CHLNet
Canadian Health Leadership Network
Le Réseau canadien pour le leadership en santé

Brief

The Value of a Common Language for Health Leadership

Purpose

This brief arose as part of CHLNet's desire to mobilize knowledge for more effective action and integration into leadership practices especially in the context of health reform and transformation.

What Is Leadership?

Leadership sits in every chair and can be defined as "the capacity of an individual or group to influence people to work together to achieve a constructive purpose."[i] Evidence is showing that, while leadership is certainly a function of time, place and circumstance, there are some common capabilities that are shared among high impact leaders. There is also a growing body of knowledge underscoring the importance of leadership to organizational and health system performance and it suggests that in a system as complex as health care, that "heroic" leadership models[ii] are at best time limited.

In the last decade, leadership itself has become a focus of study and many breakthrough theories have been proposed to explain how leadership works such as situational, trait or even behavioral.[iii] These theories help build a better understanding of the special knowledge and skills required to become an effective or high impact health leader. Leadership is no longer seen as tacit knowledge (i.e. difficult to transfer to another person) but rather can be developed through role modelling, mentorship or managing performance. It involves actively nurturing a community of practice of health leaders.

> *We can no longer expect or afford to see this as a case where the heroic Chief Executives come in and do wonderful things; health care is too complex for that; we need much more collective leadership.*
>
> Ham, 2013.

Is Leadership an Acquired Skill?

While "all leaders are born", leadership is not something you are born with, nor is it a function of your position. Rather it is a skill to be acquired. Leadership education, training and development enhances the quality of leaders and leadership within the various levels of the health system. Historically, leadership development has tended to focus on top-down, competency-based leadership development and only for the high performers: nurturing the "heroic leadership syndrome". A new view of leadership (at least for the health sector) is emerging, one that believes experiential learning that reflects one's experiences throughout the spectrum of leadership is key to leadership development and capacity enhancement. Leadership instruments and self-assessment tools such as Myers-Briggs, Firo-B, E-Q-I 2.0, and Campbell Leadership Index can help leaders throughout organizations better understand their innate abilities and personal strengths: "sell your strengths, buy your weaknesses."

What Is Distributed Leadership as Opposed to Designated Leadership?

Well accepted models of leadership such as distributed or shared leadership[iv] are on the rise as one person cannot have all the requisite expertise to effect major changes in a system as complex as health care. There is increased understanding of the importance of balancing distributed leadership with designated leadership.[v] Distributed leadership is where "some of the functions of leadership can be delegated or embedded in other persons or roles in an organization."[vi]

This collaborative leadership style is complementary to top-down, directive or autocratic styles although should not be seen as the panacea to our leadership challenges. Context is important in determining which approaches are most effective in each situation. More decentralized leadership is emerging, with sharing of authorities and accountabilities between teams and individuals as leadership occurs at all levels. Distributing leadership across several roles, all with the same shared purpose, is increasingly seen as mission critical to both organizational and system performance.[vii]

> *Learning leadership differs from learning anything else in two important ways. The first is the tools of the craft. A hockey stick and skates are the tools of hockey… but in leadership, your core attributes, values, beliefs and talents are your tools.*
>
> Dickson and Tholl, 2014.

Why Do We Need a Common Leadership Language?

It is hard to envisage a true distributed leadership system without a common language around leadership. It can provide a foundation or set of standards to facilitate the sharing of both leadership practices and leadership development programs. LEADS is just one of many frameworks that can create opportunities to have this conversation and create shared purpose. It is a "by health, for health" leadership capabilities framework built upon five key elements: Lead Self, Engage Others, Achieve Results, Develop Coalitions and Systems Transformation.

LEADS makes explicit the behaviours leaders must master to be successful in this ever-changing health leadership environment. It does this with four measureable and observable capabilities comprising each of the five domains. A common language creates shared meaning across a system; it unites rather than fragments; it creates opportunities for, and stimulates the collaboration that otherwise might not exist, and builds relationships.

What Are the Benefits of LEADS as a Common Leadership Language?

In 2006, LEADS was created based on an assessment of a full range of existing leadership models. It took the best of the best and applied these insights to the unique, "caring" health care context in Canada with distributive leadership at its core. LEADS has become Canada's preferred, common health leadership learning platform to develop new leaders, create change, and grow individual leadership capacity. Through validation both in British Columbia and across Canada, both the face and construct validity have been tested for LEADS.[viii] Adoption of LEADS has been widespread by pioneering organizations such as CHLNet, Canadian College of Health Leaders, Accreditation Canada, Canadian

Medical Association, Alberta Health Services, and numerous health regions and provinces from across Canada. The country of Australia has even adapted it for its own context.

Numerous practical benefits accrue from having a common language such as:

- Increases ability to share programs, practices and tools for people management;
- Shifts money from investment in framework creation to developing people;
- Generates a pool of leadership candidates for a system, rather than for a specific organization;
- Allows leadership development to be used as a process of change management, reducing duplication of staff and of programs;
- Empowers aspiring leaders to know what to develop in order to be successful;
- Helps people from different professions and responsibilities understand one another;
- Because the capabilities of LEADS are at a high level, customization can occur (from a behavioural expression perspective) to each individual, each organization—while retaining a common language of purpose; and
- Provides a basis for coaching, development and provision of feedback.

> *Surely if we are to really lead the future of healthcare we must believe that our own generic problem solving skills, grounded in the scientific method but tempered in the art of medicine are key to the future. The contention therefore is that if/ when medical leaders are to lead the way forward in this century towards the transformation and improvement of healthcare across the globe then we must work between us towards a simple yet clear vocabulary that we can share with our clinical, management and technical colleagues around at every meeting and every report. Does such a framework exist?*
>
> Shannon, 2014.

A decade ago, leadership was not on the policy landscape. However, with declining relative performance internationally, leadership is now seen as an integral ingredient to move to our desired future. Like health promotion and prevention, we know it is the right thing to do and now we must make the time to do it, together.

CHLNet, May 2016

ENDNOTES

[i] Dickson, G. and Tholl, W. (2014). *Bringing Leadership to Life in Health: LEADS in a Caring Environment*. London: Springer. Available at www.springer.com/medicine/book/978-1-4471-4874-6.

[ii] Heroic leadership occurs when followers place great faith in a leader's ability to overcome obstacles and crises.

[iii] Avolio, B., Walumbwa, F. and Weber, T. (2009). Leadership: Current Theories, Research, and Future Directions. *Annu Rev Psychol.*, Vol. 60: 421-449.

[iv] The literature uses interchangeably the terms distributed, collective and shared leadership. The intention here is to communicate a style of leadership that involves shared purpose combined with a redistribution of influence and power sharing.

[v] Best, A., Greenhalgh, T., Lewis, S. et al. (2012). Large-System Transformation in Health Care: A Realist Review. *The Milbank Quarterly*, Vol. 90, No. 3: 421-456.

[vi] English, F.W. (2008). *The Art of Educational Leadership: Balancing Performance and Accountability*. Thousand Oaks, CA: Sage.

[vii] Currie, G. and Lockett, A. (2011). Distributing Leadership in Health and Social Care: Concertive, Conjoint or Collective? *International Journal of Management Reviews*, Vol. 13: 286-300.

[viii] Dickson, G., Briscoe, D., Fenwick, S., Romilly, L. and MacLeod, Z. (2007). The *Pan-Canadian Health Leadership Capability Framework Project: A collaborative research initiative to develop a leadership capability framework for healthcare in Canada.* A final report submitted to Canadian Health Services Research Foundation, Ottawa, ON.