activities into a well-functioning whole. And we're not talking about some grand plan for a perfect system—but rather, a mindset that has every individual leading in his or her area of responsibility from the perspective of shaping the whole. We believe that will take us an essential step closer to a transformed health care system.

Another challenge we face in Canada is frequent turnover in leadership. The median shelf life of senior government health leaders has been estimated to be just 1.7 years [14], while research shows the time required to initiate, sustain and constantly readapt initiatives aimed at improvement is rarely taken seriously [15]. Daniel Khaneman in his book entitled *Thinking, Fast and Slow* [16] argues much leadership research ignores the dimension of time, and says the vicissitudes of situation, events and external forces over time delimit the ability of leadership to sustain true change. That will certainly be true if leaders change every 1.7 years. Change needs sustained, present and shared leadership. Long-term change needs leaders throughout the system who understand the importance of change, are committed to people-centred care and act in concert over time to achieve that goal.

Bringing LEADS to Life: The Promise for Health Care Reform

When LEADS is brought to life—as a way of thinking, acting, and developing leadership—it contributes to patient-centred, system-wide health reform. Without leadership in turbulent times—economically, politically, or socially—complexity can devolve into chaos. It is the job of leaders to ensure complex change does not become chaotic: to ensure that change remains consistent with the social good.

Change can be destructive, and change without leadership can be amoral, if it proceeds without the social good in mind. LEADS is based on the principle that you choose to lead for constructive purposes (captured in the word *Caring* in our title, *LEADS in a Caring Environment*). There will always (and should always) be change; LEADS is here to ensure it is shaped by leaders so the purposes of a universal health system are achieved. We believe that by developing and using LEADS capabilities, you will be do a better job serving the patients and citizens health reform is intended to aid.

We developed LEADS in the belief that health care brings unique challenges, and is generally regarded as different from other enterprises. How different is, to some degree, a matter of ongoing debate. But from a Canadian perspective, health care is generally regarded as a "social good," meaning normal competitive market conditions do not hold. Accordingly, the state has taken on a special role to ensure all residents of Canada have reasonable access to medically required services at the time and to the extent of their need. Relative medical necessity, not relative ability to pay, is the basis for allocating services [17]. Although the form of this social enterprise varies country to country, there is a significant similarly in approach among Canada, the U.K. and Australia (and, although less so, the U.S.A.)

LEADS is also predicated on the belief that leaders are both born and made. Everyone is born with some genetic predisposition toward being able to lead and can develop those innate talents through hard work, learning from experience, and reflecting on what they learn. You are the CEO of yourself: you can become the leader you want to be (Chap. 4 is devoted to this theme). As well, the new view of

leadership as something relational and shared suggests that developmental approaches based on the principles of experiential learning, where you learn by reflecting on your experiences while interacting with others, will guide individuals and the system itself in realizing our full leadership potential.

We also believe leadership is not a function of the power of your position but rather of the power inherent in your ability to influence others. This book is about leveraging your locus of influence, not your locus of control. Many prevailing ideas of leadership are artifacts from a bygone era where hierarchy, privilege and possession of information decided who had power and who did not. To us, someone who uses authority without showing respectful, enabling behaviour can 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* [18]. She says formal leaders have seen their authority eroded both by events and because others have acquired power through the internet and social media. Those people—traditionally considered followers—are taking the leadership agenda away from formal leaders. Bringing informal leaders into the healthcare tent and co-creating, with them, the system of the future may be the mechanism to transform the system without it devolving into chaos.

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

References

1. Friedman T. The world is flat: a brief history of the twenty-first century. New York: Picador; 2007.
2. Nicholson P. Information rich and attention poor; remarks to 11th fiesole collection development retreat [Internet]. 2009. Available from: http://www.scienceadvice.ca/uploads/eng/articles%20and%20papers%20of%20interest/peter_nicholson-information_rich_and_attention_poor.pdf. Cited Aug 2013.
3. Ford R. Complex leadership competency in health care: towards framing a theory of practice. Health Serv Manage Res. 2009;22:101–14.
4. LaRue S. Adaptive leadership theory: leading and following as a complex adaptive process. Res Organ Behav. 2011;31:125–50.
5. Obolensky N. Complex adaptive leadership: embracing paradox and uncertainty [Internet]. 2010. Available from: http://common.books24x7.com.ezproxy.royalroads.ca/toc.aspx?bookid=3745. Cited Aug 2013.
6. Edmonstone J. Developing leaders and leadership in health care: a case for rebalancing. Leadersh Health Serv. 2011;24(1):8–18.
7. Atkinson M, Beland D, Marchildon G, McNutt K, Phillips P, Rasmussen K. Governance and public policy in Canada: a view from the provinces. Toronto: University of Toronto Press; 2013.
8. Alberta Health. Working together to build a high performance health system. Alberta: Government of Alberta/Ministry of Health; 2013. Accessed from: http://www.health.alberta.ca/documents/High-Performance-Health-System-2013.pdf. p. 132.
9. Lewin K. Field theory in social science. New York: Harper and Row; 1951.
10. Vaill P. Learning as a way of being: strategies for survival in a world of permanent white water. San Francisco: Jossey-Bass; 1996.

11. Barker J. Joel barker's the new business of paradigms: 21st Century Edition [Internet]. 2013. Accessed from: http://www.thenewbusinessofparadigms.com/media/preview/Transcript21stCentPreview_NBOP.pdf. Cited Aug 2013.
12. Simpson J. Chronic condition: why Canada's health care system needs to be dragged into the 21st century. Toronto: Penguin; 2012.
13. Bégin H, Eggertson L, Macdonald N. A country of perpetual pilot projects. Can Med Assoc J. 2009;180(12):1185. doi:10.1503/cmaj.090808.
14. Tholl W, Bujold G. Functional federalism and the future of medicare in Canada report to HEAL. Ottawa: Health Action Lobby; 2012. 19 p.
15. Shamir B. Leadership takes time: some implications of (not) taking time seriously in leadership research. Leadersh Q. 2011;22:307–15.
16. Kahneman D. Thinking fast and slow. Toronto: Doubleday Publishing; 2011.
17. Evans B. Strained mercy: the economics of Canadian health care. Markham: Butterworths; 1984.
18. Kellerman B. The end of leadership. New York: HarperCollins; 2012.

Chapter 2
Putting LEADS in Context

> No man is good enough to govern another man without that other's consent.
>
> —*Abraham Lincoln*

The Foundations of Modern Leadership

There is a rich literature on leadership going back some 2,500 years. Ancient Greece and Rome are famous for their leaders.[1] Chinese philosophers Lao Tzu, Confucius and Mencius all had thoughts on leadership [1]. Machiavelli's masterpiece of political philosophy *The Prince* is often quoted (not often flatteringly),[2] [2]. Shakespeare's plays examine power through the examples of individuals who strive for it [3].

The tradition has continued: the leadership of everyone from Abraham Lincoln, Gandhi, Winston Churchill, Margaret Thatcher, Nelson Mandela to Vladimir Lenin and Adolf Hitler, has been dissected at length in more recent works on leadership.

Much of this literature focuses on the "great man" (or woman) model of leadership where personality is destiny. But there is a notable exception. In *War and Peace* Leo Tolstoy eloquently argues leadership from the unnamed many was the engine of success. He makes the point that historians give Napoleon credit for the successes of the French army in Russia, but in reality those successes were due to his commanders and front-line soldiers exercising the leadership needed to defeat the Russian army. History tends to endow individuals with great leadership

[1] See discussion of ancient leadership by P. Y. Forsyth in the essay entitled Pericles and Augustus: Ancient Leadership. Available from: http://www.classics.uwaterloo.ca/labyrinth_old/pericles.htm.

[2] 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."

G. Dickson, B. Tholl, *Bringing Leadership to Life in Health: LEADS in a Caring Environment*, DOI 10.1007/978-1-4471-4875-3_2, © Springer-Verlag London 2014

proficiency, when it may be brilliant efforts by those in the front line (who often toil in anonymity) that won the day. We ignore those unsung leaders at our peril.

In academia, there are numerous theories to explain leadership and how it works. Avolio and colleagues [4] 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 is 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.

Some newer ideas they explore include authentic leadership, servant leadership, substitutes for leadership, spirituality and leadership, cross-cultural leadership, complexity leadership and e-leadership.

LEADS is informed by an awareness of, and respect for, almost all these perspectives. How those theories, concepts and ideas play out in a modern democratic context is our first concern.

Public Sector Leadership and the Dynamics of Democracy

Modern democracy demands leadership be exercised in a different way than it was thousands or even dozens of years ago. These are some aspects of modern democracy that influence what kind of leadership will succeed:

- *A highly educated population*: Canada—like most developed nations—has the most educated populace it has 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 relevance and meaning.
- *Professionalism and expertise*: Leaders have to recognize the cultural challenges associated with professionalism, which impels members to be more influenced by peers than leaders.
- *The revolution in communication technology*: We live in what Thomas Friedman calls a flatter, faster world, where information is almost universally available [5]. Google is only a click away, giving immediate access to information that levels the playing field between providers and consumers of health care.
- *Choice and customization*: Leaders make decisions and implement them. But a dramatic growth in the choice of treatments, the ability to customize care, and public demand have complicated the choices health care leaders face and makes decisions complex.

- *Economic capacity*: Since the 2008 world wide economic collapse, we have seen developed countries facing major economic challenges, forcing tough choices by governments and families on where their money should be spent. That can pose a threat to health care, where budgets are growing constantly even as economies shrink.
- *Global awareness*: The internet, television, and easy travel are three factors that have shrunk our world and made its vast reaches available each night on the news. Modern leadership must deal with people perceiving large systems in a way we never have before, by reacting in new ways. Immediate media pressure is another factor leaders have to deal with.
- *Politics of approval*: In our media-conscious modern world, reality shows have become the new rage. One pundit has said we're so good at portraying reality on TV, audiences are hungering for "authentic" reality from their leaders.

These and other factors make the world of leadership challenging and very different from the way it was. Effective health leaders understand that and the expectations it puts on them. Health leaders have gravitated to the LEADS framework because it acknowledges this new world and defines the capabilities they need to be successful. In research terms, that gives LEADS "face validity"—it appears to be doing what it sets out to do.

But What Is Leadership?

Before we get in into LEADS and how it works, we want to examine the concept of leadership in the broader sense, in order to understand what people mean when they talk about leaders and leadership. In essence, leadership is a concept with strong connections to administration and management. But it's different. Leadership is a *quality* that can be found in anyone who exercises responsibility to rise to a challenge, and who uses his or her skills to engage others in solving that problem. Leaders need management and administration skills to solve problems but those skills alone are not enough.

Rather than try to distill the theoretical approaches into a coherent expression of leadership, we took a different tack and tried to understand it as the public does. Every word exists for the purpose of conveying a meaning not captured in another word. Douglas Simpson and Michael Jackson in their book *Teacher as Philosopher* [6], suggest one of the ways of truly parsing the implicit meanings of a word is to examine its use in conventional talk—that is, in the day-to-day discourse of society. We started by looking at the use of "leadership" in advertising slogans, where it's used to appeal to certain beliefs that will give a product inherent appeal. Some examples are found in Table 2.1:

What conventional beliefs about leadership are captured in this table?

1. *Leaders go first*: People who lead enter new territory—sometimes of thought, sometimes of action. A soldier "on point" is the first into unexplored terrain;

Table 2.1 Use of leadership words in advertising slogans and their meaning

Company/ Institution	Statement	Implied meaning
Apple Computers	*We are Apple*, *Leading the Way*	Apple is on the forefront of the technology business, all other companies are learning from the example set by Apple. Apple is a pioneer.
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 their field; their advancements—into new territory of telling time—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.
Segway	*The Leader in Personal*, *Green Transportation*	Segway is packing a double punch—they are ahead of the pack in developing alternative personal transport, and are also the foremost in green transport.
Wilfrid Laurier University	*Leading By Example*	The university is trying to express its high quality in academics, faculty and social responsibility.
KPMG	*The Mark of A Leader*	KPMG is suggesting they have a special kind of distinction and the vision, foresight and professionalism needed to succeed.

leaders, likewise, experience things first. Going first means facing the unknown alone: at least, initially.

2. *Leaders face uncertainty and danger*: Going first means taking risks. Leaders don't necessarily know the problems they will face (nor did pioneers) but they have the courage to meet them, and confidence in their ability to overcome them.
3. *Leaders have vision*: Having foresight suggests leaders see things others don't and have knowledge, information or understanding others are not yet privy to.
4. *Leaders are capable and credible*: Leaders have substance and focus. They are professional and know their business. They may be envied for the quality of their work.
5. *Leaders possess inherent quality*: Regardless of what the product is—a car, a service or health care—leaders are the best in the business. Others will follow because leaders personify quality, which people want to emulate.
6. *Leaders have followers*: The idea that leaders differentiate themselves from others is implicit in the dynamic of leadership. These others are followers, who seek leadership because it means someone else will shoulder the risk, initiate action or find a solution. Quality will emerge.

However, simply looking at private sector advertising slogans gives insufficient insight into the power of the word leadership in modern society, particularly in health care. Because Canada, like many developed countries, is a multi-cultural society, we also looked at the use of the word leadership in a variety of different cultures [7].

Starting with our first Canadians—the First Nations—there are few accessible records using the term leadership and a literal translation. However, in the *Soto* language, which is an Obji-Cree mix in Manitoba (Ojibwe with Cree inflects) the notion of a leader is closely tied to that of an elder. An elder is someone whose wisdom about spirituality, culture, and life is recognized and affirmed by the community [8]. Not all elders are old. Sometimes the spirit of 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 in a wide range of issues.

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 these children were taught leadership qualities, which are honour (personal integrity), respect (esteem for, or a sense of the worth or excellence of something), and compassion (tenderness, a desire to alleviate suffering). It is also interesting to note that in Nisga'a, the word to lead, or to chair an event, is *diyee*, suggesting conceptions of leadership include the idea of guiding, or giving direction. However, with the advent of elected chiefs, the teaching of leadership ceased.

Aboriginal and Torres Strait Islander peoples in Australia see leadership according to different values and criteria than in wider Australian society [9]. Although there are no words in the native language directly translatable to the English word, their notions of governance speak to it. To them, 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. They also see leadership *as a process* rather than an ascribed position in a hierarchy. While English usage often implies a view of the leader as the apex of a vertical hierarchy, the indigenous metaphor characterises a leader as being on the same horizontal plane as those who confer authority on him or her through consensus.

In the Hindi language, the word for leadership is *netrtva*, pronounced 'neh-tu'. It means to guide and exercise initiative. In Punjabi, leadership is leadership—obviously an inflection 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 The characters are pronounced *ling dao*. They contain the ideas of: 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 that you are deliberately honing your leadership skills, or hold a position of leadership.

In German, the word for leader is *fuhrer*, synonomous with guide, operator and pilot. In Italian, the word for leader is *capo* and for leadership, *direzione*. The word captain in English is a derivative of *capo. Direzione* is synonymous with giving

direction and guidance, as well as management. In French, the word for leader is *chef*—meaning boss, overseer or superintendent.

Key ideas pertaining to leadership in public service that were not captured in Table 2.1, but are found in the various cultural uses—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 of the above 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 were 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. The Aboriginal and Torres Islander concept of leadership and the elder approach of the Nisga'a speak to this quality.

In comparing the two lists, it is clear that public and private sector leadership have some similar attributes but differ on others. Perhaps most significantly, here is an implicit commitment and understanding of social responsibility expected of public sector leaders that is not necessarily implicit in private sector usage. It may be desired—but not expected. Public sector leadership also carries the notions of being first, foresight, excellence and professionalism, but always in application to social concerns and issues such as peace, security, and problem solving.

One other trend is obvious as well. In public service leadership, assumptions that the qualities of leaders are genetic and transferable through subsequent generations have eroded and have been replaced by public selection. In democratic societies, this trend has been expressed in the belief that leaders are elected for their motivation and ability to provide public service; they are held accountable for their ability to lead. In organizational life this trend suggests that in a hierarchy (which can be construed as a modern version of succession by birth) people are expected to demonstrate the leadership qualities implicit in their position. In a modern world of instantaneous communication, judgment and feedback, people in leadership positions can be constantly under attack if they do not demonstrate those qualities. Similarly, people not in positions of leadership, but who possess natural leadership talent, can exert the influence to be effective leaders. In today's world, those who choose to develop leadership qualities will likely trump those who do not. If positional leaders are not effective, *others will step up to fulfill their duties*.

The concepts, ideas and expectations inherent in the words "leadership" and "leader" help us understand the leadership qualities LEADS is designed to impart. They also help to determine the processes required to develop leadership capability.

Defining Leadership in Health

Now let's consider our operational definition of leadership, keeping the above notions in mind, as well as the multitudinous concepts and theories of leadership that abound in the academic literature [10]. The key ideas we've just been exploring suggest leadership is composed of taking initiative or going first and facing the risks that go with that; influence with and on people (through positional authority, character or wisdom); taking responsibility and pursuit of a shared purpose or goal (i.e., to produce quality in whatever endeavour is being pursued—products or service in private sector; peace, security, governance in public life; health and wellness in health care). They all feed into our definition of leadership in health: "*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*."

We considered adding "when facing new and unprecedented issues or challenges," but realized that doesn't define leadership, it outlines its context for action. It's that context and the imperative for change that distinguish leadership from management: when issues or challenges have already been faced, managers can use their knowledge to organize and implement a response. Predictable approaches work in a stable environment. In a turbulent environment, where new and unprecedented issues abound and change is unavoidable, nothing is predictable. Leadership is needed.

Because society is facing unprecedented issues in health care, leadership does not rest in the hands of a few high-profile people. Rather, it is the job of everyone who wishes to see health care transformed. You will find we emphasize that idea—leadership as a distributed concept—throughout this book.

Personal and Strategic Leadership

Leadership can take two forms. The first is the interpersonal behaviour an individual uses to influence others: leadership as a person-based quality. Interpersonal leadership can be displayed regardless of where an individual fits in the hierarchy or community. When leadership is a function of interpersonal influence, we called it *personal leadership*.

On the other hand *strategic leadership* refers to elements or actions that shape the direction and efforts of people beyond the direct influence of the leader. Deliberately shaping elements and actions by imposing new structures, values or beliefs to affect everyone in an organization at the same time is strategic leadership. Strategic leadership can be exercised by people working together or through leadership that determines collective action.

Guiding principles such as laws, policies and clinical protocols are all expressions of strategic leadership. If the two approaches, personal and strategic

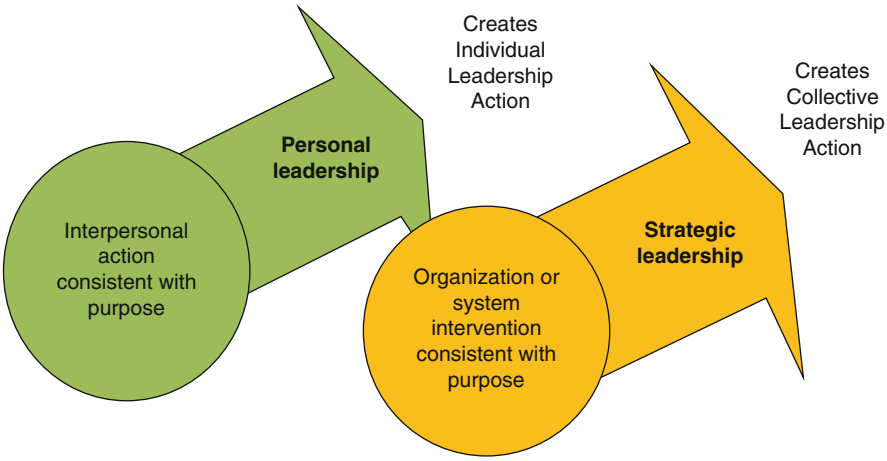


Fig. 2.1 Personal and strategic leadership

leadership, are aligned the overall impact of leadership is significantly magnified and a strong current is directed at achieving both individual and organizational goals. When they are misaligned, a significant amount of energy and power can be dissipated through friction between them.

In summary, personal leadership is the capacity to lead generated by an individual's will, motivation, and behaviour. Strategic leadership is when an organization or system intervention is the source of will and motivation (see Fig. 2.1). The more your personal values are aligned with your organization's values, the greater capacity you'll have for collective, constructive action.

Let's go back to the transformational concept of locus of influence. If the true expression of leadership is a bond between leader and follower, in which the leader engages the follower to do constructive things in order to achieve a goal, there is a flow of energy generated between them. This energy is aimed at accomplishing a common purpose. For an individual leader, this is a set of personal attributes that influence others.

However, these attributes can only be effective if others see them; or are directly influenced by them. We call this personal leadership. If those same attributes can be expressed through deliberate interventions in the practices of structure or culture, then energy can flow across the organization or system and encourage the whole to act in a manner consistent with both individual and collective purpose.

Another way of looking at it is that a strategic leader's job is to create a positive energy flow organization or system-wide, to mirror effective leadership at an interpersonal level. Together personal is strategic leadership behaviour can create an organization or system in which leadership behaviour becomes a cultural tradition.

This challenge was one reason we created the *LEADS in a Caring Environment* capabilities framework. If health care needs new and better leadership to solve system problems, and to create collective transformation, what does that leadership

look like, sound like, and feel like, both personally and strategically? Unless we know that, efforts at supporting, developing and growing leadership—either personal or strategic—are a waste of time and money.

Distributed Leadership

In Chap. 1 we said leaders are different from others. Indeed, the others are described as "followers" in conventional language. This distinction implies a stratification of leaders and followers, which suggests a hierarchical organization of power and influence. But then how can we say, as we did, that leadership can come from anyone, "…from patients, workers at every level, politicians, or the public"?

That sounds more like a shared model of leadership, not a hierarchy. Some argue distributing leadership by flattening hierarchy and encouraging leaders to emerge from other places diminishes formal leadership (see Barbara Kellerman quote in Chapter 1) [11]. In fact, those who believe leaders are born, not made, would dismiss the idea that "leadership can come from anywhere" as mere demands from disgruntled employees and citizens to take power away from more meritorious leaders.

We disagree with that notion on several fronts. First, if leadership is a natural trait, then it can be developed like other natural traits, such as abilities in athletics, painting, music or science. And, just as we try to provide basic developmental opportunities in those areas, so we should with leadership—which will provide organizations with a much broader capacity in it.

Second, research has a role in defining effective leadership. Great breakthroughs in understanding the science and art of leadership have been made in the past 10 years [4]. Therefore, as the knowledge and skills that define leadership are deliberately developed, more and more people will possess the skills necessary to be effective leaders, particularly in a well-educated society.

Third, because the complexity of health care has grown so significantly over the past 10 years, no one person can legitimately claim to have all the expertise needed to solve the problems and issues that emerge; shared leadership is necessary to find and implement solutions.

Finally, if we believe social responsibility is a component of leadership, then the democratization of leadership in health organizations is as inevitable as in the political realm. Recent excesses of power by CEOs in the United States, Canada and elsewhere have demonstrated the inadequacy and dangers of the rugged-individualist approach to leadership.

One further point about this concept of distributed leadership. It is still what might be called individualist—that is, it surmises that leadership is a finite quality that can be found all in one person, or distributed amongst many individuals, independent of one another. That view of the world is often referred to as a transactional model of leadership. Transformational leadership represents a more interactive

perspective. It suggests that when individual leadership is active, it can also be interactive and interdependent; then a force field of leadership develops. A rising tide raises all boats, as the saying goes.

At some point a tipping point is reached which exponentially increases the ability to exercise leadership in an organization [12].

The Health Leadership Challenge in Canada

The impetus for LEADS grew out of three imperatives when we began our work in 2006. The first was the speed of change; more leadership (as opposed to management) was needed, and therefore health leaders had to learn and develop those capabilities to a much higher level.

The second was the growing number of baby-boomers retiring, which was making it harder to fill jobs with people qualified to lead. Those two issues have only been exacerbated since then.

The third imperative is one of a lack of will, or commitment. Too often the lament is heard: where have all the leaders gone? For example, we often hear people asking why the federal government can't step up to the plate in health care and wondering who would show leadership like Tommy Douglas, Lester Pearson and Monique Begin did? There seems to be a lack of will to continue evolving Canada's universal health system to what it needs to be for all Canadians.

We have mused on why we are always looking somewhere else for leadership. If Tommy Douglas or Monique Begin had expected others to lead, we would not have universal health insurance or a Canada Health Act. It is not just politicians who need to 'find' their leadership. It is the heads of national associations, health authority CEOs and the many managers, doctors, nurses, and citizens in all developed countries who care about the quality of their health systems. Recently we sat at a table with the heads of about half a dozen Canadian health and social agencies. Almost to a person, they were opting to hunker down and try to be invisible, for fear that if they spoke out on their mandate, their funding would be cut and their agency eliminated by the federal government. This was a real fear: it has happened to some leaders who have dared to do so. But when did leadership become abrogating responsibility in the face of fear? Fear delimits our ability to lead. Confidence, hope, and conviction must drive our leadership and actions.

Where is that vision for health care in Canada? If no 'great wise one' is to come forward, then all of us must create that vision together. We must look within for shared leadership and we must exercise that leadership in a manner consistent with LEADS. Looking elsewhere for that leadership, and not demanding it of ourselves, is to leave us collectively bankrupt in the transformation agenda.

Distributed leadership is one of LEADS' foundational principles. It is also the reason coalitions, like the Canadian Health Leadership Network (CHLNet), are actively stewarding a national leadership development strategy (in Australia, Health Workforce Australia is championing a similar change).

Conclusions

The concept of leadership is undergoing a fundamental transformation in the context of a modern democracy. Leadership in health has become more challenging due to the pace and breadth of change. It is more about influence than control, more about collaborating and caring than dictating.

The responsibility for new and better leadership is therefore shared by all members of the health system, and has created the demand for a common language of leadership: LEADS. A common leadership learning platform, if used as a source code for the development of leaders, and as an operating system for creating change, can provide two benefits. First, we can grow our individual leadership capacity. second, we can develop collectively a more holistic approach to leadership that will let us address the challenge of transforming health care.

That was the goal of the LEADS project when it began. Through reading this book, by adopting LEADS as your language of leadership, and personal mastery as your approach to development, you can realize your potential as a modern health leader.

References

1. Creel H. Chinese thought from Confucius to Mao Tse-Tung. New York: Mentor Books; 1960.
2. O'Rourke J. Machiavelli's *The Prince*: still relevant after all these years [Internet]. BU Today. 2013 Jan 6. Available from: http://www.bu.edu/today/2013/machiavelli-the-prince-still-relevant-after-all-these-years/. Cited Aug 2013.
3. Corrigan P. Shakespeare on management: leadership lessons for today's managers. London: Kogan Page; 1999.
4. Avolio B, Walumbwa F, Weber T. Leadership: current theories, research, and future directions. Annu Rev Psychol. 2009;60:421–49.
5. Friedman T. The world is flat: a brief history of the twenty-first century. New York: Picador; 2007.
6. Simpson D, Jackson M. Teacher as philosopher. Agincourt: Methuen; 1984.
7. Dickson S. Ethnographic perspectives on leadership. Unpublished working paper. 2011 Sept.
8. Joseph R, Joseph C. Working effectively with aboriginal peoples. North Vancouver: Indigenous Corporate Training Inc; 2007.
9. Aboriginal and Torres Strait Islander Leadership [Internet]. Indigenous Governance Toolkit. Available from: http://governance.reconciliation.org.au/toolkit/4-1-indigenous-leadership. Cited 12 July 2013.
10. Yukl G. Leadership in organizations. 6th ed. Upper Saddle River: Prentice Hall; 2006.
11. Kellerman B. The end of leadership. New York: HarperCollins; 2012.
12. Gladwell M. The tipping point. New York: Little, Brown and Company; 2000.

Chapter 3
The LEADS in a Caring Environment Capabilities Framework: The Source Code for Health Leadership

As we have read, leadership is not management or administration. It is energy, influence, perseverance, dedication, strategy, and execution, applied in the world of people to create change. As Colin Powell stated, "leadership accomplishes more than the science of management says is possible to achieve [1]." The challenges facing modern health systems demand leadership.

Health care's leadership challenges are complex and enduring, arising from significant changes in the context and practices of the health system. To address these challenges, leaders must go beyond management. The management solutions to health-care problems are structural fixes—policy changes, or legislation, or technical tools and techniques such as Lean programs. Leadership, on the other hand, works through activities, approaches and strategies to engage the will and commitment of individuals and professional groups to work together to bring meaningful change to health care.

As we've said, we don't believe leadership is inherent, although there is no question some people have characteristics that lend themselves to leadership. But the foundation of the LEADS framework is a fundamental belief that leadership is a learnable skill. We designed LEADS to define and teach the capabilities of leadership, and support leadership development in the health sector. In this chapter, we explore the development of the LEADS framework. We speak often in this book of the importance of evidence in informing leadership, so the main reason for this chapter is to establish the validity of the research that went into developing LEADS.

This chapter also looks at how LEADS can play a central role in succession planning and leadership talent management (although those topics are not a primary focus of this book). Finally, we show the comparability of LEADS to leadership frameworks developed in the UK and Australia to build leadership for health-system change, and show readers in those countries the relevance of this book's content to the leadership challenges they face at home.

G. Dickson, B. Tholl, *Bringing Leadership to Life in Health: LEADS in a Caring Environment*, DOI 10.1007/978-1-4471-4875-3_3, © Springer-Verlag London 2014

LEADS in a Caring Environment

In biology, the source code of life is the DNA molecule. DNA, although comprised of a common set of nucleotides, combines them in unique ways to produce all the proteins in the human body and create the unique characteristics of each of us. That means DNA and its nucleotides are the source code for both the similarities and individual differences in human beings. In the same way, we see the five LEADS framework domains and 20 capabilities as the source code of leadership, that in its permutations and combinations provides for individual expression of who we are as people.

The LEADS in a Caring Environment capabilities framework has five domains—Lead Self, Engage Others, Achieve Results, Develop Coalitions and Systems Transformation—with four capabilities per domain (Fig. 3.1).

Lead Self: *Self-motivated leaders...*
Are self aware • Are aware of their own assumptions, values, principles, strengths and limitations
Manage themselves • They take responsibility for their own performance and health *Develop themselves* • They actively seek opportunities and challenges for personal learning, character building and growth *Demonstrate character* • They model qualities such as honesty, integrity, resilience, and confidence
Engage Others: *Engaging leaders...*
Foster development of others • They support and challenge others to achieve professional and personal goals *Contribute to the creation of healthy organizations* • They create engaging environments where others have meaningful opportunities to contribute and ensure that resources are available to fulfill their expected responsibilities *Communicate effectively* • They listen well and encourage open exchange of information and ideas using appropriate communication media *Build teams* • They facilitate environments of collaboration and cooperation to achieve results

Fig. 3.1 The LEADS in a Caring Environment Capabilities Framework [2]

Achieve Results: *Goal-oriented leaders…*

Set direction

- They inspire vision by identifying, establishing and communicating clear and meaningful expectations and outcomes

Strategically align decisions with vision, values, and evidence

- They integrate organizational missions, values and reliable, valid evidence to make decisions

Take action to implement decisions

- They act in a manner consistent with the organizational values to yield effective, efficient public-centred service

Assess and evaluate

- They measure and evaluate outcomes. They hold themselves and others accountable for the results achieved against benchmarks and correct the course as appropriate

Develop Coalitions: *Collaborative leaders...*

Purposefully build partnerships and networks to create results

- They create connections, trust and shared meaning with individuals and groups

Demonstrate a commitment to customers and service

- They facilitate collaboration, cooperation and coalitions among diverse groups and perspectives aimed at learning to improve service

Mobilize knowledge

- They employ methods to gather intelligence, encourage open exchange of information, and use quality evidence to influence action across the system

Navigate socio-political environments

- They are politically astute. They negotiate through conflict and mobilize support

Systems Transformation: *Successful leaders...*

Demonstrate systems/critical thinking

- They think analytically and conceptually, questioning and challenging the status quo, to identify issues, solve problems and design and implement effective processes across systems and stakeholders

Encourage and support innovation

- They create a climate of continuous improvement and creativity aimed at systemic change

Orient themselves strategically to the future

- They scan the environment for ideas, best practices, and emerging trends that will shape the system

Champion and orchestrate change

- They actively contribute to change processes that improve health service delivery

Fig. 3.1 (continued)

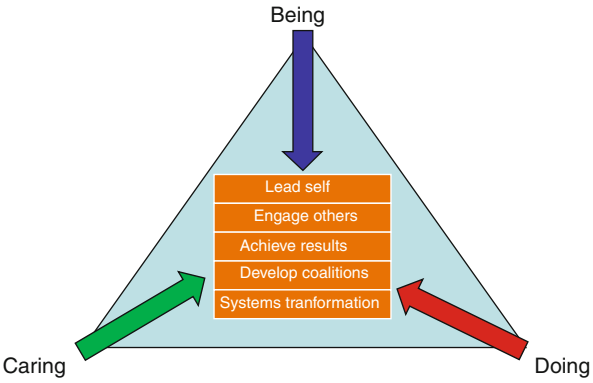


Fig. 3.2 Caring, Being and Doing interact to generate the LEADS in a Caring Environment Capabilities Framework

We chose the title for the framework carefully, to capture the other factors that shape quality leadership and leadership development in health care. Let's deal with each in turn.

Caring

Our research was unequivocal: the essence of effective health leadership is the ability to care for oneself and the health and wellness of others. Caring is the purpose of a universal, government-funded health systems. The common thread that unites all of us—administrator, physician, nurse, physiotherapist, radiologist, or any one of thousands of other health professionals—is caring about the health of others. For a health provider, caring means delivering the best service with compassion, respect, and empathy. For the leader it is to obviously show an authentic commitment to caring for oneself and for your team: championing it, promoting it, designing policies and programs in which caring shines through. Caring is the core of intention for health leadership. It is the *why* of leadership in the health sector; it is about commitment to service, to patients and clients, and to health.

However, caring alone does not make an effective leader. That requires an individual who can combine caring with who they are (being) and how they act (doing). Being is your values, beliefs, and personality. It includes your character, sense of purpose, personality and depth of commitment. Being is not about action, it is about the knowledge, assumptions and values that inspire and support your actions. Doing is the ability to express your character and commitment in behaviour that reflects who you are. When you combine caring and being with your interpersonal skills and strategic abilities, you'll be capable of influencing the actions of others to create meaningful change. Take a look at Fig. 3.2:

Environment

We used the word "environment" in the title of the LEADS framework to emphasize our concept of leadership as an organic system. That concept came from both our

reading of the literature and discussions we had with leaders in modern health systems. Both the environment in which leadership takes place, and leadership itself, are organic, where the interdependent, ever-fluid and changing human environment of health care is influenced by individual leadership action, and vice-versa. That's in contrast to management, which focuses on the technical, cause-and-effect mechanics of change—its logistics.[1]

Whether leadership is happening on a micro scale—such as one unit's nursing station—or on a macro scale through policies and legislation to improve system level access to care, it interacts with factors in the broader environment that have the potential to change it. Your effectiveness as a leader will depend on the interdependent dynamics among you, the people you're leading, and the environment in which change is happening.

Jean-Louis Denis and his colleagues see the health system in Canada as a series of ever-larger systems, from micro (patient-provider) to mega (province—citizen), with primary care practices, hospitals, regional health authorities, nested within each other [3]. In such an environment 'there is no blame'—we are all part of the problem, and all part of the solution. Together our collective leadership focus must be on three things: relationships, change, and results.

An additional element in that environment is its complexity. Randal Ford put it this way:

> Many analysts now characterize the health-care industry and health-care systems in particular as complex adaptive organizations, evolving in a rapidly transforming and turbulent industry. New hybrid organizational forms are emerging, which exhibit diverse relational-structural alliances between physicians, hospitals and/or insurers, over which administrators have limited control and restricted ability to predict or direct [4].

Complex adaptive systems have the annoying habit of being unpredictable and self-regulatory, which means when a perturbation occurs in one part of the system, a different part tends to respond to it. Their dynamic, interactive nature makes it very hard to know what to do to alter them. We'll talk more about this and its impact on leadership in Chap. 9, Systems Transformation, because as we were developing the LEADS framework, it became clear to us the complex adaptive system concept an important for understanding leadership in health care. We created the LEADS leadership framework to reflect complex adaptive system environments, and chose the leadership capabilities to develop the kind of leadership behaviour that would get results in them.

Capabilities

We decided quite early in our work on LEADS to refer to the requirements for exceptional health system leadership as *capabilities*, not competencies. There were both practical and cultural reasons for that choice. First, we, like many people, think the term competency is most appropriately used in training, to refer to the skills and

[1] A similar distinction is implicit in the terms *transformational* versus *transactional* leadership, where the former focuses on the psychological dynamics of interdependence between leader and follower, and the latter on the contractual, technical relations between them.

knowledge that individuals require to do their job in a predictable environment. For many, it refers to a bare minimum required to do the job. The term capability, however, includes competence, but also much more. The goal of developing capabilities is to raise your level of leadership much beyond the bare minimum, which you will need to do if health systems are to be reformed for the twenty-first century.

We also choose the term capabilities because we believe leadership development is a lifelong journey. Over your lifecycle of leadership, you may use different capabilities to lead in one situation as opposed to another. Having leadership capabilities implies you are able to be a leader in any situation or circumstance, and therefore also implies a lifelong process of development and growth. For this reason the LEADS self-assessment exercise you will find at the end of the five LEADS chapters poses questions at each of four levels of a career trajectory: front-line supervisor, mid-manager, senior leader and executive leader. Each of the five domains in the LEADS framework, comprised of four contributing capabilities, is expressed as context specific questions related to each of those roles. Chapter 4 describes this in greater detail.

Our third reason for talking about capabilities rather than competencies is that competencies are inconsistent with the concept of transformational leadership [5, 6]. Transformational leaders are visionaries, whose energy and passion motivate followers. They work closely with others, interactively inspiring each other. Two of the LEADS domains (Engage Others and Develop Coalitions) emphasize how the interdependence of relationships allows leaders and followers to advance to a higher level of morale and commitment. The Lead Self domain focuses on internal transformation, the one that occurs in the leader's mind to change in the world around him or her. Collectively, the LEADS framework describes all the attributes of leadership needed for system transformation[2].

Framework

We use the word framework in the title for LEADS to send the message the domains and capabilities outline the parameters of leadership, but they don't include all the details that make up what those domains and capabilities look like for each person. The five LEADS domains and 20 capabilities are like the blueprint of a house: the domains represent the rooms in the house. There is a kitchen, living room, bathroom and two bedrooms. Within each of those are certain features—a counter in the kitchen, a shower in the bathroom—common to all houses. Those are the capabilities. But what they look like depends on how you as leader choose to express them. The colours, the layout, the artwork are up to you to customize, according to the vicissitudes of your personality, talents and moral code. It is then your behaviour that exemplifies LEADS capabilities in action. Consequently, LEADS is a

[2] Henry Mintzberg, a Canadian guru in leadership and management, advocates moving away from traditional managerial language, going beyond functions, or competencies to leadership mindsets, or capabilities [7].

framework for development and action that each individual leader tailors according to their own individual strengths, weaknesses and character.

The Validity of LEADS: Can You Depend on It?

How confident can you be that the LEADS framework represents an accurate and valid treatment of leadership within the health sector in Canada, and health sectors in general? You might be excused at this point for saying to yourself "Well, some of this sounds good—some of it sensible—to what extent can it be validated by research? And even if validated, what traction does it have in the world of professional health leadership?"

In the research world, a good study exhibits two forms of validity. The first is construct validity: do the findings and results of the research reflect the data, and is the logic of interpretation sound and reliable? Researchers go to great pains when they are publishing to show the steps they've taken to create construct validity. Because this is not a peer-reviewed journal, we will give just an overview on the rigour of our research, and the processes of interpretation that ultimately led us to LEADS.

The second form of validity is called face validity, where the findings of the research resonate with people who are the users of the research. The findings make sense to them, in light of their own experiences of leadership. LEADS appears to have satisfied many people in both aspects of validity, but we'll provide some information here about how.

Construct Validity of LEADS

Behind the apparent simplicity of the LEADS framework lies a 6-year process of research, dialogue, discussion and use of LEADS—carried out by two major research teams from Royal Roads University working with professional decision makers in the health system across Canada. The work was done in two phases. The first phase was what's called "participatory action research," where the research was conducted in cycles of experimentation and reflection, a collaborative effort looking at questions of importance to the research team,[3] [8]. The action research phase was conducted in three cycles between 2006 and 2009.[4]

The first phase (April 2006–March 2007) was essentially the beta phase testing in British Columbia Canada. It essentially involved a systematic review of the literature and a series of key informant interviews through a participatory action

[3] Traditionally, Participatory Action Research is conducted by a team of both academic researchers and decision makers, who are trying, together, to use inquiry-based methods to generate change in the context of the real world and study it at the same time.

[4] It is called the action research phase because most of the activities were formally undertaken using a 'Participatory Action Research' approach. Consequently, the research was conducted in cycles, each consisting of ongoing steps of research; sharing those findings with decision makers, refining the research, and bringing it back to researchers, until the product (ultimately LEADS) was consistent with the 'construct' of the research process.

research protocol. This produced what we describe as LEADS 1.0, including five booklets in support of each of the five domains.

Phase two (March 2007–March 2008) involved broadening the scope of analysis across the country, including a series of focus groups, further analysis of the literature and a national symposium and compassion. This work produced what was known as the Five Cs Framework: Champion caring; Cultivate self and others; Connect with others; Create results; and Change systems [9]. For all intents and purposes this was seen as having validated all of the key findings from the BC work.

So, phase three (through to September 2009) involved a series of focus groups to determine how the two frameworks could be combined to serve cross-Canada purposes. It was determined that the face validity of the LEADS framework had much to recommend it but that the "caring dimension" needed to be expressly captured. Hence, after another round of updating the literature, LEADS 2.0 was created and is now known as: *LEADS in a Caring Environment*.

Face Validity of LEADS

The second phase of validation, from 2009 to the publication of this book might best be termed the utilitarian phase. During that time the framework was tested in the crucible of real organizational life. Its take-up and subsequent use by individuals and organizations is a barometer of its face validity. There were two tests along the way. First, its initial appeal: was LEADS intuitive enough, accessible enough and accurate enough in its portrayal of leadership to be accepted at all levels of the health system—from executive to citizen on the street? Second, was LEADS utilitarian enough in its current form to be used effectively for leadership development, talent management, and succession planning?

LEADS had notable initial appeal. Between 2006 and 2008, the Health Care Leaders' Association of British Columbia, a voluntary professional association, and the province's six health authorities[5] formally endorsed the framework as a foundation for their leadership-related endeavours. In November 2009, the Canadian Health Leadership Network[6] (CHLNet) entered a formal agreement with Leaders for Life to

[5] Vancouver Island Health Authority (VIHA) (now known as Island Health); Provincial Health Services Authority (PHSA); Interior Health Authority (IHA); Northern Health Authority (NHA); Vancouver Coastal Health Authority (VCHA); and Fraser Health Authority (FHA) are the six regions in British Columbia, (Note: Providence Health care—a catholic service entity—operates in collaboration with the other HAs) that offer full programs of health services to British Columbians. Note: the PHSA is a quaternary service delivery entity that offers provincial programs in cancer, transplants, etc. in partnership with the other five regional health authorities.

[6] The Canadian Health Leadership Network (CHLNet) is a not-for-profit, **Value Network** comprised of health organizations across the country. The network facilitates or brokers joint work among and between its Network Partners; using the LEADS framework as a foundation for much of that work. This joint work cuts across the health disciplines and across the lifecycle of leaders. CHLNet believes that leadership is a life-long pursuit and is Canada-wide. It is through this joint work that CHLNet produces a unique value, adding to the growing number of individual leadership initiatives across Canada.

jointly increase awareness of the *LEADS in a Caring Environment* framework and the availability of LEADS-friendly leadership tools across Canada [10]. The health leadership network—which has over 40 regional, provincial and national members—has made LEADS the foundation for its strategic directions until 2015. In 2010, the Canadian College of Health Service Executives (now known as the Canadian College of Health Leaders), endorsed the framework as the foundation of leadership development for its members, and for a certification program for leaders.

As this book is written, LEADS is being used extensively across Canada. Accreditation Canada references LEADS in its standards for organizational leadership and governance. The Canadian Medical Association has made LEADS the foundation for the 20 courses in its leadership education program.[7] Alberta Health Services—the largest regional health authority in Canada—has endorsed LEADS for all leadership development, talent management, and succession planning in the province. The provinces of Saskatchewan, Prince Edward Island and Manitoba are all using LEADS for talent development and succession planning. Health Authorities—such as the six BC health regions, Vitalite and Horizon regions in New Brunswick, and Capital Health in Nova Scotia offer LEADS based programs. National organizations including the Canadian Agency for Drugs and Technology in Health, the Canadian Institute for Health Information and the Canadian Nurses' Association are also using LEADS-based programming.

The Reach of LEADS

We believe the three-part philosophy shared by the organizations sponsoring the research that created the LEADS Framework has unquestionably driven its widespread acceptance and use. The first part of that philosophy was that Canada needed a comprehensive strategy for developing leadership capacity in health care, based on a shared understanding of what leadership looks like, sounds like, and feels like. That philosophy guided the efforts of Royal Roads University, the Canadian Health Leadership Network and the Canadian College of Health Leaders, to continue to work together towards a common language for leadership that they could all support.

In carrying out this work Royal Roads University[8] took responsibility for research and knowledge mobilization on the project. The Canadian Health Leadership Network (CHLNet) undertook to create a network for regional, provincial and national CEOs to support LEADS-based talent management, succession planning

[7] The Physician Management Institute (PMI) is the arm of the CMA that provides leadership programming for its physician members. It offers both open enrolment and in-house programs to physicians and health organizations across Canada.

[8] Royal Roads University, based in Victoria, British Columbia is a national and international university that provides high quality, innovative, competitively priced, and applied post-secondary education to working professionals and career-focused students in Canada and around the globe.

and leadership development. The Canadian College of Health Leaders championed the use of LEADS for certification of its members.

The second part of our philosophy, which helped drive rapid acceptance and spread of the LEADS framework, was the collaborative approach that shaped the work from the beginning. We coined the phrase "leadership without ownership," to stress that in a true system, no one organization "owns" leadership, and none should claim exclusive rights to develop leaders. If lack of leadership is a system problem, the solution must be owned by all the organizations in the system. A national strategy demanded that all CEOs, organizational development professionals, universities and others invested in better leadership be encouraged—and empowered—to work together to advance the common cause of leadership in health.

It was that concept that led to the creation of CHLNet. Dubbed a coalition of the willing, its purpose is to draw together individual and collective efforts to raise awareness around the importance of leadership development, talent management and succession planning and support leadership capacity development across Canada, based on the LEADS framework. The other collaborating groups, the Canadian College of Health Leaders and Royal Roads University, as well as the intellectual property owners of the LEADS framework, quickly embraced the notion that any health organization in Canada that wishes to use the framework to build leadership capacity, should be able to do so without restriction. The partners have agreed the framework can be used for free by any person or organization as long as it's "in the public domain, by health organizations, for not-for-profit purposes."

The final aspect of our philosophy—which is extremely important in shaping how it can be used—is our belief that anyone can grow their ability to lead. Traditional concepts rarely distinguish between the boss and the leader; the LEADS framework rejects that narrow approach. Based on the notion that 'a rising tide raises all boats', the work is based on the belief that anybody—citizen, doctor, nurse, manager, politician—who chooses to take on a leadership role can grow and develop their capacity to do so. There's more on this in Chap. 4. The purpose of the framework is to outline what people need to be capable of to lead successfully. The goal of LEADS is to build leadership throughout the health system, horizontally as well as vertically. When leadership qualities are distributed throughout the system, it will be much easier to rally the innovation and flexibility required to meet the challenges of twenty-first century health-care.

