Leading through the first wave of COVID: a Canadian action research study

Elizabeth Hartney
Royal Roads University, Victoria, Canada and Canadian Health Leadership Network, Ottawa, Canada

Ellen Melis
Canadian Health Leadership Network, Ottawa, Canada

Deanne Taylor
Interior Health Authority, Kelowna, Canada and Canadian Health Leadership Network, Ottawa, Canada

Graham Dickson
Professor Emeritus, Royal Roads University, Victoria, Canada and Canadian Health Leadership Network, Ottawa, Canada

Bill Tholl and Kelly Grimes
Canadian Health Leadership Network, Ottawa, Canada

Ming-Ka Chan
Department of Pediatrics and Child Health, University of Manitoba, Winnipeg, Canada and Canadian Health Leadership Network, Ottawa, Canada

John Van Aerde
Department of Pediatrics, Faculty of Medicine and Dentistry, University of Alberta, Edmonton, Canada and Canadian Health Leadership Network, Ottawa, Canada, and

Tanya Horsley
Royal College of Physicians and Surgeons of Canada, Ottawa, Canada and Canadian Health Leadership Network, Ottawa, Canada

Received 18 May 2021
Revised 15 July 2021
Accepted 23 August 2021

Abstract

Purpose – This first phase of a three-phase action research project aims to define leadership practices that should be used during and after the pandemic to re-imagine and rebuild the health and social care system. Specifically, the objectives were to determine what effective leadership practices Canadian health leaders have

Many thanks to the other members of our Steering Group, who are not listed as authors and gave freely of their time for this project: John Sproule (Institute of Health Economics), Dr Susan Moffatt-Bruce (Royal College of Physicians and Surgeons), Geneviève Martin (Health care Excellence Canada) and Jonathan Mitchell (HealthCareCAN). We send our gratitude to those Canadian health leaders on the front line of this pandemic who took the time to share their experiences with us. This project was self-funded by the Canadian Health Leadership Network.

Leadership in Health Services

1751-1879
DOI 10.1108/LHS-05-2021-0042

used through the first wave of the COVID-19 pandemic, to explore how these differ from pre-crisis practices; and to identify what leadership practices might be leveraged to create the desired health and care systems of the future.

Design/methodology/approach – The authors used an action research methodology. In the first phase, reported here, the authors conducted one-on-one, virtual interviews with 18 health leaders from across Canada and across leadership roles. Data were analyzed using grounded theory methodology.

Findings – Five key practices emerged from the data, within the core dimension of disrupting entrenched structures and leadership practices. These were, namely, responding to more complex emotions in self and others. Future practice identified to create more psychologically supportive workplaces. Agile and adaptive leadership. Future practice should allow leaders to move systemic change forward more quickly. Integrating diverse perspectives, within and across organizations, leveling hierarchies through bringing together a variety of perspectives in the decision-making process and engaging people more broadly in the co-creation of strategies. Applying existing leadership capabilities and experience. Future practice should develop and expand mentorship to support early career leadership. Communication was increased to build credibility and trust in response to changing and often contradictory emerging evidence and messaging. Future practice should increase communication.

Research limitations/implications – The project was limited to health leaders in Canada and did not represent all provinces/territories. Participants were recruited through the leadership networks, while diverse, were not demographically representative. All interviews were conducted in English; in the second phase of the study, the authors will recruit a larger and more diverse sample and conduct interviews in both English and French. As the interviews took place during the early stages of the pandemic, it may be that health leaders' views of what may be required to re-define future health systems may change as the crisis shifts over time.

Practical implications – The sponsoring organization of this research – the Canadian Health Leadership Network and each of its individual member partners – will mobilize knowledge from this research, and subsequent phases, to inform processes for leadership development and, succession planning across, the Canadian health system, particularly those attributes unique to a context of crisis management but also necessary in post-crisis recovery.

Social implications – This research has shown that there is an immediate need to develop innovative and influential leadership action – commensurate with its findings – to supporting the evolution of the Canadian health system, the emotional well-being of the health-care workforce, the mental health of the population and challenges inherent in structural inequities across health and health care that discriminate against certain populations.

