

Running head: MIDWIFERY LEADERSHIP

Living into Our Values and Vision:

Courageous, Compassionate, Principled Leadership within Ontario Midwifery

by

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A Thesis Submitted to the Faculty of Social and Applied Sciences in the Partial Fulfillment of
the Requirements for the Degree of

Master of Arts

in

Leadership

Royal Roads University

Victoria, British Columbia, Canada

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October 2020

 Kelly Armstrong 2020

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Abstract

Ontario Midwives recently celebrated 25 years of funding and regulation as part of the Ontario healthcare system. Head Midwives are peer leaders, providing the connecting link between frontline midwives and the leadership of the hospital organizations. This project adhered to Royal Roads University's Research ethics policy. Through the Association of Ontario Midwives, this action research engagement study employed a survey and a learning circle to engage Head Midwives across Ontario in answering the question: "How might Head Midwives be influencers of a profession-wide culture change towards courageous, compassionate, principled leadership?" Key finding included wide variance in the Head Midwife role, a commitment to a distributed leadership model, and desire for system equity and fairness. Recommendations focused on (a) naming equity and fairness as core values, (b) developing personal leadership and followership capabilities throughout the profession, and (c) focus on Head Midwives' leadership capabilities as peer leaders and frontline care providers.

Acknowledgements

One wee page seems far too brief to capture the gratitude I have for the support, encouragement, generosity, wisdom, and patience I have benefited from throughout this learning journey. This thesis coexisted with the white-water adventures of clinical practice and family life, and I am humbled and appreciative beyond words to be able to complete this project. To my academic supervisor, John Van Aerde, I thank you for your shining example of what it means to live one's core values. Your commitment to caring and learning resonated with compassion as I navigated through this project, my clinical life, and my family commitments. I am truly blessed, and forever changed having had this opportunity to work with you. To Niels Agger-Gupta, my second committee member, I thank you for your time, feedback, and always providing me with more opportunities to learn and grow. To Dr. Grootenboer, I am honoured that you were willing to take the time to review this thesis, as your writing on middle leadership resonated and inspired me with a sense of possibility. To Allyson Booth, my project sponsor, a sincere thank-you for your time, encouragement, and perspective throughout this project, and to Mary K. Dunn, the Association of Ontario Midwives Policy Analyst, for your support of all aspects of Head Midwives. A special note of gratitude to Trish Steele, a former Head Midwife and recently retired Midwife, your sense of possibilities, rooted in experience and coupled with generosity of time, was invaluable to this project and to my own sense of self. To all the Head Midwives who participated in this inquiry, thank you for leading the way and creating the path at the very same time.

Finally, thank you to my husband Craig and our kids, Irene, Lillian, and Rowan. Thanks for your support, understanding, and love throughout this project. I could not have accomplished it without the commitment of my family.

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Chapter One: Focus and Framing

Midwifery in Ontario recently celebrated 25 years of recognition and regulation as part of Ontario's healthcare system. The Association of Ontario Midwives (AOM; 2017) is the "professional organization which represents midwives and the profession of midwifery in Ontario" (p. 3). The purpose of the AOM is "to promote, protect and enhance the profession of midwifery and support midwives" (p. 3).

I am a registered midwife in my twelfth year of professional practice, fulfilling the role of Lead Midwife and credentialed staff member at Orillia Soldiers Memorial Hospital (OSMH). In the hospital setting, I am a primary care provider. I strive to work collaboratively with my colleagues, including midwives, physicians, nurses, and other healthcare professionals. For clarity, while OSMH uses the term Lead Midwife, a range of titles are in use throughout Ontario, including Chief of Midwifery, Lead Midwife, and Head Midwife. The diversity in titles mimics the disparate responsibilities and compensations afforded to midwives within their hospital leadership role. Head Midwife is the title most commonly used by the AOM and the Ontario Hospital Association. In this thesis, I adopt the term Head Midwife to denote the midwife in a position of leadership who is "responsible for the supervision of the quality of midwifery care provided in the hospital" (Ontario Hospital Association, 2010, p. 47) as well as representing the midwifery perspective and facilitating midwifery input into relevant decision-making processes and committees (p. 47).

In the fall of 2017, the AOM conducted a survey on bullying and the findings reflect a concerning current state. According to the AOM (n.d.-a) position statement on bullying, "81% of respondent midwives reported they considered bullying to be a major or very significant problem in healthcare and 73% . . . consider bullying to be a major problem in the profession of

midwifery” (para. 3). The AOM (n.d.-c) acknowledges that midwives engage in bullying behaviours towards each other at the practice level, and the AOM is striving to find ways to end horizontal violence and promote a healthy, supportive practice culture (para. 1). These survey findings led me to be curious about the experiences and conditions of Head Midwives throughout the province of Ontario and how we could support one another to embody respect, support, and overall well-being. The purpose of this inquiry was to understand the current demographics and work environment of Head Midwives and what it means to be a courageous, compassionate, and principled leader. My role as inquirer served to “help people analyze their situation, consider findings, plan how to keep what they want and change what they do not like” (Stringer, 2014, p. 21). To that end, my inquiry question was: How might Head Midwives be influencers of a profession-wide culture change towards courageous, compassionate and principled leadership?

To deepen and support my main inquiry question, I sought answers to four subquestions:

1. What is the current reality of Head Midwives as leaders across the province of Ontario?
2. How do Head Midwives define what it means to be an influencer?
3. What actions might an influencer take in supporting a profession-wide culture change toward equity and possibility in the Ontario Health system?
4. What resources can support current and future Head Midwives?

Significance of the Inquiry

The AOM’s survey on bullying has documented the prevalence and breadth of behaviours that have “numerous negative impacts at many levels: on the target, on their workplace, and on the broader healthcare system” (AOM, n.d.-a). Utilizing an appreciative lens in this inquiry, Head Midwives identified the “best in people, their organizations and

communities” (Cooperrider & Whitney, 2007, p. 75), focusing on what is already working in their organizations or within the midwifery community. Action inquiry is self-reflective in its nature, and as such, it requires both the researchers and co-researchers to seek insights into how their own assumptions are created (Ellis & Kiely, 2000). This inquiry provided an opportunity to explore courageous, compassionate, and principled leadership and ignited conversations about the meaning of leadership in midwifery from the personal context, to the interpersonal or relationship context, and to the organizational context. The organizational context encompassed both the AOM and the hospitals midwives work within.

Leadership development is an organizational commitment that must be approached as a major cultural change with full engagement of multiple stakeholders (Block & Manning, 2007). The key beneficiaries of this inquiry are the current and future Head Midwives, registered midwives, the hospital organizations served, and their professional colleagues. Midwives who live into the values of courage, compassion, and principled leadership will be bright lights inspiring others to see what else is possible. According to Brené Brown (2010), “Courage is contagious. Every time we choose courage, we make everyone around us a little better, and the world a little braver” (p. 15). Investing in leadership that is principled, compassionate, and courageous is a tangible antidote to a culture of bullying and incivility, both of which are associated with decreased patient safety and increased stress of the healthcare provider (Felblinger, 2009). Healthy, skilled, connected Head Midwives are of great value to the AOM and the professional midwifery community in Ontario and Canada. This inquiry has identified opportunities and challenges affecting midwives in leadership within the hospitals throughout Ontario.

The internal stakeholders are the midwives and the AOM. External stakeholders include College of Midwives of Ontario, hospitals, midwifery practices, the Midwifery Education Program in Ontario, members of the community (e.g., families, organizations, businesses, and physicians), public health, the Provincial Maternal Child Health Council, and the provincial healthcare system.

Dickson and Tholl (2020) defined leadership in health as “the collective capacity of an individual or group to influence people to work together to achieve a common constructive purpose: the health and wellness of the population we serve” (p. 1). Ontario midwives need to work collectively to develop their leadership abilities and co-create a culture where midwives can thrive. Leadership is vital to shift from a culture where bullying exists to a culture of courageous, compassionate, and principled leadership that serves to promote the health and well-being of all. Systemic oppression is considered a root cause and contributor to bullying in the midwifery profession (AOM, n.d.-c) and is closely intertwined with horizontal violence. Horizontal violence is “associated with oppressed groups and can occur in any arena where there are unequal power relations, and one groups self-expression and autonomy s controlled by forces with greater prestige, power and status than themselves” (Hastie, n.d., para. 9). The negative ramifications of bullying are far-reaching and pose risk management issues, personal health issues, and impact the culture of both midwifery practice groups and larger healthcare settings. Addressing the issue of bullying is a priority for the AOM. The 2017 survey (AOM, n.d.-b) highlighted the detrimental toll of bullying on its membership, including serious negative impacts on the health, relationships, and career satisfaction. The negative impact results in midwives taking sick leaves, stress leaves, or leaving the profession completely.

In order for Ontario midwives to continue to provide high-quality care and promote longevity in the profession, the current bullying issue needs to be effectively addressed and a new culture established. Head Midwives are ideally positioned throughout the province to influence cultural change in the midwifery profession. Simply asking Head Midwives to consider their role as courageous, compassionate, principled leaders planted “the seeds of change . . . inform[ing] dialogue and inspire[ing] images of the future” (Cooperrider & Whitney, 2007, p. 83). It is imperative to begin this change journey so that current suffering diminishes and thriving begins.

Organizational Context

Located in the Greater Toronto Area, in the province of Ontario, the AOM is the organization that represents midwives and the profession of midwifery in Ontario (AOM, 2017): “The purpose of the AOM is to promote, protect and enhance the profession of midwifery and to support midwives” (p. 3). The AOM’s purpose is carried out through a wide range of activities, including risk management, research, education for membership and the general public, support for high quality care, policy creation, advocacy, and promotion of health and well-being for midwives (p. 3). This is not an exhaustive list, but a small sampling of a wide range of accountabilities supported a membership base of fewer than 1,000 people (S. Tonkin, personal communication¹, August 16, 2018). Please see Appendix A for the AOM organizational chart. The responsibility to address the issue of bullying is primarily under the department of Quality and Risk Management, while support and guidance of Head Midwives falls within the Policy department’s bailiwick (A. Booth, personal communication, June 6, 2018). Therefore, this

¹ All personal communications in this report are used with permission.

research project spanned both the Policy and the Quality and Risk Management departments at AOM, allowing either director to comment or provide input.

The mission of the AOM (n.d.-e) is: “Advancing the clinical and professional practice of Indigenous/Aboriginal and Registered Midwives in Ontario” (para. 1). In order to advance the clinical and professional practice of all midwives in Ontario, midwives need to learn how to be with each other, their clients, and their colleagues in a way that reflects the courage, compassion, and principled behaviours they profess. As noted by Senge (2006), this means to “extend our capacity to create, be part of the generative process of life” (p. 14). As Senge named it, this is the shift or “real learning . . . [that] gets to the heart of what it means to be human” (p. 13) and “reflects what we aspire to be as a profession” (AOM, n.d.-c, para. 19).

The AOM’s (n.d.-e) vision is: “Midwives leading reproductive, pregnancy, birth and newborn care across Ontario” (para. 2). This vision is impossible to achieve in the face of bullying: “Bullying can negatively impact the individual’s health, engagement, work satisfaction, and can lead to burnout and the perpetuation of bullying . . . and can compromise the quality of care provided” (AOM, n.d.-a, para. 4). The main inquiry question of this project arose directly out of the AOM’s list of values in the *AOM Mission, Vision, Values* statement on its website (AOM, n.d.-e). There are nine bullets under the heading of “our values”. The first value, “provide courageous, compassionate and principled leadership” (para. 3) formed the basis of this inquiry. The entire value list speaks to the principles midwives value, including social justice, advocacy, equity, quality, and systems-thinking. It is imperative that midwives learn, reflect, and grow into a culture that supports members’ individual and collective health and well-being in order to achieve AOM’s vision of midwives leading in reproductive, pregnancy, birth, and newborn care.

Through this inquiry, Ontario Head Midwives shared their lived experiences with courageous, compassionate, and principled leadership as well as their struggles, challenges, and hopes for the future. The closing bullet in the AOM's (n.d.-e) list of values is "enhance the potential of midwifery to contribute to the well-being of society" (para. 11), which ties in all the listed values and intentions to one simple notion. If members can lead with courage and compassion using the agreed-upon values as their principles, midwives can make the world a better place for all.

The AOM's role is to support midwife members. One key area of support is in ensuring midwife members can meet the regulatory standards set out by the College of Midwives of Ontario (CMO). The timing of this current inquiry was in alignment with many forces impacting midwife members of the AOM, including the move to denounce bullying (AOM, n.d.-c) and the CMO's (2018) adoption of principle-based regulations. The CMO made significant changes to the regulatory approach of midwives in Ontario, effective June 1, 2018, shifting from a prescriptive set of regulations to a principle-based approach. "Leadership and Collaboration" (p. 3) is one of the five regulatory principles adopted by the CMO and was key to this current inquiry. The other four principles are commitment to self-regulation, integrity, person-centred care, and professional knowledge and practice (p. 3). All require skilled leadership now and in the future. With both the CMO and AOM calling for midwifery leadership, the imperative to support ongoing midwifery leadership development has been magnified. Action inquiry is an approach that uses specific dialogue to improve working relationships between organizational members (Torbert, 1999). Therefore, an action-inquiry approach was a good fit for the problem and the solution.

Systems Analysis of the Inquiry

Registered midwives in Ontario provide primary care to birthing families and are members of the hospital credentialed staff in their hospital, not hospital employees. In the Ontario healthcare system, family physicians who practice obstetrics are the closest comparator to midwives, with the caveat that Ontario midwives also provide the labour care. In the Ontario model of midwifery, individuals from a wide variety of backgrounds become midwives after completing a four-year degree program or equivalent education, and there is no requirement to be a nurse first (AOM, n.d.-f). Ontario midwives are an integrated part of the Ontario provincial healthcare system, and Head Midwives represent the link between midwifery practice groups and hospitals. According to Williams (2011), three main concepts provide the foundation in all systems theories: “interrelatedness, perspectives and boundaries” (p. 3). A diagram is included to aid in understanding the complex environment Head Midwives are challenged to lead within (see Figure 1).

The blue squares are representative of the hospitals, and the circles represent midwifery practice groups. Individual practice groups are different colours, and the “x” in each circle denotes the number of midwives in a given practice, the coloured lines between the circles, and the blue squares represent the hospitals where midwives from a given practice hold privileges. The small circle in the blue square represents the Head Midwife’s practice affiliation. “Systems-thinking is a discipline for seeing wholes. It is a framework for seeing interrelationships rather than things . . . to make full patterns clearer and to help us see how to change them effectively” (Senge, 2006, p. 7). The AOM is in the centre of the diagram, as it is the professional organization for midwives in Ontario. The bi-directional lines between each practice and the AOM reflect that the AOM serves the membership, and the membership contributes to the goals

and direction of the AOM. The dotted lines between Head Midwives and the AOM are less definite in the diagram and are representative of the informal social structure between individual head midwives and the AOM.

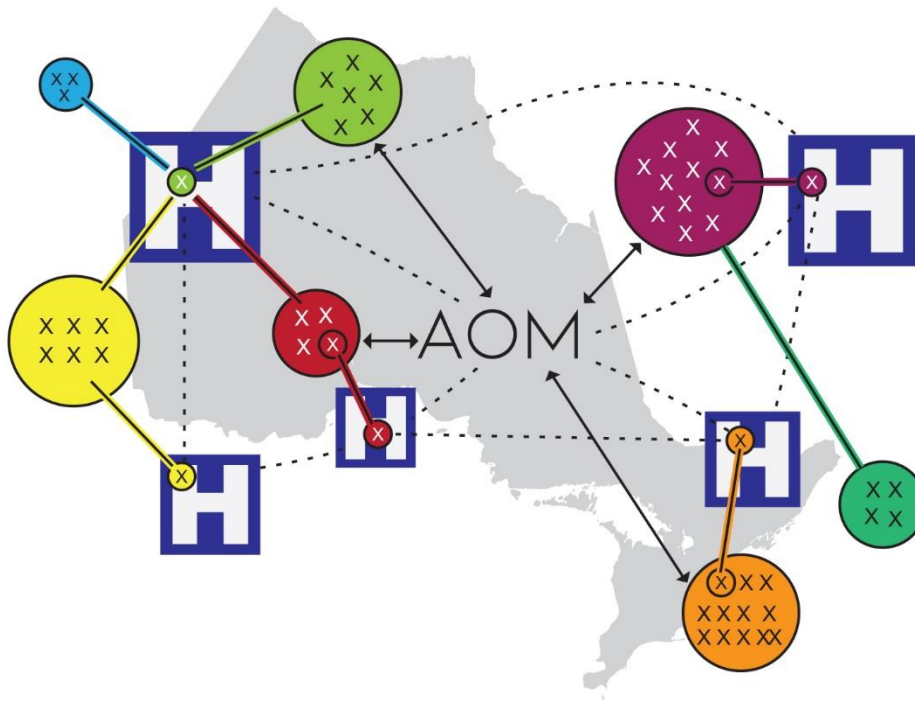


Figure 1. The complex environment Head Midwives are challenged to lead within.

It is important to note that midwifery practice groups are often credentialed staff at more than one hospital, and one midwife might be Head Midwife in one hospital and be credentialed at another hospital with a different Head Midwife. The diagram presented in Figure 1 represents examples of potential midwifery practice and their hospital affiliation to illustrate the sense of the complexity and variation. Oshry (2007) wrote, “We humans are systems creatures. Our consciousness—how we experience ourselves, others, our systems and other systems—is shaped by the structure and process of the system we are in” (p. xiv). Oshry argued that many issues,

conflicts, and challenges are not personal ones, but systemic, and most humans are blind to the systemic forces at play.

The Cynefin framework is made up of four domains that “help leaders to determine the prevailing operative context,” and each context/ domain requires a particular approach of action (Snowden & Boone, 2007, The Cynefin Framework section, para. 1). The relationship patterns of Ontario midwives are taking place in the complex environment of the Ontario healthcare system. The key leadership approach in complex environments, where there are no “right” answers, is to “probe first, then sense, and then respond” and experiment a way forward (Snowden & Boone, 2007, Complex Concepts section, para. 2). The aim of this inquiry, in line with complex systems, was to probe Head Midwives for their lived experiences and sense or gather their experiences, paying particular attention to the emergent patterns and, with a collective group, go forward with curiosity to see what will work. Action inquiry promotes change at three levels: (a) with the individual, (b) within a group of people, and (c) across the organization (Torbert, 2004). It was my hope that change would occur with the individual Head Midwives, the collective of Head Midwives in the province, and the many organizations midwives serve.

Summary

The research opportunity, organizational context, and inquiry significance for Ontario midwifery and across hospital settings were outlined in this chapter. The AOM is the professional association that represents midwives and midwifery in Ontario with the purpose of promoting, protecting and enhancing the profession of midwifery and supporting midwives (AOM, 2017). Bullying is a documented concern throughout Ontario midwifery resulting in a number of negative consequences for midwives themselves and the families they serve (AOM, n.d.-a). Using an appreciative inquiry lens, this current inquiry focused on Head Midwives in

peer leadership roles within Ontario hospitals in an effort to cultivate a practice wide culture shift away from bullying and towards courageous, compassionate and principled leadership throughout Ontario midwifery.

The literature foundational to this inquiry is explored in Chapter 2.

