LEADS and the Health Professions

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This chapter describes how LEADS can serve as an antidote to some of the leadership challenges health professionals experience—including fragmented health care systems, limited engagement and burnout among staff, diversity and equity issues and demand for high quality leadership practice. We focused on physicians and nurses because together they are the majority of clinicians in the health system. We offer specific examples of how LEADS is being used by physicians and nurses as well as ideas for further use of the framework. However, we're not giving prescriptive answers—instead inviting you to explore what you think is possible with LEADS.

This look at LEADS considers four main challenges. First, using LEADS for professionals working in fragmented systems; second, LEADS as an enabler of professional engagement and as a means of supporting professional health and well-being; third, fostering diversity and equity through a LEADS-based distributed leadership model; and fourth, LEADS as a pathway to the development of high quality leadership in the health professions.

Challenge One: Using LEADS for Professionals Working in Fragmented Health Systems

Earlier in the book Canada's health system was described as fragmented [1, 2], Constitutional, geographical and structural silos detract from the quality of patient care. Even in regions—created to link care across institutional boundaries—silos prevent patients from getting the continuity of care they need, whether they are elderly people transitioning between hospitals and hospices, adolescents with mental health issues bounced around among social services, or patients moving from hospital to community or home care. Patients with multiple chronic ailments also

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struggle to navigate the primary-specialist care continuum, if they can get a primary care physician at all.

At the same time, physicians' attention is fragmented by struggles with electronic records and barrages of emails, by ever-increasing expectations of patients and dwindling resources, and by redefining their professional roles. A final touch of fragmentation may be added by the uniquely legislated role of physicians that makes most of them independent practitioners running businesses based on fee-for-service payments [3], in contrast to other care givers—like nurses—who are employees of organizations. However, in their organizational silos, nurses can also feel disconnected from other parts of the organization that have responsibility for patient care. It should come as no surprise patients become disoriented when they enter our fragmented non-system without a map and little clarity on where services are located.

This structural and functional fragmentation goes hand in hand with professional fragmentation, as an increasing number of subspecialties and programs are created. There are also multiple agencies representing the interests of nurses and doctors. Do they compete with one another for their members and for the attention of politicians? Do they act to protect the status quo of their profession at the expense of needed change? The answer to both questions, more often than not, is yes. It is tempting for professional bodies, health organizations and providers to look after their self-interest and performance, rather than to work in partnership with others for the benefit of all [4].

In both instances—at a micro or patient-care level and in macro systemic reform—LEADS is increasingly seen as an antidote to fragmented leadership across health care. It works in three ways: as a universal vocabulary for leadership action, by embracing distributed leadership for system change and by emphasizing the unifying goal of caring for one another and patients as the goal of health leadership.

LEADS as a Common Vocabulary for Leadership in Prince Edward Island's Health System

In July of 2010, Prince Edward Island formed a single provincial health authority, Health PEI, which assumed the operational services of the government's new Department of Health and Wellness. One board was created, and leadership development was united across silos—all facilities and practice areas. At that time, the LEADS framework was implemented by the senior leaders.

During these changes, a new clinical information system and a shift to a collaborative model of nursing were introduced simultaneously. The IT implementation and the introduction of collaborative care caused a lot of unrest in the system, requiring leadership for the change throughout the system. This example demonstrates that the LEADS framework works best when it is interpreted as a framework for both leadership development and as a model to implement change.

In April of 2018, in keeping with using LEADS as a common leadership vocabulary, the Medical Society of Prince Edward Island kicked off a custom, seven-month run of its Physician Leadership Development Program which is cross referenced with the Canadian College of Health Leaders' LEADS framework and prepares doctors to work with others in PEI's health system [5].

In the case of PEI, LEADS offers a simple and clear vocabulary for leadership that can be shared among clinical, administrative, and technical partners. This helps overcome the fragmented relationship that can exist between physicians and non-physician leaders due to their unique contractual connection to the system, as well as different mental models of each other's roles [6]. If leadership is a force to overcome systemic fragmentation, its language must reflect that. LEADS provides a common vocabulary for people trying to create an organizational culture that engages staff and makes them receptive to change and innovative practices [7].

The story below shows how Alberta Health Services is putting LEADS to work in a professional context to accomplish these goals (see Chap. 12 for further detail).

LEADS as a Common Leadership Language for Distributed Leadership in Alberta

Alberta Health Services (AHS) is the province-wide health authority responsible for delivering service to the population of Alberta. Presently, AHS is designing a leadership development institute based on the LEADS capabilities and adapted for different levels of leadership expertise, some for physicians specifically [8]. *Covenant Health, a faith-based health organization, also uses LEADS for its leadership development purposes.*

To build synergy with the work of these two delivery systems, the Alberta College of Family Physicians and the Alberta Medical Association decided to embrace LEADS in primary care. In 2016 the college sponsored a LEADS in-house facilitator program offered by LEADS Canada, to prepare 16 individuals—eight of them physicians—to develop leadership development facilitators that could act as a resource for the Alberta Primary Care Network initiative sponsored by the Alberta government.

The facilitators developed LEADS programming to support their colleagues in dealing with the challenges of integrating government policy, primary care physician needs, and the concept of a patient medical home (promoted by The College of Family Physicians of Canada) into primary care networks dedicated to improving patient care. The common language of LEADS helped network leaders engage with other leaders in Alberta Health Services and the ministry in discussing leadership issues.

