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LEADerShip at a Glance

LEADS "Top Ten" Suggested Readings[*]

Fuhs, Clint. (2008). ***Towards a Vision of Integral Leadership: A Quadrivial Analysis of Eight Leadership Books.*** **Spring, Vol. 3, No. 1: Suny Press. Pp. 139-162.**
http://www.clintfuhs.com/files/pdf/Fuhs_Leadership_Final.pdf

Purpose: To use Ken Wilber's Integral Theory to categorize seminal leadership books according to their content related to the integral theory quadrants.

Rationale: There are as many definitions of leadership as there are leaders and as many leadership frameworks as leadership writers. Leadership definitions are simple statements that encapsulate the core beliefs, values, and attitudes a person holds towards leadership. As such, their range of meaning is vast. It is therefore important to get a sense of how these books deal with the "territory" of leadership as it can be understood; i.e., as a holistic map of the various dimensions and perspectives on leadership.

A leadership framework is an orienting map that describes the territory and work of leaders. If a leadership definition answers the question, "What is leadership?" a leadership framework, as commonly conceived, would address the question, "How do I actualize and embody that definition?"

This article outlines the use of the four-quadrant model of Ken Wilber to analyze eight well-known leadership texts to ascertain their focus in terms of how they make sense of leadership based on the territory of leadership. To represent that territory, the four quadrant model of Ken Wilber is used as an organizing construct. The quadrants arise as four fundamental aspects of an individual's being-in-the-world, experienced simultaneously as the individual and collective subjective (interior) and objective (exterior) experiences of the world. The four quadrants are the interior – individual (subjective self); the exterior – individual (objective personal behaviour); the interior collective (subjective culture) and the exterior – collective (objective organizational processes). The eight books analyzed are:

- *Good to Great: Why Some Companies Make the Leap...and Others Don't* by Jim Collins.
- *The 7 Habits of Highly Effective People: Powerful Lessons in Personal Change* by Stephen R. Covey.
- *The Fifth Discipline: The Art and Practice of the Learning Organization* by Peter M. Senge.
- *Leadership without Easy Answers* by Ronald A. Heifetz.

[*] As recommended by Dr. Graham Dickson (CHLNet Academic Advisor) and Bill Tholl.

- *Action Inquiry: The Secrets of Timely and Transforming Leadership* by Bill Torbert and Associates.
- *Leadership and the New Science: Discovering Order in a Chaotic World* by Margaret J. Wheatley.
- *Leadership and Self Deception: Getting Out of the Box* by The Arbinger Institute.
- *Primal Leadership: Learning to Lead with Emotional Intelligence* by Daniel Goleman, Richard Boyatzis, and Annie McKee Barrett.

The author's analysis suggests that most leadership books focus more on the exterior, individual and collective world of leadership, and indeed, mostly on the exterior, collective quadrant. Personal development and individual intentions, motivations, vision, feelings and how they manifest in behaviour are too often overlooked as critical aspects in the development of an individual's ability to work effectively in a system, or to become a leader in their own right.

***Link to LEADS*:** This paper suggests that a framework for leadership – e.g., *LEADS in a Caring Environment* capabilities framework – needs to have a balance between the four quadrants of leadership territory. It is important that the LEADS framework expresses leadership in a way that recognizes that interiors and exteriors – behaviours and intentions – co-arise and that both are of equal importance. It needs to reflect, in its language, the interactivity of those quadrants, and the balance between them. An exercise like the one outlined in this paper will be a valuable one in the next step of LEADS evolution.

Finn, R., Learmonth, M. & Reedy, P. (2010). Some unintended effects of teamwork in healthcare. *Social Science and Medicine.* Vol. 70, No. 8. Pp. 1148-1154.
http://econpapers.repec.org/article/eeesocmed/v_3a70_3ay_3a2010_3ai_3a8_3ap_3a1148-1154.htm

Purpose: The purpose of this article was to explore whether or not literature claims related to the virtues of teamwork and managerial expectations related to teamwork played out in practice in two settings in UK hospitals.

Rationale: Teamwork has been emphasised as a key feature of health service reform, essential for safe, efficient and patient-centred care. Bringing together literatures from the sociology of healthcare and organizational theory, the authors examined how the teamwork phenomenon plays out in practice. Drawing upon material from two ethnographic studies, conducted in an operating theatre and a medical-records department in separate UK NHS hospitals, they explored some of the discursive teamwork practices of healthcare staff.

The study revealed how the teamwork discourse did not play out in the way in which policy documents and managerial pronouncement intended. It highlights how teamwork discourse can be utilized to reinforce the very occupational divisions it is designed to ameliorate, or be simply ignored as irrelevant when compared to more attractive forms of collective identity.