Chapter Two: Literature Review

Courage is contagious . . . If we want people to fully show up, to bring their whole selves . . . so that we can innovate, solve problems and serve people—we have to be vigilant about creating a culture where people can feel safe, seen heard and respected. (Brown, 2018, p. 12)

The first bullet in the AOM’s (n.d.-e) values list is: “Provide courageous, compassionate, and principled leadership” (para. 1), which was the inspiration for this inquiry. Courage and compassion are often found together in the literature (Barchard, Sixsmith, Neill, & Meurier, 2017; Brown, 2018; Hall, 2013; Wasylyshyn & Stefano, 2005), while the concept of principled falls under a variety of names, such as values, ethics, integrity, character, or morals (Brown, 2018; Holmes, 2010; Morales-Sánchez & Cabello-Medina, 2013; Sotile & Sotile, 2002; Tanner, Christen, Tanner, & Christen, 2014; Wasylyshyn & Stefano, 2005).

Leadership “occurs as practice . . . [and is more about] what people may accomplish together” (Raelin, 2016, p. 3). Distributed leadership encompasses both the concept of leadership as practice and the idea that effective relationships are foundational to leadership for those with or without formal leadership roles (Dickson & Tholl, 2020; Harris & Gronn, 2008; Harris & Spillane, 2008; Spillane, 2005). Closely aligned to distributed leadership is the concept of effective followership, where qualities of leadership such as self-management, commitment to purpose, continual ability improvement, and courage are held in common with leaders (Kelley, 1988).

Leadership and followership operate within the context of organizational and professional culture. Culture plays a central role as a critical factor in transformation of organizations (Best, Saul, & Willis, 2013; Schein, 2017). Frontline ownership emphasizes the imperative nature of

involving the people impacted by any change in the design, implementation, and follow-through of those changes, particularly in healthcare (Zimmerman et al., 2013) Middle leadership emphasizes both the idea of leading from the middle of one's group and as the link between peers and management (Grootenboer, 2018). In an effort to contextualize Ontario midwifery leadership, this literature review encompasses a compare and contrast section of midwife, nursing and physician leadership. This literature review examines the established literature relevant to the inquiry question: How might Head Midwives be influencers of a profession-wide culture change towards courageous, compassionate, principled leadership?

Four sub-questions were used to deepen the literature review:

1. What is the current reality of Head Midwives as leaders across the province of Ontario?
2. How do Head Midwives define what it means to be an influencer?
3. What actions might an influencer take in supporting a profession-wide culture change toward equity and possibility in the Ontario Health system?
4. What resources can support current and future Head Midwives?

Courageous, Compassionate, and Principled Leadership

The capacity to provide courageous, compassionate and principled leadership is imperative in order to achieve excellence in the care provided (National Health Service England [NHS], 2014). To do this, it is important to face our fears as leaders and followers, connect with the suffering of others, and be guided by our core values (Brown, 2015, 2018; Crigger & Godfrey, 2011;). The literature is reviewed for the definitions of courageous, compassionate and principled as it pertains to leadership, followership and the associated behaviours. If Head Midwives are to become influences of courageous, compassionate, and principled leadership, it

is imperative to have a deep and broad understanding of courageous, compassionate, and principled leadership.

Courageous leadership. Courage is a growing theme in the healthcare leadership and followership literature (Brown, 2018; Chaleff, 2009; Crigger & Godfrey, 2011; Sekerka, Bagozzi, & Charnigo, 2008; Walston, 2003). Brown (2018) reported that courage is a collection of four skill sets that can be “taught, observed and measured” (p. 11). Brown named the four-courage skill sets as (a) rumbling with vulnerability, (b) living into our values, (c) braving trust, and (d) learning to rise (p. 11). Vulnerability as the only route to courage cannot be overstated, and Brown declared, “You can’t get to courage without rumbling with vulnerability” (p. 10). Vulnerability is present in a wide variety of acts such as setting boundaries, showing up for meetings, and speaking up on behalf of others. It is demonstrated by both leaders and followers (Brown, 2018; Chaleff, 2009).

Courage was defined by Crigger and Godfrey (2011) as “the ability to face the fear, acknowledge it, and live through it. . . . In a broad sense, the ability of an individual or group to overcome actual or perceived threat or loss in order to achieve another outcome” (p. E13). Brown (2010, p. 12) used the term “ordinary courage” to highlight the everyday acts that require courage and emphasized that *cor* is the root of the word courage, the Latin word for heart. Detert and Bruno (2017) defined “workplace courage [as] a work-domain-relevant act done for a worthy cause despite significant risks perceivable in the moment to the actor” (p. 625). Crigger and Godfrey (2011) provided examples of professional nurses displaying courage through refusing pharmaceutical company gifts, advocating for safe patient care, or taking risks to change an inferior practice. These actions aligned with Treasurer’s (2009) definition of courage as pushing through fear in the service of a worthy goal or cause to better the lives of others. These

actions also reflect Brown's (2015) research that it takes courage to define what is ok and what is not ok, otherwise known as setting boundaries.

Compassionate leadership. Compassion is an interpersonal process that unfolds on three contextual levels—personal, relational, and organizational (Dutton, Workman, & Hardin, 2014). At an organizational level, when leaders embody compassion, they nurture a wider culture of compassion throughout the organization, which in turn, results in significant positive impacts on patient and professional well-being (West, Eckert, Collins, & Chowla, 2017). According to West et al. (2017), compassionate leadership creates the conditions for innovation at both the individual and system level. The role of leadership is key, as leaders connect people to “their own humanity and core purpose . . . align people to organizational purpose and . . . leverage organizational infrastructure” to cultivate compassionate patterns of behaviour (NHS, 2014). In order to understand the elements of compassionate leadership, it is important to understand compassion at the level of the individual.

Hojat (2016) defined compassion as residing in the space between sympathy and empathy, where sympathy is viewed as emotional, or suffering with an individual, and empathy is viewed as cognitive understanding of another's pain and suffering. Brown's (2015) definition of empathy is also reflective of the concept of understanding. She defined empathy as “the ability to understand what someone is experiencing and reflect back that understanding” (p. 155). Singer and Klimecki (2014) defined empathy as “the capacity to share the feelings of others” (p. 875), both positive and negative, and does not include the reflective element. While Brown (2015) and Hojat (2016) were aligned with their respective definitions of empathy, their approach to sympathy was different. Hojat wrote about sympathy as emotional and suffering with an individual. In contrast, Brown defined sympathy as removed, or feeling for the person, as

in: “I feel sorry for you” (p. 156), which aligned with Riess’s (2018) description of sympathy as: “I feel bad for you” (p. 13). Sympathy is viewed as a form of disconnection, and empathy is “the heart of connection” (Brown, 2015, p. 156). Riess suggested the term empathic capacity rather than empathy, as it conveys that empathy is made up of many different physiological and psychological facets, and our empathic capacity “requires specialized brain circuits that allow us to perceive, process, and respond to others” (p. 10). Klimecki, Leiberg, Ricard, and Singer (2013) and Riess (2018) have proven through their research that empathy is a learnable skill set. Empathy without compassion is associated with stress, poor health, and burnout (Klimecki et al., 2013; Singer & Klimecki, 2014).

Kristen Neff (2011) offered a definition of self-compassion as a trifecta of self-kindness, common humanity, and clear-sighted way of relating to ourselves. It is available when we “fall flat on our face, embarrass ourselves, or otherwise come in direct contact with the imperfections of life” (p. 6). Similarly, Riess (2018) employed the term self-empathy as the “acknowledgment that like all human beings, you deserve understanding and compassion” (p. 189) and strikingly offered a very similar real life example: “To truly practice self-empathy to its fullest, you must be willing to use it even when you trip over your own feet and make mistakes that leave you feeling embarrassed or wishing you’d stayed home” (p. 189). Heffernan, Quinn Griffin, McNulty, and Fitzpatrick (2010) studied the relationship between self-compassion and emotional intelligence and found a positive correlation. To be a compassionate leader, it needs to start with the self, through personal beliefs, values, and behaviours (NHS, 2014).

Acts of compassion are “felt at a personal level . . . through values and behaviours (NHS, 2014, p. 18). Brown (2015) defined compassion as “recognizing the light and dark in our shared humanity” and committing to practice loving-kindness for ourselves, and others in the face of

suffering” (p. 155). Compassion is action-oriented or motivated to offer some relief to the suffering (Riess, 2018; Singer & Klimecki, 2014). Similarly, Atkins and Parker (2012, p. 526) defined compassion through four components: (a) noticing, (b) appraising, (c) feelings, and (d) action.

Principles or values. A literature search for principled leadership yields references to values and ethics. Brown (2018) defined a value “as a way of being or believing that we hold most important” (p. 186). She emphasised each human being has only one set of values, which do not alter at work, school, or one’s personal life. Brown stated, “Daring leaders always carried with them a clarity of values” (p. 186). Bendaly and Bendaly (2012) echoed the importance of common values to define a team and achieve their collective goal. In contrast, when one’s values are chronically not aligned with those in the workplace, burnout occurs (Maslach, Schaufeli, & Leiter, 2001).

Equity is a core value for Ontario midwives and is listed within their values as: “Create systems and tools that uphold equity within the midwifery profession, in relationship to clients and within the health system” (AOM, n.d.-e, Our Values section, para. 6). Equity “is about each of us getting what we need to survive or succeed—access to opportunity, networks, resources and supports—based on where we are and where we want to go . . . each of us reaching our full potential” (Putnam-Walkerly & Russel, 2016, para. 9). Braveman (2014) defined health equity as:

[The] principle underlying a commitment to reduce—and ultimately, eliminate—disparities in health and its determinates. . . . Pursuing health equity means striving for the highest possible standard of health for all people and giving special

attention to the needs of those at greatest risk for poor health, based on social conditions.

(p. 6).

Similarly, equity in healthcare has been defined as “equal access to available care for equal need; equal utilization for equal need; equal quality of care for all” (Leenan, as cited in Whitehead, 1991, p. 218). Inequity in the context of health “has a moral and ethical dimension . . . [referring] to differences which are unnecessary and avoidable [and] also considered unfair and unjust” (p. 218).

Another facet of inequity facing midwives is pay inequity. Systemic sexism led to Ontario midwives being paid inequitably compared to male equivalents. This eventually led to Ontario midwives successfully arguing a landmark pay equity case at the Ontario Human Rights Tribunal (AOM, n.d.-d). Equity is closely intertwined with fairness: “Fairness communicates respect and confirms people’s self-worth. Mutual respect between people is central to a shared sense of community” (Maslach et al., 2001, p. 415). By contrast, “the experience of being treated unfairly has an intense emotional impact” that undermines one’s relationship with work (Leiter & Maslach, 2001, p. 48). The perception of equity from an organization, or leadership within the organization contributes to the perception of fairness by those who work there (Bridgeman, Bridgeman, & Barone, 2018). Vianello, Galliani, and Haidt (2010, p. 405) reported that employees respond with “intense positive emotions to the display of fairness and moral integrity” as demonstrated by their leadership, which both strengthened positive attitudes and enhanced organizational behaviour.”

Leadership in Healthcare

Dickson and Tholl (2020) wrote, “Health leadership is vital for achieving the healthcare we need. Ensuring services are people-centred, creating healthy workplaces where providers can

thrive and give their best care and reforming the systems that deliver that care are the job of leadership” (p. 08). Leadership begins at the level of self (Dickson & Tholl, 2020; NHS, 2014; Senge, 2006). Health system leaders may hold formal titles or be lead without designation, and followers are a key element of leadership practice (Spillane, 2005). Middle leadership is discussed as peer leadership of one’s frontline colleagues, and midwifery leadership is contextualized within the Ontario healthcare and education system.

Leadership starts with self. Dickson and Tholl (2020) posited that leadership is a life-long pursuit that must be “solidly grounded in who you are” (p. 57). Kouzes and Posner (2012) added that leadership “requires patience, reflection, humility and commitment to making a difference (p. 6). Lead Self is the foundational domain for all other capabilities in the *LEADS in a Caring Environment* leadership development framework (Dickson & Tholl, 2020). The lead self domain is rooted in ethics and morality, and encompasses four capabilities: (a) self-awareness, (b) self-management, (c) self-development, and (d) demonstrates character (p. 79).

Self-awareness highlights the ability to be aware of one’s values, assumptions, principles, strengths, and limitations (Dickson & Tholl, 2020). Self-awareness is the antidote to self-delusion—not being in touch with your true nature or beliefs (Dickson & Tholl, 2020). Clarifying that which matters to us is aligned with Brown’s (2018, p. 186) statement: “A value is a way of being or believing that we hold most important.” Brown as well as Kouzes and Posner (2012) spoke to the importance of practicing one’s professed values through action.

Self-management highlights the internal landscape, including emotional intelligence with emphasis on personal health (Dickson & Tholl, 2020). Emotional intelligence is the ability to demonstrate self-control, personal regulation, and read verbal and non-verbal behaviours (Goleman, 2006). Mindfulness is one component of self-compassion and includes cultivating

awareness of the present moment, considering it with greater objectivity and perspective, and avoiding over-identification with the “story-line of one’s own pain” (Neff, 2011, p. 4). Building on Neff’s work, Brown (2018, p. 149) used the term “paying attention.”

Self-development is the idea of continual learning, growing, and changing (Dickson & Tholl, 2020). Senge’s (2006) definition of personal mastery is at the heart of self-development. He defined personal mastery as “the discipline of continually clarifying and deepening our personal vision, of focusing energies of developing patience and seeing reality objectively” (p. 7). Senge argued that personal mastery is the key to an organization’s ability to learn and grow, stating that “an organization’s commitment to and capacity for learning can be no greater than that of its members” (p. 7). The importance of an organization developing the leadership capabilities throughout its membership was echoed by Dickon and Tholl (2020) and Kouzes and Posner (2012).

Distributed leadership and effective followership. Relationships and interactions are at the heart of the distributed leadership model. Similarly, leadership-as-practice views leadership as emerging and unfolding through day-to-day experiences, and the people who are affecting leadership are embedded within it, emphasizing the collective nature of leadership (Collinson, 2018; Raelin, 2017). From a distributed leadership and effective followership perspective, members of an organization spanning a myriad of relationships will fulfill the role of both follower and leader depending on the particulars of an interaction, regardless of official position or title (Spillane, 2005). The importance of followers as key to effective nursing teams was highlighted by Lopez and Freeman (2018). Much of the literature on distributed leadership arose from the school system and contained two central ideas. The first is that multiple individuals are involved in the leadership of an organization encompassing those with formal positions and

those without (Harris & Spillane, 2008; Spillane, 2005). The second idea involves looking at leadership-as-practice, comprised of a variety of interactions and relationships throughout the organization with a strong emphasis on collective action (Collinson, 2018; Harris & Spillane, 2008; Netolicky, 2018; Raelin, 2016, 2017; Spillane, 2005; Timperley, 2005). Distributed leadership is not a single homogenous entity, but rather a set of emerging ideas “that frequently diverge from one another” (Spillane, 2005, p. 14).

Dickson and Tholl (2020) stated that healthcare is one of society’s most complex social enterprises. They defined leadership as “the collective capacity of an individual or group to influence people to work together to achieve a common constructive purpose: the health and wellness of the population we serve” (p. 1). Their definition of leadership is specific to the healthcare environment and includes a strong focus on capability development, which reflects the ideals of courageous, compassionate, principled leadership.

The LEADS framework approach outlines the capabilities individuals require to inspire and lead change in the healthcare system, regardless of official position or title (Dickson, 2010; Dickson & Tholl, 2020). This is congruent with distributed leadership, which Spillane (2005) described as “about practice, rather than leaders of their roles, functions, routines or structures” (p. 146). In their seminal work on distributed leadership practice, Spillane, Halverson, and Diamond (2001) wrote that “a distributed perspective can help leaders identify dimensions of their practice, articulate relations among these dimensions, and think about changing their practice ” (p. 27). Using distributed leadership as a framework brings attention to the idea of “leadership as *practice* rather than leadership *as role*; it focuses attention on the complex interactions and nuances of leadership in action” (Harris & Spillane, 2008, p. 33). Leadership-as-practice “privileges the value of social interactions and connectedness . . . [and is] intrinsically

collective” (Raelin, 2017, p. 217). Collinson (2018) critiqued leadership-as-practice for neglecting the issues of power, hierarchy, and asymmetry in the relationships between leaders and their subordinates. Ford (2016, p. 223) echoed this critique, stating that due to its focus on “collective engagement, divergence, intersubjectivity and ambiguity” leadership-as-practice has the potential to either offer a fresh and different approach to leadership or unconsciously reinforce long-established patterns of privilege and power differentials. Distributed leadership is a collective enterprise with a variety of stakeholders who hold varied and potentially divergent interests, and it is most likely to succeed when spread out both vertically and horizontally across levels and across organizations (Chreim & Macnaughton, 2016; Chreim, Williams, Janz, & Dastmalchian, 2010; Ford, 2016). As such, distributed leadership has the potential to address issues of equity, fairness, and diversity.

Followers and followership are integral to a distributed leadership perspective (Spillane, 2005). Crossman and Crossman (2011) defined followership as “a relational role in which followers have the ability to influence leaders and contribute to the improvement and attainment of group and organizational objectives” (p. 484). Chaleff (2009) described two key behaviours for effective followership that are held in creative tension: (a) the courage to support leaders and policies and (b) the courage to challenge the leader’s behaviour or policies. Kelley (2008, pp. 14–15) echoed this, arguing that followers who exercise “courageous conscience” ought to be viewed as “primary defenders against toxic leaders or dysfunctional organizations.” Kellerman (2007) used one key metric to categorize followers—their level of engagement, ranging from completely unengaged and unaware to a deep and strong level of dedication. Lopez and Freeman (2018) reviewed the importance of the follower role in nursing teams and how to integrate both leadership and followership competency into the profession. Engaged and

courageous followership and leadership skills are needed throughout the membership of the AOM from frontline midwives to AOM leadership.

Leaders need to possess the ability to see things from the frontline, or followers' perspective, and understand the factors that promote effective and engaged followership (Kellerman, 2007; Lopez & Freeman, 2018). Both leaders and followers have specific responsibilities and contributions to make in order to achieve desired outcomes. The characteristics of effective followers are similar to those of effective leaders: (a) commitment to the organizational values and goals, (b) commitment to learning and courage, and (c) strong self-management skills (Kelley, 1988; Lopez & Freeman, 2018). While there are certainly some clusters of courageous, compassionate, and principled leaders and followers in the profession of midwifery, the development of such has not been a priority for the AOM to date. I believe the key is to start at the individual level to create critical awareness of one's place in the system.

Middle leading. Middle leadership is an emerging area of research in the realm of distributed leadership and is applicable to the role of Head Midwives in hospital settings. The bulk of the middle leadership literature primarily arose through school system research, in particular, teachers who hold a leadership role such as a department head in addition to their active classroom presence. These teachers work in the space between formal leaders, such as principals, and purely frontline teachers (Grootenboer, 2018). Middle leaders "work in the complexities of a sort of relational and structural sandwich" relating to those in formal leadership positions above them and to their frontline colleagues, across or below them (p. 7). A central idea of middle leadership is the leadership of peers aligning with the distributed leadership model (Grootenboer, 2018; Spillane, 2005).

Leithwood (2016) wrote that middle level leaders were underutilized and that underutilization negatively impacts change and reform efforts. Middle leaders are well-positioned to influence change as they can establish a community of practice with a small group of professionals, they have a specialized knowledge in their area, and can provide leadership specifically to the identity of the group (Leithwood, 2016). The idea of engaging middle leadership as being key to co-creating meaningful and lasting change was echoed by Martin and Waring (2013). There is an emerging emphasis on the need for healthcare leaders, in particular engaged clinical and frontline leaders across the system (Martin & Learmonth, 2012; Zimmerman et al., 2013). The professional development of middle leaders must be tailored to leading peers, emphasizing the development of strong interpersonal skills and the ability to lead professional learning, neither of which are capabilities inherent within the frontline role (Fleming, 2014; Irvine & Brundrett, 2019; Thornton, Walton, Wilson, & Jones, 2018).