The facilitators used their knowledge of LEADS to help develop provincial change agents and physician leadership networks to facilitate a number of improvement initiatives for network members. They also supported the networks in developing leadership skills in their teams to implement the Alberta's unique approach to primary care (Terri Potter. Executive Director, Alberta College of Family Physicians. Personal Communication, 5 May 2019).

Distributed leadership, promoted by the LEADS Framework, helps overcome fragmentation by releasing the considerable leadership potential of medical, nursing, and administrative staff [9]. Distributed leadership emphasizes the need for collaborative skills in leaders, and the responsibility of people, in formal and informal leadership roles, to take initiative [10–12]. The collaborative skills are also important for physicians and nurses in the context of patient- and relationship-centred care.

But perhaps the most compelling influence LEADS has against fragmentation is its emphasis on caring. Caring unites the efforts of physicians, nurses, and other health professionals through its appeal based on a common purpose, and each

profession's identity. An explicit emphasis on caring can unite professionals across what might otherwise be fragmented scope and practice boundaries. Care is a shared value and strong motivator that binds and connects everybody involved in the health care system (see section below on caring, empathy and burnout).

Challenge Two: LEADS for Professional Engagement and for Wellbeing of Health Professionals

Both doctors and nurses have been central to health care from the beginning, although they took different routes to the roles they play today. Physicians began as independent practitioners in the days of barber-surgeons and barber-apothecaries and weren't integrated into institutions until the mid-twentieth century [13]. Nurses, on the other hand, essentially created health care institutions: hospitals started as hospices where people went to die, and both the nursing and administrative components were offered by religious groups, mainly nuns [14].

Because nursing evolved from that original group of caregivers, nurses have been more engaged in the health care system from the beginning. While the nurses were *caring* inside the hospitals, the physicians were *curing* outside the walls of those institutions. But as more and more complex equipment and technology were needed to diagnose and treat patients, physicians increasingly needed to have a connection with at least one hospital.

It's only in the last few decades that physicians have, somewhat unwillingly, become full participants in the entire health system and they've done so without historical or cultural knowledge of how that engagement might work. From this historical and cultural perspective, it is understandable physicians often perceive their accountability is to the patient first, their profession second, and to the organized health care system third—if at all.

LEADS and Professional Engagement

For centuries physicians were considered leaders by virtue of their profession and standing in their community, but they had no background or training in leadership [15]. Today, in response to the changing demands in the field, medical leadership is undergoing a paradigm shift from its traditional role to one founded on collaborative leadership and administration [16]. At the end of the twentieth century, the medical profession came to a turning point due to two related concepts: quality control and leadership. Evidence shows a link between these two concepts for physicians: studies have found physicians are more likely to become engaged in health system reform if they take on leadership roles in quality improvement initiatives [8, 17, 18].

In Canada, several recent reports have highlighted the importance of physician leadership and engagement for health care reform [7, 19, 20]. According to the Canadian Society of Physician Leaders, physicians have a unique place and

responsibility in the delivery of universal health care, and efficient and effective reform cannot happen without their active and willing participation. As a result, leadership development has become a priority [7, 21–23].

Similarly, leadership from nurses is vital in terms of shaping and influencing processes, procedures, and practices for optimal patient care, whether those decisions are made in the corporate office or on the front-line or care delivery: [24, 25] nurses "…must engage with physicians and other health care professionals to deliver efficient and effective care and assume leadership roles in the redesign of the health care system" [26].

Spurgeon and colleagues defined physician engagement as a two-directional social process where the organization must reciprocate the engagement of individual physicians with high quality care by putting in place opportunities and processes for physicians to participate (Fig. 15.1) [27]. This model can be extrapolated to include nurses, although it has not been validated by research in that context.

This model of professional engagement contains two dimensions: individual capacity which reflects skills leading to increased self-efficacy and personal empowerment to tackle new challenges (the horizontal axis of Fig. 15.1), and organizational opportunities reflecting structural, political and cultural conditions that facilitate doctors becoming more actively engaged leadership activities (the vertical

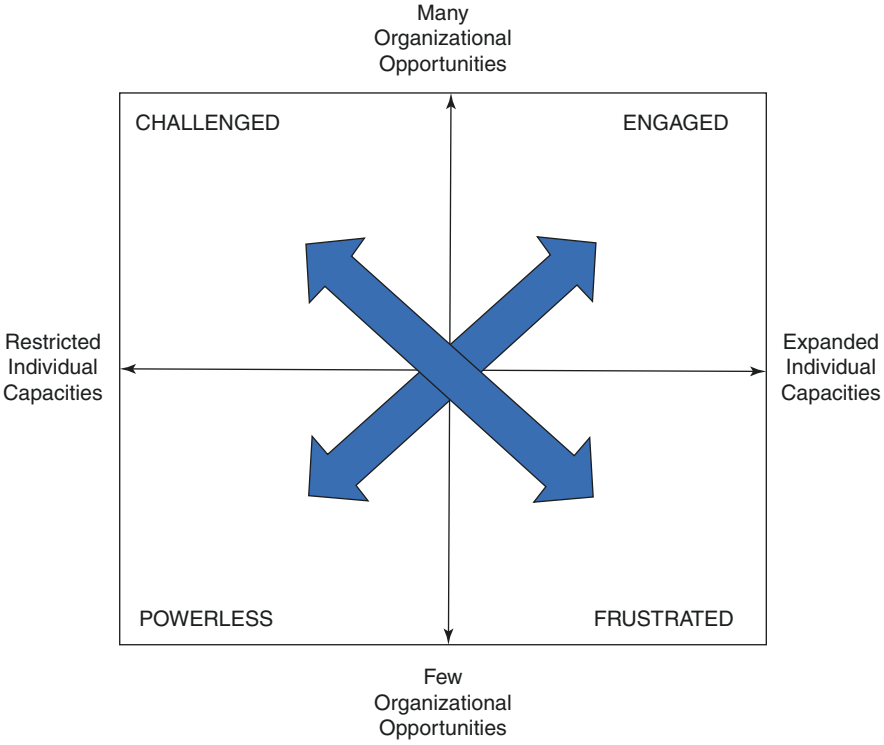

Fig. 15.1 The Spurgeon model to guide improvements in professional engagement [27]

