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Personal Leadership Style

Learning Log

Date	Description	Organisation/ Location
18/07/18	Welsh Clinical Leadership Fellow (WCLTF) Presentations 2017-2018 cohort	Academi Wales/Wales Deanery
19/07/18	Introductory meeting with Project Supervisor	General Medical Council (GMC)
08-09/08/18	Devolved Office Business Planning Meeting Manchester	GMC (DO teams)
03-04/09/18	STEME Conference, Cardiff City Stadium	Representing GMC, Wales Deanery
05/09/18	WCLTF Induction	Wales Deanery
06/09/18	Welsh Government Induction	Welsh Government
10-12/09/18	Faculty of Medical Leadership & Management (FMLM) Four Nations Induction - Leadership styles - Communication skills - Personal branding	FMLMUK / Regent's Park, London
13/09/18	FMLM 'A Healthier Wales: Leadership Challenge' Conference - Invited to present on leadership styles and behaviours with GMC Wales Lead Katie Laugharne - Opportunity to meet local senior clinical leaders	FMLM Wales/ Cardiff Metropolitan University
17/09/18	NWIS WCP Mobile App Workshop	WCLTF
19-20/09/18	GMC Fellow Induction	GMC
24/09/18	HEIW launch event	HEIW/ Cardiff City Stadium
16/10/18	UK Advisory Forum	GMC
24-15/10/18	Introduction to Medical Leadership Programme (MLP)	Academi Wales, Cardiff
14-16/11/18	Leaders in Healthcare FMLM/BMJ Conference - Highlight keynote speaker Matt Hancock, Secretary of State for Health and Social Care	FMLM / Birmingham
20/11/18	MLP: Understanding Political and Strategic Context	Academi Wales, Cardiff
28/11/18	Out and About in Westminster - Understanding political engagement - Attended plenary sessions - Exploring Houses of Commons and Lords	FMLM / Westminster
19/12/18	FMLM Fellows Day at Health Foundation - Organised by FMLM England fellows - Explored current NHS challenges	FMLM / London
10/01/19	MLP: Understanding self and others/Action Learning Set (ALS)	Academi Wales, Cardiff
11/01/19	Value Based Healthcare Introduction - Sally Lewis and Rebecca Richards	WCLTF
22/01/19	WCLTF Meeting with Welsh Government	WCLTF

	- Frank Atherton - National Clinical Plan	
29/01/19	Public Health Wales Introduction - Giri Shankar	WCLTF
30/01/19	MLP: Leading Engagement & Collaboration Workshop	Academi Wales, Cardiff
01/02/19	GMC Fellows Medical Practitioners Tribunal Service (MPTS) Introduction - I organised a deep dive day	GMC/MPTS, Manchester
04/02/19	Rosemary Soper Library Services - Update on library resources	WCLTF
07/02/19	Public Health Wales - John Boulton	WCLTF
18/02/19	Six-month presentation of patient impact project - Opportunity to showcase progress and share ideas with peers and host organisations	Academi Wales/HEIW/GMC
19/02/19	Meeting with Frank Atherton - Discussed Return to Practice in Wales	Representing GMC, Welsh Gov
20-22/02/19	MLP: Residential Learning Community: Leading People & Teams - Leadership styles theory - Effective team working activities - Chance to network	Academi Wales, Elan Valley, Powys
25/02/19	Professional Behaviours training	GMC
26/02/19	GMC Photoshoot	GMC
11/03/19	HEIW The Learning Environment Conference	GMC
12/03/19	MLP: Academic skills/ALS	Academi Wales, Swansea
12/03/19	Henry Marsh, Neurosurgeon and author - Evening talk organised by FMLM England fellows	FMLM, London
14-15/03/19	MIT Course at Sloan School of Business Management: Communication and Persuasion in the Digital Age - Fortunate and unique opportunity - Participated alongside international business leaders - Transferable skills and sharing ideas	Massachusetts Institute of Technology, Boston
27-29/03/19	Institute for Healthcare Improvement International Conference - Variety of high-quality sessions - Poster presentation with WCLTFs - Clinical Leadership Training	IHI, Glasgow
03/04/19	MLP: Coaching for Performance - Teaching on coaching techniques - Opportunity to practise	Academi Wales, Cardiff
04/04/19	Cardiff Business School Breakfast Session - Networking event - Talk on homelessness	WCLTF
30/04/19	MLP: Leading and influencing/ALS	Academi Wales, Swansea
16/04/19	NHS Wales Informatics Services (NWIS) Introduction - I organised a day of talks and workshops delivered by the NWIS team - Covered role of NWIS in clinical practice	WCLTF
23-24/04/19	Leadership and Innovation in Digital Services	WCLTF / London

	- Organised by one of the WCLTFs - Visits to Cerner, Google DeepMind and Great Ormond Street Digital Innovation Hub	
16/05/19	MLP: Leading the quality and safety agenda workshop	Academi Wales, Cardiff
03/06/19	NHS Wales: The Bigger Picture Conference - Organised by WCLTFs for trainees in Wales - Talks and breakout sessions from senior clinical leaders in Wales	WCLTF
05/06/19	MLP: Academic skills session/practice presentation/ALS	Academi Wales, Swansea
18/06/19	MLP: Leading and Communicating with impact - Media training - Social media and healthcare	Academi Wales, Cardiff
04/07/19	MLP: Skills workshop/ALS - Outdoor ALS	Academi Wales, Cardiff
16/07/19	Doctors in Training Welsh Roundtable - Helped organise GMC/HEIW event	GMC
17/07/19	MLP: Patient Impact Project presentations	Academi Wales/HEIW
07/08/19	Return to clinical practice (80%) Continued work at GMC as Clinical Lead for Induction & Returners (Supporting a Profession Under Pressure) (20%)	Aneurin Bevan Health Board/GMC

I also had regular meetings with:

- Katie Laugharne, Head of GMC Wales, Project Supervisor
- Anthony Omo, Director of Fitness to Practice, GMC, London
- GMC Clinical Fellows across the UK
- Mentors from the clinical practice

Personal Development SWOT and Plan

Strengths ✓ Cheerful ✓ Making new connections and maintaining old ones ✓ Commitment ✓ Valuing people and making time for them ✓ Compassionate and open ✓ Enthusiastic ✓ Mentor/role model ✓ Working under pressure ✓ Democratic and collaborative ✓ Face-to-Face reflective practice	Weaknesses ○ Slow to read long text ○ Making too many new connections ○ Emotional ○ Influenced by others' behaviours ○ Not able to say no ○ Tend to talk too much when uncomfortable and not say enough when needed ○ Not feeling credible ○ Can be quite intense at work ○ Too detailed ○ Poor at coming with ideas
Opportunities ➤ Networking – maintain but more selective ➤ Do more things of value – more selective in choice of opportunities ➤ Assertiveness/confidence in areas out of my comfort zone ➤ Prioritise effectively	Threats ▪ Not doing things of value therefore taking on too much ▪ Not completing something important as I am spending too much time on the details of something else ▪ Enthusiasm wears or isn't as genuine at times ▪ Compassion fatigue ▪ Limited political awareness

➤ Take care of myself to work better for my team and patients ➤ Be creative	
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SKILL	CURRENT LEVEL	TARGET	DEVELOPMENT OPPORTUNITY	CRITERIA FOR SUCCESS	TIME SCALE	EVIDENCE
Knowledge: GMC structure and affiliations	Brief outline of what the GMC does	Understand the internal structure and organisations affiliated with GMC	Online internal learning modules. Discussion with GMC peers	Complete induction modules. Be able to contribute in GMC meetings	November 2018	Online learning complete and feel comfortable talking internally and externally about the GMC
Personal: Working from home	Not able to manage time effectively when trying to work at home. Lack of experience.	Be able to work productively at home – video conference meetings and individual work	Participate in home working including meetings	Achieve daily goals despite home working	July 2019	Proved that after persistence and practise I have the discipline for home working. Extrapolated successfully to working in other environments e.g train/cafe

