Multiprofessional leadership development: reflections from a doctor in training

Yang Chen

Institute of Cardiovascular Science, UCL, London, UK

Correspondence to
Dr Yang Chen, Institute of Cardiovascular Science, UCL, London WC1E 6DD, UK; ychen89@cantab.net

ABSTRACT

Background In July 2020, the National Health Service (NHS) People Plan was refreshed, giving further impetus to staff development and leadership training. Through a series of interwoven tales, I discuss my own journey of leadership development and offer an analysis of the value of dedicated courses and the importance of providing this to the wider workforce.

Story of self I am a doctor in training and was among the first three cohorts placed onto the new Rosalind Franklin programme, organised by the NHS Leadership Academy. I share my key reflections of the impact of this course on my personal and professional development.

Story of us My cohort contained professionals from a diverse range of backgrounds—their challenges, views and insights contrasted greatly with my own. Having the protected time to build trust, form teams and discuss issues that crossed organisational boundaries provided novel insights that helped all of us.

Story of now As the COVID-19 pandemic has taken hold, we are in a state of extreme flux. As a result, I have become aware of how important it is to marry expertise with generalist skills and knowledge of the wider healthcare system. Enduring the initial surge of COVID-19 was about staff working together and blending specialism with generalist pragmatism. The ability to harness and sustain this type of working will represent a legacy from COVID-19 that is positive and one which galvanises our greatest asset—the talents and experiences of our diverse workforce—in order to meet future healthcare challenges.

MIRROR MIRROR ON THE WALL

I graduated in 2013 with a clear vision of where I wanted to go with my career (in those days, I was even tenacious enough to say aloud that I wanted to become an 'Academic Cardiologist').

Working as a junior doctor was a shock to the system. Gone were the summative assessments, rote memorisation of facts and certainty in what was right or wrong in clinical scenarios. Instead, I had to adapt to working with a diverse group of people from different backgrounds, constant rotation changes and decision-making in the face of uncertainty.[1] Soon into my first few placements, what I thought were the fundamentals of being 'good at my job'—content expertise and efficiency of communication—expanded to include qualities that were previously in my blind spots. A few humbling moments along the way helped to accelerate my learning about the value of more personable qualities such as empathy, kindness and sharing an inspired purpose.

By 2017, I had achieved the milestone of being awarded an Integrated Academic Training number in Cardiology. My younger self would have looked in the mirror and prematurely concluded 'all is well, and everything is going according plan'. However, my lived experiences of working with different people had already made me consider whether this plan was the all-encompassing one that I should exclusively follow.

CHANGING THE ANGLE OF VIEW

I started to challenge my assumption that developing into 'a good doctor and leader' would automatically follow through completing a specialist training programme and a higher research degree. I realised that I wanted a broader system-level view of the National Health Service (NHS) and by serendipity of timing, I saw that a new leadership course was available aimed at aspiring leaders.

The Rosalind Franklin programme delivered by the NHS Leadership Academy represented a leadership opportunity that was experiential and integrated within existing job schedules.[2]

The programme—9 months of distance learning mixed with face-to-face workshops—was unlike any I had experienced. The curated resources, my fellow course colleagues and facilitators, and the opportunity to try and test different approaches at my usual work environment were a career highlight.

I now share the most salient reflections during my leadership development, analyse the key literature which helped frame my learning and consider how such a dedicated course could be useful not just for doctors in training but the wider healthcare workforce.

BEYOND MATTERS OF THE HEART

My early experiences of leadership were probably typical of a motivated junior doctor. In a rush to be useful and in the narrative of junior doctors as agents of change,[3] I signed up to perhaps too many projects in my first few years. One of the biases that I developed while trying to be an 'agent of change' was a tribal mentality around working with a certain type or group of people (usually academic researchers or aspiring cardiologists). The drawback of working with people with similar views—homophily—was recently described by Matthew Syed in his book Rebel Ideas.[4] This was brought to my attention during the Rosalind Franklin programme when we undertook a project analysis using the NHS sustainability model.[5] The blind spots in the analysis which my usual work colleagues and I conducted were highlighted within minutes by fellow Rosalind Franklin participants.

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Table 1 Example of a Johari window which I made during *Module 2: Taking stock*, Rosalind Franklin Programme

	Known to self	Not known to self
Known to others	Job title	Blind spot
Not known to others	Façade	?

When the concept of a Johari window[6] (table 1) was subsequently introduced, I found this to be a particularly powerful way of framing task and project analysis. Crucially, I realised that what is 'known to others' will be different depending on their individual backgrounds and lived experience.

PROTECTED TIME

After the first few Rosalind Franklin sessions, I reflected on the impact to my leadership style of having dedicated time to explore such concepts that would never have ordinarily arisen in my daily practice. I recognised that being focused on doing things in a singular way and canvassing a limited range of views missed the key element of both collaboration and self-development that I could harness if I broadened my outlook and networks. The importance of having explicitly protected time to receive formal leadership training and to reflect on its impact is outlined in the popular 70:20:10 model of leadership development[7] (table 2).

By being on the Rosalind Franklin programme, and having the commodity of protected time to engage in guided exploration and reflection, I was able to leverage my day-to-day experiences in a way I had not done so before. A culinary analogy used by Health Education England (HEE) in their '*Leadership Development for doctors in postgraduate medical training*'[8] publication is a particularly powerful one:

> the 10% is like salt, you don't need much, but the 70% and 20% don't make much sense without it

LEADERSHIP AND FOLLOWERSHIP

One example of the importance of 'adding the salt' was when the concept of the *shadow system* was introduced. This is a term coined by Ralph Stacey[9] to describe the informal network of relationships within organisations, evident in casual corridor or canteen conversations that are actually the ways used to 'get things done'. Coming from an especially hierarchical medical specialty, I had used the shadow system to gain influence in ways not afforded to me through title alone. For example, working with peers to create small networks of influence locally as well as collaborating on larger national projects.[10] Gaining explicit knowledge of this framework has helped to strengthen my understanding of how to lead more effectively, using contexts that I can directly lead and influence and acknowledging others where followership and the buy-in of key stakeholders are required.

