Leading Through the COVID-19 Crisis:

A Proposed Action Research Study

Introduction

The Canadian Health Leadership Network (CHLNet)'s vision is "Better Leadership, Better Health—Together". CHLNet is a network of over 40 national, provincial and local partners, representing the health care professions, health authorities, governments, and citizen advocacy groups--that are dedicated to defining and practicing what 'better leadership' is: and then ensuring that it is utilized to improve the health of Canadians. The notion of working together emphasizes a belief in distributed leadership; in that Canada's health system needs to act and perform as a system; and it is our collective job—formal or informal leader, CEO or family member, politician or patient, to exercise our collective responsibility to create a system that delivers better health. CHLNet believes leadership is critical to success in this uncertain time. This proposal outlines an action research project (similar to a live case study) in support of our mandate to build health leadership capacity and capabilities across the country.

Purpose

In keeping with CHLNet's mandate, beliefs and principles, CHLNet's Research and Evaluation Working Group proposes to undertake an action research study that has two primary purposes. These are:

1. To chronicle and curate current leadership practices (evidence and experience-based) used by Canada's health workforce and the system to address the COVID-19 challenge; and
2. To explore together as leaders, what existing, experience-based, and emerging/innovative leadership decisions and practices should be used to build our future health and care system.

The Scope of the Canadian COVID-19 Leadership Challenge

The 2020 Coronavirus pandemic is a crisis of global proportions. Ironically, it can be a catalyst to allow dedicated ethical health care leaders to exercise the kind and form of leadership that is

needed to co-create a modern, people[1] and/or relationship[2]-centred system of care that truly responds to the needs of today's citizens.

The chaos and complexity created by COVID-19 defies conventional rules and many of us are relearning our ways of leading and organizing work and daily life. Health leadership—formal and informal--is being tested in novel and uncertain ways. The mix of leadership styles and approaches that worked in more stable and predictable environments will not suffice[3,4]. It is an ongoing natural experiment in crisis leadership, and lends itself to deliberate, 'just in time' action, reflection, and documentation.

A leader's job is to integrate systems so they can serve patients, families and systems well; to ensure health care workers are able to work in a psychologically and physically safe work environment; and to facilitate meaningful innovation and reform[5]. These demands—which have been growing steadily over the past 15-20 years in health care—have remained stubbornly resistant to change. Yet many leaders have expressed a strong desire to be part of a different story of health care: a story that allows us to focus on our successes, not our failures; and that speak to a system that we are all proud of; one that has transformed itself to be people-centred. Many leaders want to contribute to creating that future. Now is the time to begin that journey.

Prior to the pandemic, there was a growing awareness that we wanted a public health and healthcare system that was different. That same consciousness today is enabling us to implement innovations that were unthinkable in the previous environment. If indeed, what Otto Scharmer[6] says is true: i.e., that:

1. Everything we knew wasn't sustainable is collapsing now;
2. As systems collapse, people rise; and
3. We are one system.

[1] Cole, C., Thiessen, H., & Andreas, B. (2020). The LEADS in a Caring Environment Framework: Putting LEADS to Work in People-Centred Care. In *Bringing Leadership to Life in Health: LEADS in a Caring Environment* (pp. 261-277). Springer, Cham.

[2] Van Aerde, J. (2015 Winter). Opinion: Relationship-centred care: Toward real health system reform. The Canadian Journal of Physician Leadership (pp. 3-6); and Nundy, S., & Oswald, J. (2014, December). Relationship-centered care: A new paradigm for population health management. In *Healthcare* (Vol. 2, No. 4, pp. 216-219). Elsevier.

[3] In terms of the scope of research sources into the global epidemiological response see this link: https://www.mcmasterforum.org/find-evidence/guide-to-COVID-19-evidence-sources

[4] Dickson and Tholl (2020). Bringing Leadership in Health to Life: LEADS in a Caring Environment, Second Edition. London: Springer-Verlag.

[5] Ibid.