axis of Fig. 15.1). Depending on what conditions are missing, professionals can feel powerless, frustrated or challenged.

Spurgeon's research showed that engaged physicians are positively associated with organizational quality [28]. In the NHS, the introduction of the Medical Leadership Competency Framework [29] together with organizational opportunities to be engaged, has led to improved medical engagement scores and better outcomes, including lower mortality rates and fewer patient safety incidents. Once doctors become engaged throughout the system, the scores for patient experience improve as well, as was seen in Cleveland Clinic [30]. Although studies do not directly use the Spurgeon model in relation to nurses, there is evidence validating the importance of nurses feeling engaged [31, 32].

Learning how to lead is fundamentally important to Spurgeon's construct of developing individual capacity. According to the 70/20/10 concept of blended learning [33], 10% of learning takes place in the classroom by knowledge transfer and formal learning [34], the *knowing* or expertise component of learning leadership. Twenty per cent of learning leadership comes from a variety of activities that include social learning, mentoring and coaching. The 70% share comes from hands-on-experience [35], in the form of challenging assignments [36] comprising the practice and acquisition of skills derived from the classroom knowledge (sometimes in simulated situations) [37].

The LEADS framework, the 70/20/10 approach to learning, and the Spurgeon model can be integrated to explain how to engage physicians and nurses: when everybody who works in an organization has leadership skills and opportunities to use them, true engagement happens. While an individual's ability or capacity increases an individual's 'can do,' organizational opportunities improve personal motivation and the 'want to do.' The LEADS framework provides a set of expectations and standards that can be used both to guide leadership development for individuals (Lead self, the horizontal axis of Spurgeon model) and for organizations (other LEADS domains for the vertical axis) by embedding leadership practices reflective of the framework "in action" (see Fig. 15.2).

By following LEADS practices, opportunities for professionals to engage are enhanced. For example, evidence indicates increasing the percentage of doctors on boards has a positive impact on organizational performance and improving patient experience [37]. Other examples of organizational opportunities include quality improvement initiatives [18] or incorporating professionals in the provincial health care governance structure, as the province of Saskatchewan in Canada has [38]. Embedding opportunities for engagement in organizational structure is important (vertical axis of Fig. 15.2). Professionals who learn LEADS capabilities are also motivated and able to take on organizational opportunities because they have the skills to do so (horizontal axis of Fig. 15.2). When both work together the professional's engagement increases, and more clinicians move into the right upper quadrant of the model.

St. Joseph's Health Care in London, Ontario has LEADS-based leadership development programs for all staff, including nurses and physicians—although for the latter, the leadership development program is a hybrid between the CanMEDS 2015

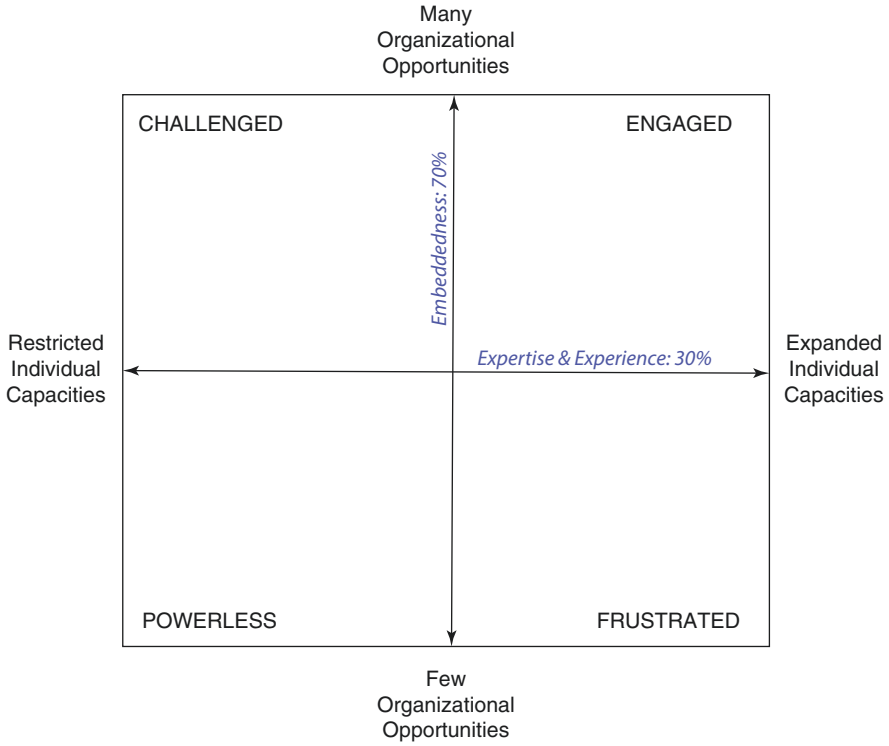

Fig. 15.2 Clinical engagement model and blended learning (Modified from Spurgeon et al., 2008) [27]

role of Leader [39] and LEADS. It's designed for three levels of physician leadership: entry level for newly recruited physicians, mid-career level as part of talent management, and executive level. The following vignette explains the St. Joseph approach in greater detail.