Link to LEADS: An Engage Others capability is "Builds Teams". It is accepted within the literature and within clinical practice that inter-disciplinary or multi-disciplinary teams are the solution to chronic disease management, as well as improved productivity in other settings (e.g. hospital). This analysis presents a very different picture of teamwork within much management and health policy writing.

Gawande, Atul (2011, October 3). Personal Best: Top athletes and singers have coaches. Should you? *New Yorker Magazine.*
http://www.newyorker.com/reporting/2011/10/03/111003fa_fact_gawande

Purpose: To outline the unique attributes of "excellence" coaching and make a case for its relevance for physicians, and other individuals in high performance roles.

Rationale: Professional athletes use coaches to make sure they are as good as they can be. But doctors don't. Doctors understand expertise in the same way. Knowledge of disease and the science of treatment are always evolving. We have to keep developing our capabilities and avoid falling behind. So the training inculcates an ethic of perfectionism. Expertise is thought to be not a static condition but one that doctors must build and sustain for themselves.

Coaching in pro sports proceeds from a starkly different premise: it considers the teaching model naïve about our human capacity for self-perfection. Vocalists employ voice coaches throughout their careers. What about regular professionals, who just want to do what they do as well as they can? Elite performers, researchers say, must engage in "deliberate practice" – sustained, mindful efforts to develop the full range of abilities that success requires.

The author then decided to try "coaching" for his surgery as it would be employed by a pro athlete, or musician. He found the experience extremely valuable and it propelled him to a new level of performance as a surgeon. He pointed out that many of his colleagues would find this approach somewhat challenging, but would encourage them to do so.

***Link to LEADS*:** Provides a perspective on "Fosters the Development of Others" capability of Engage Others. The article promotes coaching as a developmental tool for anyone who wishes to achieve excellence in their career. It also suggests that there is great value of one-to-one coaching for leaders who wish to excel in their field.

Gillam, Stephen. (2011). Teaching doctors in training about management and leadership. *British Medical Journal.* Pp. 1-2. http://www.bmj.com/content/343/bmj.d5672

Purpose: The purpose of this editorial was to raise awareness within the physician community in the UK as to the importance of leadership and management development, and the existence of the Medical Leaders Competency Framework, recently developed, that can be used as a foundation for curriculum development in medical schools.

Rationale: The idea that doctors can just "manage" is naive. Various trends in health system delivery demand ever greater involvement of doctors in management roles. These include the expansion and systemization of medical knowledge, constrained health service budgets, informed users, and changing attitudes towards the professions. Doctors everywhere must be prepared to engage in the continual transformation of the service they provide. This highlights the importance of learning leadership and management. The Medical Leadership Competency Framework outlines the skill sets of effective leadership and expresses them as collective leadership: not restricted to the use of those in designated roles. The proposed national Leadership Academy to accredit development programmes, support their delivery and evaluation, and investigate the effects of investment in this area make sense.

Link to LEADS: In the UK each group that practices leadership – health care managers and administrators, as well as physicians – are working with leadership frameworks that are "profession specific". LEADS in non-profession specific, and as such, represents a common language amongst many professional bodies as it relates to leadership. It also encompasses the content of the UK Medical Leadership Competency model. The UK example highlights both the importance of a framework, but also the strides made in Canada to agree on a common one.

Homer-Dixon, Thomas (2011). Complexity Science. *Oxford Leadership Journal: Shifting the Trajectory of Civilisation.* Vol. 2, No. 1 (January). Pp. 1-15.
http://www.oxfordleadership.com/journal/vol2_issue1/homerdixon.pdf

Purpose: This article uses concepts and principles of complexity theory to outline the challenges leaders face in creating public service enterprises that are responsive to the needs of society. It also proposes approaches necessary to instil in public service leaders the creative capacity needed to deal with complexity.

Rationale: We now live in a world that is, in its deepest essence, complex and turbulent. It's actually quite difficult to say whether complexity is good or bad. Significant, even severe, breakdown is going to be part of our future. Instead of denying this fact or desperately trying to figure out how to keep breakdown from ever occurring, our public managers should think about what our societies can do at moments of crisis to produce deep and beneficial change.

Our public service confronts a problem of "entanglement" of principles of compliance with measurements of performance. Increasingly we are using objectified measures of how people perform within our public services as a way of establishing firm control over their actions. This entanglement of compliance and performance appears to be instilling a culture of fear within our public services. The *culture of compliance* now dominating the public service reduces the possibility and potential for experimentation. We need to reform that culture. Our public-service leaders need to be constantly probing the critical systems we depend upon to determine patterns in the changing solution landscape. They can't know exactly what will happen in these systems in the future, so they should engage in interventions to gather information. They can use small safe-fail experiments as probes to help everyone – leaders and the public alike – learn how the landscape is changing.