Originality/value – An interdisciplinary group of health researchers and decision-makers from across Canada who came together rapidly to examine leadership practices during COVID-19's first wave using action research study design.

Keywords Stress, Health leadership competencies, Trust, COVID-19, Transformational leadership, Quality of working life

Paper type Research paper

Introduction

The COVID-19 pandemic is a global health crisis (Winter, 2020) and its impact on the Canadian health system and on Canada as a whole, has clearly exposed inadequate preparation (Allen, 2020). We consider these circumstances, while difficult to experience, a catalyst for change that allows health-care leaders to exercise the leadership needed to co-create a modern, people-centered (Cole *et al.*, 2020) and relationship-centered (Van Aerde, 2015) system of care, that truly adapts and responds to the needs of citizens and communities (McMahon *et al.*, 2020). Part of a health leader's role is to integrate systems so they can serve patients, families and systems well; to ensure health-care workers are able to work in psychologically and physically safe work environments; and to facilitate meaningful innovation and reform (Dickson and Tholl, 2020).

The chaos and complexity created by COVID-19 has reconceptualized our ways of working and many of us are re-learning and re-conceptualizing health-care leadership in this

new context. Formal and informal leadership is being tested on a scale not yet experienced by our generation. The mix of leadership styles and approaches that maintained an imperfect system in more stable and predictable environments no longer works. Canada's health-care system was already operating at capacity before COVID-19 struck. Without government intervention to help reduce the spread of the virus in the first wave of the pandemic, from March to November 2020, the Canadian health system might have collapsed under the demands created by the pandemic. Canada's decentralized health-care system lends itself to an ongoing natural experiment in crisis leadership, involving deliberate, just-in-time action, reflection and documentation.

Even at the best of times, health systems leadership is difficult. The first wave of the pandemic amplified the difficulties and at the same time, compounded the complexity for how to move forward. Health systems leaders had little choice but to forge ahead in this unknown new world to ensure that the public health care system maintained the ability to provide health-care services. The question arose of whether the same leadership practices used prior to the pandemic would suffice or whether a new expression of leadership would emerge. Our pan-Canadian study team explored how health leaders navigated this new world, specifically asking them about their experiences and what leadership attributes they used. This paper describes the findings from the first phase of this study and discusses its implications of how the lessons learned may inform the next phases of this action research and ultimately, health system transformation in the future.

Background

Health care requires coordinated, decisive leadership, particularly in a crisis to provide guidance and mobilize action toward a common goal. The pandemic has provided many examples of caring and compassionate health leadership in Canada (Dickson and Tholl, 2020; de Zulueta, 2016; Edwards *et al.*, 2018). One such example comes from Dr Bonnie Henry's mantra as the Provincial Health Officer of British Columbia: "be kind, be calm, be safe." While top-down, assertive, directive leadership styles may have seemed necessary at the beginning of the crisis, as the pandemic unfolded, they had to be balanced with the use of more inclusive leadership styles (Sukhera *et al.*, 2020a, b), to pull people together in a manner needed to manage the pandemic. Similarly, others have argued that we must rely much more on distributed (Günzel-Jensen *et al.*, 2016) or collaborative leadership (VanVactor, 2012), with empowerment being central during crisis times.

Even before COVID-19, health leadership was in crisis (Lloupis, 2020) and burnout was increasingly recognized as a serious concern for physicians (CMA, 2018; Drummond, 2014), nurses (Leiter and Laschinger, 2006) and other health professionals. The need for health-care leaders to change leadership practices was recognized as essential to sustain the emotional health of themselves, the health-care workforce and the patients they serve (Hartney, 2018; Kisely *et al.*, 2020). In today's over-stressed health-care system, this will continue to be of paramount importance.

Although for many health leaders the COVID-19 pandemic was perceived as an unpredictable crisis, we cannot overlook similar events in history that may provide insights. In the past two decades, numerous pandemics have preceded COVID-19, including severe acute respiratory syndrome, Middle East respiratory syndrome, H5N1 (bird flu), H1N1 (swine flu) and Ebola. In addition to the loss of life directly attributable to these diseases, the mental health consequences of anxiety of those directly unaffected, widespread grief of those bereaved, as well as depression and other mental health consequences of survivors, including suicide (O'Malley, 2009), are important considerations for health leaders and the health workforce.