Three Levels of Physician Leadership Program at St. Joseph's Health Care

About 15 years ago, Dr Gillian Kernaghan, President and CEO of St. Joseph's Health Care, helped develop a leadership program in collaboration with Western University, where many physicians have cross-appointments. LEADS capabilities were used to develop performance evaluation tools in order to individualize the development of each physician's leadership skills. As a result, the organization's culture is one of ongoing learning and evaluation: LEADS-based self- and 360-evaluations are used to review goals, strengths and areas for growth, aligned with templates for role descriptions. There are three levels to physician leadership development.

The Foundational Leadership Series (entry level) has to be taken by all newly recruited physicians during their first three years. Its focus is on self-development, knowledge and skills, including running efficient meetings, ethics, career development, finances 101,

and working in a unionized environment. To ensure the series meets needs, the content and delivery are tweaked based on feedback to questions like "What do you know now that you wished we would have told you when you started?" This level corresponds to the Lead self, Engage others and Achieve results domains of LEADS.

The Talent Management System (mid-level) runs in collaboration with the university. It is appropriate for site chiefs, divisional leaders, program leaders, associate deans—middle management roles. In talent management, self-awareness and self-management are further explored, along with engaging others through teamwork and collaboration, strategic thinking and planning and systems theory. This level of the leadership development covers all five domains of LEADS. Templates with role descriptions of physician leaders are complemented with a list containing the skills and LEADS capabilities that are required for different leadership roles. St. Joseph Health Care also uses a recruitment tool that maps candidates' LEADS capabilities against the capabilities needed for the position they're applying for.

The Executive Level of the development program is designed for the departmental chairs, Medical Advisory Committee chair, vice-dean and medical directors of large programs. Talent management, including succession planning, and leadership development are all integrated. The self-assessment and 360s are used as part of succession planning—for example, the capabilities of a physician being considered for a job are compared with the LEADS capabilities required for that role. In collaboration with Western University's Ivey School of Business, physicians can do leadership projects, including quality improvement initiatives, in their organizational environment. This approach reflects the vertical axis of the physician engagement Spurgeon model.

Dr. Kernaghan says "LEADS has given our organization a framework for leadership development and physician engagement," adding "A framework is all very good, but it's what you do with the framework and how you embed it in the organization that makes the difference."

Leadership, LEADS, Psychological Well-Being and Burnout

A recent Institute for Health Improvement paper on well-being at work emphasized that workers are unlikely to become engaged if they don't feel psychologically safe in their workplace [40]. Figure 15.3 shows a continuum of psychological states from engagement and leadership at the top to burnout at the bottom. Without trust or psychological safety health care workers won't engage, instead descending into change fatigue and moral distress, ultimately leading to moral injury and burnout.

As the evidence makes clear, burnout is a growing problem: physicians, nurses, pharmacists, residents, and medical students are increasingly struggling with high levels of stress, which is a key precursor to burnout [41–46]. Burnout reduces work effort by professionals [47] and leads to more mistakes and lower quality of care. Burned-out doctors order more unnecessary tests, prescribe more unnecessary drugs, have a negative impact on team satisfaction, and provide less empathetic care [51].

Physicians' wellness also suffers when they can't provide the quality of care they want to because of system limitations [48]. While personal characteristics like perfectionism were originally identified as the main reasons for burnout, more recently organizational and systemic factors are getting the blame [49]. The main causes of burnout are embedded in the structure and culture of

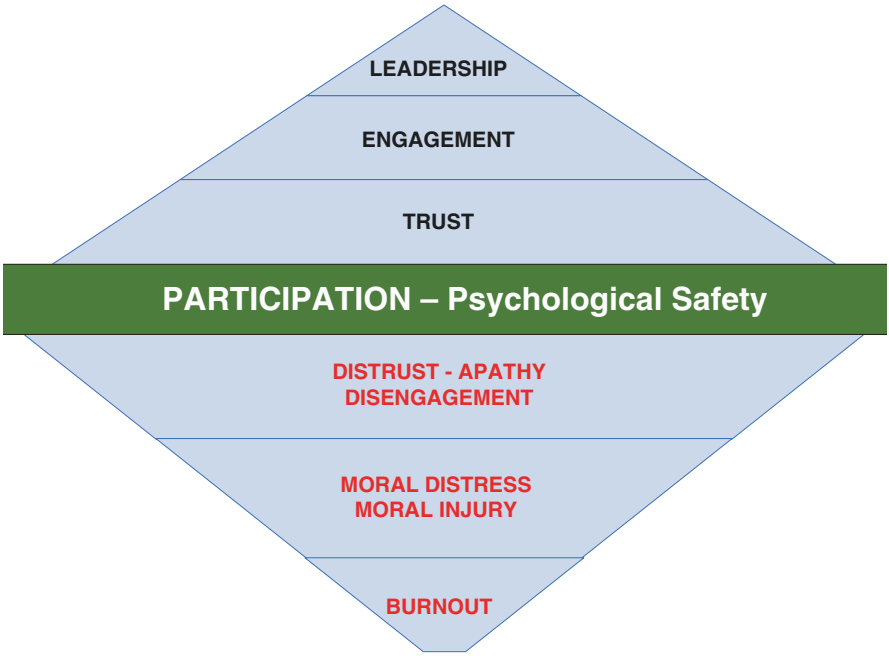

Fig. 15.3 Degrees of engagement and psychological stress in the health care system