As this book is being published, the main partners continue to work together as part of the LEADS Collaborative which supports health organizations using the LEADS framework to build leadership capacity (see Chap. 11). Programs, booklets, tools, techniques and instruments are available from the Collaborative.

Knowledge Mobilization Strategies

You will be excused if at some point in our description of LEADS you said something like, "LEADS is a pretty simple depiction of leadership: surely there is more to it than that?" You're right, there is. However, complex research is of little value if

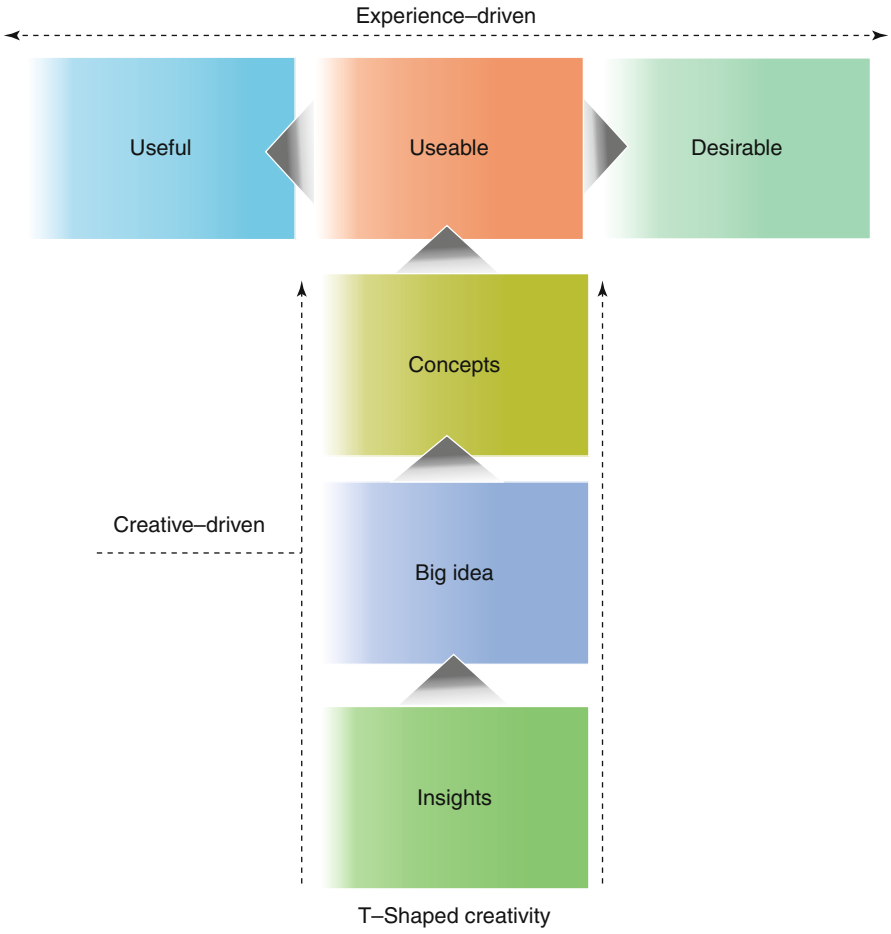


Fig. 3.3 The process of interactive marketing design (represented as T-shaped creativity) [12]

the people who need it can't access it, or have it converted into products, tools, and instruments that are valuable and useable at the same time. The point of knowledge mobilization—that is, putting knowledge into active service to benefit society—is to make research findings accessible and usable by turning complex ideas into products and services with practical application. In the business world taking complex research into leadership and making it accessible and valuable to decision makers is what David Armano [11], [9] calls interactive marketing design. Armano depicts that idea in a diagram he calls T-Shaped Creativity (see Fig. 3.3).

Interactive marketing design combines logic and emotion into a disciplined process of converting big ideas (such as thoughts on how leadership can shape change

[9] David Armano is Managing Director of Edelman Digital Chicago. This is his personal digital property where he shares insights, ideas and opinions on doing business in a connected age. His website is http://darmano.typepad.com/logic_emotion/2006/06/creativity_2e.html.

in the health system) into products, processes, services, events and environments useful for consumers, in the case of LEADS these consumers are individual leaders in health care, or organizational development professionals who are charged with the responsibility for leadership development and succession planning in their organization. With LEADS—beginning with the acronym itself—researchers, decision makers and professional brand strategists collaborated to create products and materials that would allow people to use the research base of LEADS both for the practice of leadership, and for developing it further.

T-shaped creativity looks straightforward—but is in fact difficult to pull off. Take away just one building block of the T and the interactive experience is incomplete. Figure 3.4 outlines shows how T-shaped creativity worked with the LEADS framework.

On the creativity axis of the model, there were two approaches. The first was to find ways to express leadership in a manner that makes it easily accessible or consumable. This became the idea of an identity-driven acronym. The second was to combine these ideas into a new approach to operationalizing leadership for decision makers.

Let's look at the creativity behind the LEADS acronym, which was chosen with great deliberation. The design team—researchers, decision makers, communications and brand people—wanted a simple window into the research. However, simplicity that couldn't express the complexity of leadership wasn't enough and there was a long debate over whether an acronym could capture the complexity of health leadership.

There were other considerations. First, by packing lead self, engage others, achieve results, develop coalitions and systems transformation into one word, LEADS represents the wholeness of leadership itself: from transformation of self to transformation of systems. LEADS—and the logo—became the brand of the enterprise. Most depictions of leadership focus on parts of leadership (Goleman's six styles [12]; Kotter's steps of change [13]; Covey's focus on personal traits and character elements [14]) LEADS encompasses all its aspects, while remaining true to important management and leadership research[10].

In communications and marketing, effective acronyms are said to have four characteristics: people who hear them can retain them, recall them, repeat them and research them:

Retain – Is your message simplified so your audience can retain it?
Recall – Can the audience recall your message 2 min, 2 h, 2 days, 2 weeks or two martinis later?
Repeat – Can they repeat it?
Research – If they can't do any of those, do they at least know what the acronym is so they can research why you are relevant in their world?

[10] In fact, that was one of our challenges; to be valid LEADS had to encompass as much meaningful research that we were aware of that had been done on the effective practice of leadership. We had to make sure we included key constructs and ideas such as those of Goleman, Kotter, and many other leadership authors.

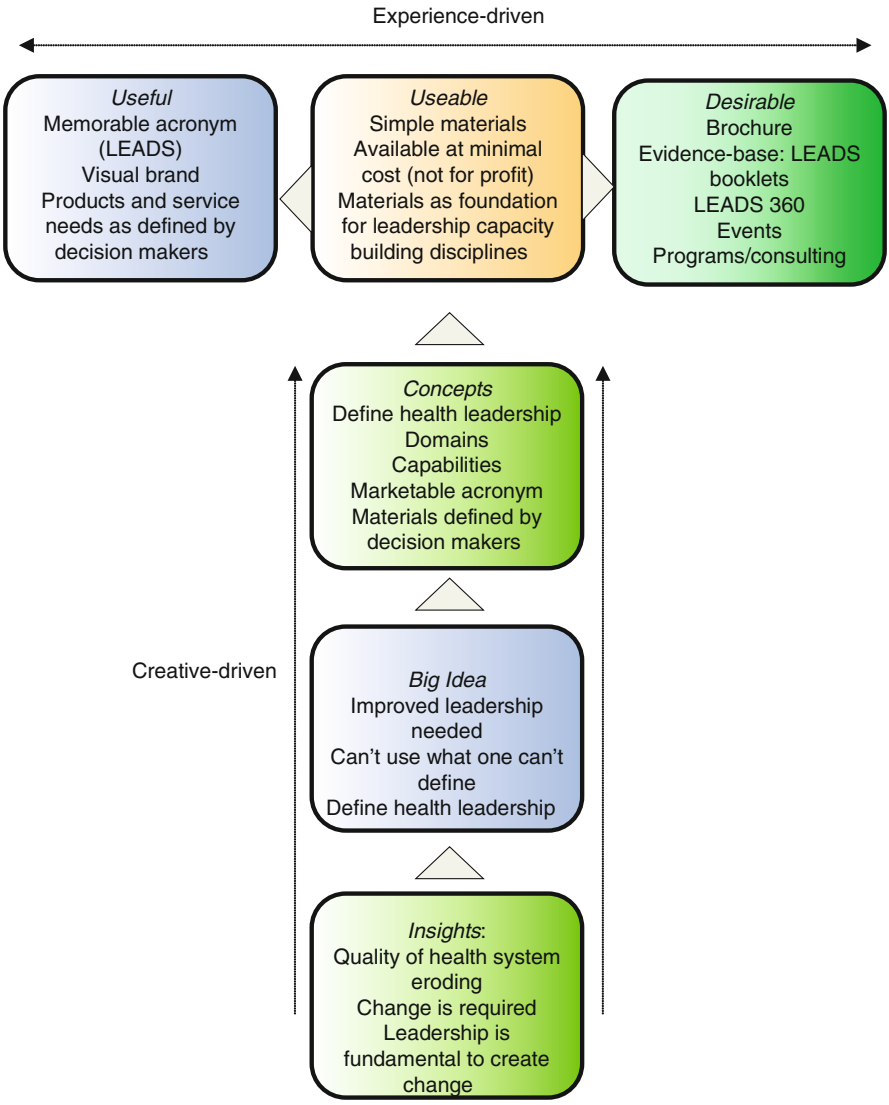


Fig. 3.4 The T-Shaped Creativity approach applied to the LEADS framework

People tell us the LEADS acronym is one of the reasons for the framework's appeal: once you've learned a bit about the framework, the acronym helps you remember its parts. People can recall LEADS easily; and if the content of the framework doesn't come immediately to mind, leaders can go to the LEADS brochure, the LEADS three-page research summaries, and the LEADS booklets to determine its relevance in the health world.

The creative axis builds into the experience axis, where we show our efforts to take the useable products of the creative process that led to LEADS and package them into desirable and useful products. On the desirable end of the T-model we have a range of reference materials, including a one-page brochure that outlined the framework, branded with the LEADS logo. In it, we described our belief that anyone can be a leader, to broaden LEADS' appeal.

Other reference material included 1-page, 3-page and 25-page summaries of the research behind LEADS and examples of LEADS in action. That was to meet the health sector's demand that evidence for new initiatives must be clearly documented and outlined, and its validity assessed. But decision makers also wanted examples and stories of LEADS in action. All the LEADS material is available in PDF and hard copy and has contributed greatly to the framework's acceptance and use.

Another of the products desired early on by decision makers was the LEADS 360 assessment tool that has been tailored for four different levels—front line supervisors, middle managers, senior leaders and executive leaders. People who want to hone their leadership skills can use the tool to judge how they're doing and plan for growth and improvement (there's more on this in Chap. 4). Our final desired product was face time—we offered speakers from the LEADS Collaborative to health authorities, across Canada that wanted to learn more about LEADS. We think this combination of products has helped make LEADS a popular approach to building leadership capacity across Canada.

Similar Efforts in Other Countries: UK, Australia and the Link to LEADS

Further validation of LEADS' effectiveness is provided by its similarity to other health leadership frameworks; one already in place in the United Kingdom and another two that have been developed in Australia. There are important similarities among the three frameworks in both content and approach to leadership. We are referencing them here so readers from those other countries can see the relevance of LEADS to their roles and work (We did not make comparisons to the United States because it has no single framework that purports to represent a common language for leadership across all professions and jurisdictions.[11])

[11] A framework within the US that comes closest to claiming to be a representation of leadership shared throughout the health system is the *Healthcare Leadership Alliance* Competency Directory, an interactive tool to ensure that future healthcare leaders have the training and expertise they need to continue meeting the challenges of managing the nation's healthcare organizations. The Healthcare Leadership Alliance is comprised of the nation's premier professional societies representing over 100,000 members across the healthcare management disciplines. In this framework, leadership is one set of competencies—and does not appear to represent a similar belief—as found in the Canadian, UK, and Australian situation—that leadership is the overarching skill set needed by all professionals in all health organizations for successful reform to take place.

Fig. 3.5 The National Health Services (Englang, UK) Leadership Framework

The United Kingdom

Figure 3.5 outlines the UK's National Health Service (NHS) Leadership Framework. This framework, like LEADS, "…provides a consistent approach to leadership development for all staff in health and care irrespective of discipline, role, function or seniority and represents the standard for leadership behaviours that all staff should aspire to [15]."[12] The NHS approach, like LEADS, acknowledges that "leadership is not restricted to people who hold designated management and traditional leader roles," but in fact is "most successful wherever there is a shared responsibility for the success of the organization, services or care being delivered."

Readers will note that there are significant overlaps between key topics of this framework and LEADS, such as "setting direction," which this is very similar to the Achieve Results capability includes "creating the vision". The sections "delivering the service" and "managing services" are also reflected in Achieve Results. Other domains that echo each other include Lead Self and the NHS category of "demonstrating personal qualities." "Working with others" reflects the Engage Others domain. "Improving services" in the UK model has elements of Systems Transformation, but the UK model does not put as much emphasis as the Canadian model does on capability of set direction leader's role in systemic change. "Working with others" is similar to the Develop

[12] Regardless of this contention in this quote that the framework so profiled is common to all professions, it should be noted that the UK has also created a separate 'Medical Leadership' competency framework for physicians, but is very similar in its overall framing to the NHS framework.

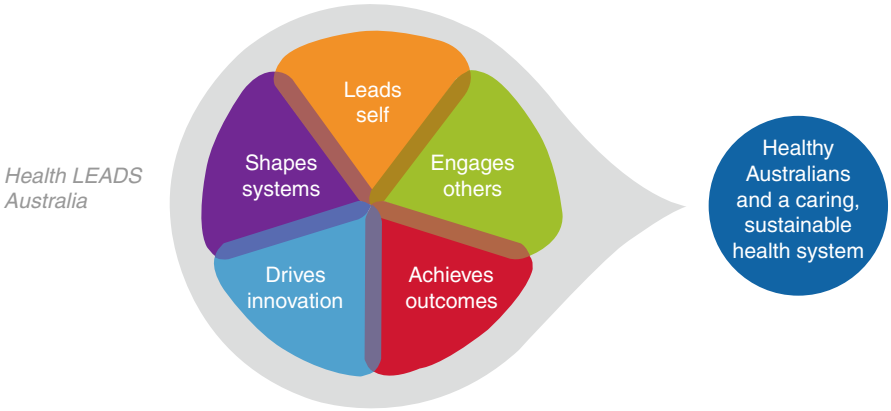


Fig. 3.6 Health LEADS Australia framework [16]

Coalitions domain but not emphasized as much, likely because the National Health Service is not fragmented the way Canada's health system is. Finally, the NHS model leans more towards a management focus than LEADS does.

Australia

Health Workforce Australia is a national coordinating body dedicated to system reform. In 2010, it released the *National Health Workforce Innovation and Reform Strategic Framework for Action*, *2011–2015*. It described the complex overlapping roles of current and future health workers and said leadership would be crucial in successful health reform. The plan called for "a leadership framework that defines the capabilities needed for leaders in all areas of health,"[13] and a draft document called *Health LEADS Australia* was released for public consultations, which were completed early in 2013. The framework, depicted below, was formally endorsed in June, 2013 (Fig. 3.6).

[13] For a fulsome summary of the HWA approach, read the report entitled, "HWA (2012) *Leadership for the Sustainability of the Health System*: *Part 1 A Literature Review*." Available at: http://www.hwa.gov.au/publications

Other strategies include:

- Working together to embed the leadership framework in all education, training and continuing professional development programs.
- Building national health leadership training and development opportunities to drive innovation and reform and improve productivity.
- Strengthening and supporting leadership capacity within the Aboriginal and Torres Strait Islander workforce to accelerate progress in achieving the goals of *Closing the Gap*.
- Promoting and sustaining collaborative inter-professional clinical practice, workforce learning and expanded roles to ensure outstanding care and service in the Australian health system.

Fig. 3.7 The New South Wales Health Leadership Framework (HETI) [17]

Health LEADS Australia is the result of 18 months of independent research and dialogue with stakeholders across the Australian health system. The penultimate draft showed the capacity organize its leadership qualities under the L-E-A-D-S acronym. As Professor Dickson was in Australia at the time and present at the stakeholder consultation workshop, this was negotiated on the spot with agreement later formalized to recognize the Canadian work and influence. The two frameworks are similar, as this description shows.

> Leadership requires reflection and improvement of self (Leads self), fostering change in others in the workplace (Engages others), communicating a vision for the future and enabling decisions to support value propositions (Achieves outcomes). To achieve those outcomes, leaders embrace the spirit of change and innovation (Drives innovation) and strategically understand and align complex systems with the vision and desired outcomes (Shapes systems) [15].

Four of the five domains are almost identical to the canadian framwork; as in the UK, one that differs most significantly is "Develop Coalitions". In the Australian model, that concept is captured in the Engages Others domain, and the D in LEADS in Australia is Drives innovation—which reflects the high priority the Australian providers, health stakeholders and government give to the need for not only innovating for reform and improvement, but doing so in ways that will maximize the diffusion and take up of successful improvements. Similarly, Health LEADS Australia shares with the Canadian LEADS, concepts emphasizing the public good that leadership represents in health, the lifelong nature of leadership development and the

collective growth of leadership capacity and the distinct characteristics that each person brings to their leadership practice.

The state of New South Wales in Australia endorsed a framework similar to the Canadian LEADS framework in 2013, but did its development work prior to the formalization of the HWA work.[14] The Health Education and Training Institute leadership framework for New South Wales Health is shown in Fig. 3.7

The five domains of the New South Wales framework are given in a different order, and packaged slightly differently but have very similar content to LEADS. Significant independent research done in New South Wales also validates the five domains of LEADS.

Conclusions

The *LEADS in a Caring Environment* Capabilities Framework is a by health, for health depiction of the leadership necessary to reform and sustain the health system. It is the source code for individual, organizational and systems-level leadership. LEADS is a valid, research-based framework that has been adopted by the Canadian Health Leadership Network, the Canadian College of Health Service Executives, and many other Canadian health organizations as a 'standard' defining the qualities of leadership needed to engender change in Canada's health system.

LEADS is soundly based on the leadership literature, but also reflects what stakeholders told us were qualities they needed and wanted to see in healthcare leaders. It is consistent with frameworks emerging in other international jurisdictions. We think its sound research base and the resonance it has had with those who have seen it and tested it so far are measures of its validity. We very much hope individual Canadians dedicated to health care and the institutions and organizations they work in will take this opportunity to acquaint themselves with the framework through this book, and use it as a valuable tool to generate change and transformation in modern health service delivery. Similarly, we trust that leaders in the UK, particularly as it revises its approach in the light of a major national report recommending changes to leadership will see the relevance of the LEADS framework to the exercise of leadership in their system. We are collaborating with Australia and expect over time, this collaboration will enable each systems' experience of health leadership to enrich the other.

Each of the next five chapters explores one of the five domains of LEADS, and offers you the opportunity to start your leadership growth by reflecting on your experiences and what you're reading.

[14] It is to be noted that HWA did not just "take up" LEADS). Independent research and extensive consultation was done prior to adopting the LEADS acronym and the contents reflect the unique culture and situation of health reform in Australia.

References

1. iWise Wisdom on Demand [Internet]. 2013. Available from: http://www.iwise.com/TPU7r. Cited 11 July 2013.
2. Leads Collaborative. LEADS in a caring environment [brochure]. CHLNet; 2013.
3. Denis J-L, Lamothe L, Langley A. The dynamics of collective leadership and strategic change in pluralistic organizations. Acad Manage J. 2001;44(4):809–37.
4. Ford R. Complex leadership competency in health care: towards framing a theory of practice. Health Serv Manage Res. 2009;22(3):101–14.
5. Pawar B, Eastman K. The nature and implications of contextual influences on transformational leadership: a conceptual examination. Acad Manage Rev. 1997;22(1):80–109.
6. Down C, Martin E, Hager P, Bricknell L. Graduate attributes, key competence and judgments: exploring the links. Paper presented at: HERDSA annual international conference, Melbourne, 12–15 July 1999.
7. Mintzberg H. Managers, not MBAs: a hard look at the soft practice of managing and management development. San Francisco: Barrett-Koehler; 2004.
8. Stringer E. Action research. 3rd ed. Thousand Oaks: Sage Publications; 2007.
9. Dickson G, Briscoe D, Fenwick S, Romilly L, MacLeod Z. The Pan-Canadian Health Leadership Capability Framework Project: a collaborative research initiative to develop a leadership capability framework for healthcare in Canada. Ottawa: Canadian Health Services Research Foundation; 2007. 21 p.
10. Philippon D. The leadership imperative in publicly funded universal health systems with a particular focus on the development of the Canadian Health Leadership Network (CHLNET) [Internet]. Ottawa: Canadian College of Health Leaders; 2011. Available from: http://www.chlnet.ca/sites/default/files/Fellowship%20report%20.pdf. Cited 13 July 13.
11. David Armano. Creativity 2.E [Internet]. 2006. Available from: http://darmano.typepad.com/logic_emotion/2006/06/creativity_2e.html. Cited 13 July 2013.
12. Goleman D, Boyatzis R, McKee A. Primal leadership: realizing the power of emotional intelligence. Boston: Harvard Business School Publishing; 2002.
13. Kotter JP. Leading change. Boston: Harvard Business School Press; 1996.
14. Covey SR. The 7 habits of highly effective people: powerful lessons in personal change. New York: Simon & Schuster; 1989.
15. NHS Leadership Academy. Leadership Framework (LF) [Internet]. 2013. Available from: http://www.leadershipacademy.nhs.uk/discover/leadership-framework/. Cited 13 July 2013.
16. Health Workforce Australia. Health LEADS Australia [Internet]. 2013. Available from: http://www.hwaleadershipframework.net.au/. Cited 13 July 2013.
17. HETI. The NSW health leadership framework. New South Wales: HETI; 2013. 8 p. Image of NSW Leadership framework; p. 1.

Chapter 4
Learning LEADS: A Lifelong Journey

The tallest tree in the forest is not the tallest just because it grew from the hardiest acorn; it is the tallest also because no other trees blocked its sunlight, the soil around it was deep and rich, no rabbit chewed through its bark as a sapling, and no lumberjack cut it down before it matured.

–Malcolm Gladwell [1]

The old adage "leaders are born, not made" is misguided. Our premise in developing the LEADS framework and writing this book is quite the opposite: we contend leadership can be learnt and developed. As Malcolm Gladwell points out in his book *Outlier*s (above) an individual must be nurtured in an environment that creates the conditions for success. In this chapter, we outline an approach where it's up to you, the leader, to create that nurturing environment for yourself. You are, after all, CEO of self!

Building on the genesis of LEADS over time, this chapter underscores leadership development as a life-long pursuit. Its purpose is to help create a bridge between the theory and the practice of leadership and to explain the activities we call "learning moments" for each domain.

The Approach

Most leaders develop their craft in the workplace, through experience. It's not an easy path: Mark Twain said "A man who swings a cat by its tail learns something he can learn in no other way." Many of us who've learned leadership on the job feel like that man: scratched and bitten, but knowledgeable and experienced.

The *LEADS in a Caring Environment* framework describes the capabilities needed to be an effective leader in health care. But knowing what those capabilities are and where they came from is only the first step. You'll be trying them out in the crucible of the real world. To keep you from getting discouraged as you do that, we're recommending you use *experiential learning*. Sometimes called *action learning*, it's a developmental approach that has groups of people work together on real

G. Dickson, B. Tholl, *Bringing Leadership to Life in Health: LEADS in a Caring Environment*, DOI 10.1007/978-1-4471-4875-3_4, © Springer-Verlag London 2014

issues, but in a structured way that encourages collective discussion and reflection so what happens is carefully considered and its impact studied to shape future activity.

Learning Leadership: Why It's Different from Learning Anything Else

Learning leadership differs from learning anything else in two important ways. The first is the tools of the craft. A hockey stick and skates are the tools of hockey. For rock music it's guitars and drums, a hammer and saw for carpentry.

But in leadership, your core attributes, values, beliefs and talents, are your tools. You can change superficial behaviour to influence others but—as we noted in Chap. 3—to truly be effective, your behaviour must be consonant with who you are. Kouzes and Posner [2] put it this way: "leadership is an art—a performing art—and the instrument is the self." You are the instrument; your growth as a leader is all about tuning yourself.

Learning leadership is also different because the setting for leadership is almost always fluid and unpredictable, and there are factors at play in dynamic settings that can make learning a challenge. Learning leadership must adapt to these factors:

- Leadership is situational;
- Effective leadership is in the eye of the follower;
- Experience is both practical and emotional;
- Growth happens through learning and unlearning;
- Learning leadership is a lifelong process.

Leadership Is Situational

What you as a leader must do always depends on the time, place and conditions of events, the nature and needs of the follower, and your own skills. What works in one instance may not work in another. Leaders need to be able to read the moment to decide what to do; they can't depend on a standard recipe. One concept of leadership—the contingency theory—reflects this perspective [3–5]. We think of it as a fact of leadership life.

Effective Leadership Is in the Eye of the Follower

It may seem paradoxical to say it in this book, but leadership is all about the followers. What works, and what doesn't, to influence them most effectively?

True leadership in health care is the ability to encourage, enable and empower others to do their work serving patients and citizens [6].[1] To do that, a leader must be in tune with those others, to influence them and shape the situation most effectively. And she must also be open to feedback on whether she was successful from the follower's perspective. This is not to say, however, that an individual is always a leader or always a follower. Consistent with our belief in distributed leadership, we believe the role of leader and follower can shift from person to person, depending on the situation, the circumstance, and the capabilities of the people involved.

Experience Is Both Practical and Emotional

Emotions are an important part of experience, but learning how to separate emotions from events and use emotions constructively is not easy. Dr. Sandy McIver, a colleague of ours, has helped create high-performance teams across North America—that is, teams capable of accomplishing high-quality work while finding the experience rewarding and enjoyable [7]. He recognized early in his work that most efforts at team building emphasized the logical and instrumental processes of effective teamwork, but downplayed the emotional aspect of it.

McIver calls that "emotion demotion." Downplaying or even refusing to acknowledge emotions in the belief logic and reason are all that matter ignores important aspects of the experience that need to be better understood. Leaders need to be conscious of, and reflect upon, the emotion in an experience and respond to it appropriately.

Growth Happens Through Learning and Unlearning

Chris Argyris, a professor at Harvard Business School is known for his work on learning organizations. He says both learning and unlearning are important for developing successfully [8]. According to him, learning is when you add new behaviour you need to be successful in a future endeavour, while unlearning is taking away behaviour that gets in the way of your effectiveness. His point, explained in a 1991 Harvard Business Review article called "Teaching Smart People to Learn" is that successful people are often not used to failure and have never learned from it. They have a tendency to let certain approaches become habitual because they have been proven over time to work for them. They are

[1] Jim Kouzes and Barry Posner, in their book *The Leadership Challenge*, define five qualities of effective leadership: Inspire a shared vision; Encourage the heart; Enable others to act; Model the way; and Challenge the process.

defensive when things go wrong, blaming other people or circumstances, but unable to admit they might have made mistakes. They are unconscious of these habits and can't see when they are getting in the way of responding effectively to new situations.[2]

Peter Senge [9] calls these habits mental models. He defines mental models as "deeply ingrained assumptions, generalizations, or even pictures or images that influence how we understand the world and how we take action. Very often, we are not consciously aware of our mental models, or the effects they have on our behaviour" [9]. Those unconscious mental models can lead to what he calls "the delusion of learning from experience," doing the same thing over and over, but not taking the time to plumb the experience for its natural lessons.

It's important to note that unlearning doesn't always mean forgetting and eliminating some capability or mental model. Unlearning is about bringing mental models or habitual behaviour into the open and recognizing when they are inappropriate [10].[3] Sometimes the habit is a constructive one, such as teaching, which is often, but not always, a good thing to do. However, some behaviour—like micro-managing, which really means taking power away from followers—should be flushed out permanently. Good and bad habits, as we know, can be addictive, and overcoming them can be as arduous as overcoming any other addiction.

Learning Leadership Is a Lifelong Process

In order to adapt to the various roles that we encounter during life, it's important to be constantly learning. What works when you are a clinician won't work as a CEO. And what works as a senior executive in a hospital does not necessarily work when you are on the board of a homeless person's society. At one point in your life you may be a citizen who wishes to lead change at the community level; in another, you might be a health-care provider who needs to "lead" a patient to taking greater responsibility for his own health. In each case, the knowledge and skills required to lead effectively is dictated by the role. Strategic change is important to the CEO. Knowledge of community power structures is helpful to the citizen leader. And empathy for the patient and the ability to communicate is fundamental to the health-care provider. Being able to grow and develop in order to meet the needs of all of these situations is lifelong learning.

[2] A movie devoted to this theme is Groundhog Day, starring Bill Murray. For an enjoyable and funny treatment of the need for both learning and unlearning, you are encouraged to watch it.

[3] In academic parlance "unlearning" is similar to meta-cognition. Meta-cognition is knowing about knowing; that is, the ability to know and understand—in this instance—the negative impact one's behaviour may have on one's leadership of others. However, meta-cognition does not have a second element of unlearning implicit in it: the ability to suppress and/or alter that behaviour.

One Way to Learn Leadership: The Hero's Journey

According to cultural anthropologist Joseph Campbell, in times of turbulence and confusion we often look to heroes to give us courage and hope. He defines the hero as "the champion not of things become but of things becoming….The dragon to be slain by him is precisely the monster of the status quo. The hero's task always has been and always will be to bring new life to a dying culture" [11]. We look to iconic figures who personify these qualities for inspiration: that is, to lead us to a better future.

Jim Kouzes and Barry Posner underscore this point [6]. They describe leadership as the ability of an ordinary person to rise to the challenge of situation and circumstance and do extraordinary things in response. Average people can demonstrate a heroic ability to inspire and encourage others: that's leadership. Sometimes leadership is charismatic and sometimes quiet and unassuming. But the result is the same: followers are empowered to act, rather than remain victims of circumstance.

There is deep appeal and power to mythology such as the hero's journey. Webster's dictionary describes a myth as a "traditional, typically ancient story dealing with supernatural beings, ancestors, or heroes that serves as a fundamental type in the worldview of a people, as by explaining aspects of the natural world or delineating the psychology, customs, or ideals of society." Campbell called the hero's journey a mono-myth: a repeating pattern of cultural stories that express the worldviews of many societies, and that underpin our instinctive way of understanding the challenge of experiential learning in order to become a better person.

In his book *The Hero of a Thousand Faces*, Campbell describes the hero's journey [11].[4] The title reflects the numerous examples, in many cultures, of how an ordinary person can be transformed into a leader by experience. In Herman Hesse's *Siddhartha*, the central character decides he must venture away from his accustomed life and go on a journey to attain spiritual enlightenment. In Homer's Iliad, Ulysses is transformed by his experiences.

George Lucas's deliberate use of the archetype of the hero's journey in the *Star Wars* movies is well documented. Dorothy, in the *Wizard of Oz*, undertakes her own hero's journey. There are also many true examples: Nelson Mandela's transition from insurrectionist to president personifies the hero's journey.

Figure 4.1 shows the journey as a series of experiences that ultimately lead to personal growth and transformation [12]:

1. *The call to adventure: innocence lost.* Experiential learning, like a hero's journey, begins with the leader in a state of unconscious innocence—chugging along comfortably in his role. But something happens—for example, a new

[4] Indeed, some critics have interpreted the use of the term hero in the title as implying only special individuals can lead; and that the concept seems to support the "great man" theory of leadership. However, we interpret the title as saying the exact opposite: that there are thousands of heroes, and the ability to be heroic resides in all of us. And the way to realize that potential is to recognize the power of experiential learning, as represented by the hero's journey, and to make it the discipline we employ to grow our leadership capability.

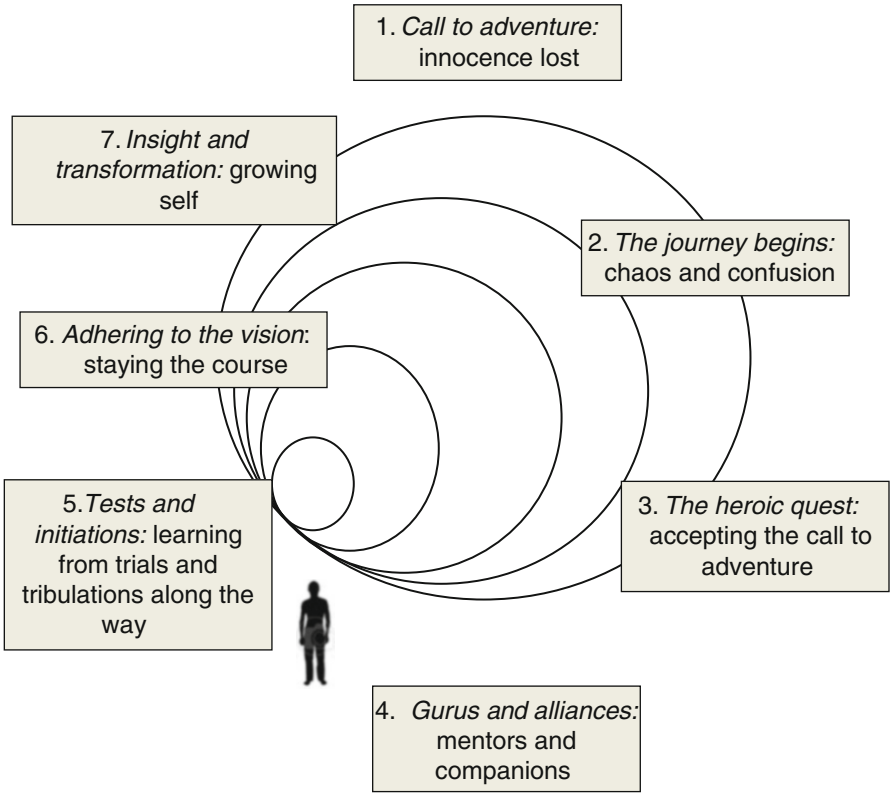


Fig. 4.1 The hero's journey of experiential learning [12]

government policy, a relationship that goes off the rails, or restructuring—that disturbs that innocence, and thrusts the leader into an adventure (desired or not). A journey that will bring about change is afoot.

2. *The journey begins: chaos and confusion.* What happened? What do I do now? How do I cope? Do I just hunker down and wait out the change? Do I like the change? Why can't we just go back to the old way? The Sufi poet Rumi has a metaphor for attempts to recapture what once was but has gone: "There is no use in [wine] trying to become a grape again." Sometimes the individual resists the call, at least initially. Finding a way out of chaos and confusion seems daunting—and the way forward is anything but clear.
3. *The heroic quest: accepting the call to adventure*. This is crucial. The leader must choose between remaining awash in confusion and inaction, hoping the situation will resolve itself; or taking the initiative to act. To take initiative is to lead. To remain a victim is to follow. The desire to take initiative may come from some insight, sheer will or deep-seated frustration. This is not to say that the leader knows what to do and how to do it; but she is willing to act—to begin a journey to a more desirable future state. This is the essence of leadership; and in

the case of experiential learning, the step at which the leader chooses to learn or unlearn, as the case may be.

4. *Gurus and alliances: mentors and companions.* In almost all hero's journey myths, the protagonist cannot learn or lead alone. Along the journey, she meets others who provide her with guidance, insight, and friendship—and who share the goal of the journey with her (such as the Tin Man, the Lion, and the Scarecrow from the Wizard of Oz). In leadership, your companion may be a buddy from the office, a team member, such as a peer with skills you don't have, or an expert who can mentor you along the way. Leaders do not lead—or learn—alone and you should be prepared to include it in your experiential learning.
5. *Tests and initiations: learning from trials and tribulations along the way.* Not everyone will share your vision and goal. Some resist, some don't understand, some don't have the energy to change. Sometimes leaders have enemies who oppose what they're trying to do. At other times they face obstacles, perhaps policy, practice or culture that are antithetical to their vision. But, as the saying goes, "what doesn't kill you makes you stronger." Learning from experience means accepting that difficulties create opportunities with the greatest potential for insight—if you are open to them and take time to reflect on them.
6. *Adhering to the vision: staying the course.* Many leaders abandon their vision, perhaps exhausted by the effort of achieving it. Leaders—and experiential learners—need to be resilient. An old Chinese proverb says "a leader is someone who is knocked down seven times and gets up eight." So it is with learning leadership: it is a lifelong endeavour. The good news is that if you are open to learning throughout the journey, your leadership skills will be profound later in life. The bad news is many of us abandon learning too early in our career. Learners and leaders must stay the course to realize their learning potential.
7. *Insight and transformation: growing capacity.* The ultimate benefit of going on a leadership journey is returning home again, but enriched from your experiences. For an experiential learner, that result is personal insight and knowledge of practices that will make you the leader you want to be. The previous steps prepare you for transformation into the leader you want to be; the trick here is to retain the wisdom you have gained, integrate it into your practice, and share it with the rest of the world.

We're using the hero's journey as a metaphor for experiential learning, but also to show the adventure and risk in setting out on a learning journey. Adventure has no certain outcome or pre-determined path. If it did, it would be a plan, not an adventure. T.S. Eliot, in his poem *The Wasteland*, suggests hero's journeys (plural) are the stuff of life, and as long as one is open to opportunity, never over: rather, something destined to renew itself in ever-increasing opportunities for fulfilment and enlightenment:

We shall not cease from exploration
And the end of all our exploring
Will be to arrive where we started
And know the place for the first time.

We encourage the readers of this book to see their leadership learning journey in the spirit of opportunity, adventure and exploration, ultimately to be realized as personal fulfillment as a leader.

Experiential Learning and Leadership

A second way to think about learning leadership in the workplace comes from experiential or action learning. Experiential learning helps us to:

- Make sense of the chaos and confusion of changing experiences that are natural and confusing.
- Reduce the unknown elements of change to a comprehensible level.
- Develop ways to determine how to respond to and interact with changing internal and external environments; and
- Define our personal space in change and our individual view of the context in which we are being asked to change [13].

These are not new concepts and have been written about by many scholars over the past 50 years [14, 15] but there are particular nuances when it comes to learning leadership [16, 17].

Many interpretations of experiential learning are reflected in David Kolb's work [18]. Marilyn Taylor subsequently characterized learning as a continuous process of disorientation, exploration, reorientation and equilibrium. It's a cycle and the desired state is multiple loops through the cycle. The cycle is pictured in Fig. 4.2.

Let's explore experiential learning further in this story:

Gerry, vice-president of strategic planning at a large health authority got a call from Marilynn, a colleague in another department, who had once been a student of Gerry's when he was guest faculty at a master's program at a local university. She called him because she was struggling with an issue and wanted to discuss it.

The next morning the two met at Starbuck's. After a few pleasantries, Marilynn laid out her issue: she was struggling with her supervisor Barbara, who travelled regularly, and was always so busy when she was there Marilynn could not get decisions on very important, time-sensitive issues.

Gerry said to Marilynn, "Well, if it were me, I would go to her executive assistant and book a meeting. They always control their boss's agenda. Or you might try to button-hole her at lunch time when she's leaving the office."

Marilynn grimaced and said, "Well, the executive assistant approach won't work. Diane is very protective of her boss and won't schedule meetings for direct reports unless she asks Barbara first…that's been part of the problem. And as for the lunch idea, Barbara always brings her lunch, and prides herself on working through lunch."

Gerry tried a second time. "Why don't you hang around Barbara's office before she comes in, and try to intercept her then?"

Marilynn shrugged. "You never know when Barbara comes to work. Half the time she's dropping her kid off at school; the other half she's at a meeting with some stakeholder group or at an off-site function. That's part of the problem. We never know her schedule."

Gerry, ever helpful, tried again. "Why don't you send her an email, saying it's really important you meet with her, and ask her to suggest a time?"

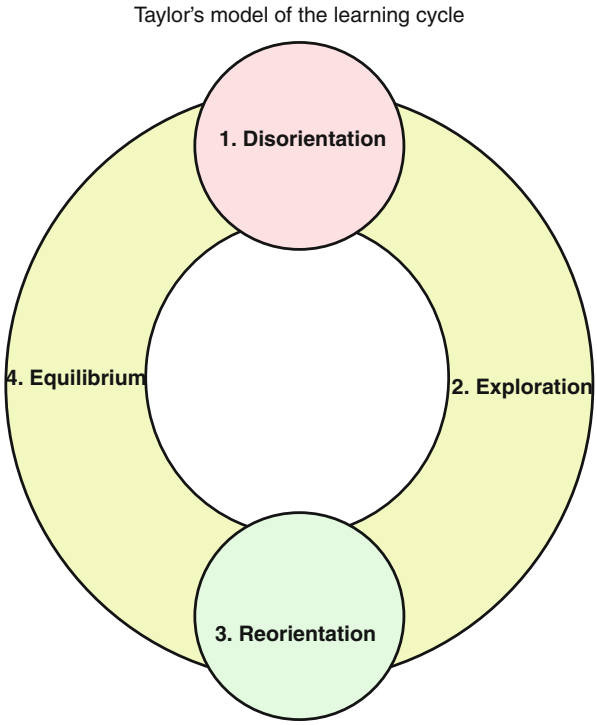


Fig. 4.2 Marilyn Taylor's model of experiential learning [19]

"Goodness", said Marilynn, with a touch of asperity in her voice. "You don't think I've tried that? That was the first thing I did."

"Well", said Gerry, "Do you want me to talk to Barbara?" He could see that Marilynn was becoming distressed and wondered what he had done. After all, he was just trying to help.

"NO!" Marilynn said, clearly annoyed. "That would be the worst thing you could do". She picked up her purse and plunked a couple of dollars down on the table. "Thanks for the coffee, Gerry" she said. "I'll figure something out. Much appreciated." She walked away, clearly distraught.

Gerry walked back to his office, puzzled by how the conversation had gone so wrong. He knew he and Marilynn respected each other and he hadn't expected such a reaction to his advice. When he got back to his desk he pondered the discussion. "What did I do?" he wondered. He reflected on their conversation, contemplating his suggestions and Marilynn's responses. He had suggested several solutions but Marilynn responded more negatively to each one. "What's that about?" he wondered.

Then he remembered a lesson he had taught in his master's program—about the difference between teaching and coaching. He pulled out the LEADS framework and quickly reviewed the Engage Others domain. Under Communicates Effectively, he read: "They listen well and encourage open exchange."

Suddenly it came to him. He realized that he had been teaching, not listening. "For Pete's sake", he said, talking aloud. "There was no open exchange…and I didn't listen," Gerry said to himself. "I did all the talking—I was teaching! And of course I was, that's my background (Gerry had been a teacher for ten years prior to changing his profession). It's what I do well…but she needed coaching!"

He turned to his computer and Googled coaching for improvement. He read through the steps: 1. Define the performance problem. 2. Invite the employee into the discussion.

3. Listen closely so you can understand the employee's perspective on the situation. 4. As needed, explore possible causes…together.

When he reviewed the conversation, Gerry realized that he had fallen into his tried and true practice of being the expert with all the answers, which was particularly easy to do with a former student. He had forgotten that she had moved on to be an expert in her own right, and needed coaching, not teaching. The essence of coaching—asking questions, on the assumption the individual has the answer within them and just needs to discover it—was completely at odds with his approach. Gerry was frustrated at himself for not recognizing his "mental model" but decided to correct the oversight.

He called Marilynn and asked to meet again the next day over lunch—his treat. He promised that he would like to give it another go, if she was up for it. Marilynn agreed cautiously. That evening, Gerry reviewed some of the resources he had on coaching, and devised a coaching approach, including preparing himself to recognize the signs of the teacher in him coming to the fore.

At lunch the next day, with Gerry in coaching mode, both discovered Marilynn did have an idea for a solution—putting the issue in a briefing note, with a request it be discussed at the next management meeting. Apparently Barbara liked to use briefing notes to structure her management meetings—which Gerry did not know and would never have suggested.

This a story of learning by experience (with a little help from LEADS and Dr. Google). In it, Gerry learns the importance of including the knowledge and skills of coaching among his leadership tools, and he unlearns his natural urge to teach, rather than coach. Let's look at how it follows Taylor's cycle of experiential learning.

The cycle begins with an experience, Gerry's initial conversation with Marilynn. This is a unique situation because the dynamics between Gerry and Marilynn are different from other relationships and the circumstances she was talking about were different in context, events and personalities from any others. Gerry and Marilynn each understood that experience, identified in Taylor's model as the disorientation step, differently. Gerry provided advice, which Marilynn had already considered. Marilynn became annoyed, frustrated and despite Gerry's good intentions she was left with no solution. This is the innocence lost period of a hero's journey and both were clearly disoriented due to the exchange.

The next step is Gerry's reflection on the event. This is the exploration step of the Taylor model. He played the experience over in his mind, wondering why Marilynn had reacted as she did. He parsed out his actions (Marilynn's growing negative reactions and no effort by him to find out what Marilynn had already done or not done). His reflections show the importance of recognizing the emotions of both people, because the experience is not defined not just by what occurred but Marilyn's emotional reaction. In fact, her emotions triggered Gerry's desire to reflect on the situation, and to learn. We need to note that his reflections led him to wonder what he could have done better and led to his insight that he had been teaching rather than coaching. This is the "chaos and confusion" stage of the hero's journey.

In keeping with the third step in Taylor's learning cycle, Gerry reoriented his thinking and decided to act differently (coaching instead of teaching). In the hero's journey, this step is the "heroic quest." He decided to try again to meet Marilynn's needs. He turned to the literature to clarify how teaching and coaching differ. This is the "searching out gurus and alliances" stage in the hero's journey. Then he planned the conversation he would have with Marilynn—not only what he would do

to craft questions, listen to responses and be in the moment with her—but also what he would do to suppress his natural tendency to act as a teacher.

Finally, in step four, Gerry and Marilynn initiated a new action—in which Gerry practiced the skills of coaching with her. This restored some equilibrium to the relationship (Taylor's fourth step). This is the "tests and initiation" stage of the hero's journey. In this conversation he asked questions to establish what Marilynn had already done and about Barbara's management style and how she made decisions. He listened and asked probing questions, such as: When you've been successful in getting Barbara's attention in the past, what worked? What likely made it work? How did what you did fit into Barbara's preferred management style? If you were to follow a similar pattern in this instance, what would it look like? Rather than give advice, he inquired to understand, using a principle of Stephen Covey's —"seek first to understand, then to be understood" [20].

Gerry also kept himself consistently aware of his natural desire to leap in and provide advice, and suppressed it. He had to or relive the dynamics of the conversation the day before. This is the "staying the course" stage on the hero's journey. It was clear from the conversation that Marilynn already knew the solution; she just had to be reminded of what she knew, and take ownership of it.

Later Gerry reflected on the successful second meeting with Marilynn, getting the insight he needed for transformation. If, however, the conversation had not worked, Gerry would have had to go through the cycle again, to parse out the dynamics of the situation and what he might do differently to achieve a positive result.

A Discipline to Learn Leadership

Integrating the experiential learning cycle and the hero's journey led us to these top ten guidelines for learning leadership in the workplace:

- Look for the leadership opportunity in any situation.
- If that situation feels chaotic, confusing, or perplexing to you—and you are uncomfortable with the result—it represents an opportunity to learn (or unlearn).
- Reflect on the situation to make sense of it: what do the people I am trying to lead need from me that they are not getting? What did I do to contribute to the confusion?
- Use what you've learned this time to set a goal for personal improvement—what aspect of your behaviour do you need to change?
- Enlist others you trust (it could be colleagues, mentors or writers) to support and guide you as you learn.
- Practice your desired behaviour in the workplace. Look for situations where you can test yourself.
- Gather feedback on your effort, then reflect on what you heard. What insights have you gained? Were you successful? Why? Why not?