Previous research has identified that health organizations are vulnerable to crises, have inadequate damage containment mechanisms to prevent or manage crises and rely heavily on planning and technological damage containment mechanisms, while human and social methods are typically overlooked (Canyon, 2013). Leadership in times of crisis often promotes characteristics of charismatic leadership (Bass, 2010) and organizations will often default to established leadership culture (Bargh and Chartrand, 1999). As a crisis can generate cognitive overload, initial deep reflection on effective leadership is often lacking (Lord and Maher, 1993). A re-evaluation of leadership assumptions surfaces later upon reflection and emerging ways of thinking are often shaped through new social interaction patterns, coupled with stress, conflict, ambiguity and uncertainty (Balogun and Johnson, 2004; Probert and Turnbull James, 2011). This underscores the interplay between individual leadership capabilities and organizational leadership culture (Schein, 2004). Deitchman (2013) identified a need for crisis leadership skills in health leaders and demonstrated that these skills are not routinely taught in public health curricula. Deitchman drew together criteria for crisis management skills for health leaders from the literature on the attributes of successful crisis leadership in aviation, public safety, military operations and mining. Yet, there is no empirical evidence that the crisis management skills required in these very different contexts have applicability in the health system. Our continued reliance on short term, mechanical approaches to problem-solving, as opposed to long-term, organic systems approaches, have ill-prepared us for the current pandemic (Dickson and Tholl, 2020). Consequently, we have experienced an unimaginable health crisis, with untold suffering and thousands of preventable deaths. The current project fills this gap by identifying health-care-specific crisis leadership skills, developed, used and evaluated in the field in real-time. It provides an opportunity for health leaders to reflect on leadership failings, which could help us to better understand how future crises could be prevented (Duarte, 2020) and to better appreciate the resilience that carries leaders and health-care systems to survive and thrive beyond this pandemic (Kaczorowski, 2020).

Aims and objectives

This project is the first phase of a three-phase action research project. By using a national sample of health-care leaders reflecting on their own "in situ" leadership (Robinson *et al.*, 2019; Bowen *et al.*, 2019; Coleman, 2015), this project makes an original contribution to the empirical research literature. Conceived through discussion among Canadian health leaders who wished to identify effective practices during the pandemic and to promote leadership education dialogue, the project is important as health care is the system most profoundly impacted by COVID-19, in Canada and globally and the functioning of an integrated, psychologically healthy health and care system depends on the quality of health leadership.

This paper describes the first phase of a three-phase action research study. It has the overall aim to identify promising leadership practices that could be leveraged to re-imagine and re-build our future health and care system, during and after the COVID-19 pandemic. The objectives of the project were to:

(1) Determine what effective leadership practices Canadian health leaders have used through the first wave of the COVID-19 pandemic.

(2) Explore how these differ from pre-crisis practices.

(3) Identify what leadership practices might be leveraged to create the desired health and care system of the future.

Methodology

Participants

Drawing on the expertise of members of the research team, we sampled health leaders working in the Canadian health care system during the first wave of the COVID-19 pandemic during the spring and summer of 2020. Through iterative discussions, we aimed to recruit health leaders with a balance between individuals directly impacted or experiencing the pandemic unfold (frontline workers including learners and senior leaders of health delivery organizations) and those categorized as operational (pan-Canadian organizations, academics and organizational design/human resources professionals). Selection criteria included considerations for diverse geographic representation, health profession (nurse, physician and other), employment context (primary organization of work) and gender. In total, 11 men and 7 women participated in the interviews with 3 questions based on the project objectives framing the conversations. Most (n = 10) were working at the executive level of leadership, with four working at the senior Level, 2 at the mid-level and two at the emerging level. The participants worked in a range of health-care organizations, including health authorities (n = 5), national organizations (n = 5), academic organizations (n = 3), not-for-profit organizations (n = 2), government (n = 2) and long-term care (n = 1). They were located across Canada in the provinces of Alberta (n = 5), British Columbia (n = 4), Ontario (n = 2) and Nova Scotia (n = 2), with four others identifying as leading nationally while physically located in Ontario and one identifying as leading nationally while physically located in British Columbia.

