Pathway to Professionalization of Health Leadership

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Do not die in the history of your past hurts and past experiences, but live in the now and future of your destiny.

Michelle Obama

Michelle Obama's quote could have been about the future of both modern health care systems and of the leaders who will create them. Modern health care systems are full of hurts and difficult experiences and newspaper headlines reflect pressure for change: "Review ordered after Nova Scotia man dies waiting for hospital transfer;" "Researchers aim to find solutions to 'hallway medicine' in hospitals;" and "Ontario inspects health care facilities in 'blitz' to curb workplace violence" [1]. But, as the stories in this book suggest, health care is also full of examples of caring, compassionate and efficient service. Leadership's job is to replace the former with the latter. Achieving the goals of seamless service, healthy workplaces and efficient and effective transformation of health systems is the territory of leadership and the job of leaders. Therefore, instead of dwelling on hurtful experiences, and giving up on the job, leaders need to learn from past mistakes while scaling up and spreading successful innovations and stories.

In Chap. 9 we quoted John F. Kennedy saying the essence of leadership in modern society is learning. That was a theme we introduced in Chap. 1 and kept returning to in subsequent chapters. We also emphasized the importance of learning personal and organizational leadership in Chap. 4, advocated for the capability of self-learning in Chap. 5, introduced the four capabilities of Achieve results as an

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G. Dickson, B. Tholl (eds.), *Bringing Leadership to Life in Health: LEADS in a Caring Environment*, https://doi.org/10.1007/978-3-030-38536-1_16

ongoing learning cycle for organizations and systems in Chap. 7 and stressed how coalitions should be used for learning in Chap. 8. In Chaps. 10–15 we outlined what we've learned about LEADS as a change model and invited other authors to share their knowledge of putting LEADS to work in different ways in different contexts.

In this, the final chapter, we share macro lessons we gained writing this book. And since the point of learning is to understand the world around us better and appreciate its beauty and challenges more, it's our job as leaders to use what we've learned to improve our world. We're concluding by summarizing the steps we as leaders can take to improve our leadership—and subsequently the health and wellness of the public we serve.

Lessons About Health Leadership, LEADS and Making a Better System

Leadership in health care is about accomplishing three key functions: integrating care for patients and families, creating healthy and productive workplaces and changing the system to respond to environmental pressures and population needs. Leadership is not the person or the position: it is a responsibility shared by those who choose to lead. We lead from where we are and who we want to be.

We defined leadership earlier 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." This definition, when operationalized in context, in Canada, became the LEADS in a Caring Environment capabilities framework.

This second edition of our book has five themes: the importance of learning to effective life-long leadership; how LEADS has been put to work in Canada and Australia; the importance of caring as a driving force of health leadership (including equity, diversity and inclusion), how context fundamentally affects leadership, and the significant advances made in leadership and leadership development as chronicled in the research literature and grey literature: i.e., in Canada, Australia, England, Scotland and New Zealand.

A review of the chapters considering these five themes highlights five key lessons for us. They are:

1. LEADS works.
2. Caring leadership is gaining ascendancy in modern health systems.
3. Context shapes leadership.
4. The speed of change demands a culture of leadership.
5. It's time to professionalize health leadership.

LEADS Works

The reader is not likely to be surprised we make this claim. After all, the purpose of the book was to provide a five-year retrospective on ways the LEADS in a Caring Environment capabilities framework (and its Australian counterpart) have been put

to work to deal with service integration, healthy workplaces and meaningful health reform. The stories and the vignettes interspersed throughout and the chapters, where leaders of all stripes testify to how LEADS can contribute to their leadership and to developing others, testify to that.

We've looked at LEADS being put to work at different levels of responsibility, ranging from deputy ministers, board members, chief executives and front-line leaders, to informal caregivers. The construct and face validity of LEADS have been independently reaffirmed in Canada and in other jurisdictions. But we cannot assume the framework is inviolate; we must always be open to adapting it to changes in context and circumstance.

LEADS works, we think, for three main reasons. First, the effort to use it has been a collaborative effort, engaging many leaders in shaping how it can and should be used. By emphasizing leadership without ownership and ownership by all (distributed leadership), our LEADS work has become an invitation to participate in an important and inclusive project aimed at improving Canada's health system.

The second reason LEADS works is the willingness of leaders to stick with it. A few people who initiated the work have kept promoting it, keeping its values and vision alive and (in the spirit of losing control, discussed in Chap. 9), trusting others to join in. It has helped that organizations have resisted the urge to develop their own frameworks, instead accepting the argument that a common leadership vocabulary will contribute to better integrated health care across the country.

The third reason is the integrity of the LEADS framework and the belief systems behind it. People accept the framework is an expression of the fundamental practices of good leadership and that those practices must reflect the person you are as a leader, and be adapted to the context in which you work.