- Transform your behaviour by adding a new behaviour, or figuring out how to unlearn habitual practices and mental models that aren't constructive.
- Find time for ongoing, systematic self reflection.
- In the spirit of lifelong learning, start again.

You can apply these guidelines for learning leadership in the workplace in three contexts. The first context is completely informal; you simply choose to employ the guidelines and take care to integrate their ideas in your day-to-day work. You can try a mixed formal and informal approach, perhaps by enrolling in a leadership program and using the guidelines to apply what you learn at work. The third context is decidedly formal, by creating an organizational policy requiring leaders to get formal training, document it and show evidence of growth and success. Try all three!

Note too that the learning opportunity was enhanced by access to learning resources: the LEADS framework itself, and Dr. Google that provided needed knowledge on the difference between teaching and coaching. In keeping with the hero's journey metaphor, learning resources such as those are brought along in your backpack for the journey.

This book is one of those resources, and the many tools, techniques and approaches highlighted in the chapters on LEADS can also assist you in learning.

Conclusions

In this chapter we've discussed the significant evidence that leadership can be learned and developed, like music or athletic ability, through acquiring skills and knowledge and practising; and there is a discipline for doing that. Warren Bennis, a professor at the University of Southern California, once said that leadership cannot be taught, but it can be learned [21]. He recognized the discipline needed for success in leadership depends on the will and commitment of people who want to increase their leadership capacity. Consistently striving to be better is a life-long pursuit.

You won't learn leadership from a single training program or an individual event. Malcolm Gladwell, in his book *Outliers,* suggests to be truly proficient is a matter of practicing a specific task for a total of around 10,000 h [1]. Successful leaders use experiential learning for ongoing development, because it lets them see recurring patterns of experience and understand what works and what doesn't.

In the spirit of this chapter the remainder of the book will employ three primary strategies to assist the reader to learn from experience. First, a few select stories will be used to simulate the various capabilities of the LEADS in a Caring Environment capabilities framework. Second, in sections called "Learning Moments" questions will be posed to provide you with opportunities to reflect on your leadership capability. Some suggestions as to how to practice a particular capability in the workplace are provided. Each chapter will then end with a self-assessment on the LEADS

domain to engender another round of learning. We now invite you to embrace the opportunities to learn that the workplace provides for you and to use LEADS as a guide. And that takes us to the first of the LEADS capabilities: Lead Self.

References

1. Gladwell M. Outliers the story of success. New York: Little, Brown and Company; 2008.
2. Kouzes J, Posner B. The leadership challenge. 4th ed. San Francisco: Jossey Bass; 2007.
3. Fiedler F. A theory of leadership effectiveness. New York: McGraw-Hill; 1967.
4. Morgan G. Images of organization. Thousand Oaks: Sage; 2007.
5. Yukl G. Leadership in organizations. Custom ed. Upper Saddle River: Pearson Custom Publishing; 2010.
6. Kouzes J, Posner B. The leadership challenge: how to make extraordinary things happen in organizations. San Francisco: Jossey-Bass; 2012.
7. MacIver K. A systems-based model for team development. Victoria: K. A. McIver and Associates; 2000.
8. Argyris C, Schön D. Organizational learning II: theory, method and practice. Reading: Addison Wesley; 1996.
9. Senge P. The fifth discipline. New York: Doubleday; 2002.
10. Pfeffer J. Changing mental models: HR's most important task. Hum Resour Manage. 2005;44(2):123–8.
11. Campbell J. The hero of a thousand faces. New York: Pantheon Books; 1949.
12. Brown J, Moffat C. The hero's journey: how educators can transform schools and improve learning. Alexandria: Association for Supervision & Curriculum Development; 1999.
13. MacKeracher D. Making sense of adult learning. 2nd ed. Toronto: University of Toronto Press; 2004.
14. Taylor M. Emergent learning for wisdom. Basingstoke: Palgrave MacMillan; 2011.
15. Marquardt M, Leonard S, Freedman A, Hill C. Action learning for developing leaders and organizations. Washington, DC: American Psychological Press; 2009.
16. Cocowitch V, Orton S, Daniels J, Kiser D. Reframing leadership development in healthcare: an OD approach. In: Collaboration, culture change, and leadership development. OD Practitioner. 2013;45(3):10–19.
17. Hanson B. The leadership development interface: aligning leaders and organizations toward more effective leadership learning. Adv Dev Hum Resour. 2013;15(1):106–20.
18. Kolb D. Experiential learning: experience as the source of learning and development [internet]. Englewood Cliffs: Prentice Hall; 1984. Available from: http://academic.regis.edu/ed205/Kolb.pdf.
19. Jarche H. Disorientation in learning [internet]. 2007. Available from: http://www.jarche.com/2007/06/disorientation-in-learning. Cited 20 July 2013.
20. Covey S. The 7 habits of highly effective people: powerful lessons in personal change. New York: Simon & Schuster; 1989.
21. Bennis W. On becoming a leader. New York: Addison Wesley; 1989.

Chapter 5
The *LEADS in a Caring Environment* Framework: Lead Self

If I feel in my heart that I am wrong, I must stand in fear, even though my opponent is the least formidable of men. But if my own heart tells me I am right, I shall go forward, even against thousands and ten thousands.

Confucius

Introduction

Leadership is taking charge to make a better future, and regardless of culture, nation, or enterprise, leadership is essential when innovation, change or transformation is required.

Successful leadership must be solidly grounded in who you are. Only that grounding will give you the confidence—and ultimately the skill—to lead. Who you are inevitably affects your ability to influence others. Personality, strengths and weaknesses, values, beliefs and emotional intelligence make up our interior leadership landscape. This landscape is the focus of the *Lead Self* domain, which is grounded in concepts of leadership throughout the ages.

Those who offer leadership in healthcare are described in the literature as "servant leaders," people whose role and responsibility is to represent the needs of others and act on their behalf. As a health leader, you serve and lead patients, providers and citizens; you dedicate your time to their health and wellness and to the system that supports them.

Confucius's words from *The Book of Changes* [1] seem to touch on the notion of servant leadership. He taught that leaders needed to be considerate not just to each other but also toward the common people who were the backbone of the state. Both humble men and men born into positions of leadership, he said, needed to develop *li,* which means "to sacrifice" (and which we call servant leadership). He saw the commitment to sacrifice for the common good as the essence of leadership.

Servant leadership is more global than Western; it reflects virtues highlighted in the five major religions — Buddhism, Christianity, Islam, Hinduism, and Judaism.

G. Dickson, B. Tholl, *Bringing Leadership to Life in Health: LEADS in a Caring Environment*, DOI 10.1007/978-1-4471-4875-3_5, © Springer-Verlag London 2014

J. R. Wallace [2] says each of those religious traditions "provides a series of individuals as role models who exemplify leadership behaviour as well as acceptable life patterns, not to mention their inclusion of heroes and heroines who arise in times of crises to provide guidance and inspiration."

Leadership on behalf of the common good is a foundational element of the LEADS framework, and central to the *Lead Self* domain. See how this principle plays out in the following story:

Janice was in a quandary. She was a clerk at a large health region, working with electronic medical records for a number of primary care practices. Her friend Fran had told her she had inadvertently thrown a disc with private health records into the garbage.

The quandary was that Fran had made the disclosure in confidence. "Ironic," Janice thought. "Here I am, feeling constrained by my privacy commitment to Fran not to reveal a breach of our patients' privacy rights!"

She pondered her difficult options. It was tempting to do nothing, and hoping, like Fran, the disc would be destroyed and no one the wiser. But she was aware it might be found, which could mean serious repercussions for patients, her friend and the region.

Truly distressed, Janice wondered what to do. "I could ignore the whole thing; that's the easiest thing to do; it's not my responsibility." But that didn't feel right. "Or, I could tell the manager, and let her deal with it—that's likely the right thing to do, although that'll get Fran in trouble."

Janice reflected on what she knew that would help her resolve the problem. She then recalled a leadership workshop she'd attended, where the facilitator talked about how people tend to see issues as either/or but leaders know there are resolutions that don't force that kind of choice. The leader described them as "a solution where one and one equals three."

Janice wondered what the "three" solution might be for the disc situation, one that would be fair to Fran and to patients whose information might be compromised. In the end, she decided to go to her friend and offer to go with her to tell the manager what had happened. There might be time to find the disc and in any case, management would be aware of the problem.

"But what if she doesn't go along?" Janice paused. "I guess I'll just have to tell her that if she isn't willing to come forward with me, then I will have to go forward myself: I just can't live with the possibility that all our good work will go down the drain if the disc is discovered."

Having come to a resolution that worked for her—and her conscience—Janice planned how to approach Fran. She focused on the fact that telling the truth was the right approach for all involved.

Janice acted as a leader should. The welfare of the people she was serving was a compelling factor in her decision. Will Fran? Will her manager? What would you do in Janice's place?

Learning Moment
Take a moment to reflect on the past 6 months at work.

- Have issues of 'moral conscience' arisen for you? How and why?
- Are you comfortable with how you resolved those issues? Why or why not?
- Have a dialogue with a trusted colleague or friend. How do they resolve issues of moral conscience? What lessons can be learned from this discussion?

Each of us could face a similar issue at any time: ethical decisions as a foundation of public service leadership have been with us for centuries. Confucius' goal was to make men of humble backgrounds into leaders who cared above all for those they led and who could maintain their values in the corridors of power. Part of that was to focus his students on developing "etiquette," which we might describe as demonstrating leadership through behaviour, showing courtesy, respect and consideration for the people you're responsible for.

Were the goals of Confucius much different from the goal of leaders in healthcare today? From your goals? Concern for peoples' health and wellness is the foundation for effective health leadership (the caring in the *LEADS in a Caring Environment* framework). If you want to use the framework to develop your own leadership skills, we ask you to work internally, to discover and hone your sense of duty, consideration and respect for others. But we also ask you to learn and display the outward behaviour that demonstrates caring to others. The best of intentions, if they're not reflected in your behaviour, may stay hidden and significantly diminish the currency of your influence.

Each of us must determine why we lead, what attributes we have to lead, and find the strength to lead when others need us. Some say that shows leaders are born, not made, but we disagree. As we outlined in the previous chapter, knowing what it takes to lead and what you have to offer is a starting point. From there you can start to develop your potential as a leader, regardless of what that potential is.

Because the foundations of the *Lead Self* domain are ethics and morality, the self is fundamentally challenged in the exercise of effective health leadership. More than in any other domain, you are accountable to yourself, and your conscience is your guide and judge. This is not easy. To lead self is a lifelong hero's journey.

Consequently the Lead Self domain also provides a foundation for all of the other domains. Leadership starts first with oneself. If you can't model appropriate behaviour for yourself, your credibility (and ultimately ability to influence) is severely compromised.

There are four capabilities in the Lead Self domain. Those who lead themselves (1) are self-aware; (2) manage themselves; (3) develop themselves; and (4) demonstrate character. We'll explore those capabilities now.

Self-Awareness

> *To know oneself is the first step toward making flow a part of one's entire life. But just as there is no free lunch in the material economy, nothing comes free in the psychic one. If one is not willing to invest psychic energy in the internal reality of consciousness, and instead squanders it in chasing external rewards, one loses mastery of one's life, and ends up becoming a puppet of circumstances.*
>
> *Mihaly Csikszentmihalyi*

As a self-aware leader you are aware of your own assumptions, values, principles, strengths and limitations. To be self-aware is to look internally for your motivations, fears, and beliefs. Psychologist Carl Jung said "Your visions will become clear only when you can look into your own heart. Who looks outside, dreams; who looks inside, awakes" [3]. If you are not aware of your own deep-seated motives, emotions, beliefs and assumptions, how can you be sure your idea is ultimately to the benefit of others and yourself? Having that awareness allows you to act in a manner consistent with who you are and to be seen by others to be acting with intention and conviction. Sometimes this is referred to as *authentic leadership*. In health care followers need leaders with confidence, intention and conviction. Commensurate with its caring identity.

Take a moment to reflect on political leadership. Politicians often go to great pains to portray themselves as a certain kind of person: bold, considerate and knowledgeable on issues. They craft their images carefully. But if that image crumbles because of a leaked document, a sexual peccadillo, or conflict of interest, the media pounces. In healthcare, images are also closely scrutinized. One CEO recently said "I was not prepared for how I was besieged on so many levels; vilified by professions, governments and the media. It became harder and harder to take bold stance." And almost impossible to sustain our leadership if the image we've created isn't genuine, or we forget why we are in health care.

Why are people so intrigued by political leaders' stories? Mostly we want to know "the real person." That person can be flawed, as long as he or she admits to those flaws as being part of who they are; and we are more comfortable with the genuine person than with someone we perceive to be fake. We're even more uncomfortable with people who start to believe in the images they've created. Authentic leaders are aware of who they are, and accept it, flaws and all [4]. Tennessee Williams said "There comes a time when you look into the mirror and you realize that what you see is all that you will ever be. And then you accept it. Or you kill yourself. Or you stop looking in mirrors." Leaders never stop looking in mirrors.

Another reason leaders need to be self-aware is to combat self-delusion, the opposite of self-awareness. Self-delusion—whether it's lying to yourself, rationalizing decisions, refusing to acknowledge your true nature, or not being in touch with your true beliefs—lets you justify actions that are easy and self-gratifying, rather than taking difficult actions for the common good [5] . Research has shown all humans are prone to self-delusion: it is almost a necessary part of survival. It is, however, a matter of degree: after all, if we lead from a place of self-delusion, how can we meet the needs of others? Self-delusion is easier because it allows you to retreat into your own view of the world, and not attempt to understand the world view of others.

One form self-delusion takes is unchallenged, unconscious assumptions or self-stories. Zaphron and Logan [6] call this phenomenon "rackets," to show how self-serving stories are a kind of fraud, keeping us from acting constructively. Self-perpetuating assumptions and beliefs have also been called "mental models" [7].[1] Both refer to perpetuating a story that conditions how we react to the outer world, and that sometimes demonizes others. Such perspectives can determine behaviour towards people and groups. Exposing these internal frauds is a productive function of self-awareness. Why? Because, as Jeffrey Pfeffer argues, "…in order to do different things, at least on a consistent, systematic basis over a sustained time period, companies and their people actually must begin to think differently. That's why mental models affect organizational performance and why they are a high-leverage place for human resources to focus its organizational interventions" [8].

In health care, separate, unchallenged world views can create a disconnect between groups. Physicians, for example, can seduce themselves into believing they are the only patient advocates and champions of quality—often to the point of strident advocacy on behalf of a single patient. That view, in turn, cements in some administrators the belief physicians have no sense of how to serve large populations of patients. At the same time, many administrators tell themselves they are the guardians of value for money, and physicians are out of touch with the reality of limited financial resources. These self-perpetuating stories can lead to a significant rift between physicians and administrators and negatively influence a leader's potential for collaborative health reform [9].[2]

To combat self-delusion and become more self-aware, each of us as leaders needs to first acknowledge our potential for self-delusion, become conscious of our world views, assumptions and mental models, then rigorously challenge them to root out delusional notions.

---

[1] For example, Don Berwick describes one mental model that exists as the boundaries among professions, and between physicians and administrators.

[2] For further delineation of a comparison of the mental models of physicians and administrators, see Ref. [9].

Learning Moment
Take the opportunity to have a dialogue with a trusted colleague, friend, or family member. Put aside half an hour for this opportunity.

Directions: Part 1

1. One of you will be A; one of you B. Each of you will take turns interviewing each other. A will interview B; then B interview A. Allot seven and a half minutes for each interview.
2. Each interview will start with the interviewer asking the interviewee the following question: *Why do you want to be a leader in health care?* The interviewee will provide an initial answer.
3. When that question is answered, the interviewer will then ask, "And why is that important?" The interviewee is then asked to reflect, introspectively, on the rationale for the original answer, and provide that rationale.
4. This practice continues for four more "Why is that important?" questions.
5. Repeat with roles switched.

Directions: Part 2
Discuss the following questions:

1. If you were to listen to your own answers, what are your true beliefs when it comes to your reasons to lead in health care?
2. Are these beliefs consistent with the concept of patient-centred care?
3. Reflect back on the past 6 months. Would others in your workplace see you acting in a manner consistent with those beliefs? Why or why not?

This exercise is designed to help you uncover your internal stories, test them, and decide whether you want to adjust your world view. But internal adjustment is not enough. You must also consider whether your actions reflect your changed world view, and change them if they are not commensurate with the good of the group.

Brain research has shown that one of the hallmarks of self-awareness is the ability to reflect on one's own thoughts, feelings and actions. Brain imaging studies have shown that when subjects reflect on their own experiences, they also activate the brain circuitry (in the prefrontal cortex) they use when empathizing with someone else's feelings. This suggests that being self-reflective also helps prime better connections with others [10, 11].

Self-awareness can be developed in several ways, according to Paul Mohapel, a neuroscientist and avid leadership scholar [12]. It can be done through workshops and exercises devoted to building self-awareness such as action learning, role play, asking others for feedback, by working with counsellors or mentors, by keeping a journal and through psychometric development assessments. On your own you can seek out books and movies that explore the seductiveness of power and self-delusion; there is no shortage of examples of this Achilles heel of leadership.

Manages Self

The second capability in the Lead Self domain is that leaders manage themselves—that is, they take responsibility for their own performance and health.

Why is manage self a capability of the *Lead Self* domain? In this instance the term 'manage' is used to imply the application of technical discipline and rigour to our behavior, and to do so 'in the moment'. To manage anything is to control, plan, organize, and implement a practice: to bring a disciplined process to bear on an otherwise disordered world. In the case of this capability, it means that an internal discipline is being brought to bear on the *internal* landscape that shapes your practice of leadership, and if not 'managed' can stimulate non-productive behaviour.

In this section, we will explore three areas of your internal landscape: emotional intelligence, leadership mindsets, and role specification. The following story illustrates.

> *Ray was CEO of a health region in Australia. His first task after he was appointed was to articulate a strategic direction for the region. Ray and his management team consulted with stakeholders, worked with their planners and researchers and drew on outside consultants. Once they had developed a set of strategic directions Ray hosted a meeting of regional managers to outline the plan and get feedback. He knew he needed to engage the people who would implement the plan, so they would feel some ownership of it and to give it legitimacy in the eyes of the board.*
>
> *At the meeting, after a presentation outlining the plan, Ray invited feedback from the audience. Several managers got up to express support. The fourth speaker was Jim, a union steward invited as a matter of strategy. Jim thanked Ray for the presentation, but the rest of his message was not what Ray wanted to hear.*
>
> *"In my view you left out one of the most important priorities of all—it is as if you were completely unaware of the poor morale, pitiful engagement, and disenchantment of almost all our staff. When I speak to my members—and also, with the physicians I know and others—there is a strong sense of demoralization permeating this region. It is beyond me how you could put forward the plan you did without this being priority Number 1. Thank you".*
>
> *A murmur moved throughout the room. Ray felt his head thrust forward and his face flush. Before he could check himself, he heard himself answering through gritted teeth in an aggressive, combative voice, "Thank you Jim, for your feedback. I am sure that all of us on the management team will give it serious consideration. NOW…" he continued, as his glittering eyes roamed the room "Anyone else have some feedback they want to SHARE?" Needless to say, the mikes remained empty.*
>
> *Ray was deeply disappointed in himself. Once again, his inability to control his emotions and the defensiveness that had plagued him throughout his career had undermined his leadership. He had failed in the fundamental responsibility of listening to all viewpoints, whether they agreed with his or not. He had failed to display the leadership mindset of "being prepared to follow in order to lead." He vowed to work harder to overcome this recurring weakness of his.*

Ray's defensive response to the union steward was counterproductive. In the words of Stephen Covey [13] he was not "response-*able.*" Response-able leaders don't blame genetics, circumstances or conditioning for our behaviour. We take ownership of becoming the leader we need to be and see what we do as a choice, not something pre-ordained. Each of us understands how we respond is a choice and we take the initiative to create personal change [14]. We do not allow our natural

emotional reactions to highjack our common sense and knowledge. To become response-able Ray had to learn what kinds of situations triggered his negative emotional response, be conscious of those in the moment, act immediately to counteract his instincts—and ideally, convert that emotional response into a positive one.

There were three things Ray needed to do to manage himself better. First, be aware of his emotions and recognize the need to manage them. Second, develop a leadership mindset to help him respond appropriately—in this instance by being aware one must sometimes follow in order to lead. Third, he needed to realize that as CEO his role was to engage the employees in the strategic plan by listening to their input.

Emotions, mindset and roles shape how we manage our performance and health as leaders. We will deal with each in turn.

Emotional Intelligence

Overcoming unwarranted defensiveness was for Ray an exercise in what the literature calls emotional intelligence. All of us, like Ray, have triggers; being aware of what they are, knowing how to minimize their impact, and adopting behaviour that diminishes our emotional responses to triggers are important components of being able to manage ourselves. It should be noted that Ray not only looked inwards to identify his triggers, he realized that his outward behaviour would demonstrate to others he was in control or Moreover, he found that acting in control actually contributed to minimizing his feelings of defensiveness.

Emotions are a source of much energy. They fuel our desire, commitment and will to do productive work. However, emotions also stimulate attitudes and beliefs that can be counter-productive to effective leadership. Managing one's emotions so as to fuel one's personal sense of satisfaction and efficacy is key to long-term leadership effectiveness. Modern neuroscience has also told us that emotions may be innate; that is, hard-wired—but it also tells us that the brain has multiple nodes, or information processing systems that can override them and determine how they are expressed. Stephen Pinker says that our "…minds are packed with combinatorial software that can generate an unlimited set of thoughts and behavior" [15]. This ability—when it is directed at 'managing' our emotions, is called emotional intelligence.

In the book ***The EQ Edge*** by Harold Book and Steven Stein, emotional intelligence is defined as "an array of non-cognitive capabilities, competencies and skills that influence one's ability to succeed in coping with environmental demands and pressures" [16]. Daniel Goleman, who is probably the most well-known writer on emotional intelligence, describes it as: "the abilities to recognize and regulate emotions in ourselves and in others. This most parsimonious definition suggests four major domains of emotional intelligence: self-awareness, self-management, social awareness, and relationship management" [17]. Emotional intelligence is a complex set of skills that enables us to make our way in a challenging world—the personal, social, and survival aspects of common sense that are essential to everyday life.

Table 5.1 Five realms of emotional intelligence [16]

Self-*perception*	*The interpersonal realm*
Self-regard	Empathy
Self-actualization	Social responsibility
Emotional self-awareness	Interpersonal relationships
The stress management realm	*Decision making*
Flexibility	Problem-solving
Stress tolerance	Reality testing
Optimism	Impulse control
Self-expression	
Emotional expression	
Assertiveness	
Independence	

Emotional intelligence can be measured through an instrument called the E-Q-I 2.0. Developed by Reuven Bar-On, the EQ-i has been validated by the American Psychological Association [16]. Based on 15 constructs of emotional intelligence, organized into five realms, the test has demonstrated in many studies that individuals with higher scores in emotional intelligence outperform those in similar fields with lower emotional intelligence. The 15 components of emotional intelligence are shown in Table 5.1.

The aspects of emotional intelligence in the shaded boxes above are those that apply to the Lead self domain because they are subject to triggers but can be controlled by conscious effort. The other dimensions are called as social intelligence and are more likely to be a function of interpersonal relationships. They are dealt with in the Engage Others chapter.

There are numerous exercises and programs to help you build your emotional intelligence muscle. We use the word muscle, because developing emotional intelligence is not unlike going to the gym to tone up—it must be done consistently and deliberately.

Leadership Mindsets

A leadership mindset is the mental predisposition that shapes our leadership responses, and therefore our level of effectiveness. Leadership mindsets are conscious orientations of thought, informed by our best knowledge and continually enriched by experience and reflection (unlike mental models, those stories and assumptions that can unconsciously distort our responses). In the absence of these deliberate orientations of mind, which keep you aware of the practices that define leadership, you might not recognize situations in which your emotions need to be channeled, or why.

Leadership mindsets often require the leader—you—to juggle and balance a tension between what might otherwise be seen as competing choices. We as leaders often overlook the tension between conflicting ideas and rush to choose one over another, rather than trying to mindfully find a point that maintains them in balance.

For example, Ray sought to find a mindset that balanced the tension between knowing when to lead and when to follow. What are some other mindsets that leaders need to bring to the practice of their role?

One important leadership mindset is "pursuing the 100-year vision in the immediate moment." What does that mean? A colleague of Chinese ancestry once told us he was guided by a 100-year vision in his work: to maintain perspective on day-to-day progress, he had to need to damp down impatience for short term success, and put it in the context of a 100-year time frame. He understood that to succeed in a 100-year vision, he had to divorce his self-esteem from immediate gratification, or ongoing frustration, and attach it to a long- term purpose. At the same time, however, leaders need to be in the moment: that is, fully conscious and committed to the moment as key to achieving the long term goal.

Dean Koontz, a popular novelist, described the link between being in the moment and a long term vision in the following way:

"Not one day in anyone's life…is an uneventful day. No day without profound meaning, no matter how dull and boring it might seem…Because in every day of your life, there are opportunities to perform little kindnesses for others, both by conscious acts of will and unconscious example. Each smallest act of kindness… reverberates across great distances and spans of time, affecting lives unknown to the one whose generous spirit was the source of this good echo…Likewise, each small meanness, each thoughtless expression of hatred, each envious and bitter act, regardless of how petty, can inspire others, and is therefore the seed that ultimately produces evil fruit, poisoning people whom you have never met and never will. All human lives are so profoundly and intricately entwined…that the fate of all is the fate of each, and the hope of humanity rests in every heart and in every pair of hands….Every hour in every life contains such often-unrecognized potential to affect the world that the great days for which we, in our dissatisfaction, so often yearn are already with us; all great days and thrilling possibilities are combined always in this momentous day" [18].

Learning Moment

Professional athletes, interviewed during a championship, often emphasize the importance of not looking beyond today's game. They stress the importance of being in the moment to be successful today; and in being successful today, ultimately achieving their long term goal. They also emphasize the importance of "letting go of failure" and focusing on tomorrow, if today's win was not forthcoming.

1. Can you as a leader, be "in the moment" to achieve your long term vision? Can you articulate the importance of today in a long term future?
2. How easy is it for you to let go of failure—or at least, of immediate results that didn't work today. If hard, why? How might focusing on the future vision help ameliorate that?

A second mindset you are encouraged to develop to manage yourself is *embracing chaos to discover order*. On a psychological level, this is letting go of the need to be in control, which reflects dominance of lower-brain functioning (with emotions of fear and anxiety), while the ability to embrace ambiguity reflects higher-order brain functioning (more positive emotions). Beverly Kaye described this as leaders being comfortable in ambiguity and chaos [19, 20]. It's also captured in the concept of seeing opportunity in chaos. Chaos usually means that there is an underlying flow of ideas or forces, which has disrupted expected patterns of order. Looking for those patterns and understanding them can open up opportunities. In Ray's case, the 'chaos' was created by the union steward who challenged him. It could have been a chance for Ray to respond productively by welcoming feedback, learning about poor morale and addressing it, which would have encouraged staff to take ownership of the strategic plan. But Ray didn't have the mindset available to make that happen.

Another way of embracing chaos to discover order is to shift your mind from focusing on predictable operational disciplines to the dynamics of change. There is an underlying force in change, just as there is an underlying force in stability, but the two differ. In change, the force is a surge of new values so powerful they trigger change. In stability, the force is long-standing values that sustain and perpetuate the status quo. When one set of values begins to trump another, actions seem chaotic. For leaders, who are always on the cusp of change, exploring surface chaos to determine the underlying order is important. Knowing the tension between new values and status quo values is the key to understanding why we need to change and the difficulties we—and others—will have with it. Value shifts are difficult places to be in, but we, as leaders, need to find ourselves there.

An alternative way of embracing chaos is to see it as an opportunity to be creative, to explore, to generate new goals and directions—in other words to envision a better future. For the follower, chaos is uncomfortable; it creates (in the words of the Hero's Journey) confusion and sometimes resistance or fear of being inadequate. Followers don't know what to do to move forward in chaos; it is a leader's heroic quest that imparts freedom to act and to exercise initiative to meet a need.

A third mindset for the self-managing leader to develop is *be strong and weak at the same time.* In other words, be mindful of when it is appropriate to be strong, and when it is appropriate to bend to the will of others. This paradox is a longstanding theme of leadership. The historical images are clear: the leader as reed that is flexible enough to bend in the wind, yet rooted in purpose, vision, and service. Another image is the benevolent dictator, ruthless in maintaining power but with compassion for individuals in need. Modern health leaders must know when to bend and be flexible, when to be steadfast on principle and when to exercise compassion.

Role Clarity

The responsibilities and accountabilities of your different roles influence how you manage yourself. As individual leaders we cannot be response-able if we don't

understand and accept the responsibilities of our role, and what those roles mean for the exercise of leadership. The LEADS 360 assessment tool acknowledges that roles create unique contexts for the exercise of leadership, as well as different situations for a leader to deal with. We saw how Ray needed to remind himself of his responsibilities as a CEO, and how those responsibilities required him to choose to manage his behaviour in the future. A mid-manager at the meeting would also have had the responsibility to hear the union steward, but that responsibility might only extend to the implications of what the steword said for that manager's area of responsibility. (That's why the LEADS self-assessment tools at the end of each chapter are tailored to different roles leaders can hold).

One final comment on the challenge of managing self. In the definition, the obligation is to take responsibility for both your performance and your health. The latter may seem disconnected, but is not. First, we can't bring our talents and influence to the table if we are either mentally or physically unhealthy. Second, there is deep power in modeling for others the health and wellness the health system is dedicated to developing. Third, being committed to our own health links us to the patients and citizens we serve. Not accepting responsibility on this front undermines our authenticity as leaders.

Develops Self

> *It is absurd that a man should rule others, who cannot rule himself.*
>
> —*Latin Proverb*

The ability to develop self is fundamental to effective leadership, because the context for the work of leading is always evolving. To develop yourself, you have to keep learning, changing and growing. If we as leaders are not open to changing ourselves, how can we ask others, or the organization, to change? Change means doing some things differently and often, to stop doing things we're comfortable with, that are part of our role before change (this is the unlearning we talked about in Chap. 4) [21]. But accepting and demonstrating how you've changed can model for others what you expect of them. As noted consultant and scholar Peter Senge has said, "There is an old tradition that you see in many parts of the world that if you're going to be in a position of authority, you should be a *cultivator*. Leaders should be people who are deeply involved in their own realization of becoming a human being" [22].

The story of Ray earlier on in this chapter left him facing a personal challenge in self-development. Let's continue that story:

> *Ray explained his need to control his defensiveness to Jolene, the vice president of human resources. She put him in touch with an executive coach, and together they outlined a plan. Jolene would help Ray in meetings by giving him a hand signal if he started to get defensive and interrupt him if he didn't notice. They would also meet for coffee now and then talk about how to minimize his bad habits. The coach helped Ray identify what triggered his defensiveness. Ray slowly learned to identify the triggers and started to unlearn his natural*

response. He paid attention to his natural physiological responses (rigidity, a flushed and angry tone) and worked on learning alternative responses: practicing breathing slowly, speaking calmly and relaxing his posture. In six months, Ray had 'developed himself' to less defensive and therefore more productive.

There are three fundamental principles that underpin developing self. The first is to know your personality, strengths and limitations—what you do well and what you don't. Self-awareness is the precursor to self-development. The second is to take a systematic approach to learning, making it part of your daily regimen that includes a formal method of getting feedback on your development. The third is the commitment to applying what you learn. The LEADS Framework is an invaluable resource for putting all three principles into practice: it gives guidance on what is important to know, offers tools and activities to help you learn and grow (such as the LEADS Framework self-assessment tool), and can act as a compass for continuous learning over time by defining the qualities of leadership valued in the workplace.

Personal Mastery: A Discipline for Self-Development

The self-directed approach to developing your leadership is sometimes referred to *personal mastery* [23],[3] which Peter Senge defines as "the discipline of continually clarifying and deepening our personal vision, of focusing our energies, of developing patience, and of *seeing reality objectively*" [24]. It is that last aspect that obliges leaders to seek out evidence of personal performance, to assist them in setting directions for growth. In many of the learning moments in this book we use activities designed to help you see your leadership "objectively". We put quotation marks around the word "objectively" because in our view, Senge's definition should be amended to *seeing reality subjectively.* Yes, we should gather evidence and feedback on our performance as a leader, but even 360 evidence is based on another's subjective interpretation of reality, not an objective one. Objectivity as it relates to leadership—like beauty—is not possible; it can only be approximated.

Personal mastery is a disciplined process where leaders open themselves to feedback about how they appear to others—and then let that information influence how they think and act. Personal mastery puts self-management and self-development into practice. Pierce and Manz say self-leadership skills "include self-observation, self-goal-setting, self-reward, rehearsal, self-job redesign, and self-management of internal dialogues and mental imagery….These principles require the leader to gather data through self-reflection, using instruments, directed learning tools, and journaling, and to use that data to set goals and monitor progress through a personal learning program" [25].

[3] Self-directed approaches to learning are compatible with many professional groups, and professionalism itself. For example, the Canadian Medical Association explored this option in a research project conducted in 2007, and outlined in Dickson, G., Norman, P. and Shoop, M.

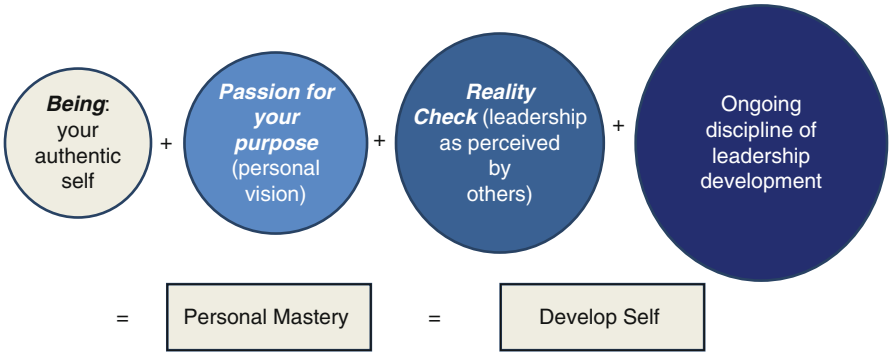


Fig. 5.1 The dynamics of personal mastery

Here is a diagram of the process of personal mastery (Fig. 5.1):

Personal mastery begins with examining the challenges we face as leaders in the health system and our role in it. Facing those challenges consistently requires us to remind ourselves of our authentic self: our values, personality, emotional reactions and talents, and ensuring they are in the forefront of what we do. Then we move to purposing, or clarifying our personal vision and infusing it with passion so we can tackle workplace issues with our leadership energy. As we do that and interact with others, our personal mastery regimen expects us to gather feedback on how we are resonating with the aspirations of followers: a reality check, or what we have called seeing reality subjectively. The final stage of personal mastery is to establish directions for growth.

Seeing reality objectively is the science in personal mastery, while passion and purpose are the art. In essence, personal mastery is about becoming a master artist in our chosen profession, which means maximizing the "instruments of self" that we each possess (as we emphasized in Chap. 4)

A Strengths-Based Approach

Each of us possesses talents; many are under used. Developing leadership requires us to know what our talents are and how to use them for maximum effectiveness. Addressing weaknesses doesn't lead to outstanding performance; it just helps you reach a competent level. An excessive focus on weakness leads to mediocrity, not innovation. However, developing a strength can potentially lead to of outstanding or exceptional performance. Innovative people are often a mix of over-developed skills and glaring weaknesses in other areas —few are truly well-rounded [26]. Several instruments and activities are available to help identify talents worth developing and put them to effective use [27].

Paul Mohapel states it this way: "Proactive leaders work from their strengths, have a clear purpose and vision, have a plan, and understand that they have choices

in any given situation. They achieve greater success by focusing on things they have direct control over, such as their own behaviour and reactions, and spend less time on things they have indirect or no sway over, like other people's behaviour and reactions" [12].

However, focusing exclusively on your strengths is not a guarantee of success. In fact, a strength used inappropriately can turn into a weakness [28, 29].[4] For example, if your strength is being results-oriented, and you employ that strength when compassion or listening to input from others is needed, you will not be successful. Focusing solely on your strengths can lead to complacency and stagnation, undermining your ability to deal with new situations. You can avoid those pitfalls by taking on new assignments, which can help you develop by demanding different skills.

Learning Moment
For the purposes of this book, we define talent as any recurring pattern of thought, feeling or behaviour that can be productively applied in leadership. If you're instinctively inquisitive, it's a talent. If you are charming, it's a talent.

Take a moment to "interview" yourself with the following questions. What talents does the interview reveal?

1. At various stages of your life what activities, hobbies or enterprises did you enjoy doing? What skills came easily to you?
2. What are your strengths in emotional intelligence, personality and values?
3. At various stages of your life, what knowledge or skill have you been able to learn quickly and easily?
4. At various stages of your life, what experiences have given you the greatest satisfaction?

Demonstrates Character

Good character is more to be praised than outstanding talent. Most talents are to some extent a gift. Good character, by contrast, is not given to us. We have to build it piece by piece—by thought, choice, courage and determination.

— John Luther

Character emerges from self-awareness, managing self and developing self. A recent research study asked senior leaders from across Canada to identify qualities of leadership. The qualities mentioned most — passion, integrity, focus, resilience,

[4] For some very practical suggestions about how to recognize strengths and the signs of their overuse, see Lombardo and Eichinger [28].

commitment, persistence, courage, and credibility — all spoke to character. We noted a similar trend when we were doing the research for LEADS and that led us to this capability, demonstrates character. As one interviewee stated, when speaking to the character traits of integrity and credibility, "In reality you only have one tool in your toolbox and that is your word. Your word has to mean something."

Bernard Bass, the father of transformational leadership, believed character matters in leadership. "This is not to deny that evil people can bring about good things or that good people can lead the way to moral ruin. Rather, leadership provides a moral compass and, over the long term, both personal development and the common good are best served by a moral compass that reads true" [30].

Your character as a leader is defined by the qualities you can call on in difficult situations. Those you lead look to you to know when your character is being tested and to rise to the occasion. It's also important that you learn from the trials and tribulations that test character. Luckily, there are plenty of opportunities to do that: most health leaders find their characters tested regularly as they struggle with the needs of the patients or citizens they serve. For example, it requires courage to persevere in doing the right thing in difficult circumstances, or when it runs counter to what formal authority might want.

The degree to which one demonstrates character is closely associated with one's emotional intelligence. For example, when making complex decisions that require moral or ethical considerations, activation of the more primitive emotional centres of your brain (the limbic system) coordinate with the newer parts of your brain involved in planning and social empathy (the prefrontal cortex). Clinically, people who have underdeveloped character, such as sociopaths, have been shown to have poor connection between these brain centres. In other words, the ability to act morally requires a healthy connection between the feeling and thinking centres of your brain. (P. Mohapel, personal communication, Jan 22, 2013).

What characteristics make for a good leader? Honesty, with others but also with yourself; the ability to understand emotions (your own and those of others). You'll need self-confidence, but not hubris; emotional maturity, integrity and the ability to feel rewarded through the satisfaction of others (known as enlightened self-interest). These qualities are required of people who want to succeed in health leadership.

A strong character is essential for a leader to engage others in the pursuit of a shared vision, or to conduct a difficult conversation, or to adjust your ideas or vision to accommodate the input of others. Knowing what to give up, and what you have to insist on, is a fundamental test of character.

Character, like any other attribute we are born with, can be developed. Leaders need to be conscious of what constitutes character, and of the need to develop it. How to do that? Probably one of the most important ways to develop character is to focus on it. Recognize it; recognize challenges to it; and reflect on your reaction to those challenges. Share those reflections in dialogue, or through story-telling. Listen carefully to what others did in situations they faced, and think about how you would like to react in similar circumstances. Gene Klann, in collaboration with the Center for Creative Leadership in the United States has devised a five-step process for

character development called The Five E's of Character Development. He says you develop your character by focusing on examples, education, environment, experience and evaluation[5] [12].

Conclusions

As we've seen, leadership is an on-going process of development. Those pursuing it:

- *Are Self Aware*
- *Manage Themselves*
- *Develop Themselves*
- *Demonstrate Character*

Leadership requires a high level of introspection, internal dialogue and self-directed learning. We're recommending a self-directed approach to developing leadership that's known as *personal mastery* [22],[6] where leaders work continually to strengthen their vision while building their ability to see reality objectively. To be a leader, you need to hone your emotional intelligence, the personal, social, and survival skills that are essential to everyday life. Leaders need to create positive, effective "mindsets," conscious orientations of thought shaped by their best knowledge and experience. Finally, being aware of, and being conscious of how character is demanded of us in the exercise of our leadership, prepares us both for our job and for our life outside of work.

Each of the four capabilities of the *Lead Self* domain is aimed at clarifying and focusing you on building internal strength so you can lead others with confidence, purpose, and conviction. As a colleague once commented, first you must trust yourself before you can be trustworthy in the presence of others. The exercises and

[5] Paul Mohapel, in his book on Lead Self, references [32] who defines example as leveraging the natural human tendency to emulate the behaviour of individuals, especially those who are held in high esteem. A leader's behaviour sets the standard for the entire organization, and modeling is considered one of the most powerful ways to influence others [34]. Education refers to explicitly addressing the needs of character and the challenges of maintaining integrity under pressure. Effective educational practices might include discussions of case studies and scenarios that involve difficult moral or ethical choices [31, 32]. Environment refers to the organizational culture and how it shapes the values and actions of people. Leaders with high integrity can set the tone of the organization environment by surfacing the standards or values of the organizational and acting congruently with them [32, 33]. Experience is about providing stimulating and challenging environments that allow for others to grow and develop their character. Finally, evaluation refers to providing clear expectations and feedback on the patterns of behaviour of others. Leaders can use feedback sessions and performance evaluations to gauge their progress, reviewing specific instances when their integrity may have been challenged [32].

[6] Self-directed approaches to learning are compatible with many professional groups, and professionalism itself. For example, the Canadian Medical Association explored this option in a research project conducted in 2007, and outlined in Dickson, G., Norman, P. and Shoop, M.

stories in this chapter highlight how the *Lead Self* capabilities reinforce each other to build trust in yourself that you can convey to others.

To help you lead yourself, we'll end this chapter with a self-assessment exercise. Please evaluate yourself, and based on your results, identify one capability you think you should work on to improve your leadership.

Learning Moment

To use this questionnaire, find the right category for your level of leadership (e.g., front-line mid-management, etc.). Then assess how well you demonstrate the four lead Self capabilities, where "1" is don't do this well at all; "7" is i do this exceptionally well, and "N" is not applicable in my current role.

Which capability do you need to improve on? Why?

Lead self self-assessment

Front-line leader responsibilities:									
In order to use my attributes of self to be a better leader, I:									
1.0	Make a disciplined effort to continuously surface my assumptions, values, principles, strengths and limitations, and understand them in the context of my supervisory role	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
2.	Take responsibility for managing my emotions, mindsets and role expectations as they relate to my role of supervisor	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
3.	Systematically seek out opportunities for learning and apply a disciplined approach to developing myself in the context of my supervisory role.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
4.	Recognize the qualities of character as demanded of me in my supervisory role, and try deliberately to exercise it accordingly	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
Mid-manager leader responsibilities									
In order to use my attributes of self to be a better leader, I:									
1.	Make a disciplined effort to continuously surface my assumptions, values, principles, strengths and limitations, and understand them in the context of my mid-management role: connecting senior and supervisory leaders	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
2.	Take responsibility for managing my emotions, mindsets and role expectations as it relates to my role of mid-manager	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
3.	Systematically employ personal mastery—either formally (e.g.,) through a personal learning plan or informally—in the context of my mid-management role	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
4.	Recognize that qualities of character are often tested in a mid-management role in the unique responsibility of bridging senior and front-line leadership roles; and try deliberately to exercise them as appropriate	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**

Senior leader responsibilities.									
In order to use my attributes of self to be a better leader, I:									
1.	Make a disciplined effort to continuously surface my assumptions, values, principles, strengths and limitations, and understand them in the context of my strategic role to connect mid-managers with organizational priorities	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
2.	Take responsibility for managing my emotions, mindsets and role expectations as it relates to interacting with the executive and mid-management	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
3.	Systematically employ personal mastery—either formally (e.g., through a personal learning plan or informally)—to enhance my interpersonal and strategic capabilities.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
4.	Recognize that qualities of character are regularly tested in bridging strategic and operational responsibilities; and try deliberately to exercise them as appropriate	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
Executive leader responsibilities.									
In order to use my attributes of self to be a better leader, I:									
1.	Make a disciplined effort to continuously surface my assumptions, values, principles, strengths and limitations, and exercise them appropriately in my interactions with the board, media, other executives, professional groups, staff, stakeholders and the community	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
2.	Take responsibility for managing my emotions, mindsets and role expectations as it relates to interacting with the board, media, other executives, staff, professional groups, stakeholders, and the community	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
3.	Model personal mastery—either formally (e.g., through a personal learning plan or informally)—in a process aimed at enhancing my executive capabilities	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
4.	Recognize that qualities of character are constantly required when dealing with multiple audiences and their priorities; and deliberately exercise them as appropriate	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**

References

1. Creel HG. Chinese Thought From Confucius to Mao Tse-Tung, Mentor Books, New York; 1960.
2. Wallace J. Servant leadership: a worldview perspective. Int J Leadersh Stud. 2007;2(2): 114–32.
3. Sharma R. The monk who sold his ferrari. New York: HarperCollins; 1998.
4. Cashman K. Authentic influence. Leadersh Excellence. 2009;26(10):12.
5. Arbinger Institute. Leadership and self-deception: getting out of the box. San Francisco: Barrett-Koehler; 2010.
6. Zaphron S, Logan D. The three laws of performance: rewriting the future of your organization and your life. San Francisco: Jossey-Bass; 2009.
7. Berwick D. Crossing the boundary: changing mental models in the service of improvement. Int J Qual Health Care. 1998;10(5):435–41. doi:10.1093/intqhc/10.5.435.