Design

This project used an action research methodology. Action research is "a way of investigating professional experience, which links practice and the analysis of practice into a single, continuously developing sequence" (Winter, 1996, p. 13). Action research was considered by the research team as particularly appropriate for studying health leaders during the pandemic, as it allowed the collection of and responses to the unfolding crisis leadership practices of committed health-care leaders, as well as their adaptation, refinement and development through the future phases of the COVID-19 pandemic. Specifically, action research allows for holistic discoveries and corrections through processes of reflection and reflexivity and the refinement of theory through real-world testing of interventions, rather than the purely abstract conceptualizations offered by traditional biomedical models of research (Morton-Cooper, 2000).

Consistent with the action research approach described above, conducted in the context of an ongoing natural experiment in crisis leadership, we invited participants into a disciplined process of reflection to identify and document leadership practices that work to fulfill the functions of leadership. From this, we envision and articulate aspects of organizational design, community engagement and service delivery models that respond to the needs of a modern, technological, democratic and inclusive society.

Ethical considerations

Prior to data collection, the project received ethics approval from both the Royal Roads University Research Ethics Board (REB) and the Interior Health Authority REB.

Procedure

After obtaining REB approval, the sample was recruited through the team's leadership networks. Data were collected through audio and/or video-recorded interviews conducted virtually, except for one participant who submitted a journal entry documenting their

experiences. All data were transcribed by a third-party transcriptionist and anonymized prior to analysis. Grouped to minimize bias, the researchers engaged in either data collection or analysis.

Data were analyzed using grounded theory through open coding, which was then shared with the working group for validation and feedback, then axial coding, which resulted in the core dimension and key themes. The themes were verified through a dimensional analysis. The final analysis was shared with the remaining co-authors for validation.

Results

The results of the grounded theory analysis are illustrated in Figure 1.

Disrupting entrenched structures

The core dimension of health leadership during the first wave of the COVID-19 pandemic that emerged from the data are *disrupting entrenched structures and practices*. This overarching theme corresponded to how leaders described responding to the sudden, unknown and rapidly changing context of the pandemic, with the resulting impacts on the health system, by making decisions quickly, often with incomplete information and involving many people from within and outside the organization. Faster decision-making and innovations, greater collaboration with co-creation and supportive workplaces are changes that leaders would like to enhance in the future. Leaders' narratives clearly illustrated interconnections between present, past and future, to answer our research questions.

Responding to emotion in self and others

A considerable portion of the data related to leaders *responding to emotion in themselves and others*. This theme emerged in every interview and was different from the emotions leaders responded to at work prior to the pandemic. Their empathy now had to encompass

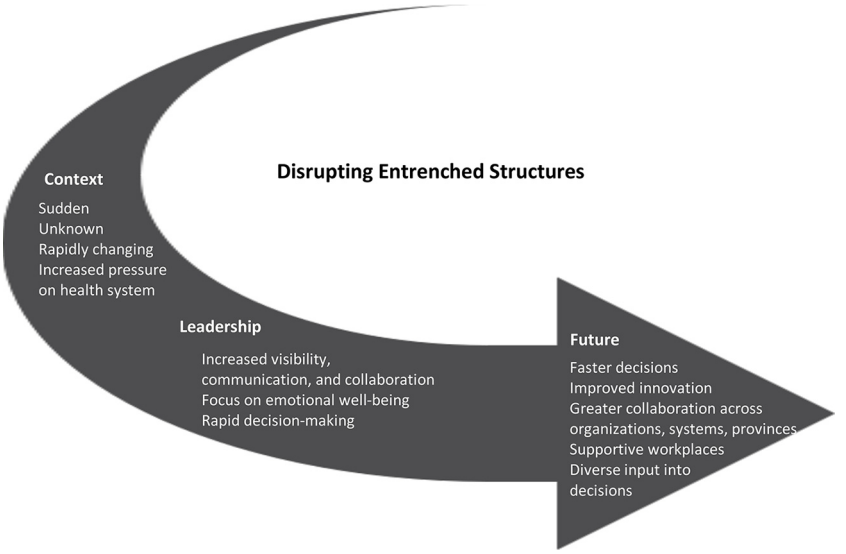

Figure 1.
Disrupting entrenched structures

responses to guilt, anxiety, grief and concerns arising from disruptions to home life that dominated the first wave of the pandemic.