The Ascendancy of Caring Leadership

The concept of caring leadership—central to the LEADS framework—is spreading, which can be seen in both grey literature (primarily out of the UK), and published leadership literature more broadly. Its impact across Canada is reflected in the LEADS stories we've collected and in the relationship between the LEADS framework's desired leadership practices and the goal of creating healthier workplaces.

In the UK, articles such as "Collaborative and compassionate leadership" [2] and "Caring to change: how compassionate leadership can stimulate innovation in health care" [3] show a growing emphasis on creating healthier workplace cultures; and this emphasis is reflected in efforts by the NHS England and NHS Scotland to support leaders becoming capable champions of creating healthy workplaces. In business, some authors have also emphasized the importance of compassionate and caring leadership [4–7]. The emphasis we put on mindfulness in Chap. 5 resonates with this view of compassionate leadership [8] and recent systematic reviews of leadership theory highlight the growing influence of transformational (empowerment) and moral theories of leadership (distributed, authentic, servant, ethical, spiritual) and their positive impact on workplace cultures and productivity [9–11].

The growth of a caring ethos in health leadership may well be because evidence shows many health workplaces are surprisingly unhealthy, and unhealthy providers

cannot provide optimum patient and family care. The discussion of healthy workplaces in Chap. 6, the alignment of LEADS to the National Standard for Psychological Health in the Workplace discussed in Chap. 10 and the struggles doctors and nurses have with burnout outlined in Chap. 15, all demonstrate the point.

The emphasis on caring and compassion also fuels a growing desire for greater diversity, equity and inclusion in the ranks of health care leaders, for two reasons. First, it can be difficult to understand a group's needs when you have not experienced its issues. Diverse role models are therefore required—as Nelson Mandela said "if you talk to a man in a language he understands, that goes to his head. If you talk to him in his language, that goes to his heart." Chapter 14, on leadership viewed through the two-eyed seeing of Indigenous culture, underscores just how important it is for non-indigenous leaders to speak the language of the heart—in the spirit of Wichitiwin (working together from the heart).

A second reason for the ascendency of a caring culture across health systems is the value of fairness implicit in caring. Our invited authors and case studies and stories tell us LEADS helps attain the twin goals of fairness and equity. A significant majority of stories and vignettes—highlighting the use of LEADS—feature women leaders. This was not by design, it's just what we found. Clearly LEADS is particularly appealing to women who aspire to leadership roles. Dr. Ivy Bourgeault put it this way:

> *LEADS is empowering. The framework helps lift leaders and leadership up. It helps women leaders to lead from where they are and who they are; to effect change from where you and your colleagues are on the ladder of leadership.*
>
> *Building on the LEADS premise of shared leadership, we have also learned the more you let go (for example in working with Indigenous health leaders), the more you are able to accomplish together.*
>
> *Because it is strength-based and capabilities-based, rather than competency-based and focused on shoring up weaknesses, I think LEADS has been particularly emancipating for women health leaders across Canada.*
>
> *I think women are really good at acknowledging and dwelling on their weaknesses and not nearly as good at recognizing and building on their strengths. If a senior leadership job comes open with ten boxes to tick and a woman believes she can't tick all the boxes she is far less likely to apply than a male colleague who realizes he might only tick half the boxes but still applies and then gets the job.*

Chapters 13–15 also highlight the need leaders have to understand and care about the perspectives of diverse groups—patients, families and citizens, Indigenous populations, and health care professionals—in order to get them actively engaged in their care and improve the health care organization or system. Chapter 13 featured the patient's perspective, challenging leaders' notions of where organizational boundaries are, and encouraging all of us to expand those boundaries so patients and families can be part of planning and operations, not just recipients of care. If we truly care about the welfare of patients, families and citizens, we will commit to engaging them meaningfully in shaping the health systems of the future. We will also seek to become advocates for those who do not have a clear voice. In Chap. 8 we feature how we can all be allies in giving voice to the voiceless or the disenfranchised in health care systems. Chapter 14 lays out the raw and deeply disturbing

challenge facing leaders trying to improve health conditions in Indigenous communities: having to rebuild trust with peoples who have experienced decades of paternalistic abuse. In this chapter Dr. Alika Lafontaine, Caroline Lidstone-Jones and Karen Lawford describe how LEADS can be translated to hold all of us more accountable for being more culturally responsive. Chapter 15 outlines the need to care for our providers: to recognize their unique needs by creating healthier workplaces, and to invite them—through LEADS—to be real partners in our leadership efforts.

Context Shapes Leadership

Beginning in Chap. 2 and throughout the rest of the book we have emphasized what the recent literature on leadership is telling us: context shapes how leadership is practiced and developed. Context is created by structural and environmental conditions, the mindsets of followers and through broadly shared cultural beliefs [12, 13].