To build leadership capacity throughout the system, individuals are encouraged to expose themselves to the widest range of leadership opportunities possible (Irvine & Brundrett, 2019). The role of middle leadership in healthcare literature was scarce by comparison, but the fundamental idea that midwifery leaders must possess both strong clinical skills and have a high level of ability to work effectively with their peers was echoed by Byrom and Downe (2010) in their article on the subject of good midwifery and good leadership.

Midwife, nursing, and physician leaders. The literature on midwifery leadership or midwives as leaders that is directly applicable to Ontario, or even Canada, is scant. A literature search of “midwifery and leadership” was conducted in the Medline, CINAHL and OVID databases. I reviewed the subjects listed for each article, searching for any related to Ontario or Canada. All of the scholarly literature related to midwifery leadership was from countries other

than Canada. The midwifery leadership research that does exist primarily arose out of the UK, where the route to becoming a midwife is through nursing, and the model is frequently a hospital-based employee model. In contrast, Ontario Midwives are fee for service and hold privileges at their respective hospital. Under the Midwives Act in England and Wales, midwives were awarded professional status, but were to “maintained a professional hierarchy in which midwives must defer to physicians” (Cross, 2014, p. 143). As such, despite a large quantity of midwifery leadership, it did not apply to the Ontario context. Thus, it is clear there is a dearth of applicable research that needs to be filled.

Byrom and Downe (2010) reviewed what constitutes good midwifery leadership through qualitative phenomenological interviews, highlighting that “confidence and competence emerged as essential characteristics” (p. 130). Byrom and Downe emphasised that credibility at a strategic and clinical level is important: Good leaders are knowledgeable about their own job and the jobs of the people they are leading. Warwick (2007) described supervisors of midwives in the UK as “midwives with vision and advocates for best midwifery practice” (p. 641). To do this, she suggested three possibilities: (a) be visible, get out there and promote high standards of practice; (b) have a vision, stand up and be counted, and fight for change; and (c) an optimistic belief in the possible and the ability to create change (p. 641).

The essential difference in the Ontario context between nursing and midwifery leadership is that nurses most commonly work under an employee model that continues as nurses take on greater leadership roles and responsibilities, such as becoming managers or Chief Nursing Officers. Midwives in Ontario work in hospitals as members of the credentialed staff and are financially compensated through their practice and, ultimately, the provincial government. The closest comparators are physicians as non-employee, credentialed staff. Because of the lack of

literature for the midwifery leadership in Canada, I took a closer look at the physician leadership literature.

In a study on physician leadership in Canada, Van Aerde (2015, pp. 30–31) reported that “1 in 4 of [physician] respondents in formal leadership roles are not paid and 18% receive a stipend only;” 1/3 of physician leadership learning was acquired through courses offered by their own organization or persuaded independently through the physician’s own initiative and personal cost. The other 2/3 of all leadership learning is acquired through the Canadian Medical Association’s Physician Leadership Institute courses and the annual Canadian Conference on Physician Leadership (pp. 30–31). In the same study, Van Aerde, reported on the barriers to physicians taking on leadership roles, including a “lack of training in leadership skills” (p. 31), the work being “portrayed as increasingly complex” (p. 31), the requisite long and sometimes unpaid hours without recognition, and the ensuing struggle to maintain work-life balance (p. 31).

Culture in Healthcare Organizations

Culture is an invisible force that impacts organizations and the people who are an intrinsic part of them (Schein, 2017). Culture is based on taken for granted beliefs, values, and assumptions that are often an “unconscious part of a group and are therefore, less tangible and less visible” (p. 10). Culture provides group stability and that stability is what makes culture difficult to change (Schein, 2017). Culture is comprised of a number of elements, including language, social rules, and meaning (Bellot, 2011; Schein, 2017). To gain a greater depth of understanding of this topic, three subtopics will be covered: (a) organizational culture, (b) organizational culture in healthcare, and (c) focusing on values in healthcare change.

Organizational culture. According to Parmelli et al. (2011), organizational culture is defined as pertaining “to the multiple aspects of what is shared among people within the same

organization: for example, beliefs, values, norms of behaviour, routines, traditions, sense-making” (p. 2). Bellot (2011) reinforced the shared aspect in her statement that “organizational culture is socially constructed, the product of groups not individuals, and based on shared experiences” (p. 31). Mohr, Young, and Buress (2012, p. 224) examined the effect of a “group orientated” organizational culture on employee turnover rates and impact and concluded that there was a positive relationship between strong group-oriented culture, improved performance, and reduced employee turnover. Tapp et al. (2008) stated that the culture of an organization determines which tasks the organization takes on and its response to both opportunities and problems. Organizational culture can be pathological, bureaucratic, or generative, which is largely determined by the type of leadership within the organization (Tapp et al., 2008). It has been posited that generative organizations encourage behaviours such as problem solving and innovation (Senge, 2006; Tapp et al., 2008).

Organizational culture in healthcare. In their review of the literature, Montgomery, Panagopoulou, Kehoe, and Valkanos (2011) stated that organizational culture within healthcare impacts how physicians function, the way patients are treated, the quality of care and patient safety. Montgomery (2011) argued that there is a strong link between organizational culture, patient safety, and physician burnout. In contrast, a Cochrane review reported a significant lack of evidence that improving healthcare culture has any impact on performance (Parmelli et al., 2011). In numerous reports, Spurgeon described the role that engagement plays in performance for physicians (Spurgeon, Barwell, & Mazelan, 2008; Spurgeon, Long, Clark, & Daly, 2015; Spurgeon, Mazelan, & Barwell, 2011). These authors noted that while physicians may be competent, it is the degree to which they feel engaged that provides the fertile ground for individual and organizational performance. Mintzberg (1997) wrote specifically about hospital

cultures and made a strong case for a bottom-up approach in order to create systemic change in healthcare settings.

Focusing on values in healthcare change. Healthcare environments are complex, highly dynamic, and challenging; therefore, it is important to understand the key cultural characteristics required in specific contexts (West, Lyubovnikova, Eckert, & Denis, 2014). To nurture a culture shift, leaders, leadership behaviours, and collaboration all need to be aligned with the values central to the culture envisioned (NHS, 2014; West et al., 2014). The importance of values as both anchors and guide posts were a repetitive theme in the literature (Bohmer, 2016; Brown, 2018; Kozes & Posner, 2012; Smollan & Sayers, 2009). Bohmer (2016) highlighted that one of the characteristics of organizations that sustain change is the heavy investment in creating a widely understood set of values and norms that serve to align professional and organizational behaviours and goals, and subsequently, the values and norms guide behaviour through ambiguity and complexity. Brown (2018) used the term operationalizing to describe transforming values into tangible, everyday behaviours.

Values, in collaboration with personal, relational, and systemic, or organizational structure are the keys to leading and sustaining change (Bohmer, 2016; Dickson & Tholl, 2020; Grenny, Patterson, Maxfield, McMillan, & Switzler, 2013; Zimmerman et al., 2013). According to Bohmer (2016, p. 710), creating change in healthcare is comprised of a “long series of local experiments,” and to truly achieve transformation, “sustained change in individual behaviour, team interactions, and operations design” needs to occur. Similarly, Grenny et al. (2013) used a model for change at the personal, social, and structural categories, and they further subdivided each of those three by motivation and ability for a total of six areas that need to be addressed to

make change: (a) personal motivation, personal ability; (b) social motivation, social ability; and (c) structural motivation, structural ability (p. 69).

In healthcare organizations that achieve lasting change, there is a heavy investment in the leadership development of clinicians, with a reduction in clinical duties to create sufficient time for change work (Bohmer, 2016). Frontline ownership is one inspiring example of problem-focused leadership to improve patient safety (Zimmerman et al., 2013). Ownership involves having the people who are impacted by the change doing the work of developing the ideas, making the decisions, and designing and acting on plans (Zimmerman et al., 2013, p. 8). Behavioural and cultural challenges are addressed by creating an environment for staff to interact and communicate in new ways (Zimmerman et al., 2013) Frontline ownership is in high contrast to the current healthcare culture and draws on the positive deviance body of work (Zimmerman et al., 2013). In contrast, top-down change imposed on organizations, even when there is agreement as to the goals, has been demonstrated to have a negative impact (Ovseiko & Buchan, 2012).

Talent Management and Succession Planning in Healthcare

Future leaders need to be identified and cultivated for the long-term health and vitality of the organization and wider system. Talent management and succession planning are key considerations to ensuring there are people with leadership capabilities ready when needed.

Talent management. This includes “the attraction, recruitment, management, retention, and development of a broad range of clinical, technical and managerial health professionals” (Turner, 2018, p. 5). Cabral, Oram, and Allum (2019) captured that upcoming leaders want internal and external supports to develop their leadership abilities including: coaching and mentoring; peer support; further leadership education/study and opportunities to be exposed to

leadership roles through shadowing and secondment. Powell (2014) echoed similar supports as facilitators of career progression.

Stanley and Sherratt (2010) highlighted the differences between nursing leadership and clinical leadership, and they encouraged the development of both to improve care and enhance the profession. Talent management needs both a quantitative and qualitative approach, meaning enough health professionals for the upcoming leadership roles and the necessary set of skills (Turner, 2018, p. 39). Having a clear definition of talent that is well understood within an organization is key in order to further develop future strategy and management (Turner, 2018).

Succession planning. Succession planning is an essential part of healthcare leadership talent management (Walker, 2019). Succession planning incorporates “those actions, activities and interventions intended to ensure that capable motivated and talented individuals are ready to assume the leadership roles” (Griffith, 2012, p. 901). It is oriented towards developing the individual for an increasing level of leadership responsibilities (Stanley & Sherratt, 2010) It purports to deliberately identify and develop future leaders (Titzer & Shirey, 2013). Effective succession planning contributes to staff development, preserves organizational culture, commitment, continuity, and vision by ensuring talented individuals are prepared and skilled to assume the future leadership role and contributes (Griffith, 2012; Walker, 2019). Succession planning is a systematic approach that involves the early identification and preparation of recruits so that experienced leaders can begin preparing their replacement (Griffith, 2012; Titzer & Shirey, 2013). Focusing on ongoing performance development and learning will, in turn, ramp up training around coaching and mentoring (Walker, 2019).

Titzer and Shirey (2013) stressed the importance of an integrated and systematic approach to succession planning in order to avoid placing an inexperienced and under-educated

nurse in unfamiliar and overwhelming leadership positions. The goal of managing talent is to ensure that health care organization has “the right people at the right places at the right times to do the right things” (Rothwell, 2010, p. 46). Frontline leadership development is proactive and responsive; it “represents the first step in establishing a successful strategy for organizational stability and maintaining health care’s competitive advantage” (Ohnmacht, 2012, p. 62).

Planning for leadership succession promotes an environment of trust, engagement, and productivity (Garman & Tyler, 2007). In contrast, lack of planning around leadership transitions increases the chaos and complexity and “creates the risk of developing an operational environment characterized by uncertainty, decreased staff engagement, and negative effects on organizational performance outcomes” (Garman & Tyler, as cited in Ohnmacht, 2012, p. 62).

Summary

A review of the literature relevant to the research question was provided in this chapter. Throughout the chapter, literature relevant to courageous, compassionate, and principled leadership; healthcare leadership; organizational culture; and healthcare talent management and succession planning were reviewed and discussed. The literature reviewed has served to define various aspects of leadership, including personal mastery, middle-leading, and distributed leadership in the context of Ontario’s healthcare system. The reviewed literature provided a foundation to address the research question and support the development of Head Midwives’ leadership capabilities and the personal leadership or followership of all midwives in Ontario to influence a profession-wide culture shift towards courageous, compassionate, and principled leadership.

In Chapter 3, the research methods and methodology used in this study will be discussed in detail. Additionally, the data collection process and data analysis relevant to this project are presented along with the ethical considerations that impacted this inquiry project.

Chapter Three: Methodology

The approach and methodology used for this inquiry project are described in this chapter. Ontario midwifery has just celebrated 25 years as a regulated health profession within the Ontario healthcare system. This inquiry was both prudent and timely, as there has been growing recognition of the need to develop leadership in the midwifery profession that is grounded in principle and operates with courage and compassion. Action research is about change and always involves two goals “to solve a problem and contribute to science” (Coghlan & Brannick, 2014, p. 48). In this section, I outline the action research approach used for this inquiry, which encompassed both quantitative and qualitative methodologies, specifically a survey and learning circle. The goal of the data collection was to address the research question: How might Head Midwives be influencers of a profession-wide culture change towards courageous, compassionate, and principled leadership? Subquestions included:

1. What is the current reality of Head Midwives as leaders across the province of Ontario?
2. How do Head Midwives define what it means to be an influencer?
3. What actions might an influencer take in supporting a profession-wide culture change toward equity and possibility in the Ontario Health system?
4. What resources can support current and future Head Midwives?

Inquiry Project Methodology

Action research “uses a scientific approach to study the resolution of important social or organizational issues together with those who experience these issues directly” (Coghlan & Brannick, 2014, p. 46; see also Stringer, 2014). Action research through an appreciative stance was the methodology chosen to govern this project in order to build on what is already successful

and enable the emergence of generative thinking and solutions (Bushe, 2013). According to Stringer (2014, p. 6), the primary purpose of action research is to “provide the means for people to engage in a systematic inquiry and investigation” in order to create an approach to accomplish a specific goal. This research approach was “associated with shifting attitudes, perspectives, knowledge, and values among people in the organization by enhancing meaningfulness, clarity and commonality of purpose, motivation, and commitment for change” (Rowe, Graf, Agger-Gupta, Piggot-Irvine, & Harris, 2013, p. 19). It focused on solving real problems, bringing about change, and developing competencies within people and organizations (Walsh & Fisher, 2005). Action research focuses on “research *in action*” using a scientific approach to both create change, and create knowledge about how change is created” (Coghlan & Brannick, 2014, p. 6). The basis for action research is the partnership between the researcher and the members involved in the situation that needs to be changed. Action inquiry promotes change at three levels: (a) with the individual, (b) within a group of people, and (c) across the organization (Torbert, 2004). It is a cyclical process of constructing, planning action, taking action, and evaluating, or to use Stringer’s (2014) words: “Look, Think, Act” (p. 9).

An appreciative stance “is a complex science designed to make things better” (Cooperrider & Whitney, 2007, p. 74). The intention of this inquiry was not to disregard the bullying behaviours, but to approach them from “the other side” (p. 74): the realm of positive social sciences. Appreciative inquiry framed the question through the lens of what can be done and which behaviours does the organization want to grow, rather than what needs to be remedied or what behaviours need to change (Lewis, Passmore, & Cantore, 2016). Action research through an appreciative stance served as an excellent approach throughout this inquiry because stakeholders were engaged in a strengths-based process that explored generative possibilities of

the future. According to Cooperrider and Whitney (2016), the appreciative inquiry stance used in this project affirmed that “the positive core of organizational life is one of the greatest and largely unrecognized resources in the field of change management today” (p. 337). Cooperrider and Whitney (2007) had earlier described that appreciative inquiry begins with “discovery and analysis of the positive core . . . [or the] root cause of success analysis” (p. 76), shifting the focus away from solving a problem to growing what is already successful and generative. This inquiry utilized both a quantitative and qualitative approach to capture and understand the experience of Head Midwives throughout the province and begin the strengths-based conversation of influencing the shift towards courageous, compassionate, and principled leadership as both individuals and organizational members (Glesne, 2016).

The findings, conclusion, and recommendations were then presented back to a group of stakeholders using a series of liberating structures to ensure resonance and engage people in next steps to make their vision of 2025 into a reality. This inquiry project encompassed the “look, think, act” elements of the organizational action research cycle as published by Rowe et al. (2013). Please see Appendix B for the cycle diagram.

Project Participants

The inquiry project participants were registered midwives in Ontario in the role of Head Midwife at the time of the data collection. From a total of 80 potential respondents, 27 survey responses were received and 19 were completed in full. Six survey respondents subsequently participated in the learning circle as well. To my knowledge, the collective voice of Head Midwives as midwifery leaders has not been sought prior to this inquiry. The Ontario Hospital Association (2010) has a vague definition of a Head Midwife due to the wide variation of hospital governance structures. The Head Midwife is defined as the person responsible for “the

supervision of the quality of midwifery care provided in the hospital” (p. 58) and “facilitating midwifery input into relevant committees and decision-making structures, and for representing the midwifery perspective” (p. 48). According to the Ontario Hospital Association, in 2010, there were 71 hospitals with privileged midwives attending births. Mary K Dunn at the AOM stated that the current number is closer to 80 (personal communication, October 19, 2018). Head Midwives are uniquely positioned as both frontline clinical care providers and as holding a leadership position within Ontario hospital organizations. In order to understand the role, supports, and attitudes of Head Midwives in Ontario, I began my inquiry with a survey. At the time of the survey release, all Head Midwives in the province of Ontario were invited to participate through the AOM Head Midwife email listserv and the AOM weekly newsletter, *Midwifery Memo*, which is distributed to all AOM members.

Qualitative research is the appropriate approach, as the “variables are complex, interwoven and difficult to measure” (Glense, 2016, p. 10). The learning circle was chosen to engage the lived experience across the range of narratives Head Midwives experience in their professional life. The circle served to verify the survey findings and generated both energy and ownership in the next step of creating a courageous, compassionate, and principled leadership culture.

Inquiry Team

To support this project, I recruited a voluntary inquiry team consisting of three people. One managed the audio recording of the circle, and the other two supported my survey and circle question development and data analysis. The first inquiry team member had an extensive background in radio and recording and as an administrator at Orillia Midwives. I asked her to be present at the learning circle to support recording logistics. A former classmate and Royal Roads

University Health Leadership graduate provided survey question feedback. A recently retired Head Midwife provided feedback and supported my data analysis as a second set of eyes to ensure an authentic interpretation of the qualitative data. Each member of the inquiry team signed a letter of confidentiality (see Appendix C). My AOM project sponsor and other staff members also provided feedback for the project including the survey.

Data Collection Methods

The design of this research project centred on creating a positive climate to engage and ignite conversations about midwifery leadership in the context of Head Midwives and beyond, as evidenced in the descriptions of the data collection, study conduct, and the process of reflection and analysis presented in this section.

Survey: The survey was the first step in understanding the current reality of Head Midwives in Ontario. Online surveys provide a means to engage a large number of participants, particularly when there are significant time constraints and the subject may contain sensitive information (Sue & Ritter, 2012). The survey included a number of multiple-choice questions, Likert scale questions, and a few open-ended questions. The intention of the survey was to understand the demographics and role of Head Midwives within their respective hospital organizations, including governance structure and individual leadership education. The survey allowed people to participate at a distance, at a convenient time, and without disclosing their choice to participate or not. As a Head Midwife, I neither had power over nor undue influence over other Head Midwives, yet Ontario Midwifery is a small community, and anonymity was important so that midwives could feely choose to participate or decline. I used an electronic online survey to gather primary data to build a broad picture of the environment, accountabilities, and supports of Head Midwives in Ontario Hospitals.