For example, one participant described their surprise at the extent of the anxiety expressed by staff when their long-term care home was locked down, early in the first wave of the pandemic:

> [. . .] in March [. . .] when I locked the care home down, it was very stressful for a number of people that I didn't expect to react with anxiety [. . .] interesting [. . .] and so it was, it was fascinating to see. (Participant 017)

Another participant described how they responded to grief among staff within their organization:

> This was very much a shared experience and a shared concern and a shared desire to make it make things easier for people who were on the front line. And frankly, people who were impacted directly by COVID. [. . .] within two weeks of our organization starting to work from home, we had to essentially do [. . .] a memorial service with our staff following the death of a person who is very close to someone in our organization. So, the position and the productivity and all of that really fall by the wayside and it was really about responding to need [. . .] that was identified in the moment. (Participant 015)

This resulted in a greater focus on psychological well-being, and the desire for workplaces, which support people more fully in their lives than before the pandemic, including in their home lives. Moreover, connecting more authentically with staff, leaders also applied this focus to themselves to enhance their self-care and reflective practice:

> [. . .] we feel guilty if we sit down for five minutes when everyone else is running around. And so that self-reflection was really important to me. I have to recognize at some point in time that my contributions were every bit as important while I might not be and might not feel like I was putting in the time that everybody else or some of my colleagues appear to be in it. (Participant 008)

While this reflective practice was essential for leaders to get themselves, their staff and the communities they served through the pandemic, it was identified as a leadership practice to take forward into the future.

Agile and adaptive leadership

Leaders described engaging in *agile and adaptive leadership*, again, typically to a greater degree than prior to the pandemic due to the accelerated pace of change:

> Decisiveness is important. But so is flexibility, agility and nuance. (Participant 003)

Several participants noted that this agility went against the usual way that the health system operates, for example:

> For myself, the level of frustration that must be present for administrators when it comes to moving things quickly [. . .] in a system, that's not really designed to move things quickly. And [. . .] the difference between iterating on the ground level versus having this thoughtful academic [. . .] double-blinded [. . .] structured approach to responding to crisis and kind of the middle ground that we have to have it sometimes reached when it comes to responding to COVID. (Participant 001)

This adaptability allowed leaders to move systemic change forward more quickly, which was considered desirable going forward post-pandemic. Some also reflected on how the

pressure of adhering to COVID guidelines allowed progress to occur that should have happened previously, but the impetus was not there, for example:

> So, there's a level of cleanliness that we haven't seen, it probably should have been there before. But we've really had to step it up because it was just [. . .] unacceptable in light of COVID, my belief is that it was unacceptable before, but [. . .] we were powerless to change it or maybe not sufficiently motivated. So that would be a change. (Participant 012)

Integrating diverse perspectives to accelerate innovation

In the context of the sudden, unknown and rapidly changing environment of the early first wave of the COVID-19 pandemic, leaders found themselves *integrating diverse perspectives*, both within and across organizations; for example, bringing physicians into the decision-making process was described by one participant:

> I think physicians should be at the table with [. . .] the leadership people or by corporations. Yeah. Provide more effective infrastructure. I think some of the most successful deliveries are. (Participant 018)

Another described the large number of people consulted on decisions:

> I look at when I came to my organization, the idea that you might consult with 30 people who were impacted by a decision without giving up [. . .] decision making, or without feeling you need it to move away from decision making authority if it was required, [. . .] after all consultation. That was new for me about five years ago. But surprised that people talk about intentionally bringing others into the decision-making circle. (Participant 015)

This shared leadership had the result of leveling hierarchies through bringing together a variety of perspectives in the decision-making process and engaging people more broadly in the co-creation of strategies. For example, one participant described the positive impact that the pressures of the pandemic have had on shared or "lateral" leadership and more effective teamwork:

> (During COVID) You have an opportunity to do [. . .] more of a [. . .] lateral style leadership where you've got real teams and real opportunities to work collaboratively with people [. . .] I've seen that work so efficiently [. . .] in the last couple of months, it's been incredible the way that [. . .] the team in my facility has come together even more so [. . .] than before. Because we had to rely on each other when we've had to send people home and, and work with a skeleton crew [. . .] just to be able to rely on people, to do [. . .] above and beyond what they would normally do [. . .] it just gives an opportunity for people to take the ball, to run with it [. . .] to do more than what you would expect or what you would think [. . .] being part of what would normally be expected and it gives an opportunity to reimagine what leadership is, what leadership looks like. We have an opportunity to rework [. . .] corporate leadership. Personal leadership perhaps [. . .] and rework the way things go. (Participant 009)

Leaders also described greater collaboration across jurisdictions:

> I was online in the middle of the night with a colleague from [. . .] [another province] saying, 'what's going on?' What are you doing? [. . .] And that was the first week of the [. . .] pandemic [. . .], so we were very fortunate that we have strong communication strategies across our country. (Participant 017)

This level of collaboration reflected a large-scale mental model shift toward actively seeking input into new possibilities, increasing capacity for *accelerated adoption of innovation*. A good example of this is virtual health-care services:

> [. . .] A lot of things that we believed before COVID suddenly became things that we didn't believe. For example, virtual care is something that patients won't accept. [. . .] overnight, [. . .] virtual care was something everybody wanted to get involved in. (Participant 001)

This accelerated adoption of virtual care is a practice that participants felt should be reflected in future health leadership. For example:

> So, the pace of change can't continue as it has. But the openness to change that there's been a change in attitude and I really love that. And I don't know what we can do to maintain that so that people don't think well that was for COVID but now that's over. So, we're back to our stodgy selves. And [. . .] we can now we can sit on our iceberg and wait. I'm hoping that we don't get back there. We've made changes [. . .] in our perspective, that will be enduring. (Participant 012)

While some seasoned leaders described how they *applied their existing leadership capabilities*, emerging leaders may not have established these skills. As one senior leader stated:

> I was fortunate enough, I guess I've got enough resilience. I wasn't anxious. I was, I was applying all the stuff that of course the LEADS [health leadership framework] has taught me [. . .] in the many years that I've used it. [. . .] and those capabilities gave me the tools and the confidence to just deal with the situation. (Participant 017)

Decisive, frequent communication linked to credibility

Leaders had a greater *awareness of systems at play*, including the heightened expectation of leaders, socio-political influences and reduced control over decision-making, which required adaptations to greater complexity:

> I think that's one of the things that I learned early on, is that it really pays to get everybody on the same page early, because if you don't, there's risk that clinicians will see or think they're hearing inconsistencies. They won't feel that they need to take accountability for some of the decision making. So, it's really making sure that everybody feels that they were a part, even if it's like a small group of leadership, that they are taking accountability for the messaging. And, you know, pretty much, messages go out with like, the whole senior leader team, not the C-suite team but the director level team needs to agree the message before it goes out. (Participant 014)

Many leaders commented on how *communication changed frequently* during the first wave of the COVID-19 pandemic, based on emerging evidence and messaging. This impacted the credibility of leaders through the inconsistent and changing communication. For example, one participant described the importance of communication to maintain credibility as a leader:

> Trust and confidence and the credibility that almost any office holder in a leadership position relies on, because the loss of their credibility means an instantaneous inability to ultimately perform, perform the functions effectively. (Participant 003)

Leaders responded to this by *communicating more frequently and decisively to help build trust*. Future practice should increase communication to build credibility and trust within and across organizations.

Limitations

Some limitations of the study include the small participant sample size and the self-selected nature of the sample, through a network of health leaders focused on positive approaches to leadership development. This may have impacted the results. In the next phase, it will be important to recruit participants from more diverse locations, backgrounds and career

stages. Given the interviews took place during the early stages of the pandemic, it may be that health leader's views of what may be required to re-define future health systems may change as the crisis shifts over time.