Personal: Speaking in public without preparation	Able to present even to large groups when fully prepared and rehearsed but struggle with answering questions	Be confident enough to answer questions from an audience	Speak in public with little preparation. Practise answering questions in public.	Feel more comfortable doing this and be able to do it well. Try to be part of a panel of speakers	August 2019 Ongoing	Successfully spoke on a panel answering questions from the audience. Feel more comfortable but only on topics I know well.
Self-awareness: Learn to be compassionate towards myself	Often focus on others and not spend time taking care of myself. High risk of burnout. Always find I have no time to reflect	Learn to make time for myself. Learn wellbeing coping strategies. Think of what is of value to me and brings me joy	Take advice from talks at conferences and a wider range of resources e.g. podcasts, books. Learn from others' good practice	Less sense of burnout. More focus on work after taking time to take care of my own wellbeing	September 2019 Ongoing	I make time daily to focus on my mind and allow time to reflect and rest
Leadership: Assertion	Comfortable doing this clinically but not otherwise	Have a confidence to transfer skills of assertion outside of the hospital	Practise when making decisions for my project. Exercise assertion in new role in GMC	Use this to achieve my patient impact project goals. Feel more confident asserting myself.	August 2018 Ongoing	Peer/mentor feedback.

Self-awareness: Reassess core values	Personal life event made me question all of my values	Know what my core values are and how they align professionally and personally	Discussions at counselling and professional coaching. Self-reflection.	Develop a list of my core values and how they related to me personally and professionally	June 2018	See personal leadership values section
Personal: Time management	Work in a pressure-prompted fashion. Often start work early but leave the majority to the last minute	More effective time management with realistic goals especially when working as part of a team	Practise self-discipline and setting earlier goals. Learn from others who practice differently	Completing work before the deadline. Better team working with regards to deadlines	Ongoing	Mentor feedback. Improvement in timeframes with work but further development needed

Personal Leadership Values and Styles

I believe that one's professional values influence their leadership style, behaviours and interactions with others. These are often entwined with one's personal values and it is reasonable to accept that leadership styles may well change over time. Stojanovic-Aleksic comments on the complexity of leadership being due to the influence of "personal circumstances, as well as...skills, social characteristics and environment" (2016). In the current healthcare climate, there is a much-needed focus on wellness and personal resilience of the workforce in the context of maximising patient care (Bohman et al, 2017). A significant life event in 2018 gave me a stark realisation and deep insight into just how much the above is true and prevalent. My personal, and therefore professional, values were put into question. I then transitioned from clinical practice to unfamiliar surroundings in a healthcare organisation and spent much of my year re-evaluating my values and what it is that shapes me as a person, a doctor and a leader.

After self-reflection, analysis of diagnostic tools, professional coaching sessions, personal counselling and discussions with friends/colleagues/mentors/family, I have considered my professional values and how they align with me personally.

The first is **compassion**. I believe that without showing compassion to yourself and to others, one would not thrive working in healthcare and not as a leader. With this in mind, I am pleased that this has been a dominant theme from previous multi-source feedback reports, my recent healthcare leadership model 360 report and as an Extraversion/Sensing/Feeling/Perceiving (ESFP) Myers-Briggs Type Indicator® Step II (MBTI-II) type, compassion is a key element (Quenk and Kummerow, 2019). I also believe that we do not do enough to look after ourselves and those around us in our healthcare system, being mindful that time and workload are often unfortunate barriers to this. I have been inspired by many talks recently, aiming to disseminate the message of 'improving joy at work', for example Dr Swensen at the Institute for Healthcare Improvement

conference and have carried this forward returning to clinical practice and reading his work (Exponential Medicine, 2019). Whilst showing compassion to others and asking, “Are you okay?”, comes naturally to me, I have recognised to ask myself “Am I okay?”: the need to focus on being compassionate towards myself, including doing things that bring me joy and value and improving

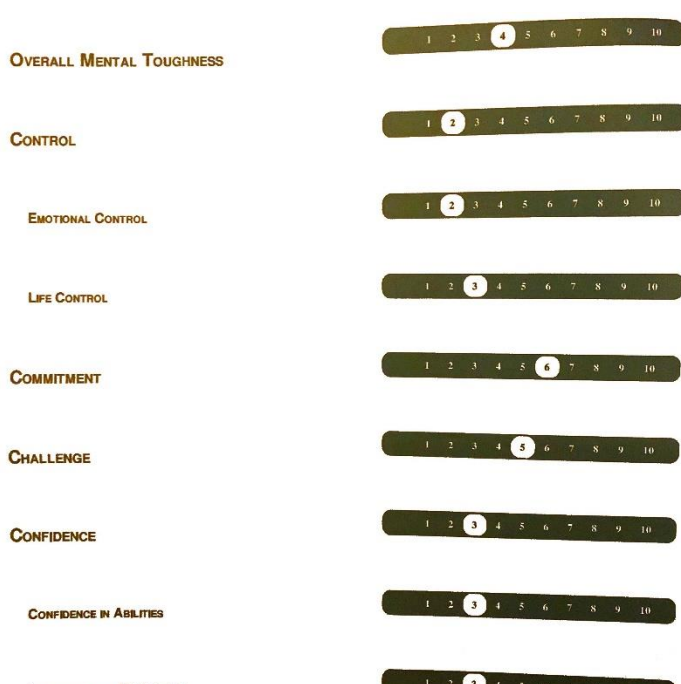


Figure 1: My MTQ48 Results (2019)

low-scoring elements of the Mental Toughness Questionnaire (MTQ48) – emotional and life control (MTQ48 Development Report, 2019).

The second is **togetherness**. I favour, and naturally fall towards, a more collaborative approach to leadership with a focus on inclusivity, equity and horizontal leadership as shown in my ‘Push me – Pull you’ results (CTR Training). The message of collaboration and softer approaches in Timms’ #newpower resonates with me and is where I see the future of leadership in

healthcare (2019). I often find that putting emphasis on radiating enthusiasm, energy and hope can carry myself, the team and our goals far. Drivers questionnaire completed recently leading towards a team development day in the GMC, showed my main driver as ‘pleasing people’ (Totem Consulting, 2016) – which can be both positive and negative.

Be Strong	Be Perfect	Try Hard	Hurry Up	Please People
56	76	60	76	83

Figure 2: My Drivers Questionnaire Results

This becomes ‘patient pleasing’ in the clinical setting where time does not allow for a softer collaborative approach due to patient safety. Another aspect of togetherness is encouraging a sense of belonging and a psychologically safe environment, i.e. one where there is transparency and shared responsibility: unity, not uniformity is key to a functioning team.

The last, and I believe to be the overriding learning point from last year, is that everything to do with leadership and healthcare is about **people**. I have watched those in leadership positions around me form strong professional relationships by valuing and making time to spend with

people. And when I have made time for others, showing kindness and compassion, it is clear that this enables them to feel valued, appreciated and improves productivity. Chris Turner of civility saves lives suggests that if we respect “complexity, both of individuals and systems, we give ourselves the chance to create the best outcomes for all” (Civility Saves Lives). I naturally enjoy spending time with others, connecting those around me (Belbin Team Role Report, 2019) and prefer to wear an ‘emotionally-driven hat’ when thinking of De Bono’s thinking hats (1985). I show a high degree of commitment (I believe more people-focused than task-focused) (MTQ48 Development Report, 2019), favouring a mentorship type role: trusting that being a good role model equates to strong leadership. With this value of people, naturally comes communication and the need to use this effectively, in an authentic and honest way, to collaborate and function. A Director in the GMC, who became an important mentor last year stated: “The only right way to lead is to do it in your own way: be genuine”. In healthcare especially, the need for clarity of communication with patients and relatives is paramount. I have also reflected on feedback in my 360 report about having too much of a focus on people. Perhaps last year due to personal circumstances I opened myself up to too many new contacts. However recently, I have focused on relationships of quality that bring me joy.