More generally, leaders should be "gardeners" who create conditions for experimentation and for – as Mel Cappe argued many years ago – creative failure. At the moment, it seems, there's very little possibility for creative failure in our public service. We're getting a timid, risk-averse, conservative and conventional public service with crippled morale, whereas we desperately need a creative, nimble, flexible public service that can help lead a creative, flexible, innovative, and resilient society.

Links to LEADS: The article specifically addresses key elements of the Systems Transformation domain of LEADS. It outlines how complexity science identifies challenges faced by modern public service enterprises, such as health, as the level of interconnectivity and complexity grows, and the system has to adapt itself to the challenges associated with those changes. It outlines the prevailing trend within public service managers (including health) and identifies what leaders must do to overcome what might otherwise be a dissatisfactory consequence for health systems transformation.

Morgan, S., Cunningham, C. (2011). Population Aging and the Determinants of Healthcare Expenditures: The Case of Hospital, Medical and Pharmaceutical Care in British Columbia, 1996 to 2006. *Healthcare Policy* Vol.7, No.1, pp. 68-79.
http://www.longwoods.com/content/22525

Purpose: This research study was conducted to investigate the gap between the rhetoric and reality concerning healthcare expenditures and population aging.

Rationale: Although decades-old research suggests otherwise, there is widespread belief that the sustainability of the healthcare system is under serious threat owing to population aging. To shed new empirical light on this old debate, the authors used population-based administrative data to quantify recent trends and determinants of expenditure on hospital, medical and pharmaceutical care in British Columbia. The authors modelled changes in inflation-adjusted expenditure per capita between 1996 and 2006 as a function of two demographic factors (population aging and changes in age-specific mortality rates) and three non-demographic factors (age-specific rates of use of care, quantities of care per user and inflation-adjusted costs per unit of care).

Link to LEADS: A major argument rampant in health care is that the demographic profile (projecting an ever-growing aging population) for Canada's future is threatening the financial sustainability of universal health care. This is used as an argument for leadership development, CHLNet – and of course, the centrality of LEADS. Yet the authors found that population aging contributed less than 1% per year to spending on medical, hospital and pharmaceutical care. Moreover, changes in age-specific mortality rates actually reduced hospital expenditure by –0.3% per year. Based on forecasts through 2036, they found that the future effects of population aging on healthcare spending will continue to be small. They conclude that population aging has exerted, and will continue to exert, only modest pressures on medical, hospital and pharmaceutical costs in Canada. As indicated by the specific non-demographic cost drivers computed in our study, the critical determinants of expenditure on healthcare stem from non-demographic factors over which practitioners, policy makers and patients have discretion.

Philippon, Don. (2011). ***The Leadership Imperative in Publicly Funded Universal Health Systems with a particular focus on the development of the Canadian Health Leadership Network (CHLNet).*** **A project submitted as part of the requirements for the Fellowship Program, Canadian College of Health Leaders. (See attached PDF.)**

Purpose: This paper intends to review the Leadership development strategies in several countries. The development of the Canadian Health Leadership Network (CHLNet) in Canada will be outlined. The situation in the United Kingdom, with a particular reference to England, Sweden, New Zealand and Australia will also be highlighted.

Rationale: These countries were chosen as comparators for the Canadian experience in that they all share similar values around health care. Each country provides a health system that is universally available to all its citizens and the systems are largely publicly funded. However, while there has been much attention on the need for change in the Canadian health system, very little focus has been placed at an overall system level on how to create the leadership capacity to drive these changes. It is in this context that the Canadian Health Leadership Network (CHLNet) was born. The broad purpose of CHLNet is to "identify, develop, support and celebrate leaders throughout the leadership continuum and transcending all health professions. More, specifically the goal of CHLNet was to provide organizations and individuals interested in leadership with access to: applied leadership development tools; collaborative dialogue and networking opportunities; and health leadership development research. Despite the fact that Canada has the most decentralized governance and delivery system of all the afore-mentioned countries, the paper profiles "lessons to be learned" and practices from these other jurisdictions related to specific programs, initiatives and services re leadership development that might be of interest to CHLNet and its member organizations.

Link to LEADS: The paper identifies five key themes that are relevant to the work of CHLNet and in particular, to LEADS. Theme three states, "the effective use of leadership capability frameworks in leadership development programs" – and of course, LEADS is the common framework that unites members of CHLNet. The other themes are also relevant to maintaining momentum and sustainability in health system leadership development – and should be seriously investigated in terms of their relevance to the ongoing use of LEADS, and of course, the role of CHLNet.