8. Pfeffer J. Changing mental models: HR's most important task. Human Resource Management. 2005;44(2):123–8. doi:10.1002/hrm.20053.
9. Dickson G. Anchoring physician engagement in vision and values: principles and framework. Saskatchewan: Regina Qu'Appelle Health Region; 2012. 46 p.
10. Goleman D. Social intelligence. New York: Bantam-Dell; 2006.
11. Carissa L, Philippi J, Feinstein S, Khalsa A, Tranel D, Landini G, Williford K, Rudrauf D. Preserved self-awareness following extensive bilateral brain damage to the insula, anterior cingulate, and medial prefrontal cortices. PLoS ONE. 2012;7(8):1–17. doi:10.1371/journal.pone.0038413.
12. Mohapel P. Lead self. LEADS in a caring environment capabilities framework: book 1 of five research booklets. Victoria: Canadian College of Health Leaders and Canadian Health Leadership Network; 2010.
13. Covey S. Seven habits of highly effective people. New York: Free Press; 1990.
14. Kostenbaum P, Block P. Freedom and accountability at work: applying philosophic insight to the real world. San Francisco: Jossey-Bass/Pfeifer; 2001.
15. Pinker S. The blank slate: the modern denial of human nature. New York: Penguin; 2002.
16. Stein S, Book H. The E.Q. edge: emotional intelligence and your success. Mississauga: Wiley Publishing; 2000.
17. Goleman D, Boyatzis R, McKee A. Primal leadership: realizing the power of emotional intelligence. Boston: Harvard Business School Press; 2002.
18. Koontz D. From the corner of his eye. New York: Bantam; 2001.
19. Kaye B. Help them grow or watch them go: a development edge gives retention results. San Fransisco: Berrett-Koehler; 2012.
20. Goldsmith M, Govindarajan V, Kaye B, Vicere A. The many facets of leadership. New York: Pearson; 2003.
21. Argyris C, Schön D. Organizational learning II: theory, method and practice. Reading: Addison Wesley; 1996.
22. Senge P, Scharmer C, Jaworkski J, Flowers B. Presence: human purpose and the field of the future. Cambridge, MA: Society for Organizational Learning; 2004.
23. Dickson G, Norman P, Shoop M. Self-directed learning as a strategy for improved health literacy and health human resource continuing professional education. Victoria: Royal Roads University; 2007.
24. Senge P. The fifth discipline. New York: Doubleday; 2002.
25. Pearce C, Manz C. The new silver bullets of leadership: the importance of self- and shared leadership in knowledge work. Organ Dyn. 2005;34(2):130–40. doi:10.1016/j.orgdyn.2005.03.003.
26. Buckingham M, Coffman C. First, break all the rules. New York: Simon & Schuster; 1999.
27. Rath T. Strengths finder 2.0. Washington: Gallup Press; 2007.
28. Lombardo M, Eichinger R. For your improvement: a development and coaching guide. South Minneapolis: Lohminger; 1998.
29. Zenger J, Folkman J. Ten fatal flaws that derail leaders. Harv Bus Rev. 2009:p. 18.
30. Bass B, Steidlmeier P. Ethics, character, and authentic transformational leadership behaviour. Leadersh Q. 1999;10(2):181–217.
31. Allio RJ. Leadership development: Teaching versus learning. Management Decision, 2005;43:1071–1077.
32. Klann G. Building character: strengthening the heart of good leadership. San Francisco, CA: Jossey-Bass 2007.
33. Lord RG and Hall RJ. Identity, deep structure and the development of leadership skill. The Leadership Quarterly 2005;16:591–615.
34. Schriesheim CA and Neider LL (Eds.) Power and influence in organizations: New empirical and theoretical perspectives. Charlotte, NC: Information Age 2006.

Chapter 6
The *LEADS in a Caring Environment* Framework: Engage Others

Employee engagement may have begun life as a corporate buzzword, but over the last decade, it's been widely acknowledged as a critical element in drawing out discretionary effort from workers. But findings from our 2012 Global Workforce Study show that the steps organizations have taken to improve engagement are beginning to fall short.

—Towers and Watson

For many of us, the phrase "getting engaged" usually means the launch of the marital relationship that sustains us through life, a great source of mutual respect and self-realization. But what does *engagement* mean in the context of leadership in the health system? Does it demand the same commitment, and return it?

It would be a very special organization if that were the case. But engagement is an important factor in having your life enriched by work. Indeed, numerous research studies both in the health sector and outside the health sector emphasize the value of positive engagement to all [1]. For example, West et al. reviewed engagement scores in the UK, and concluded that the more engaged staff members are, the better the outcomes for patients and the organization generally [2].

One consistent finding in that research is that the quality of leadership in a unit is a primary determinant of its level of engagement. Good leadership can lead to high engagement; toxic leadership to dysfunctional engagement.[1] And since the No. 1 driver of engagement is the quality of an organization's leadership, collective leadership capacity is vital to its accomplishment [3].

Let's look at an example of an organization that takes engagement seriously, measuring it every two years and responding to the results. We've disguised the name of this large Canadian region, calling it North Star.

Wendy Johnson, vice-president of human resources in the North Star Health Region, was excited. The most recent results of the employee engagement survey were about to be presented. She was keen on knowing whether the changes made since engagement was measured in 2010 had improved results and wanted to know what new directions her department should take. Earlier results had not been what the North Star hoped for. She

[1] Gallup' research suggested that the quality of the direct supervisor has a huge role to play on engagement in a particular unit or department.

G. Dickson, B. Tholl, *Bringing Leadership to Life in Health: LEADS in a Caring Environment*, DOI 10.1007/978-1-4471-4875-3_6, © Springer-Verlag London 2014

was particularly interested in whether perceptions of the quality of leadership had shifted, because she knew research identified leadership as a major factor determining perceptions of engagement.,

The employee survey characterized engagement as a function of employee connection to the workplace.

To measure engagement, the survey given to employees (and to medical staff and volunteers) essentially assessed their satisfaction with six statements:

- *I am proud to tell others I work for NSHR.*
- *I am optimistic about the future of NSHR.*
- *NSHR inspires me to do my best work.*
- *I would recommend NSHR to a friend as a great place to work.*
- *My job provides me with a sense of personal accomplishment.*
- *I can see a clear link between my work and NSHR's long-term objectives.*

Results by question were then presented, as well as an overall score (Fig. 6.1).

Wendy was initially pleased with results that showed clear improvements (see left-hand column for the improvement ratings). However, all benchmarks for desirable performance (the right-hand column) fell well below what was hoped. She had lots of work to do, particularly with medical staff.

Statistics on satisfaction with leadership indicated almost a quarter of employees were looking for or thinking of accepting a job elsewhere. One of the key reasons for that was "immediate manager leadership skills." The results went on to show satisfaction with immediate supervisors was 60 per cent, one per cent below benchmark and unchanged since 2010. Satisfaction with the CEO, senior vice-presidents, and executives was 33 per cent, up five points since 2010 but 19 per cent below benchmark. Satisfaction with vice-presidents was 37 per cent, up 9 points since 2010 but 16 % below benchmark. When she put that information together with other statistics—low satisfaction with organizational

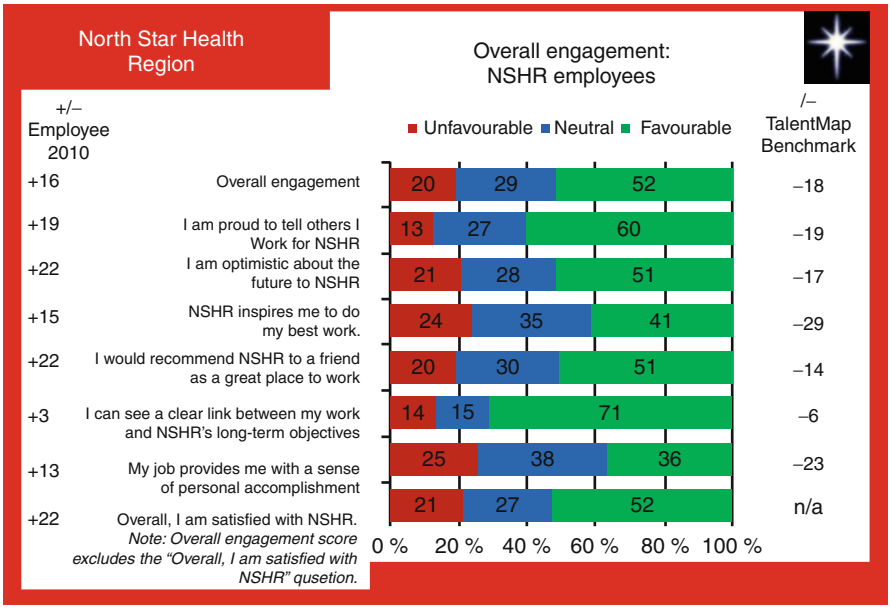


Fig. 6.1 Results of NSHR Engagement Survey

vision and patient focus, both 20 points below benchmark—she realized that leadership development was urgently needed.

"And these are the average scores" she mused. "I bet if I looked at the scores of individual departments, I would find some quite high and some quite low." Reminding herself that the quality of an individual's supervisor is a major determinant of engagement, she vowed to push for more time, money and energy for leadership development.

Learning Moment
Take a moment to reflect on the group, department or organization where you are a leader.

- Have you surveyed engagement? If so, did engagement rate as high, medium, or low?
- If not, what might you expect the results to be? What are the reasons for your answer?
- Consider using our model to conduct your own survey (if you're concerned people might not respond candidly to you, find someone independent to do it).
- How would you use the results? Are you prepared to make changes in your own behaviour if the results suggest it?

The distributed leadership idea introduced in Chap. 2 suggests that the dispersal of leadership across levels, and the ability of the collection of leaders to act in concert to achieve common goals, is required for true organizational or system change to happen. While measuring engagement overall is important for the senior VP of Human Resources, it is equally important for to measure it in smaller units. Indeed, distinct differences in culture, unit to unit, can reveal whether than alignment is happening and signal whether or not leadership is in fact operating or is absent (or even toxic) in some parts of the organization. And since leadership is a function of what you do rather than your role, we're going to look at *how* you lead, not who, in this chapter.

Health system leaders are collectively engaged in relationships aimed at improvement — unit improvement, organizational improvement, community improvement or system improvement: that is, creating change. Those relationships, and the whole notion of distributed leadership, mean that regardless of role, sometimes we lead and sometimes we follow. It's a difficult dance. The first step is to have the interpersonal and tactical skill to build positive relationships with a wide array of the people you work with—in particular with your direct supervisor, because that relationship will help leverage your own morale and productivity. To have an effective relationship with your supervisor, sometimes you will lead, and sometimes you will follow.

The strength of that relationship is measured by looking at engagement. We define engagement in health-care organizations as "the degree of constructive interactivity between a leader and a follower aimed at achieving a shared vision of quality patient care in a sustainable universal health system".

The engagement survey from North Star shows these factors improve engagement:

- Better communication
- Clear and consistent vision
- More opportunities for professional growth
- More/improved training
- More freedom to make suggestions.

Almost all studies of what works to promote engagement include those factors, and all but clear and consistent vision are part of the *Engage Others* domain.[2] All of them are also readily influenced by leadership. Yet leaders cannot motivate another person: they can only generate the conditions for that person to become motivated. Engagement is very much a voluntary, discretionary commitment. Ask yourself: How persistent and consistent am I in creating conditions that motivate others to change in my workplace? Or, even more fundamentally: *Why should anyone be led by me?* [4].

Learning Moment
Take a moment to reflect on your leadership in the past few months. Consider how others reacted when you tried to show leadership.

- What answers do you have to the question "Why should anyone be led by me?"
- What did you do—say, plan, decide, or promote—that influenced others? Were they motivated to join you? What kind of behaviour did they respond to most?

Engagement is a function of how the employee's personality, character, knowledge and resources interact with the context of the workplace in which he or she works, or in a particular project. That interaction can be either enhanced or impeded by actions of the leader, the organization or project and the individual.

Three factors influence the quality of engagement:

- The actions of the leader in a unit, department, or organization.
- The employee's contributions—both psychological (i.e., commitment) and practical (skill set, qualifications, etc.).
- The organizational context—size, culture, structure, politics.

These factors are interactive. A change in one will likely create a change in another: engagement is always dynamic and fluid.

[2] Note: 'Clear and consistent vision' is captured within the Set Direction capability of the Achieve Results domain.

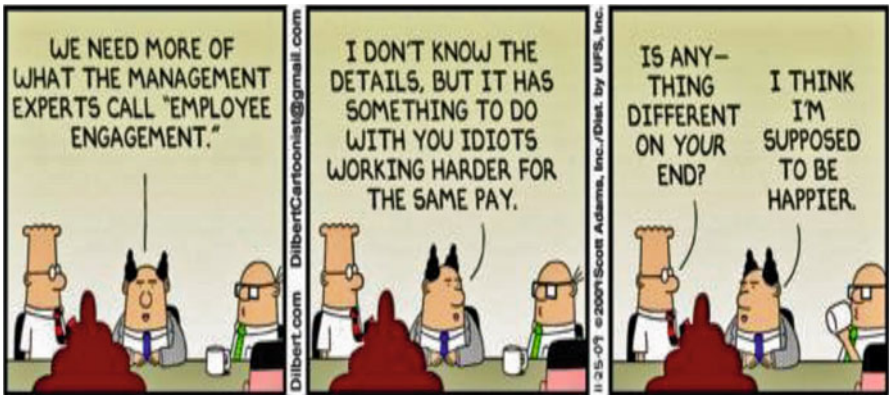


Fig. 6.2 Dilbert cartoonist Scott Adams has a knack for revealing the rhetoric of leadership and management that organizations so rarely live up to (Dilbert © 2009 Scott Adams. Used by permission of Universal Uclick. All rights reserved)

Engagement is both individual and collective. One individual can be completely engaged when another is not. Determining the engagement of an individual must be done on a one-to-one basis through conversation or as part of the performance management process.

The engagement of a group of employees and leaders as a whole can be measured collectively (as in the example of the North Star region) [5, 6].[3] That example also shows that engagement can be experienced differently by different groups. In the example of the North Star Health Region they measured engagement for three sub-groups: physicians, employees and volunteers. Physician engagement is often singled out in the health sector as an issue of particular importance.[4] Many physicians are informal leaders, people with influence but not necessarily part of the formal power structure of the health region. In Canada, many work both independently and on a contracted (fee-for-service) basis to an organization, which means conditions that enhance their engagement may be different than they are for others and also different amongst distinct groups of physicians (i.e., primary care versus hospitalists) (Fig. 6.2).[5]

---

[3] A number of instruments have been validated as methods to measure engagement. The Gallup Corporation has developed an engagement instrument that was used in the story of the North Star Health Region, and that is used widely in Canada. They also have a distinct tool for measuring engagement within the physician community (Gallup Corporation). A Medical Engagement Scale has been developed and used in the UK (Spurgeon P, Barwell F, Mazelan, P).

[4] For example, see the Regina-Qu'Appelle Health Authority, 2012, website in which three papers commissioned on physician engagement are being used to direct policy directions in that health region (http://www.rqhealth.ca/cgi-bin/texis.cgi/webinator/search_rhd/?query=physician+engagement&x=17&y=8&suffout=Most&pr=rqhr&q1=1).

[5] Recent research within Canada, sponsored by the *Canadian Foundation for Health Innovation* (http://www.cfhi-fcass.ca/SearchResultsNews/13-04-16/c2dcf12c-680f-4b63-91ab-bc3e726b523f.asp) and the *Regina-Qu'Appelle Health Authority* (http://www.rqhealth.ca/inside/publications/physician/index.shtml) on the challenge of physician engagement, has identified

Research shows that when leaders exercise the capabilities of the Engage Others domain the potential for improving engagement increases [2, 7, 8]. Research also shows the level of engagement contributes to achieving a patient-centred work environment and a patient safety culture [9].[6] The engagement challenge embraces a broad range of people, from physicians to clerical staff, physiotherapists and nurses to dietary workers—all partners in the delivery of health. Citizens and patients also need to be engaged. Unless you engage all your stakeholders, you can't maximize the potential of what you're trying to do.

According to our research, leaders need four capabilities to engage others. We'll look at them more closely now.

Foster Development of Others

The first of the four Engage Others capabilities is foster development of others. Leaders do that by supporting and challenging people to achieve their professional and personal goals. Developing others is a driver of improved engagement both in and outside health care. A recent Maclean's Magazine survey of Canada's top 100 employers says giving workers the chance to develop is one of the major factors differentiating top employers from others [10]. They profile 3 M Canada and the Aboriginal Peoples Television Network Inc., which both encourage employee development by subsidizing tuition, professional accreditation, career planning, mentoring and in-house and online training programs.

There are two Toronto hospitals on the Maclean's list. The Hospital for Sick Children supports employee development with in-house and online training, mentoring, a formal management training program and subsidies for professional association memberships and tuition. Sunnybrook Hospital invests in development by subsidizing tuition and professional accreditation, giving bonuses for some completed courses through training designed to improve employees' leadership skills.

These are a few examples of formal programs to foster development. However, as the Gallup research suggests, how we work individually to foster the development of the people we lead is equally important [11]. A supervisor who discourages time off for learning, or who doesn't support employees who want to pursue personal development can deflate energy and commitment and will likely undermine

---

many of the factors and processes that both influence engagement of physicians at different places in their career, as well as 'best practices' for doing so. Some of the strategic methods will be discussed in Chap. 9, as part of the Systems Transformation domain. Interpersonal approaches are the purview of this Chapter.

[6] Graham Lowe, in his article *How Employee Engagement Matters for Hospital Performance,* provides evidence to show that employee ratings of engagement are directly correlated to the creation of a patient-centered, safety oriented culture.

engagement. Not recognizing achievement, or failing to provide feedback to help correct poor performance, will also hinder employee development and levels of engagement.

Developing others is even more vital during times of change. Change requires people to do things differently—be it to exercise new skills, create new relationships, or master new knowledge. Failing to recognize the need for retraining can dramatically diminish peoples' enthusiasm for change. Max Caldwell, in his studies of health workplaces in the United States, notes that health-care employees are highly negative about the potential impact of health-care reform [12]. Why? Is it because they believe management won't support the learning and growth they will need to master the change? Leaders would investigate those needs, and commit to providing the necessary resources; but many of us fall short, perhaps because we ourselves are jaded and feeling a lack of commitment and engagement.

Certain styles of leadership foster the development of others. According to Daniel Goleman's work on emotional intelligence leaders who think and act as coaches do more to develop others. A coach-style leader is committed to helping employees improve by helping them build on their strengths, work on weaknesses and encouraging them to establish long-term development goals [13].[7] As a coach, you have to be attuned to feelings of inadequacy and helplessness, and able to distinguish between resistance to learning and fear of trying. Coaching leaders establish agreements with employees about their role and responsibilities in a development plan, and provide instruction and feedback. Effective leaders also set an example by embracing development themselves.

Leaders whose style includes delegation can use it as a way to both develop and engage people. Blanchard and Hersey advise leaders to determine the readiness of employees to take on new responsibilities. They say employees can be rated in maturity from very capable and confident to unable and insecure. They counsel leaders to be aware of how ready staff members are for delegation [14].

The antithesis of coaching and the death-knell for fostering development is micro-management. Micro-management is the need to control and take charge of every aspect and detail of another's work. It is a pathology, or symptom, of poor leadership. It makes people feel undervalued, promotes disengagement and stifles the desire to learn and grow; the opposite of what effective coaching and delegation can do. It also radiates distrust. Consider this story about our friend Wendy from the North Star Health Region:

> *Wendy was preparing for an interview with Kosta Colano and Monica Gregorius, chief operating officer and director of human resources at one of the region's hospitals. Wendy was following up on the need to enhance leadership in the region, which had been identified in the employee engagement survey.*

[7] Daniel Goleman, in outlining his six styles of effective leadership, refers to the 'coaching' style of leadership, which 'develops people for the future'.

Survey results from the hospital where the two worked were dismal: at least five to 10 points below the regional average which was itself well below benchmark expectations. Worse, they had declined noticeably since the previous survey. Wendy was puzzled by the results. Monica had attended a number of regional meetings and seemed to be well-intentioned. Wendy did not know Kosta, who was appointed after a well-respected COO retired.

Kosta and Monica arrived and pleasantries were exchanged. Wendy noticed at once that Monica was very deferential to Kosta, waiting meekly to speak as Kosta went on at some length about how important it was to improve engagement, and how he would pull out all the stops to turn the situation around. When Wendy asked Monica for her perspective, Monica began to answer hesitatingly, clearly worried about Kosta's reaction. And he quickly jumped in, saying, "Yes, yes, that's nice, Monica. But I don't care what the survey says, or what the staff are telling you. I know what the issues are and I'm going to make it my priority to go to every department and engage the staff in a dialogue about how to improve our engagement scores. I just don't think—with all due respect to you, Monica, because I know you've been meeting with them—that our managers have given the messages to staff that I have asked them to give. I don't trust them to have the story straight. I guess I will just have to do it myself."

Wendy listened, watching Monica's frustration grow. When Monica hinted Kosta himself might commit to a behaviour change to model his expectations for staff, he scoffed at the idea; the problem was that others were not doing their job. Kosta was a classic micro-manager and a bully: nothing anyone else could do, or wanted to do, was good enough—he would be in charge. It was obvious what at least one major contributor to the poor engagement scores was.

This story shows how our interactions with others, including the language we use and the attitudes we bring, are crucial in creating the conditions that foster their development. If leaders do not create the conditions to enable development—offering resources, time and personal support for people to learn and grow—then development and the potential for engagement are at best minimized, and at worst, completely extinguished.

Contribute to the Creation of Healthy Organizations

A healthy organization is a productive organization, characterized by high attendance amongst the people who work there as well as high retention rates and low turn-over. Leaders can create the conditions for a healthy organization. The first thing a good leader can do is signal the importance of being a healthy organization by making it a priority, and gathering data and information related to work-life quality, both in terms of morale and productivity. Without such data leaders can easily lose touch with the work-life experiences of others. The example[8] in the following 'learning moment' profiles the importance of that measurement, while at the same time highlighting many of the factors contributing to a healthy work environment.

[8] This learning note is constructed from the document, *A Snapshot of Worklife Measurement in Canadian Healthcare Organizations: Indicator Survey Results* Published by Accreditation Canada. Information presented within is the intellectual property of the Quality Worklife – Quality Healthcare Collaborative.

Learning Moment

In Canada, the Quality Worklife-Quality Healthcare Collaborative (QWQHC) is a coalition of 12 national health organizations committed to the promotion and enhancement of healthy workplaces in healthcare, with the objective of improving patient care. In recent years, the collaborative has called on health-care leaders to improve the quality of work life and of health care through system-wide engagement, action, accountability, and knowledge exchange.

One of the coalition's priorities is promoting and supporting measurement of quality of worklife to help organizations and systems achieve those goals. The collaborative has so far identified seven indicators all health organizations could use to gauge and improve their workplace practices and environments. These evidence-based measures are:

- *Turnover rate*
- *Vacancy rate*
- *Overtime*
- *Absenteeism*
- *Workers' compensation lost time*
- *Training and professional development*
- *Health provider satisfaction*

Reflective Questions

1. *Can you put your hands on data related to turnover rate, vacancy rate,* etc.*, for your unit? If so, how healthy is it? If not, why not?*
2. *If you do not belong to an organization, but are leading a community change or volunteer group, how often do they attend meetings? Participate in events?*
3. *What could you do to ensure that such data is available to you on a systematic basis?*

Work-life data reflects health and wellness in an organization, including levels of injury and stress. Sadly, many health organizations in Canada—and elsewhere—are not doing well by these measures. One senior leader in a national organization said "Healthcare employees are off more on sick leave, workers' compensation and long-term disability than any other business." He added that the biggest and fastest growing claims are stress and anxiety related. The largest and fastest growing claims on hospital benefit plans are prescriptions related to stress and anxiety. In addition, he said, a recent U.S. study found that hospital employees are more likely to be diagnosed with chronic conditions like asthma and obesity in addition to depression, and were 5 % more likely than the general population to be hospitalized (Hugh MacLeod, personal communication).

Leaders can create a culture that promotes healthy living. They can offer wellness programs, pursue a healthy lifestyle themselves and let employees know they're expected to take care of their own health. Towers Watson, a leading professional services company, published an article called *Boost Employee Health and Wellness With Behavioural Economics* [15]. In it they say employers can positively influence employee decisions and behaviour by leveraging social, cognitive and emotional cues to increase engagement in health-promotion programs—which in turn will work best in organizations where there is robust employee engagement.

The mental and spiritual side of employee wellness, what might be called morale, is greatly helped when leaders are simply present in the workplace. Absentee leaders are thought not to care about productivity, unable to make judgments about performance and distant or aloof. And present leadership is not just physical presence—it's also emotional and psychological presence. If doors—both real and mental— are closed to the perspectives of others, a leader may be physically present but perceived as mentally absent. Stories about the leader start being told, almost always negative. Leaders who walk around, who are visible and mentally present, are much more able to engage staff.

How many people you deal with as a leader is a critical success factor in your ability to build a healthy workplace. We talk about leaders having a "span of influence," the range of people we can connect with and have an effect on. That might be five or it might be 200 or more—but how can a leader connect with as many as 200 people? It is even more difficult in health care, where many organizations operate 24/7, but the majority of managers work the day shift Monday through Friday [16]. This factor may be mitigated by the assumption that inherently, professionals are autonomous and can manage themselves better than non-professional employees. However, in a static environment, professional autonomy may be logical; in a dynamic environment like health, much closer connections must be built between all partners in the delivery of health services.

How decisions are made also contributes both to morale and productivity. Leaders who use a variety of decision-making styles—adjusted to the situation and circumstances—are perceived by others to be in touch, but are also able to recognize when employees need to be part of a decision. Daniel Goleman identified six leadership styles to reflect how a leader's emotional intelligence plays out in the making of decisions. Emotionally intelligent leaders have five common characteristics. They:

- Are aware of how they feel in the presence of others;
- Are conscious of how others are feeling;
- Do not express their feelings in a way that would generate negative feelings or destructive conflict;
- Can make good decisions and take appropriate action despite (or because of) their feelings; and
- Have constructive, ongoing professional relationships.

It is noted that these factors are consistent with a number of the elements of emotional intelligence defined by Book and Stein and profiled in Table 5.1 in Chap. 5

(Lead self) under the titles of Decision Making (e.g., problem-solving, reality testing and impulse control) and the Interpersonal Realm (empathy, social responsibility, and interpersonal relationships). Goleman outlines three styles of decision making that employees think enhance engagement—the authoritative, or visionary style, the democratic style, and the affiliative style. He argues that there are two styles—pace-setting and coercive—that are not engaging, unless used sparingly in special circumstances. (Table 6.1) shows which leadership style works best in different situations.

In healthy organizations, people have meaningful opportunities to contribute. They do their best in jobs they enjoy, when they know the organization values their contributions, and when the environment—collectively—is productive. The two go together: workplaces with great morale are usually highly productive.

As a leader, you can create an environment where people can contribute by ensuring:

- People can see the benefit of their work to patients or citizens or their workmates.
- People know what is expected of them.
- Barriers (e.g., red tape, unneeded regulations, infrequent or too frequent meetings) that impede effectiveness are removed.
- People receive feedback on their work through formal performance reviews and in a constructive manner.
- Individuals are assigned tasks and roles that take advantage of their talents and skills.
- Work processes are efficient and effective.[9]

It's us, as leaders, who are most responsible for creating those conditions, either in units or across organizations.

Another aspect of encouraging employee contributions is to create an environment where conflict is productive, rather than destructive. When people are able to disagree on some difference in perspective or issues of professional training, but can still work together to define problems, explore root causes and come up with workable solutions, conflict is productive. Conflict is unproductive when it leads to entrenched views, fragmentation of effort, and refusal to collaborate.

In fact, almost all the approaches we describe for leaders to engage employees and build relations are aimed at creating conditions for diverse views to emerge, and ways to maximize conflict's productive potential while minimizing its destructive potential. However, leaders also need to know how to ameliorate conflict to avoid rifts with or among employees, which can be incredibly destructive if they fester, or leave people feeling threatened.

[9] For many health workplaces, approaches such as Six Sigma, Business Process Engineering, and Lean are being used to redesign work process to make them more efficient and effective. However, such processes often require leaders to be much more present with their staff, and put a premium on the leader's ability to be proficient in the skills of dialogue, coaching, measurement, and decision-making.

Table 6.1 Goleman's six styles of leadership [17]

	Commanding	Visionary	Affiliative	Democratic	Pacesetting	Coaching
The leader's modus operandi	Demands immediate compliance	Mobilizes people toward a vision	Creates harmony and builds emotional bonds	Forges consensus through participation	Sets high standards for performance	Develop people for the future
The style in a phrase	"Do what I tell you."	"Come with me."	"People come first."	"What do you think?"	"Do as I do, now"	"Try this."
Underlying emotional intelligence competencies	Drive to achieve, initiative, self-control	Self-confidence, empathy, change catalyst	Empathy, building relationship, communication	Collaboration, team leadership, communication	Conscientiousness, drive to achieve, initiative	Developing others, empathy, self-awareness
When the style works best	In a crisis, to kick start a turnaround, or with problem employees	When changes require a new vision, or when a clear direction is needed	To heal rifts in a team or to motivate people during stressful circumstances	To build buy-in or consensus, or to get input from valuable employees	To get quick results form a highly motivated and competent team	To help an employee improve performance or develop long-term strengths
Overall impact on climate	Negative	Most strongly positive	Positive	Positive	Negative	Positive

Learning Moment
Think of the last 6 months of work.

1. Have you experienced any destructive conflicts that have detracted from your ability to do your work, or have hindered others from doing theirs?
2. Are there principles and approaches—from a process perspective—that if employed, might improve the resolution of conflicts of this nature? If so, what are they?

Communicate Effectively

Communication is critical for engaging people and leading change. Effective leaders listen well and encourage the open exchange of information and ideas, using appropriate media. Communicating effectively is central to your ability to influence others—and to their ability to influence you when you need to follow.

Only through communication can we create shared understanding and meaning. Communication is the vehicle to reduce the potential for destructive conflict or mitigate it when it arises. Your ability to communicate will either build relationships or diminish them. When communication is poor, energy is diverted from the change process and performance to interpersonal or group conflict. Read the story below:

Franklin had been incredibly busy over the past six weeks. As chief of surgery, he was working on a project at his hospital to make the operating theatres and surgical processes more efficient. He'd had only limited contact with his VP, Grandison, mostly through emails asking for updates on progress. Franklin had provided regular updates, but there were a few issues he wanted to discuss in person. He had repeatedly asked for a meeting, but got no response. He began to wonder if Grandison wasn't interested in the project, or simply didn't want to talk to him.

One day, Franklin spotted Grandison in the cafeteria and approached him. "Grandison, how are you? I saw you in line and thought maybe we could touch base. Got a minute?"

"What about?" Grandison said gruffly, clearly irritated.

"Well," said Franklin, "You've sent me a number of emails about how the operating room project is coming along. There are a couple of issues I wanted to talk to you about and I tried to set up a meeting but we didn't seem to be able to connect. I thought I would just take the opportunity, if you have the time, to talk now."

"What is it about process that you don't understand?" Grandison said. "I'm incredibly busy—in fact, just off to an executive meeting. I don't have time to meet with everyone to discuss their pet projects".

Franklin was taken aback. Grandison had never spoken to him like this before. Besides, this wasn't his pet project. He'd been assigned the task! But he tried again. "There's just a couple of issues I can't deal with on my own, without your help. I would appreciate the opportunity to discuss them with you—when it's convenient," he said.

"If you can't deal with the issues on your own, maybe we should get a new lead for the project," Grandison said irritably. "Excuse me…I have no more time to waste." And off he went.

Franklin was appalled—to the point of considering resigning. Grandison wasn't interested in him—nor on dealing with important issues. He felt belittled. For weeks, his

productivity, energy, and commitment waned. He avoided Grandison whenever he could, as he perceived him as cold and interested solely in procedure and position. When Franklin got the chance to take on a new role under a different supervisor, he jumped at it. It was little satisfaction when one of the issues he had wanted to talk about became a crisis.

What does this story teach us about engagement and communication? First, how important quality, face-to-face communication is. By quality, we mean timely, using respectful language and deep listening. Secondly, how demeaning communication can be, if those quality features are not attended to. Thirdly—as the literature on employee engagement says—how engaged someone feels is often a function of their perception of their immediate supervisor. If an individual doesn't trust and respect that person, his or her engagement can suffer dramatically. In this case, Franklin moved on to another role in the organization.

A final lesson for us as leaders is a more subtle one. An astute colleague of ours once said "in the absence of ongoing communication, people start telling themselves stories…and the stories are almost always negative." In this case, because Grandison had not taken the time for a meeting, Franklin began to tell himself stories about Grandison being cold and uninterested in the project. The face-to-face communication reinforced that story to the point it became fact for Franklin. If their face-to-face interaction had been respectful, inviting and based on the issues, the story would have been countermanded. Instead, it was reinforced. We need to remember others often judge our leadership ability by the quality of our communication, as it can be the source of many stories about character, quality and motives.

Communication is a very complicated process because it has so many aspects. There is the message itself, the medium used and the audience. It's also more than transmitting thoughts and information but rather an interchange involving both people and ideas which, to be successful, requires concentration and a true desire to understand the perspective of the other person. There is no single best way to communicate; it depends on the situation and the people involved. Leaders and organizations need to constantly assess and explore ways to communicate better. We will look at three aspects of communication in this section: deep listening, the use of dialogue and using appropriate media.

Deep Listening

"Deep listening" is a more receptive kind of listening, where we overcome our inherent assumptions and interests, and become more open to the other person's meaning and intentions. It's a skill that enables you to understand people better, and —in an ideal world—helps to create shared meaning with them. Shared meaning is more than understanding, which is to grasp the content and purpose of a message. Shared meaning adds to that grasping the values underpinning the message.

When combined with productive inquiry, deep listening enhances the potential for shared action. John Dewey defines productive inquiry as using probing questions to get clarifying answers about what we need to know in order to accomplish what we want to achieve [18]. Effective leaders use deep listening and productive inquiry to build connections with people and create shared meaning, which generates collective action.

Most leaders can listen reasonably well, but it is often a challenge to do it all the time. This is particularly true when we don't want to listen or emotions are running high and we can't "hear" from the other person's perspective (such as when we are being criticized or attacked personally). In those situations, we have to learn to concentrate, without being defensive, on understanding what the other person is trying to say. As one senior leader advises: "Count to three. When that doesn't work, count to ten!". Consider where is the attack coming from. If your behaviour is indeed the cause, accept responsibility for the behaviour, but not the anger—that's the other person's responsibility. And when we have to work with people we don't like, or with whom we disagree, emotional intelligence combined with sophisticated communication skills will be essential to doing that successfully (qualities described in Table 5.1 as part of the Interpersonal and the Decision Making Realms of emotional intelligence).

Dialogue

Dialogue emphasizes deep listening in a group setting. It encourages the open exchange of information and ideas, and if done well, creates shared meaning among a group of people. Effective dialogue is central to coaching and group work.

Dialogue requires a deep-seated desire to inquire and understand where other people are coming from; it's about building shared meaning based on the contributions of each person involved. Any kind of prejudgment or shutting down gets in the way of a team of people attempting to create something special together. As Stephen Covey says, "seek first to understand, and then be understood" [19].

Robert Fritz says that an organization is the "sum of its conversations" [20]. Observation will show you many groups don't support collaborative conversation in their ways of speaking and interacting. Those conversations often are characterized by advocacy and debate whereby one person tries to impose his or her ideas on others, or win the argument. Dialogue is characterized by open and honest inquiry—asking questions of clarification and understanding, rather than advocating for one's own point of view. There is a true desire to co-create understanding and meaning, by building on each other's contributions. How about your workplace? Do personal mental models, silence and defensive behaviour patterns get in the way of effective listening, shared understanding and learning? A group's problems are often inseparable from the way they think and act with one another. Dialogue is a process that enables people to be aware of, understand, and be prepared to engage in a collaborative conversation.

If you want to create the conditions for a viable dialogue with others, here are some steps to follow:

- Suspend your own assumptions.
- Keep the other person's best interests in the forefront of your mind, which entails a frank and open dialogue to bring issues and concerns to be addressed to the surface.
- Adopt an "intention and inquiry" approach, rather than giving advice or guidance, and don't feel you must reach a decision.
- Use deep listening and paraphrasing to develop shared meaning.

Learning Moment

1. Can you think of a time recently when you had a real dialogue? What were the conditions that made it happen?
2. Are there issues, problems or concerns you're facing that would benefit from a dialogue, as opposed to a debate, or discussion? Why?

Use of Social Media

E-mail, blogging, Twitter and Facebook have brought limitless new opportunities for conversation, knowledge gathering and relationship building to the workplace; but with these opportunities come issues and concerns. Social media may have made communication easier but they've also created many opportunities for miscommunication (we've all heard stories of an unfortunate tweet or e-mail landing someone in hot water or an unintentional "reply all"). Still, they are as much part of the leadership landscape as our buildings. Leaders must become conversant with their strengths and weaknesses; and rather than be overwhelmed by them, determine how they can be used to enhance employee engagement.

Many of us find it hard to get used to the idea of how transparent modern media can make us. Consider the story of a dean of a medical school who was giving a speech at a graduation ceremony. In his speech, he used a unique phrase to describe a point he wished to make. A medical student in the audience thought the term was familiar, and Googled it on his phone. Up popped a speech—identical to the one being given—spoken 6 months ago by the dean of medicine in a prestigious American university. By the time the speech was over, all the students in the audience were aware of the plagiarism and many in the outside world as well: through the power of Twitter!

The younger generation has known little else; yet more seasoned leaders may not realize how public their indiscretions can become through social media. Then there are people like Grandison, who rely on e-mail rather than engaging in face-to-face discussion, especially for difficult conversations.

A whole new industry has developed to advise leaders on improving productivity with communication technology. Look at the language in this advertisement:

Communicate like never before. Respond immediately. Share information, anytime, anywhere, via any device. You'll have the power of a unified communications system that connects everyone— your people, your customers, your partners. A system that's incredibly sophisticated, yet remarkably simple to use. Go ahead and grow—XXX is fully capable of handling up to 1,000 users in a single site or across multiple sites. With XXX, you have a complete, across-the-board solution that brings it all together. From telephony and video to mobility and call centre applications, to networking, security, and ongoing services, XXX will help give your business a competitive edge. Lets you do more with less. Drive profitable growth, without driving up costs. Perform better now and in the future.

As leaders we need to remember technology's value lies in its ability to enhance and enable communication to increase engagement. But don't assume more and different media enable you to recognize people, listen deeply to people, and dialogue with others more productively. Volume is not necessarily better than quality. You need to see social media for what it can be: a personal toolbox for improving how you practice leadership. Those tools must be used with care and awareness.

Build Teams

Leaders do not work alone. The belief that a single person can lead the rest of us to a successful future is a myth. Yet for some the word "leader" still conjures up a vision of a rugged individualist, endowed with experience, knowledge, skill, charisma and vision enough for all challenges. The reality in health care is different: leaders get results through their ability to convert independent, capable, and self-motivated individuals into an interdependent, well-functioning, high performing team. The ability to bring individuals together—whether they're different types of professionals, executives, community members or a board of trustees—is an essential aspect of leadership.

Shifting from an emphasis on individual leadership to team work is not an option in health care. New primary care models depend on professionals of different backgrounds, administrators and researchers working together. In hospitals, interprofessional teams deliver clinical service in emergency and operating rooms. Administrators and health professionals work collectively on operational and strategic issues. Managers have to work together cooperatively to achieve common goals.

However, studies have shown that without a deliberate effort to create effective teams most efforts to change work approaches fall short [21]. For example, executive and senior management groups often are not teams in the truest sense of the word. They have the name, but do not practice effective teamwork, which involves sharing responsibility for identifying problems, solutions, and action. Peter Senge calls this scenario the myth of the management team, likening executives to warlords who come to the table to divide up the spoils [22]. Without discipline to guide their interaction, executives often act independently and in conflict when interdependent action is required. With discipline, consciously employed, team dynamics can be improved [23].

A high-performing team is a specialized group of individuals with complementary skills and interdependent functions. They may be permanently grouped, or on

a short-term project. They share responsibility for a well-defined unit of work and achieve it, creating a whole that is greater than the sum of the parts. Some of you may feel that promoting teams is an abdication of a leader's accountability. It is not. It simply means the leader recognizes that they have to share that accountability for serving patients well with many other individuals, professional and non-professional. It also means that you, as a leader, and the individuals on the rest of your team must share the skills of creating interdependent action—that is, processes and practices that achieve collective goals and results.

Leaders of teams have two responsibilities. The first is to know when to lead. The second is to know when not to lead. This is one art of leadership: knowing when to shape events, and knowing when to let others do so.

However, the formal leader must exercise responsibility in the creation of the team itself. To do that, you must know:

- What you want the team to achieve;
- The specific skills needed to do that;
- The roles required on the team;
- Who possesses those skills.

Once the team is formed, use a combination of deep listening and dialogue to:

- Reaffirm the purpose of the team.
- Have the team shape a vision statement and establish their direction.
- Find out if team members have talents that might be useful beyond those that led you to choose them.
- Decide the values that should guide the team's work.
- Establish ground rules for behaviour, roles, responsibilities and meetings.
- Determine what behaviour and attitudes members look for in a leader that will make them want to contribute and feel confident to do so.

Practical experience and research has spawned a significant number of books and team-building tools.[10] One team assessment tool we particularly like was created by Dr. Sandy MacIver, a career coach and advisor on building high performance teamwork. His ten criteria for successful teams are outlined below [24].

1. Diversity
   - Comprised of individuals who have complementary skills and perspectives (i.e., appropriate scope and breadth of clinical practice skills needed to serve the patient population; or expertise to address management or leadership challenges)
   - Having, identifying, using and celebrating strong elements of diversity
2. Team direction
   - Clear values to guide the team
   - Inspiring each other with a clearly articulated vision and purpose
3. Trust, mutual respect, and guidelines for team dynamics
   - Establishing ways to trust, respect and support one another at all times
   - Establishing rules by which the team agrees to operate

4. Problem-solving, decision-making and conflict management
   - Establishing protocols for decision making and dispute resolution
   - Working together to define problems, explore root causes and come up with synergistic, implementable solutions
5. Role definition and expectations for all group members
   - Establishing and sticking to the right team roles at the right time and place
   - Distributed responsibilities
6. Creativity: brainstorming, fun, experimentation, and/or flexibility
   - Having some fun and taking some risks
   - Being creative: going outside the norm
7. Effective meetings and gatherings: balancing key things
   - Holding meetings and other gatherings of the team that are well worth attending
   - Successfully balancing tasks and people, listening and speaking, inquiry and advocacy, work and breaks
8. Outside contacts and resources
   - Know when to use carefully selected resources outside the team
   - Using outside resources effectively
9. Getting the job(s) done
   - Defining who the customer/audience is for what we are doing
   - Ensuring the outcomes reflect a job done with quality
10. Regular evaluation of performance, self-correction and timelines
    - Establishing measurable outcomes which speak to the achievement of the vision reviewing our performance as a team regularly and critically-establishing measurable outcomes which speak to the achievement of the vision
    - Reviewing our performance as a team regularly and critically

We strongly encourage you to invest in building supports for teamwork in your workplace. Both the Northern Health Authority in British Columbia and the Capital Health Authority in Nova Scotia have done so. The Northern Health Authority has a set of tools to support the development of inter-professional team work [25][10] and the Capital Health Authority has two full-time equivalent positions for team coaches, to provide advice and guidance to teams that are being formed, or having difficulty. Interestingly, one of the provisos for asking a coach for help is that once they've done so, a team can't fire the coach. They may not like the coach's message, but they have to accept it.

[10] The Northern Health Authority has developed a set of tools to support the development of inter-professional team work.

Creating a team charter can also be helpful for embedding MacIver's criteria for high-performing teams. To develop a team charter book a meeting to discuss how you will work together.

Learning Moment
Think of teams you have been on in the past. Categorize them anywhere along a continuum from high performing to dysfunctional.

1. Using MacIver's list, can you identify (1) criteria that were present and that contributed to the performance of the team; or (2) criteria that were absent, and as a consequence, contributed to its dysfunction?
2. Which of the criteria mentioned above would you like to build into teams you are part of? Why? How might they help?

Conclusions

Having a staff, or group of highly engaged professionals dedicated to meeting the needs of citizens and patients, is a desirable goal for leaders in healthcare. We've now looked in some detail at the four leadership capabilities you'll need to promote engagement:

- *Foster the development of others*
- *Contribute to the creation of healthy organizations*
- *Communicate effectively*
- *Build Teams*

These capabilities work well in organizations and systems where there are enough leaders to do those things. However, we've also presented evidence in this chapter that suggests that density or connectivity of leadership doesn't exist in health care. Engagement scores in health care are lower than the average in most other sectors. Absenteeism and health issues are rising. Leaders have spans of influence of up to 200 direct reports.

There are two conclusions we can draw. One is that managers and leaders need to work much harder at engaging others. The second is there is not enough density of management and leadership in the system to fulfill those expectations. In many cases, that's because when budgets are cut, we look to cut management or to regionalize care to reduce management. One individual we spoke to said "We've taken the cream out of the Oreo cookie, to the point it isn't an Oreo anymore."

Regardless, each of us must strive to maximize our ability to engage others. We hope this chapter has helped to clarify the importance of building interpersonal relationships in your sphere of influence, and to use them to engage others—our followers, clients and patients—in contributing to effective change. The exercises and stories highlight how the capabilities interact to achieve that, and guide you toward bringing about change with deep consideration for the welfare of others.

Now, evaluate yourself with the *Engage Others* self-assessment tool. Then, based on your results, identify one capability you should put energy into developing.

In the next chapter we will move on to *Achieve Results*.

Learning Moment

To use this questionnaire, find the right category for your level of leadership (e.g., front-line mid-management, etc.). Then assess how well you demonstrate the four Engage Others capabilities, where "1" is *i don't do this well at all*; "7" is *i do this exceptionally well*, and "N" is *not applicable in my current role*.

Which capability do you need to improve on? Why?

Engage others self-assessment

Front-Line Leader Responsibilities:								
In order to engage others in working to make the health system better, I:								
1. Challenge and support my direct reports to develop personal and professional goals, enable their pursuit, and provide feedback on performance	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
2. Monitor the morale and productivity in my unit, and do my best to provide clinicians and employees with the tools required to do their work	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
3. Encourage an open exchange of ideas and information through active listening, use of appropriate media and effective meetings	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
4. Create and participate in collaborative inter-professional or inter-unit teams to achieve particular goals	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
Mid-Manager Leader Responsibilities								
In order to engage others in working to make the health system better, I:								
1. Champion and support the use of professional development opportunities, personal learning plans, or performance management processes to achieve personal and professional goals	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
2. Monitor morale and productivity, seek feedback on, and implement processes in my department that staff feel might improve morale and productivity	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
3. Listen well and establish both formal and informal processes for exchanging ideas and information through conversation, dialogue, appropriate media and effective meetings	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
4. Advocate for, help set up and provide leadership to collaborative inter-professional or inter-unit teams designed to achieve particular goals	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
Senior Leader Responsibilities.								
In order to engage others in working to make the health system better, I:								
1. Ensure there is funding, processes and procedures, and appropriate accountability for professional development, personal learning plans, or performance management processes to help staff achieve their personal and professional goals	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**

2.	Measure the quality of morale and productivity in my department, and ensure action is taken—with clinician and staff input—to improve morale and productivity	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
3.	Listen well and establish strategic communication processes (using appropriate interpersonal communication, media and meetings) to elicit open exchange of ideas, evidence and information	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
4.	Provide materials and support for the creation and sustainability of high-performance teams in my department, and at the senior management table	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
Executive Leader Responsibilities.									
In order to engage others in working to make the health system better, I:									
1.	Ensure we have policies supporting personal and professional development and performance management; and monitor the implementation of those policies	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
2.	Systematically measure the quality of engagement in my organization, and ensure the strategic plan endorses improving morale and productivity	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
3.	Establish communication strategies to encourage the open exchange of ideas, evidence and information and to deal with the media; and practice effective interpersonal communication with others	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
4	Develop policy to support the creation of high-performance teams in my organization, monitor its implementation and adhere to it at the senior executive table	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**

References

1. Payne D, Briscoe D. Engage others. Book two of five LEADS booklets. Victoria: Canadian College of Health Leaders, Canadian Health Leadership Network and leadersforlife; 2010.
2. West M, Dawson J. Employee engagement and NHS performance [internet]. London: The King's Fund; 2012. Available from: http://www.kingsfund.org.uk/sites/files/kf/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf. cited 2013 July 13.
3. Global Workforce Study. Engagement at risk: driving strong performance in a volatile global environment. Towers Watson, 2012. Available from: http://towerswatson.com/assets/pdf/2012-Towers-Watson-Global-Workforce-Study.pdf.
4. Goffee R, Jones G. Why should anyone be led by you? Harv Bus Rev. 2000;78(5)63–70.
5. Harter J, Schmidt F, Killham E, Asplund J. Q12® Meta-analysis [internet]. Gallup Consulting. At: http://strengths.gallup.com/private/Resources/Q12Meta-Analysis_Flyer_GEN_08%2008_BP.pdf. Accessed online on 20 Aug.
6. Spurgeon P, Barwell F, Mazelan P. Developing a medical engagement scale (MES). Int J Clin Leadersh. 2008;16:213–23.
7. Dalal R, Baysinger M, Brummel B, LeBreton J. The relative importance of employee engagement, other job attitudes, and trait affect as predictors of job performance. J Appl Soc Psychol. 2012;42:295–325.
8. Leadership and engagement for improvement in the NHS. Together we can [Internet]. London: The King's Fund; 2012. Available from: www.kingsfund.org.uk/publications. Cited 12 Aug 2012.
9. Lowe G. How employee engagement matters for hospital performance. Healthc Q. 2012;15(2):29–39.