Thinking about the relationship between my personal values, emotions and behaviours has enhanced my interactions with others. My values will naturally drive my emotions and this state will drive my behaviours. Therefore, I believe that I have had in a way, a paradigm shift over this year as there has been a change in my behaviours and thought processes based on a shift in my values. This has happened over a length of time and I am sure will continue to evolve as I face more challenges ahead.

On reflection, my favourite quote from a mentor last year is:

Leadership is not about being the best. Leadership is about making everyone else better

The two most valued, trusted and admired mentors that I gained last year epitomise this quote

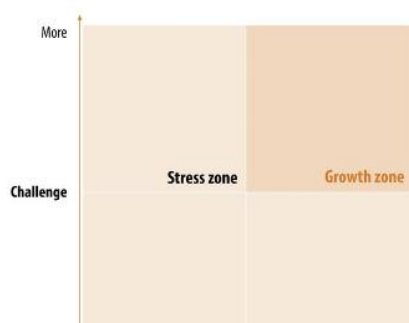


Figure 3: Support and Challenge Model Template (Mitchell, 2017)

and demonstrate that a true leader is one that has this ability in abundance. I watched as they consistently, selflessly invigorated and motivated those around them, allowing their team members to have autonomy and achieve their potential, whilst fully supporting them when needed. According to the support and challenge model (Figure 1), they keep their team in the top right ‘growth zone’ (Mitchell, 2017). They are

simultaneously able to show empathy, compassion and give people their time, in a genuine, inclusive way that makes others feel they are valued, appreciated and listened to: drawing upon a difference between leaders and managers in that the latter can often make others aware of their importance whereas leaders make others feel important. This is the type of clinical leader I strive to be every day. I feel incredibly fortunate to have met these mentors and believe that watching how they behave and interact with others has not only helped me develop professionally but changed my life and made me a better person.

I believe that without compassion, togetherness and focusing on people, being a leader who can make everyone else better is not possible. A system does not work without the people within it and at the heart of what we strive to achieve in healthcare are people: our patients.

Reflective Accounts

Diagnostic Tools and Impact on Reflective Practice

I have completed several diagnostic tools for behaviour assessment over the last year and have found them to be a useful and structured method of gaining personal insight, in particular the Myers-Briggs Type Indicator® Step II (MBTI-II) and the 'Push me – Pull you' influencing style questionnaire (CTR Training). I had done online versions of MBTI Step I previously but had not explored other similar tools or delved into the complex facets of MBTI-II. When looking at my results in depth, it is sensible to use Kolb's experiential learning cycle (See Appendix 1), but also appreciate that these tools are often a simplification of complex psychological types and behaviours. (1984)

My MBTI Step I clarity of preferences, as per my MBTI-II report, shows I am an ESFP type (Extraversion, Sensing, Feeling, Perceiving). I was encouraged to read that this 'enthusiastic improviser' MBTI-II type is most likely to be happy working in an environment that is "friendly, realistic, flexible and action-orientated" (Quenk and Kummerow, 2019). Reflecting on my career choice, this strongly relates to acute medicine departments.

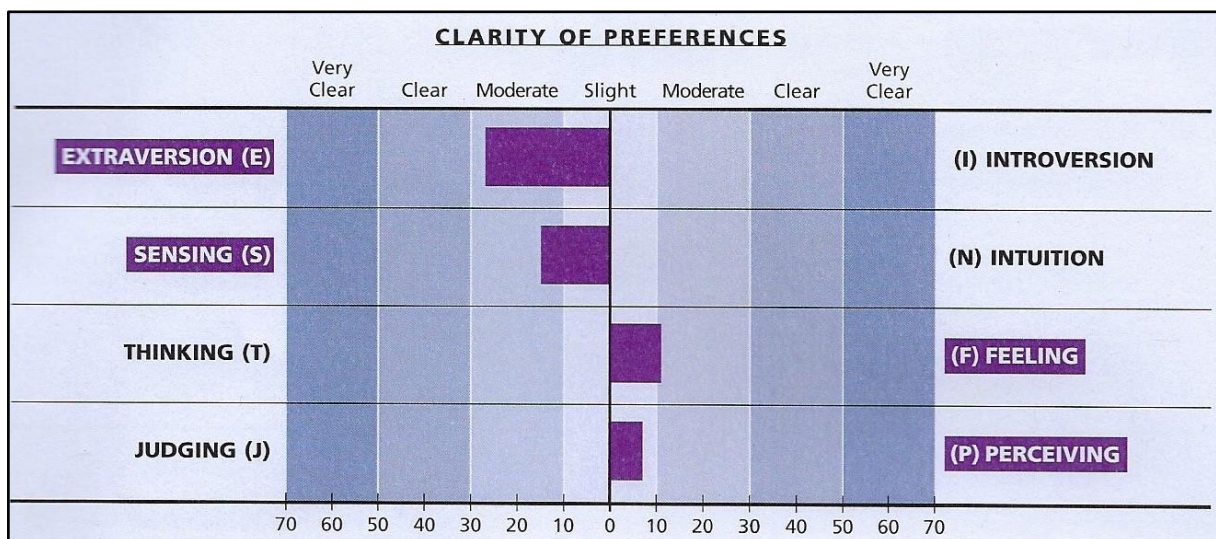


Figure 4: My MBTI Preference

When looking at the facets beneath extraversion, I am not surprised that mine all lie in preference and that this is my most strongly expressed preference. I have always known and been told that I am 'sociable', but often not thought of myself as a typical 'extrovert' (as the term is used in popular culture). The ability to embrace this and understand that this preference is not about how I behave, but rather relate to where I get my energy from, has been beneficial in both my personal and work life. This has been especially pertinent in circumstances where I now recognise the need to mitigate against times of low energy. I am also not surprised that the highest clarity of preference is only in the 'moderate' category, as I will often change my behaviour depending the requirement of the circumstances.

Reflecting on results using simpler MBTI tools online, extraversion is persistent, whereas all others have varied:

	2016	Present
icould.com	ESFJ	ENFJ
MBTI Step I online tool (The Myers-Briggs Company)	ESFJ	ENTJ
MBTI Step II Report (Quenk and Kummerow, 2019)		ESFP

Figure 5: MBTI Types Comparison

Initially receiving the MBTI-II report, I was perplexed at how variable these results could be, but reviewing my facets for sensing/intuition, thinking/feeling and judging/perceiving, the two ends of each preference form a spectrum on which I slide across depending on many factors such as situation, people, mind frame etc. Particularly in the judging/perceiving preference, I am strongly pressure-prompted but also strongly methodical. This leads me to respect that not only will I draw upon different aspects of my personality at different times, but those around me will too, seemingly for a variety of reasons. This mentality has enabled me to discard of generalisations of how certain people or cohorts may behave, allowing for a fresh perspective on my interactions with others.

My results from the 'Push me - Pull you' tool shows that I have a natural preference for a motivational style of influencing, with a stronger preference for personal approaches and

ITEM SCORES										STYLE TOTALS	
1	1	13	1	21	2	31	2	6		6	Force
7	3	12	2	24	2	32	0	7		7	Rules & Standards
2	1	14	1	29	1	34	1	4		4	Exchange
5	3	18	2	22	3	33	3	11		11	Persuasion
6	2	19	3	28	2	37	2	9		9	Assertion
PUSH TOTAL: 37											
9	2	17	2	30	2	38	2	8		8	Personal Magnetism
3	3	11	3	25	2	35	2	10		10	Visioning
4	3	16	3	26	3	39	4	13		13	Bridging / consensus
10	3	15	2	27	3	36	3	11		11	Environmental
8	3	20	3	23	2	40	3	11		11	Joint Problem Solving
PULL TOTAL: 53											

Figure 6: 'Push me - Pull you' Influencing Style Tool – My results

bridging. My lowest preference style of influencing others is using force and I wonder whether this is because this is the least effective style when others are attempting to engage me. I had mixed feelings about these results at first as there are positives and negatives to both styles. I also wondered whether, perhaps a few years ago, these results may have differed, at a time when my confidence levels and therefore maybe assertion levels would have been higher.