I additionally reflected on the power of titles and stereotypes: for doctors in training or junior doctors, those words alone may confer a lack of credibility. When speaking to colleagues at work, some of whom were in their late 30s with over a decade of clinical experience, this seemed a general source of frustration and a view shared by fellows at the Faculty for Medical Leadership and Management.[11]

So how do 'junior doctors' overcome these barriers which can impede their ability to effect change?

From my own experiences, I have noticed the transformative power of acquiring more familiarity with leadership and management literature including the concepts mentioned above. However, I reflected on the motivation necessary to engage with such literature—a nudge from an extrinsic driver such a leadership course was needed. While I was more comfortable reading reports from randomised clinical trials and registries, I began to see how impactful different types of research could be. The Healthcare Leadership model[12] used by many NHS organisations is perhaps the best example of a distillation of decades of theory into a pragmatic, useable framework. My own detailed 360° report has stuck with me in a way that other 'traditional research headlines' have not: it catalysed a crucible moment where I realised that 'knowing the most' about something did not necessarily mean leading with a certain style or even, as an individual, leading at all.

At the end of the course workshop, a topic that our group discussed was how to make leadership training more inclusive. When I first met my fellow Rosalind Franklin candidates in July 2019, we discussed the irony of knowing individuals from our own workplaces who were not there and who were perhaps most in need of such a programme.

A TIME FOR ROLE MODELS, NOT HEROES

As I write this, we are in the midst of the COVID-19 pandemic. I have seen first-hand how in times of such crises, people naturally look towards recognised leaders. At my own hospital, our Chief Registrar and a fellow doctor in training has been a voice of calmness, answering questions and directing fellow clinicians to appropriate sources of information, demonstrating the many traits of Kolditz's theory of successful leadership in extremis.[13]

On a personal note, I have taken many elements of what I had learnt during my leadership journey and applied it over the past few months—for instance I feel I am better anchored and more resilient to stress and also a better role model for others. In particular, I recognised that the plurality of views and reactions to COVID-19 within my workplace meant that I needed to be more open and engaging with others, to better signpost people to recognised sources of help when they needed it or to empower team members with ad hoc coaching conversations.

Thus, while the evidence base for the value of leadership development is mixed,[14] one must caution in the heterogeneity of study designs and the framing of what it means when 'leadership courses work'—my own experiences during the COVID-19 surge is that many positive actions may not necessarily be captured and a more holistic view about what 'valuable' leadership means should be argued for.

In light of the recent publication of the *NHS People Plan*, as well as the Future Doctor Programme commissioned by HEE,[15 16] I am optimistic that system leaders have recognised

Table 2 The 70:20:10 model of leadership development

Indicative proportion of development and learning about leadership	Activity
70%	Work-based tasks, challenges and problem-solving
20%	Learning through reflection, mentoring, coaching, social networks
10%	Formal education and training

this point and also the impetus that COVID-19 has provided to upgrade leadership training for all clinicians.

The pandemic may even catalyse a reframing of what leadership encompasses in the future. Small behaviours that we need to role model, and those that we must fight against—such as microaggressions[17]—may not fit the traditional definition of heroism or heroic leadership—but nevertheless can cause personal and systemic ripples far greater than the sum of their parts.

I saw how during the pandemic, role modelling positive, authentic and collaborative behaviour, rather than self-orientation helped to create a culture of inclusivity that capitalised on solutions generated from diversity of thought. Unique projects such as the NHS Nightingale Hospitals were a testament to this idea, and provide for an added emphasis on learning organisational lessons that could leave an indelible mark on the NHS. The prioritisation of a just culture, a flat hierarchy and a focus on well-being[18] is an inspiring story that can help to ensure that leadership training is inclusive and imbued with those values.

THE FUTURE HEALTHCARE TEAM

From a staff development perspective, one particular quote from a series of interviews with top performing chief executives in the NHS[19] stands out in capturing perhaps the issue that would make the biggest difference for trainees:

'You need to remain absolutely patient focused, eternally optimistic, make decisions and do difficult things: to keep your health, your nerve, your confidence and you need people around you, you need a great team'.

For the average doctor in training, who often rotates around several departments or hospitals a year, few will feel like they belong to a real team described by Michael West.[20] Real change for staff may thus start with the formation of better structures to allow real teams to emerge. My own postgraduate experiences would have echoed the above, were it not for the recent combination of participating in the Rosalind Franklin programme, and the galvanising effect of COVID-19—I now feel embedded within my hospital team and the wider healthcare system.

Moving forward, I hope we can continue to cultivate the spirit of teamwork and multidisciplinary working while also reducing the burden of a system of staff governance and progression that is currently rigid and bureaucratic. For example, anecdotal and published evidence highlight concerns about arbitrary assessments which measure clerical rather than clinical ability.[21] By adopting a more agile approach to staff development, we can realise the vision of the *NHS People Plan*'s desire to 'increase flexibility in medical training and careers, enabling doctors to develop a broader range of skills and more easily adapt to changes in service requirements and patient safety practice'.[15]

As a consequence, we may find ourselves better able to generate visionary changes that can help prepare us for the future challenges to our collective health, be it multimorbidity, delivering precision medicine, or mitigating against climate change and future black swan events.[22]

Twitter Yang Chen @DrYangChen

ORCID iD
Yang Chen http://orcid.org/0000-0001-6032-3387

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