[6] Scharmer, O. (2020). A New Superpower in the Making: Awareness-Based Collective Action. Presencing Institute. [Internet]. Accessed on 15 April 2020 @ https://medium.com/presencing-institute-blog/a-new-superpower-in-the-making-awareness-based-collective-action-83861bcb9859 .

Then it is imperative-- in the spirit of never let a good crisis go to waste--that we identify and lock down the leadership practices that will build that one health and care system that meets the needs of today, and the future.

The Research Concept

Action research overlays the vicissitudes and challenges of day-to-day life with an inquiry methodology that is intended to help us understand what we are doing, why we are doing it, and to document lessons learned.[7] It is 'in the moment' research, intended to study action while at the same time informing it[8]. It relies on an inductive approach[9], because it makes no claim to identifying cause and effect relationships for predictive purposes, but rather intends to understand the interdependency of what can and should be done by leaders within the specific context that they find themselves in; and from a 'knowing' perspective, recognizes the difficulty of distinguishing the subjectivity of the knower from the objectivity of the known.

Action Research [10] does not separate researcher from policy maker, front-line leader from clinician or employee, or provider leader from patient, family member, or citizen. It asks individuals, in whatever role they are playing, to assume two roles at once: to observe (see, reflect, and understand), and then act on that understanding. Action research formalizes this process. It assumes that by understanding how our leadership plays out *in context* that it will prepare us to be more sensitive to context and the impact it has on us as leaders. To be able to do so will enable leaders to respond more effectively to others' needs; and it will help us understand that when the context changes, so must our leadership practice.

The above description implies that action research is a PDSA (Plan, Do, Study, Act) cycle applied to leadership. In this sense the primary independent variable is the timeframe of each cycle. For example, one might argue that emotional intelligence is action research *in action:* asking a person to be conscious of what they are doing; reflect on the impact it is having on others; and then make immediate readjustments so as to have the desired impact in the situation one is in.

---

[7] Robinson, F., Piggot Irvine, E., Youngs, H., & Cady, P. (2019). Struggling to achieve desired results from your AR projects? insights from the Evaluative Study of Action Research may help. *Educational Action Research*, *27*(5), 778-797.