10. Yerema R. Canada's top 100 employers [Internet]. 2012. Available from: http://www.canadas-top100.com/national/. Cited 20 Apr 2013.
11. Buckingham M, Coffman C. First, break all the rules. New York: Simon & Schuster; 1999.
12. Caldwell M. Employee engagement and the transformation of the health care industry [Internet]. Towers Watson, 2011. Available from: www.towerswatson.com/en-US/Insights/IC-Types/Ad-hoc-Point-of-View/Perspectives/2011/Employee-Engagement-and-the-Transformation-of-the-Health-Care-Industry.
13. Goleman D, Boyatzis R, McKee A. Primal leadership: realizing the power of emotional intelligence. Boston: Harvard Business School Press; 2002.
14. Hersey P, Blanchard K. Management of organizational behavior: utilizing human resources. Englewood Cliffs: Prentice Hall; 1977.
15. Levin-Scherz J, Mason R, Wood M. Boost employee health and wellness with behavioural economics [Internet]. Towers Watson, 2011. Available from: www.towerswatson.com. Cited 13 July 2013.
16. Span of control [Internet]. The economist. 2009. Available from: http://www.economist.com/node/14301444. Cited 15 Mar 2013.
17. Goleman D. Leadership that gets results. Harv Bus Rev. 2000;78(2)82–3.
18. Brown J. From new learning environments for the 21st century [Internet]. Aspen, 2005. Available from: http://www.johnseelybrown.com/newlearning.pdf. Cited 13 July 2013.
19. Covey S. Seven habits of highly effective people. New York: Free Press; 1990.
20. Fritz R. The path of least resistance for managers. New York: Berrett-Koehler; 1999.
21. Kilpatrick K, Lavoie-Tremblay M, Ritchie J, Lamothe L. Advanced practice nursing, health care teams, and perceptions of team effectiveness. Health Care Manag. 2011;30(3):215–26.
22. Senge P. The dance of change. New York: Doubleday; 1999.
23. DeChurch L, Mesmer-Magnus J. The cognitive underpinnings of effective teamwork: a meta-analysis. J Appl Psychol. 2010;95(1):32–53.
24. MacIver K. A systems-based model for team development. Victoria: K. A. McIver and Associates; 2000.
25. Optimizing inter-professional team work: report on current practices. Prince George: Northern Health Authority Patients First; 2006. Available from: http://hdl.handle.net/10296/280. Cited 30 Apr 2013.

Chapter 7
The *LEADS in a Caring Environment* Framework: Achieve Results

Knowing is not enough; we must apply. Willing is not enough; we must do — Goethe

No leader—certainly not you—goes into the health system to make the results worse! You, I and all health leaders envision a better future. We are always trying to improve results. That goal guides us through all the decisions and actions we take. In practical terms, much of our leadership energy goes to improving both efficiency and effectiveness [1],[1] where "Efficiency is doing things right. Effectiveness is doing the right things" [2]. This is where good leadership (doing the right things) meets good management (doing things right) to achieve results.

Some results, of course, are more important than others. The Achieve Results is the most task-oriented of the five capabilities of the LEADS framework. It's about focusing you on identifying which tasks matter most, showing you how to use them to set priorities, and then how to measure action on them to track success and set direction. Regardless of your role—CEO, mid-manager, front-line supervisor or community leader—Achieve Results will help you make decisions to identify priorities and take the actions to achieve them.

"The only vision worth pursuing is one that is impossible to achieve" Richard Farson says [3]. Nevertheless, pursuing a vision, and measuring progress toward it, should decide which direction you'll follow, and the actions you undertake. "Health for all by 2020" has been adopted by the World Health Organization as its unifying vision, replacing "Health for All by 2000." This is an example of a worthy horizon objective, likely unattainable but worth striving for. Either way, it can be translated into a series of measurable end-point and intermediate results that will give you points to navigate by in your journey as a leader. (It is one of the paradoxes of leadership that we need a clear vision to pursue, and concrete results to measure our progress and keep us on track, yet we may never reach our dreamed-of destination).

[1] Chris Hodgkinson terms values as efficiency and effectiveness as "meta-values" of public service enterprises such as health, i.e., moral commitments that underpin the enterprise. Two other meta-values of health care in a universal health system such as Canada's are equity and caring.

G. Dickson, B. Tholl, *Bringing Leadership to Life in Health: LEADS in a Caring Environment*, DOI 10.1007/978-1-4471-4875-3_7, © Springer-Verlag London 2014

There are four capabilities in the Achieve Results domain:[2]

- Set direction
- Strategically align decisions with vision, values and evidence
- Take action to implement decisions
- Assess and evaluate

They are your navigational aids for setting a course to your vision. Let's begin with the story of Janelle.

Janelle, in her first year as nursing supervisor, was trying hard to be an effective leader, and very committed to the concept of patient-centred care. She was excited to be asked by her manager to be champion for it on her ward. However, it quickly became apparent that some nurses on the ward did not share her enthusiasm. She could see why: the new program required significant changes in practice, meetings before or after shift; a new scheduling approach, and learning new clinical protocols. But there was also a critical shortage of nurses. Combined, they added up to an immense burden on the staff.

One day, Melissa, a friendly, dependable nurse who had recently transferred from another hospital asked to go for coffee. But as soon as they sat down, Melissa began to apologize. The words just poured out. "I have to give some bad news. I know how hard you are trying, and how much you believe in patient-centred care—and I do too, from an ideals perspective—but I can't do it any more. I can't balance the demands on me now: work, home, kids. I've had to take three extra shifts in the past two weeks to make sure the staffing protocol works, my husband is furious because he's had to take two half-days off work when the kids got out of school early and I missed their piano recital last Saturday. Next month I'm supposed to go to Vancouver for a training session. I'm so sorry, you're a great friend and I know you believe in this, but I just can't do it anymore. There's an opening back in my old unit and I'm transferring out."

Janelle was shocked. Melissa had been a tower of support on the unit. She felt guilty too; she hadn't thought of the impact of the change. She'd just thought—usually disparagingly—about how to deal with the nurses who balked at the change. "I know you'd probably like to talk me out of it," Melissa said, "But my mind's made up. I just can't do this anymore." With that, she walked back to the ward—to continue, as Janelle knew, to do her stellar work on behalf of patients.

That night, after talking with her husband, Janelle began to understand. Improving patient care—as a long term vision—was laudable. But was the goal attainable if it drove away the best nurses? When the job becomes a burden, burn-out, quitting or transferring are the options, none of which help the patient. How does a leader who cares for both the patient and the care-giver balance competing demands?

Janelle reviewed her conversation with Melissa. She realized she was so caught up in the promise of patient-centred care, she had not understood the impact it would have on her staff. She didn't know if her staff understood the long-term benefits of the new approach, whether they accepted them, or whether they could actually implement it. She realized the resistance she was encountering from some of the nurses might be due to stress or burnout. To top it off, she had no idea Melissa had worked three extra shifts and had to go to a four-day training session. She was still committed to the vision, but more was needed.

Janelle was determined not to lose any more Melissas. She realized she needed to understand the impact patient-centred care would have on the nursing staff, and they

[2] One might also argue that the other domains of the framework are devoted to maintaining the spirit, energy and motivation to pursue an impossible dream–and not be distracted by the inevitable disappointments along the way; the desirable 'short cuts' when one is tired; or sometimes the willingness to 'settle down' when a short destination is achieved.

needed to be given a concrete sense, with measurable markers of success, of how it would benefit patients. The plan also needed to include some "caring for the care-givers" by setting metrics to track the pace of implementation and gauge its impact and success. She would approach her manager and use data and evidence to help her understand the impact of the changes on the nurses. Otherwise, the patient-centred care initiative might fail altogether.

Learning Moment
Take a moment to reflect on Janelle's situation outlined in the story above.

- If you were in Janelle's situation, what measures might you develop to assess patient-centred care that would resonate with other nurses?
- Like Janelle, leaders always have to balance ideals with the challenges of achieving them. Janelle decided her balance was off. Are you in balance? What would your colleagues say? Direct reports?
- Share Janelle's story with a colleague. Are there lessons in her story that apply to leadership in your organization?

Janelle's story contradicts the old adage that the ends justify the means. Putting patients' interests first can sometimes translate to, or be perceived as, putting the interests of your team last. As a leader you need to possess a very clear sense of what success looks like both in the short- and longer term. You need to be guided by strong values and beliefs around how best to achieve *sustainable results.*

So now let's turn our focus to looking at the four capabilities in the Achieve Results domain of the *LEADS in a Caring Environment* framework, and how together they can help focus your leadership on the task of improving health for our citizens.

Set Direction

Set direction is the first capability in the Achieve Results domain. We define it as "inspiring vision by identifying, establishing, and communicating clear and meaningful expectations and outcomes." Visions can be leader-driven, management-team driven, or created collaboratively by engaging members of the organization; the latter approach is generally the most effective way to win broader acceptance for a vision [4]. After all, we own what we all help create.

What is clear from the work of a number of writers [5, 6] is that visions need to be inspirational in their own right about the better world you're pursuing. However, if you have a compelling vision but can't inspire others with it, you may find yourself in an uncomfortable place.

Strong visions enhance organizational performance [7], but even compelling visions expressed passionately may only inspire for a while, until reality sets in, and people start the hard work involved in realizing them. We're willing to bet that after about 50 days at sea, buffeted by storms and running out of food, even Christopher Columbus had difficulty inspiring his crew by talking about China and the riches awaiting them.

Is it really different in health care? Sure, you can be inspired—as Janelle was—by ideals. But when the staff starts to grumble, good employees leave, hostility surfaces, and resources get scarcer, it's difficult for anyone to remain inspired. That's why it's so important for a leader to identify clear and meaningful expectations and long- and short-term results, which can be measured to show whether the vision is being translated into action. Measurable results can give a distant goal relevance and infuse day-to-day efforts with meaning and purpose.

A second reason to establish and communicate milestones and expected results is that without them, we can lose sight of where we are at on the journey. A CEO who grew up in the Canadian prairies is fond of telling a story about growing up in Saskatchewan.

Canada, like Australia, is a large country with vast prairies. It is a rite of adulthood that a young teenager growing up on the prairies is suddenly asked one day to take the wheel of the tractor and cultivate the field. My dad had been making great progress. The field was half done with nice straight furrows when he said to me: "Your turn, see what you can do!"

So I took the wheel of the tractor and carefully set off down the field looking backwards to follow his furrow. I got to the end of the field and turned to see how I had done. I was crushed to see that my furrow was as crooked as a dog's hind leg. I turned to my Dad and asked "So what did d I do wrong? How is it that your furrow is so straight?" He laughed and said: "Well, the first problem is that you were looking backwards the entire length of the field and every time you hit a rock in the field, it set you off course and you over corrected to get back on track. The trick is to look forward, not backward."

"That's fine then, Dad, but how is it that you get back on track so quickly that your furrows look so straight?" "Well," he said. "I pick a fencepost on the horizon and I line up the tractor's smokestack with the fencepost and that helps me to get back on track quickly when I hit the rocks in the field."

The field of health care also has many unexpected rocks. Facing them, leaders need the fencepost of a compelling vision and a smokestack (benchmarks by which to gauge progress) to that vision.

Here is another story to emphasize the point.

Grant was the CEO of a large national association, attending a meeting with leaders of other national organizations, to discuss how to work together on transforming Canadian health care.

During the discussion, another CEO named Brian interrupted. "What's all this talk of doom and gloom?" he shouted. "We all know Canada's got one of the best health systems in the world—just look at our neighbours to the south—they are envious of what we have. Why do we want to fix it when it ain't broke?" Silence followed, and Grant found himself agreeing with Brian. "He's right. I don't think the situation has gotten that much worse." But before he could say anything, Sharon, the CEO of a major nursing organization spoke up.

"I understand your frustration, Brian, but let's be clear on what the real issues are. I care passionately about universal health care and the Canada Health Act. I also believe in our collective ability to fulfill its expectations. That's why I go to work every day. But I believe the challenges—the doom and gloom, you call it—are real.

"I asked my research department to help me get a handle on what's happening," she continued. "The data they found indicate Canadian healthcare systems were on top of the world 10 or 20 years ago, but they're not any more. Our health outcomes are down, our per capita spending is up and our international ranking is declining rapidly, which you can see in reports the OECD, WHO and the Frontier Centre for Public Policy all published in 2010. Combine their statistics with our aging demographic profile, and we clearly have some serious challenges."

Sharon concluded by saying, "With all due respect, Brian, it seems to me complacency is our worst enemy—we need to pay attention to what these statistics are telling us. They're saying we are moving away from our vision, not toward it—and it's our job as leaders to work together to reverse that trend."

Sharon's answer shook Grant. He realized it was quite a while since he had looked at comparative data on his field, and wondered if it, too, would show the downward trend Sharon described. "I'd better get on that", he thought. "Last thing I want is to be the captain of a ship that goes down on my watch. I'd better know what's going on and what it means for our vision as an organization."

The people in the room were all dedicated to preserving Canadian health care, but Sharon had data that showed they were falling short on achieving that vision. Armed with the facts, she could inspire them to take action, expressing her belief that they had the ability to meet the challenges the data represented. In order to speak truth to power, it is helpful if you have a very good sense of what truth is. Sharon was able to speak with authority and she did so in a compelling way. This is an example of set direction in action.

Learning Moment

Peter Senge, in his book, the *Dance of Change*[3] says complacency can be our worst enemy. He uses the parable of boiling a frog to illustrate his point: A frog in a pot of water brought very gradually to a boil never tries to jump out. But if it's plunged straight into boiling water it does its best to leap away.

It is said that during change you're either moving forward or moving backward—and in the health system, we're always in the middle of change. What data do you have that could tell you whether you're moving toward your vision or away from it?

[3] *Learning moment inspired by Peter Senge* [8].

As a leader, you set direction by:

- Establishing values that speak to the fundamental principles and ideals you and your people believe should guide your work together, and ensuring the culture of the organization reflects them.

- Defining, in collaboration with others, the shared vision you are working to achieve, then writing a mission statement that expresses the vision as a clear sense of purpose; and
- Identifying performance indicators for measuring whether you are adhering to your values and making progress toward achieving your vision.

Learning Moment: What Do Powerful Visions Look Like?[4]
Business strategy and leadership writers offer some common characteristics for powerful visions:

- Concision
- Clarity
- Future orientation
- Stability
- Challenge
- Abstractness
- Desirability
- Ability to inspire.

Think about these questions:

1. To what extent do you believe visions in health care organizations are different from those in the private sector?
2. Are there characteristics of powerful visions that do not apply in health care?
3. Consider your organization's vision statement in light of these characteristics. How does it fare?

[4] *Qualities of an effective vision are drawn from Kantabura and Avery* [7].

The health system is a series of concentric circles, representing larger and larger playing fields in which you are expected to exercise your primary influence as a leader. Formal leaders usually have responsibility for leading in a specific field. Informal leaders choose where they wish to exercise influence. Each playing field needs boundaries—which are the values, vision, and performance indicators we've described. Because they are nested, formal leaders always need to align values, vision and key indicators across all the fields. Informal leaders face a similar challenge, but without the well-defined boundaries.

Strategically Align Decisions with Vision, Values and Evidence

The second capability of the Achieve Results domain is to strategically align decisions with vision, values and evidence. We define this as the capability to "integrate organizational missions and values with valid evidence to make decisions." The key word is "decisions" because they are the currency of effective leadership. They represent the responsibility for setting priorities that comes with the leadership

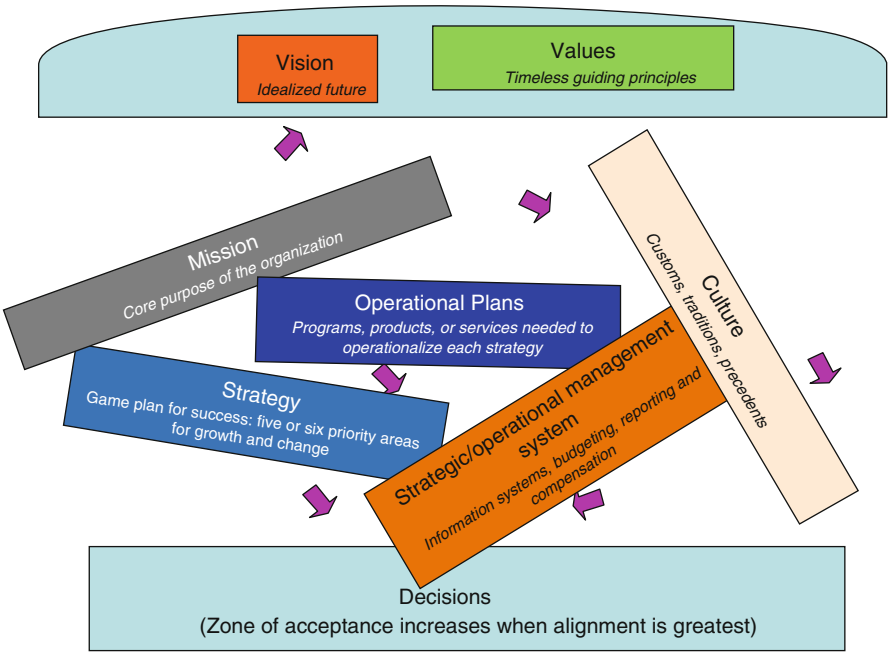


Fig. 7.1 Challenges of alignment without results and valid evidence

responsibilities of efficiency and effectiveness. Decisions are how you focus, direct and maximize the use of an organization's resources to achieve its purpose.

Often, your credibility as a leader will be determined by how the people who act on, or are affected by your decisions, feel about them. They expect your desicions to align with organizational values and be practical. Chester Bernard, in his book *The Functions of the Executive* [9], contends all leaders have authority to make decisions within a particular "zone of acceptance" given to them by their followers. When leaders make decisions within the zone, the scope of the zone grows. But if they make decisions outside the zone it shrinks. Aligning structure and meaning is what establishes the boundaries of your zone of acceptance.

What do we mean by alignment? As a noun, it refers to "the degree of integration of an organization's (or local service delivery system's) core systems, structures, processes, and skills; as well as the degree of connectedness of people to the organization's (or system's) strategy. As a verb, aligning is a force like magnetism. It is what happens to scattered iron filings when you pass a magnet over them" [10].

Figure 7.1 shows how impossible it is to align vision, values and the organizational environment when there are no measurable results or valid evidence to keep the enterprise on track.

Measurable results and valid evidence to back them are missing from the diagram, and therefore, connectedness is missing, too. Measurable results help alignment by grounding the vision with measurable targets to assess progress and encourage effort. Valid evidence contributes to alignment because facts narrow the range of acceptable decisions. Leaders, like clinicians, need to use evidence to shape and support their decisions. Figure 7.2 shows how results and evidence contribute to alignment.

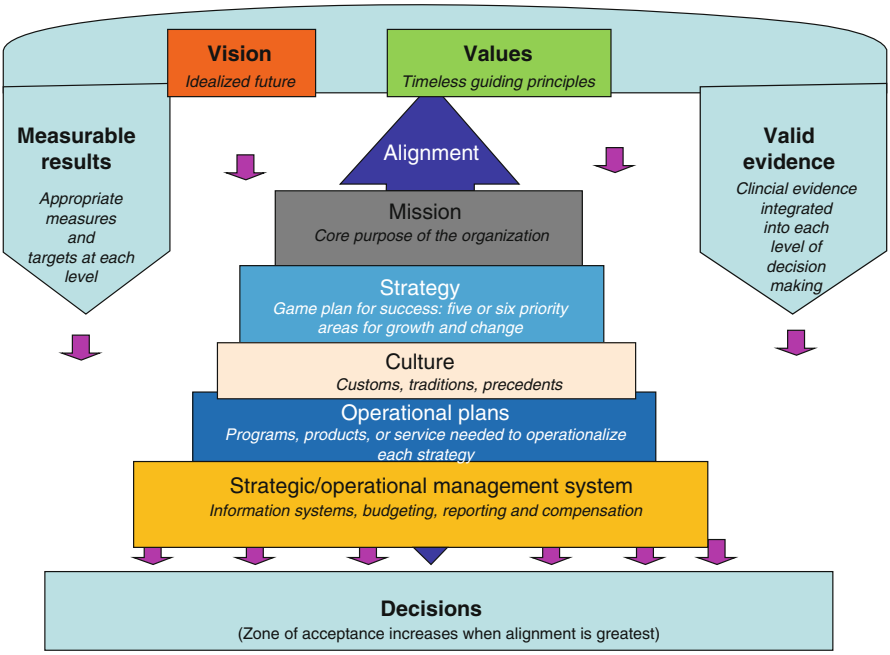


Fig. 7.2 Shows how results and evidence contribute to alignment

Of course, the linear image in Fig. 7.2 exists only in a perfect world. Leaders have to align multiple factors, including what other leaders are trying to do. Their collective efforts may support overall alignment but they may not. Ronald Heifitz [11] describes this as the challenge of "perfect understanding" and likens it to being on a balcony and on the dance floor at the same time. On the balcony you can see the whole and how it works together; on the dance floor, you're dealing with the unique challenges of your own area. Measurable results and valid evidence maximize the potential for alignment, but can never achieve it. Complete alignment, like a perfect vision, is never possible, but the closer you come, the more efficient and effective your decisions will be.

Learning Moment
Consider the metaphor of being on the balcony and the dance floor at the same time. Discuss the following question with a friend or colleague:

- How would knowing the measurable results as defined by the board of your organization help you make decisions aligned with theirs?
- Do decisions in your organization clearly reflect valid evidence? Why or why not? How might this improve decision-making?

Take Action to Implement Decisions

Decisions without action are meaningless, yet it's not unusual for decisions in health organizations not to be followed up on, which explains our third capability—leaders take action to implement decisions. Leadership is not simply knowing what to do and deciding to do it; by our definition, leaders "act in a manner consistent with the organizational values to yield effective, efficient public-centred service."

Returning to Heifitz's metaphor, being on the balcony means knowing what to do and how to do it while aligning all the factors of a complex health system; being on the dance floor is making sure it gets done according to your organization's vision and values. It is about taking the steps necessary to make sure decisions made are implemented. Leaders also need to be good managers: as pointed out earlier in this chapter, they need to do things right as well as do the right things.

To be an effective leader you must understand the dynamics of change and turn that understanding into action others will support. "Walking the talk" matters: people judge us by our actions. When there's a disconnect, our credibility suffers. So should you, to borrow a phrase from Nike, just do it? That isn't easy for a lot of people. Knowing how to jump out of an airplane and jumping out of an airplane are two very different things. Fear must be conquered. Words found. New skills exhibited. Relationships altered. Comfortable patterns of behaviour changed.

Some interesting research done by Patterson and Grenny [12] suggests that action—in the form of implementing organizational priorities for change—can be stimulated by using their Influencer model. The Influencer model outlines specific actions to take to support action for change in your own area of responsibility. It actually combines capabilities of the Engage Others and Achieve Results domains in an artful way to create action. There are three steps to using the Influencer model.

Step 1. Clarify measurable results

Don't waste time on how to create change until you've clarified what you want, why you want it, and when you want it. The result you are looking for will be:

1. Specific and measurable. It is quantitative, not qualitative.
2. What you really want. It's the outcome that matters.
3. Time bound. It comes with a completion date.

Step 2. Find vital behaviour

Vital behaviour exponentially improves your results. Crucial moments tell you when it's time to act, vital behaviour tells you what to do and how to do it. Vital behaviour tends to stop self-defeating and escalating behaviour. It often starts a reaction that leads to good results. Here are the keys:

- Behaviour is action
- Behaviour is not results or qualities
- Not all behaviour is equal
- Only a few are genuinely vital.

Step 3. Six Sources of Influence

Your influence can trigger action when others are motivated to do something. However, motivation is not enough: they also must have the ability to act. The table below provides an overview of three levels of motivation and ability that must mesh together for action to happen. Patterson and Grenny [12] contend if you can respond in the affirmative to questions in four of the six cells, action will commence. It should also be apparent that if the answer to the questions is no, you know where to exercise your own actions as a leader to create the conditions for others to act.

Table 7.1 Six Sources of Influence

	Motivation	Ability
Personal	**1. Make the undesirable desirable** **Questions to ask:** *Are they willing to engage in the behaviour?*	**2. Surpass your limits** **Personal ability** *Do they have the knowledge, skills, and strengths to do the right thing even when it's hardest?*
Social	**3.** Harness peer pressure **Social motivation** *Are other people encouraging the right behaviour and discouraging the wrong behaviour?*	**4.** Find strength in numbers **Social ability** *Do others provide the help, information, and resources required at particular times?*
Structural	**5.** Design rewards and demand accountability **Structural motivation** *Are rewards, pay, promotions, performance reviews, perqs, or costs encouraging the right behaviour or discouraging the wrong behaviour?*	**6.** Change the environment **Structural ability** *Are there enough cues to stay on course? Does the environment (tools, facilities, information, reports, proximity to others, policies) enable the right behaviour or discourage the wrong behaviour?*

Leaders are always asking both themselves—and others—to change, to act differently from how they are acting now. It is one thing to take on that challenge for oneself (the Lead Self domain of LEADS). It is another to demand it of others. Change—big or small—is a consequence of having a vision for a better tomorrow, of improving the results we are all trying to achieve. Let's review Melinda's story, as an example of change:

Melinda was a director of maternal health with responsibility for all births in her city and the surrounding suburbs. Her supervisor, just back from a meeting with senior management, told her they'd discussed recent data from the Canadian Institutes of Health Information (CIHI) showing the local rate for Caesarian sections was 31 per cent, 5 percentage points higher than most comparable regions. The senior management team wanted to know whether it was time for action to reduce the number of C-sections and if so, how the organization would go about doing so. They wanted Melinda to put together a briefing.

Melinda's research showed two physicians in particular who were responsible for almost half the C-sections. Other physicians in the region were spot on the provincial average. In addition, she found valid research that showed that regions where midwifery was part of obstetrical care had rates much below the average, lower costs, and fewer adverse events.

As she considered these findings, she realized both the physicians with exceptionally high Caesarian rates were very influential in the region. One was the husband of the chair of the board and the other was chair of the medical advisory committee. She also realized that to champion midwifery, she would have to recommend moving funds from the hospital to home and community care. The change would likely improve outcomes, but it would reduce the income of physicians doing obstetrical care, because they would deliver fewer babies overall, and do fewer better-paid C-section births.

"Can I recommend this?" she wondered. She knew her briefing note was going to get a lot of attention, and fallout from it — particularly from the two physicians most responsible for the high rates — could be particularly difficult for the CEO and chief medical officer. And the budget re-allocation wouldn't be popular either. She wondered if her supervisor would even want to present the briefing note with those recommendations in it. It could be bad for her career.

Learning Moment
Reflect on how the Influencer model could provide Melinda with a plan for action.

1. What results does Melinda want to achieve?
2. What vital behaviour will determine whether or not she is successful? (Here the capabilities outlined in the Lead Self and Engage Others chapters will help).
3. What four sources of influence will assist her in achieving her goal?

Discuss with a trusted colleague or friend. There is no right answer; just the answer that would work for you if you were faced with Melinda's challenge.

Melinda's story shows us just how powerful culture can be and how leadership inaction or inertia often carries the day. Being a leader takes courage and always involves personal and professional commitment. Advancing the cause of maternal health involves a number of factors, only one of which is the actual number of C-sections. And the culture of the care delivery process can be a powerful opponent of change. In this case, the spectre of "once a C-section always a C-section" takes hold and it becomes very difficult to change the practice of physicians but also the preferences and attitudes of their patients.

Good leaders are aware of the need for authority and accountability to be aligned. Having accountability for delivering on results with little or no authority over the policies or programs to get the job done is one reason for the churn rate in senior leaders and why younger leaders are reluctant to take on more senior leadership roles. This is perhaps what Hans Selye, the great expert on stressors, had in mind when he used the term "stress of distress" [13]. And this is where good leaders are guided by the serenity prayer: "God grant me the serenity to accept the things I cannot change; courage to change the things I can; and wisdom to know the difference."

Assess and Evaluate

The fourth capability in the Achieve Results domain is assess and evaluate: "leaders measure and evaluate outcomes. They hold themselves and others accountable for results achieved against benchmarks and correct the course as appropriate." Assess, evaluate and accountability are the key words in this capability. They describe the pointy edge of leadership—the process of knowing whether our responsibilities have been achieved, and accepting the consequences.

To assess something is to measure it. To evaluate something is to determine its merit or worth. A leader may need to know, for example, how many operations are being conducted in any particular hospital: that is assessment. Knowing how efficient or effective those operations are is an evaluative process—and one that is done by designing and employing benchmarks or targets to ascribe merit or worth to that result.

All leaders in health care face measurement challenges. Some things—like spending—are relatively easy to measure. Other things—like caring for a patient, for an employee, or for self—are much harder to measure. Many of the benefits and costs of health care appear to be intangible. But they are not: it is just harder to find the appropriate measurement. Assessment and evaluation create the need for measurement and accountability, because measurement helps us be accountable. Accountability is different from responsibility, because you can be responsible for something but not 'held to account' for it. It's important in leadership to be accountable for what you are responsible for.

Accountability has two forms. First, there is consequential accountability, which is accepting consequences, or being held to account for achieving your assigned responsibilities. The second is procedural accountability, which is being held to account for procedures and protocols that are expected to be adhered to, such as clinical protocols or financial protocols.

Holding yourself consequentially accountable for reaching benchmarks [14] means you're accepting responsibility to make changes if the results don't stand up. Many organizations establish benchmarks (that is, gauge acceptable performance by comparing results to certain standards, often data from other jurisdictions). They show performance relative to the benchmark on charts that make the implications of the data transparent. Many have policies dictating consequences if performance is significantly below par (we elaborate on one such model below). This kind of measurement formalizes accountability: "People live up to what they write down" [15].

When measures suggest significant changes are required, consequential accountability may conflict with procedural accountability. It may be the process is not being followed effectively, leading to poor results; or, the process itself may be unable to achieve those results. It is your job to ensure processes that should be followed are; or to change processes that don't work, to improve results.

There are two measurement models you might wish to look at, one is the balanced scorecard created by Kaplan and Norton [16] which has significant traction in health

care [17][5]. A second is the triple aim construct promoted by the Institute for Healthcare Improvement in the United States [18]. Both models expect the leader to go beyond measuring financial results and assess results including customer or patient satisfaction, productivity (such as clinical accomplishments), employee engagement and how well important clinical practices are being implemented. The principles and procedures in both can be applied by leaders at any level.

Once you have chosen a measure, evaluate whether performance on it is satisfactory, judge whether action needs to be taken, and accept responsibility for undertaking that action. And finally, the more transparent you are—the more potential there is others will understand and support the action that needs to be taken.

Let's review three examples of efforts to assess and evaluate performance to create effective accountability and corrective action.

The first example is the movement toward Accountable Care Organizations (ACO's) in the United States [19]. ACO's use population outcome data to assess and evaluate performance and then generate accountability by tying provider reimbursements to those quality metrics. Their purpose is to use data to reduce, wherever possible, the total cost of care for an assigned population of patients. Leaders who adopt an accountable care approach are aware they are accountable, through the linking of results to budgets, for the overall funding for and outcomes of the organization. The process supports improvement and provides confidence that savings are achieved when care is improved.

The Dartmouth Institute for Health Policy and Clinical Practice in Dartmouth College champions the concept of accountable care, created in an effort to end fragmentation of care and rein in costs. "To create a more sustainable system, we need a new model that holds health systems and providers accountable for the quality of care delivered to patients." [6] The accountable care model promotes strategic integration of services and rewards, based on measures of quality. Better care not only benefits patients, it improves the financial picture for the organization and the people who work there. Accountable care organizations use data from the Dartmouth Atlas. It uses Medicare data to assess and evaluate the efficiency and effectiveness of health programs in national, regional, and local markets, as well as hospitals and their affiliated physicians. Accountable Care Organizations can set goals and accountability for them based on the data, and measure their performance against it.

Another organization that has converted measures and accountability into strategic action is Canadian Blood Services (CBS). Since 1998, CBS has used the Kaplan and Norton balanced scorecard as a lever to make the changes necessary to overcome the crisis of confidence in the blood supply caused by the tainted blood

[5] Bob McDonald profiles the extensive use of the Balanced Scorecard in numerous health jurisdictions in Australia and other developed nations.

[6] The Accountable Care Organization (ACO) is an approach being championed in the United States as a key element of effective health reform. This excerpt was downloaded from http://tdi.dartmouth.edu/initiatives/accountable-care-organizations#sthash.SyqClj4h.dpuf; more information about ACO's is available on this site.

scandal [20]. The balanced scorecard uses financial measures for assessing and evaluating performance. But it's important to note that financial concerns alone are not sufficient to guide change; it's equally important for change efforts in health care to include developing long-term capabilities among employees and involving patients and citizens [21]. You must develop measures for all those factors, and assess and evaluate their implications and impact. Only with all those aspects balanced can an organization be considered on track.

CBS's vision is clear and concise: "Canadians have trust in us." Its mission is to "operate Canada's blood supply in a manner that gains the trust, commitment and confidence of all Canadians by providing a safe, secure, cost-effective, affordable and accessible supply of quality blood, blood products and their alternatives." It uses the balanced scorecard, adapted to its mandate, to guide strategic change. CEO Dr. Graham Sher says using metrics derived from the balanced scorecard's four priorities (finances, program processes, human resources, and customer results) "… has improved our internal alignment, enhanced our metrics-based decision-making, and …(made)…allocating resources against priorities easier…In short, it has changed how we manage the blood system by crystallizing what's important to our organization and its mission" [22].

CBS uses the balanced scorecard metrics to assess and evaluate progress and keep changes on track (it even measures openness in organizational culture) [23]. They developed their own measures, only looking outside the organization to help set targets when no internal data is available. The organization tracks and reports results quarterly; if it doesn't meet a target, they discuss how to generate initiatives for meeting it [24].

Alberta Health Services (AHS), which administers the province's health care system, publicly reports on 55 performance metrics. They look at everything from life expectancy, workforce absenteeism and wait times to whether the budget is on track and patient satisfaction. These are reported on quarterly. As well as being used internally to set direction for improvement, the public can also assess and evaluate how AHS is doing, leading to de facto accountability for the senior management of that organization [25].

Being able to "talk numbers" is a very useful leadership skill. It is essential in today's health care to "count what counts" and to know how to use data to inform balanced decisions and action. In today's health care, measurement and accountability are key to success and yet they must be approached with caution. A measure that shows performance consistently below average creates pressure for action, but under pressure you may not make the best choice of how to proceed. Focusing on a problem area at the expense of others that had been doing better is not unknown.

There are other challenges in assessing and evaluating. Sometimes (as in Melinda's story) the action you have to take requires you to challenge the practices of important people. Will they resist, and do you have the skills to manage that resistance? Here the influencer model may be handy, as it provides a tool to plan for the situation—but obviously you must tread carefully.

There's also the question of what you'll do if your unit or organization consistently underperforms compared to its peers. When that happens, leaders can be tempted to fiddle their results to look good, which is what happened in the early 1990s when U.K. Prime Minister Tony Blair established maximum waits of 4 h in

accident and emergency departments. To meet the standard hospitals had to attend to the needs of 98 % of accident and emergency patients within 4 h. If they did, they would receive a £100,000 performance bonus. The goal was well intentioned. But various studies [26, 27] showed admission rates spiked in the final minutes before the 4-h target as staff scrambled to clear cases from emergency. As well, sicker patients who might normally have been seen sooner saw their waits stretch as less-sick patients nearing their 4-h mark for waiting were attended to first.

Assessing and evaluating service is not straightforward, as this example shows. The imperatives of quality and quantity do not always align, but organizational values and culture must do so. And, in every instance the leader must look inside (Lead Self) for the guidance and fortitude to address the problem. It is a learning challenge; a change challenge.

Learning Moment
Reflect on the past 6 months. How often have you:

- Looked up measurable results and compared them to benchmarks and targets, to determine what mid-course corrections should be made within your area of responsibility?
- How balanced are the metrics you are using? Do they reflect the four categories of the Kaplan and Norton Balanced scorecard?
- How politically challenging is it for you to make change when armed with solid data and information? How might you overcome some of those challenges?

Conclusions

This chapter provides an overview of the Achieve Results domain of the *LEADS in a Caring Environment* framework and its four leadership capabilities:

- Set Direction
- Strategically Align Decisions with Vision, Values and Evidence
- Take Action to Implement Decisions
- Assess and Evaluate

Each of the four capabilities of the Achieve Results domain is aimed at clarifying and focusing you on the results of change, and on how to use those results to gauge progress and for course correction. In our experience, the discipline required to succeed in the Achieve Results domain, particularly for "taking action to implement decisions" and "assessing and evaluating," is very challenging for modern health leaders.

We've observed that while measurement is often used effectively at the clinical level, it is used less effectively at the department and organization levels. That may be because of rapid amalgamation of small health units into big ones, requiring the coordination of disparate and fragmented data and information systems.

We've also noted that the rapid evolution of technology lets leaders develop information systems but does not necessarily prepare them for the politics of transparency and accountability. Even when good measures exist sometimes leaders are either unaware of them or reluctant to face the implications of them. It can be uncomfortable to be transparently accountable, with your performance out there for everyone to see.

When leaders are apprehensive about being accountable, uncoordinated information systems allow them to avoid it. However, the demands for sustainability, accessibility and quality in health care ensure measurement and accountability will not go away. Your challenge is whether you will take charge of the opportunities that assessment and evaluation provide, or wait for the government, media and the public to do it for you. All of us have to learn and change as the world around us, and its expectations, change.

Learning Moment

To use this questionnaire, find the right category for your level of leadership (e.g., front-line mid-management, etc.). Then assess how well you demonstrate the four Achieve Results capabilities, where "1" is *I don't do this well at all*; "7" is *I do this exceptionally well*, and "N" is *not applicable in my current role*.

Which capability do you need to improve on? Why?

Achieve results self-assessment

Front-line leaders:								
Consistent with the organization's values, vision, desired results and purpose, I:								
1. Develop a plan that outlines key milestones, timelines and expected results to be achieved by my unit	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
2. Make decisions that align with best-practice evidence and the key responsibilities of my unit	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
3. Take the actions necessary to keep me and my staff focused on the desired results for my unit	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
4. Assess and evaluate the desired results of my unit, and monitor those results to determine course corrections	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
Mid-management leaders:								
Consistent with the organization's values, vision, desired results and purpose, I:								
1. Set direction for the department through operational plans that outline key milestones, timelines and expected results to be achieved by all units	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
2. Advocate for adjustments to work practices, as necessary, to align them with valid evidence and changes made by other departments	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
3. Take corrective actions necessary to ensure ongoing availability of critical services within my department	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
4. Ensure valid measurement tools are in place for assessing my department's responsibilities, and are used to improve services when necessary	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**

Senior leaders:									
Consistent with the organization's values, vision, desired results and purpose, I:									
1.	Set direction through strategies that outline key approaches and tactics to achieve the results expected within my strategic area	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
2.	Can clearly describe how current decisions within my strategic area align with overall organizational strategy	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
3.	Gain support of other senior leaders and staff for successful implementation of strategies, and for changes to those strategies when those changes are validated by new evidence	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
4.	Hold myself and others accountable for establishing outcome measures consistent with our strategies, and for achievement of the targets we are responsible for	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
Executive leaders:									
I:									
1.	Collaborate with province, board, colleagues, and staff to create a compelling statement of values, vision, purpose and desired results for the organization as a whole	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
2.	Make strategic decisions based on aligning those statements of values, vision, purpose and desired results with the organizational structures that are in place	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
3.	Provide necessary support (e.g. systems, processes, resources) for implementation of the organization's strategic decisions	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
4.	Ensure that measures, benchmarks and targets are established to assess and evaluate desired results for the organization as a whole, and are used to course correct where necessary	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**

References

1. Hodgkinson C. The philosophy of leadership. Oxford: Blackwell; 1983.
2. Drucker P. The effective executive-The definitive guide to getting the right things done. New York: HarperCollins; 1963.
3. Farson R. Management of the absurd: paradoxes in leadership. New York: Touchstone; 1996.
4. O'Connell D, Hickerson K, Pillutla A. Organizational visioning: an integrative review. Group Organ Manage. 2011;36(1):103–25. doi:10.1177/1059601110390999.
5. Kaplan R, Norton D. The execution premium. Boston: Harvard Business School Publishing; 2008.
6. Lipton M. Demystifying the development of an organizational vision [internet]. Sloan Manage Rev. 1996. Available from: http://sloanreview.mit.edu/article/demystifying-the-development-of-an-organizational-vision/. Cited Aug 2013.
7. Kantabutra S, Avery G. The power of vision: statements that resonate. J Bus Strategy. 2010;31(1):37–45. doi:10.1108/02756661011012769.
8. Senge P. The dance of change. New York: Doubleday; 1999.
9. Barnard C. The functions of the executive. Cambridge: Harvard University Press; 1938.
10. MacLeod H. A complex system. Discussion paper. Edmonton: Alborta; 2011 Aug 24.
11. Heifitz R, Grashow A, Linsky M. Practice of adaptive leadership: tools and tactics for changing your organization and the world: a fieldbook for practitioners. Cambridge: Harvard Business Press; 2009.

12. Patterson K, Grenny J. Influencer: the power to change anything. New York: McGraw-Hill; 2008.
13. Selye H. Stress without distress. Philadelphia: J. B. Lippincott Co; 1974.
14. HealthCare Benchmarks and Quality Improvement. Toyota situation is no reason to abandon Lean, say experts [internet]. HighBeam Research. 2010. Available from: http://www.highbeam.com. Cited 2 July 2012.
15. Cliffe S, and Cialdini R. The uses (and abuses) of influence. Harv Bus Rev. 2013;91(7-8): 76–81.
16. Kaplan R, Norton D. The execution premium: linking strategy to operations for competitive advantage. Boston: Harvard Business School Publishing; 2008.
17. McDonald B. A review of the use of the balanced scorecard in healthcare [internet]. BMcD Consulting. 2012. Available from: http://www.bmcdconsulting.com/index_htm_files/Review%20of%20the%20Use%20of%20the%20Balanced%20Scorecard%20in%20Healthcare%20BMcD.pdf. Cited Aug 2013.
18. Bisognano M, Kenney C. Leadership for the triple aim. Health Exec. 2012;27(2):80.
19. Schultz S, Abercrombie S, Crownover D, Hockzema G, Krug N, Maxwell L, Mazzone M, Mitchell K, Shaffer T, Tuggy M. Accountable care organizations: an opportunity for synergy. AnnFamMed. 2013;11(3):283–284.
20. Romilly L, Tholl W. Achieve results. Third of five papers on the LEADS in a caring environment capabilities framework. Ottawa: Canadian College of Health Leaders and Canadian Health Leadership Network; 2010.
21. Balanced Scorecard Basics [internet]. North Carolina: Balanced Scorecard Institute. Available from: https://www.balancedscorecard.org/BSCResources/AbouttheBalancedScorecard/tabid/55/Default.aspx. Cited 19 July 2013.
22. Canadian Blood Services honoured for excellence in strategy management [internet]. Canadian Blood Services. 2007. Available from: http://www.blood.ca/centreapps/internet/uw_v502_mainengine.nsf/9749ca80b75a038585256aa20060d703/42ff1ff6045db49d85257375004f451a?OpenDocument. Cited 19 July 2013.
23. Abecassis M, Benjamin D, Tessier L. Clear blood. Stanford Innov Rev. 2009;7(2):67–71.
24. HR metrics: doing the math, finding the path [internet]. Peopletalk. 2008;11(3):11–6. Available from: http://www.heatherconn.com/pdfs/1035HRC_People_Talk.pdf. Cited 19 July 2013.
25. Petch J, Palmer R, Tierney M. Can "bottom up" measurement improve the quality of canadian health care? [internet]. Healthydebate. 2013. Available from: http://healthydebate.ca/2013/05/topic/quality/health-system-measurement. Cited 19 July 2013.
26. Frances R. Independent inquiry into care provided by mid Staffordshire. England: the Mid Staffordshire NHS Foundation Trust Public Inquiry 2010. 2013. Available from: http://www.midstaffsinquiry.com/assets/docs/Inquiry_Report-Vol1.pdf.
27. Kelman S, Friedman J. Performance improvement and performance dysfunction: an empirical examination of impacts of the emergency room wait-time target in the english national health service; Harvard University – Harvard Kennedy School (HKS); National Bureau of Economic Research (NBER) August 2007 KSG working paper no. RWP07-034.

Chapter 8
The *LEADS in a Caring Environment* Framework: Develop Coalitions

If you want to travel fast, travel alone. If you want to travel far, travel together
—African Proverb.

In the world of nature, threatened birds flock together. Bait fish form schools to appear bigger than they really are to ward off predators. Cattle gather into herds as menacing thunder clouds appears on the horizon. Even microbes "glob" together as the electrolytes change in their environment.

In the world of business, as economic conditions wax and wane, firms merge or are acquired and strategic partnerships are formed to make it more difficult for competitors to enter the market. Increasingly, multinational conglomerates form to take advantage of economies of scale and protect their profits.

This same dynamic has characterized health care's response to the forces at play in our democratic environment that we outlined in Chap. 2. The context for coalition building in health care is an environment characterized by:

- Regionalization of services; the creation of large corporations to manage the demands for efficiency and coordination of services.
- The proliferation of different lobby groups and patient advocate groups representing the growing number of specialty conditions emergent in society.
- More and more professional health provider groups, and greater specialization within those groups, as our knowledge and expertise grows and expands.
- New and valuable approaches to community based care to deal with the chronic health needs of many and the aging population (home and community care; palliative care; etc.).
- Patients who interact with the health system over a prolonged period of time as opposed to receiving short, episodes of care.
- Empowered patients and family members (i.e., through access to information over the internet) who expect high quality care, cutting edge care, and immediate care.
- Financial constraints that threaten the ability of the taxpayer to fund the system.

The result is a dispersion of effort across a variety of provider groups as it relates to an individual patient's care, and competition for resources to support their efforts.

G. Dickson, B. Tholl, *Bringing Leadership to Life in Health: LEADS in a Caring Environment*, DOI 10.1007/978-1-4471-4875-3_8, © Springer-Verlag London 2014

There is fragmentation of effort on one hand; but an increased overall capacity to serve on the other. However this capacity is unfocused and competitive, rather than focused and collaborative. Different organizations in a system need to work together to serve the patient or citizen. Shrinking budgets also provide coalition building opportunity! For leaders, diminishing resources provide the very incentive to seek out collaborations necessary for improving services and creating efficiencies.

In the world of health, there is a great need to form coalitions or networks, which is the subject of this chapter. In it, we'll focus on the conditions for developing successful coalitions and the leadership capabilities required to advance shared goals. Coalitions are a multidimensional construct, and building them is both an art and a science. They create the need for many leaders to become "boundary scanners"—individuals who are skilled at building relationships across boundaries rather than within them [1].

The same trend is to be seen abroad, according to a senior researcher from the Manchester Business School: "The last 5 years have given rise to a real cultural shift in public leadership. More and more people are recognizing that collaborative leadership can generate the relationships necessary to resolve the tensions between rising expectations, smaller budgets and more innovative solutions" [2].

