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Leaders supporting leaders: Leaders' role in building resilience and psychologically healthy workplaces during the pandemic and beyond

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Abstract

The COVID-19 pandemic is now endemic and has taken a terrible toll on the health workforce and its leaders. Stress and burnout are rampant, and health workers are leaving in record numbers. Using data collected during the first four waves of the pandemic, and a longitudinal analysis of these data, the authors identify ongoing challenges to health leadership related to building resilience and psychologically healthy workplaces. The article is organized around three questions: What happened during Waves 1 to 4? What did we learn? And what should be done differently? Eight actions emerged around the theme of "leaders supporting leaders": build personal resilience; practice compassionate leadership; model effective interpersonal leadership behaviour; ensure frequent and authentic communication; participate in networks and communities of practice; balance short- and long-term commitments; apply systems thinking; and contribute to a collaborative, national strategy.

Introduction

Since its emergence, the COVID-19 pandemic has taken an immense toll on the health workforce and its leaders. Even prior, the imperative for healthcare organizations and the health system to strengthen resilience and invest in the psychological health and safety of its workforce and in particular, its leaders, had been apparent. The Canadian Health Leadership Network (CHLNet) has conducted research with health leaders over the pandemic to understand challenges faced, and personal experiences of leadership. This study identified COVID-19's impact on the workforce as a quantum threat to our Canadian health system if not addressed immediately.[1] Arising from data collected during the first four waves of the pandemic, and current knowledge of leadership (what happened?), this article identifies key lessons learned relative to building resilience and psychologically healthy workplaces (what did we learn?) and focuses on what leaders must do to support learners, health colleagues and themselves in resolving this threat (ie, what should be done differently?).

Context

By the end of 2021, two years after the emergence of COVID-19, the World Health Organization reported over 280 million cases worldwide with over 5.4 million deaths.[2] These deaths along with other direct/indirect health and social consequences of COVID-19 take a toll on worker psychological health and wellness. The Omicron variant further threatened already stretched healthcare systems; critical care and overall inpatient capacity is again overwhelmed (with downstream effects) with widespread reports of burnout, stress, and early retirements across the health workforce.[3-6]

Naturally, the toll on the psychological health of clinicians and staff is prodigious.[7] Dr. Theresa Tam, Canada's Chief Public Health Officer, reported to Parliament stating: "the pandemic has served as an important wake-up call on the need for public health renewal in Canada…our public health system is stretched dangerously thin, and it needs critical reinforcements."[8] Even before COVID-19, Canada lagged well behind comparator countries on key indicators. The Organization for Economic Cooperation and Development comparisons rank Canada 26th of 39 in physicians per 1,000 population; 17th/39 for nurses per capita; and a woeful 36th/39 for hospital beds per capita.[9] Prior to the pandemic, levels of burnout and distress were high for physicians (65%) and nurses (78%),[10] pointing to a healthcare system already lacking stretch capacity to care for those needing care,[11] and ill-equipped to care for those caring for the sick.[12,13]

The pandemic has amplified known concerns; innovative leadership approaches are essential to respond to the call-to-action to create psychologically healthy and resilient workers and workplaces.[14] Because it is the responsibility of formal and informal healthcare leaders to collectively address these issues, it is important to gather evidence about their experiences relative to these challenges and look for new ways forward. A fundamental subtext is how leaders will support leaders in filling that responsibility.

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Methodology

This paper is a summary, as of December 2021, of a subsidiary project undertaken by CHLNet as a response to the first phase of its "Leading Through COVID" (LTC-19) action research study.[15] A major challenge for leaders identified in the first phase was the need for personal and organizational resilience, while supporting workers in their psychological health and safety.

Data informing this paper—beyond the first phase—were derived from the following sources: (1) facilitated focus-group dialogues at the CHLNet November 2021 round table (n = 45); and (2) a joint CHLNet and HEAL survey (n = 39) from another project on leadership pathways for health workforce wellness.[16] These data were analyzed by the writing team and results triangulated to identify key themes.

What happened: Challenges, perspectives, and experiences of leadership during the four waves of the pandemic

Collected data highlight the leadership challenges faced, and leaders' personal experiences as they progressed through the four waves of the pandemic. Relevant data explaining "what happened" relative to the issue of resilience and psychologically healthy individuals and workplaces are outlined.

Wave 1 to 3 (March 2020-August 2021)

In the first wave, many leaders exercised command and control, the long-standing practice for health system crisis management.[17] This leadership style provided a sense of being able to decisively manage the uncertainty of the pandemic. However, it was soon apparent this approach was of limited effectiveness, as established policies, processes, and plus top-down control were too rigid to address the ongoing fear and anguish people were experiencing. With the toll on patients/families, workers, and the public increasing—leaders needed to respond to complex emotions in themselves and others and engage diverse perspectives to cocreate the direction forward. Collective trust was key to managing the sheer confusion, ever-changing contexts, and unpredictability COVID-19 created. Frequent, decisive communication was necessary to build trust and counter the misinformation surfacing widely.