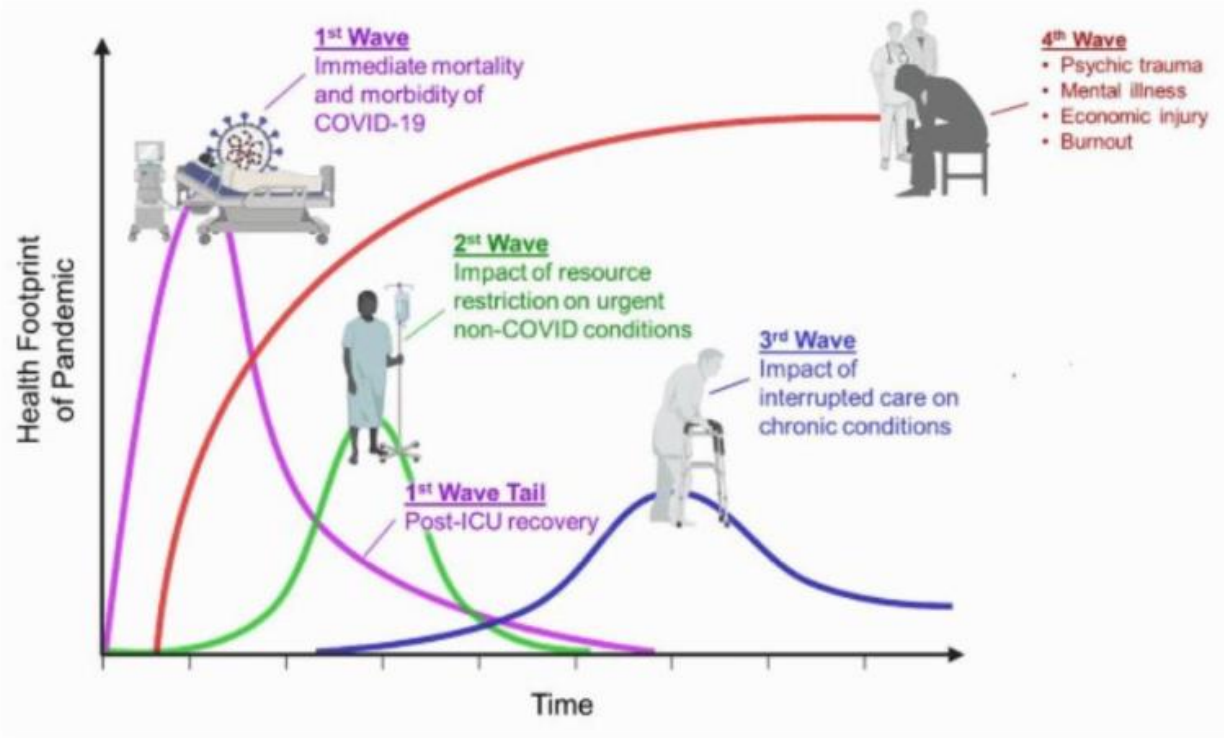
[8] Bowen, S., Botting, I., Graham, I. D., MacLeod, M., De Moissac, D., Harlos, K., ... & Knox, J. (2019). Experience of Health Leadership in Partnering With University-Based Researchers in Canada–A Call to" Re-imagine" Research. *International journal of health policy and management*, *8*(12), 684.; Eljiz, K., Greenfield, D., & Taylor, R. (2020). The Embedded Health Management Academic: A Boundary Spanning Role for Enabling Knowledge Translation; Comment on "CIHR Health System Impact Fellows: Reflections on 'Driving Change' Within the Health System". *International Journal of Health Policy and Management*, *9*(4), 170-174; and

[9] Coleman, G. (2015). Core issues in modern epistemology for action researchers: Dancing between knower and known. *The SAGE handbook of action research*, 392-400.

[10] O'Brien, R. (1998). An overview of the methodological approach of action research. University of Toronto. Available @ https://www.web.ca/~robrien/papers/arfinal.html#_Toc26184654

Instantaneous action research if you like, in which the timeframe for observing, reflecting, and changing behaviour is in the moment. But those time frames can be determined at the whim of the researcher, and therefore gives the method some flexibility to deal with situations such as what we are now experiencing.

In the case of COVID-19, we also see different policy responses in a very dynamic epidemiological context (Figure 1) playing out across different jurisdictions across Canada and around the globe. This provides an opportunity for a natural experiment, in contrast to a planned experiment. Natural experimental studies are often recommended as a way of understanding the impact of population-level policies on health outcomes or health inequalities.[11] They are also ripe for the application of action research methods.



https://twitter.com/VectorSting/status/1244671755781898241?s=20 Dr. Victor Tseng

Given this description of action research conducted in the context of an ongoing natural experiment in crisis leadership, it invites others into a disciplined process of co-creation: i.e., in this case two-fold: (1) to continue to identify and document leadership practices that work to fulfill the functions of leadership described earlier in this research proposal; and (2) to envision and articulate aspects of organizational design, community engagement, and service delivery

[11] They are part of the more general class of epidemiological or observational studies stretching back to John Snow and are most relevant when studying sudden shocks such as epidemics or in this case a pandemic. See UK link on how to make the best use of natural experimental approaches to evaluate population health interventions www.mrc.ac.uk/naturalexperimentsguidance.

models that truly respond to the needs of a modern, technological, democratic, and inclusive society.

The Research Approach

Numerous factors describe to the proposed research approach.

1. *Establish a Research Steering Group*

It is proposed that we create a research steering group to oversee the process and ultimately document/write up the study. This research group, reporting to CHLNet's Research and Evaluation Working Group (R&E WG) will be comprised initially of volunteer members from R&E WG, and upon agreement within that group, invite others to participate, as needed, as the project. It will include a mixture of academics and decision makers.