I discussed these results with a close, longstanding, honest friend who reaffirmed they are in keeping with how I have always been, saying "You get people around to your way of thinking in a different way that is your own, you have never preferred to tell people what to do". I pondered then, on the correlation between confidence and assertion, and that one doesn't necessarily have to be full of confidence to be assertive. There are certainly times, for example urgent clinical scenarios, where I will use a 'push' style with assertion and authority, but my ability to engage this side of my personality declines with an unfamiliar context or people. However, whilst implementing change or recruiting to my speciality, I am much more likely to engage on a personal level and take on a role model or mentoring role. Moving forward, there are times, keeping this tool in mind, when I could knowingly draw on this 'push' style more and challenge myself in all aspects of my life when faced with an unfamiliar context.

I valued the depth of MBTI Step II but felt that towards the end, my responses were partly influenced by question fatigue. The simplicity of the 'Push me – Pull you' tool leads to results that, for me personally, are likely to be close to how I behave, despite this tool being less validated. When looking at my results from any of these tools, I think it is important to keep in mind that there are likely to be many confounding factors. For example, I answered different questions with different frames of reference: clinical work, leadership year and some from a personal point of view. I also believe that one's mindset at the time of completion has some bearing on engagement and positive/negative influence on results.

Having always had an interest in group dynamics, this addition of asking myself "what sort of MBTI preference are they?", "are they drawing on a lesser used aspect of their personality?" and

“how does this influence their interactions with myself and others?” challenges my current thinking and acts as a tool to better understand others and the workings of the team. For example, introverts will sometimes not appreciate my energy, and often intensity, but there are ways I can show my understanding, for example, allowing the other person space and time. Valuing and respecting that not everyone is ‘wired’ in the same way as myself has already proved, both socially and in the workplace to be beneficial in improving my relationships. I have begun to discuss the results of these tools and how they can support my development during professional coaching sessions – thus far they have been essential in guiding constructive conversations to help re-shape my values.

Consolidating results from these diagnostic tools and relating them to my actions and behaviours has been the most effective personal development exercise and the closest I have had to a true understanding of myself. I have overall, always formed strong relationships with people both personally and professionally; but the addition of a deeper appreciation that people differ in their motivations, interests and therefore how they behave means that I can control my reactions and interactions with others, whilst appreciating their values and skills. A self-awareness of the need and variability in drawing upon different characteristics means that I appreciate others may engage different behaviour patterns in different circumstances. Leadership styles are situational and I have learnt that the most effective leaders have the emotional intelligence to know when to draw upon which style.

Team Working – When it Goes Wrong

Failure is success if we learn from it

(Forbes)

For this reflection, it is reasonable to use either Gibbs reflective cycle or Schön model (OT MSc Student, 2016). I have chosen the Schön model (see Appendix 2) as I am interested in the constructive evaluation of events in the moment they were happening as well as retrospective manipulation - as clinical leadership often requires this of us.

The Academi Wales Medical Leadership Programme (MLP) attended a residential course in February 2019 in Elan Valley, Wales focusing on leading people and teams. We were split into teams of around six members each to complete tasks competing against other teams. I made some

initial observations of our team based on previous interactions and Goleman's descriptions of distinct leadership styles (2000, p. 3):

- Two prefer a more 'directive', 'coercive' approach to leadership
- One believes they come across as 'democratic' but are generally more 'directive'
- One has a relaxed approach to leadership but probably errs towards the 'democratic' style when allowed
- The final member and I have a relatively similar mixed style, usually avoiding the 'directive' approach, but both driven by people and emotions, preferring the 'affiliative' approach.

When looking at Belbin's team roles (2010), our group lacked a 'plant' and an 'implementer'. I was immediately anxious at working in this team due to the prevalence of directive styles, the lack of 'visionary' and 'coaching' styles and the anticipation of some voices being drowned out by stronger characters.

However, I perhaps naively, felt positive despite my discomfort, that I could bring the team together through our common goals with energy and enthusiasm. Having worked with disparate groups before and succeeded in working effectively as a team, I felt that I would be able to put two of my top three Belbin roles of 'resource investigator' and 'teamworker' to good use. My MTQ48

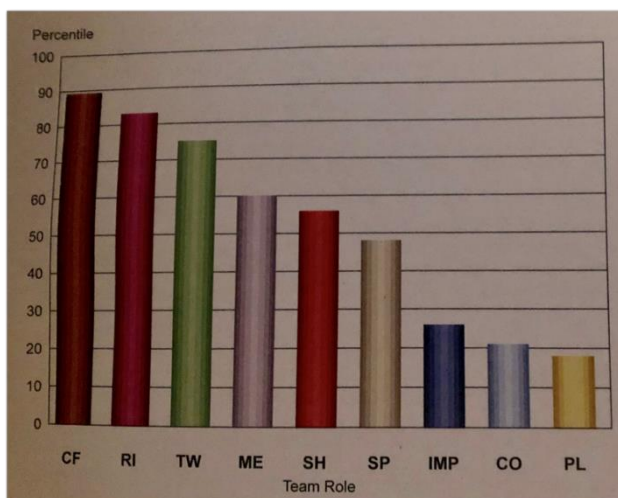


Figure 7: My Belbin Team Role Overview (Belbin Team Role Report, 2019, p. 3)

results complement my top Belbin role of 'completer finisher', which shows I have a moderately high level of commitment, usually enthusiastic and motivated but variable under extreme pressure (Belbin Team Role Report, 2019, p 8). The same report shows I am generally comfortable with a significant degree of risk and challenge. I was certainly committed to the challenge of bringing together this varied group, whilst having awareness that challenges in my personal life at the time

may have an impact on my interactions with others. In addition, as a 'completer finisher', I am aware that my level of detail is not always favourable to others.

For most of the tasks, we failed to work together as a team and were unsuccessful. Any positive remarks were dismissed by the group. Even when we showed improvement, this was viewed

negatively as the task was a failure. Perhaps to be expected in a team of high achievers? At the time, I felt disappointed and like a failure to my team, having put pressure upon myself to 'fix' this problem. I was frustrated as I did not have the courage to speak up but could see that our team was becoming ineffective. Combining my preference for 'red hat thinking' as per De Bono's six thinking hats model (1985) with my MTQ48 results showing poor emotional control, I am often quick to express my true emotions especially when I feel that things are not going in the direction I had envisaged.



Figure 8: Lencioni's Five Dysfunctions of a Team (2002)

Deliberating over events now, in almost textbook-like fashion, we had demonstrated the five dysfunctions of a team as described by Lencioni (2002). We lost trust in each other, becoming unable to communicate effectively and fearful of the consequences of speaking up even if it might

help the team. Consequently, commitment started to wane, with one team member disengaging and leaving before the end without telling the team. By the end, we were a divided team who lost focus on our end goal, even starting not to take the tasks seriously, wanting to cut corners.

Mindful of these experiences, if in this situation again, I would recognise the first chain of team dysfunctions and overcome this by having the courage to speak up and communicate our strengths, weaknesses and motivations whilst listening to each other. I should not let hierarchy or directive styles of others influence my actions if they are for the good of the team – something I am much less able to do outside of clinical work currently.