Learning Circle: Baldwin and Linnea (2010) wrote, “The circle way is a practice of re-establishing social partnerships and creating a world in which the best of collaboration informs and inspires hierarchal leadership” (p. 11). Lovett and Gilmore (2003) explored the idea of circle as a model for professional development, and in many ways, there are similar challenges facing healthcare professionals. The learning circle method is a way of listening for meaning. Each participant is invited to sit in the circle and contribute what she/he feels comfortable contributing. An object is held when a person wants to speak. Without the object in hand, participants are expected to listen. Baldwin (1994) outlined specific agreements and expectations of calling the circle. There is a strong element of formal ritual with the intention of creating a space of trust and openness so that participants might be able to have conversations and gather information that is otherwise unobtainable. The circle provided the opportunity for six Head Midwives to come together as learners and leaders in the Ontario Healthcare system to share experiences, successes, and dreams of what the future of midwifery leadership could be.

Study conduct. Upon receiving ethics approval for this study from the Research Ethics Board at Royal Roads University, as governed by the Royal Roads University (2011) ethics policy, I conducted a pilot of the questions in order to ensure that my research questions made sense. The processes for the survey and learning circle are presented in this section.

Online survey. I started with my survey questions (Appendix D), reviewing them with my sponsor, the policy director at the AOM, and my inquiry team. Once I believed my questions were solid, I asked a few past Head Midwives and other volunteers to pilot the survey on-line. Based on the feedback, I revised my questions for clarity and flow. I used the LimeSurvey platform (<https://www.limesurvey.org/>) for the survey, and by having some volunteers pilot it through the on-line platform, I ensured the survey flowed smoothly and the questions were set up

appropriately. For example: If participants were asked to “choose as many as apply,” the pilot volunteers helped ensure that question would allow the respondents to select multiple boxes. Once I was satisfied the survey was ready for the participants, I inserted the live link into the invitation (Appendix E).

My AOM project sponsor and a member of the AOM team reviewed and provided guidance for the combined research letter and online survey invite (see Appendix E) to ensure a friendly and welcoming tone and layout to encourage participation. The survey invitation was sent out on my behalf by Mary K Dunn, Policy Analyst at the AOM. By having Mary K Dunn issue the invitation, I attempted to ensure it would not end up in the “junk” folder in various Head Midwives’ email, encourage participation through use of the AOM staff name, and denote this project has been approved by the AOM.

Learning circle. A learning circle followed the survey as the second data collection method. This method also required piloting. There are two aspects to practice: (a) the gathering and facilitating of a circle and (b) the actual questions. I created an opportunity to lead a circle of women at my own home to practice facilitating a circle. I reviewed the questions for the learning circle with my inquiry team and midwifery education colleagues to ensure clarity. Once the survey data were compiled and analyzed, I updated the circle questions to ensure relevancy and depth.

To recruit participants, they were automatically redirected to a short survey after the anonymous survey was completed, asking if they would be interested in phase two of this inquiry, the learning circle (see last page of Appendix D). Volunteers who affirmed their interest were asked to provide contact information. Using the list of volunteers, I sent out the invitation to participate in the learning circle with an anonymous doodle poll to determine the best date and

time to ensure the circle would have adequate participation. I set it up to be anonymous from the perspective of other potential participants and requested participants select as many as they could commit to, off-call (Appendix F). A research information letter was also sent with the learning circle invitation (see Appendix G), and a link that outlined the basics information and expectations of circle participation. I selected the date with the greatest number of people as no one date had more than five off-call volunteers. Two additional people expressed interest in attending while on-call, so I invited them once I had confirmed enough participants so that the circle would run. One person withdrew prior to the beginning of the circle, resulting in a total of six participants. The person who sets the tone and purpose for the circle is called the host (Baldwin, 1994), and for this research, I assumed this role.

Due to geography and difficulties with scheduling, the circle was held via conference call. As soon as the date was confirmed, I sent the Learning Circle consent form, requesting it be returned prior to the beginning of the Learning Circle (see Appendix H). A few days prior to the learning circle, I sent a simple PowerPoint via email to the participants, with the circle questions in the foreground and photos of the circle centre, which I had created (see Appendix I).

I began the circle with gratitude for their participation and asked them to imagine that we were together in person. Instead of passing an object for permission to speak, participants left silence in between speaking. In conducting the learning circle, I needed to be cautious of bringing unchecked bias into the circle. I strove to keep questions open ended and held space for the voices involved in the circle to potentially have radically different experiences and interpretations of those experiences compared to previous data gathered. Questions for the learning circle are presented in Appendix I. I sought to understand the tension between the personal story, professional practice, and the role of leadership. The learning circle served to

both validate the findings of the survey and further highlight our strengths and growth areas to support courageous, compassionate and principled leadership now and into the future. The circle provided a unique opportunity, particularly in a healthcare setting, to bring Head Midwives together to share their personal stories. The chance to both listen deeply and share in a safe space can create energy and commitment in unique ways (Baldwin & Linnea, 2010).

The findings of this inquiry were presented to the Head Midwives, AOM staff members, and the incoming AOM board president, and an open invitation was made to the broader Head Midwife community. The themes, conclusions, and recommendations were presented by the author of this inquiry, and then followed up with a number of liberating structure activities to confirm resonance, cultivate ownership, and identify next steps. Liberating structures (Lipmanowicz & McCandless, 2013, p. x) are activities designed to engage and include everybody present in “unleashing a culture of innovation” through unconventional methods of harvesting each person’s contribution, thereby increasing the rates of success. The overall experience of this inquiry, the findings, and the outcomes from the liberating structures activity may be presented at the provincial conference in the future or form the basis for a scholarly article.

Data analysis. Coghlan and Brannick (2014) stated that authenticity in action research is “characterized by four process imperatives: be attentive (to the data); be intelligent (in inquiry); be reasonable (in making judgements); and be responsible (in making decisions and taking action)” (p. 29). I strove for authenticity by revisiting and reviewing the process imperatives throughout this inquiry.

Credibility, or trustworthiness of the data, is about quality and rigour of a study and includes prolonged engagement and persistent observations, triangulations, and member

checking (Glesne, 2016; Stringer, 2014). I incorporated prolonged engagement and persistent observations through regular reflection and dialogue with my sponsor. Triangulation has been demonstrated through the use of a survey and the learning circle (Stringer, 2014). Member checking (Stringer, 2014) was incorporated through the learning circle and my final activity. It was important that the participants confirmed and validated the data and the authenticity of the inquiry implications.

The survey analysis started with the facts and statistics, such as the number of surveys received and how many were completed. The quantitative data were compiled to illustrate the demographic and position in the hospital governance structure, as suggested by Sue and Ritter (2012). I reported the compiled responses to each question (see Appendix J).

For the open-ended questions within the survey and the transcription of the circle, I used a qualitative approach of looking for repeated themes and words (Glesne, 2016). A few open-ended questions requested a fact-based list, such as leadership training attended in the past, while others were more of a qualitative nature. The qualitative open-ended questions in the survey arrived in transcribed form ready for theming. The learning circle was audio recorded, and I transcribed it verbatim to familiarize and immerse myself in the data. The written transcription and the direct answers from the qualitative survey questions served as the data source for analysis. Ryan and Bernard (2003) wrote that there are four main tasks in analysing data, which included “discovering themes and subthemes; winnowing themes to a manageable few; . . . building hierarchies of themes or code books, and linking themes into theoretical models” (p. 85).

I used the typed transcripts to review on a line-by-line basis in order to be “immersed in the data and discover what concepts they have to offer (Glense, 2016, p. 196). I made notes of

possible code words, which are categories of activity that the data represent (Glesne, 2016).

Using a printed copy of the transcript and the qualitative survey results, I physically cut apart the transcript and sorted them into potential themes posted on large papers around my office.

Originally, I had named six themes, but upon reflection, one was truly a subset of another. As suggested by Ryan and Bernard (2003), I paid particular attention to repetition of words or ideas, similarities, and differences. I strove to be aware of what did not fall into my themes and reviewed the parts of the physical transcript that were left over after theming. “Researchers have long recognized that much can be learned from qualitative data by what is not mentioned” (p. 92). I reviewed all of my findings with an inquiry team member so that my own bias was minimized.

I stored the data on two encrypted hard drives, so that one would be back up should anything happen to the other. I kept the hard drives and any printed raw data in a locked safe in my home. The participant data will be destroyed by December 31, 2021, or after I graduate, whichever comes first.

Ethical Issues

In any research, it is imperative that consideration be given to ethics throughout the design, data collection, analysis, and ongoing recommendations phase (Glesne, 2016). In action research, it is particularly “imperative to ensure that all participants know what is going on, and the processes are inherently transparent to all” (Stringer, 2014, p. 89). This research project complied with the ethical standards and guidelines in the 2011 Royal Roads University *Research Ethics Policy* and the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (Canadian Institutes of Health Research, Natural Sciences and Engineering Research

Council of Canada, & Social Sciences and Humanities Research Council of Canada [Tri-Council], 2014).

Meeting the formal ethics requirement is only one component of ethics. At all times, I strove to treat each and all participants in a way that put their well-being above all else. The three core principles for ethical research with humans included (a) respect for persons, (b) concern for welfare, and (c) justice (Tri-Council, 2014, p. 6).

When humans are involved in the research, their participation must be secured in such a way that is completely voluntary and demonstrates informed consent; this demonstrates the ethical principal of respect (Glesne, 2016), and consent must be “free, informed and on-going” (Tri-Council, 2014, p. 27). Respect, informed consent, and voluntary participation were demonstrated through the anonymity of the surveys, research information letters, and confidentiality of the data.

To recruit volunteers, I was transparent regarding the purpose of the research and my involvement as the researcher to analyse the survey results and conduct the circle. There were potentially three midwives in the parallel position of Head Midwife at another hospital, who were also credentialed staff at the hospital where I am Head Midwife. This could have been considered a conflict of interest or a power-over situation. The survey was anonymous to safeguard their right to participate or choose not to without my knowledge. None of them volunteered for the learning circle portion. I did not have any other conflicts of interest.

The potential benefits and risks of participation in the survey were provided in the email invitation and in the preamble within the survey. I provided the potential benefits and risks of participation to everyone who volunteered for the circle group and emphasised that the participant was welcome to withdraw from the study at any time. As a member of AOM and

credentialed staff member at OSMH, I was not involved in the employment, performance-evaluation, or in any way have input into the engagement of Head Midwives in Ontario.

Therefore, there were no power-over issues with other Head Midwives, with the exception of the two previously mentioned.

Summary

In this chapter, the research methodology and methods used for this study were outlined. The inquiry used an on-line survey and virtual learning circle to collect data relevant to the research question. The process of data analysis was described, and included member-checking as well as the involvement of inquiry team members to ensure trustworthiness, and validity of the findings. Additionally, ethical considerations were summarized, along with the measures taken to address and mitigate potential issues. In Chapter 4, a detailed discussion of the findings and conclusion arising from the data will be provided, and the strengths and limitations of this project will be delineated.

Chapter Four: Inquiry Project Findings and Conclusions

This research inquiry explored the question: How might Head Midwives be influencers of a profession-wide culture change towards courageous, compassionate, principled leadership?

The subquestions used to deepen this inquiry included:

1. What is the current reality of Head Midwives as leaders across the province of Ontario?
2. How do Head Midwives define what it means to be an influencer?
3. What actions might an influencer take in supporting a profession-wide culture change toward equity and possibility in the Ontario Health system?
4. What resources can support current and future Head Midwives?

Survey Study Findings

This inquiry used two data collection methods: (a) an on-line survey followed by (b) a learning circle. The survey was instrumental in collecting data from a larger number of Head Midwives throughout Ontario. Out of an estimated pool of 80 potential respondents, the survey collected 27 responses. Nineteen respondents completed the survey in its entirety. Twenty-one responses were received for Parts A and B only. A copy of the survey is provided in Appendix D.

Part A findings: Titles, hospitals, departments, and remuneration. Survey Part A was aimed at understanding and describing the current situation of Head Midwives regarding their place in the hospital governance structure (see Figure 2) and the availability of leadership remuneration: for example, a stipend or education allowances. Twenty-one people responded to Part A questions.



Figure 2. Hospital title, number of practices, and departments where midwives hold privileges.

The Ontario Public Hospitals Act (1990) regulates the Medical Advisory Committee (MAC) which plays a key role in the scope and granting of hospital privileges. It is composed of “elected and appointed members of the medical staff” (§35(1)) and is a seat of power in Ontario Hospitals. Three respondents (14%) identified they had both a seat and a vote on MAC, four (19%) had a seat only, and the majority (67%) were not involved in the committee at all. Four respondents reported 5–9 midwives in their hospital, seven had 10–15 midwives, four reported 15–20, and six respondents had 20 or more.

Financial and educational support for leadership is an area of interest in the physician leadership literature (Van Aerde, 2015), which has yet to be studied in Ontario midwifery. Eight participants identified receiving a stipend from their hospital organisation, and one participant identified receiving a salary. Twelve Head Midwives identified that the source of compensation for their leadership activities came from caseload variables, which are a form of self-funding through the midwife’s own practice.

The majority of the respondents (67%) reported that the Head Midwife role is chosen by midwives who hold privileges at that hospital. Four (19%) reported that the hospital leadership chooses. Three respondents picked “other,” explaining that historically, the Head Midwife was chosen by the group, but that currently nobody was interested in the role. Two mentioned a hybrid process whereby a group of privileged midwives submits the names of candidates for Head Midwife, and the hospital leadership interviews and selects a new head. For hospitals with more than one midwifery practice group, practice group affiliation of the Head Midwife was a key consideration for only three (14%) respondents.

In Ontario, hospitals are designated Level 1, 2, or 3 (see Figure 3), with Level 1 providing care to women and infants who have the lowest level of identifiable risk and

complexity of care, with increasing levels of risk and care at Level 2 and 3 (Provincial Council for Maternal and Child Health, n.d.). Four of 19 Head Midwives hold privileges at additional hospitals where they are not Head Midwives. The majority of Head Midwives (67%) hold privileges only at the hospital where they are Head Midwife.

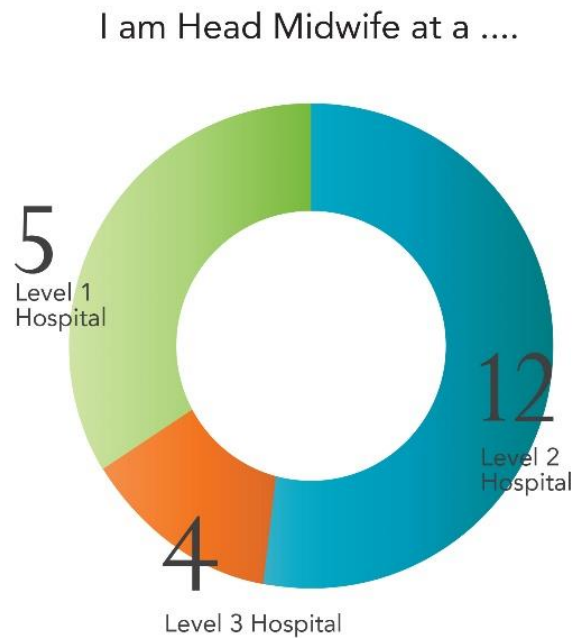


Figure 3. Level of hospital where Head Midwives practice.

Part B findings: Head midwife demographics. The second part of the survey captured the experience, age, and additional leadership roles Head Midwives are engaged in. All participants reported a minimum of five years in practice as a registered midwife (see Figure 4).

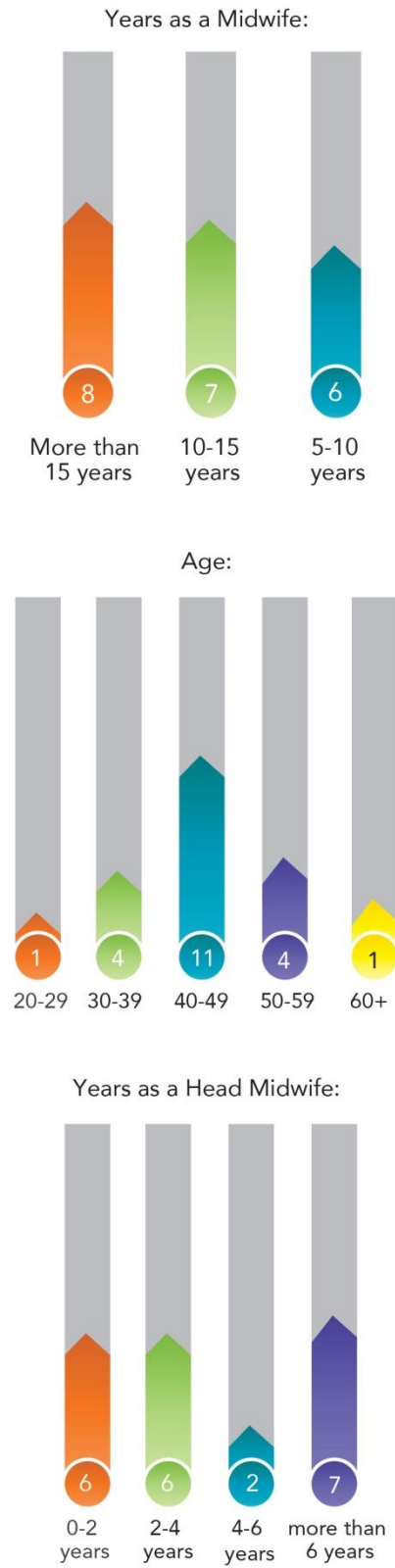


Figure 4. Head Midwife demographics.

Five Head Midwives planned to complete their term within the next year, five chose unknown/undecided, and the rest ranged between one and four years. Participants could choose more than one answer to this question. Additional roles included practice partner (17), educator in the Midwifery Education Program (7), AOM or CMO roles (2), and other (6). Other roles included Board Member at Birth Center; Neonatal Resuscitation Program Instructor; Emergency Skills Workshop Instructor; Fetal Health Surveillance Instructor; Canadian Association of Midwives consultant, as well as clinical leads, preceptors, and various regional, provincial, and professional committees (see Figure 5).

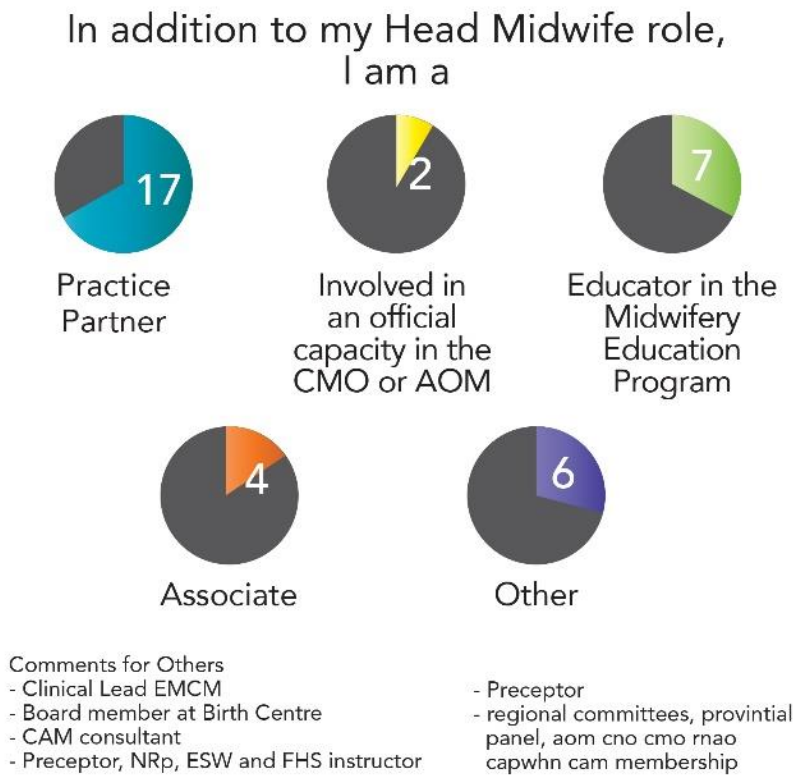


Figure 5. Additional roles of Head Midwives.