Discussion

This action research project had the first objective of determining what effective leadership practices Canadian health leaders have used through the first wave of the COVID-19 pandemic, the second objective of exploring how these differ from pre-crisis practices and the third objective of identifying what leadership practices might be leveraged to create the desired health and care system of the future. Within the overall theme of disrupting entrenched structures, we identified five key areas in which health leaders changed their leadership practice during the first phase of the pandemic. We discuss the implications for the next phase of the study and future health leadership practice and system change, below.

The first approach leaders used was responding to more complex emotions in themselves and others. The implication for future practice is to create more psychologically supportive workplaces in health care that support health-care workers more fully in their lives. Concern about the psychological wellness of the health workforce was recognized well before the pandemic (Dodek *et al.*, 2020; Hartney, 2018; Wall, 2015) in the face of burnout among health-care workers (CMA, 2018; Drummond, 2014; Leiter and Laschinger, 2006) and has been reiterated during the pandemic (Kisely *et al.*, 2020). Moral distress and the need for psychological support at the individual (self-care), peer-to-peer support and team level have been recognized (Maben and Bridges, 2020). Studies have highlighted the pressure the pandemic has a place on the health and wellness of our workforce (Possamai, 2020; Rubin *et al.*, 2021a; Rubin *et al.*, 2021b). The findings of this first phase underscore the need for leaders to focus first and foremost on their own emotional well-being and creating supportive workplaces sufficient to sustain the health-care system. It is unclear whether those currently in the health workforce will stay if such supports are not forthcoming. Given the relentless pace of change during the pandemic, it is clear that the system is not prepared for the longer-term impact the pandemic will have on health teams and their readiness for ongoing change is unclear. For system transformation to be actualized, specific investments may be required to provide the time, support and human resources needed to respond to these needs. The next phase of the action research will help to determine how the health-care system can better support its workers, although immediate action is required both during and after COVID.

The second approach leaders used was agile and adaptive leadership. It is unclear in the responses from participants whether they were using these terms in the sense of common discourse or from the perspective of leadership scholarship (Joiner, 2009, 2019; Heifitz, 2011). While many leaders practice rapid decision-making, it is the entrenched processes of the health system that slow down innovation and change. In future phases of the project, it will be important to explore the long-term impact of new structures and practices. "Entrenched structures," such as collective agreements, bureaucratic hierarchical management systems and autonomy of physicians have clarified gaps in the *locus* of authority and accountability for many people in health care (Lumby, 2019; Meier and Krause, 2003). The first phase of the action research has also helped us to better understand decision-making processes, specifically the shift from top-down decision-making to work around and "distributed" leadership. Previous arguments have been made that these shifts are needed for the future of health leadership (Dickson and Tholl, 2020). Future practice should allow leaders to move systemic change forward more quickly. In addition, it is imperative that the health system put processes into place to plan for future crises and pandemics, rather than relying on

leaders to manage such crises in the context of the lack of preparation experienced during COVID. If this preparation had been done after previous pandemics, many lives could potentially have been spared.

The third approach leaders used was integrating diverse perspectives, within and across organizations, leveling hierarchies through bringing together a variety of perspectives in the decision-making process and engaging people more broadly in the co-creation of strategies. Multiple horizontal coalitions were built – across provinces, across organizational boundaries, across economic sectors – to address emergent challenges, based on shared leadership rather than typical top-down leadership in which permission for innovation and action was sought from above. While direction from the top came too late or at inopportune times, innovation emerged on the front-line and individual leaders acted based on just-in-time information and the needs of the moment. Moving from "command and control" leadership to show decisive action early in the first wave, they shifted to more inclusive leadership styles (Goleman, 2017), in response to emergent circumstances. While more seasoned leaders drew on leadership experience and applied learned leadership skills, such as the LEADS framework, more emerging leaders will be recruited in the next phase of the action research to reflect the demographic shift in leadership. High quality, person partnered health care requires a collective leadership culture with shared leadership emphasized across the organization, avoiding a "command and control" leadership style (West *et al.*, 2014). Organizations must develop a leadership development strategy that focuses on the leadership qualities and practices it will foster going forward and then establish programs to deliberately nurture the desired cultural change. To facilitate an integrated approach, leaders of this complex change must consider and build on the organization and system enablers for successful transformation (Manley and Jackson, 2020). As a result, leadership training, mentorship and succession planning will need to be expanded to better prepare health-care leaders of the future. It also means dismantling structural inequities in our health and health systems and social systems to allow for true inclusion of diverse voices and system wide change.