During the second and third waves, leaders needed to enhance "relationality" (ie, the way in which two or more people or things are connected in a relationship) and demonstrate flexibility. Relationality exerted itself within and across institutions/jurisdictions/regions, including efforts to engage and respect the voice of others, whether colleagues, professional, staff, or patients/caregivers/communities. Some leaders experienced intersecting and sometimes conflicting social identities underscoring how emergent complexities created additional vulnerability that could negatively affected worker wellness and patient care. For example, with the blurring of margins between work and home, leaders had to adapt to a virtual interface with their workforce and be flexible in response to the impact of these blurred lines. While everyone had unique experiences, the differential burden for women is noteable.[18]

COVID-19 highlighted the imperative to protect workers doing direct patient care, who were subject to a constant cyclone of disruption which aggravated existing psychological malaise. Compassionate leadership was necessary for self and others. While compassion had always been implicit to effective health leadership, the pandemic highlighted it as a requisite element for relationship-centred health and healthcare.

Wave 4 (September 2021 to December 2021)

During the fourth wave, CHLNet's partners met virtually to discuss how their experiences entering this wave had either reinforced Wave 1-3 lessons or illuminated new ones, and to provide insights to their own current psychological health and wellness.[19] To accompany this dialogue, a partners' survey began to define leadership pathways to improve health workforce wellness.

Earlier key themes were reiterated including compassionate leadership; respecting boundaries and limits of the workday; and the need for clear, concise, and consistent communication. Social media continued to be a two-edged sword enabling frequent public health messaging while spreading misinformation and fueling polarizing ideas around topics such as vaccines and masking. Many of our leaders and workers had not experienced deliberate "mal-information" attacks previously and struggled with how to respond effectively.

In the fourth wave, new themes arose such as feeling "dehumanized." Leaders at all levels had felt "super-humanized" earlier in the pandemic, but the fourth wave left them "open to attacks and deterred them from seeking the support they needed." Leaders and their workforce were now "bone tired." While some leaders noted leadership growth, for many others chronic stress and moral distress were now are at an all-time high.

Another theme that arose was systems thinking. Many commented that a national, coordinated strategy on dealing with workforce shortages and wellness, one with better data and planning,[20] is critically needed.

Leaders supporting leaders: What did we learn, and what should leaders do differently going forward?

Going forward, an emphasis needs to be placed on providing supports and reflective time for leaders at all levels to build resilience, that is, to be able to bounce back in the face of adversity, personally, organizationally, and systemically. Just as we respect the humanity of our patients and their families, there

is a need more than ever to respect the humanity of the workforce and its leaders, including the boundaries and limits each brings to their work and to their health.

Given this, if we apply our learnings about leadership and building resilience and psychologically healthy workplaces going forward, what will we do differently? Eight actions that move from leading self, through to interpersonal and systemic leadership arise as outlined below.[21]

Build personal resilience

Many leaders have experienced compassion fatigue while exercising compassionate leadership.[22] The ennui of COVID-19 contributes to ennui of self. Leaders need to recognize the factors that symptomize personal burn-out and stress. With time now needed to "heal," it is even more crucial to know when your "compassion quotient" is exhausted. Leaders must dedicate time and energy to building their own resilience, as well as that of others.[23] Take the personal time needed and in so doing, model it for others.

Practise compassionate leadership

Leaders recognize that individual "storms"—that is, crises of staff confidence, potential departures, or mental health challenges—are going to be stronger, more prevalent, divisive and conflict-ridden, and will require "healing" leadership to address them. Greater reserves of compassion, caring, and support, and deep and sophisticated skills of relational leadership are needed—especially as we all commit to improving inclusivity in our workplace. We need to continue to challenge personal, team, and organizational biases as well as structures and conditions that inhibit caring and compassion and distance us from realizing relationality potential in our leadership.