Part C findings: Leadership values and skills. The third part of the survey was aimed at understanding the beliefs, values, and skills related to Head Midwife leadership. Two of the 21 respondents did not complete Section C, so the denominator for Part C is 19. On a scale of 1 to 5, participants were asked to indicate the ownership or frequency they engage in a particular behaviour. Five indicated fully agree or regular participation, and one indicated completely disagree or no participation. Please see Appendix J for full results.

The greatest disagreement was in reference to the statement “I have all the support I need in my role as Head Midwife,” with one respondent choosing fully agree, three fully disagree, and nine squarely in the middle, demonstrating the wide range of support, or lack thereof, that Head Midwives experience. There was strong agreement and commitment to working well as a group, treating each other with respect and commitment to a professional culture without bullying. The skills and learning around leadership had the most variable answers. While no participants outright disagreed with statements possessing the skills needed to approach tough conversations, understand how the hospital works, and the knowledge and skills of an effective leader, the answers did range from 2 (mostly disagree) to 5 (in full agreement). This demonstrated the self-declared wide range of leadership knowledge and skill set for Head Midwives in Ontario.

When asked about leadership training, 10 respondents indicated they had received some level of formal leadership training. The collective list included a wide range from masters programs, to Physician Leadership Institute courses, to specific skill-based courses such as crucial conversations. The remaining nine indicated no formal leadership education or instruction.

Three qualitative, open-ended questions looked for examples of courageous, compassionate, principled leadership, behaviour contributing positively to the organizational

culture, and support for development of midwifery leadership. The findings from these questions are explored alongside the learning circle data in the next section.

Qualitative Survey and Learning Circle Findings

Building on the qualitative questions in the survey, the learning circle provided the participants an opportunity to explore their experiences of courageous, compassionate, and principled leadership with greater depth, while in the learning circle, participants were able to listen to the experiences of their peers. Through the open-ended questions of the survey and the subsequent learning circle, five main themes emerged:

1. Leadership: Fulfilling a vision or filling a void?
2. Courage as showing up, speaking up
3. Respect, equity, and excellence
4. Sharing and mentorship
5. Leadership talent management and succession planning

Theme 1: Leadership: Fulfilling a vision or filling a void? Participants shared their stories of becoming Head Midwife as either life-long patterns of seeking leadership or as stepping into leadership in the absence of other volunteers. This theme of vision or void emerged from the data in both the survey and the learning circle. Learning circle participants are identified as LCP-#, with the number indicating the different participants. Due to the anonymity of the survey respondents, no ID coding is used.

Three learning circle participants shared their void-themed stories. Learning circle participant 4 (LCP-4) stated, “We needed someone from our practice to step up and I happened to be the only one who volunteered.” The void theme was echoed in LCP-3’s statement of “nobody really wanted to do it” or LCP-2’s comment that “no one else wanted the job of Head

Midwife.” One survey respondent wrote, “I would like another midwife to take the role [of Head Midwife] in one year, but am uncertain if anyone will take it on.” In contrast, two other LCPs described an orientation towards leadership that aligned with becoming the Head Midwife. One participant shared,

My journey to being Head Midwife started in grade four when I was my school council president. I’ve always been interested in leadership my entire life and always felt that burning desire to change things from a leadership . . . position. (LCP-5)

Another LCP reflected being an early graduate of the Midwifery Education Program in Ontario:

We were sort of graduated as midwives from the program with the expectation that nobody would just practice. . . . There were few enough people in the province at that point in time that there was sort of an expectation that everybody would be doing something else in addition to midwifery practice and so, it just became habit for me to become a joiner. (LCP-1)

Setting the expectation to contribute to building the profession aligns with Warwick’s (2007) midwifery leadership approach as having a vision and fight for change, and leaders inspiring a vision was repeated in the literature (Dickson & Tholl, 2020; Kouzes & Posner, 2012).

Theme 2: Courage as showing up, speaking up. Participants commented that simply showing up to meetings in a hospital setting requires courage. One survey respondent wrote, “Because of the political climate in the hospital and lack of full integration of midwifery I think stepping into a meeting as Head Midwife is courageous.” LCP-2 stated, “For six months, I sat in [hospital] meetings and felt very intimidated. . . . I felt, especially in the beginning [of her term as Head Midwife], courageous when I showed up to a meeting.”

The definitions of courage offered in Brown's (2018, p. 189) work of choosing courage over comfort and by Crigger and Godfrey (2011) highlighted the importance of an individual's capability to acknowledge and live through fear. Another survey respondent wrote that courageous leadership is when "I stand up for my principles while working together with hospital leadership." Standing up for one's principles, or "living into our values," is one of four courage skill sets (Brown, 2018, p. 11). LCP-6 shared,

If I feel that something is the right thing to do, whether for myself, clients or for our community, then I need to stand up . . . and I need to accept some people are going to be critical.

Speaking up as a courageous act arose as a theme in the data, especially when in contrast to the status quo. LCP-4 shared an example of the chief of staff standing up at the Medical Advisory Committee in support of the creation of a Department of Midwifery, and LCP-1 spoke of courageous leadership as being "whenever somebody steps up and takes on systemic change."

Participants valued systemic change whether it was change in the hospital governance or the expansion of midwifery services to address a community need and noted that courageous value-based leadership was a key element to creating the desired change (Brown, 2018). In reference to an expanded model of midwifery care for pregnant women with substance misuse, LCP-5 stated, "I was blown away by the leadership that was demonstrated in terms of bringing midwifery care to [underserved] populations. . . . The principles of courage were absolutely at play."

When Head Midwives spoke of courageous leadership, they shared experiences of showing up, speaking up, and advocating for systemic change. This included caring for vulnerable populations or changes to the hospital governance structure, which reflected the

literature's definition of courage, and courageous leadership (Brown, 2018; Crigger & Godfrey, 2011; Treasurer, 2009). Head Midwives repeatedly described themselves as simply showing up and speaking up, and seeing other midwifery and healthcare professionals do the same were identified as acts of courage.

Theme 3: Equity and fairness. Participants reflected that professional equity and professional fairness in the healthcare system were inseparable. Equity for midwifery leaders and fairness for the profession arose throughout the inquiry as something for which to fight and aspire. One survey respondent wrote, "Feeling like you always need to fight for legitimacy or respect can wear you down. It lowers our ability to integrate legitimate feedback or change of practice. It makes it harder to see ourselves as part of the team." There was a robust discussion about the health system and the need for midwives to have a respected, valued place in it, while providing high quality care. In dreaming of the "best possible life as a midwife," LCP-1 stated,

Ontario Midwives would be known . . . for provid[ing] excellent, cutting edge, high quality care. . . . People wouldn't question whether midwifery was a valuable contributor to the clinical environment. . . . Midwives would be seen as improving population based outcomes, patient experiences; providing care in a way that made sense for the healthcare system. . . . Midwives themselves would feel like being a midwife was something that not only felt good, but that they were valued by the system.

The dream of being respected was echoed by LCP-2: "I would love to feel proud and feel respected and not always have to fight." Participants expressed a sense of burden, of being worn down by the need to constantly educate colleagues about midwifery, to advocate for growth, or to defend the position that more pregnant people want midwifery care. Participants dreamt of a future when

[Midwifery would not be so] vulnerable to the vagaries of relationships . . . to new people coming in and having to educate new leaders to support us. . . . So in 2025, midwifery [is] so well established and so well entrenched that we wouldn't necessarily need someone else to stand up and fight for and protect us. (LCP-1)

As outlined by Dickson and Tholl (2020), distributed leadership to coordinate large-scale change across the healthcare system can address the fragmentation and division circle participants described. LCP-5 highlighted a future and what equity would look like: "It's equity in leadership, in pay, in recognition, in access, in being able to provide services responsive to needs and in being valued." She shared her dream of 2025, where a midwife would feel "peace and contentment, not a feeling of scarcity or fear or vulnerability, or . . . [fear] the future."

Theme 4: Leadership Talent Management and Succession Planning. When participants were asked to describe exemplary leadership, they highlighted the contributions of one particular midwife. They shared that her contributions to the Head Midwife listserv had a significant influence on their own leadership behaviours. LCP-2 shared, "I was blown away by how quickly she responded. She was always positive and encouraging, and it really made a difference for me as a leader and as an approach." LCP-2 continued on to reflect how that influenced her own leadership behaviours, noting that "because people shared so generously with me, I really want to empower other people to find that leader within themselves. So when we've had successes, we've shared it . . . and continue that capacity building." LCP-5 echoed the admiration and appreciation for "the generous sharing" of resources, the time and energy to post them, and reflected that developing her sharing behaviours is a leadership behaviours she plans to improve on: "I do struggle sometimes with [expressing] what's in my head, and getting it out

there to teach or to share. . . . So I am going to challenge myself to get better at that.” Sharing resources was identified by participants as an act of compassion as well as leadership.

LCP-1 reflected on the example of compassionate leadership embodied by her mentors who

seemed to come from a place of assuming the best in people, acting with integrity and making sure if there was an opportunity to invite a new midwifery practice into a community, or new midwives into a hospital that it was done in a way that set them up for success . . . and midwifery has grown.

LCP-2 reflected her desire for mentorship of future Head Midwives, stating, “It would be nice if there was some training you could get because you’re preparing to be the next Head Midwife.”

LCP-4 stated, “I am really trying within my own hospital to mentor those who would like to go into leadership . . . and asking others in leadership positions a bit more for their advice,” which reflected both mentoring and being mentored as continuous growth and learning.

The participants recognized that the skill set needed for Head Midwife includes understanding the make-up and dynamics of the hospital system as well as leading peers within. The skill set required is distinct and in addition to the clinical skills set of frontline midwives. This idea of leading one’s peers, the additional skills required, and the profound impact leading can have on an organization were well reflected in the middle leadership literature as a subset of the distributive leadership body (Grootenboer, 2018).

Theme 5: Leadership, talent management, and succession planning. Leadership talent and succession planning comprised the fifth theme reflected in both the qualitative survey answers and the learning circle questions. Looking to the future, LCP-2 asked what she could do with the knowledge and wisdom, sometimes gained through “trial by fire,” to support and

develop the future of midwifery. Talent management encompasses “the attraction, recruitment, management, retention and development” of midwifery leaders (Turner, 2018, p. 5). Head Midwives, particularly those approaching the end of their terms, wanted to know how they could contribute to the further development of leadership. LCP-2 asked, “Where does my knowledge go when I leave [the Head Midwife role]? . . . It would be nice to somehow have that body of knowledge retained.”

Middle leaders require a specific skill set (Grootenboer, 2018). It is, by definition, a mediating position between their peer colleagues and the organization, including nurses, physicians, and hospital leadership. When asked about what Head Midwives need to develop capacity for courageous, compassionate, principled leadership, one survey respondent wrote:

I think two workshops a year provided by the AOM would be great. One that is strictly for new leaders which could provide the basics of how credentialing works, how different organizations structure, what to aim to have included in the role and scope of a midwifery leader. And a second one for more advanced leaders which might focus a little more on problem solving situations in a way that would improve Courage, Compassion and Leadership.

The theme of wanting more opportunities to learn, collaborate, and learn about hospital systems and leadership approaches was repeated throughout the survey and the learning circle. LCP-3 shared a vision of a yearly in-person retreat, “where Head Midwives, or former Head Midwives or upcoming Head Midwives . . . [could] meet and talk about leadership or strategy or sharing sessions.” When asked outright if the learning circle participants would be willing to make a future commitment to an in-person event with at least one overnight (so that informal as well as formal learning opportunities could be harvested), each LCP was enthusiastic. LCP-1

stated, “I think there is something you get from being face-to-face with each other that you can’t get really in any other way.” The need for support and skill building was reflected in this survey participant’s comment:

While I try to demonstrate leadership [that is courageous, compassionate and principled], often being Head Midwife feels more like being a peacemaker who calms troubled waters rather than really showing leadership, [and] when relations with the hospital are tough, I feel like an inadequate leader from both sides (hospital and practice group).

LCP-5 stated she needs

to start asking for what we need as leaders. . . . I don’t think in my time. It’s been four years, I have ever actually asked the AOM or my practice for anything, and I think I need to start getting better at asking for the tools I need.

Another survey respondent added, “Leadership needs to be the first to model a healthy workplace.”

Study Conclusions

This inquiry aimed to answer the question of how might Head Midwives be influencers of a profession-wide culture change towards courageous, compassionate, and principled leadership. I have reached these four conclusions.

1. There is no standardized role for Head Midwives in Ontario.
2. Head Midwives develop leadership in themselves and others through the principle of sharing.
3. Midwifery leadership in Ontario is about practice, not position.
4. Systemic equity and fairness is the desired state for Ontario Midwives.

Conclusion 1: There is no standardised role for Head Midwives in Ontario. This conclusion answers the research sub question: What is the current reality of Head Midwives across the province of Ontario? Head Midwives have a minimum five years of clinical experience and are frequently in their forties. There is no clear universal role of a Head Midwife across the province. The Head Midwives who participated in this inquiry described a wide variety of titles, roles and responsibilities, compensation, and education as Head Midwife. There are Chiefs of Midwifery, Division Heads of Midwifery, Lead Midwives, and Head Midwives serving in their respective hospital organizations as midwives privileged under Departments of Midwifery, Departments of Obstetrics, and Departments of Family Medicine. According to the Ontario Hospital Association, a chief of a department “means a member of the Professional Staff appointed by the Board to be responsible for the professional standards and quality of care rendered by the members of that department at the Hospital” (Ontario Hospital Association, 2011, Article 1(e)). In contrast, a division head is a “member of the Professional Staff appointed to be in charge of one of the organized divisions of a Department” (Article 1(m)). While at first the differences in title appear to be an argument of semantics, they represent a significant variation in power and in the ability to self-regulate. One Head Midwife receives a salary from her hospital organization for her headship, yet a number of other Head Midwives receive no compensation for their leadership duties from the hospital or no compensation at all. Most Head Midwives reported compensation for their additional leadership commitments through their own practice, utilizing a limited form of billing called caseload variables.

This study was limited to describing the department, governance structure, and title of Head Midwives. The breadth and depth of Head Midwife responsibilities was beyond the scope of this study, but one may infer the potential diversity from the range of titles from Chief of

Midwifery to Lead Midwife and from the departments where they hold privileges. Some Head Midwives have a seat and a vote on the Medical Advisory Committee, some just hold a seat, and others are excluded from that decision-making body in their own organization. Despite the lack of standardization of the Head Midwife role across hospital organizations, all Head Midwives were actively engaged in professional practice and practiced as “a leader among peers” while navigating the complex world of middle leading (Grootenboer, 2018, p. 8). De Nobile and Ridden (2014) developed a framework that included five broad categories of middle leading practices of teachers, which included management, administration, supervision, staff development, and leadership. To varying degrees, these can be inferred as the practices expected of Head Midwives, yet with the disparate compensation and role titles, there cannot be equal, or perhaps even effective, contributions across the province.

Formal leadership education of Head Midwives was markedly distinct between individuals, varying from no additional education to a directly applicable graduate degree. Many inquiry participants reported engaging in education around leadership skills after accepting the formal Head Midwife position. Head Midwives who actively sought leadership positions were also more likely to have greater amounts of education as opposed to those who accepted the position in the absence of other volunteers. It is important to note that Head Midwives identified holding a number of other professional leadership roles, including those in the AOM and CMO, practice ownership, practice management, and educators of midwifery students. Despite holding a number of leadership roles, formal leadership education was inconsistent and scant. The need for education and support for leading peers has been noted throughout the middle-leading literature, with particular emphasis on the particularities of this frontline leadership role (Grootenboer, 2018; Irvine & Brundrett, 2016, 2019).

Presently, there is no universal or standardized Head Midwife title, level of responsibility, compensation or qualifications, participation in the Medical Advisory Committee, or department affiliation across the Province of Ontario. The spectrum encompasses the range from minimal responsibilities, skills, and compensation through to being the Chief of a Midwifery department and program director with a salary.

Conclusion 2: Head Midwives develop leadership skills in themselves and others through the principle of sharing. The inquiry participants described exemplary leadership as the generous sharing of resources. Under the LEADS framework, the first capability under the domain of “Engage Others” is “foster development of others” (Dickson & Tholl, 2020, p. 102). Throughout this inquiry, Head Midwives shared stories of their own leadership development through the support of other Head Midwives connected by the Head Midwife listserv. The peer support contributed to their personal leadership approach and influenced how they, in-turn, mentored newer leaders. For example, five of the six learning circle participants talked about the influence the sixth participant had through the Head Midwife listserv on their own personal leadership, stating,

[This midwife] embodies [courageous compassionate and principled leadership] because every time I had a problem, . . . she provided policies, programs, protocols, suggested processes, shared templates and resources, and I think sharing so readily, . . . it really made a difference for me as a leader and as an approach. (LCP-2)

This is a strong example of how compassionate leadership begets a compassionate culture through the embodiment of compassion in a peer leader (West et al., 2017). Mentoring by other healthcare leaders was also described by one learning circle participant as impacting her own leadership capabilities as well as her desire to share her hard-earned experience and skill set with

future midwifery leaders (LCP-2). Mentoring and sharing resources as midwifery leaders, both established and emerging, is an organic example of frontline ownership from which learning and adaptive outcomes emerge (Uhl-Bien, Marion, & McKelvey, 2007; Zimmerman et al., 2013).

Conclusion 3: Midwifery leadership in Ontario is about practice, not position. When participants were asked to describe examples of courageous, compassionate, principled leadership in action, relationships across disciplines were highlighted as integral to achieving specific goals. Examples given ranged from establishing a department of midwifery, to increasing the number of midwifery births within a hospital, to providing care to a vulnerable population. One LCP shared an example of courageous leadership when a group of community midwives started a new program providing care to a particular underserved vulnerable population as a form of healthcare equity: “Whenever somebody steps up and takes on the systemic change and challenges the status quo, . . . that feels like courageous leadership” (LCP-1).

The theory of distributed leadership encompasses those with and without formal leadership positions and highlights the many sources of influence within an organization, focusing on the interactions between leaders, followers, and their situation (Harris & Spillane, 2008). Both learning circle and survey participants described leadership as caring for individual families, advocating for cultural needs, and courageously speaking up or showing up outside of their comfort zone. In caring for individual families or advocating for culturally appropriate care, midwives are exemplifying courageous followership, working from a family-centred care value and challenging the status quo (Chaleff, 2009).

One survey participant offered an example of taking the lead and working through interdisciplinary conflict in a constructive manner as frontline leadership. Relationship webs

between people with varied levels of experience allows for the “application of a richer set of observations, insights and resources” (Zimmerman et al., 2013, p. 13). Head Midwives demonstrated relationship building, peer-leadership, and followership in their Head Midwife listserv. Chaleff (2009) described the two key behaviours of effective followership, held in tension, as the courage to support and the courage to challenge. The learning circle participants described both experiences of support and challenges offered in the shared Head Midwife listserv. The supports and challenges ranged from policy examples, relational support, and sharing individual experiences as potential narratives of how to proceed (Chaleff, 2009; Spillane, 2005). This idea of leading wherever one is in the healthcare system through relationship building across disciplines came out clearly in this study, from simply showing up outside one’s comfort zone, to family-centred care, to becoming a Department of Midwifery.