Terms of reference to include:

a. Define the overall research protocol including affirming the research questions
b. Establish timelines and procedural rigour, including whether an ethics review is necessary[12]
c. Investigate potential funding sources
d. Operationalize project management and accountability for the project
e. Expedite a preliminary ethics review
f. Gather the data using a mixed methods approach
g. Analyze the data
h. Generate appropriate findings
i. Write up a final report
j. Disseminate key findings from the report.

2. *Operationalize the action research inquiry frame*

Action research begins with questions that can only be answered through documenting deliberate responses at the individual (micro), organizational (meso) and systems (macro) levels to an emergent situation, reflecting on the appropriateness of those actions, and then deciding what to do next (i.e., a cycle of action research). Studies may move on to a second cycle of inquiry,

[12] Traditional university-driven research studies, and indeed, studies undertaken within most health organizations, are required to submit ethics applications to ensure that the study does no harm to desired participants. Such requests traditionally take significant amounts of time to gain approval; and the degree of planning is often prodigious. This is particularly true if there are multiple organizations involved in the study. Recent projects undertaken by CHLNet—i.e., Benchmark 1 and 2; LDI Toolkit; Wise Practices—have not required an ethics review. If this project is a CHLNet project, guided by individuals on the R&E Working Group, but not sponsored by their organizations, then a formal ethics review is not required. Of course, the project will be guided by the principle of 'doing no harm'. The Research Team should discuss and formally agree on an approach.

informed by the first: i.e., the Research Team may pose additional questions to guide the actions of the second cycle of inquiry. The action researchers (i.e., people in the field doing leadership) do their best to act commensurate with the learning in the first cycle and the new context in which those actions are required; and reflects and documents on successes (and failures) of those actions. This is the time variable mentioned earlier; and it is a decision of the Research Team, whether to conduct a second cycle of action research to correspond to what might be a naturally occurring new phase of action.

At the time of writing this proposal it is recommended that the first cycle of action research correspond to the timeframe for the first wave of COVID-19. Subsequent cycles may be conducted—and are anticipated--should there be a second or third wave as depicted in Figure 1.

3. Define research questions for the study

It is proposed that three primary questions guide the study:

1. What leadership practices have been effective (or contrarily, ineffective) in dealing with the COVID 19 crisis?
2. How do effective practices differ from pre-crisis leadership practices?
3. What leadership practices can be leveraged to create the desired health and care system of the future?

NOTE: these are NOT questions that contributors will be asked to answer; they are for the study overall. For ease of participation from solicited contributors (i.e., volunteer action researchers) they will be asked questions that are more personalized to their individual context, and will only be asked to answer one or two questions that are of greatest relevance to their experience.

4. Select volunteer action researchers

The Steering Group will identify a representative group of leaders (from all levels in Canada)[13] to become our action researchers to understand what we are learning about leadership in these trying times in different contexts. It is important to seek out people who want the opportunity to have their opinions heard. If the research team creates an accessible platform and a variety of modes of input people are more likely to participate. Consideration can be given to providing an incentive (if needed). We will start by creating a list of potential participants known to the Research Team.

We seek a self-selected sample of people who care about leadership and possess the hope that their input will be helpful. Ideally the pool of participants will represent different perspectives on system experience (see Appendix A).

[13] If feasible, and appropriate, at some point in the study individuals from other countries (Australia, United Kingdom, and Scotland), may be invited to participate in similar studies in their national jurisdictions.

Given the immediacy of the project, a natural body of potential leaders are those contributing to the new LEADS second edition book (approximately 45 leaders playing a wide range of leadership roles in the context of the COVID crisis); CHLNet's Health Leadership and Exchange Working Group; as well as interested members of CHLNet member partners. A snowball approach—i.e., once these individuals are aware of the project and can either participate or not—enables them to pass on the participation opportunity to other leaders that they see as having something meaningful to contribute.