I believe it is not entirely negative to be emotionally charged, after all, the healthcare setting is naturally brimming with emotion. However, better emotional control will allow me to perform at my most effective and prevent burnout, low morale and poor mental health; all of which can negatively impact on patient safety. Realising when some things are out of my circle of control or influence and not needing to be the one responsible for 'fixing' things all the time – perhaps sometimes the best a leader is having the emotional intelligence to know when to step back and engage in followership instead. I also recognise that, to maintain my optimism, I may need to find an alternative resource for positivity and encouragement if my immediate team are unable to

provide it e.g. the psychological safety of action learning sets with MLP or the Welsh Clinical Leadership Fellows (WCLTFs). Linking the results from my Driver's questionnaire and my 360 report, there are certainly times when being a 'people pleaser' can actually be a hindrance to a crisis. In addition, I could be vulnerable with high scores for pleasing people and being perfect yet lower scores for being strong. In the future this is something I need to develop in the non-clinical setting.

Looking at the lack of certain leadership styles within our team, are some members forced to work outside of their comfort zone in an alternative role? Could this be perceived as a positive challenge but with potential negative consequences for the team's goals?



Figure 9: Belbin Team Roles (McMahon, 2018)

My personal effectiveness within a team lies towards the end of a task and within the action and people orientated team roles. (McMahon, 2018) This is a remarkably useful insight to know when to take a step back when working in a team and when to have the self-belief to say "this is where I am most effective, I can do this". Much like a clinical leader will need to draw upon a differing styles, a team requires a mixture of skills and

experience. A healthy and successful team is one that communicates, listens and trusts each other to adapt to various organisational climates.

Using Influencing Skills – When it Goes Right

For this reflection, I have chosen Kolb's experiential learning model (1984), having had a chance to put my learning into practice (see Appendix 1)

Outside of my clinical and General Medical Council (GMC) work, I have been helping establish and run the Welsh Acute Physicians' Society (WAPS). We promote our speciality and form an acute medicine network of junior doctors, consultants and the wider multidisciplinary team in Wales. I work with four other members on council to run educational events including the annual training week and symposium. Whilst it was relatively simple to create with shared vision and enthusiasm

in the beginning, over the last two years it has become more difficult for us to make improvements as some council members have been resistant to change.

I found that mentioning any changes e.g. moving to an online ticketing service for events, were often met with defensive and slightly aggressive conversation, perhaps by fear of not wanting to alter the initial administrative set-up. Being mindful that the results are based on self-perception, my MTBI-II facet report for judging/perceiving is interesting in that although I have an overall perceiving

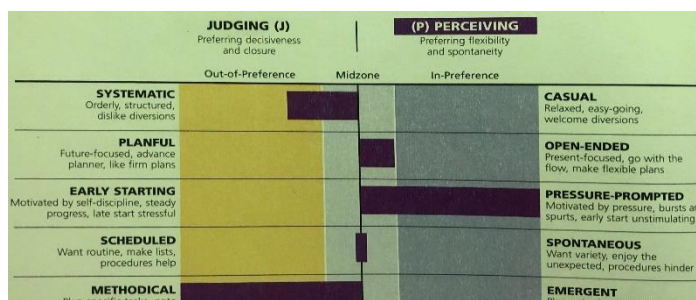


Figure 10: My MBTI-II Judging/Perceiving Facet Analysis (Quenk and Kummerow, 2019)

preference, I sit at two extremes with pressure-prompted and methodical. This may well make me frustrating to work with in small team as I will have a detailed logical approach but will often leave this time-demanding plan until the last minute. Therefore, despite my gregarious and expressive style when suggesting changes, others may not be openly responsive to me, based on past experiences. In addition, their interests and motivations within their role on council may be different to mine.

I have found the talks on influencing styles and techniques engaging and inspiring this year and have often found myself relating and reflecting on my role in WAPS during the talks. In particular, the idea that there are three main ways of influencing: ethos, pathos and logos (PathosEthosLogos.com, 2015). My natural preference would be towards an emotional pathos approach but this may not be the most effective method in every situation. I actively used all three depending on the receiving council member to persuade them to invest in a more expensive but highly valuable speaker at our symposium this year.

Another concept, delivered both in Academi Wales and at Massachusetts Institute of Technology, has changed my approach within a team: Cialdini's six principles of influence - reciprocity, commitment, social proof, liking, authority and scarcity (2007). This struck me as a clear way of influencing in most situations, in combination with the emotional astuteness to know when to use which method. The 'Push me – Pull you' assessment tool reiterated that I naturally lean towards a democratic, collaborative approach when it comes to influencing. Mindful that my usual methods would not be effective, I actively used consistency and social proof to persuade the rest of council to change to an online ticketing service and was successful.

The essence of influencing seems to be people and communication. From listening to talks and watching mentors this year, the most effective way to influence is to understand others, their motivations and interests and use that to guide your conversation. When I put this into practice,

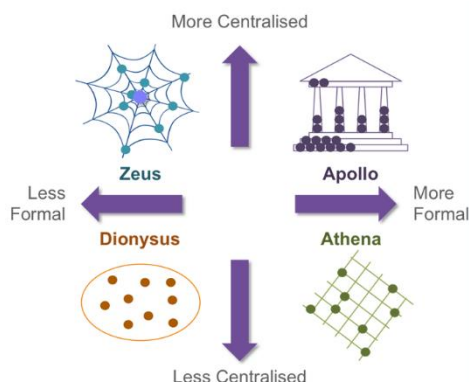


Figure 11 Handy's Gods of Management
(Clayton, 2016)

the thought processes take more time, but the outcomes are positive and rewarding. This also applies to organisations; another concept that will stay with me for the rest of my career is Handy's Gods of Management (2009). I believe that the GMC is an 'Apollo' organisation. Being mindful that none of these cultures is 'the best one', an understanding of how your organisation *thinks* is key to influencing or implementing change, as well as managing your own expectations. The day after this talk I changed my mindset and the shape of discussions

within the GMC – with a focus on logos, minimising risk and making small changes – with positive results. This is unquestionably an alternative approach for me but a valuable lesson learnt that my natural styles are not always the most effective, especially in environments not so well known

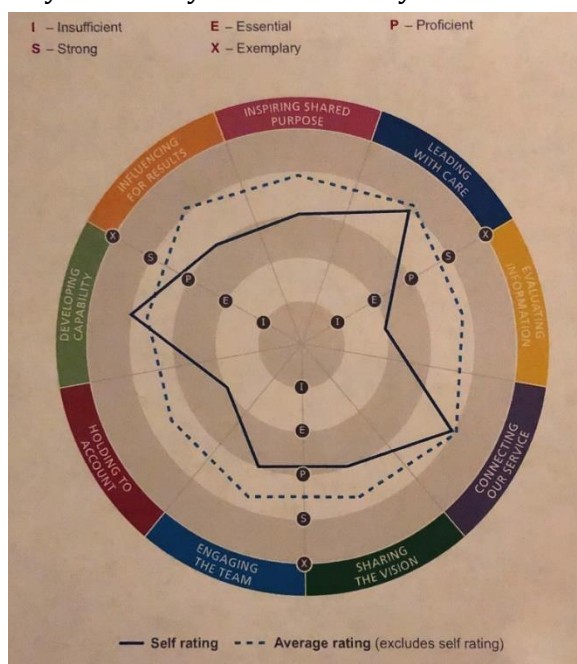


Figure 12: My Healthcare Leadership Model Results (2019)

to me. The 360 report is one of few assessments that provides feedback from others making it highly valuable, reflecting on hidden strengths and blind spots. Looking at my 360 report in the influencing for results section I have self-rated much lower than my raters. Perhaps my confidence and assertion in this area will now naturally increase.