Conclusion 4: Systemic equity and fairness is the desired state for Ontario

Midwives. When asked to envision the future of midwifery, LCP5 summed it up with one word: “equity.” Equity is a core principle for Ontario midwives and listed within their values as “create systems and tools that uphold equity within the midwifery profession, in relationship to clients and within the health system” (AOM, n.d.-e, Our Values section, para. 6). Health equity is striving for the highest possible standard of health for all, “giving special attention to the needs of those at great risk for poor health based on social conditions” (Braveman, 2014, p. 6). The midwives in this inquiry repeatedly used the term equity to describe their future place in the healthcare system, yet their examples were consistent with the notation of fairness. Maslach et al. (2001) stated, “Fairness communicates respect, and confirms people’s self-worth. . . . Unfairness can occur when there is inequity of workload or pay” (p. 415).

LCP-5 expanded on where equity needs to be present: “It’s equity in leadership; it’s equity in pay; it’s equity in recognition, in access, in being able to provide services responsive to needs and in being valued.” The idea of equity encompassed both the social determinates of health and health access (Braveman & Gottlieb, 2014; Whitehead, 1991) as well as the place of midwives in the healthcare system. LCP-4 commented that equity is “really important in terms of the respect that we deserve to receive in a hospital that this is an equal position like in relation to other departments and chiefs.” The group echoed this idea of equity in the hospital setting through notions of pay equity for department leadership, legitimate formal leadership positions to increase visibility, and a human resource plan for maternal newborn services. Participants advocated for the “right mix” of maternal-newborn healthcare providers who would ensure high quality, sustainable healthcare for future generations.

Scope and Limitations of the Inquiry

These results may not be generalizable beyond the specifics and boundaries of this inquiry. Ontario Midwifery is primarily composed of community-based practice groups and is not an employee model, although there are a few examples deviating from this norm. Surveys were distributed through the Head Midwife listserv, which is moderated by the AOM. To add to the challenge, many midwives have multiple email addresses, and one survey participant shared that her Head Midwife listserv is not one she checks frequently. The survey response was 24%, based on 19 full responses out of a possible 80. Email and survey fatigue could have contributed to the response rate, as well as not all Head Midwives may be subscribed to the Head Midwife listserv. Eighty is the very best estimate as per the AOM policy person and me, but in the shifting landscape of amalgamation in Ontario, a firm denominator of eligible participants was somewhat difficult to ascertain.

Summary

The findings and conclusions from the Head Midwife survey and the subsequent learning circle were reviewed in this chapter in order to answer the primary research question: How might Head Midwives influence a wider cultural change towards courageous, compassionate, principled leadership? The findings were organized into five main themes: (a) vision or vision, (b) courage as showing up, (c) equity and fairness, (d) sharing and mentorship, and (e) growing in leadership. From these themes, four conclusions were reached to address the topic of this inquiry: (a) the current role of Head Midwives in Ontario is disparate; (b) Head Midwives develop leadership in themselves and others through the principle of sharing; (c) midwifery leadership in Ontario is about practice, not position; and (d) systemic equity and fairness is the desired state for Ontario midwives. The strength and limitations of this inquiry were reviewed. Despite the acknowledged limitations of this research, the data provided powerful insight into the current state of Head Midwives in Ontario, their leadership practice and needs, and the vision Head Midwives have for the future. In the final chapter, I will outline recommendations for the AOM to move from conclusions to actions, review possible implications of these findings, and highlight future possibilities for further research.

Chapter Five: Inquiry Implications

In the final chapter of this inquiry, recommendations are provided to the AOM based on the research findings based on participants' input and conclusions supported by relevant literature. Additionally, organizational implications resulting from this inquiry are presented along with future research opportunities.

This inquiry engaged Head Midwives through a survey and a small group learning circle in exploring the overall question: How might Head Midwives be influencers of a profession-wide culture change towards courageous, compassionate, and principled leadership? Four sub-questions were also addressed:

1. What is the current reality of Head Midwives as leaders across the province of Ontario?
2. How do Head Midwives define what it means to be an influencer?
3. What actions might an influencer take in supporting a profession-wide culture change toward equity and possibility in the Ontario Health system?
4. What resources can support current and future Head Midwives?

The recommendations presented in this chapter speak to the opportunities and possibilities for change and how the AOM can influence, support, and champion courageous, compassionate, and principled leadership throughout the profession. The participating Head Midwives voiced their:

1. vision of a healthcare system where midwives are valued and treated with respect, and
2. commitment to equity and fairness throughout the profession as demonstrated through expanding as well as sharing resources and knowledge to build leadership capacity.

Study Recommendations

The study recommendations are based on the findings of this inquiry as described in Chapter 4. In addition, in developing these recommendations, the sponsor and I engaged in a number of conversations about the current and future culture of midwifery and the role of leadership. These recommendations are intended to provide an understanding of how the AOM can support a profession-wide culture change towards courageous, compassionate, and principled leadership.

Concerns regarding bullying continue, and a recent AOM study detailing experiences of racism within the profession and broader healthcare system highlighted a need to change the way we behave as a profession (AOM, 2019). To change the culture in any organization, investments need to be made at three levels: the personal, the relational or social, and the organizational or systemic (Grenny et al., 2013; Stringer, 2014; Torbert, 2004). A clear set of well-understood values and norms is key to aligning and guiding professional behaviours, especially where there is ambiguity and complexity (Bohmer, 2016; Brown, 2018). As a professional association, the AOM is well positioned to lead the development of midwives' leadership capabilities. Using clear principles and engaging members at all three levels are foundational to building a healthy future of Ontario midwifery (Bohmer, 2016; Brown, 2018; Dickson & Tholl, 2020; Grenny et al., 2013; Stringer, 2014; Torbert, 2004).

Ontario Head Midwives envision a healthcare system based on equity and fairness, generous sharing, and the distributed leadership model while providing high quality clinical care. To that end, based on the findings and conclusions drawn from this study, I offer three recommendations to the AOM:

1. Adopt equity and fairness as the values of the AOM to clarify the mission, vision, and values of the organization.
2. Engage and support all AOM members in developing their personal leadership and followership capabilities.
3. Develop and maintain Head Midwife leadership capabilities.

Recommendation 1: Adopt equity and fairness as the values of the AOM to clarify the mission, vision, and values of the organization. Through this inquiry, midwives clearly expressed commitment to the principles of equity and fairness in their stories of courageous, compassionate leadership. Kouzes and Posner (2012) wrote that when leaders make a commitment to shared core values, they make a commitment for the entire organization and hold others accountable to those values and standards. A small number of core values is key to tether behaviours and guide decisions, and these core values ought to “be so crystalized in our minds, so infallible, so precise and clear and unassailable that they don’t feel like a choice—they are simply a definition of who we are in our lives” (Brown, 2018, p. 189). Bohmer (2016) reinforced the importance of a set of widely understood values and norms in aligning professional and organizational behaviour through change, particularly in circumstances of ambiguity and complexity. Equity and fairness are the values that shone through this inquiry, clearly defining what it means to be a midwife in Ontario.

The AOM’s (n.d.-e) mission, vision, and values website lists nine separate values. Each value is stated in a sentence of at least six words. The current list presented in the Our Values section encompasses

Provide courageous, compassionate and principled leadership

Consider Indigenous issues and social justice in all decision making

Promote and support the restoration and renewal of Indigenous midwifery

Promote, safeguard and support normal birth

Advocate for members' rights that promote long term career satisfaction

Create systems and tools that uphold equity within the midwifery profession, in relationship to clients & within the health care system

Respect client dignity, autonomy, cultural safety and experience as central to decision making in midwifery care

Establish accessible, high quality and responsive services which meet the needs of the membership

Enhance the potential of midwifery to contribute to the well-being of society.

Brown (2018) argued that if everything on the list is important, then nothing is truly a key driver. Clear, unifying values align both organizational goals and the behaviours required to meet those goals (Bohmer, 2016; Brown, 2018). In this inquiry, equity and fairness arose repeatedly as themes across stories and settings, with high-quality clinical care as the established norm. In their vision of the future, participants spoke of midwives being respected contributors of the healthcare system, treated with equity and fairness, and providing excellent care to a wide range of populations to promote health equity (Braveman, 2014; Gordon, 2016).

Equity and fairness are the two values this inquiry highlighted as core for the research participants, but naming the organization's core values is only a starting place. In order to live our values, a list of three to four behaviours or actions that support each value needs to be defined and created (Brown, 2018). These actionable behaviours were beyond the scope of this inquiry, but should be developed in the future.

Recommendation 2: Engage and support all AOM members in developing their personal leadership and followership capabilities. Courageous, compassionate, and principled leadership begins with oneself. The LEADS in a caring environment platform is increasingly utilized as the common leadership language and framework in the Canadian health system (Dickson & Tholl, 2020; Dickson & Van Aerde, 2018). *Leads self* is the first domain in the LEADS framework. Ethics and morality are described as foundational, and four capabilities are highlighted: (a) self-awareness, (b) self-management, (c) self-development, and (d) demonstrates character (Dickson & Tholl, 2020; NHS, 2014). Similarly, National Health Service in England uses the self-mastery and reinforces the idea of personal discipline to build the self-awareness, resilience, mindfulness, and emotional intelligence required to be present and available to care for others (NHS, 2014). The current foci of the AOM are bullying and racism. To address both challenges will require that all AOM members have the capabilities to develop self-mastery in order to contribute to a safe and healthy work environment (AOM, n.d.-a, n.d.-b, n.d.-c, 2019).

In AOM's hierarchical world, talking about leadership often means focusing on a few key people within an organization. Developing the abilities of both leaders and followers results in the inclusion of everyone, with emphasis on the complementary, interdependent relationship. The skill set of effective leaders and effective followers is well-aligned (Chaleff, 2009; Kellerman, 2007). To create change, sometimes midwives must lead, and sometimes they must follow, a difficult dance based on one's ability to form positive relationships with a wide array of the people with whom they work (Chaleff, 2009; Dickson & Tholl, 2020; Spillane & Mertz, 2017; Spillane & Orlina, 2005; Timperley, 2005).

According to Block and Manning, (2007) leadership development is an organizational commitment that must be approached as a major cultural change. This cultural change needs to

start with the individual members of the AOM to build their personal leadership and followership, or self-mastery, abilities. To be self-aware means you are aware of your “own deep-seated motives, emotions, beliefs and assumptions” (Dickson & Tholl, 2020, p. 80). This definition reflects the AOM’s call for its membership to engage in “critical self-reflection” (AOM, n.d.-a, para. 10). Self-awareness is to have integrity, demonstrating congruity between your values and your behaviours, particularly as viewed by others (Brown, 2018; Dickson & Tholl, 2020). “To stand up for your beliefs, you have to know the beliefs you stand for” (Kouzes & Posner, 2012, p. 44). Self-awareness also serves as the antidote to self-delusion or mental models (Dickson & Tholl, 2020; Senge, 2006). Mental models are deeply ingrained assumptions, generalizations, or images that influence how something is understood or a solution is found (Senge, 2006). The discipline of surfacing, testing, and improving our mental model understanding is key to our collective learning (Senge, 2006). Self-management brings together emotional intelligence, leadership mindset, and role clarity as the trifecta to be addressed to take responsibly for one’s performance and health (Dickson & Tholl, 2020). Self-mastery throughout the midwifery membership is the key to the AOM’s ability to learn and grow as an organization (NHS, 2014; Senge, 2006).

I recommend that the AOM identify and offer opportunities for its membership to engage in learning about the discipline of self-mastery, including the capabilities listed under *Leads self*: self-awareness, self-management, self-development, and demonstrates character (Dickson & Tholl, 2020). Given the nature of the on-call hours that midwives work, I believe it is particularly important to ensure that self-compassion, comprised of self-kindness, feelings of common humanity, and mindfulness, are purposefully included (Neff, 2011). The nature of the learning experiences could range from in-person to on-line interactions, with educational opportunities to

practice listening and questioning, personal coaching, mindfulness, and self-care (Brown, 2018; NHS, 2014). Leadership “has a moral imperative that . . . dignifies the construct of distributed leadership, whereby influence and power is shared amongst many rather than exercised by few” (Dickson & Tholl, 2020, p. 26). Building the membership’s ability to access growth and learning opportunities to develop self-mastery is a foundational step in cultivating a leadership culture throughout midwifery and creating a force field of midwifery leadership in the Ontario healthcare system.

Recommendation 3: Develop and maintain Head Midwife leadership capabilities.

Head midwives are in various degrees of formal leadership positions across the province providing peer leadership while at the same time continuing to provide frontline clinical care. This arrangement is consistent with the literature on middle-leading (Grootenboer, 2018). Middle leadership “must be understood as highly complex and characterized by negotiation amidst networks of professional and power relations” (Branson, Franken, & Penney, 2016, p. 2). The middle leadership term primarily arises out of education settings and encompasses heads of faculty, department heads, and discipline area coordinators (Branson et al., 2016; Grootenboer, 2018). The term middle leadership has yet to be widely applied to the healthcare setting, yet the parallels for Head Midwife role are strong. Middle leaders are peer leaders, and relationships are central to the complexity of the role (Branson et al., 2016). These relationships encompass peers, professional colleagues, and the leadership team the Head Midwife is accountable to. Middle leadership is frequently described using the metaphor of a sandwich, caught between senior leadership and peers for whom the leaders have responsibility (Grootenboer, 2018). The question of alignment arises frequently in the risk management department at the AOM (A. Booth,

personal communication, January 20, 2020), and the sandwich metaphor was independently offered by a survey participant.

The geographical spread and frontline peer leadership role of Head Midwives means that they are well-positioned to transform the professional culture of midwifery throughout the province. Bohmer (2016) wrote that “lasting transformation requires the relentless hard work of local operational redesign” (p. 709). Zimmerman et al. (2013) highlighted that change is often initiated and led by committed front-line clinicians striving to create better-functioning systems. Head Midwives are an engaged group of leaders whose participation in both the listserv and this inquiry underscored the rationale for AOM to further invest in developing their leadership capabilities. Investing in the development and maintenance of Head Midwives’ leadership abilities would create a core group who can skillfully lead their peers, champion midwifery within the hospital, and be living examples of courageous, compassionate, and principled leadership in service of equity, fairness, and excellence. This leadership development, in conjunction with clinical experience and expertise, has the potential to position Head Midwives as “powerful and influential leaders, capable of seeing new possibilities, inspiring others, breaking down silos, creating a new vision of health care delivery and transforming their vision into reality” (Satiani, Sena, Ruberg, & Ellison, 2014, p. 542).

To deepen formal support of Head Midwives, the AOM will need to be proactive about connecting with members in the Head Midwife role. Currently, there is no formal process to ensure that the AOM is aware of a newly appointed Head Midwife, although it is indicated annually as part of the AOM membership renewal processes. Head Midwives are primarily connected to each other through the Head Midwife listserv. Head Midwives can contact the AOM staff for advice or guidance as needed. Through increasing the connection, support, and

skills of Head Midwives, a community of practice would be created. A community of practice would benefit Head Midwives' access to the collective wisdom of other peers in similar leadership positions. As formal support of head midwives by the AOM deepens, mentoring and succession planning will be incorporated. Aligned with the mission, vision, and values of the AOM, potential future leaders will be identified and supported to develop their leadership capabilities needed for future leadership roles (Trepanier & Crenshaw, 2013). Current and former Head Midwives will offer mentorship to new head midwives. Head Midwives in this inquiry valued opportunities for sharing as a means to develop their own and others' leadership capabilities. Mentoring is a shared leadership process, and the benefits include increased professional skills, insight, self-esteem, and a reduction in stress and anxiety (Dziczkowski, 2013). Through the creation of a process to identify, connect, and provide mentorship for new and future Head Midwives, the AOM would build on the identified sharing capacity of Head Midwives and create the envisioned future of system equity and fairness.

Organizational Implications

The AOM sponsor for this inquiry is the director of Quality and Risk management. Bi-monthly meetings were held throughout the inquiry to discuss the findings and themes as well as the draft recommendations of this study. At times, we engaged with members of the policy department, who are responsible for Head Midwives. Leadership is an emerging theme springing up throughout the profession. There are an increasing number of leadership development-themed discussions on the AOM listserv, as well as a new leadership course on offer by an experienced midwife and talk of a potential graduate course focused on midwifery leadership. Therefore, this inquiry was quite timely.

The demographics and realities of Head Midwives captured in this study are a subset of the Head Midwives' progress across the province. Yearly data collection similar to the survey distributed through this study would provide a baseline, document future trends, and capture the evolution of Head Midwives across the province. If the AOM instituted a yearly census and ensured there was representation from all hospitals with privileged midwives, over time, the data would document and describe trends in midwifery leadership within hospitals as well as provide an important advocacy tool and resource.

This inquiry provided valuable insights from Head Midwives in Ontario about courageous, compassionate leadership in pursuit of equity and fairness and denotes a starting place for future research, leadership development, and the role of Head Midwives in the Ontario healthcare system. Head Midwives identified their commitment to generous sharing, distributed leadership, and followership as they work towards equity and fairness throughout the system.

Next Steps

This project was guided by the principles of the action research methodology, ensuring that the findings, conclusions, and recommendations were developed in collaboration with a number of stakeholders, including the AOM, practicing midwives, and a former Head Midwife. In addition, the study results were shared with AOM's members and head midwives through an online "begin the change" meeting utilizing a series of liberating structure activities.

The "begin the change" meeting included invitations to all the Head Midwives who previously participated in the circle. In addition, an open invitation was posted on both the Head Midwife listserv and the AOM's weekly newsletter, inviting any identified potential, current, or former Head Midwives to attend. Due to the on-call nature of the profession and Ontario's geography, the meeting was held via the online application Zoom. A mix of Head Midwives and

AOM staff attended, including the Director of Quality and Risk Management and the incoming president. The Zoom application allowed for both a presentation and subsequent dialogue. I started by presenting the research findings, conclusions, and recommendations. Participants were asked to engage with three questions. The questions invited dialogue about what resonated for them, what would be the collective next steps, and how each person could contribute to making this happen. After a moment of personal reflection following each question, participants were grouped through the breakout function into groups of two and then four. This method included engaging participants in personal reflection and then collectively in a larger group discussion activity called 1-2-4-All, from *Liberating Structures* (Lipmanowicz & McCandless, 2013). This dialogue approach allowed for each person to voice their ideas with another before bringing it back to the whole group. Participants shared the highlights of their collective conversations with the full group. Participants were engaged around building leadership capacity throughout the profession, increasing the Head Midwife connection through face-to-face and on-line meetings, and developing resources aimed at supporting the Head Midwife role within hospital organizations.

Those who attended the “begin the change” event identified a number of areas where the research resonated with them and requested further support and development. Demonstrating leadership throughout the profession was highlighted as a key area, particularly in the context of Ontario’s current healthcare transformation and the creation of Ontario Health Teams. Profession-wide leadership development as well as strong succession planning and mentorship were key themes highlighted in this session. In addition, further education and connection for all Head Midwives was an identified priority for the group gathered. Members requested education around hospital governance and privileging regulations. The need for a structured approach to

leadership and increased funding to support the increased time commitment of leadership were confirmed. Within the learning circle and the “make-it-happen” activity, a Head Midwife overnight retreat was suggested repeatedly as a longer-term goal to further develop the connection and problem-solving abilities of Head Midwives as a group.

Head Midwives requested regular meeting opportunities to connect in real time, and monthly or quarterly options were discussed. A regular Zoom meeting comprised of a 10-15-min educational component, followed by a structured agenda was suggested. This format would allow for education and space for dialogue regarding opportunities challenges across the province. The need to develop on-line written materials to support Head Midwives was highlighted. These materials could be created by Head Midwives at the proposed regular meetings. The “make it happen” participants confirmed the need for more leadership training, both specific to midwifery and in conjunction with other disciplines.