Finally, participants described the challenges of communicating effectively in an ever-changing information landscape. Information changed frequently based on emerging evidence and the accuracy of messaging; misinformation was rife. Leaders felt responsible for building credibility in the information they shared but found it difficult in a modern social media context in which they did not control information flow. Kouzes *et al.* (2011) argued that the three foundations of credibility are trustworthiness, competence or expertise and conviction: if people do not believe in the messenger, they would not believe the message. To maintain trust, it was important to communicate more frequently and decisively with competent, expert information. With the rise in information flow through social media and the internet, clear, consistent and credible messaging is needed to serve as an antidote to employee and public confusion.

As we move into the second phase of the project, we construe the ongoing COVID-19 situation as a crisis perpetuated. The pandemic has morphed into a syndemic or "a set of linked health problems involving two or more afflictions, interacting synergistically and contributing to excess burden of disease in a population" (Singer *et al.*, 2017). This cumulative crisis has involved issues around the availability of personal protective equipment (Snowdon and Forest, 2021), extended care challenges (Mialkowski, 2020), racism (Gravlee, 2020; Irfan *et al.*, 2021), exacerbated substance use and addictions (Hartney, 2021; Walker *et al.*, 2020) and mental health delivery, as the stresses on individuals and families put increasing demands on mental health and social services, as well as family stability (Jenkins *et al.*, 2021). It is unclear whether the entrenched structures on which the current

health system is based will adapt or break down as the syndemic unfolds. In addition, the impact on the economy has affected many in the workforce and will have long-term consequences.

This discussion raises the practical question of what impact this and subsequent studies might have on the previously understood practices of leadership within the constraints of the organizational structures the pandemic itself is now starting to challenge. In Canada, the *LEADS in a Caring Environment* capabilities framework has become a de facto statement of desirable leadership practices (Canadian Health Leadership Network, 2020). An exploration of the consistency of this study's findings with the guidance of *LEADS* is the subject of another article (Dickson *et al.*, 2021). Yet, regardless of the consistency of our findings with existing models of leadership, one conclusion is inescapable: current leaders and existing leadership development programs, need to embrace the practices of leadership described in this paper as they represent a shift in focus from leading in a somewhat stable environment to a focus on leading in a very unstable environment; one that is likely to persist as a matter of course into the future.

However, what if post-pandemic changes in health care are so profound so as to challenge current conceptions of health leadership? What will the interactive effect of dealing with the impact of COVID variants, disrupted vaccination schedules, on-again, off-again lockdowns, extended social distancing and isolation, economic disruptions and bailouts and the rapid changes in technology, have on the structure of the health system going forward? Van Aerde (2020) argued that our health system may well be in a state of decompensation: moving into a renewal phase the results of which cannot be predicted. In that context, what will the long-term impact be on funding for health, the publicly administered delivery systems currently used, the willingness of the health workforce to sustain its commitment and on the public's own trust in current models of delivery? Will the results of this phase of the study be relevant to later phases? Further phases of this study are dedicated to exploring these questions.

Conclusion

Prior to the pandemic, there was a growing awareness that change was needed across Canada's health system to expand leadership capacity. The pandemic has proven that innovation and rapid systemic change is possible. Looking ahead, it is imperative that we identify and communicate the leadership practices that will build a renewed, unified health system that meets the needs of Canadians, today and in the future. With the growing recognition that COVID-19 is part of a larger syndemic, future questions for the study include identifying the desirable future of the health system, what leadership practices are necessary to create that desired future and how we ensure there is a sufficient leadership capacity, investment and resources across the health system to realize its desirable future.

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Corresponding author
Elizabeth Hartney can be contacted at: Elizabeth.Hartney@royalroads.ca