organizations. That in turn creates conditions that clash with the personal and professional values of physicians and nurses. Trying to care for people in the face of increasing limits on resources results in a demoralizing misalignment between professional values and meeting patients' needs, for reasons that are beyond an individual professional's control [49]. Paradoxically, the introduction of electronic health records, which were supposed to improve patient care, has led to widespread complaints from physicians that they reduce the quality of physician-patient interaction, leading to less satisfaction and more burnout [50].

Chen and Chen identified leaders' ineffectiveness and lack of emotional intelligence as a major contributor to nurses' burnout. Contrarily, leadership effectiveness and positive emotional intelligence reduce burnout [51].

Two specific LEADS capabilities should help leaders to deal with the burnout raging through health care. The Lead self domain calls for leaders to model self-care by taking responsibility for their own health, which is as important for employees to see as it is for the benefit of the individual leader. One of the Engage others capabilities is to contribute to the creation of healthy organizations; i.e., changing so people have the resources they need to do their jobs encourages engagement [52].

Other suggestions for supporting the mental health of physicians include work from the Massachusetts Medical Society, the Massachusetts Health and Hospital Association, together with Harvard's School of Public Health and Global Health Institute. They suggest organizations should, in the short-term, improve access to

staff support offices which provide health and mental health assistance and resilience learning [53–55]. Medium term, they say, organizations can increase physician engagement in design, implementation and customization of electronic health records and promise to reduce the burden of documentation and measurement they place on physicians (LEADS has been used successfully in the design and implementation electronic health records) [56]. For the long term, they recommend improving resources for patients and appointing chief wellness officers to study and monitor staff wellness as a quality of care issue. This proposal to use individual and systemic tools for wellness resembles the horizontal and vertical axes of the Spurgeon model for embedding leadership and leadership development throughout the system, using LEADS as an instrument (Fig. 15.2).

Based on two decades of research in organizations in the U.S.A., Amy Edmondson has created frameworks to create psychological safety in the workplace for learning, innovation and growth [57]. In Canada, LEADS was mapped against the National Standard for Psychological Health and Safety in the Workplace and can be used as a framework to improve psychological safety for all who work in the health care system [58].

Challenge Three: Distributed Leadership to Foster Diversity and Equity in the Health System

Equity and diversity inside and outside health care are receiving increasing attention recently, including issues of gender, inclusion of patients and their advocates, ethnicity, and age [59–62]. All affect the professions but this section focuses on gender challenges for leaders in health professions, including creating equity among professions and roles through distributed leadership. Generally, gender issues in professional communities focus on female nurses and doctors struggling to be well-represented in leadership roles [63–68]. One 2018 literature review found gender discrimination limits women's potential for seniority and leadership and said gender gaps in modern health organizational leadership are driven by stereotypes, discrimination, power imbalance and privilege [69]. Carolyn's story, below, speaks to gender issues faced when female nurses move into leadership roles.

Challenging Stereotypes: A Nurse's Story

Carolyn Pullen is the chief executive officer of the Canadian Cardiovascular Society with a Ph.D. in nursing. This is her story of challenges with diversity.

> *My early experience in formal leadership was as a young adult leading extended canoe trips in the high Arctic. I grew into this summer job naturally, coming up the ranks in Canada's tradition of summer camps and gaining the required skills, certifications and experience. However, leading self-sufficient groups of high-paying customers on northern rivers characterized by challenging white water, extreme weather conditions, and an*

abundance of bears is typically seen as a role for males. When corporate clients disembarked from float planes at the headwaters of a wild river, I imagined their reaction would be "Where's the larger-than-life, burly, hairy, six-foot guy in whom I will place my trust and safety?"

To address this self-imposed credibility problem, I felt I needed to demonstrate traits I perceived as more typically male: boundless confidence, strength, and bravado. In short, I tried to act like a guy. I tried on personas that told brave tales and bawdy jokes. I carried loads across portages that weighed more than I did. Before long, I realized I felt uncomfortable playing an inauthentic role, and I got a really sore back!

Furthermore, I overlooked the fact that no one—not the clients, my male colleagues, or my employers—expected me to be anything other than what I was: a collaborative, capable young leader. I was slow to realize it was my differences they valued: a calculated approach to managing risk, strong interpersonal and team-building skills, expertise in northern flora and fauna, etc.

In addition, the company owner and longest-serving guide was a woman—a diminutive, calm, solid leader. She subtly suggested she understood my position and would share insights and model ways to lead from the seat I occupied: a female leader with unique strengths who enhanced the diversity of her team. She shared tips for doing the physical aspects of the job in a way that didn't require herculean strength (e.g. finesse over brawn). She demonstrated confidence in her abilities and her role and was effective and thoroughly acceptable to our high-adventure clients. She helped me understand that, in a stereotypically male role, it is fine to be a female and be yourself. I went on to be among the longest-serving guides for the company, leading dozens of high Arctic expeditions, often as the solo guide.