5. *Determine data collection methods and establish a collection process*

Volunteer action researchers will be asked to reflect on practices of leadership they are observing, experiencing, or utilizing; and the impact—good or bad—on others. The leader—who is living the context—will reflect also on its influence on the decisions made. In creating these periods or reflection to share their leadership experiences with COVID in real time, the action research process can be seen as therapeutic in helping leaders grow personal resilience.

To keep it simple, and ease the time demands of participation, data gathering will be restricted to asking people to dedicate *no more than 30 minutes* of their time to the task of preparing for and providing individual datum.

Individuals who wish to share their ideas will be encouraged to do so in a variety of art forms: e.g., in the form of vignettes, stories, case studies, podcasts, or video recordings which should not exceed 10 minutes in length. They will be invited to submit them for potential publication (i.e., in CHLNet's e-blasts, Canadian Society of Physician Leaders/CSPL podcasts or other partner vehicle); and for review and analysis in the context of this study. Given the extent of this pandemic, more modified and succinct method for data collection may be used for the first cycle.

Other data—in the form of contributions from publicly available reminiscences (i.e., email exchanges: with permission), peer reviewed articles, grey literature, podcasts, new stories, and social media postings—will populate another data set.

Data collection will be through the creation of a web portal that enables people to submit their personal contributions.

6. *Frame data analysis*

From an analytical perspective, it is proposed that the data from the two pots of data are themed separately (either using N-Vivo or manual methods) to identify key concepts and themes extant in both.

To bring some order to the data analysis, we suggest using a LEADS[14]-informed process of inquiry, action, reflection, documentation that the research team can overlay on their work to help

[14] Dickson and Tholl (2020). Bringing Leadership in Health to Life: LEADS in a Caring Environment, Second Edition. London: Springer-Verlag.

organize data and to create a maximal potential for learning and explanation (given 80% of health delivery organizations in Canada employ LEADS to define effective leadership)[15]. We believe the LEADS framework[16] is well suited to describing and evaluating how systems and individuals come together to achieve shared results: in a first instance, bending the COVID-19 curve, balancing individual and societal risks and thereby mitigating avoidable deaths during the crisis; and in a second instance, ensuring we have more integrated public health and healthcare systems for the future that can meet the needs of citizens in an optimal fashion.

7. *Seek funding/resource supports*

A preliminary analysis has been conducted and it is proposed that in the short term, we approach funding agencies such as the Max Bell foundation (Calgary-based), the Canadian Institutes for Health Research (Institute for Health Services and Policy Research), and CHLNet's own partners for monetary and in-kind support. Most of the work will be undertaken on a voluntary basis. That said, an initial budget of approximately $10,000 may be required for what should be considered a 'developmental phase' for the project: i.e., initial setup of the research team; outreach to participants; a review of success (i.e., was data collected and was it valuable) before (and if) a second phase is developed and funding sought for it (in the order of another $15K might be required.