Head Midwives clearly voiced their desire for connection, support, and education to support their leadership, and they expressed gratitude for the dialogues provided through this inquiry. The opportunity to connect as hospital leaders energized them and provided fresh perspectives for leading. Head Midwives demonstrated a hunger to learn more, share more, and contribute to the development of leadership throughout the profession.

On the practical front, AOM needs to identify who will support the desired leadership development, including organizing regular meetings as requested. Funding and financial compensation will need to be addressed for midwifery leaders and for educational opportunities, including a Head Midwife retreat. The next step is to identify potential sources of funding. To achieve real, sustainable change, successful healthcare organizations invest heavily in the leadership development of clinicians, while at the same time reducing clinical duties to free up

time for this change work (Bohmer, 2016). As both frontline clinicians and peer leaders, Head Midwives are well positioned to champion change towards equity and fairness from the bottom up (Grootenboer, 2018; Zimmerman et al., 2013). AOM's investment in this group of midwives would have ripple effects on the profession as a whole and contribute to fulfilling the AOM's stated mission of advancing midwifery.

Implications for Future Inquiry

This inquiry served to engage Head Midwives with the intention of influencing the beginning of a profession-wide culture change. Head Midwives in the learning circle expressed appreciation for the opportunity to connect for deeper dialogue with a clear focus. Given Ontario's large geography and midwives' call schedules, the opportunity to connect for a purposeful discussion utilizing the conference line worked well and could be considered for future initiatives. This format created a sense of unity and energy amongst the Head Midwife participants who participated from their home community. Head Midwives reported feeling a sense of renewed focus and energy for their leadership role and their Head Midwife community.

The findings of this study represent the initial steps of understanding what it means as a profession to demonstrate courageous, compassionate, and principled leadership in service of equity and fairness. Equity and fairness were the core values identified by participant Head Midwives. In the future, engaging the whole AOM membership in defining their core values and the associated behaviours would be an important project. Future research projects could include a wider and deeper inquiry throughout the midwifery membership to explore if a commitment to fairness and equity is universal for the identity of the midwifery profession across Ontario and Canada.

Further inquiries could examine the skill set necessary to operationalize equity and fairness into behaviors, particularly at intersections of other professions who may not share the same values. To create lasting cultural change, AOM needs to identify vital behaviours with measurable outcomes (Grenny et al., 2013). For example, what skills or behaviours effectively contribute to a culture of fairness and equity? Regulated midwifery in Ontario is still a young profession with fewer than one thousand members, which provides both opportunities and challenges in building a future of courageous, compassionate leadership in service of fairness and equity.

There are robust recommendations from the literature to invest in change at the personal, interpersonal, and systemic level (Bohmer, 2016; Dickson & Tholl, 2020; Grenny et al., 2013). As midwives' professional body, AOM needs to ensure that future change efforts are undertaken with clarity of purpose and address change within the personal, relational, and systemic level. This inquiry recommends an approach that encompasses learning about self, others, and the larger system in order to change the culture.

LEADS in a Caring Environment (Dickson, 2010; Dickson & Tholl, 2020) is the leadership framework that an increasing number of healthcare organizations are using as the basis of their leadership development. Future inquiries could address if AOM should also adopt LEADS as their leadership development framework. Considering the system more broadly, another area to explore is how to incorporate leadership and followership development into the midwifery education program. Exposing midwifery students to the concepts of leadership and followership would ensure future midwives enter the profession with an orientation to leadership capability development.

Thesis Summary

This research initiative set out to answer the question: How might Head Midwives be influencers of a profession-wide culture change towards courageous, compassionate and principled leadership? This inquiry engaged Head Midwives in Ontario through a survey and a learning circle as potential influencers of a wider cultural change. Head Midwives value leadership through sharing of resources, system equity, and fairness. Head Midwives voiced their commitment to learning more, sharing generously, and working towards equity and fairness throughout the healthcare system, from the populations midwives serve to the organizations they are part of.

To support both Head Midwives and the general midwifery population, three recommendations are made:

- Focus on equity and fairness by clarifying the mission, vision, and values of the organization.
- Influence and support all AOM members to develop their individual leadership and followership abilities at the personal, relational, and systemic abilities.
- Develop and maintain Head Midwife leadership capabilities

This inquiry could not have happened without the support of the AOM and generous participation of Head Midwives throughout the province. The wealth of data gathered will serve to inform Ontario midwives and the AOM around how to develop leadership at the personal, relational, and systemic level. Though this inquiry, dialogue and conversations were ignited about the value of leadership development at the individual and organizational level and how leadership can serve to transform the larger healthcare system to create a culture of fairness and equity.

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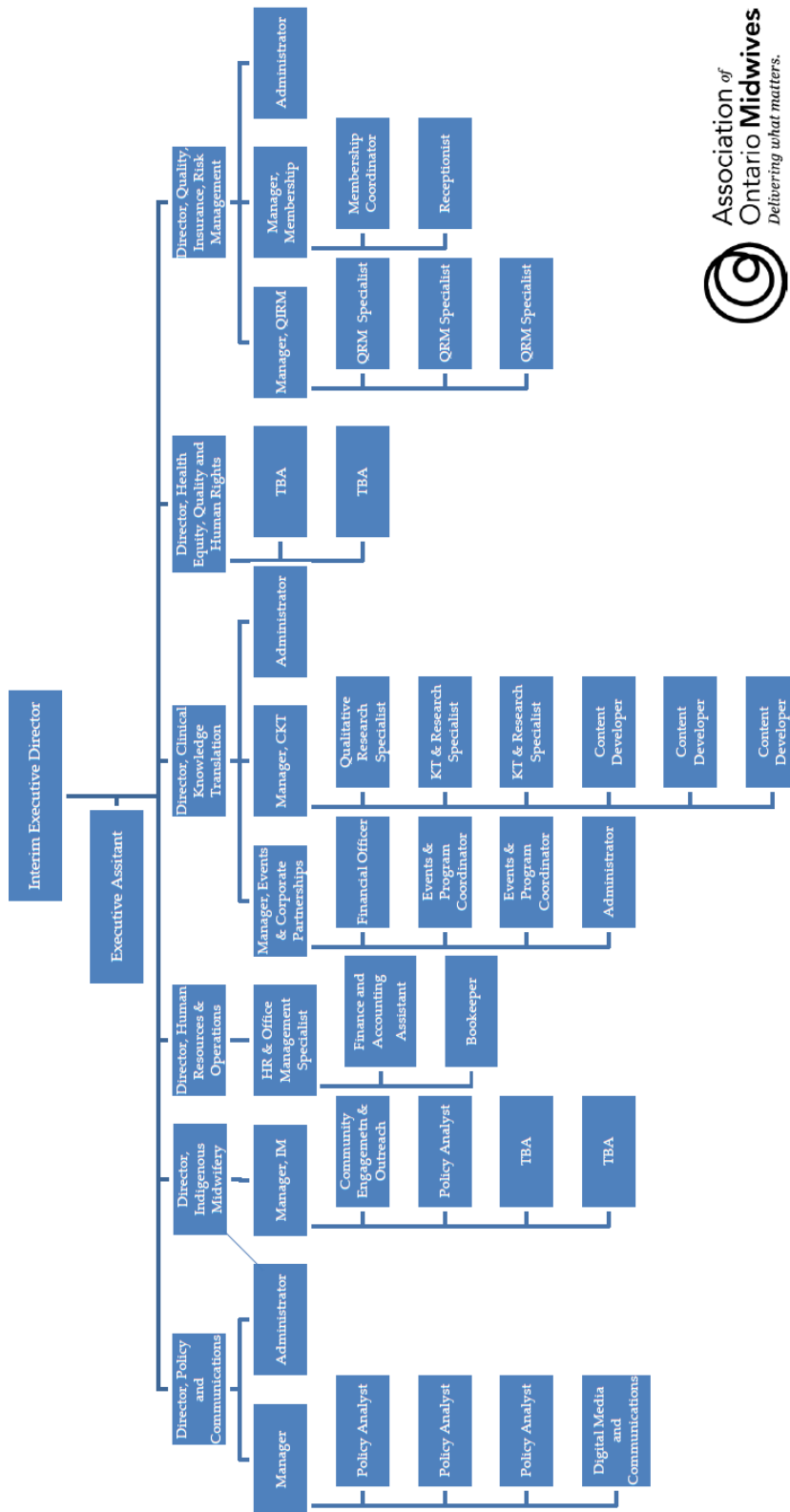
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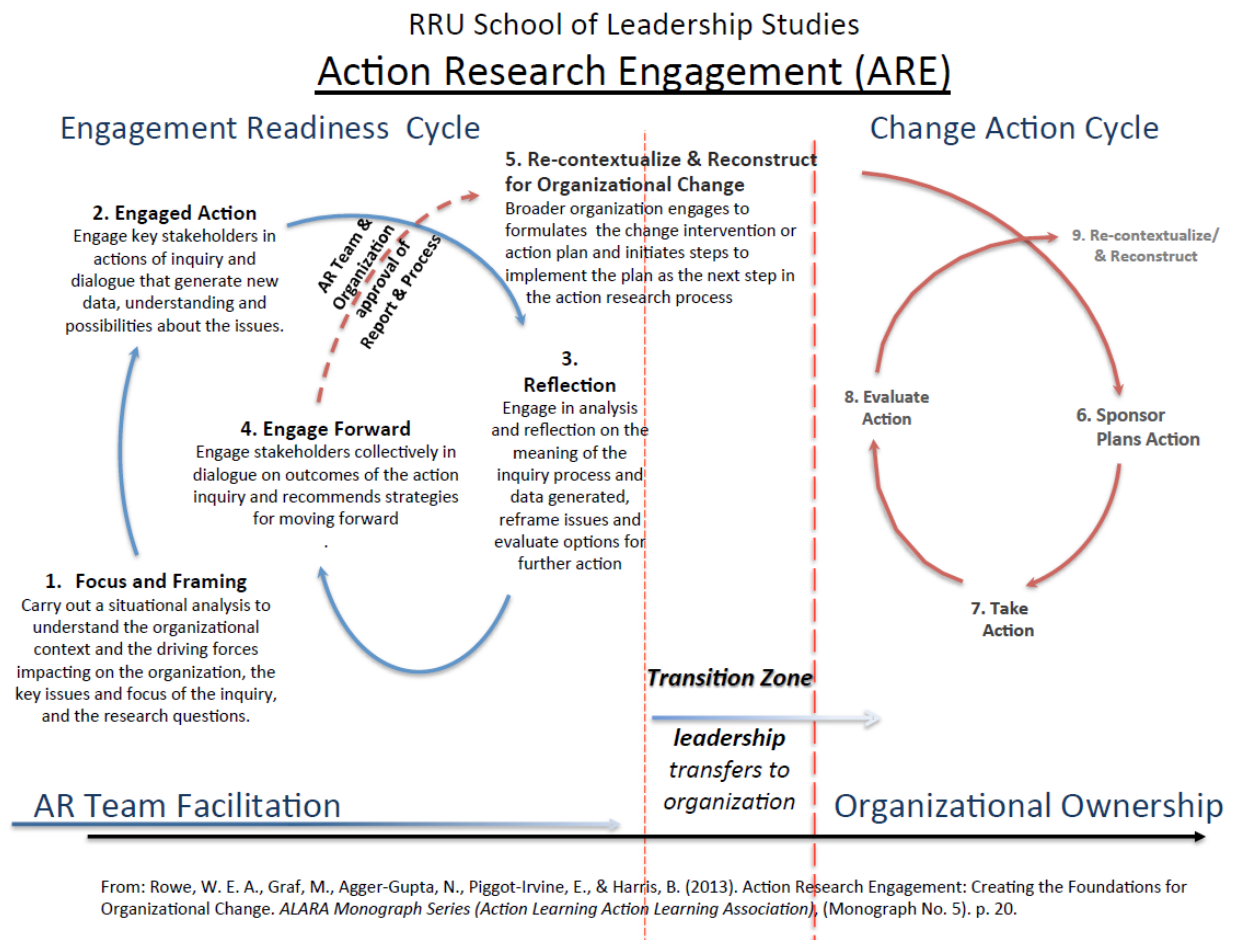
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Appendix A: Association of Ontario Midwives Organizational Flow Chart



Updated June 17, 2020

Appendix B: Organizational Action Research Cycles



From: Rowe, W. E. A., Graf, M., Agger-Gupta, N., Piggot-Irvine, E., & Harris, B. (2013). Action Research Engagement: Creating the Foundations for Organizational Change. *ALARA Monograph Series (Action Learning Action Learning Association)*, (Monograph No. 5). p. 20.

Appendix C: Inquiry Team Member Letter of Agreement

Living into our values: Towards Courageous, Compassionate and Principled Leadership

In partial fulfillment of the requirement for a Master of Arts in Leadership Degree at Royal Roads University, *Kelly Armstrong* will be conducting an inquiry research study with the support of the Association of Ontario Midwives in an attempt to answer: *How might Head Midwives be influencers of a profession-wide culture change of courageous, compassionate, principled leadership?*

Kelly Armstrong's student credentials with Royal Roads University can be established by calling Dr. Catherine Etmanski, Director, School of Leadership, at [phone #] or email [email address]

Inquiry Team Member Role Description

As a volunteer Inquiry Team Member assisting the Student with this project, your role may include one or more of the following: providing advice on the relevance and wording of questions and letters of invitation, supporting the logistics of the data-gathering methods, including observing, assisting, or facilitating an interview or focus group, taking notes, or reviewing analysis of data, to assist the Student and the Association of Ontario Midwives organizational change process. In the course of this activity, you may be privy to confidential inquiry data.

Confidentiality of Inquiry Data

In compliance with the Royal Roads University Research Ethics Policy, under which this inquiry project is being conducted, all personal identifiers and any other confidential information generated or accessed by the inquiry team advisor will only be used in the performance of the functions of this project, and must not be disclosed to anyone other than persons authorized to receive it, both during the inquiry period and beyond it. Recorded information in all formats is covered by this agreement. Personal identifiers include participant names, contact information, personally identifying turns of phrase or comments, and any other personally identifying information.

Bridging Student's Potential or Actual Ethical Conflict

In situations where potential participants in a work setting might feel undue influence to participate due to a collegial relationship with the Student, you, as a neutral third party with no supervisory relationship with either the Student or potential participants, may be asked to work closely with the Student to bridge this potential or actual conflict of interest in this study. Such requests may include asking the Inquiry Team Advisor to: send out the letter of invitation to potential participants, receive letters/emails of interest in participation from potential participants, formalize the logistics for the learning circle data-gathering method, including contacting the participants about the time and location of the learning circle group.

Inquiry Team members asked to take on such 3rd party duties in this study will be under the direction of the Student and will be fully briefed by the Student as to how this process will work, including specific expectations, and the methods to be employed in conducting the elements of the inquiry with the Student's colleagues, and will be given every support possible by the Student, except where such support would reveal the identities of the actual participants.

Personal information will be collected, recorded, corrected, accessed, altered, used, disclosed, retained, secured and destroyed as directed by the Student, under direction of the Royal Roads Academic Supervisor.

Inquiry Team Members who are uncertain whether any information they may wish to share about the project they are working on is personal or confidential will verify this with Kelly Armstrong, the Student.

Statement of Informed Consent:

I have read and understand this agreement.

Name (Please Print)

Signature

Date

Appendix D: Survey Questions**Survey Questions: Head Midwife Survey**

For the purpose of this research project, the Head Midwife is defined as *the link, or contact person between credentialed midwives in an Ontario Hospital, and the Hospital leadership.*

Part A: Titles, Hospitals, Departments and Supports

A1. The Ontario Hospital Association, and the AOM use term Head Midwife, but other hospitals may use Chief, or Lead, or a different term.

Are you currently in the role of Head Midwife?

Please choose one. Yes___ No ___ Other _____

If you picked other – please explain below:

A2. My current title is

- Head midwife
- Lead midwife
- Chief Midwife
- Other_____

A3. Where is the midwifery group at your hospital located? For example, Does a Department of midwifery or a Division of Midwifery?

- Department of Midwifery
- Division of Midwifery
- Midwifery Service
- Other: please specify_____

A4. Midwives at my hospital hold privileges in the

- Department of Midwifery
- Department of OB
- Department of Family Medicine
- Other, Please specify_____

A5 As Head Midwife, I am supported financially through this role by (check as many as apply)

- A stipend from the Hospital;
- A stipend from my practice
- Salary from the Hospital
- Caseload Variables per my practice budget
- Caseload Variables from other practices I serve
- An education allowance from the hospital
- _ other – please describe below:

A6. At the hospital where I am head midwife, there are ____ practices with privileged midwives.

- One
- Two
- Three
- Four
- More than four

A7. There are a total of ____ midwives who are privileged at this hospital

- 4 or less
- 5-9
- 10-15
- 15-20
- 20 or more

A8. If you are Head Midwife at a Hospital for multiple practice groups, please comment on the challenges experienced, real or perceived.

A9. Do you regularly attend Medical Advisory Committee Meetings?

- Yes, as a voting member
- Yes, as a non-voting member
- No, there is not a Head Midwife Seat on MAC

A10. The individual in the Head midwife role is

- Chosen by the Midwifery Group
- Chosen by the Hospital

A11. The practice affiliation of the Head midwife

- Is not relevant – It is more important to be skilled and committed to the role.
- Should be a key consideration
- Not Applicable to my situation. There is only one midwifery group

A12. The Hospital I serve as Head Midwife at is a

- Level 1 Hospital
- Level 2 Hospital
- Level 3 Hospital
- More than one hospital – please comment below.

Comment _____

Do you also hold privileges at a hospital where you are not head?

- Yes
- No

Part B: Demographics

Please choose the category that best describes you:

B1. I have been a Registered Midwife for

- 0-2 years
- 2 – 5 years
- 5 – 10 years
- 10-15 years
- More than 15 years

B2. I am _____ years old

- 20-30
- 30-40-
- 40-50
- 60+

B3. I have been in the role of Head midwife for:

- 0-2 years
- 2 – 4 years
- 4– 8 years
- Other _____

B4. I plan to continue in my Head midwife role

- Less than a year
- One more year
- Two more years
- 3 or More years
- Unknown/ Undecided

B5. In addition to my Head Midwife role, I am also a

- Practice partner
- Associate
- Educator in MEP
- Involved in an official capacity with AOM or CMO

Part C: Courageous, Compassionate and Principled Leadership

C1. The following statements pertain to your beliefs, values and skills related to leadership, and your role as the Head Midwife.

Please indicate the degree to which you agree, or disagree with the following 12 statements about leadership itself, skill sets, knowledge and personal behaviour.

1 = I Disagree Completely 5 = I am in Full Agreement

- a. Leadership is a set of skills that can be learned.
- b. I regularly engage in self-reflection and am self-aware.
- c. I can name my core values.
- d. I welcome feedback and integrate it regularly into my practice.
- e. I can engage others and work well as a part of a group.
- f. I have the necessary skills and understanding to have tough conversations with colleagues.
- g. I have a strong understanding of how the hospital works as an organization / Institution / system.
- h. I have the skills and knowledge to be an effective leader.
- i. I am always respectful in my treatment of clients, midwives, colleagues and others.
- j. I enjoy the challenge of being Head Midwife.
- k. I am committed to being part of changing the midwifery culture away from bullying.
- l. I have all the support I need in my role as Head Midwife.
- m. I have the skills I need to mentor and support future Head Midwives.