There is an uncomfortable part of me that, at times, felt I was manipulating rather than influencing. When assessing the broader picture however, influencing others for the good of the team, or indeed, influencing patients in their best interests, can surely be viewed less

negatively – after all is leadership not about one life influencing another? These new concepts have also opened my eyes to the way in which I may be influenced by others. I especially find that I am open to a pathos approach as much as I find that easy to use on others, especially from strong characters. I wonder then if others are understanding me more than I am understanding them?

I believe maintaining authenticity in my democratic, people-focused approach to leading and influencing is important, but equally I have proved to myself that combining this with a varied menu of persuasive styles, even if they come less naturally to me, can enhance my effectiveness and reap rewards for my team, my society and more significantly my patients.

Imposter Syndrome

The ultimate measure of a man is not where he stands in moments of comfort and convenience but where he stands at times of challenge and controversy (King)

Is it possible to feel like an imposter everywhere you go? This is how I felt at the beginning of my leadership year when I became one of few doctors sat within our regulating body at the GMC, yet still in contact with my clinical colleagues.

For this reflection, due to its psychological impact, recurrence and the potential usefulness of considering assumptions, I will use a deeper reflective tool: the Atkins and Murphy cyclical model (1993, p. 32) (See Appendix 3)

I became aware of uncomfortable feelings quite early on in my year away from clinical practice. I am proud and passionate about working as a doctor and have a strong sense of loyalty and comradeship with my profession. There was a high profile, complex case involving multiple system failures, a junior doctor and the death of a young child early last year, which had resulted in the doctor being removed from the medical register (Wickware, 2018). The relationship between the GMC and my profession was strained. I felt emotionally charged, along with my colleagues and thought very carefully before choosing to spend my year with the GMC.

This new experience was confusing on many levels - a new, non-clinical environment; new, non-clinical colleagues; and a new, almost alien, non-clinical line of work. These feelings reminded me of the beginning of university or in hospital as a medical student. In addition, I was internally battling between forming positive relationships with my new team versus not aligning with the organisation's recent actions and standing with my profession.

Early in the year, I was invited to join a meeting group that discussed intelligence surrounding this complex case. Delving into comments from my Healthcare Leadership Model 360 report and

Around the same time, I started to receive what seemed like benign, jovial comments from friends and clinical colleagues, such as: 'dirty turncoat', 'you're being brainwashed', 'you've turned to the

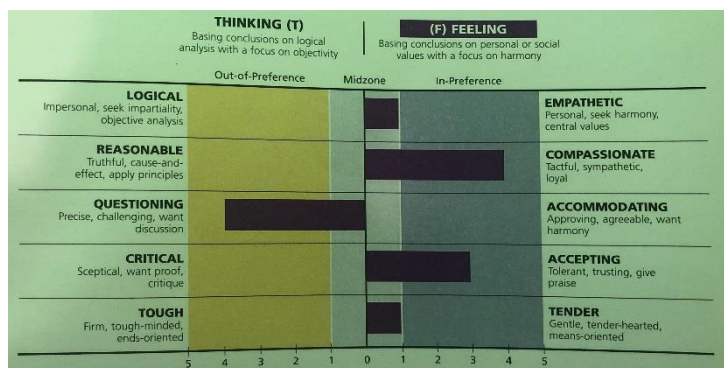


Figure 13: My MBTI-II Thinking-Feeling Facet Analysis (Quenk and Kummerow, 2019)

dark side' and 'you're one of them now'. I have always known that I thrive on positivity from those around me and it was not surprising that my Drivers questionnaire showed I am a 'people pleaser' - that I need encouragement and support (Totum Consulting, 2016). Looking at the thinking – feeling analysis of my MBTI-II report, it is interesting to

see a mixed picture (Quenk and Kummerow, 2019). I am in-preference for 'accepting' and 'compassionate', often *expecting* kindness from others and being in touch with others' feelings. However, I am strongly out-of-preference for 'questioning'. Perhaps this led to my feeling of disappointment at hearing those comments but parallel enquiring thoughts as to why they were said. These events also made me question my own emotional intelligence, and whether I had acted similarly negatively towards colleagues in the past.

The resulting feeling of the events of the first few months was that I did not belong to either the GMC or my profession. I was asked to speak at the Welsh Faculty of Medical Leadership & Management conference in September 2018 on leadership behaviours and cultures but sensed I had no authority to do so. I felt like I was losing credibility as a doctor and failing in my leadership role. Considering that at the time I was realising that I value a sense of togetherness and belonging highly, I wondered whether I had made the right decision.

Looking back, these feelings can be described as imposter syndrome - from both the clinical and non-clinical aspects of my life. I had not been aware of experiencing this in the past but perhaps I have, without it being labelled as such. Tucker writes that this self-doubt is not uncommon in our profession, with 30-40% of doctors in training experiencing it at some point during our careers

and being due to many factors (2018). As a profession, we are generally self-critical and expect the best from ourselves, no matter what external stressors are present, making us rather vulnerable and in need of mental toughness. This self-doubt, vulnerability and psychological distress was most likely exacerbated by events in my personal life as well and no doubt had an impact on my performance at work, further intensifying a sense of imposter syndrome.

This recognition and knowledge that others may be experiencing similar feelings enabled more of a 'growth' mindset rather than a 'fixed' one (Dweck, 2016) and allowed for helpful discussions with my peers in similar situations, especially the other junior doctors working in the GMC. This comradery fed my value of belonging and alleviated the burden that this was happening to me alone. The importance of reflecting with peers is a lesson I will carry forward.

Through the year, I discovered more about my values and behaviours through assessment tools and discussions with others, which helped me reflect on my own position and value within the GMC. Towards the end of the year, I was appointed as the Clinical Lead for Induction and Returners for the GMC across the United Kingdom (UK). On reflection, this was a turning point for my leadership journey and diminishing the feeling of imposter syndrome. I am a strong believer that leadership is not about titles or roles, but in this case, in keeping with what Drivers questionnaire result of being a 'people pleaser', it reinvigorated me to use my skillset and experience effectively in the GMC.

The recurrent nature of imposter syndrome makes it a high priority to mitigate against, especially considering the potential psychological and clinical consequences. Since initial events, I have experienced hostile social media comments, further negativity from clinical colleagues and fascinatingly, a similar imposter syndrome feeling returning to clinical practice.

I believe it is better to be either consciously incompetent/competent, rather than unconsciously incompetent/competent and therefore being able to recognise and acknowledge uncomfortable feelings or experiences is a vital step. After these recurrences, I have felt much more able to openly discuss with my peers and have understood where to get the encouragement and support needed to motivate me. I have also spoken about leadership as part of a panel at an international event, this time feeling more credible and having confidence in my abilities. Perhaps also in part due to having more experience and completing my leadership year.

On a more personal note, pondering the need for belonging that I hold so highly and my low scores for emotional and life control on the MTQ48, I have come to realise that perhaps the sense of

belonging I seek must come first from within and not be reliant on others. Having my own sense of belonging, is likely to naturally improve self-confidence, assertion and lead to imparting that amongst my team.

Considering the prevalent and recurrent nature of imposter syndrome, I do not doubt that I will feel it again. Being now able to anticipate, recognise and mitigate against it, will serve me well in the future and ensure that confidence and credibility will surpass self-doubt and vulnerability, as well as being able to exercise emotional intelligence to support those around me.

Multiple Levels of Change

For this broad reflection I have chosen to use Rolfe et al's framework for reflective learning based on "What? So What? Now What?" questions to enable a deeper reflection at each level and with each related event as behaviours are modified in an iterative fashion (2001). (see Appendix 4)

Over the past two years there have been many changes within all aspects of my life of varying impacts, with some affecting my reactions to consequent changes more than others. I had a significant personal life event early in 2018 which left me questioning all my personal values and led to changes in every part of my non-work life. I then left clinical practice to pursue a thoroughly different and somewhat alien environment as a clinical fellow in a political and corporate climate.