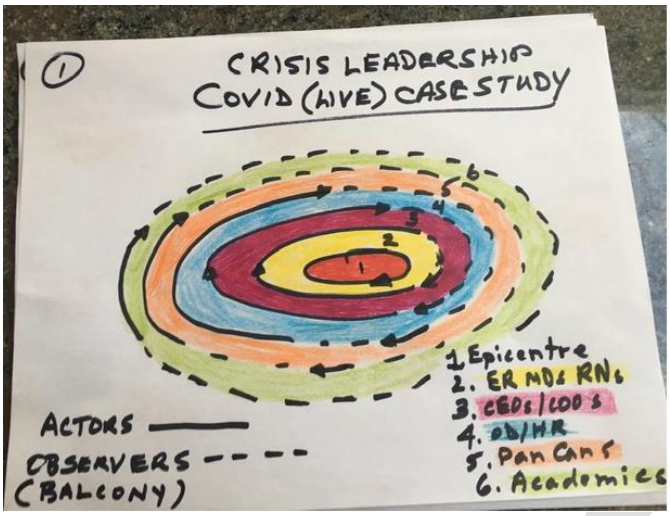
Summary

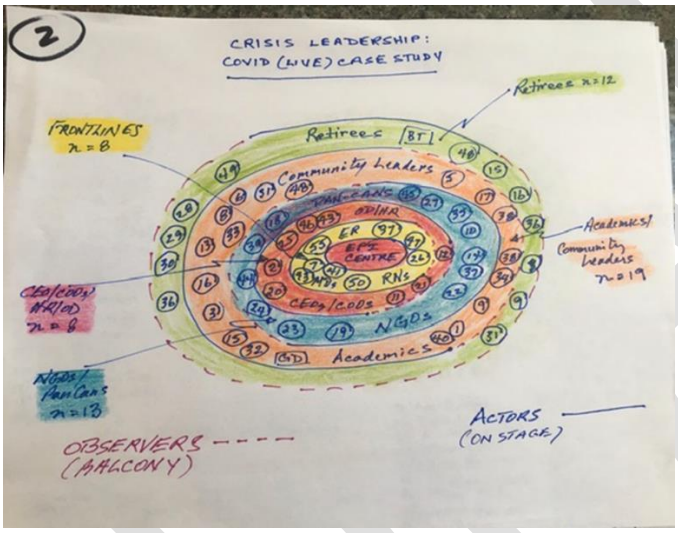
This proposal outlines a action research project to study health leadership in times of crisis that could have a significant influence on our understanding of leadership, its practices, and what might be done in the future to enhance our overall leadership capacity and capabilities. It is a study that is consistent with the mandate and purpose of CHLNet, timely, and opportune: i.e., unique times demand an exceptional response. To be successful, we believe that the first phase of this project should be initiated by the end of April.

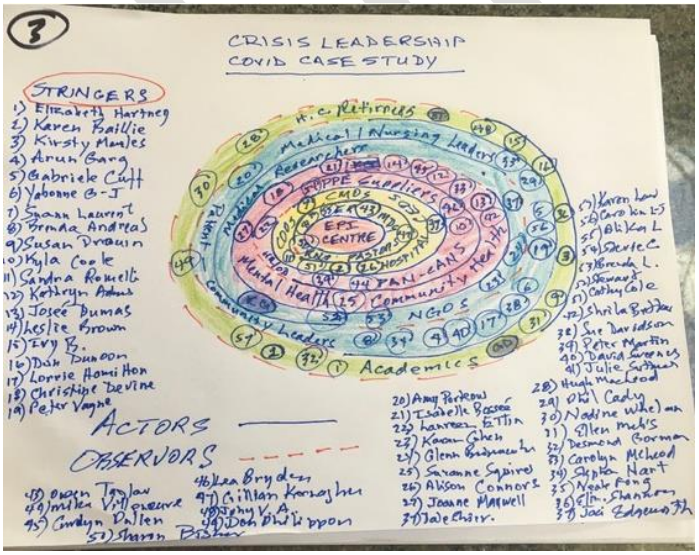
[15] CHLNet 2020: Benchmarking Health Leadership in Canada 2020: Report of the CHLNet Steering Group. Draft report.

[16] NOTE: Input from this study can be used to either validate LEADS or inform the expression it takes in different contexts and situations.

Appendix A


1
CRISIS LEADERSHIP
COVID (HIVE) CASE STUDY
1 Epicentre
2. ER MDs RNs
3. CEOs/COO's
4. OB/HR
5. Pan Can's
6. Academics
ACTORS
OBSERVERS
(BALCONY)


2
CRISIS LEADERSHIP:
COVID (HIVE) CASE STUDY
FRONTLINES
Retirees
Community Leaders
Academics
ER
EPI CENTRE
RNs
CEOs/COOs
NGOs
ACTORS
(ON STAGE)
OBSERVERS
(BALCONY)


3
CRISIS LEADERSHIP
COVID CASE STUDY
STRINGERS
ACTORS
OBSERVORS
Retirees
Academics
EPI CENTRE
NGOs