One way to think about creating the winning conditions for purposeful, effective coalitions is to think about the metaphor of carpooling.

Carpooling Anyone? A Checklist!

1. **Share the same destination.** When you're carpooling, the first question you need to ask is, where are you going? If you don't share a destination, you'll get to the first intersection and one of you will be severely disappointed. It's the same with coalitions. Be clear you have a shared destination.
2. **Share the same values.** You might also want to ask your carpool whether it's smoke free and whether speeding can be accepted. When you're building a coalition, be sure you share the same core values, such as honesty, integrity, reciprocity and consensus decision making. Set these expectations down formally and call your partners if you think these core values are being breached.
3. **Share the load.** As a carpooler, you may want to share the cost of gas, share the driving and even share payment for speeding tickets. You certainly want to be clear on who's doing the driving. Coalitions need to agree on how to share in the financial, legal and (often underestimated) risk to personal and organizational reputation.
4. **Share the knowledge.** If you need a map to chart a route, share it. If there is knowledge of the road that he or she needs in order to remain safe, or if there is evidence to show one route is quicker and safer than another, share that as well.
5. **Share the credit.** When you reach the destination, don't claim to have driven all the way alone. Credit should be shared, too. And, as your mother always said, it's better given than taken.

When you're contemplating building a coalition to create results, it's wise to clarify expectations. Taking the time to go through the carpool checklist can help avoid unpleasant surprises. And, if your coalition seems to be going sideways, reviewing the checklist can help.

There are advantages to forming coalitions—increasing the quality of patient service across boundaries is one. A second is to enhance your voice, clout or presence in the marketplace of public policy. Sharing financial, legal or reputational risks in pursuing small or big system change is another. Other advantages include eliminating undue waste associated with competitive or disconnected practice, not vying with one another for political attention, or gaining efficiency by leveraging limited resources and providing mutual support or political cover.

Coalition building can also come at a cost. As the African proverb we opened with says, travelling with others will take more time. Coalitions can slow you down, especially in the early going as trust is being built and the common purpose is being clarified. Conflicts arise as a consequence of different organization structures, leader personalities, distribution of power, culture, and size.

Learning Moment
Reflect on the metaphor of carpooling:

1. Select one example from your experience where working together has resulted in an enduring formal or informal strategic coalition. Does the carpooling checklist work for you? Is there anything missing from that checklist?
2. Select a second example where working together as a coalition did not pan out. Does the carpooling checklist help you identify what went wrong? If so, how would you change what you did to make the coalition more successful?

To discuss coalitions we're drawing on the concept of "distributed leadership" [3] introduced in Chap. 2. Coalitions are simply this construct writ large: the practice of collaboration between organizations and organizational leaders as they work together. In the context of building coalitions, the practice of distributed leadership suggests it is important to clarify what is being distributed, by whom and for what purpose.

Coalition building is hard and collaboration is complex. Working with others is not always easy, especially where there is a history of competition or where cultures clash. "Successful coalitions do not just *happen* and they do not just *remain* successful. They are made up of individually successful people who do the right things, at the right time, with the right structures and processes, in the right context, for the right purpose" [4].

We see the Develop Coalitions domain as the strategic analogue of the Engage Others component of the LEADS framework, helping you create cross-organizational relationships to accomplish your patient/citizen-centred vision and results.

Coalitions or networks are almost always formed under conditions of uncertainty, where the external threat of not working together is greater than the internal threat of working together. As Benjamin Franklin said, "We must all hang together, or assuredly we shall all hang separately."

Realizing the benefits of working together, "…demands a sophisticated set of skills, knowledge, and abilities to envision, form and implement change" [5]. We'll now look at the four leadership capabilities that comprise the Develop Coalitions domain.

Purposefully Build Partnerships and Networks to Create Results

In Chap. 7 we learned how important it is to have a clear and compelling vision. It is equally as important when you're building coalitions. Effective leaders create connections and establish and maintain trust while working together toward this common constructive purpose. The word "purposefully" is chosen to suggest that whatever form of coalition is built (we will discuss different forms a little later) is done so in an intentional, deliberate manner, with clarity of purpose throughout.

Here's a story to set the stage for successfully working together and the leadership capabilities required to do that:

Judy and Paul were CEOs of Canada's doctors and nurses, respectively. They both grew up in New Brunswick but had not known each other prior to taking on their respective CEO roles. They did share the same values, however, and quickly grew to respect and trust each other. Their lunches often featured as the main course, a focus on shared challenges. In this particular case, the conversation shifted to the fact that despite their respective best efforts, they had not been effective in shining a light on the damaging effect of year over-year budget cuts on the care being provided to patients. Each had tried repeatedly to get their messages through at the federal Treasury Board table but met the same brick wall: doctors are just protecting their pocketbooks and nurses are just protecting their jobs. Today, however, the conversation shifts.

Judy: "Listen Paul, we are going to have to change the dynamic if we are going to be successful getting the attention of legislators and get the policy changes we need to preserve and advance the national integrity of the health system".

Paul: "I'm all ears. We just commissioned a public opinion poll to determine why we've been so unsuccessful in engaging Canadians in the future of Medicare in this country. The survey basically comes to the conclusion that governments have been successful in playing nurses off against doctors and health care against health. We're being seen in the public eye as being self-serving on behalf of our members."

Judy: "I'm disappointed–but not surprised. Anything else?"

Paul: "Well the good news is that the poll goes on to suggest that only 16 % of Canadians trust politicians. When it comes to doctors and nurses, the polls suggest that if we can work together and with the hospitals we sit "atop a rocket ship of public opinion".

Judy: "Well, what we're doing certainly isn't working. I think we need to look at ways to work better together. I think it's time to form an issue-specific, time limited alliance with patients. Your doctors and my nurses need to come together with the hospital association for the sole objective of arresting the relentless cuts in federal health care support for

Medicare. We need those dollars to be strategically invested in health care innovations. I've already talked to Carol at the Canadian Hospital Association. She's game."

Paul: "That sounds promising. We also need the patient voice to the table. What about asking Jean, the Health Chair of the Consumer's Association of Canada, to join the group?"

Judy: "That's a great idea and, while I don't want to the group to get too big, the government continues to play the health care organizations against one another. Health is broader than healthcare. We need to address this as well. I suggest inviting Gerry from the Public Health Association to the table. He's been around. He knows the players".

Paul: "That's great Judy, but in order to be really "bullet proof" from a self-interest perspective, we also need to have the perspectives of some of the other professions who are also worried about the effects of downsizing the system on their patients. Pierre from the psychologists is plugged in. And, I think Sharon from the Long Term Care Association has the ear of the government. Let's bring them in as well".

Judy; "That's seven. That's enough. What are we going to call the coalition?"

Paul: "How about we call ourselves the Health Action Lobby or "HEAL"?

"And who's actually going to make this happen?" asks Judy.

"Well," said Paul, "I just hired a senior official from Health Canada who knows all the players and understands the policy agenda. I'd suggest we ask William to help spearhead our coalition of the willing."

The story about the genesis of HEAL illustrates some of key items on any carpooling checklist—HEAL members agreed on a destination, they had shared values, and they understood they'd do better together. It also shows us some of the leadership capabilities needed to create the winning conditions for collaborative action and applying "distributed leadership" in practice. Let's now look at this example more closely. While the example is one at the highest policy level, the lessons are applicable whether developing a cross-boundary relationship between leaders of senior policy organizations, or between leaders of clinical programs or in a community setting.

Building and Sustaining Trust

Paul and Judy grew to know and trust one another quickly because of their shared values. Leveraging personal relationships is one way to build trust. In addition the literature [4] suggests six other ways:

- Contractual: trust based on honouring accepted or legal rules of exchange
- Good Will: trust based on mutual expectations of commitment beyond contracts.
- Institutional: trust based on formal structures and processes.
- Network: trust based on personal, family or other ties.
- Competence: trust based on reputation for skills and know-how
- Commitment: trust based on achieving self-interest through shared goals

Trust, as we all know, is built up by instalments over time by working together. To maintain trust clear, regular communication among partners is required. It is measured ultimately by actions and behaviour, not words. It can be lost in an instant

if you have a lapse of judgment and put your personal or organization's interests ahead of shared goals. Once broken, like a windshield, it is difficult to reconstruct. In short, "trust management is about managing risk" [6]. The deeper the level of trust in a coalition the better its performance.

Reciprocity: Sharing Risks and Benefits

Another success factor for building successful coalitions is reciprocity. Working together means everyone must give slightly more than they take. Coalition members must put in more than they collectively take out or the coalition will devolve. Similarly, if bigger players try to dominate smaller players, the coalition will fail.

Like most democratic processes, coalitions are often judged by how the weaker members are treated. Mutual respect is not a function of size. In the case of HEAL, the larger organizations (Canadian Medical Association and Canadian Nurses Association) funded over 75 % of the total shared costs, but all seven founding organizations contributed financially and had an equal say. Working together is all about expanding your shared sphere of influence through mutual respect, not control.

Reciprocity reflects, in many ways, the philosopher David Hume's concept of "enlightened self-interest" or economist Adam Smith's "invisible hand" for market economics [7, 8]. In the health sector it means "leadership without ownership." Health improvement is a social good with significant positive (or negative) spillover effects from one organization to another as overall capacity expands. Working independently, the actions of one organization can have immediate, albeit sometimes unintended consequences for others. Broad-based coalitions help mitigate negative spillovers and optimize positive synergies.

Clarity of Purpose

Successful coalitions have a shared commitment to achieving the same results. They need to resist the temptation to drift toward other concerns and away from sight of the common destination. Paul and Judy both sensed a threat to Canada's Medicare program and converted this sense of urgency into joint action, another key ingredient to building a successful coalition. Building and sustaining effective coalitions requires relentless pursuit of a shared goal.

HEAL developed a charter signed by all seven founding organizations. HEAL has not incorporated, but each organization's board had to approve moving forward and commit to a financial contribution. The HEAL charter laid out the shared objective, and detailed how the coalition would be governed (rotating co-chairs, consensus decision-making and provisions for opting out).

Forms of Coalitions

Coalitions can take many different forms. Those forms are a function of the degree of control and centralization needed to achieve the results they wish to accomplish. They are:

- *Bi-partite or multi-party alliance* (a pact, coalition or friendship between two or more parties, made in order to advance common goals and to secure common interests).
- *PPP, or P3* (Public Private Partnerships a long-term performance-based approach for procuring public infrastructure where the private sector assumes a major share of the responsibility in terms of risk and financing for the delivery and the performance of the infrastructure, from design and structural planning, to long-term maintenance).
- *Informal or legal partnership* (equal risk, equal benefit).
- *Merger and/or acquisition* (the combining of two or more agencies into one). Regionalization is a health example.
- *Consortium* (agencies working with a defined structure and governance arrangements).
- *Joint venture* (a business agreement in which the parties agree to develop, for a finite time, a new entity and new assets by contributing equity)
- *Network* (a loose association of organizations with an overarching purpose but no formal governance structure).
- *Collaborative project work across organizational boundaries* (inter-professional teams; task forces; community action groups established to accomplish a specific task in the short term).

The choice of the appropriate approach (or combination thereof) should be intentional, determined by the desired results, the degree of interactivity required to achieve them, the resources (time and money) available, and the anticipated timeframe of collaboration.

Lifecycle of a Coalition

Coalitions have a natural lifecycle. It is helpful to set out the expected timetable for working together and milestones for success. If you do achieve your goal, you may decide (or not!) to adopt another shared purpose—which is a moment to consider inviting others into the carpool. Remaining together for the sake of being together without a viable purpose is a recipe for waste, disillusionment and reputational risk.

Let's consider again the case of HEAL. Its original objective of stopping the haemorrhage of federal cash funding of the system was accomplished with the

signing of an agreement between the federal government and the first ministers of the 14 health jurisdictions in Canada.[1] Subsequently, HEAL invited key players from all levels of government and political stripes to a joint celebration. It also communicated its success widely, being careful not to identify winners and losers. But HEAL was created to tackle one issue, in a limited amount of time, so it had a decision to make. Should it be shut down or be repurposed?

Over the next few years HEAL held a series of facilitated strategic sessions. Members decided to renew their commitment to work together on a shared policy agenda. Today, HEAL has over 40 member organizations which share an interest in the future sustainability of Canada's public health insurance programs and in holding the federal government to account for its overall leadership and stewardship responsibilities. Still, expanding HEAL opened up the possibility of mission drift, and could make it harder to shape policy, because of the difficulty of getting consensus in a larger group. Successful coalitions or networks, as we shall see below, need to remain agile, resilient and responsive.

Learning Moment
Take a moment to reflect on the HEAL Story:

- What leadership qualities from leads self, engage others and achieve results domains stand out for you in the HEAL example?
- Have you had similar experiences in terms of working with others to create a coalition? What helped it to be successful?
- If it didn't work out, what insights does this story give you in terms of what you might have done differently?

Mobilize Knowledge

The second capability in the Develops Coalitions domain is your ability to mobilize knowledge. In a knowledge economy effective leaders employ methods to gather intelligence, encourage open exchange of information, and use quality evidence to influence action across the system. With respect to coalitions, Philip Friedman argues that "Today…the traditional boundaries between politics, culture,

[1] The Accord providing for some $41.3 Billion in federal (strategic) re-investments in health through the province, The Accord providing for some $41.3 Billion in federal (strategic) re-investments in health through the province, helping to reverse and restore the federal financial stake in Medicare helping to reverse and restore the federal financial stake in Medicare.

technology, finance, national security and ecology are disappearing. Therefore, to be an effective (leader) you need to learn how to arbitrage information from all these sources and then weave it together to produce a picture of the world that you would never have if you looked at it from one perspective" [9].

Knowledge arbitrage is the process of exchanging, transferring, and using knowledge across organizational boundaries to create new value that benefits all partners. Using knowledge of quality control processes in the airline industry to create quality care in health or using process re-engineering knowledge from the automotive industry (e.g., the Toyota Lean approach) to eliminate waste and improve patient value are two examples of knowledge arbitrage.

Knowledge arbitrage is much more than gathering knowledge and sharing it. One reason to have a coalition is to facilitate the use of knowledge to learn or understand how to deal with new or trying situations that members are collectively facing. The 38 members of the Canadian Health Leadership Network described in Chap. 3 (a partner in the LEADS Collaborative) has, as a strategic goal, to sponsor research together and share knowledge to better understand leadership of health reform. The purpose of the Seniors Health Research Transfer Network in Ontario, Canada [10] is to share knowledge pertaining to high quality frail and elderly care. Communities of practice (CoPs) are promoted in the healthcare sector as a means of generating and sharing knowledge and improving performance within coalitions [11].

Successful health coalitions put a high premium on scientific evidence as a source to develop new protocols for patient care that effective and efficient. There are frameworks to help coalition members carry out this process in an information rich environment. One is the Five As of the health information cycle as developed by our Canadian colleague, Dr. Rob Hayward [12]. According to him, all effective leaders know how to conduct the Five A's:

- Ask the right question,
- Acquire the right information
- Assess the reliability of that information
- Adapt or repackage that information as necessary, and
- Apply that evidence strategically.

As part of that process, leaders need to be able to ensure there is a thorough assessment of the available evidence, and that findings are presented in a clear, compelling way. Effective coalition leaders can build procedures to operationalize this discipline and ensure decisions are evidence-informed. Your management skills will then ensure the right things are done right!

An interesting example of a collaboration to employ an evidence-based approach across organizational boundaries is being undertaken by the Capital Health Region in Nova Scotia and the Fraser Health Authority in British Columbia. Leaders are collaborating to look at how they can create a new worker position that coordinates and navigates the healthcare system for the near and frail elderly. The vehicle for generating this collaboration is through what is called the EXTRA program (which

teaches and employs the Hayward approach).[2] Leaders from the two organizations will enroll together as a team in the EXTRA program and utilize the experience to generate the solution that they hope will be a model emulated nationally.

Once a coalition is established, there are four factors that determine whether or not there is effective knowledge mobilization. A first factor is making the implicit assumptions coalition leaders bring to the task explicit. Being clear about what you want to accomplish is critical to implementing effective knowledge mobilization processes. Coalitions can waste a lot of time and resources trying to implement flawed processes based on faulty assumptions. Many coalitions stall because they fail to ask tough questions out of fear of offending colleagues, before agreeing to carpool. Frame the key challenge or question in concrete terms, then acquire and apply the best evidence to advantage. For example, HEAL commissioned outside experts on questions of health-system financing and constitutional constraints on federal spending power [13]. They did so because before trust had been established, an offer to collect evidence by any one member might have been as an effort to co-op the policy agenda. The source of the information was an important part of building trust; and the information itself helped validate their collaboration.

A second factor to enhance knowledge mobilization is to make it a formal intent of the coalition. A formal process will maximize the potential to do so. The use of well-established programs or procedures to guide decision making will help. Intentional strategies, policies and procedures need to be in place to mobilize knowledge both internally and across coalition boundaries [1]. Practically, there are many approaches that can be employed to stimulate knowledge mobilization. Collectively investing in robust shared research and development to systematically refresh the knowledge base of the coalition is one. Data and information systems can be coordinated in such a manner as to provide the "right" information to manage the coalition's shared programs and services. Another is to systematically employ joint "after action reviews" [14],[3] or regular program evaluations. These lead to improved learning. Encouraging and supporting shared Communities of practice (CoP's) also mobilize knowledge [15]. One novel idea comes from an organization that had different groups of people engaged in cross-sector task forces. It often had its employees engaged off site in the other organization. They had a practice of bringing those people together once a month and gathering intelligence about what lessons were learned and how to make the partnership work more effectively.

A third factor to stimulate knowledge mobilization is the ability of individual leaders able to work together. Here the interpersonal skills of collaboration are

[2] The Executive Training for healthcare improvement (EXTRA) program is a 14-month team-based fellowship that offers focused training in better management and use of evidence for quality and performance improvement. See more at: http://www.cfhi-fcass.ca/WhatWeDo/EducationandTraining/EXTRA.aspx#sthash.XTqyxhl4.dpuf.

[3] An after action review is a structured review or debrief process for analyzing *what* happened, *why* it happened, and *how* it can be done better, by the participants and those responsible for the project or event.

paramount. Some research suggests that leaders who are good at coalition building have a particular set of personal attributes. They value relationships: more often than not they are extrovert personalities, evidenced by being outgoing, sociable, friendly, people centred and cheerful. They also possess moral soundness such as respect, openness and honesty, and finally, characteristics that emphasize commitment, persistence and hard work [1].

A fourth factor relates to the ability of the individual organization to absorb knowledge and put it to good use internally: its organizational learning capacity [14, 16]. To do so requires a shared awareness of the contextual dynamics that either limit or enhance the organization's ability to grow their overall capacity to contribute to the coalition. The collective ability of a coalition to be creative is a function of the ability of each organization to leverage knowledge internally.

Effective communications is another form of knowledge mobilization. If the purpose of a coalition is to advocate for change, it needs to use all avenues of communication to get its message out. Otherwise shared policy positions or directions can easily be misconstrued, especially when coalitions attempt to mobilize the public to advance their cause. For example, talking about the student demonstrations against tuition increases in Quebec in 2012, former McGill University president Dr. Heather Munroe-Blum said:

> "If you think about the difference between the 1990s and today, the role of Internet and social media has transformed the world of how you make a compelling argument based on evidence. And fiction becomes fact in 30 seconds, and fact becomes obliterated. And so it isn't enough to have an evidence-based approach…that worked well in the nineties. I think we have to have parallel ways of engaging the public in understand what the dynamics are." [17]

This flatter, faster, world [9] also requires messaging to be clear and consistent or again, trust can be eroded over time.

Learning Moment
Reflect on a collaborative relationship you have with someone from another organization (or department if you are not involved in any coalition).

1. How transparent are you and your partners in sharing knowledge and information relative to the purpose of the coalition (i.e., its mandate)?
2. How open and willing are you and your partners in sharing information that would allow each other to understand the internal dynamics of each other's organization?
3. Is certain information "off limits"? Why? Is some of that information vital to one of the partners being able to fulfill their responsibilities effectively?
4. How well does your own organization take in information and knowledge from the partnership and use it internally for growth and improvement? What might you do to improve it's ability to do so?

Demonstrate a Commitment to Customers and Service

The third capability of the Develop Coalitions domain is that collaborative leaders demonstrate a commitment to customers and service. They facilitate collaboration, cooperation and coalitions among diverse groups aimed at improving service. The words "customers" and "service" are used to suggest health-care serves more than the patient. Modern health care is people-centred—which means meeting the health needs of family and care givers as well as citizens who want to enhance their wellness.

The purpose of developing coalitions must always be to bring tangible benefits to the health and wellness of patients and citizens. We earlier called this a Copernican shift in how we organize, deliver and finance health care. Just as the Polish astronomer showed the sun, not the earth, was the centre of the solar system, so we see that health care no longer revolves around the providers. What does that shift mean in the context of developing coalitions?

In *Patient Centred Care: Rediscovering our Purpose* [18], published by the King's Fund in the UK, the primary theme is that many leaders in health care allow other priorities and factors to cloud patient or people-centred decision making. The example profiled in the report was drawn from The Independent Inquiry Into Care Provided by Mid-Staffordshire NHS Foundation Trust, led by lawyer Robert Francis, who described care at Stafford Hospital as horrific and shocking, though he declined to estimate how many deaths might have been prevented if it were properly run. Importantly, it took leadership from a citizen to generate the outcry that led to the Francis report and its damning criticism of the Trust's leadership [19]. This example supports our contention that leadership can come from people without official positions, as long as they are committed and have the skills to marshal energy behind a cause.

Let's look at another inspiring story about the "power of one" that led to the founding of another coalition to help ensure the system stays on the path to becoming more patient centred. This is a true story that helped launch the creation of the Patients Association of Canada. Note the impetus for creating the association didn't come from Shalom Glouberman's years of work in health care, but from his experience as a patient.

> *Sholom Glouberman, a senior policy advisor at a Toronto health centre, was in his early 60s. Because of a family history of colon cancer he began having regular colonoscopies at age 50, as recommended. Three or four procedures showed no problems. However, in 2005, his 91-year-old gastroenterologist found one polyp and removed it but didn't have time to explore another. Three years passed before the next scheduled procedure, this time the surgeon was not past his best before date. He found and removed one polyp but could not extract a second and had to schedule a laparoscopic bowel resection.*
>
> *Sholom was in the recovery room when he experienced a series of fainting and waking spells. Because of a childhood history of fainting, this was not considered a problem, but it was masking the real problem—the reconnected colon was still bleeding. After he received several units of blood, the fainting spells subsided and he was discharged.*
>
> *After just a few days at home, he developed a high fever, returned to the hospital emergency room and prepared for a CT scan by taking the contrast medium. No one had warned him however, of the "explosive" bowel movement it caused. He was in an open area of the ER, and very embarrassed. "It happens," said the nurse.*

He was given antibiotics to address an infection of unknown origin and sent home again, Sholom spotted pink fluid oozing out of his bandage and he headed back to the hospital emergency department. At least, he thought, they knew where the infection was and could clean it up. Another surgery followed, but this time the wound was left open to heal from the inside. No one told him till he got home that it would take six to eight weeks, a far longer convalescence that he'd hoped for, but he tried to take it in stride.

Instead, just a few days later he woke up shivering and shaking, feeling very ill once again. Back to the hospital ER he went. This time it was septicaemia; if he wasn't treated immediately, he would die. In the interventional radiology suite another battery of tests ensued, and a big blood ball on the bowel was removed. He hoped his nightmare was finally coming to a close.

Thank goodness if did. But it is experience led him along a new path. Sholom Glouberman worked in health care at a senior level. He knew the ropes. He thought he knew what to expect of the system, what questions to ask and of whom. But despite all that knowledge, all that commitment, it took a personal experience with care to highlight the inadequacies of the system that employed him. In a personal communication with Dr. Glouberman he wrote; "Patient-centred care is not about high thread-count sheets, private rooms, spectacular views, or room service-style meals. Patient-centred care is safe, compassionate care delivered in partnership with patients and their family caregivers with the highest quality and level of patient safety. Patient-centred care means care that I would want for myself and my family. To me, that's the ultimate standard" [20].

Through his experience he found both concern and communication. And he decided to do something about it, using some powerful coalition-building tools. He published a book. He started a blog. He skyped with others and helped start a "patient led and patient governed" movement, the Patients' Association of Canada. Created as a charity in 2010, with funding from a number of individuals and private foundations, the association's mission is to develop partnerships between patients and providers in setting policies and redesigning procedures to make them more patient friendly. As a charity, it relies on donations for its core funding. It promotes the patient perspective in health care in order to improve everyone's healthcare experience. It has compiled a very large number of patient narratives, a web-based resource library and a user guide with tips on how to navigate the health care system. According to Dr. Glouberman, the association holds open meetings bimonthly and actively supports having a patient and family caregiver presence in all major policy discussions. At the time of writing, PAC was reaching 8,000 individuals per week through social media, which is increasing by more than 50 per week. It is about to be rebranded as Patients Canada with a new board, a revamped website and a renewed commitment to give voice to patients and their family caregivers.

It will be interesting to see how Patients Canada fares. However, as Aesop said, "when all is said and done, more is said than done." Patients Canada and similar organizations operate on shoestring budgets with volunteers. So how does a leader develop coalitions to ensure patient and citizen welfare is in the forefront at all times? You can:

- Always bear in mind the "caring purpose" that brought you to health care and keep it at the forefront of your thoughts and actions.

- Support a vision or purpose for the coalition that defines its role in terms of benefits to patients and citizens.
- Ensure regular measurements of progress toward that vision are made and used to correct the coalition's course of action.
- Include stories of individual's experiences in your meetings and discuss them in light of the purpose of the coalition.
- Interact formally with patients and citizens to gather input and suggestions to shape the coalition's work.
- Include patient or citizen representatives on the governing body of the coalition.
- Designate a "people experience" officer at both strategic and operations meetings whose job it is to observe your deliberations from the perspective of benefit to customers.

Learning Moment
Choose two coalitions your organization is part of.

1. Is the patient or citizen purpose clearly articulated for those coalitions? If not, how might you ensure it is?
2. Do all members of the coalition actively support, through their decisions and actions, the patient or purpose of the coalition? If so, how? If not, what more could they do?

Navigate Socio-political Environments

The fourth capability in the Develop Coalitions domain is an essential one for health leaders: navigating socio-political environments. Collaborative leaders must be politically astute and able to negotiate conflict and rally support—which are particular challenges in the politically divisive and controversial world of health and health care.

There are both small and large "p" politics. Both forms affect the socio-political environment of leadership. Small-p politics are how you deal with the power dynamics and interplay of relationships in your role as a leader – your ability to introduce new ideas, build interest in them, remove obstacles, gain approval, resolve conflict and drive the ideas forward. We have discussed many of the skills needed in the

Engage Others chapter. Being politically astute in the context of coalition building is simply more challenging: knowing where the minefields and opportunities are in dealing with leaders who have commitments to their own organizations as well as to the coalition and who work in cultural environments that may differ dramatically from yours (imagine the differences in culture that arise in a P3, for example).

There's often a sense that organizational politics are muddled and characterized by competing views, compromise, or even conspiracy with people manipulating situations [21]. But they are a fact of life, arising from democracy: different groups have different interests, cultures, and rules. Politics are the interplay among them. Politics are about exercising influence built on respect, a belief that collaboration is possible, and that organizations enter and leave coalitions by choice.

In coalitions, organizations are equals unless they negotiate otherwise, which puts a premium on political astuteness beyond that required in a single organization. In a coalition you can't rely on your role in a hierarchy to determine issues such as who will chair meetings or what staff support will be available.

Coalitions also create many potential sources of conflict that need to be thought through and anticipated. Figure 8.1 summarizes them succinctly.

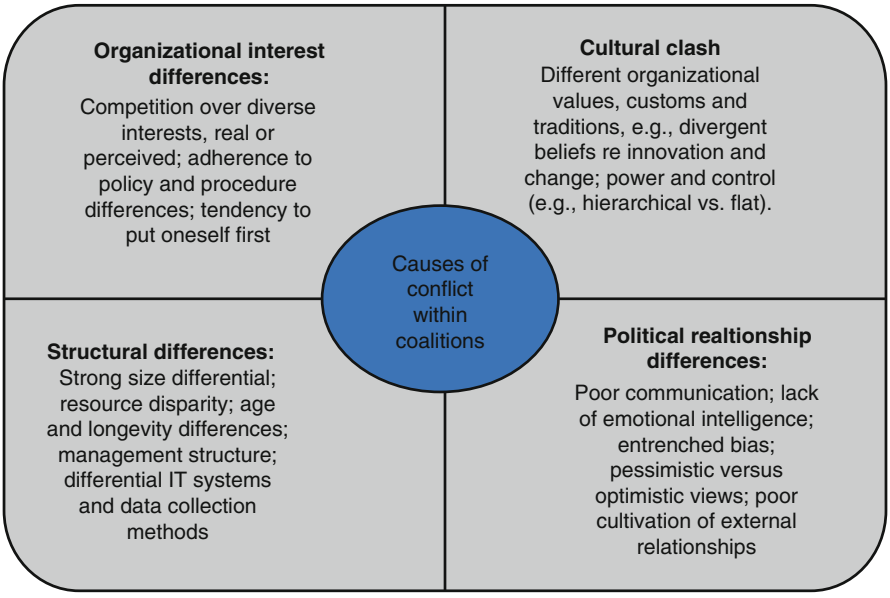


Fig. 8.1 Sources of potential conflict in a cross-sectoral collaboration [22]

Table 8.1 Factors and mitigating actions to avoid coalition failure

Factors leading to failure	Mitigating political actions
An inability of one partner to rise above self-interest and remain dedicated to the collective interest	Constant reinforcement of the 'patient/citizen-centred' purpose of the collaboration Provide support to another partner if his or her self-interest is taking them away from the coalition
Leadership drift: turnover, and new priorities, cause one or more partners to drift away from commitment to the initial purpose of the collaboration	Ensure the vision of the collaboration is well-understood and valued by other leaders, so the loss of an individual can be mitigated Encourage each partner organization to refer to the coalition in its strategic plan
Lack of trust amongst the partners and a heavy reliance on legalistic mechanisms to guide action; becoming bogged down in proceduralism	Create enabling agreements, but resist spelling out how every aspect of the work will be done Build robust relationships based on the factors outlined earlier. Such relationships build trust and reduce the need for policies to become more detailed when trust erodes
Lack of a clear stewardship structure to maintain oversight (note we are not talking about *governance,* which is not necessarily appropriate for networks or project teams)	Create an appropriate structure to oversee both strategic and operational functions. Ensure meetings do not put off for internal issues
A disconnect between the operational needs to fuel collaborative action and strategic support for the coalition	Hold regular meetings of both operational and strategic partners with linked agendas; attend each others' meetings
A lack of the dedicated time, energy, and financial resources from participants	Make people accountable for the success of coalitions they are part of and build its needs into their plans
A lack of collaborative skill among participants	Provide relationship and political skills training to people involved in coalitions
Cultural differences that create confusion	Acknowledge cultural differences before starting Don't enter into a coalition where cultural differences are so profound they will endanger collaboration Take action to discuss and ameliorate cultural differences that might prevent working together
An inability to anticipate and address conflict (see Fig. 8.1 above for potential sources of conflict)	A conflict resolution process agreed in advance by all partners

Realistically, coalition members need to identify potential conflicts in the partnership, and organize in order to mitigate them. We also recommend developing a formal process for resolving conflict when it arises (which it will).

Politically astute leaders also understand coalitions can fail over time; some of the reasons and related political actions are outlined in Table 8.1:

Chris was a doctor in a primary care office with three other physicians. They had a medical assistant each, and of course a finance officer; but it was a small team.

Chris received a phone call from Kyla, one of his physician colleagues. She had been contacted by the physician lead in another small primary care centre nearby in the same city. The practices had coexisted for years, but other than socially the doctors had not had any formal contact.

Chris's partner described the conversation: "Chris, apparently the ministry has decided—demanded!—that seven primary care offices in our part of the city work together as a division

*of primary care—whatever that means! They are forcing us to integrate our services to deal with the population in our geographical area…what a crock. Apparently they also expect us to staff up with nurses and maybe even a physio so we can deal with chronic patients better. Where the *%$$# will that money come from? I thought I'd call you because they have invited one of us from our practice to a meeting to hear more about it. I'll call the others too. I think we should just ignore this; without our support it'll just go away anyway. What do you think?"*

Chris thought for a moment. He admitted to himself that he was intrigued. After all, chronic disease patients were really a challenge: he had said many times to his colleagues that they needed to think through how better to deal with them. And he had heard about the power of inter-professional care for co-morbid patients at a recent professional conference.

Flexing his small-p political skills, Chris responded. "I get where you are coming from, Kyla…I must admit that I am suspicious of anything the ministry does. However, I don't think just ignoring it is necessarily wise. After all, if there are any ideas here that will benefit our patients I would like at least to explore them."

"How about I do a few things? He continued first, I know a guy in the medical association who can maybe give us some further skinny on what is planned. Second, how about we meet—the four of us in our office…" hearing the protests at the other end, he continued: "I know, I know, I get frustrated at all the meetings too…but better to do than be done to, right? So let's just put aside half an hour over breakfast on a day we are all in the office later this week." Hearing a grumbling assent, he went on.

"Third," he continued, "Give me the phone number of the physician who called you. I'll call her back. I'll invite her to meet so I can get a sense of where their office is coming from on this, and how serious they think it is. I also want to check out whether or not there might be a comfortable working relationship, if in fact we're forced to work together. Let me gather some further info before we make up our mind what to do, OK?"

This story shows Chris using four political skills. First, his ability to utilize informal connections. Second, his willingness to gather knowledge. Third, the use of language to minimize conflict. And finally—and maybe most important of all—reaching out to others to build relationships and gain understanding. Politically astute leaders don't wait for the issue to come to them; they cross the street to it.

Large-P Political Astuteness

Large P politics are a different story; it's about having the skill to maneuver through governments and political party systems. For example, the HEAL coalition had to take the ideology of the federal governing party into account when it was created and as new mechanisms for health transfer agreements were introduced. Few of us deal directly with the political process, but it's important for all of us to understand what some leaders do and we must respect the challenges they face.

Ultimately, Large-P decisions affect leadership at all levels of operation. Any CEO in Australia who has recently been involved in regionalization knows the importance of dealing with state and municipal politics as hospital services are rationalized. CEOs of regional health authorities in Canada also know the challenges of dealing with provincial and municipal politics. There are a number of strategies to enhance your Large-P political astuteness:

- *Be aware of election cycles.* If your coalition is intended to last over more than one term, time its launch and any strategic reviews of its work to coincide with municipal and provincial elections; it will be easier to get politicians' attention when they are looking for votes.

- *Build relationships with political representatives.* Most health organizations or regions have numerous municipalities and several provincial parliamentary representatives within their geographical boundaries. Non-partnership is important to be preserved.
- *Know your communities*. Each community has a unique economic and social context and therefore unique health needs. Seek out data and information on them.
- *Remind yourself of the demands of long term change*. Most significant change takes much longer than an election cycle to accomplish. Your coalition will need strategies to maintain momentum and protect your work from political shifts.
- *Don't necessarily rely on government funding*. If your coalition gets support from government you're vulnerable to changing political priorities. Look for other surces of support.

Conclusions

Early in the LEADS research we realized coalition-building is extremely important for our audience because of the size and complexity of health care. Overcoming the natural tendency of systems to fragment requires working together and developing the capabilities needed to create and sustain coalitions. The ability to develop coalitions is a necessary attribute of a leader. You'll need to be able to:

- *Build the right kind of partnerships and networks to achieve the results you want;*
- *Mobilize knowledge;*
- *Demonstrate commitment to your patients and clients that you put their needs first;*
- *Navigate socio-political environments*

In our experience, many people take coalition building for granted but many leaders struggle to grasp opportunities for collaboration, and don't employ the discipline to create collaborations that are effective over time. Self-interest tends to dominate, and coalitions form only when the external threat of not working together exceeds the internal threat to autonomy and control. As a result, they're often put together quickly and not well thought out.

This chapter gives ideas to maximize your odds of successfully developing coalitions: share the same destination; share values; share knowledge; share in the risks and benefits, and share the credit. The capabilities we've described are actions you can take to ensure your collaboration puts the needs of patients and citizens first. Coalitions are essential in a complex system, an antidote for the tendency of health organizations and the system as a whole to operate in silos.

Learning Moment

To use this questionnaire, find the right category for your level of leadership (e.g., front-line mid-management, et.). Then assess how well you demonstrate the four Develop Coalitions capabilities, where "1" is *I don't do this well at all*; "7" is *I do this exceptionally well*, and "N" is *not applicable in my current role*.

Which capability do you need to improve on? Why?

Develops coalitions: self assessment

Front-line leaders: Consistent with the coalition's potential on behalf of patients and citizens, I:								
1.	Actively work on projects with experts, specialists and front-line leaders representing outside organizations	**1**	**2**	**3**	**4**	**5**	**6**	**7 N**
2.	Interact with patients and citizens so as to determine their needs in relation to the partnership project	**1**	**2**	**3**	**4**	**5**	**6**	**7 N**
3.	Understand the importance of the evidence shaping the operational parameters of the partnership project and ensure fidelity to that evidence is maintained	**1**	**2**	**3**	**4**	**5**	**6**	**7 N**
4.	Resolve emergent conflict with coalition representatives through pro-active planning and personal conflict resolution skills	**1**	**2**	**3**	**4**	**5**	**6**	**7 N**
Mid-management leaders: Consistent with the coalition's potential on behalf of patients and citizens, I:								
1.	Work collaboratively with other managers from coalition partners, internal and external to the organization, on projects consistent with a shared patient or citizen mandate	**1**	**2**	**3**	**4**	**5**	**6**	**7 N**
2.	Actively integrate knowledge of the quality of "results to the customer" into the coalition's operational plans	**1**	**2**	**3**	**4**	**5**	**6**	**7 N**
3.	Develop processes to integrate evidence from a variety of knowledge sources into work practices, task	**1**	**2**	**3**	**4**	**5**	**6**	**7 N**
4.	Demonstrate an awareness of the 'key players' influencing a given situation (their vested interests and competing priorities), and an ability to negotiate through conflict	**1**	**2**	**3**	**4**	**5**	**6**	**7 N**
Senior leaders: Consistent with the coalition's potential on behalf of patients and citizens, I:								
1.	Bring together multi-organizational groups to develop coalition infrastructures and build connections consistent with the service mandate of the coalition and his or her own organization	**1**	**2**	**3**	**4**	**5**	**6**	**7 N**
2.	Actively support and develop processes to involve, or seek input from customers when planning changes that may impact the customer (patient, family or citizen)	**1**	**2**	**3**	**4**	**5**	**6**	**7 N**
3.	Develop processes to encourage the gathering, interpretation, and dissemination of quality evidence and knowledge to influence coalition action	**1**	**2**	**3**	**4**	**5**	**6**	**7 N**
4.	Mobilize commitment and resources from many different sources in the system to support achievement of the coalition's desired results and engage in a process to resolve emergent conflicts	**1**	**2**	**3**	**4**	**5**	**6**	**7 N**
Executive leaders: Consistent with the coalition's potential on behalf of patients and citizens, I:								
1.	Develop strategic frameworks for formal and informal coalitions that cut across traditional areas of shared interest, when it is to the best interest of the patient/citizen and my organization to do so	**1**	**2**	**3**	**4**	**5**	**6**	**7 N**
2.	Project a sense of passion about the importance of our coalitions to individual patients and the health of communities, and ensure the coalition adheres to that purpose	**1**	**2**	**3**	**4**	**5**	**6**	**7 N**
3.	Ensure that the work of the coalition is based on relevant evidence and knowledge, and uses that evidence to keep the coalition on track	**1**	**2**	**3**	**4**	**5**	**6**	**7 N**
4.	Demonstrate advanced small p and large P political skills in building and leading the coalition	**1**	**2**	**3**	**4**	**5**	**6**	**7 N**

References

1. Williams P. The life and times of the boundary spanner. J Integr Care. 2011;19(3):26–33. doi:10.1108/14769011111148140.
2. Maddock S. Transformational public leadership is collaborative. Hum Resour Manage Int Dig. 2011;19(7):40–1.
3. Currie G, Lockett A. Distributing leadership in health and social care: concertive, conjoint or collective? Int J Manage Rev. 2011;13:286–300.
4. Cikaliuk M, Tholl W. Develop coalitions. Book four of five LEADS booklets. Victoria: Canadian College of Health Leaders, Canadian Health Leadership Network and leaders for life; 2010.
5. Kanter RM. Collaborative advantage the art of alliances. Harv Bus Rev. 1994;72:96–108.
6. Huxham C, Vangen S. Researching organizational practice through action research: case studies and design choices. Organ Res Methods. 2003;6(3):383–403.
7. Smith A. Wealth of nations. London: Methuen &Co., Ltd; 1776.
8. Hume D. A treatise of human. Oxford: Clarendon; 1739.
9. Friedman T. The world is flat. New York: Farrar, Straus & Giroux; 2005.
10. Conklin J, Lusk E, Harris M, Stolee P. Knowledge brokers in a knowledge network: the case of seniors health research transfer network knowledge brokers. Implement Sci. 2013;8(7):1–10.
11. Ranmuthugala G, Plumb J, Cunningham F, Georgiou A, Westbrook J, Braithwaite J. How and why are communities of practice established in the healthcare sector? A systematic review of the literature. BMC Health Serv Res. 2011;11:273–89.
12. Hayward R. Leveraging knowledge tools and strategies for action: Embedded evidence. 7th annual invitational workshop. 2005. Montreal: Canadian Health Services Research Foundation; 2005. Available from: http://www.cfhi-fcass.ca/migrated/pdf/event_reports/2005_afternoon_e.pdf.
13. Thomson A. Federal support for healthcare: a background paper. Ottawa: Health Action Lobby; 1991. 30p.
14. Liptshitz R, Friedman V, Popper M, Friedman V. Demystifying organization learning. Thousand Oaks: Sage; 2007.
15. Shannon E, Stevens S. Engaging a professional services community: collaboratively responding to the leadership development needs of the tasmanian department of health and human services. Next steps: co-producing knowledge for social impact; 2013, Melbourne: Engagement Australia; 2013.
16. Tasai K-H. Collaborative networks and product innovation performance: toward a contingency perspective. Res Policy. 2009;38:765–78.
17. Bradshaw J. Outgoing university presidents speak candidly about the future [internet]. Globe and Mail, Education. 2013. Available from: http://www.theglobeandmail.com/news/national/education/outgoing-university-presidents-speak-candidly-about-the-future/article10824565/.
18. King's Fund. Patient-centred leadership: rediscovering our purpose. London: King's Fund; 2013. 44 p.
19. Francis R. Independent inquiry into care provided by mid Staffordshire. England: The Mid Staffordshire NHS Foundation Trust Public Inquiry 2010. 2013. Available from: http://www.midstaffsinquiry.com/assets/docs/Inquiry_Report-Vol1.pdf.
20. Glouberman S. My operation: a health insider becomes a patient. Toronto: Health and Everything Publications; 2010.
21. Crick B. In defence of politics. 5th ed. London: Continuum; 2005.
22. Moore C. The mediation process: practical strategies for resolving conflict. 3rd ed. San Francisco: Jossey-Bass; 2003. Circle of Conflict; p.64.

Chapter 9
The *LEADS in a Caring Environment* Framework: Systems Transformation

Those who anciently wished to exemplify illustrious virtue to the whole world first ordered their own states. Wishing to order well their states, they first regulated their families. Wishing to regulate their families, they first cultivated their own characters. Wishing to cultivate their characters, they first rectified their hearts. Wishing to rectify their hearts, they first made their thoughts sincere. Wishing to make their thoughts sincere, they first extended their knowledge to the utmost. This extending of their knowledge to the utmost lay in the investigation of things.

—Confucius

This quote from the Book of Changes [1] shows the complexity of change is nothing new. Confucius was not thinking of health care, but nevertheless shows us the interconnectedness among systems transformation (large scale change), smaller scale change (unit and organization) and personal change.

All of the LEADS capabilities—Lead self, Engage others, Achieve results, and Develop coalitions—are therefore part of transforming systems. Successful systems transformation changes all the small systems nested inside larger systems; a change in one reverberates through all. Many of the lessons we'll talk about in this chapter apply as well to units as to organizational or system change.

We describe what's happening as transformation, because we believe health systems are going through "a marked change in form, nature, or appearance: a metamorphosis to something new and better." It's not restructuring or reform. It's big change and the result may look very little like the health system of today.

Learning Moment
Reflect on your current role and responsibilities as a leader.

- How many different change projects are you supposed to be stewarding?
- What are some of the difficulties inherent in those change projects?
- How much time do you have in your day to devote deliberate energy to those projects? Is it sufficient? Why or why not?

G. Dickson, B. Tholl, *Bringing Leadership to Life in Health: LEADS in a Caring Environment*, DOI 10.1007/978-1-4471-4875-3_9, © Springer-Verlag London 2014

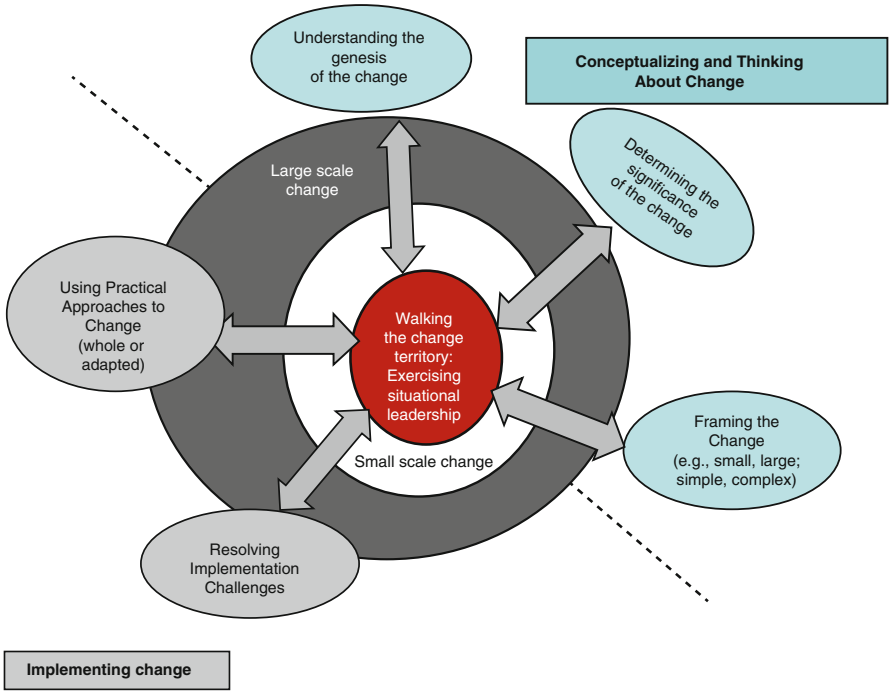


Fig. 9.1 The change map

When you put the two words together—systems and transformation—there are many implications for us as leaders of change. One is that seeing a new vision does not realize it. Even though there has been a societal consensus around the promise of patient-centred care, leaders must still bring it about by supporting changes to everything from how providers and the system work to the culture they work in. If you see a compelling vision but don't work with others on the changes needed to realize it, you may find yourself in an uncomfortable place: there's an old saying, "the general who is too far out in front of the army begins to look like the enemy."

To succeed in large-scale change, leaders must move beyond their own abilities to develop a system-wide, collective capacity to lead, and from individual to shared wisdom. Your role as a leader is to provide the strategy needed to draw collective leadership together to back large-scale interventions and changes.