This learning translated well into my career in health care. As a developing leader, nurse leader and new CEO I have found support and sponsorship from female and male leaders alike. It is the connectors, collaborators and strong communicators, regardless of gender, who embody highly effective leadership. I believe in drawing fully from a broad cross section of perspectives and styles to leverage diversity across genders, generations and geography to develop and bring the most talent to tackling our wicked problems in health care. Today, I strive to intentionally lead highly collaborative and inclusive teams and I have those northern trips to thank for this insight.

Carolyn's story emphasizes the mental shifts required to realize one's potential to be a leader. She needed to be aware of her own assumptions, as the first capability of the Lead self domain says. If she had not challenged her own notion of who is a leader and who is a follower, she would not have recognized her own leadership. Similar changes in thinking are required to confront equity and diversity challenges in the professions. An effective multidisciplinary team, for example, needs leadership to be distributed amongst the professions [9]. West et al showed teams that share responsibilities decrease age-standardized deaths after emergency surgery by 275 per 100,000 [70]. But effective teamwork can't be achieved unless the stereotype of physicians as leaders and nurses as followers is eradicated (see Chap. 2: Build teams).

There's also an equity issue in the views administrators and physicians have of each other. It's common for doctors to see administrators as getting in the way of their care for patients, while administrators often see doctors as impediments to system change. Essentially physicians see themselves as advocates for each patient's care, while administrators advocate for all patients [6, 71]. Solving this requires the two groups to share their talents in a distributed leadership model, which could be helped by more emphasis on dyad models where physicians and administrators are

paired to work together [72]. Efforts to distribute leadership on teams can benefit from the Lead self, Engage others and Achieve results domains, while the work between physicians and administrators requires the capabilities of all five domains of LEADS.

Leader-follower similarities can also be seen in the doctor-patient relationship, which has evolved from profession-centred to patient-centred, and which will have to evolve into relationship-centred care, focused on the relationship between patients and the teams that care for them [12]. Because the primary purpose of the health care system is to respond to the needs of the patient, the process of real engagement of patients and citizens for their care in the system can only occur through relationship-centered care based on distributed leadership and effective followership. This is a delicate dance between all engaged partners.

One of the prime leadership functions of LEADS is to address issues around integration of care. Use your knowledge of LEADS to analyze how distributed leadership and effective followership could have resolved the disconnected care that led to the disastrous and unfortunate death of Greg Price [73], described in the following Learning Moment.

Learning Moment: Greg's Wings

Greg Price was in his early thirties when he died following a series of health care mishaps, mainly caused by poorly coordinated communication and no continuity of care. As a result, instead of being cured of testicular cancer that was detected early, he died two years later. It was a prime example of a complete lack of continuity of care or shared leadership.

In the first six months after his death, Greg's father and his family connected with the Health Quality Council of Alberta (HQCA), an organization designed to measure, monitor and survey the health system in Alberta. Following the study by the HQCA, Dr. Ward Flemons, the lead on the report approached the Price family about turning Greg's story into an educational film, with the intent of using the finished product to reinforce the importance of teamwork, shared leadership, effective followership, and communication in the health care system.

Falling Through the Cracks: Greg's Story [73] explores Greg's journey through the health care system, noting the lapses in communication and breaks in the continuity of his care. The movie has won several awards. It is not just shown to people inside the health care system, but also to the public across the country; more than one hundred times in the first year alone. It stresses the importance of public engagement when it comes to effecting change in the health care system. In a relationship-centred context, patients want greater involvement in their care, they want to participate in making decisions about that care and they want to know that things are moving along at a reasonable pace.

Greg's Wings, the non-profit organization behind the movie, has demonstrated two things that relate to shared leadership:

1. Greg's death is an example of failed continuity of care due to an inadequate information system and lack of distributed leadership or effective followership.
2. By engaging people inside and outside the health care system, the Price family and Dr. Flemons demonstrates how patients, the public and the health care workers can change relationships with the health system. By practising the delicate dance between shared leadership and effective followership, the Price family and the health care workers alternate roles toward the common goal of optimizing continuity of care.

LEADS was not part of Greg's care, but his story shows the possibilities of distributed leadership and effective followership.

EXERCISE: Reflect on how the LEADS domains might have influenced what happened before and after Greg's death.

Challenge Four: LEADS as a Pathway to Develop Professional Leaders

How can LEADS be used to embed life-long leadership learning for physicians, nurses and other health professionals into the structure and culture of organizations and the health system? Efforts by physician- and nursing-education bodies in the UK, Australia and in Canada (using LEADS) are models for developing leadership in the professions.

Blended Learning Approaches to Leadership Development

Earlier, the concept of 70/20/10 model of blended learning was mentioned as an essential part of developing individual capacity. The model combines formal learning with workplace and informal learning opportunities. The following story shows how the Holland Bloorview Kids Rehabilitation Hospital put LEADS to work through that kind of blended approach.

Putting LEADS to Work in Leadership Development

The Holland Bloorview Kids Rehabilitation Hospital in Toronto, which employs about 1,000 people, has developed a 90-minute session for each of the twenty LEADS capabilities. Because resources, particularly time, are limited, participants have welcomed the 90-minute

sessions at the hospital. Knowledge, relevance and potential application are explored for each capability in an integrated real-life way, to make them easier to translate into the workplace. This is where many leadership training programs stop—staff go back to work, where the culture doesn't make using their new skills easy, and the effort is soon dropped.

However, Holland Bloorview follows up the training sessions with real-time coaching and 360 evaluations to help leadership learners try out and develop each capability on the job.

