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.

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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.

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