Finally, to understand systems transformation, you must understand change never stops. The health system is a journey and the answer to "Are we there yet?" is always no. As a leader, change (for the better) must be your purpose. Let's take a few moments to explore the metaphor of change as a journey. The idea of a journey suggests that there is a territory for the leader to explore. Let's call this the "territory of change": the places you as a leader need to visit as you participate in large-scale change.

One of us recently worked with a team on a study of large-scale change as it relates to the Canadian context [2]. Our study endeavoured to bring some conceptual clarity to the territory of change by creating a change map (Fig. 9.1) that reflects the dynamic, interdependent nature of the change process, in a manner consistent with the principles of a complex adaptive system [3].

Large scale change associated with systems transformation can be complex, random, and confusing. However, our review of the literature suggests a macro-pattern applies, which we show in the map. At the centre of the map is the decision maker (leader), who is the integrator for a change process. To transform systems, you are encouraged to develop your mastery of change from your individual perspective, your organizational or citizen role, and from a system perspective (society and healthcare).

Figure 9.1 suggests leaders traverse two main landscapes. The first is Conceptualizing and Preparing for Change (three blue circles on top right). It is the "intention, understanding and mental preparation" stage of the change journey. Many leaders don't have time for this element of the journey. For example, one of the project's key informants stated, "In [my organization] there is a tendency to 'do it' without doing the background work re culture, readiness, strategies to implement. [We]…don't do the background stuff well."

There are three dimensions to conceptualizing and preparing for change: genesis, or understanding the reason for the change, significance, or the importance of the change from a personal, organizational, or systems point of view, and framing, or the fit between the view you bring to the experience of change and the views of the other groups that are part of it. All three must be part of planning for change. Conscious deliberation on each of these factors should assist you to reduce some of the challenges of large-system change and minimize the inevitable unanticipated consequences.

The second landscape, Implementing Change, has two dimensions: challenges and opportunities, and practical applications (two circles on bottom left). Here you assess the implementation challenges you are facing, then choose approaches to enact the change. Travel through this landscape shows you the wide selection of evidence, approaches, tools and instruments that you can use to inform and shape your decisions.

Systems Transformation Capabilities

Essentially, the four capabilities of the Systems Transformation domain are ways the leader, at the centre of the change map, can think and act strategically to address the challenge of large-scale change. The four capabilities are:

- Demonstrate systems and critical thinking
- Encourage and support innovation
- Orient themselves strategically toward the future
- Champion and orchestrate change

The capabilities are a combination of mindsets, tools, ways of thinking, and ways of acting that focus you on large-scale change. As you go through them, reflect on how they relate to the other LEADS capabilities, how they are consistent with LEADS principles, and the contribution they make to your leadership repertoire.

These four capabilities work together to create the energy for change in large complex systems, as well as with the other capabilities of the remaining four domains of the LEADS framework.

Demonstrate Systems/Critical Thinking

To lead large-scale change, you are encouraged to think analytically and conceptually, challenging the status quo, to identify issues, resolve them and design and implement new processes. Our Change Map identified five domains of focus to apply systems and critical thinking. Thinking conceptually about all five aspects involves recognizing that human endeavours such as health have both organic and mechanistic systems properties. When faced with simple change—that is, simple re-ordering of a limited set of variables, you can use mechanical systems thinking. It will let you focus on the physical tasks that comprise a service—delivery, resource allocation, the logistics of information flow and communication, and organizing steps into a linear process that is efficient and effective.

In complex change, adaptive leadership, based on organic systems thinking may work better. Ronald Heifitz describes adaptive leadership as the leadership needed to address changes created by forces that require significant (and often painful) shifts in people's habits, status, role, identity, way of thinking, etc. [4]. An organic systems approach acknowledges human intentions are variable and change depends on the understanding and willingness of people to embrace it. In organic systems leaders adjust and continually redefine individual tasks through interaction with others. Therefore the future is not predictable, except as it emerges through co-creation. In this sense, organic systems are complex adaptive systems [5, 6] that demand adaptive leadership.

One of the challenges for adaptive leaders in large scale change is maintaining a balance between a mechanistic approach, best when the problem is technical and simple[1] or a complex adaptive approach for a complex situation. That balance may be a function of your need for control [7]. In a simple environment (few variables) control over the environment is reasonably easy to maintain; in a complex one

[1] When faced with simple change—i.e., change that can be accomplished through linking a bounded set of finite variables, and for which risk is acceptable and results predictable, mechanical systems thinking is applicable. When applied to health care mechanical systems thinking allows leaders to take structural approaches to change. The change can focus primarily on the physical tasks that comprise a service delivery, resource allocation, the logistics of information flow and communication, and organizing steps into a linear process that is efficient and effective. People issues—such as need for training, potential resistance, and lack of commitment—still apply; but the practices outlined in the Engage Others domain of LEADS are applicable in that context.

(innumerable variables), virtually impossible. A leader who requires too much control limits the potential for giving others a say in the future; yet one who exercises too little control allows total anarchy and confusion to rein. Organic systems models, when used by leaders (and which we will introduce in this chapter) attempt to achieve a balance between giving people some freedom to create the future, yet not so much liberty as to generate a confusing space for change in which people's efforts are diffused and chaotic.

Another challenge for adaptive leaders is that big change may not be incremental. It can be sudden and dramatic. Geology tells us that over time, forces build up along fault lines in the earth's plates until there's an earthquake. The same happens with people: witness the French revolution; the fall of the Berlin wall; the collapse of the Soviet Union; the Arab Spring. The theory here says systems comprise a number of interacting individuals, organizations and interest groups with an identity defined by their values. The interaction among all of them makes predicting how the system will evolve uncertain. Such human interactions are complex and can exhibit rapid, unpredictable change with no apparent pattern. Behaviour can appear complex and random (another term, self-organization, is often associated with this phenomenon) [7].

If we as leaders are blind to the forces driving change, through complacency, lack of awareness, or because we're resisting them, we won't be prepared when they reach critical mass and rapid transformation hits [8]. We need to bear in mind we don't control change, we simply have some influence over it.

Critical thinking skills are necessary for knowing when to use systems thinking to challenge practice, focus on critical issues or create new ways to enhance service delivery. Here's a story about how systems and critical thinking shape conceptualizing and planning for change.

Linda was vice-president of Shared Services at a large Canadian health authority. Recently she was asked to steward the integration of the Emergency Ambulance Services Commission into her portfolio. The commission had been independent for fifty years but, following a difficult strike by paramedics the province wanted it to become part of the health authority.

Linda faced both logistical challenges (such as budget transfer, integrating office space and merging job descriptions) and people issues (such as protection of professional standards, union-management dynamics, individual and group resistance to change, and engagement). As the change was more likely to be delayed by people issues, she felt she should apply a systems lens to the challenge. She arranged a meeting with Jayne, the director of Organizational Development, who had an extensive background of using systems thinking in large-scale change. Linda told Jayne she could think through the logistical issues in the merger, but wondered about the systems issues associated with the change.

Jayne pondered, then said "I think we need to think of this from three perspectives. The first is what might be called a 'framing' perspective. How big is the change? Is it going to affect everyone in at the ambulance commission, or are you just integrating management responsibility? If it's the former, how much change will they face? Minor or major? The second perspective is the challenges and opportunities this change poses—what are they? And the third is, what kinds of models or tools might help us? So…how big is the change? Band-Aid, or transformation?"

Linda thought for a few moments. "I think it's transformational. We want the paramedics to see themselves as the first step in an integrated patient journey—making their work

part of a well thought-out process of treatment they share with other providers. New technology lets paramedics communicate directly with physicians in the emergency room before they get there, and once we get the system up and running, they'll also see patient records electronically in the ambulance itself. This means a much tighter relationship than has previously existed."

"What about challenges and opportunities?" Jayne asked. "For example, what about management? Are you keeping the existing structure—just reporting to you—or do you want to integrate it into the health authority's structure? What about HR, budgeting, information systems…how much are you going to integrate them?"

"From an opportunities perspective it will reinforce both organizations' visions of patient-centred care," Linda replied. "One of the prime drivers for this is to improve the patient experience and eliminate errors. It should also be an opportunity for financial sustainability. Rationalizing our logistical systems should help that. Also, we'll likely close some ambulance bays in lower-volume areas, which will eliminate some administrative costs, but upset some communities and groups, plus politicians and people from the commission worried about their jobs."

Jayne agreed. "We'll be dealing with a change in organizational and even community identity, a sense of loss, media coverage and managers waiting for the axe to fall." She mentioned she'd met the ambulance service's VP of human resources at a reception recently and he had wondered whether he would have a job in the new configuration.

"Another factor we have to think about is whether people are open to change, or suffering from 'change fatigue,'" she continued. "People are cynical about change and the scope of this one will stir rumours about why it's happening. Some may just hunker down and hope it goes away—and there are lots of proposals for change that never go anywhere, which doesn't help."

Jayne also foresaw cultural issues, because the ambulance service had a militaristic and hierarchical culture, very different from the Shared Services department's informal tone.

"So what do we do about all of these issues?" Linda said, sounding disconsolate. "They seem overwhelming. Where do we start? I know it's a long-term process, but we've got to get off on the right foot, or it'll be lasting a lot longer than either of our jobs," she added wryly.

Jayne thought for a moment: "We might be lucky there. The commission has a leadership meeting scheduled for late next month. What if we brought the two groups of leaders together and focused the meeting on initiating the change process?"

"But how?" Linda said. "There'll be 400 people in the room. How can we organize the meeting to address all the issues, get the support of at least the majority of managers for the change and get a handle on how to move forward?"

"That's where the third perspective comes in" said Jayne. "What kinds of models or tools will help us? There's a large-group system intervention called Open Space that is designed to bring people together to talk about and collaborate in a way that lets them explore divisive issues. There's no advance agenda; the idea is to develop a positive, forward-thinking, action-oriented perspective on large changes. I also know a facilitator who is extremely skilled in conducting them. It will cost, but it should give us an agenda that will get us off on the right foot."

"Let's do it," said Linda. "Can you bring him in later this week and in the meantime, we need to talk further about specific outcomes for the session. Also, there is one thing I know I will need to do: speak from the heart about the patient-centred vision and its advantages, so that people can see the opportunities in this. I want you to know that I am absolutely committed to this change," she added, bringing the meeting to a positive close.

This story highlights the value of the change map as a systems-thinking tool. Jayne used it to help her locate a focus of her critical thinking: analysing the

situation for challenges and opportunities, where the genesis of the challenge came from, its significance for patient-centredness and sustainability. She also focused on framing the change as having both mechanistic and organic systems properties, how big the change was, who was affected and how.

The story highlights a second aspect of systems/critical thinking: the larger the change, the greater the significance of the organic systems issues. Most of the logistical challenges could be solved given time; but what would put the merger at risk were people issues: mindsets, cultures, different perspectives depending on different roles.

The reality is leadership is dealing with people, who are driven by their own values and who are sometimes wilful and emotional. You'll need to explore how those factors play out in large scale change: reflected in stakeholder group mandates, social movements, community identities and informal organizational cultures and sub-cultures, prior to introducing change. As the story shows, the larger the scope of change, the greater number of variables you have to deal with. Predicting cause and effect between what one group is doing and whether another will follow is difficult to do. You'll have to juggle conflicting identities, unpredictable communications, structural, political and cultural variables. At some point, the complexity of interactions may leave you feeling overwhelmed.

Organic systems thinking was helpful to Linda in dealing with her complex situation because it gave shape and structure to the complexity. Jayne used it to critically explore the mental and emotional processes that different individuals and groups bring to the change process, such as mental models, personal intentions, professional sub-cultures, and organizational climate. Together they decided to explore a large group system intervention to bring some but not too much control to the process. You'll be more effective at creating change on a large scale if you learn to use organic systems thinking to understand the landscape of that change.

A third aspect of Linda's story worth noting is that the use of systems/critical thinking allowed the two women to anticipate the challenges and opportunities in a large system change. That's an important step for senior leaders, and it's equally important to follow up with a process that allows leaders throughout the system to share those opportunities and challenges. In this case, Jayne and Linda use Open Space, a system that operationalizes a basic truth of change: people support what they help create.

Large systems approaches such as Open Space create an environment of collaboration and dialogue on divisive issues in the community, allowing participants to assess the depth of the issues, while subtly distributing ownership of the challenges throughout the group participating in the activity.

Table 9.1 profiles Open Space and four other models that have potential to guide large system change [9].

Try one of these models the next time you're leading small or large-scale change (Note: it is advisable to hire a facilitator to organize and manage the process, so you can observe or participate as you wish). You'll need to use your systems and critical thinking skills to determine which of the models is best for your situation.

Table 9.1 Five models to engage large systems in systems/critical thinking [9]

Approach	Number of people potentially involved/ duration	Description and purpose
Open space	5–2,000 1 day to 6 months	Open Space enables people to engage in an activity which uses self-managed groups to create a dialogue around what is important to them. Leadership is shared, diversity is a resource to be used instead of a problem to be overcome, and individuals are empowered to have a say as it relates to the issues at the forefront of the change. Every issue of concern will be on table, discussed to the extent people wish, and a full record of the proceedings available. Priorities will have been recognized, related issues converged, and initial action steps identified
Dialogue and deliberation	5–5,000 1 month to many years	Dialogue and Deliberation (DD) uses a process to help people learn more about themselves or an issue (Exploration), resolve conflicts and improve relations among groups (Conflict Transformation), improve knowledge and influence policy (Decision Making), and empower people to solve complicated problems together (Collaborative Action). It is used to create clarity/provide a group with direction on an issue or situation; and to address contentious issues that attract only argument and debate
Integrated clarity	1–500 2 weeks to many months	Integrated Clarity (IC) is a process that helps an organization or community discover and articulate its needs critical to its sustainability in a way that benefits the whole system and the people in it. It does this by changing the way people communicate and creates conditions that engage people in a way that is more productive than what most are used to
Technology of participation	5–1,000 1–3 days	Technology of Participation (ToP) consists of methods that enable groups to (1) engage in thoughtful and productive conversations, (2) utilize critical thinking, (3) develop common ground for working together, and (4) build effective short and long range plans. ToPs focus on surfacing things that can unify a group rather than dealing with things that may divide it. The purpose is to elicit participation of a group, organization or community in creating thoughtful and critical discussion related to short and long term change
World cafe	12–1,000s (with no upper limit in theory)	The World Café is a conversational process that employs a simple methodology that can evoke and make visible the collective intelligence of any group, increasing people's capacity for effective action in pursuit of common aims. The integrated design principles evoke collective intelligence through dialogue. The purpose is foster the conditions for engaging people in dynamic strategic conversations that matter to them

Encourage and Support Innovation

As a precursor to large system change, and to act as a potential catalyst for that change, you are expected to encourage innovation. In the process you are also encouraged to enable and reward creative thinking as part of day-to-day practices. In health care, many models of innovative process, such as Lean and Six Sigma—emphasizing what is called continuous improvement—are found in the literature [2]. Use of these processes creates cultural receptivity for, and is a catalyst for large-scale change.

One of the challenges Linda and Jayne discovered during the Open Space session with union leaders and management teams from both the health authority and the ambulance commission was very different attitudes toward innovation and creativity between the two organizations.

It's part of the process that anyone can bring up topic for small-group discussions and someone submitted 'maintaining identity.' Many people flocked to the table to discuss this, almost all of them from the ambulance group. Jayne listened carefully. What she heard were managers who prided themselves on sticking with existing protocols for patient care; found their identity in their uniforms and badges; and took comfort in hierarchical power and rank structures. Indeed, she overheard one manager say, "No way I'm going to ask my guys to change how they do their work…I don't care how many incentives, programs, or directives they give out, my guys are going to stick with the tried and true." Another stated, "I've heard rumours that they are going to take away our uniforms. If they do that, the whole system will collapse…I mean, those uniforms are a source of our pride: they are our identity."

In a session on 'patient transition,' Linda heard one of the health authority managers suggest using the Lean approach for continuous improvement to address the handoff process between emergency services and the emergency ward. One of the ambulance managers snapped "What's that? A way to cut costs and staff?" When the other manager tried to explain, the ambulance manager replied that it sounded like a plan for continuous disruption. "We're already doing the best we can," he said. "Forget Lean."

Both sessions set off alarm bells for Jayne and Linda. Their health authority used Lean methods to improve patient-care pathways and eliminate waste. It had resulted in many successes—not system-wide, but in many departments.

Learning the ambulance managers weren't open to the concept of continuous improvement told Linda and Jayne they had a disconnect in cultures that would challenge them during the merger. They needed to come up with a plan to deal with it.

Continuous improvement processes use scientific methods to act on suggestions from workplace teams on how they could do their work better (using the Build Teams capability). Action is based on evidence of outcomes (using the Take Action to Implement Decisions and Assess and Evaluate capabilities). Improvement involves change; and change, on a small scale, is innovation. But it's also creative—drawing on peoples' ability to transcend established ideas, rules and patterns and create new ones. Creativity gives continuous improvement insights, discernments and inspirations that extend logical thinking into visionary thinking. Innovations can be *breakthrough* ideas that put scientific principles into practice in new ways. They can be new combinations of existing elements that make logical sense but when combined, create new possibilities. Or innovations can come from seeing how small adjustments to a process improve it. Sometimes a number of creative innovations, when combined, can create large-scale transformation (like cell phones and the internet).

Practical Ways to Encourage and Support Innovation

Lean, which originated in the auto industry, is mainly focused on quality and safety; its aim is to reduce waste by identifying and eliminating activities that do not add value to patient care. It's just one of many similar approaches health systems use to accomplish the same purpose, some of which we show in Table 9.2 [2]. This emphasis on quality improvement was stimulated by the work the Institute for Healthcare Improvement in the U.S. and by Ross Baker and Peter Norton in Canada. Studies show both nations' health systems had appalling rates of deaths caused by medical error [10, 11]. Since that time, continuous quality improvement has been driving change in health care.[2] Lean is one of the most popular methodologies for doing that, because it also addresses sustainability and cost-effectiveness [12–14].[3]

Quality-improvement literature provides considerable proof of Lean's effectiveness [15–17].[4] It requires behaviour changes by both management and employees, and often a change in the leadership culture as well, to incorporate the Encourages and Supports Innovation capability. Sustaining it draws on even more of your LEADS capabilities [18].

A pattern with Lean is that it's usually tried unit-by-unit in hospitals, but not for large-scale change [19]. The province of Saskatchewan in Canada is challenging this precept by trying to introduce Lean across its whole health system. At the same time, it has introduced a leadership initiative aimed at developing LEADS capabilities to complement the Lean initiatives. Dan Florizone, the province's former deputy minister of health, said the approach was a "game changer" with the potential to "turn the system on its head" [20, 21].

So far we have pointed out a number of models (see Table 9.2) which in themselves encourage the practice of innovation to improve services to patients. We have also stressed that to be successful, not just when you integrate the approach into the workflow, but in the long term, culture change is necessary. But if like Linda and Jayne, we have a culture that is resistant to change and innovation, the question arises: can the leader change it?

---

[2] For example, the World Medical Association endorsed, in 2009, a statement saying that "Ethical guidelines for health care quality improvement matter to all physicians, as well as to institutions providing health care services for patients, those providing continuous quality improvement services to assist physicians and organizations, health care payers and regulators, patients, and every other stakeholder in the health care system. Taken from the WMA Declaration on Guidelines for Continuous Quality Improvement In Health Care, Adopted by the 49th World Medical Assembly, Hamburg, Germany, November 1997 and amended by the 60th WMA General Assembly, New Delhi, India, October 2009. Available from: http://www.wma.net/en/30publications/10policies/g10/.

[3] Articles on the use of Lean for quality improvement suggest it is used worldwide. Three articles show its use in the UK, Australia, and India. See Refs. [12–14] for these articles.

[4] A recent review of the literature revealed a number of articles that outline the power of Lean, its innovative power, and creating a culture of continuous improvement. See Refs. [15–17].

Table 9.2 Five models used for innovation and continuous improvement [2]

Approach	Purpose	Innovation approach
Lean	Lean is a core methodology for redesigning health systems. Lean aims to improve the value proposition to the patient, and on eliminating waste. Many health systems adapt Lean to a variety of contexts	Process redesign involving staff at the front line reviewing all processes and procedures in light of desired outcomes and streamlining them. Creates expectations for ongoing dialogue between management and front line staff to identify new ideas for continuous improvement
Six sigma	Six Sigma seeks to improve process by identifying and removing causes of defects and minimizing variability in clinical care practices	Six Sigma's methodology for innovation is to define a problem, collect data, and used statistical methods to determine sources of variation and opportunities to improve. Processes are then adjusted to remedy the problem, and data are collected and analyzed multiple times to check for improvement in error rates
PDSA cycle	This model tests incremental improvement in rapid cycles in a discrete component of a system, usually related to quality and safety	The PDSA cycle creates innovation through creating continuous cycles of incremental change. It is an action research methodology. The four steps are Plan the work; Do the work; Study whether the outcome was achieved and Act on change by adjusting effort as needed, then repeat
Donabedian's quality assurance model	Donabedian's three-part model (structure, process, and outcome) is used to assess safety and quality infrastructure. It can be adapted to assist in measuring whether elements are in place to assure quality and/or safety	Donabedian's model creates innovation in three ways. Structural innovation refers to redeploying resources, such as time and money, for working with quality improvement or to adjusting administrative practices for quality systems, such as documentation of routines and staff support. Process innovation is directed at quality improvement culture and cooperation within and between professions. Innovation in outcomes refers to establishing evaluative processes for achieving goals and developing competence related to quality improvement
Positive deviance	The concept of positive deviance is that no matter how seemingly intractable a problem, every community has individuals whose practices or behaviour let them find better solutions to problems than their neighbours	Positive deviance creates innovation through a disciplined process to discover unique and uncommon successes in one setting; examine the conditions for that success; and attempt to replicate these successes where possible in other settings

Organizational Culture and Innovation

Culture change is one of the challenges and opportunities destinations on the change map. For Linda and Jayne, it *was* both. Their health authority had embraced Lean and continuous improvement, but the ambulance service did not.

Organizational culture is the ingrained patterns of thinking and feeling that make up a group's shared mindset. Cultural identity can be shared by everyone in an organization, or it can be in sub-groups, such as just the ambulance service or just the administration. It is usually unconscious; it drives responses and behaviour without people being aware of it. There are clues to culture in the symbols an organization uses and its stories, who its heroes are and the day-to-day rituals it preserves. They're all grounded in value imperatives that were once important but may no longer be.

The health-care landscape is made up of many professional sub-cultures, which are often stronger than a prevailing organization-wide culture. Medicine, in particular, is accustomed to having the autonomy of its members recognized, and to putting allegiance to professional values ahead of organizational ones [22].[5] Doctors by tradition play a unique role in health organizations and therefore must be involved in changes to them. You are advised to recognize the need to have special strategies and tactics to engage physicians in change [23, 24].[6] Other professions have a similar sense of autonomy and professional accountability, and also influence the change process.

Culture, however, can be opened up to discussion and deliberately dealt with. There are instruments that can be used for this purpose [25].[7] Sometimes culture can be used to your advantage in bringing about change, or can resist it. For example, doctors often buy in to a quality agenda when they realize it is aimed at improving patient care (i.e., the quality agenda).

Chris Hodgkinson says culture is malleable until it becomes ideological—when customs, beliefs and traditions go beyond reason and become part of people's identity [26].[8] That appeared to be the issue when a former Canadian Minister of Health, Tony Clement, called for the Supreme Court to rule on the right of a safe

[5] For example, the Royal Australasian College of Medical Administrators makes the following statement: "The medical profession holds a rare position characterised by high respect and trust of the community which in turn is inextricably tied to significant professional and personal responsibility". Royal Australasian College of Medical Administrators (2012). Issues paper – performance appraisal and support for senior medical practitioners in Victorian public hospitals. Melbourne: Australia. Accessed on-line on August 20 2012 @ http://www.health.vic.gov.au/clinicalengagement/downloads/pasp/dla_phillips_fox_issues_paper.pdf.

[6] See three commissioned papers on physician engagement in Refs. [23] as well as article in Ref. [24].

[7] Nine such instruments were reviewed in a study conducted by Scott, et al. See Ref. [25].

[8] Christopher Hodgkinson has outlined what he calls a value typology—suggesting that humans possess values of differing strength and power to motivate one's actions. When values are so deeply ingrained that they become linked to a person's sense of personal identity, they become 'ideological'—and impervious to reason.

injection site to remain open in Vancouver, B.C. He did so despite the plethora of evidence showing its value and worth. However, to him, it was an existential issue; that is, one of ideological belief that providing safe injection sites for drug addicts was wrong.

Learning Moment: Assessing Your Organization's Culture of Innovation

An Australian study of private-sector businesses found the images used to portray the business can reveal whether theirs is an innovative culture. Innovative company cultures were represented by images of luxury, sleekness, speed, and quality. Weaker performing and less-innovative companies were represented by images of constraint, greyness, stolidity and introspection.

The study outlined attributes of innovative organizational culture:

- Lots of intellectual stimulation, sharing of ideas, articles, etc.
- Leadership is visible/vocal in its support of innovation.
- There is a democratic approach to innovation: it comes from anywhere.
- A history of smart risk-taking; people in the organization make a point of learning from, not punishing, failure.
- There is collaboration and networking across boundaries to solve problems.
- Innovative practices are measured and monitored for success.
- There is accountability for creating innovation.
- Innovation successes are regularly communicated.

Try rating your organization against those measures, from 1 (very little) to 7 (a great deal). Where is your organization strong? Where might it improve? What steps might you take to improve its innovative culture?

Leaders who employ continuous improvement methodologies are encouraging and supporting innovation. To achieve long-term benefits, you'll have to be conscious of aspects of culture that might impede or facilitate innovation and continuous improvement.

Orient Themselves Strategically Toward the Future

Leaders see the future faster, scanning the environment for ideas, best practices and emerging trends that will shape the system. They then weigh them against their organization's history and values. It's a bit like being the Roman god Janus [27], who could see the past and future at the same time. Janus is a great metaphor for leadership in systems transformation—except he didn't have to collaborate with a bunch of other Januses to make things happen (Fig. 9.2).

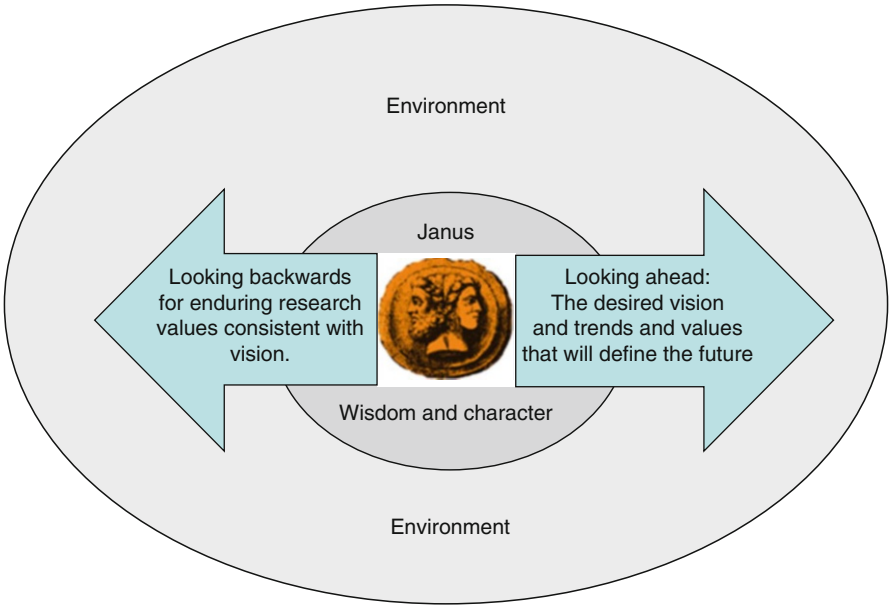


Fig. 9.2 The Janus approach

Like Janus, you too must find creative ways to reconcile competing trends and forces that will define the future with evidence and values from the past that must endure. It is your wisdom and character that will determine what strategies will move you and the system to its future vision [28, 29].[9]

Wise strategists constantly probe the environment to identify emerging trends and values, then use personal experience and their character to determine what patterns they should pay attention to and which are passing fads. Doing that lets them see the limitations of a purely scientific or research-based approach to leading change. By definition, research is knowledge of the past. When it appears to lead against the best interests of the public, wisdom allows you to assess other factors (such as values, ethics and innovation) that should help shape your decision. Leaders often have to act before they have all of the information, not recklessly, but counting on intuition, experience and conviction. Leaders cannot rely on certainty, nor can they eliminate risk. In particular, you will always face a risk in co-creation, because there are no guarantees when you work with others and no blueprint to plan the future. Being able to live with that uncertainty is one thing that separates those who become leaders from others.

[9] Nonaka and Takeuchi, in a recent article in the Harvard Business Review, define practical wisdom as "experiential knowledge that enables people to make ethically sound judgments [28]." Barbuto and Millard describe wisdom as "…an awareness of the limitations of self-views…wisdom comes from the openness to re-examine, re-define, and re-evaluate views and the creation of a lucid perspective, and adaptation to changing contexts [29]."

So how do you learn the leadership capability of orienting yourself to the future? First, enhance your own environmental awareness. Focus your mind on discerning what trends, events, or movements in the environment cannot be ignored. Use informal meetings, discussions and encounters to assess what others believe is important. Then use your wisdom to discern factors that can be used to achieve your vision.

Second, use the wide variety of tools and techniques available for scanning the environment and gathering intelligence. Some of the most popular are outlined below in Table 9.3 [9].

Table 9.3 Four approaches for orienting strategically to the future

Approach	Definition	How to use it
PEST	Political, environmental, sociological, technological analysis	1. Use the four categories of PEST to brainstorm changes happening around you. Tailor the questions to suit the needs of your organization or system 2. Brainstorm opportunities arising from each of these changes 3. Brainstorm threats or issues that could be caused by them 4. Take appropriate action
SOAR	Strengths, opportunities, aspirations, results	A facilitated process, with four steps: 1. **S**trengths: What trends, values, beliefs out there support our vision? 2. Opportunities: What opportunities—economically, politically, socially, technologically—can we take advantage of? 3. Aspirations: What is our preferred future, from the point of view of the people we serve? 4. Results: What are the measurable results that will tell people we have been successful?
Force field analysis (adapted)	Forces in the external and internal environment driving change, and impeding change in light of your preferred future	A process, employing focus groups, surveys, or part of a facilitated strategic planning exercise that gathers intelligence around the following questions: 1. What political forces are at play in the global, national and regional political arenas that will either drive change in support of our preferred future, or impede it? 2. What technological forces are at play, in the global, national, and regional arenas that will either drive change in support of our preferred future, or impede it? 3. What economic and social forces are at play, in the global, national, and regional arenas that will either drive change in support of our preferred future, or impede it? 4. What forces are at play inside our organization or system that will either drive change in support of our preferred future, or impede it?

(continued)

Table 9.3 (continued)

Approach	Definition	How to use it
Scenario planning	Scenario planning, also called scenario thinking or scenario analysis, is a strategic planning method use to make flexible long-term plans	Facilitated process for small or large groups Scenarios are stories that describe how the environment may evolve in the future. They depend on environmental scanning to provide information on which the scenarios are based. The scenarios can portray current conditions or refer to future states of the organizational environment. Scenario planning may involve systems thinking, specifically recognizing many factors may combine in complex ways to create some surprises. The method also allows the inclusion of factors that are difficult to formalize, such as novel insights about the future, deep shifts in values, unprecedented regulations or inventions

Third, develop your information and communication systems so you can engage and consult outside groups quickly and often. New technology lets us enter exchanges with stakeholders and the public in ways never dreamed of. Two examples come from the cities of Surrey (Canada) and Newcastle (Australia). They use internet technologies to gather knowledge from communities and individuals on creating the future cities of Surrey and Newcastle [30].

Fourth, consider two or three key principles of systems and critical thinking, and use them as you contemplate the future. Take the systems principle of interdependence, the idea everything is connected, with mutual, rather than linear, cause and effect. An example can be found in one of Canada's largest health authorities. A patient presented herself ten times to the emergency ward in a large city hospital in a year. Four times she went for a stay in the intensive care unit: a series of visits with a cost of $400,000. When an administrator (seeing her for the eleventh time) began to investigate the pattern of presentation, he found out it was due to her inability to purchase her medications ($30–$40 a month). Further investigation found that Social Services would not cover it. With some negotiation, (i.e., the health system paying for the medication) the visits stopped. A savings of almost $399,500 a year to the health system! Just as in this example, look for connections among social, economic and political events: how are they connected? How might they interact and what happens if they do?

Complex adaptive systems, which we mentioned earlier, is another facet of systems thinking that may help give you insight into the importance of events and trends. We described them earlier as systems made up of interacting organizations or groups defined by their values. Interaction among them is complex and predicting how it will evolve uncertain. They can exhibit rapid, unpredictable change with no apparent pattern. The 2008 housing crisis in the U.S. is an example. It spiralled out of control, leading to numerous company and bank collapses, but alert observers would have seen signs of instability were present. Similarly, complex adaptive systems can have positive effects, such as breakthroughs in innovation because of a confluence of ideas and technology.

Learning Moment

1. What social, political, economic, or technological trends do you see having a long-term impact on your country's ability to sustain universal health care into the future? Why?
2. If you were to stand in the future—in the vision of a patient-centred universal health care system—what fundamental intervention would you propose to move the system from where it is now to where it should be?
3. How difficult would it be for others to see the power of that intervention? How might you help them see it?

Champion and Orchestrate Change

To champion and orchestrate change connotes action. Your leadership will show in how actively you work to support and implement system change. To champion something is to advocate, support and fight for it. To orchestrate it is to shape and combine its parts to achieve a desired effect. Both verbs emphasize inclusiveness and connectedness, in tune with all the LEADS capabilities. However, we are not so naïve as to think that coercion and force are unnecessary. Indeed, one of the most important leadership abilities might be knowing clearly who your adversaries are, and a willingness to deal with them. However, your leadership should primarily be based on engaging people, on inspiring, on building partnerships: not force.

How do you apply your leadership to championing and orchestrating change? By being a leader in action, not inaction. By connecting. Through knowledge of large-scale practical approaches. By finding and following simple rules to guide change. We'll talk about those each in turn.

Leadership in Action

In the process of writing this book we had discussions with leaders from across Canada about the challenge of redesigning large health systems. There was a general consensus (and general frustration) that Canadian health leaders just can't get on with the changes the health system needs. One leader said "We all know what to do…why aren't we doing it?" There were lots of answers to that, including lack of time, lack of commitment and support from politicians, lack of ability to tackle large-scale change because it is complex and confusing, middle-management apathy, and a lack of information and data to back changes.

They all sound reasonable. However, you can always look for more information or wait for more support, or for someone else to take the lead. Yet almost all the leaders we interviewed agreed that if change was going to happen, they would have to do more than they are to bring it about. In some ways they were being unfair to

themselves. They are acting—on many fronts. Their frustration probably stemmed from three things. First, all kinds of action is undertaken in isolation, disconnected from anyone else's efforts. Second, many leaders who honed their skills in the relatively small boundaries of traditional organizations find their leadership practices are not suited to changing a large system. Finally, large-scale change takes time, which is why leaders struggle in political environments dictated by short election cycles. However, the people we spoke to agree on two things. Achieving large-scale change would take more working together, and they needed models and methods to engage the public and patients in it.

One tool we haven't discussed yet is leverage. In systems parlance, leverage is knowing when to intervene in a system to re-order patterns of thinking and action to create the change one is hoping for. Leverage also implies prescience, what the Greeks call *kairos*: the intuitive sense of knowing when to act.

A leader in the university sector on the west coast of Canada had been working on a small-scale project that was a version of a national initiative that had been pursued for over two years by a number of health leaders. The problem at the national level was insufficient funding and a meeting was scheduled the next day for a 'make it or break it' decision on the future of the initiative. He wrote a short proposal suggesting the cost of a national program could be reduced by leveraging the work he had done and using data and expertise developed in his province. His proposal arrived on the desk of the person convening the meeting just hours before it was to begin. It was accepted and his efforts leveraged a large-scale national initiative that benefitted Canadians well beyond his province.

Learning Moment
Reflect on your experience as a leader.

- Looking back, can you think of a time where an action on your part might have made a big difference in the outcome of a change?
- What factors made it the right moment to act?

Connectedness

It has been said that "Leadership is the ability to overcome the natural tendency to fragment." Connectedness—of leaders, within and across organizations, so they can work together to generate change—is another method that helps bring about effective large-scale change.[10] No matter what role you play in the health system, it's only by working with other leaders at multiple levels that you'll effect large-scale change. Clearly, that's not easy. CEOs struggle with getting concerted action in their own organizations, much less across a system. We need new ways of working together to get more coordinated action on large-scale change (previously we described this as distributed leadership).

[10]It should be pointed out that relationships and connectedness is a fundamental principle underpinning the LEADS framework, the NHS framework, and the Australia HWA framework, referenced in Chap. 3. It is also a major theme in almost all leadership works; after all, the leader-follower dynamic is a relationship.

Interestingly, the individuality and power implicit in the word leader—qualities that attract some people to leadership—are the very things that limit our ability to share leadership with others. But if you're too wrapped up in your own role, you're at risk of overlooking what others have to offer in creating system change (as we discussed in Chap. 8). Collaboration can achieve change where a lone leader is not successful [31].

Connectedness is what makes a system a system, both vertically (from micro- to macro-levels of the system) and horizontally—across departments, organizations, and jurisdictions (such as community agencies and institutions). Yet most health systems remain fragmented [32].[11]

Learning Moment[12]

One observation we heard in our interviews was that governments are reluctant to make bold policy changes because health care is a political minefield. But there are examples outside Canada of countries that have encouraged innovation and change. Sweden made significant policy changes in 2009 to move toward a more market-oriented, demand-driven health care system. While visiting Sweden, we heard about two new policies, one called "challenge" and the other a form of contracting out.

Under the new challenge policy, a large urban hospital was challenged by a Finnish company, which claimed it could deliver orthopaedic patient outcomes more effectively and efficiently than the in-house department. The department was given 6 months to respond with a compelling case for why the challenge should not be accepted. After a feverish Lean redesign, the department fended off the challenge.

Under the contracting out policy, boards have the right to designate certain services open to bids to improve the efficiency and effectiveness of their business and medical service plans. The management of a psychological treatment centre for youth in Stockholm was notified by its board that it was being opened to bids. One of the doctors on the staff partnered with a colleague, hired a lawyer and financial expert, and built their own bid to run the centre. They won the contract, and the doctor became CEO, bringing in the changes he and his colleague had proposed.

These and other market-driven changes were introduced to challenge the perceived complacency in the system. The jury is still out on whether they're having the desired impact on patient care; but they have catalyzed transformation.

[12] See Refs. [33–35].

[11] For example, a study done in Australia, in 2012, interviewed a diverse sample of Australian health managers. The findings showed that they viewed the health system as one of constant change, mostly non-adaptive and a system of parts controlled by bureaucrats and political interests [31].

1. What do you think are the pros and cons of such approaches? Would they create the large scale change that you think is necessary?
2. Are these approaches too bold, or are they the kind of measures leaders should be considering? What's the rationale for your answer?

One CEO told us, "I wasn't prepared for this." He was referring to the complexity of large-scale change. Depending on your vintage and where you've worked, that may be your experience, too. However, connectedness, like other aspects of leadership, can be achieved through coordinated leadership development initiatives based on a common language of leadership—such as LEADS, Health LEADS in Australia, or through the NHS framework. Any leadership development or succession planning program should facilitate systems awareness through interaction and dialogue among participants from a variety of roles. Grandy and Holton say leadership development programs that address social, cultural, political and economic context, while focusing on individual behaviour, skills, knowledge in real-life situations help build connected leadership [36].

Large Scale Approaches to Change

There are a number of models and approaches for carrying out large-scale change based on the principle of connectedness. Many embody LEADS capabilities. They bring a disciplined approach, embracing all partners, mobilizing knowledge and generating ownership in the change. They are designed to bring the wisdom of many to a change process. Five are profiled in Table 9.4 [2].

Large-scale change approaches are ways to champion and orchestrate change. Most address the "challenges and opportunities terrain" on the change map we profiled earlier. They allow issues such as culture and sub-cultures to be examined for their impact and can create shared meaning among participants on vision, purpose, and direction of change. They allow you to determine which groups and which individuals are resisting change simply from not understanding it as opposed to those whose values are at odds with the change. The right model can identify resources, help you align participants' efforts and help create momentum for a long-term process of change (the more organizations and groups that get involved, the harder it is to get going, or when already going, to stop). They provide arenas for gathering intelligence, developing a vision, and planning.

Finally, the decision to use a large-scale change model prompts us to recall a fundamental principle of systems thinking: there is no blame. If change is not happening at the scale we think it should, or inertia or resistance is holding it back we all tend to blame someone—politicians, the public, doctors. But we need to remember that while a system is made up of individuals, each of us is part of the behaviour blocking progress. We are all interconnected, and what is happening is no one's fault, or it's the fault of all of us. The point of large-scale change activities is to help us design the path forward together.

Table 9.4 Models and approaches to large scale change [2]

Change approach	Benefits	Description
Charters (e.g., Ottawa charter, design rules, proclamation for change)	Clear direction Principles of working together Momentum for change	The purpose of these approaches is to gain commitment and support for generating large-scale change by taking different groups affected by a change through disciplined processes aimed at expressing and gaining that commitment. Philosophically no single person or institution "owns" either the problem or the solution, rather it is owned collectively. Similarly the responsibility for the problem and the solutions is shared throughout the community. There is an interaction between the individual and the environment. The healthy behaviour of an individual is shaped by his or her environment, and whose behaviour in turn shapes a healthy environment
IHI framework for leadership for improvement and IHI framework for spread	Clear direction Implementation focus	Based on lessons from organizations, national initiatives, large-scale programs, fieldwork and interviews with health care clients and leaders from outside health care, IHI has developed a seven-factor framework for leading large-scale quality improvement. They are:
	Processes to expand small scale change to large-scale change	1. Establish and oversee specific systems-level aims at the highest governance level 2. Develop an executable strategy to achieve system-level aims and oversee their execution at the highest governance level 3. Channel leadership attention to system level improvement: personal leadership, leadership systems, and transparency. 4. Put patients and families on the improvement team 5. Make the chief financial officer a quality champion 6. Engage physicians 7. Build improvement capability IHI's Framework for Spread identifies six components for planning and implementing spread. It suggests general areas to be considered. It includes "checklists for spread" on leadership, knowledge management and transfer, communication, and measurement

(continued)

Table 9.4 (continued)

Change approach	Benefits	Description
NHS large-scale change	Conceptualization and planning focus and implementation focus Disciplined approach to organizing and planning change	NHS has an academy for large-scale change, created to give leaders grounded theory of large-scale change in order to be confident and effective in their leadership. It presents participants with a theory of large-scale change, and a seven-element model for it. The elements are: leadership for change; spread of innovation; improvement methodology; rigorous delivery; transparent measurement; systems drivers and engagement to mobilise. These seven elements revolve around, and are aimed at achieving the "shared purpose" of the change
Large scale action research (Community-based or participatory action research)	Ongoing disciplined analysis of success and failure Mobilizes knowledge Builds momentum and institutes ongoing action	Action research is a cyclical approach to change in which researchers and decision makers work together to initiate change. There are many versions of it but they all adapt and adjust the change process, based on lessons learned through a disciplined process of planning, initiating, implementing, and reflecting on changes. Action research enlists those who are most affected by a community issue – typically in collaboration or partnership with others who have research skills – to conduct research on and analyze that issue, with the goal of devising strategies to resolve it. Action researches adds to or replaces academic and other professional research with research done by community members, so that research results both come from and go directly back to the people who need them most and can make the best use of them

Simple Rules

Systems thinking gives rise to a phenomenon called simple rules, which are broad principles of change leaders can use in many different contexts. Simple rules operationalize the concept of concerted action implicit in the practice of distributed leadership [37].

Allan Best and colleagues, in an article called *Large-System Transformation in Health Care: A Realist Review*, describe studying transformation initiatives to inform change processes in Saskatchewan [38]. They identified five simple rules of

large-systems transformation they thought were likely to increase the success of the initiatives. To succeed, they said, system change should:

1. Blend designated leadership with distributed leadership
2. Establish feedback loops
3. Attend to history
4. Engage physicians
5. Include patients and families.

These rules, interpreted and applied with some flexibility by leaders to account for different contexts, will help leaders determine what to do.

Conclusions

The Systems Transformation domain of LEADS in a Caring Environment framework has four leadership capabilities:

- *Demonstrate systems and critical thinking*
- *Encourage and support innovation*
- *Orient themselves strategically toward the future*
- *Champion and orchestrate change*

Together these capabilities—and the approaches associated with them—can assist leaders together to achieve large scale, systemic change in health care. Yet it is clear that in Canada and other international jurisdictions, the cohesiveness required to sustain change over time remains elusive. Our systems remain fragmented despite the best actions of leaders. Is that because we adhere to the old models of leadership emphasizing control over our fiefdom? Is it because we implicitly like the independence and autonomy that such a system perpetuates? Or are we reluctant to learn about, and truly wrestle with the challenges of large scale change? Are we comfortable using models of change that actually devolve responsibility to managers, community leaders, and stakeholders, to shape how the system should work with us? Each of you is asked to consider these questions and one other: how much fragmentation in a system is in the best interests of the patients and citizens? One hope is that gaining agreement on a common language of leadership—e.g., LEADS in Canada, and LEADS Australia in that country—leaders will use that language to inspire and grow the concerted leadership needed to sustain health reform into the future, whatever that optimal level of fragmentation—and freedom of action—is.

Learning Moment
To use this questionnaire, find the right category for your level of leadership (e.g., front-line mid-management, etc.). Then assess how well you demonstrate the four Systems Transformation capabilities, where "1" is *I don't do this well at all*; "7" is *I do this exceptionally well*, and "N" is *not applicable in my current role*.

Which capability do you need to improve on? Why?