Cumulative effect: As I was settling into work at the GMC, my project team was disbanded. The assistant director left the organisation closely followed by the project administrator. The replacement assistant director also then left the workstream. The initial assistant director leaving, by far, but perhaps disproportionately so, had the biggest impact on me during my leadership year. It was not until a few months later that I realised just how much my mentor, boss, project supervisor and friend leaving the GMC had affected not just me but my team, my directorate and the whole organisation. I suspect for me though it was a cumulative effect of many recent changes in my life and a few years prior I may not have felt the same sense of loss. I became quite despondent, anxious about work and found it increasingly difficult to find purpose and rebuild my core values.

At the same time, I was trying to thrive in an environment I was already not comfortable in, persevering with work I felt I was failing it. Perhaps the lack of clinical practice to boost my

confidence was partly to blame, but at the time I felt like I was losing those fundamental skills as well. In my role at the GMC, I was trying to drive forward change, following Kotter's eight step process for leading change (2019) but parallel to this, I was dealing with personal change and transitions of my own. The Kubler-Ross graph illustrates my rollercoaster of emotions last year and is a useful framework for which to think about any big life changes, not just grief (1969).

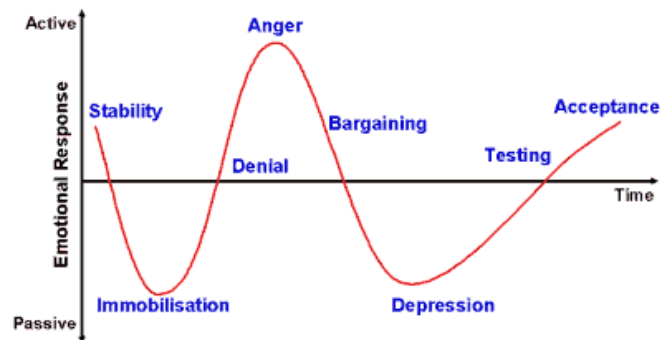


Figure 14: The Kubler-Ross Grief Cycle (Changingminds.org)

Interjected along this curve, it seemed like aspects of my non-personal life were adding to the weight of this rollercoaster. As a profession we are trained to persevere through mentally tough times and prove our resilience, often feeling psychologically unsafe to do otherwise. It was clear that these feelings were too important to ignore.

Recognising these uncomfortable feelings was an important step. I then started to talk to my peers, friends and mentors and counsellor. One helpful mentor suggested asking myself these questions:

- Who am I?
- How did I get here?
- Where do I want to be?

These questions forced me to then ask *how* am I going to get to where I want to be? I had delayed professional coaching initially because of ongoing counselling, as the focus is on how your present can shape your future, as opposed to counselling which aims to deal with how the past affects the present. Once I started to ask myself 'how do I want to get to where I want to be?', coaching seemed like the natural next step.

Bridges in his book 'Transitions' encourages one to embrace change and view it in an opportunistic way (2004). Another book recommended to me was 'Who moved my cheese?', which, in a unique light-hearted way, encouraged me to change my mindset at the GMC and realise that the cheese will always be moving, especially in large organisations (Johnson, 1999). As well as moving along with change, it also helps to understand your own expectations – of yourself, your team and your organisation. One of the medical directors I shadowed last year advised not to

expect change too fast in big systems. Reviewing my Drivers questionnaire result, where I scored second highest for 'hurry up', it is helpful for me to manage my own expectations of organisations in this sense.

It has always been clear that I thrive on interactions and relationships with people and need regular boosts of encouragement, support and positivity – which mentors, colleagues, family and friends have provided in abundance recently. But despite my MBTI-II preference of extroversion, there may not always be time to spend with others and I should value time to myself equally.

Moving forward, one of my mentors advised some simple life rules which resonated with me:

- Focus on what is important or of value to you
- Avoid unnecessary responsibility
- Think of what is within your sphere of control
- Give yourself 'Kannan time'

With each change since the climax of the cumulative effect, I have felt more able to deal with it by coming back to these simple rules. Some may be more pertinent in certain situations, e.g. transitioning back into clinical practice, I avoided unnecessary responsibility of taking on new projects as I need to focus on obtaining a consultant post. The last rule however, I now think of daily. I anticipated that returning to clinical practice, whilst juggling my ongoing GMC role, may leave little free time for myself. However, with self-discipline and acknowledging that looking after myself first is the foundation of looking after others, I am successfully focusing on small sustainable lifestyle changes as suggested by Dr Chatterjee: relax more, eat smart, move better and sleep clever (2017).

I am somewhat saddened that it has taken 35 years of living and a junior doctor career of 11 years to be able to develop ways of dealing with change. Perhaps I needed the combination of a life-changing event, other changes and transitions in work life alongside the time out of clinical practice to truly reflect on my behaviours and attitudes towards change.

Our year was entitled 'clinical leadership' – for me the focus was not to have a title or role at the end but to understand myself professionally and personally and to appreciate how to use my skills and energy to greatest effect. There has been much change over the past two years, but I have gained a much clearer picture of who I am, what my values are and how to recognise when and what type of support I need and from who, e.g. who to go to for honesty and who to seek encouragement from. That level of emotional intelligence is much more developed than two years ago but will be ever-changing as the rollercoaster of life continues. There will be many more

changes to come but I feel I am on my way to becoming a truly flexible and adaptable clinical leader. I have exercised lessons learnt and through this experiential learning have even felt able to support others through times of change. That humbling and rewarding experience has led me to explore gaining a coaching qualification in the future.

Working in clinical practice, it is vitally important to understand that emotional intelligence and effective relationships with people are key to remaining in control of your own life whilst being able to implement positive changes for our patients. After all, healthcare is far too important to stay the same.

Reference List

- Atkins, S. and Murphy, K. (1993) 'Reflective Practice', *Nursing Standard*, 9 (45), pp. 31-37.
DOI: 10.7748/ns.9.45.31.s34
- Belbin, R.M. (2010) *Team Roles at Work* 2nd Ed. Abingdon: Routledge
- *Belbin Team Role Report for Madhu Kannan*. (2019) Internal Report as part of Academi Wales Medical Leadership Programme. Unpublished.
- Bohman, B., Dyrbye, L., Sinsky, C., Linzer, M., Olson, K., Babbott, S. and Trockel, M., (2017) 'Physician well-being: the reciprocity of practice efficiency, culture of wellness, and personal resilience' *NEJM Catalyst*, 26th April. Available at:
<https://www.evergreenhealth.com/documents/Medical%20Staff/PHYINS-physician-well-being-reciprocity-of-efficiency-wellness-resilience.pdf> (Accessed 10th October 2019)
- Bridges, W.B. (2004) *Transitions: Making Sense of Life's Changes* 2nd Ed. Cambridge, MA: Da Capo Press
- Changingminds.org *The Kubler-Ross Grief Cycle*. Available at:
http://changingminds.org/disciplines/change_management/kubler_ross/kubler_ross.htm (Accessed: 30th October 2019)
- Chatterjee, R. (2017) *The 4 Pillar Plan: How to Relax, Eat, Move and Sleep your way to a longer, healthier life*. London: Penguin Life
- Civility Saves Lives (no year) Available at: <https://www.civilitysaveslives.com/aboutus> (Accessed 20th June 2019)
- Cialdini, R.B. (2007) *Influence: The Psychology of Persuasion* Revised Ed. New York: Harper Business
- Clayton, M. (2016) *Charles Handy Part 2: The Nature of Organisations*. Available at
<https://www.pocketbook.co.uk/blog/2016/07/12/charles-handy-part-2-the-nature-of-organisations> (Accessed: 11th June 2019).
- CTR Training (no year) *Influencing Styles: Push and Pull Questionnaire*. Available at:
<http://www.ctrtraining.co.uk/documents/PushMePullYouDiagnosticTool.pdf> (Accessed 31st October 2019)