If education and training are about the *what* of leadership, then the 70% is about *how* to lead. That 70% should take place in the organization through action learning such as day-to-day activities and problem solving [34, 35] (Fig 15.2).

Talent management and succession planning are part of the structure and culture of a learning organization and should be integrated into the development of professional leaders [12]. Adopting LEADS would make talent management and succession planning consistent across organizations and indeed an entire system.

Using LEADS to Increase the Quality of Leadership in the Professions

With the release of *To Err is Human: Building a Safer Health System* by the Institute of Medicine in 1999 [74] (which estimated between 44,000 and 98,000 people died annually in the U.S.A. from medical errors), physicians had no choice but to become engaged in quality control and leadership. That drove medical leadership to leave behind the traditional autocratic role physicians played and shift to more collaborative clinical and administrative leadership. Many were not ready for the change: physicians traditionally did not get any leadership or management training because they were automatically considered leaders by virtue of their profession. But without evidence-based best models of effective leadership, the evolution has been "anything goes!" Doctors learn by observing others or on the job [15].

To counter this phenomenon in 2015, Canada's Royal College of Physicians and Surgeons changed the CanMEDS manager role into a leader role [39, 75]. This has given rise to LEADS-based physician leadership development both in Canada and abroad.

LEADS in the Nursing Profession

The LEADS framework has been adopted by the Royal College of Physicians and Surgeons and the College of Family Physicians of Canada, which is developing a curriculum to align the competencies of the CanMEDS 2015 role of leader with the LEADS framework.

The Physician Leadership Institute under the umbrella of the Canadian Medical Association, and with the support of the Canadian Society of Physician Leaders, organizes its professional development leadership courses according to the LEADS framework (Fig. 15.4).

There's also a Canadian Certificate for Physician Executives, awarded by the Society of Physician Leaders based on achieving certain educational requirements

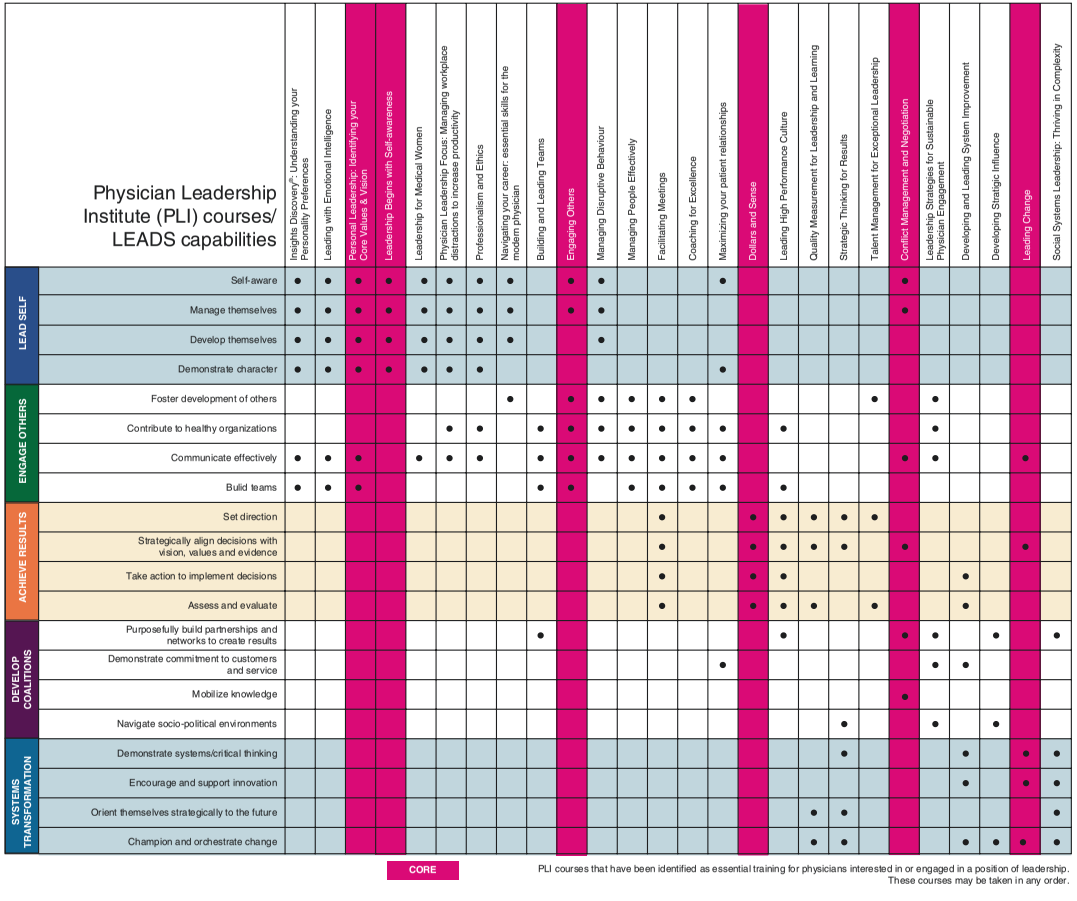

Fig. 15.4 LEADS as a foundation for Physician Leadership Institute courses (Used with permission from the Physician Leadership Institute, Ottawa, 2019 Sep 19)

and senior leadership experience (which must include all LEADS capabilities) [76]. *The certificate must be renewed every five years through the same rigorous process.*

The shift from manager to leader has also spurred changes in medical education. For example, the Association of the Faculties of Medical Education in Canada [77] *states: "Medical leadership is essential to both patient care and the broader health system. Faculties of Medicine must foster medical leadership in faculty and students, including how to manage, navigate, and help transform medical practice and the health care system in collaboration with others."*

LEADS is also being introduced into the curriculum for nurses, as the following example shows:

The Canadian Academy of Nursing was established in 2019 by the Canadian Nurses Association (CNA) as the first pan-Canadian organization dedicated to identifying, educating, supporting, and celebrating nursing leaders across all the regulated categories and all domains of practice. The Academy will build a comprehensive Canadian hub designed to educate, empower and support nurses to lead, advocate, innovate, influence public policy and create sustainable change.