One clear lesson about context is the trend we're seeing in Canada toward amalgamating smaller, more local health care systems and replacing them with single, jurisdiction-wide organizations that oversee both care delivery and health care policy (Chap. 12). The same trend is found in primary care in Australia and NHS England. The tendency to create larger organizations may reduce administrative costs and help avoid silos but it can also create new tensions between the central government and regional delivery systems. As we learned in Chap. 11, each country's constitution shapes how and in what way leaders can act to improve health care. These changes create a need to align accountabilities, authorities and responsibilities between central and de-centralized structures and a concomitant need for leaders to understand how they are supposed to work.

This situation is exacerbated by the rapid rise of technological innovation and demographic demands. We see these tensions at play in Chap. 11, where the authors discuss national systems of leadership talent management; in Chap. 12, where regionalization is in the forefront; and in Chap. 7, when we talk about the growth of accountable care organizations as new models for taking a population health approach to service delivery and financing. Technology enables new models of service delivery, empowering patients and their care providers (including informal caregivers) through instantaneous communication, measurement and sharing of information. These factors fuel the pace of change and create what we called (Chap. 9), a VUCA (volatile, uncertain, complex and ambiguous) context, rife with change.

From the perspective of the leader-follower dynamic, these structural changes require everyone in the health system to change their mindsets, sometimes their belief systems and always their behaviour. Many leaders struggle with issues around equity, diversity and inclusivity but change demands each of us learn new skills and abilities, build new relationships and adopt new practices. We have emphasized these dynamics in all the chapters on LEADS, but especially in Chap. 10 (when we looked at putting LEADS to work as a change model) and in the five invited

chapters. How leaders and followers react emotionally and logically defines the people context for change. Learning to navigate context, to pay greater attention to it, is a demand all leaders face.

A final lesson is that today's health leaders are facing a paradox: the growing need to change and the messiness it creates reduces the amount of time available for leaders to support their people. In stable environments, where practices are standardized and understood by all, there is time for human interaction. In VUCA environments—where you are, as our Indigenous authors said, "Driving a bus that's on fire, down a road that's in the process of being built"—it's hard to take your eyes off the road long enough to look at a map. There is less time for human interaction and greater stress as a result. In the context of Indigenous people, the authors called this "perpetual crisis." We sometimes feel endless, rapid change in health care is driving us to a similar state.

We began this section with the title 'Context shapes leadership'. However, we close it by saying that maybe it is also leadership's job to shape context. Context—certainly people context—is not inviolate; nor is structural context. Human beings created the context we work in and therefore human beings can change it. To simply accept what shapes us without in some cases resisting it, or reshaping it, when it is inconsistent with achieving our vision of health and wellness for all, is a diminution of our visionary capabilities. That may be the biggest leadership challenge of all.

The Speed of Change Demands a Culture of Leadership

A corollary to the lessons of leadership and context is that the speed of change demands a culture of leadership, so we can shift our approach from managing things to leading people. To shift priorities from tasks to people, we've learned leaders need to support and collaborate with followers to achieve change. To embrace the lesson on embedding caring in our organizational practices, we must make it part of our day-to-day actions, part of who we are.

NHS England [14] and NHS Scotland [15] realized their aspirations by creating caring provider cultures and showing compassion for the caregivers as well as for the recipients of care. To promote widespread adoption of the Mental Health Commission of Canada's Standard for psychologically healthy workplaces we mapped the Standard's 13 factors to the 20 LEADS capabilities [16]. To realize the maximum return on our investment as a society in health care, CHLNet developed and shared a leadership impact assessment tool. But in order to create a caring culture, people must have the skills, willingness and especially the opportunity.

What is a culture of leadership? It is an environment of human interactions in which each person accepts responsibility for initiating action to improve the health and wellness of others. As we said in Chap 2: "Leaders always cross the road first." It requires an organizational climate where the quality of relationships matters, where critical thinking and respectful communication are the norm and where people can disagree without being disagreeable. In a leadership culture, everyone,

regardless of background, can contribute their unique attributes to the shared cause. A leadership culture can exist in many contexts—nationally, provincially, regionally or in departments and teams–but unless it also resides in our minds, culture change will not happen. Creating a leadership culture will stretch our limits; yet it is a goal to be pursued not only in our workplaces or for the health care system, but for society.

To create a healthy leadership culture, formal leaders must model the behaviour consistent with it—willing to give up leadership to others when that's the right thing to do so even people who consider themselves followers can step into leadership when needed. The chapters in this book have shown us this is what providers, patients, families and citizens and leaders themselves want. It is our belief and hope the LEADS framework can be a guide to help create and sustain healthy cultures.