Model effective interpersonal leadership behaviour

Leaders must become comfortable with a variety of leadership styles, switching to more inclusive relational leadership styles (eg, affiliative and coaching) from command and control as the situation requires. We must change our behaviour (unlearn) to eliminate micro-aggressions and address biases while recognizing that all behaviours as a leader influence your and others' psychological health. Effective leaders create safe and inclusive spaces for people to feel comfortable "speaking up."[24]

Ensure frequent and authentic communication

Authentic bidirectional communication with a focus on listening, seeking feedback and balancing polarizing narratives must be adopted.[25] Effective leaders communicate more frequently and decisively to build trust, and develop tactics to ameliorate and debunk misinformation. Communications going forward will have to be even more deliberate, more carefully constructed, and timely to highlight and support the creation of a culture of inclusivity and belonging, with deliberate strategies and tactics adopted to counter 'mal-information'.[26]

Participate in networks and communities of practice

Communities of practice and learning can provide safe spaces to share experiences and practices and learn and grow. In challenging times, individuals benefit from sharing and learning with those experiencing similar challenges. CHLNet serves as a model for how networks can operate and be a vehicle for leaders to address shared challenges impacting psychological health and resiliency, such as Equity, Diversity, Inclusivity, Indigeneity, and Accessibility (EDIIA). New organizational structures should emphasize working collectively rather than separately.

Balance short- and long-term commitments

Emphasizing collaborative and systemic leadership, we must collectively seek and apply short- and long-term systems solutions to organizational and system resilience.[27] Effective leaders see the challenge of building psychologically healthy workplaces from a ten-year perspective. Leaders must support local, regional, or national long-term plans dedicated to solving the conditions contributing to these issues, but more immediately prepare for bigger storms such as the "great resignation" of our health workforce. We must take seriously measures such as engagement reports by unit, department, or profession, while simultaneously investing in our workers and creating flexible policies that support the whole person.

Apply systems thinking

Leaders must apply systems thinking, a skillset wanting even before the pandemic.[28] Issues relative to psychological health begin first with the health of the individual; second, with healthy practices/conditions created by how we organize the work; and third, the rules/regulations that exist within governments, professional bodies, and institutions. These rules mitigate or facilitate conditions needed to create collaborative work environments for workers and respect their need for autonomy and innovation. Systems thinking tools and processes can be used to co-create with larger, more comprehensive groups of diverse people in solving problems.[29]

Contribute to collaborative, national strategy

National and formalized collaborations can facilitate a truly collective response to the challenges of workplace wellness. For example, the federal government introduced legislation (Bill C-3) to make threats by anti-vaxxers to healthcare workers (and patients/caregivers) and obstruction of access to workplaces, a criminal offence. The National Standard of Canada for Psychological Health and Safety in the Workplace now provides a guide for organizations.[30,31] But we also need a coordinated, national strategy for tackling burnout and wellness of our health workforce, one that addresses EDIIA.

Conclusion

COVID-19 has shown that to weather current and future storms in our human-based health system, we must build resiliency at individual, organization, and system levels. Data gathered from health leaders show the urgent need to create psychologically healthy workplaces that care for patients/caregivers, workers, and leaders alike. To achieve healthy workplaces, our research shows that effective leaders support each other and grow in their role(s) by: building personal resilience; practicing compassionate leadership; modelling effective interpersonal leadership behaviour; ensuring frequent and authentic communication; participating in networks and communities of practice; balancing short- and long-term commitments; applying systems thinking; and contributing to collaborative, national strategy. By working together to foster better health leadership practices, we can achieve better health for all Canadians.

Notes

1. Glossary of terms:

   Health workforce: All individuals employed within the Canadian universal health system (primary, secondary, acute, and public healthcare).

   Leaders: Individuals, in formal positions of leadership or not, who choose to take initiative to resolve emergent and other issues.

   Health workers: Individuals, members, and learners of the many healthcare professions, who provide direct patient, family, or community care.

   Health leadership: The efforts made by individuals or a collection of individuals to work together to shape and influence improved workforce conditions and ultimately, patient/family/community care.

   Healthcare leaders: Individuals who focus their initiative to resolve issues in healthcare; in this case, improving the resilience and psychological health of the health workforce.

   Formal and informal healthcare leaders: Formal leaders are individuals who have authority and influence granted them through positional roles—identified as leadership roles—within the health sector. Informal leaders are individuals who choose to exercise initiative and influence without having a formal position of leadership.

2. CHLNet is a social enterprise of 40+ organizations called "network partners" who gather around health leadership founded on the twin principles of trust and reciprocity. Part of our work is to reduce duplication and share emerging leadership practices for 21st century care. In addition to many opportunities to dialogue and engage, network partners meet twice a year at semi-annual network partner roundtables. Visit www.chlnet.ca to learn more.
3. This CHLNet project is self-funded by our network partners. Thanks to HEAL members for their participation in the Wellness survey. Our gratitude to all the health leaders on the frontline of this pandemic who took the time to share their experiences with us.
4. The findings of this study are reflective of the expectations for leaders and leadership as articulated in the *LEADS in a Caring Environment* capabilities framework, a framework to guide leadership development and practice that has been validated during the pandemic.[17] CHLNet's member partners endorse LEADS or a LEADS compatible framework as its common language of leadership. By doing so, it allows for the exchange of leadership tools and evidence among its partners.

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