Systems transformation self-assessment

Front-line leader responsibilities								
Consistent with my organization's values, vision, desired results and purpose, I:								
1. Use critical/systems thinking to deal with people issues.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
2. Support the innovation required for continuous quality improvement and use my creativity to influence practices aimed at improving service to patients and clients.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
3. Personally model and encourage people I supervise to think about trends and enduring values of importance to the organization and system.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
4. Clearly understand the rationale for change approaches being employed in my organization or the larger system and change my personal practices to be consistent with them.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
Mid-manager leader responsibilities								
Consistent with the organization's values, vision, desired results and purpose, I:								
1. Use critical/systems thinking to address issues and practices to improve service to patients or citizens in my unit.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
2. Create an environment of continuous improvement in my unit.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
3. Encourage people on the unit to think about trends, issues and enduring values the broader organization is facing.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
4. Clearly communicate a compelling rationale for change and employ small-system approaches to it.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
Senior leader responsibilities								
Consistent with the organization's values, vision, desired results and purpose, I:								
1. Use critical/systems thinking to identify issues and practices that could improve service to patients or clients in my program or department.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
2. Create an environment in my program or department where innovation, creativity and continuous improvement are valued.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
3. Encourage people to think about trends, anticipate problems our department will face and create solutions in line with the values of our organization and system.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
4. Employ small- and large-system approaches to implement changes required in our department or program.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
Executive leader responsibilities								
Consistent with the organization's values, vision, desired results and purpose, I:								
1. Use critical/systems thinking to analyze system needs and identify issues and practices that could improve service to the patients or clients of my health organization and broader system.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
2. Create an environment in my organization and the broader system where innovation, creativity and continuous quality improvement are valued as sources of tactical and strategic advantage.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
3. Encourage people in my organization and partner agencies to identify future trends, anticipate issues, and create solutions in line with our own and system values.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
4. Champion and orchestrate change by using models and approaches that engage the system.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**

References

1. Walker B. Book of changes: a guide to life's turning points. New York: St. Martin's Press; 1992.
2. Dickson G, Lindstrom R, Black C, Van der Gucht D. Evidence-informed change management in Canadian healthcare organizations [internet]. Ontario: Canadian Health Services Research Foundation. 2012. Available from: http://www.cfhi-fcass.ca/Libraries/Commissioned_Research_Reports/Dickson-EN.sflb.ashx. Cited 20 July 2013.
3. Philippon D. The leadership imperative in publicly funded universal health systems with a particular focus on the development of the Canadian Health Leadership Network (CHLNET) [Internet]. Ottawa: Canadian College of Health Leaders. 2011. Available from: http://www.chlnet.ca/sites/default/files/Fellowship%20report%20.pdf. Cited 13 July 2013.
4. Heifetz R, Laurie D, Heifetz R. Adaptive work. In: Goethals G, Sorenson G, Burns J, editors. Encyclopedia of leadership. Thousand Oaks: SAGE Publications, Inc; 2004. p. 9–14. doi:10.4135/9781412952392.n4.
5. Tan J, Wen J, Awad N. Health care and services delivery systems as complex adaptive systems. Commun ACM. 2005;48(5):36–44.
6. Sturmberg JP, O'Halloran DM, Martin CM. Understanding health system reform – a complex adaptive systems perspective. J Eval Clin Pract. 2012;18(1):202–8. doi:10.1111/j.1365-2753.2011.01792.x.
7. Stevenson B. Developing an awareness and understanding of self-organization as it relates to organizational development and leadership issues. Emerg Complex Organ. 2012;14(2):69–85.
8. Ramos RT, Sassi RB, Piqueira JR. Self-organized criticality and the predictability of human behavior. New Ideas Psychol. 2011;29:38–48.
9. Holman P, Devane T, Cady S. The change Handbook: The Definitive resource on today's best methods for engaging whole systems (2nd ed.) San Francisco, CA: Barrett-Koehler.
10. Berwick DM, Calkins DR, McCannon CJ, Hackbarth AD. The 100,000 lives campaign: setting a goal and a deadline for improving health care quality. JAMA. 2006;295(3):324–7.
11. Baker GR, Jeffs L, Law M, Norton PG. Improving the safety and quality of health care in Canada. In: Safe and effective: the eight essential elements of an optimal medication-use system. Ottawa: Canadian Pharmacists Association; 2007.
12. Burgess N, Radnor Z. Evaluating lean in healthcare. Int J Health Care Qual Assur. 2012; 26(3):220–35.
13. Al-Hakim L, Gong X. On the day of surgery: how long does preventable disruption prolong the patient journey? Int J Health Care Qual Assur. 2012;25(4):322–42.
14. Chadha R, Singh A, Kalra J. Lean and queuing integration for the transformation of health care processes: a lean health care model. Clin Gov Int J. 2012;17(3):191–9.
15. Sobek D. Lean healthcare implementation: critical success factors. In: Paper presented at: the 2011 industrial engineering research conference. Reno, 2011.
16. Doolen T, Van Aken E, Holden R. Lean thinking in emergency departments: a critical review. Ann Emerg Med. 2011;57(3):265–78.
17. DelliFraine J, Langabeer J, Nembhard I. Assessing the evidence of six sigma and lean in the health care industry. Qual Manag Health Care. 2010;19(3):211–25.
18. Dickson G. The symbiotic relationship between lean and LEADS. In: Paper presented at: the Saskatchewan Medical Association's board of directors annual retreat. Las Vegas, 12–15 Jan 2012.
19. Jones D, Mitchell A. Lean thinking for the NHS [internet]. London: NHS Confederation. 2011. Available from: http://maine.gov/dhhs/btc/articles/Lean-Thinking-NHS.pdf. Cited 1 Jan 2012.
20. Saskatchewan's Health Care System and "Lean" [internet]. Saskatchewan: Ministry of Health. 2012. Available from: http://www.gov.sk.ca/adx/aspx/adxGetMedia.aspx?mediaId=1769&PN=Shared. Cited 1 Apr 2012.

21. Florizone D. Putting patients first: using lean to improve the patient experience in saskatchewan [internet]. Saskatchewan: Saskatchewan Ministry of Health. 2011. Available from: www.careoregon.org/Res/Documents/TransformingHealthCare/CSSI/FlorizoneKeynote.pdf. Cited on 1 Jan 2012.
22. Gillam S. Teaching doctors in training about management and leadership. BMJ. 2011;343:d5672. http://dx.doi.org/10.1136/bmj.d5672.
23. Dickson G, Kassi A, Grimes K, Swettenham J. 2013. Available from: http://www.rqhealth.ca/cgi-bin/texis.cgi/webinator/search_rhd/?query=physician+engagement&x=17&y=8&suffout=Most&pr=rqhr&q1=1. Cited 4 Apr 2013.
24. Spurgeon P, Mazalan P, Barwell F. Medical engagement: a crucial underpinning to organizational performance. Health Serv Manage Res. 2011;24(3):114–20.
25. Scott T, Mannion R, Davies H, Marshall M. The quantitative measurement of organizational culture in health care: a review of the available instruments. HSR. 2003;38(3):923–45.
26. Hodgkinson C. Educational leadership. New York: State University of New York Press; 1991.
27. Janus LM [Internet]. Encyclopedia Mythica. 2008. Available from: www.novareinna.com/festive/janus.html. Cited 5 May 2008.
28. Nonaka I, Takeuchi H. The wise leader. Harv Bus Rev. 2011;1:58–67.
29. Barbuto J, Millard M. Wisdom development of leaders. Int J Leadersh Stud. 2012;5(1):233–45.
30. City of Surrey. Vision critical, surrey partner to create city speaks [Internet]. Surrey: CIVICINFOBC. 2013. Available from: http://www.civicinfo.bc.ca/302n.asp?newsid=5154&r=5154&r=5153&r=5152#.UV3HzSqF8zo. Cited 4 Apr 2013.
31. Montgomery A, Dacin P, Dacin M. Collective social entrepreneurship: collaboratively shaping social good. J Bus Ethics. 2012;111:375–88.
32. Briggs D, Cruickshank M, Paliadeus P. Health managers and health reform. J Manage Organ. 2012;18(5):641–58.
33. Centre for Health Economics Research and Evaluation. Can we get there from here? Implementing health reform in Australia [Internet]. Sydney: University of Technology. 2013. Available from: http://www.chere.uts.edu.au/pdf/wp2013_02.pdf. Cited 1 Apr 2013.
34. Dickson G. Leading patient-centred change in the swedish health system: lessons from the CCHSE sweden study tour 2009. Ottawa: Canadian College of Health Service Executives; 2009.
35. Burstrom B. Market-oriented, demand-driven health care reforms and equity in health and health care utilization in sweden. Int J Health Serv. 2009;39(2):271–85.
36. Grandy G, Holton J. Evaluating leadership development needs in a health care setting through a partnership approach. Adv Dev Hum Resour. 2013;15(1):61–82.
37. Currie G, Lockett A. Distributing leadership in health and social care: concertive, conjoint or collective? Int J Manage Rev. 2011;13:286–300.
38. Best A, Greenhalgh T, Lewis S, Saul J, Carroll S, Bitz J. Large-system transformation in health care: a realist view. The Milbank Quarterly. 2012;90(3):421–56.

Chapter 10
The LEADS in a Caring Environment Framework as an Operating System for Change

A vision without a plan is just a dream. A plan without a vision is just drudgery. But a vision with a plan can change the world. ~ Old proverb

Change is the territory of leadership. Leaders have no purpose unless they are trying to create a better future. Regardless of where you are on the ladder of leadership, you find ways to take an idea and turn it into a movement. As the proverb above suggests, neither a plan nor a vision alone is enough; leaders must also know how to implement both. As we saw in Chaps. 7 and 9, all three—vision, plan, and implementation—are needed to create meaningful change.

In Chap. 3 we said the domains and capabilities of LEADS are the source codes of effective leadership. We pointed out that an individual's DNA and its nucleotides determine similarities and differences among people. For leadership differences in genetic source codes (which determine personality, morality and talents) when combined, give each of us our individuality as leaders, and determine how we express the capabilities of the framework in our behaviour.

The similarities in those source codes, when combined, create systems for leading change. LEADS provides codes to generate leadership of change. One way is through creating a common language to express the ideas in the domains and capabilities; the other is by creating common patterns of thinking and acting on change. We know the language quite well by this point. But let's review the fundamental dynamics, or patterns,[1] of bringing about change.

The first dynamic is that change is movement from the current state of patient care to the desired future state. The gap between the two gives leaders focus for improvement. The size and significance of the gap creates the need to change. It evokes comparison to the first step of John Kotter's [1] change model, creating a

[1] Dynamics is defined by the Merriam-Webster online dictionary as *a pattern or process of change, growth, or activity*.

G. Dickson, B. Tholl, *Bringing Leadership to Life in Health: LEADS in a Caring Environment*, DOI 10.1007/978-1-4471-4875-3_10, © Springer-Verlag London 2014

sense of urgency, often referred to as a "burning platform" [2].[2] Although the Lead Self and Achieve Results domain articulate this fundamental principle of change most clearly, the other domains embrace it implicitly.

The second common dynamic is that a leader takes initiative, to havnessing his or her individual influence to system change. And that, we stress again, is irrespective of one's position in the hierarchy.

The third dynamic is that leaders work with and through others, (as in the Engage Others and Develop Coalitions capabilities). Building relationships is the third common pattern of effective leadership.

The fourth dynamic is that change and transformation are engendered through action learning. Leaders grow and develop in relationship to self and others, responding to new challenges by taking initiative to create the future [Lead self and Systems Transformation domains].

The final dynamic of change is that while people may be forced to change due to environmental forces beyond their control, leaders ensure they and others have some freedom to choose *how* to change and how much effort and commitment they want to put into it. All the LEADS domains and embrace the notion of making a choice of how to think about change, how to respond to forces they can't change, and whether or not they wish to be preemptive in shaping the society that will result from those forces.

In Chap. 4 we used the metaphor of the hero's journey to discuss personal growth and development as a leader—going from the leader you are to the leader you want to be. These dynamics, combined with the LEADS domain and capability language, allow us to see LEADS as an approach that will work for us as individuals or as groups. Let's explore each of these dynamics a little further.

One change many of us have gone through is renovations to our home. "Personally, I hate change, but I love renovating my house," says Rosabeth Moss Kanter, author of the book *Evolve!* [3]. Her point: nobody likes change when it's done to them. But change we choose is different; that's the kind of change we're willing to embrace.

If you've done a renovation, you know that voluntary or not, change is difficult. It is fraught with problems that require us to learn by doing. Renovations are usually more complex than we thought, often take longer and are full of surprises. If you do the reno yourself, there is a tremendous learning curve for whatever skills you need for the job. There are always quirks you didn't plan for. If you don't do it

[2] Both Kotter and Conner's models had their genesis in the private sector. In a competitive marketplace, where the demand there is a constant demand to change to outstrip or outpace competitors, there is a compelling need to change. Some individuals have interpreted both writers as suggesting that leaders need to instill, or artificially create urgency—almost panic—to change. The reality is, however, as Conner was quoted in the above interview, "It is not about creating or exploiting a negative situation. Rather, it is about the level of commitment that is needed to get through a change. The burning platform does not refer to the energy that is needed to initiate change but to the commitment that is needed to sustain the change". Knowing the breadth and scope of the gap between current and future state tells us the work that has to be done, and therefore, the level of work and commitment required to do it. That is why in the Change Map in Chap. 9, we titled the same change phenomenon in health care, *Significance*. Communicating the significance of the change and the extent of the gap that defines it (i.e., scope and breadth) is how energy and commitment to change will be generated.

yourself, you have to manage relationships with contractors and suppliers—who don't always work the way you want or when you want. Renovation puts strain on daily work habits and in more often than not, on familial relationships. Choosing to renovate highlights the gap between your current house and the one you want. If you're lucky, you learn to see it as journey with others where you learn together along the way.

So how does this relate to LEADS?

LEADS as a Model to Guide Change

Everybody likes progress. It's the changes they don't like!
Will Rogers

LEADS can act as a model first by combining the domains into a simplified description of how to lead change, and second by establishing behaviour for leadership of change.

To generate the model, we combine the five capabilities into an interactive whole, showing how the domains work together to generate change (Fig. 10.1).

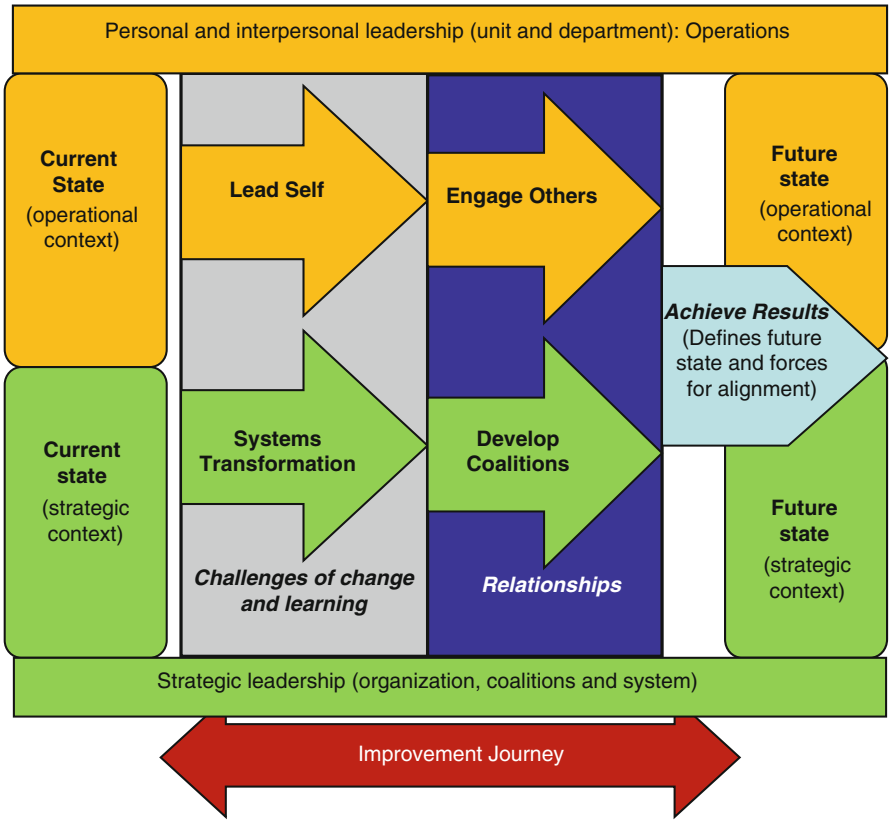


Fig. 10.1 LEADS as a model for change

The model shows the LEADS domains and capabilities are not just a list; they're an integrated whole interacting with one another to accomplish change. The model suggests leadership happens on the operational front and the strategic front, and activities associated with both are interrelated.[3] The gap between the current and future states defines that need operationally and strategically.

Carrying out the assessment of the scope and breadth needed for change is the focus of the "set direction" and "assess and evaluate" capabilities of the Achieve Results domain (the light blue shape anchored in the future state component of the model). Vision, values and desired final results make up the desired future. The model suggests you determine where the individual, organization or system is with respect to that future state. When expressed in measurable terms, the difference between current performance and desired performance shows the breadth and extent of the change you're undertaking, and suggests short-term measurements that can guide course corrections along the way. The other two capabilities of Achieve Results (align decisions with vision, values and evidence and take action to implement decisions) suggest ways leaders can align activities to ensure the journey stays on track. As change progresses, the Achieve Results domain interacts with the capabilities of the other domains to keep change happening.

The second component of the model highlights the need for leaders to have a sophisticated understanding of the landscape of change (see change map in Chap. 9) and action learning. This component is represented by the vertical grey bar linking Lead Self and Systems Transformation. To achieve better results you need to understand what goes on when people experience change. To achieve a desired future, you and others will have to change thinking, behaviour, distribution of responsibility and resources, and the structure and culture of your organization. LEADS' tools, instruments and models can help you do that. Everyone involved in change—whether they're employees, citizens, patients, or families—need to learn how to change. Leaders are encouraged to understand the challenges of change, so as to empathize with others and do their best to ameliorate the negative aspects of the change process.

The capabilities of the Systems Transformation domain help you understand the dynamics of both large- and small-scale change. They include critical and systems thinking and strategically orienting yourself to the desired future, capabilities which let you outline actions—including supporting innovation and championing and orchestrating change—that you'll need to stimulate learning and progress. Almost all of the tools, models, and approaches in Systems Transformation chapter stimulate systems and critical thinking so individuals and groups can make choices about where and how change should take place.

[3] In the five LEADS chapters we created LEADS self-assessments for both operational and strategic leaders: two at the operational level (front-line supervisor or mid-manager) and two at the strategic level (senior or executive leader).

Lead Self is the personal analog to Systems Transformation. Its four capabilities—self-awareness, self-management, develops self and demonstrates character—recognize leaders themselves have to change. Some of the changes are psychological, making demands on your emotional intelligence, or testing your resolve; others require you to acquire or unlearn knowledge and skills; others put demands on your integrity and character. Leaders who can't meet those demands have diminished ability to champion change. You have to be authentic when you model those capabilities or your credibility as a leader suffers.

A third component of the model emphasizes the power of relationships to lead change (the dark blue bar on the diagram). Relationship-building comes ahead of tasks in the process of change and both Engage Others and Develop Coalitions focus on it—Engage Others in the operational context and Develop Coalitions in a strategic context.

LEADS is also a set of standards to measure quality in leading change. LEADS can be used to set curriculum for aspiring health leaders, or to generate performance measures to shape succession planning and professional development or to guide selection of leaders. As a set of standards, LEADS inspires the possibility of making health leadership a profession with formal certification on set standards. The winning conditions for change would be inculcated in health-system LEADS leaders, and momentum for change would build.

Learning Moment

Picture your own workplace. Conceptualize one practice you would like to change, on behalf of patients, or clients of your work.

Using the model, outline steps you would take to plan the change.

1. Is your project primarily operational in focus, or strategic?
2. In that context, clarify the change gap: the difference between the future state and current state of your project. How big a change is it?
3. What 'systems change' implications does the project have? Consequently, what change challenges (unit, department, organization, coalition, system) will you face moving from where you are now to where you want to be?
4. Based on your understanding of the scope and breadth of those external changes, what internal personal challenges will you have to face?
5. Based on how big the change is, who will you need to build relationships with, and why? How will you do it? Are there approaches discussed in the chapters of this book that would help you build those relationships?

Goethe said "Thinking is easy, acting is difficult, and to put one's thoughts into action is the most difficult thing in the world." Ultimately, the LEADS framework is a model for thinking through and implementing system-wide change: one we're encouraging you to use to make change work in a systems context.

LEADS as Simple Rules

Another way to think about LEADS as an operating system for leading change is to use a variation of the "simple rules for change" concept described in Chap. 9. The three simple rules are shown here (Fig. 10.2):

In keeping with the systems construct of interdependency, the three rules interact with each other on an ongoing, fluctuating basis to create conditions for leading change. These rules work whether you're attempting to change yourself, your unit, your organization, or a coalition or system change. Let's review "Joan's story" to point out how these simple rules can help.

Joan is director of care at an extended care home in a small rural community. She has just completed her masters degree, including a major project on feeding protocols which would improve care and reduce costs. She is proud of her degree, and keen to use it to make a difference. She wants the home to introduce the protocols.

Joan's best friend—both at work and outside of it—is Natalie, the nurses' union steward. Natalie has shown some interest in Joan's studies, but has always been a

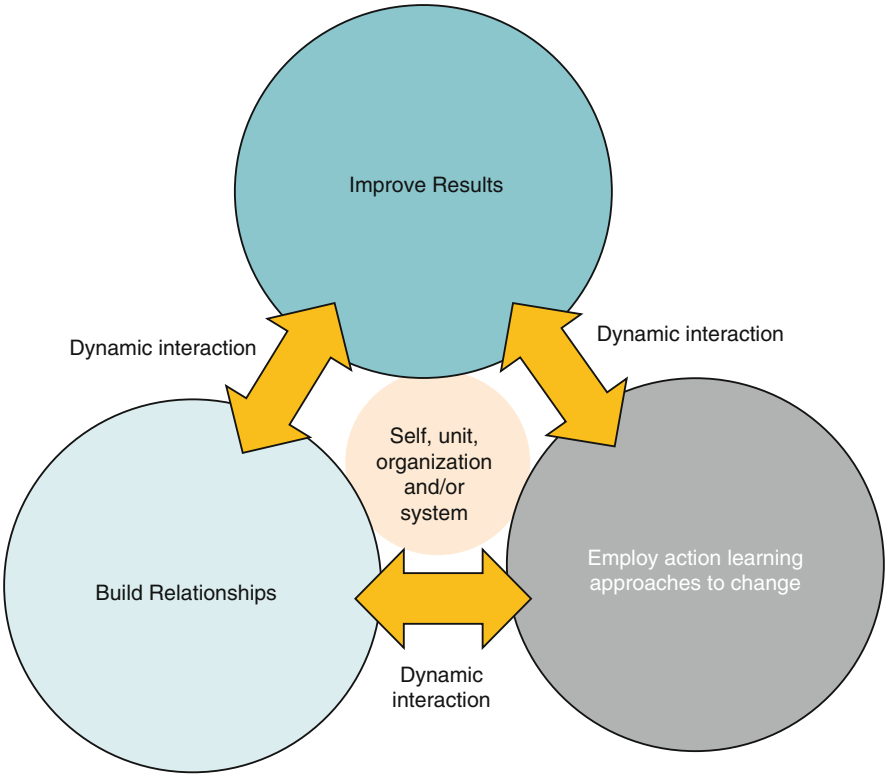


Fig. 10.2 Simple rules for leading change

little suspicious of her need to get a degree ("You don't need a degree to be a good manager.")

Joan is contemplating how to introduce the feeding protocols where she works. She has convinced herself—due to her deep commitment to patient-centred care, and her research—that the changes she proposed are clearly in the best interests of the residents. But she was a little worried about her personal and professional relationship with Natalie, whose nurses' union members have tended to resist change. Many of them don't see Joan daily, and think that her studies are out of touch with the realities of the home. They would likely push Natalie to marshal formal union resistance to this change.

Joan rummaged through her bookshelf. First, she pulled out a think piece the instructor in her final course had done on change. In it, he said there were three simple rules a leader needs to answer to begin the change process (and then continue to guide people through it). He had expressed them as three questions for the leader to answer. She reviewed the questions:

1. ***What results do we need to achieve and how will we keep on track?*** *She knew the answers to that question, but realized that no one else did.*
2. ***What change challenges will we face in moving to the future and what will we do to address them?*** *"Obviously", she thought, "I'm going to have to deal with the potential resistance of the staff. And that will be complicated as a consequence of my relationship with Natalie".*
3. ***What relationships will we have to build, and how?*** *"Well, certainly an understanding with Natalie as it relates to this project. And maybe a new relationship with my staff; I have been somewhat distanced from them because of my school work. But how?" she mused.*

Joan spent a couple of hours reviewing Goleman's leadership styles and pondered what guidance she could get from the LEADS framework brochure sitting on her desk. She picked it up and noted the four Engage Others capabilities: foster development of others, contribute to the creation of healthy organizations, communicate effectively, and build teams. Putting Goleman and LEADS together, she came up with a plan.

Joan remembered she and Natalie were going to be at the curling club the next night. She resolved to begin her plan then.

At the end of the game, Joan asked Natalie if she would like a drink before going home, on her. Natalie accepted.

Joan laid out her plan. She suggested holding meetings with the nursing teams during the last hour of the day shift and the first hour of the night shift by using casuals to cover the time. She proposed three meetings so patient service would not suffer and so all staff would have a convenient time to attend. She offered to explain how her protocol would truly improve the welfare of residents, and how it would make nurses' lives easier. She also promised to listen to all the nurses' concerns. She agreed to delay implementation until all the issues were worked out.

Natalie thought it over and agreed, setting the stage for change.

Table 10.1 Simple rules as guiding questions: an example

*Simple rule: determine the desired results of the change and how to align actions with them**		
Level 1 question	Level 2: (Initiation)	Level 3 (Ongoing)
What results do we need to achieve and how will we keep on track?	What benefits to patients or citizens are anticipated?	How are we doing in terms of moving towards the desired state?
	What is our vision for change?	Are we progressing toward our vision?
	What results speak to accomplishing our vision?	How are we progressing relative to each of those results?
How do we align our actions with desired results?	What needs to be done in our planning to ensure our actions are aligned with anticipated benefits to patients or citizens ?	What course corrections need to happen to ensure our actions are aligned with anticipated benefits to patients or citizens?
	What strategies or tactics will help us reach our vision?	How do our strategies or tactics need to be adjusted to keep us on track with our vision?
	What strategies or tactics will help us reach our individual results?	How do our strategies or tactics need to be adjusted to reach our individual results?
	What evidence will support us to achieve our vision and desired results?	How does emergent evidence suggest we should adjust our strategies and tactics?

*See Learning Moment below

As the story shows, the simple rules can be parsed as a series of questions to guide you when you initiate change and while you carry it out, as they did for Joan. Some sample questions related to the simple rule of determining results are profiled in Table 10.1.

Note that these sample questions need to be applied to the appropriate context, you, or your unit, department, organization, coalition or system.

As Table 10.1 indicates, you don't just ask the questions derived from the simple rules at the beginning of the change journey. You must ask and answer them continually as the change progresses to operationalize cycles of experiential learning. That's because dynamic interplay in a change can morph into new and unexpected challenges, either changing the desired result or how to get to it.

Learning Moment

Using Table 10.1 as a template, choose one or both of the remaining simple rules to create a table of key questions.

1. Outline the key questions you need to ask yourself to prepare for leading change, and to carry it out.
2. Share your thoughts with a colleague. Refine the table and make it work for you.

Conclusions

This chapter has shown how the *LEADS in a Caring Environment* framework is more than a list: It is also an operating system for guiding change. To be a good leader is to be good at creating change. The exercises and stories highlight how to use the framework for that purpose and how important it is for you to see the interdependency of the leadership capabilities. Change is a constant in the Canadian health system and LEADS can support you as you work with it, by outlining how you need to think and act to be a successful health leader.

References

1. Kotter JP. A sense of urgency. Boston: Harvard Business Press; 2008.
2. Galloppin L. The giant misunderstanding on burning platforms [Internet]. R. 2011. Available from: http://www.reply-mc.com/2011/01/17/the-giant-misunderstanding-on-burning-platforms/. Cited 19 July 2013.
3. Kanter RM. Evolve! Succeeding in the digital culture of tomorrow. Boston: Harvard Business Press; 2001.

Chapter 11
LEADS Learning: Epilogue

Not all those who wander are lost –J.R.R. Tolkien

When we embarked on the LEADS journey in late 2004, leadership was not part of the policy landscape. Generally, it was taken for granted, assumed to be part of the package that came in a boss, with little distinction made between good management and good leadership. If there was any leadership development, it was top down, with the focus on high flyers. Discussing the quality of leadership in an organization, individual or collective, was confined to whispers in hallways and cafeterias. The idea that the discipline of leadership was important to the social enterprise that is health and health care was just beginning to take root.

The decade since LEADS began has been a mixed one for health care in Canada. In 2004 Canada's first ministers signed the third in a string of Health Accords providing for $43 billion in additional spending over 10 years. Targets were set and the Health Council of Canada was created to track progress and hold jurisdictions to account for them. Ten years later the federal government says the Health Council's work is done and it is to be shut down. But comparisons show Canada's health-system performance continuing to slide down the international tables. While our overall health outcomes are still in the top third, we now rank second lowest relative to comparator countries in measures of efficiency and effectiveness, with only the United States doing worse. And we lag well behind countries like Australia and the United Kingdom [1].

Better leadership will be essential in reversing this state of affairs. Over its 10 years of development, LEADS has helped create a new appreciation for the importance of leadership; individuals and organizations that embrace it are demonstrating its value every day, consistent with similar enterprises emerging in countries such as the United Kingdom and Australia.

We believe the strength of LEADS lies in its focus on leveraging up individual and collective capabilities rather than the top-down competency-based models that can't deal with the complex adaptive system that is healthcare.

G. Dickson, B. Tholl, *Bringing Leadership to Life in Health: LEADS in a Caring Environment*, DOI 10.1007/978-1-4471-4875-3_11, © Springer-Verlag London 2014

This new attitude toward health leadership supports our basic contention that leadership can be learned. Kouzes and Posner say in *Leadership Challenge*:

> Yes, of course, *all* leaders are born. We've never met a leader who wasn't. So are all accountants, artists, athletes, parents, zoologists, you name it. We are all born. What we do with what we have before we die is up to us. [2]

We see the five domains and 20 capabilities that make up LEADS as fundamental to this new perspective on health leadership. LEADS is the source code for both developing better leaders and overall leadership development. As we have hopefully conveyed, developing better leaders and supporting better leadership are not the same—but they are not at odds with one another. Neither is sufficient on its own; we need both if we are to have high-performing health organizations and systems.

Five themes underpinned the content for this book. They are:

1. *Change demands skilled leadership*. Managers maintain status quo. Change demands leadership – and change today is unrelenting and ever-increasing in pace and complexity. Yet health organizations continue to be more managed than led.
2. *Leadership is an acquired ability*. Leadership can be defined and learned; it is complex, but not elusive. It is both born and made; to believe it is only born, means we tend to look for leadership from someone else, rather than in ourselves and not be able to share leadership in the way a complex system demands.
3. *A shift in vision requires a shift in leadership.* Health systems world-wide are moving from a focus on sickness care to a vision of health and wellness for all. That shift, combined with an emphasis on patient-centred care, means everyone in health-care system has a leadership role in transforming the system to be more patient people-centred. We need a system led by everyone through shared leadership.
4. *Leadership—and its development—are disciplined activities*. To be the leader you need to be in the context of complex changing systems, you need to see leadership in health as a discipline to be employed in day-to-day practices. That involves making substantial investments in yourself and in our collective social capital.
5. *Leaders need a whole systems view.* The shift from sickness focused to health focused means we need a holistic system where all parts work together to achieve wellness, and the practice of leadership needs to be conducted in this system-wide context.

Overall, it's important to remember there is no one-size-fits-all approach to leadership. Criticism of competency-based frameworks claims they fragment leadership activity rather than integrating it and undermine the importance of context [3]. We believe it must be developed and exercised in response to the historical, political, economic and cultural context in which you are operating.

In the 2 years it has taken to write this book, evidence of the importance of leadership for performance at both the system and organizational level has kept growing, which has made it difficult to take stock of how far this new perspective on leadership has come. Nevertheless, we want to try to put our Canadian experience

in context by describing the evolving health leadership environment in both the National Health Service (England) and the health system in Australia. We undertook this task with the assistance of two of our international LEADS collaborators: Chris Ham and colleagues from the Kings Fund in Britain, and Etienne Scheepers and Andi Sebastian from Health Workforce Australia.

Overall, we observe what appears to be a convergence around LEADS-based approaches to helping individuals reach their potential as leaders, working together across organizations to meet the challenges of complex adaptive health system changes.

Health LEADS Australia

We briefly introduced the Health LEADS Australia model in Chap. 3. As has been pointed out, Canada and Australia share similar systems of health financing and delivery as well as values that support universal health programs. So it's not surprising we would share an approach to leadership development in the health sector. Still, there are some important differences in the interpretation and adaptation of the five domains and 20 capabilities.

In June 13, 2013, the Council of Ministers of Health approved *Health LEADS Australia*: the Australian health leadership framework [4] to be facilitated by Health Workforce Australia (HWA). HWA is a national organization created in 2009 to address the challenges of providing a skilled, innovative health workforce to support reform to a sustainable and quality health system. Australia, like Canada, faces many challenges to the health system. The demand for care is growing because of an aging population, growth in chronic disease, and increased expectations. At the same time the health workforce is not well distributed, shortages loom in some professions and specialties, work practices can be inefficient, professional roles sometimes inflexible and finances constrained.

The genesis for *Health LEADS Australia* was a national dialogue Health Workforce Australia conducted in 2010 to set priorities for workforce reform; "Leadership for the sustainability of the health system" became one of the five domains of its Framework for Action 2011–2015. The leadership initiative calls for "a nationally consistent leadership framework for all health professions, at all organisational levels incorporated into established, ongoing professional development requirements" [5]. *Health LEADS Australia* is the response.

Core themes embedded in the Framework for Action include: distributed leadership, with development aimed at all organisation levels and in all professions; system sustainability (acknowledging that Australia's health system, like Canada's, is a disparate set of sectors and elements where too often, the interconnections are not seen and accounted for); and interconnectivity—getting all health leaders to understand the complexity of the sectors and facilitate their interaction to maximize investments in health and health care.

So far, Australia has done a scoping study [6–8] which provided a base for further enquiry and research. Scanning and analysis of national and international leadership

frameworks led to drafts of an Australian health leadership framework and discussions with state, territory and health-industry partners. The U.K. and Canadian approaches were discussed in consultations around the country. Since gaining approval of the framework, HWA is now engaged in further dialogue about how to steward implementation of *Health LEADS Australia*, which may take a form similar the Canadian Health Leadership Network or something quite different.

Agreeing on a national approach to health leadership will take time. Australia has six states and two territories, each with its own health leadership development, which vary from Queensland's adoption of an early version of the NHS Leadership Framework to New South Wales's development of a framework similar to LEADS. Others have developed their own approaches. Large private health providers have developed their own frameworks, tools and programs as have hospitals, not-for-profit and faith-based organizations, and the majority of the clinical and professional colleges.

None of these regional initiatives provide an agreed common language on health leadership and they do nothing to facilitate the growing mobility of health workers in Australia, but it is hoped Health LEADS Australia will help that situation.

Implementation Support

Stakeholders are keen to develop measurable behaviour and implementation tools collaboratively and to test them in different health areas. Finding stories and examples that will help make *Health LEADS Australia* relevant in all health environments is also important. HWA will coordinate this work, support communities of practice and link some of the early adopters of *Health LEADS Australia*.

Embedding in Training, Education and Development

During national consultation, there was strong support for embedding *Health LEADS Australia* in early career education and training, despite already-crowded curricula. *Health LEADS Australia* is being mapped against accredited professional standards and courses. Steps are also being taken with providers of professional development to include *Health LEADS Australia*.

Linking with Canada

By aligning its work closely with Canada's, Health Workforce Australia hopes to benefit from trans-Pacific collaboration, possibly through shared research, practice information, stories, and exchange programs aimed at expanding the capacity of health leadership in both countries.

National Health Service (England)[1]

Health leadership programs in the United Kingdom are in transition. After a period of growing awareness of the need for a shared approach to leadership development, consistent with the LEADS approach, NHS (England) appears to be poised to move to a more top-down, centralized approach to leadership development.[2] With the help of our friends at the King's Fund, we take a very brief look here at the very fluid situation unfolding in England.

In many important ways, our British colleagues have lead the way in recognizing that leadership is a *sine qua non* of successfully transforming health systems.

> There is unequivocal evidence in every sector that there is a strong relationship between leadership capability and performance. Good leadership leads to a good organisational climate and good organisational climates lead, via improved staff satisfaction and loyalty, to sustainable, high performing organisations. [9]

Traditionally, the NHS leadership efforts have focused on individuals "…through the enhancement of their personal attributes, qualities, behaviours, knowledge and skills" [3]. A number of programs target the senior echelons of the NHS, including "Top Leaders", which reaches out to executive leaders looking for insight into their leadership style and behaviour.

Changes to the NHS from the Health and Social Care Act (2012) build on what previous governments have done but "…go much further and much faster in introducing and extending market principles in the NHS".[3] Those changes were a response to a series of concerns over quality of care, the most devastating of which were revealed in the Francis Report [10]. Released in 2011 after an inquiry into the Mid Staffordshire NHS Foundation Trust, the report has been described as the "wake up call of all wake up calls" [11]. It chronicles a litany of leadership and management issues, describing them as a failure of culture more than individuals. The report noted the high priority placed on meeting 4-hours emergency department (A&E) treatment targets and the consequences of meeting targets "…whether justified or not, that failure to meet targets could lead to the sack". This typifies what is sometimes referred to as the "targets and terror" phase of NHS reform [12]. As one senior officer put it, the focus on wait times meant that leaders were "hitting the target, but missing the point" [13].

---

[1] This part of the book draws heavily on a trilogy of recent works coming out of the King's Fund, which provides an excellent chronology of events that we would highly recommend for those wishing to know more.

[2] It is important to note that since the devolution of governing powers in 1997 from the central United Kingdom government to the countries of England, Wales, Scotland and Northern Ireland there is increasing divergence in approaches to health care across the four countries. Wales and Scotland have tended to revert to a traditional NHS, while England has seen "…a plethora of policy initiatives that have increased the requirement both for management and administration."

[3] The new legislation eliminates Health Authorities and the Primary Care Trusts. New "clinical commission groups" were created, working within Health and Wellbeing Boards and Foundation Trusts, with decision-making devolved and significantly enhanced clinical leadership.

As a consequence of these changes, some contend that the NHS now needs a different style of leadership. "We can no longer expect or afford to see this as a case where the heroic Chief Executives come in and do wonderful things; health care is too complex for that; we need much more collective leadership" [14]. Leaving leadership to a few heroic individuals is especially challenging when the average shelf life of senior leaders in the UK is just 700 days [12]—just enough time to get yourself into trouble and let someone else pick up the pieces.

Yet the culture of a "turnaround hero" is still very strong in England. The roots of this may possibly lie in "emergency room" mentality of health care itself, in which heroic individuals save lives under huge stress and time constraints. Indeed, the NHS has been described as "riven by panics, crises, incoherence and endemic short-termism" [3].

The good news coming out of the Francis Inquiry is a renewed focus on leadership and a focus on instilling a culture of openness and accountability in the NHS, one that encourages learning rather than blaming, that is more honest and transparent in its relationship with the public and more engaging and empowering of staff and patients—that is, one that practices distributed leadership.

Implementation Support

Recent legislative changes have brought about a consolidation and reframing of leadership development programs under the aegis of the NHS Leadership Academy, which undertook to revisit its Leadership Framework. A suite of new large scale programs is being contemplated that "will provide a career-mapped, accredited development route to leadership at every level and from every profession" [15].

The approach being taken by the Leadership Academy has not been universally well received. Will it be a top down, traditional leadership development approach, pinning hopes on the few or will it be more in keeping with the LEADS approach or the shared, "place-based" leadership development model suggested by the King's Fund? Stay tuned.

Linking with Canada

As described in Chap. 3, there are a number of overlaps between key elements of the NHS Leadership Competency Framework (LCF) and LEADS—e.g. focus on achieving results, support for a compelling shared vision and the value of teams that work. There is also a convergence around the need to engage clinician leaders more effectively in leading change [12]. Like LEADS, the LCF clearly acknowledges that "leadership is not restricted to people who hold designated management and traditional leaders' roles" [15].

LEADS in a Caring Environment: Canada

We're often asked by health leaders across Canada how they can be sure LEADS isn't just the flavour of the month. There, are, after all, many leadership frameworks and related programs available. We would say it's up to all of us to avoid letting it become just another fad. Agreeing on a common framework and sticking with it over time, while nevertheless allowing it to evolve and change, is the only sustainable solution.

We seem to be managing to do that. In Chap. 3 we mentioned the increasing number of organizations that have adopted LEADS as their preferred leadership learning platform, or one of those they use. The organizations that make up Canadian Health Leadership Network are very supportive; at the semi annual Network Partners Roundtable in May 2013, one of its co-chairs, Dr. Brian O'Rourke, remarked "There is nothing fundamentally new in the LEADS framework. I have seen the elements in various forms before. What LEADS does do is provide a clear, coherent way of thinking about leadership and taking action together to improve both organizational and system performance."

One of the requirements of joining the Canadian Health Leadership Network is that organizations support LEADS, both conceptually and by making a significant annual financial contribution to the collaborative. LEADS is now used by:

- Health professions: physicians, nurses, pharmacists, dentists and others see LEADS as a common language of leadership that helps bridge traditional interdisciplinary differences.
- Health jurisdictions*:* LEADS has helped federally funded agencies and institutes, provincial and territorial governments and regional and local authorities to see leadership development as a social good.
- Private and public sector organizations: senior officials increasingly accept the link between better leadership and better health-system performance.
- Academic and applied students of leadership: we're building stronger connections for transfer of knowledge about leadership in health among universities, medical schools and the health system.
- Generations: established and emerging personnel see LEADS as a common space with a common language for advancing their capacity to improve health care.

After more than 5 years of incremental improvement we are convinced the basic principles supporting the *LEADS in a Caring Environment* framework are here to stay. The construct and face validity have been embraced by communities of practice at all levels in our system.

That said, we are committed to continually renewing the framework. Both theoretical and applied evidence is developing rapidly and LEADS can certainly be strengthened further and the tools extended. Our hope is partners in LEADS across Canada will collaborate in developing and sharing those tools.

In advancing the basic building blocks of this new perspective on health leadership, we have put a premium on updating and underscoring what we can learn from the

discipline of leadership as it applies to the unique circumstances facing leaders in health care. At the time of writing this book, a cross-national team of leading health-service researchers and senior decision-makers were just completing a multi-year series of six case studies examining the effect of leadership on health system change [16]. The early results tend to confirm what literature elsewhere suggests—that a strength-based, distributed approach to leadership development is important. The results of this study were to be available sometime in the late spring or early summer of 2014.

Implementation Support

As LEADS has been embraced by a growing community of health leaders at every level across the country and increased its market presence, we have had to move quickly to ensure there are infrastructure and support systems in place for this transformational "disruptive innovation." At the time of writing this book, the key LEADS partners[4] (including the Canadian College of Health Leaders) had just come together to form the LEADS Collaborative. It is a not-for-profit, shared effort dedicated to:

- Facilitating one stop shopping for LEADS tools and services (such as LEADS 360s and LEADS Learning Series).
- Supporting the development of expanded tools (e.g. organizational cultural assessment tools and mapping tools); and
- Evergreening the LEADS framework to reflect continuous learning from home and abroad.

The LEADS Collaborative is supported by a group of qualified, specially trained facilitators, consultants and executive coaches who work with organizations from across the country, and in both official languages, to deepen and expand the reach of LEADS in Canada.

Both CHLNet and Canadian College of Health Leaders have been pivotal in sustaining LEADS' momentum from beta testing to being adopted across Canada. By agreeing to take on the financial and legal risks associated with the roll out of LEADS, the Canadian College of Health Leaders has provided a necessary institutional home for LEADS and for the LEADS Collaborative.

Embedding in Training, Education and Development

LEADS has been adopted by the Canadian College of Health Leaders as the foundation for its credentialing and continuing professional development programs. We have helped Canada's doctors introduce LEADS to its Physician Manager Institute.

[4] LEADS Collaborative Partners: Canadian College of Health Leaders, Canadian Health Leadership Network, Royal Roads University and LEADSChange.

The Registered Nurses Association of Ontario just recognized LEADS as the template for developing its most recent leadership guidelines. And Accreditation Canada has referenced LEADS in the revision of its leadership and governance standards for accrediting health and health care facilities across the country. In short, it is our view that LEADS is here to stay.

Conclusions

The landscape of leadership is in perpetual motion, like the health system itself. There is, however, convergence around what makes for good leadership and those principles, we argue, are deeply embedded in LEADS.

Leadership is an exceptionally difficult and challenging task (or perhaps we should say calling). To do the right thing, at the right time, to get the right result is challenging even in a stable environment. In a turbulent one, it is incredibly demanding. No one individual can be that super leader; no one can master all the LEADS capabilities at a virtuoso level. As the King's Fund says, there are no more heroes. We are all too familiar with our own foibles, weaknesses, and self-interests to believe in an omnipotent leader. Indeed, if we don't see good leadership—either from ourselves or others—it may very well be the difficulty lies in getting ourselves to rise up to the standards we hold.

Happily, LEADS shows us we are better off to rely on shared leadership, hoping that the best efforts of all of us compensate for our individual limitations.

The journey of LEADS learning is far from over. You're a leader for life. Together we must continue the quest for better understanding of how processes and relationships come together to provide the complex adaptive leadership twenty-first century healthcare systems demand of us. We must all strive to be agents of change or we shall surely be the objects of change.

> *The illiterate of the 21st century will not be those who cannot read and write, but those who cannot learn, unlearn, and relearn.*
>
> Alvin Toffler

References

1. Davis K, Schoen C, Stremikis K. Mirror, mirror on the wall: how the performance of the US health care system compares internationally [Internet]. New York: Commonwealth Fund; 2010. Available from: http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Jun/1400_Davis_Mirror_Mirror_on_the_wall_2010.pdf. Cited July 2013.
2. Kouzes J, Posner B. Leadership challenge. 3rd ed. San Francisco: Jossey-Bass; 2002.
3. Edmonstone J. Developing leaders and leadership in health care: a case for rebalancing? Leadersh Health Serv. 2011;24(1):8–18. doi:10.1108/17511871111102490.
4. Australia. Health LEADS Australia: the Australian health leadership framework. Australia: Government of Australia; 2013. 9 p.

5. Health Workforce Australia. The national health workforce innovation and reform strategic framework for action 2011–2015 [Internet]. Adelaide; 2011. Available from: http://www.hwa.gov.au/news-and-events/news/27-10-2011/national-health-workforce-innovation-and-reform-strategic-framework. Cited July 2013.
6. Health Workforce Australia. Leadership for the sustainability of the health system part 1 – a literature review. Adelaide: Health Workforce Australia; 2012. 81 p.
7. Health Workforce Australia 2012. Leadership for the sustainability of the health system part 2: a key informant interview report. Adelaide: Health Workforce Australia; 2012. 26 p.
8. Health Workforce Australia. Leadership for the sustainability of the health system part 3: an environmental scan. Adelaide: Health Workforce Australia; 2012. 91 p.
9. Lynas K. How past leaders can inspire today's leaders [Internet]. NursingTimes.net. 14 May 2013. Available from: http://www.nursingtimes.net/home/clinical-zones/leadership/how-past-leaders-can-inspire-todays-leaders/5058666.article. Cited 1 Aug 2013.
10. Francis, R. Independent inquiry into care provided by mid Staffordshire. England: The Mid Staffordshire NHS Foundation Trust Public Inquiry 2010; 2013. Available from: http://www.midstaffsinquiry.com/assets/docs/Inquiry_Report-Vol1.pdf.
11. Farrar M. Opening remarks to annual general meeting of NHS confederation. Liverpool. 5 June 2013.
12. King's Fund. The future of leadership and management in the NHS: no more heroes. London: The King's Fund; 2011. 38 p.
13. Horton C. Today in healthcare: from the NHS Confederation annual conference: full coverage of the NHS Confederation annual conference in Liverpool. The Guardian [Internet]. 5 June 2013. Professional. Available from: http://www.theguardian.com/healthcare-network/2013/jun/05/today-in-healthcare-nhs-confederation-annual-conference. Cited 15 Aug 2013.
14. Ham C. Reforming the NHS in England: opportunities and challenges. Medio-Legal J. 2013;91(1):2–17.
15. NHS Leadership Academy. Leadership framework [Internet]. Leads: NHS Leadership Academy; 2013. Available from: http://www.leadershipacademy.nhs.uk/discover/leadership-framework/. Cited 29 July 2013.
16. Dickson G, McPhee M, Tholl W. National node case report #1: leadership in health system redesign. Unpublished research working paper. Canada: Canadian Institute for Health Research and Michael Smith Health Research Foundation; 2013.

Index

G. Dickson, B. Tholl, *Bringing Leadership to Life in Health: LEADS in a Caring Environment*, DOI 10.1007/978-1-4471-4875-3, © Springer-Verlag London 2014