Roberts, Glen. (2011). ***Medicare 2.0—LEAD-ing in Saskatchewan?*** **Working Paper: Regina-Qu'Appelle Health Region. (See attached PDF.)**

Purpose: This paper was written for an audience of physicians in the Regina-Qu'Appelle Health Region to engender discussion about the need for evidence-based physician leadership in order to set a new, more sustainable health policy course – one based on a shared vision of the future and with the capabilities to engage others.

Rationale: From all accounts of what lies ahead, a fundamental transformation will need to occur in how we think about health, health care and its delivery. Research suggests that the future health system will:

- be more patient-focused;
- be less hospital-focused;
- be more precise/panoramic/predictive/prevention-oriented/patient-centred/price competitive/point of care–oriented/personalized/participatory;
- use technology more aggressively to create/achieve/produce solutions/medicines/procedures that are smaller/less invasive/more convenient/faster/cheaper/used earlier on in disease cycles (e.g., smart kitchens/bathrooms, avatars, nano-medicines, biogenetics);
- involve greater use of tele-treatment and medical tourism; and
- have a renewed focus on end-of-life issues due to an increase in life expectancy, with some people living to 125 years of age.

If Canada's health care system is to truly make the transformation required, there needs to be sufficient focus on and development in leadership as a discipline. The author expresses "a call to action": calling on physicians within the Regina-Qu'Appelle Health Region to participate in efforts to develop leaders with the core capabilities and skills of LEADS. This is the pathway forward and is portrayed as the start of the "Made in Saskatchewan Medicare 2.0 Strategy."

Link to LEADS: This short paper is a compelling argument for the use of LEADS as a foundation for leadership development programming. With appropriate customization (and permission from the author of course), it is a paper that other senior leaders could use to galvanize support for leadership development within their organization.

Singer, S. J.; Hayes, J.; Cooper, J.B.; Vogt, J.W.; Sales, M.; Aristidou, A.; Gray, G.C.; Kiang, M. V.; Meyer, G.S. (2011). A case for safety leadership team training of hospital managers. *Health Care Manage Rev*, 36(2), 188-200.
http://journals.lww.com/hcmrjournal/Abstract/2011/04000/A_case_for_safety_leadership_team_training_of.10.aspx

Purpose: The aims of this study were to describe a learning-oriented, team-based, safety leadership training program composed of reinforcing exercises and to provide evidence confirming the need for such training and demonstrating behaviour change among management groups after training.

Rationale: Delivering safe patient care remains an elusive goal. Resolving problems in complex organizations like hospitals requires managers to work together. Safety leadership training that encourages managers to exercise learning-oriented, team-based leadership behaviours could promote systemic problem solving and enhance patient safety. Despite the need for such training, few programs teach multidisciplinary groups of managers about specific behaviours that can enhance their role as leadership teams in the realm of patient safety.

***Link to LEADS*:** The study operationalizes the importance of two "Engage Others" capabilities – "Fosters Development of Others"; and "Build Teams". It also provides a compelling case for using leadership development to support implementation of key strategic imperatives of change.

Wheelahan, L., & Moodie, G. (2011 (November)). *Rethinking Skills in Vocational Education and Training: From Competencies to Capabilities*. LH Martin Institute for Higher Education Leadership & Management – University of Melbourne: NSW Department of Education & Communities. http://www.bvet.nsw.gov.au/pdf/rethinking_skills.pdf

Purpose: The paper proposes for consideration a framework based on the capabilities approach developed by Nobel Laureate economist Amartya Sen (1985, 1992) and the philosopher Martha Nussbaum (2000). The capabilities approach is increasingly used in international and national public policy (Robeyns 2005; Henry 2007, 2009).

Rationale: The key argument in this paper is that VET must prepare students for a broad occupation within loosely defined vocational streams rather than workplace tasks and roles associated with particular jobs (Buchanan 2006). Education or training for an occupation is premised on the notion of development and progression so that educational and occupational progression are linked.

A capabilities framework relates the conditions individuals need to engage in work and to progress through a career with the requirements of broad occupations. It focuses on what people need to be able to do to exercise complex judgements at work and what they need to be able to do in the future, rather than on workplace tasks and roles that have been defined for them or based on existing or past practice.

This paper emphasises the importance of theoretical knowledge for vocational qualifications. Access to theoretical knowledge is a fundamental component of capability. It is essential to support the development of vocational identities and practitioners who draw from and contributeto the knowledge that underpins their practice.

***Link to LEADS**:* The LEADS in a Caring Environment *capabilities* framework expresses the expectations of career leaders in health care as capabilities rather than competencies, in keeping with the foundational arguments of this paper. It assists those who are using LEADS and those proponents of LEADS to explain why the framework is expressed as capabilities, and not competencies.