The LEADS framework — and along with principles of Strengths-Based Nursing Leadership, will serve to ground the work of the Academy. All CNA staff participated in one-day Bringing LEADS to Life team development sessions (2012) and the LEADS Capability Framework is used currently in personal performance measurement for the chief executive officer.

As the Academy activity ramps up in 2020, we will reference LEADS in spearheading the development of core capabilities and competencies for nursing leadership in Canada, including capabilities in diverse domains such as nursing administration, informatics and policy. In addition, the Academy will serve as a repository for a comprehensive roster of leadership development programs for nurses including post graduate degree programs in universities, certificate programs and professional development initiatives offered across Canada and beyond.

As of 2020, the Academy of Canadian Executive Nurses and the highly successful Dorothy Wylie Health Leaders Institute both sit within the Academy. The Dorothy Wylie residential program delivers a concentrated program of study of leadership principles, models, behaviours, skills and tools that align strongly with key capabilities of the LEADS framework. The CNA's popular workshops focused on policy leadership and change management also speak to key capabilities under the LEADS framework and will be offered through the Academy going forward.The Canadian Academy of Nursing was established in 2019 by the Canadian Nurses Association (CNA) as the first pan-Canadian organization dedicated to identifying, educating, supporting, and celebrating nursing leaders across all the regulated categories and all domains of practice. The Academy will build a comprehensive Canadian hub designed to educate, empower and support nurses to lead, advocate, innovate, influence public policy and create sustainable change.

LEADS can also be useful for feedback and accountability, both for learning and in organizations. The Health Standards Association of Canada, which runs Canada's accreditation processes, calls LEADS a guide to assist organizations in developing the standards of leadership assessed for accreditation [78].

International Examples of Professionalizing Physician Leadership

A great example of how LEADS can be integrated in resident education is Sanokondu [79], a non-profit, international collaboration of health leadership educators and organizations with interest in health leadership development. A set of modules portraying real clinical scenarios was developed for residents and preceptors, based on the five domains of LEADS and several of the CanMEDS 2015 roles, mainly Leader. Sanokondu has made those modules available free of charge online [80].

The two-year fellowship program from the Royal Australasian College of Medical Administrators in Melbourne, Australia is one of the best examples of a professionalized leadership degree for physicians [81]. According to Karen Owen, the organization's immediate-past CEO, "When the role of leader was introduced in parallel to that of manager one decade ago, LEADS was used as the framework and it allowed [us] to articulate the curriculum and courses for the role of leadership" (Personal communication, 2019 Mar 27).

Progress toward professionalization is also being made in England where the Faculty of Medical Leadership and Management has developed Leadership and Management Standards for Medical Professionals [82]. The standards are articulated as a set of core values and behaviour designed to work across all career levels. Interestingly, the standards are strongly related to the LEADS framework outlined in Chap. 3. The Faculty of Medical Leadership and Management believes an effective medical leader is defined by how and what they do, underpinned by why they do it. The faculty has introduced a fellowship program it hopes is the beginning of a professionalized leadership learning program. Younger doctors are particularly interested in taking the program, which they see more and more as part of their clinical work and career development.

To take a final example, the LEADS framework and the PLI program structure have also been influential in shaping the National Physician Leadership Training Program in Israel. After exploring the American and Canadian program structures, and after two years of consultation and dialogue with physicians, the Israeli project team chose the Canadian framework. Israel's five core competencies are

similar to the LEADS capabilities: e.g. “team engagement” correlates with Engage others; “from vision to workplan” corresponds with Achieve results; and “forming collaborations” aligns with Develop coalitions. They don’t yet have a module dealing solely with System transformation, but the capabilities are being introduced into other training modules. “The LEADS framework will definitely continue to serve as a compass for the continued development of of our directors’ training program”, says Dr. Oren Tavor, Project Director (Personal Communication, 2019, Sept 11).

In conclusion, LEADS can provide a set of standards for guiding development that will professionalize leadership in the health care system, for the individual and for organizations. Just as CanMEDS 2015 provides a framework to standardize professional competencies for medicine, LEADS can serve as a similar model to standardize leadership capabilities.

Summary

In Canada, many health care organizations, including medical, nursing and administrative organizations, have endorsed LEADS. As a common vocabulary and a set of leadership standards, LEADS can provide many benefits to health professionals in general and to the physician and nurse communities specifically. By working together and using LEADS as a common framework, health organizations can embed leadership development in the structure and culture of the Canadian health system. LEADS provides a simple entry point to understanding the research and evidence base behind best practices of leadership. It can help unite stakeholders with a collectively accepted understanding of leadership and encourage adoption of the leadership behaviour needed for health system sustainability and transformation. Finally, LEADS can be used to improve wellbeing and reduce burnout among all health professionals.

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