C2. Have you had the opportunity to further my leadership development through a formal course or program?

- Yes
No

C2b. If you answered yes, please list any formal or informal training programs involving leadership development.

C4. The AOM's Mission, Vision, Values lists "Courageous, Compassionate, Principled Leadership" first in its' list of values. <https://www.ontariomidwives.ca/mission-vision-values>

Please share your experiences with how you live this as Head Midwife

- C5. Have you discovered any specific behaviours that contribute positively to your organization's culture?
- C6. What support do you feel you require to continue to develop your leadership skills and live into being a Courageous, Compassionate, Principled Leader?

Thank you so much for your responses, I am grateful for your time and participation.

This survey is now closed, and all responses will remain anonymous.

Survey Two

Next Steps:

The next stage of my research will be a small group method. This question will be separated from all of your previous responses, and I will only receive the list of folks who indicated their interest in participating in the second data collection method.

1. I am excited to be part of the next phase of this project, and I would be willing to take time off call to participate in the next phase of dialogue.
 - Yes, and I am willing to drive and meet face to face
 - Yes, but only if offered on-line.
 - Yes, on-line or in-person
 - No thanks
2. If you indicated yes, please share your name, and contact information below.

Appendix E: Research Letter and Survey Invitation

Living into our Values and Vision: Courageous, Compassionate, Principled Leadership in Ontario Midwifery

On behalf of Head Midwife Kelly Armstrong, I invite you to participate in a research study she is conducting as part of the requirement for her Master's Degree in Leadership (Health) at Royal Roads University.

Please feel free to contact Kelly, at her contact information listed below, should you have additional questions regarding this project and its intended outcomes.

Regards,

Mary K. Dunn
Policy Analyst
Association of Ontario Midwives

Hello Head Midwife Colleagues,

I am excited to invite you to participate in my research project that I am conducting as part of my Master's Degree in Health Leadership.

My research consists of two parts –

- this survey and
- a small group dialogue.

The objective of my research project is to explore the inquiry question:

“How might Head Midwives be influencers of a profession-wide culture change of courageous, compassionate, principled leadership?”

The *Vision* of the Association of Ontario Midwives is “Midwives leading reproductive, pregnancy, birth & newborn care across Ontario” and under *Values*, “courageous, compassionate, principled leadership” is listed first. (<https://www.ontariomidwives.ca/mission-vision-values>)

As you are aware, bullying is a significant issue in our profession and in healthcare in general. As midwives throughout Ontario already in leadership positions, I hope you will agree participate in my research project, aimed at shifting our culture to one that lends itself to long-term personal and career health.

The purpose of this survey is to better understand the issues, concerns, leadership skills and capabilities of midwives in Ontario serving in the Head Midwife role. ***This informed consent document constitutes an agreement to take part in an online survey anticipated to take 30 minutes to complete.*** There will be no specific personal information collected aside from area of practice and no one individual can be personally identified. The survey will consist of multiple choice, scale-based questions, and short answers.

The data collected through this survey will be used to establish the current picture of Head Midwives in the province of Ontario, and your collective perspective on leadership skills, behaviors and capabilities. The survey and participant responses

- will be stored on the secure Lime survey platform in Canada and will remain strictly confidential
- all research data downloaded from the platform will be password protected and stored on my personal laptop, with a backup copy on my external hard drive
- compiled data will be retained for a period of one year following completion of this study at which time they will be destroyed.

Following completion of the research study -

- a final report of the findings will be submitted to Royal Roads University in partial fulfillment for a Master of Arts in Leadership (Health) Degree, and published along with other RRU students' thesis projects
- I will also be sharing the research findings with the AOM as part of their mandate to end bullying
- additionally, the research findings may be presented to the Canadian Association of Midwives at their annual conference, or submitted to their peer-reviewed journal
- the research findings may also be used toward journal articles for publication.

All current Head Midwives throughout Ontario are invited to participate. This phase of my research project will consist of an on-line survey.

Your participation in this research project is important, and should you choose to participate, your participation would be voluntary. Please be aware that you are not compelled to complete and submit this survey based on a professional relationship with me. If you do choose to participate, you are free to withdraw at any time until you submit the survey without prejudice. Individual data will not be able to be withdrawn once submitted. Similarly, if you choose not to participate in this research project, your choice will remain unknown.

Your completion of the survey confirms you have read this Research Information Letter and constitutes your informed consent.

This research project received ethics approval through the Research Ethics Review Board at Royal Roads University, Victoria British Columbia. If you have any questions in this regard please contact [email address].

By clicking on this link, you are confirming your consent to participate in this inquiry project.

Click here to begin survey: <<URL>>

*Please complete and submit the survey no later than April 4, 2019 23:59

Thank you for your time, responses and participating in this research. I am excited to collate and analyze all your responses!

Kindly,

Kelly Armstrong, RM

Orillia Midwives

Lead Midwife, Orillia Soldiers Memorial Hospital

Contact information:

Email : [email address] or [email address]

Kelly@orilliamidwives.com

Telephone:

[phone #] – Cell

[phone #] - Office

My student credentials with Royal Roads University can be established by contacting Dr. Catherine Etmanski, PhD, Director, School of Leadership Studies: [email address] or [phone #].

Appendix F: Learning Circle Invitation

Dear Midwife colleague,

Thank you for participating in the survey component of my inquiry project. You are receiving this invitation because you expressed interest in continuing to be involved in my research project titled “Living into our Values and Vision: Courageous, Compassionate, Principled Midwifery Leadership in Ontario Midwifery”. This project is part of the requirement for my Master’s Degree in Leadership-Heath at Royal Roads University.

I am inviting you to participate in the next phase of my research, a learning circle. A group of Head Midwives are invited to gather so that the information collected through the survey can be reviewed and together we can identify commitment and action to shape the future.

I am hoping for five to ten participants to come together on (date to be determined) to participate in the learning circle. The circle will be approximately two hours long. I will provide refreshments, and request an additional consent to be signed. I will facilitate the circle along with a member of my inquiry team.

Anonymous Doodle Poll: << URL >>

The date with the largest number of off-call respondents will be chosen.

The attached document contains further information about the study conduct, about the circle process and will enable you to make a fully informed decision on whether or not you wish to participate. Please review this information before responding.

You are not required to participate in this research project. If you do choose to participate, you are free to withdraw at any time without prejudice. Your decision to participate or not will be kept confidential. The information gathered in the circle will likewise be kept confidential. Please feel free to contact me at any time should you have additional questions regarding the project and its outcomes.

Please confirm your willingness to participate, and your off-call availability on the date above by either email or phone at the contact information below.

Email: **[email address]**

Telephone: [phone #] –Office

Sincerely,

Kelly Armstrong RM

My credentials with Royal Roads University can be established by contacting Dr. Catherine Etmanski, PhD, Director, School of Leadership Studies: [email address] or [phone #]

Appendix G: Research Information Letter

Living into our Values and Vision: Courageous, Compassionate, Principled Leadership within Ontario Midwifery

For those of you who do not know me, my name is Kelly Armstrong, and I am working on a research project towards a culture of Courageous, Compassionate and Principled Leadership with the support of the Association of Ontario Midwives (AOM). This research project is part of the requirement for a Masters of Arts in Leadership – Health at Royal Roads University. I can be reached at [email address], Cell [phone #], or Office [phone #].

My credentials with Royal Roads University can be established by contacting Dr. Catherine Etmanski, PhD, Director, School of Leadership Studies: [email address] or [phone #].

Purpose of the study for the sponsoring organization

The objective of my research is to gain insight into current situation of Head Midwives as midwifery leaders and generate energy to shift the culture away from bullying behaviors and towards the AOM's values of courageous, compassionate and principled leadership across the membership.

The objective of my research project is to involve a Head Midwives throughout the province to answer my inquiry question:

How might Head Midwives be influencers of a profession-wide culture change of courageous, compassionate, principled leadership?

I am interested in hearing from a wide variety of Head Midwives who serve under different titles (Chief, Head, Lead), in differently settings (Urban Tertiary Centers, and rural level 1) and across broad midwifery and leadership experience backgrounds.

There are two data gathering activities for this research project. A survey of currently serving Head Midwives across the province of Ontario, and a learning circle involving volunteers from the survey.

Your participation and how information will be collected

Survey – Head Midwives

An invitation will be sent from Mary-K Dunn, Coordinator, AOM Policy Department via the Head Midwife List, as supported by the AOM. You are free to participate or not, and your choice will be unknown to me. The survey tool chosen, Lime Survey will store all data in Canada, under Canadian laws. Data will be anonymous, but may be grouped by level or hospital, specific title or years of practice. The group categories were arranged in such a way that specific individuals cannot be identified. The survey will take thirty minutes or less to complete. It is comprised of multiple-choice demographic questions, scale questions, and a few short answer questions.

Learning Circle – Head Midwives

Participants who have already been involved in the survey, will be invited to participate in the learning circle. I am hoping to have five to ten participants. The time commitment will be approximately two hours including time to sign consent forms and enjoy refreshments. This data collection activity will be audio recorded and transcribed for analysis. One or two inquiry team members will assist with registration and consent.

Benefits and risks to participation

The benefits of this research include your ability to reflect on and voice your own experiences with courageous, compassionate, principled leadership and the opportunity to contribute to shaping the future of the midwifery culture throughout Ontario. Your contribution will help identify what is working well, and where Head Midwives need support to live into courageous, compassionate, principled leadership in policy and culture.

There are no anticipated physical risks. Sharing your personal experiences could possibly trigger you to experience some emotions including grief, sadness, and anger as well as joy.

The Association of Ontario Midwives (AOM) will benefit from this research through developing a deeper understating of Head Midwives current situation, and where more support, or actions are needed to help the organization to lead into a positive, successful future for the profession of midwives in Ontario. If the findings of this research translate into enhancing the culture of midwifery across the province, midwives, hospitals, midwifery practice groups and the families we care for will all benefit.

Inquiry team

I have asked three people to support this inquiry. One to support the practical aspects of the learning circle including ensuring consents are signed the day of, physical set-up and take down, audio recording, and assisting with observations.

I have asked two others to assist with my data analysis to minimize my bias. One is a Royal Roads classmate, and the other is a recently retired midwife who has served in the past as Head Midwife. No identifying data will be shared with either of these two inquiry members.

Real or Perceived Conflict of Interest

I am not aware of any conflict of interest. There is no funding for this research project aside from my own personal contributions where necessary. As a midwife, I want to see the culture across midwifery and healthcare support the health and well-being of the practitioners so that we can continue to care for families. My involvement with the Association of Ontario midwives is strictly as a volunteer in need of an organization to complete Masters project within and a strong committed interested in contributing to a healthy professional culture. I am genuinely curious how Head Midwives can be supported to develop their own leadership, and be catalyst of culture change.

I disclose this information here so that you can make a fully informed decision on whether or not to participate in this study.

Confidentiality, security of data, and retention period

I will work to protect your privacy throughout this study. All information I collect will be maintained in confidence with hard copies (e.g., consent forms) stored in a locked filing chest in my home office. Electronic data (such as survey results, transcripts or audio files) will be stored on a password protected external drive. Information will be recorded in an audio format and, where appropriate, summarized, in anonymous format, in the body of the final report. The data on any one individual will not be linked to them personally. But, their opinions and responses in aggregate form will be shared. All documentation will be kept strictly confidential. I will retain

the raw data for the duration of my master's project, and then destroy it within 6 months of my project being deemed acceptable to RRU. Should someone withdraw their consent, I will do my best to remove and destroy their data as soon as I am able. The survey is anonymous, so once it is submitted, it can not be removed. While I can remove specific comments from a participant from the learning circle transcript, I will not be able to remove their influence on the other participants contributions.

Due to the nature of the learning circle, it is not possible for me to keep the identities of the participants confidential to each other, or to the inquiry team member in attendance. I will ask all participants to respect the confidential nature of this research by not sharing names, identifying comments or details of our discussion outside of the group. No names of participants, or identifiers will be used in the report, or in any presentations of the data.

Sharing results

In addition to submitting my final thesis to Royal Roads University in partial fulfillment for a Master's of Arts in Leadership – Health, I will also be sharing my research findings with the AOM's risk management leadership team, and potentially the AOM board members to review findings and plan future actions. I will offer a copy of my project to participants through email when my research and data analysis are completed and suitable for publishing. I will consider submitting a journal article when the research is complete, and may present at a conference.

Procedure for withdrawing from the study

Anyone wishing to withdraw from the study can contact me by email or phone. I will remove their name from the upcoming activity –learning circle, and thank them for their courtesy. Once the survey has been completed, there will not be a means of extracting one person's data from the aggregate. If a participant chooses to withdraw after learning circle event is completed, it would be very difficult to impossible to remove their data from the process, as the dialogue was created by the participants present.

You are not required in any way to participate in this research project. By signing the accompanying consent, you indicate that you have read and understand the information above and give your free and informed consent to participate in this project.

Please keep a copy of this information letter for your records.

Appendix H: Learning Circle Consent Form

Living into our Values and Vision: Courageous, Compassionate, Principled Midwifery Leadership

By signing this form, you agree that you are over the age of 19 and have read the information letter for this study. Your signature states that you are giving your voluntary and informed consent to participate in this project.

I consent to the audio recording of the Learning Circle

I commit to respect the confidential nature of the learning circle by not sharing identifying information about the other participants

I understand that once the Learning Circle audio recording has started, it may not be possible to remove my personal contributions from the group data.

I am aware that the findings from this research project will result in a published thesis, and may form the basis for a journal article, or presentation at a conference.

Name: (Please Print): _____

Signed: _____

Date: _____

Appendix I: Head Midwife Learning Circle Questions

1. Why did you become a Head Midwife?
2. Could you share a high point experience you have had in your time as a Head Midwife?
3. Could you describe a time when you experienced inspiring/ exemplary/ brave leadership? Why was it exemplary; who was there; what was the outcome; what did you learn? What role did courage, compassion and principles play?
4. If you could imagine the best possible life of a midwife in 2025, what would that look like? What would the Association of Ontario Midwives be known for – among midwives and among people within the health system? What would it feel like to be a midwife?
5. How might the AOM become the beacon of courageous compassionate and principled leadership that you think it could be in 2025? What needs to happen? Who needs to do this?
6. What could you commit to today, to develop your own, and others capacity for courageous, compassionate, principled leadership?



The Center of the Circle

Appendix J: Survey Data

Ontario Head Midwife Survey

Potential Participants – 80

Survey Responses – 27 in total

21 Completed Parts A & B ; 20 of which are currently in the Head Role.

19 Completed Part C

Part A

My current title at the hospital is:

Division Head -8

Lead Midwife – 2

Chief of Midwifery – 4

Other – All identified as Head Midwife – 7

(Total = 21 = 100%_Pie)

Notes – Two Others identified as Head and added:

1. head midwife...really it has changed over time sometimes head/chief/co-ordinator of midwifery services
2. Head Midwife although I think it is referred to as Lead Midwife in the By-Laws

Midwives at my hospital hold privileges in the ...

Department of Obstetrics – 13

Department of Midwifery – 5

Department of Family Medicine - 1

Other - 2

(Total = 21+100%_Pie)

As Head Midwife, I am compensated for this role by (check as many as apply):

A stipend from the hospital – 8 = 38%

A stipend from my practice - 0

A Salary from the hospital – 5%

Caseload variables per my practice budget -12 -57%

Caseload variables from other practices I serve - 0

An education allowance from the hospital

Other - three noted NO compensation at all -14%

Bar Graph perhaps?

Do you have a seat at the Medical Advisory Committee Meetings (MAC)?

Yes as a voting member - 3

Yes, as a non-voting member -4

No, there is not a Head Midwife on MAC -14

Total = 21= 100% _pie

At the hospital where you are lead midwife, how many practices are there with privileged midwives?

One -10

Two - 7

Three - 1

Four -1

More than four -2

Total = 21= 100% - pie

There are a total of ____ midwives privileged at this hospital

5-9 - 4

10-15 - 7

15-20 - 4

20 or more -6

Total = 21 = 100%

The individual in the Head Midwife role is

Chosen by the Midwifery Group -14

Chosen by the Hospital Leadership – 4 (all of which indicated compensation from Hospital)

Other -3

Notes about other

1. Initially chosen my midwifery group but now, no one else is interested in taking on the role
2. A name is/names are put forward by the midwifery group. Candidates are then interviewed by senior leadership and final approval is given by the hospital's board.
3. Put forward by the Midwifery group and approved by the hospital.

The practice affiliation of the Head Midwife

Is not relevant. It is more important to be skilled and committed to the role. - 8

Not Applicable to my situation. There is only one midwifery group - 10

Should be a key consideration – 3

Total 21 = 100%

I am Head Midwife at a

Level 1 Hospital – 5
 Level 2 Hospital – 12
 Level 3 Hospital – 4
 Total 21 =100%

Do you also hold privileges at another hospital where you are NOT the Head Midwife?

No – 17
 Yes – 4

I have been a registered midwife for:

More than 15 years -8
 10-15 years - 7
 5-10 years -6
 Total = 21= 100 %

I am _ years old

20-29 -1
 30-39 -4
 40-49 - 11
 50-59 -4
 60+ - 1
 Total = 21 = 100 %

I have been in the role of Head Midwife for:

0-2 years - 6
 2-4 years - 6
 4-6 years - 2
 More than 6 years -7
 Total = 21 = 100%

I plan to continue in my Head midwife role

Less than a year - 5
 1-2 years - 2
 2-4 years -4
 4 or more years - 2
 Unknown/undecided -5
 Other – 2
 Total - 21

Comments – other

1. I would like another midwife to take the role in 1 year but am uncertain if anyone will take it on
2. Presently Mentoring my successor

In addition to my Head Midwife role, I am a

Practice Partner - 17

Associate -4

Educator in the Midwifery Education Program - 7

Involved in an official capacity in the CMO or AOM - 2

Other -6

Comments for Others

- Clinical Lead EMCM
- Board member at Birth Centre
- CAM consultant
- Preceptor, NRp, ESW and FHS instructor
- Preceptor
- regional committees, provincial panel, aom cno cmo rnao capwhn cam membership

Part C: C1. The following statements pertain to your beliefs, values and skills related to leadership, and your role as the Head Midwife. Please indicate the degree to which you agree, or disagree with the following 12 statements about leadership itself, skill sets, knowledge and personal behaviour.

1 = I Disagree Completely /Have few skills/ Never do 5 = I am in Full Agreement/ Have a strong skill set/ Regularly Do

** Two of the 21 people did not complete this section. So totals out of 19.

	1	2	3	4	5
C1: Leadership is a set of skills that can be learned	0	2	5	6	6
C2. I regularly engage in self-reflection and am self-aware.	0	0	0	7	12
I can name my core values	0	0	1	7	11
I welcome feedback and integrate it regularly into my practice	0	0	0	7	12
I engage others and work well as a part of a group	0	0	0	6	13
I have the necessary skills and understanding to have tough conversations with colleague	0	1	5	9	4
I have a strong understanding of how the hospital works as an organization / Institution / system	0	2	3	8	6
I have the skills and knowledge to be an effective leader	0	0	5	8	6
I am respectful in my treatment of clients, midwives, colleagues and others	0	0	0	4	15
I enjoy being Head Midwife	0	2	4	9	5
I am committed to contributing to a midwifery culture that does not tolerate bullying	0	0	0	3	16
I have all the support I need in my role as Head Midwife	3	3	9	3	1
I have the skills to mentor and support future Head Midwives	0	1	5	5	8

Have you had the opportunity to further your leadership development through a formal course or program?

Yes -10

No – 9