It's Time to Professionalize Health Leadership

To close, we suggest it is time to establish a pathway toward professionalizing health leadership. Professionalization is needed to ensure we and others continue to practice what we know works, so our health care systems adapt and adjust to the significant, constant changes today's world demands (and will continue to demand) of those systems. Transforming any vocation into a profession—whether its nursing, law or engineering—is the best way to ensure high-quality practice is consistently maintained in the public interest.

Professionalizing health care leadership will improve many of the aspects of health care we have discussed. It will promote integration of services, healthier and compassionate workplaces, and build systems more resilient in the face of change. It will help us eliminate the situations that led to Greg's Wings in Chap. 15, the Staffordshire crisis in the UK (Chap. 11), the burnout and bullying of clinicians and employees found in many workplaces described in Chaps. 6 and 15, and encourage everyone to take on change with the courage and boldness Canterbury Health exemplified in Chap. 9.

We believe the foundations for professionalizing health leadership are in place in Canada [17], to some degree emulating efforts in medical leadership in Australia and the UK. For a vocation to become a profession many factors need to be present. According to Barbara Kellerman [18], in medicine and law, the markers associated with professional status are:

- Generally accepted body of knowledge.
- Extended education and training.
- Required continuing education and training.
- Clear criteria for evaluation and for (re)certification.
- Clear demarcation of those in the profession and those without.
- Explicit commitment to the public interest and to a code of ethics.
- Professional organization with the power and authority to monitor the status of the profession and the conduct of its members.

The body of knowledge underpinning LEADS—as testified by the content of this book—and its acceptance in a broad-base of leadership communities, suggests we have a generally accepted body of knowledge for health leadership in Canada. This knowledge, moreover, reflects similar frameworks in the Faculty of Leadership and Management in the UK (Chaps. 3 and 11) and the Royal Australasian College of Medical Administrators (Chap. 15) and much of the content in the UK's National Health Service's Leadership Framework. Canada has the added benefit of that body of knowledge being accepted as a common vocabulary across professions and jurisdictions through LEADS.

It's also true, as we've shown in this book, there are extended education and training offerings for LEADS across Canada, including many universities and colleges offering graduate degrees in health leadership or health administration. Continuing education and training are not required yet, but it is available through many organizations in the health care system (for example LEADS Canada, the Physician Leadership Institute, and CHA Learning). Criteria for evaluation and certification in LEADS practice are also available (Chaps. 11 and 15). There is no clear demarcation between those in the profession and those outside it but the recognition in the various clinical professions of leadership as a function rather than a person or position is encouraging people to identify themselves as health leaders.

What we need is for purveyors of education and programming, of certification and of voluntary leadership associations to band together to define the scope and breadth of who is a health leader, make it official that health leadership is an explicit calling and design a professional organization with the power and authority to monitor the status of the profession and the conduct of its members.

Professionalizing health care leadership may even be a *necessary* condition for health care systems to respond to the challenges of integrating service, creating healthy workplaces, and generating productive change. In this context David Johnston, the former governor general of Canada said "Professions serve vital functions that help hold a society together. When trust in a profession erodes, this glue dissolves and society is weakened. To mix my metaphors, professions also serve as grease that help societies function more smoothly. When trust in the profession dissolves, friction results" [19]. A health leadership profession could be both the glue and the grease to accomplish the daunting goals our society desperately needs fulfilled.

Summary

The landscape of leadership is in constant flux, like health care itself. Indeed, in the five years since the first LEADS book, we have seen advances in our understanding of leadership and its application in the health sector that are almost overwhelming in breadth and scope. There appears to be a greater awareness among health leaders and the clinical professions that better leadership will lead to healthier workplaces and thus to healthier citizens.

Frameworks like LEADS, like Health LEADS Australia, the NHS' Healthcare Leadership Model, NHS Scotland's dimensions of leadership in Project Lift, the

UK's Faculty of Medical Leadership and Management standards, the New South Wales Leadership Framework, and the Royal Australasian College's leadership model are all proof of our need to define the qualities of leadership. These frameworks enable people in both formal and informal roles to know what it takes to practice their craft at the highest level. While all these frameworks are aspirational, they represent the best of leadership practice as defined by research and are what those being led are looking for. How they are used, promoted, and supported is important for practice change to occur.

It's clear that while many pockets of success exist, the challenge of being a better leader eludes many because the changes required to be one are so prodigious. The conditions that demand the exercise of good leadership can undermine our own ability to meet our leadership aspirations. Only by learning the lessons of LEADS—of caring, of context, of large-scale change, and of professionalism, and putting those lessons into practice will we succeed in leading our modern health system into its next incarnation. To develop better leadership in tomorrow's leaders, and to practice it, remains our goal and our hope (for further tools and connections related to the content of this book, go to the LEADS Global website at: http://www.leads-global.ca/).

Our lives begin to end the day we become silent about things that matter.
—Martin Luther King, Jr.

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