- De Bono, E. (1985) *Six Thinking Hats* New York: Little, Brown & Company
- Dent, F.D. (2009) *Influencing – the Skill for Success*. Available at: [http://tools.ashridge.org.uk/website/IC.nsf/wFARATT/Influencing%20-%20the%20skill%20for%20success/\\$file/InfluencingTheSkillForSuccess.pdf](http://tools.ashridge.org.uk/website/IC.nsf/wFARATT/Influencing%20-%20the%20skill%20for%20success/$file/InfluencingTheSkillForSuccess.pdf) (Accessed 13th July 2019)
- Dweck, C. (2016) 'What having a "growth mindset" actually means', *Harvard Business Review*, 13, pp. 213-226. Available at: <http://thebusinessleadership.academy/wp-content/uploads/2017/03/What-Having-a-Growth-Mindset-Means.pdf> (Accessed 6th November 2019)
- Exponential Medicine (2019) *Joy in Work*. Available at: <https://exponential.singularityu.org/medicine/stephen-swensen-on-joy-in-work/> (Accessed on 30th March 2019)
- Forbes, M (no year) *Forbes Quotes: Thoughts on the Business of Life* Available at: <https://www.forbes.com/quotes/6315/> (Accessed 13th November 2019)
- Goleman, D. (2000) 'Leadership That Gets Results', *Harvard Business Review*, 78 (2), pp. 3-17. Available at: https://s3.amazonaws.com/academia.edu.documents/33585213/HBR_MustReads_Managing_People.pdf?response-content-disposition=inline%3B%20filename%3DOne+More+Time+How+Do+You+Motivate+Emplo+y.pdf&X-Amz-Algorithm=AWS4-HMAC-SHA256&X-Amz-Credential=AKIAIWOWYYGZ2Y53UL3A%2F20191114%2Fus-east-1%2Fs3%2Faws4_request&X-Amz-Date=20191114T172854Z&X-Amz-Expires=3600&X-Amz-SignedHeaders=host&X-Amz-Signature=00d365f8b4afc1933762aeafde840ee2727db2198703deb7660a4201afbb5116#page=4 (Accessed 1st November 2019)
- Hall, L.H. et al (2016) 'Healthcare Staff Wellbeing, Burnout, and Patient Safety: A Systematic Review', *PLoS One*, 11 (7): e0159015. DOI: [10.1371/journal.pone.0159015](https://doi.org/10.1371/journal.pone.0159015) (Accessed 2nd July 2019)
- Handy, C. (2009) *Gods of Management: The Changing Work of Organisations*. London: Souvenir Press Ltd
- Heron, J. (1989) *Six Category Intervention Analysis*. 3rd Ed. Surrey: University of Surrey
- icould.com (no year) *Take the Buzz Quiz: Find out which animal you are*. Available at: <https://icould.com/> (Accessed 1st April 2019)
- Johnson, S. (1999) *Who Moved My Cheese?*. London: Vermilion

- King, M.L. Jr, (no year) *BrainyQuote.com* Available at: https://www.brainyquote.com/quotes/martin_luther_king_jr_109228 Accessed on 10th November 2019)
- Kolb, D. (1984) *Experiential Learning: Experience as the Source of Learning and Development*. Englewood Cliffs, NJ: Prentice Hall
- Kotter, J.P. (2019) *Kotter's 8-Step Process*. Available at: <https://www.kotterinc.com/8-steps-process-for-leading-change/> (Accessed: 10th July 2019)
- Kübler-Ross, E. (1969) *On Death and Dying*. London: Routledge
- McMahon, T. (2018) 'A Lean Journey', *9 Team Roles for High Performance Teams* [post]. 16 May. Available at <http://www.aleanjourney.com/2018/05/9-team-roles-for-high-performance-teams.html> (Accessed 5th November 2019)
- *Mental Toughness Questionnaire 48 Development Report for Madhu Kannan*. (2019) Internal Report as part of Academi Wales Medical Leadership Programme. Unpublished.
- Mitchell, T.A. (2017) *Teams Need Challenges to Thrive* Available at: <https://www.changeboard.com/article-details/16651/teams-need-challenges-to-thrive/> (Accessed: 16th October 2019)
- NHS Leadership Academy (2014) *Healthcare Leadership Model*. London: NHS Leadership Academy
- NHS Wales (2016) *NHS Wales Core Principles*. Available at: <https://www.wales.nhs.uk/nhswalesaboutus/thecoreprinciplesofnhswales> (Accessed: 14th May 2019)
- OT MSc Student (2016) 'Guide to models of reflection – when and why should you use different ones?', *Lifelong learning with OT* [blog]. 2 May. Available at: <https://lifelonglearningwithot.wordpress.com/2016/05/02/different-models-of-reflection-using-them-to-help-me-reflect/> (Accessed: 7th November 2019)
- PathosEthosLogos.com (2015) *Ethos, Pathos, and Logos Definition and Examples*. Available at: <https://pathosethoslogos.com/> (Accessed 31st October 2019)
- Quenk, N.L. and Kummerow, J.M. (2019) *Myers-Briggs Type Indicator® Step II™ Interpretive Report for Madhu Kannan*. Internal Report as part of Academi Wales Medical Leadership Programme. Unpublished.
- Rolfe, G., Freshwater, D., Jasper, M. (2001) *Critical reflection in nursing and the helping professions: a user's guide*. Basingstoke: Palgrave Macmillan.
- Stojanovic-Aleksic, V., Stamenkovic, M. and Nielsen, J.E. (2016) 'Personal Life Impact on Leadership Styles: Empirical Evidence from Serbian Organizations', *Proceedings of the 4th International Conference on Management, Leadership and Governance*. Saint-Petersburg

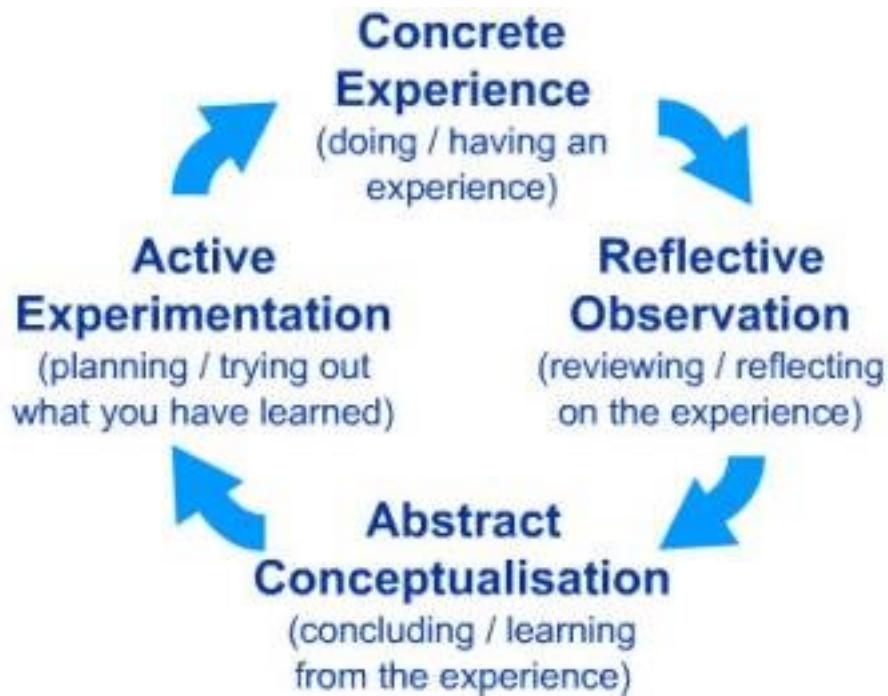
State University, April. Available at:

https://www.researchgate.net/publication/322251179_Personal_Life_Impact_on_Leadership_Styles_Empirical_Evidence_from_Serbian_Organizations (Accessed 16 October 2019)

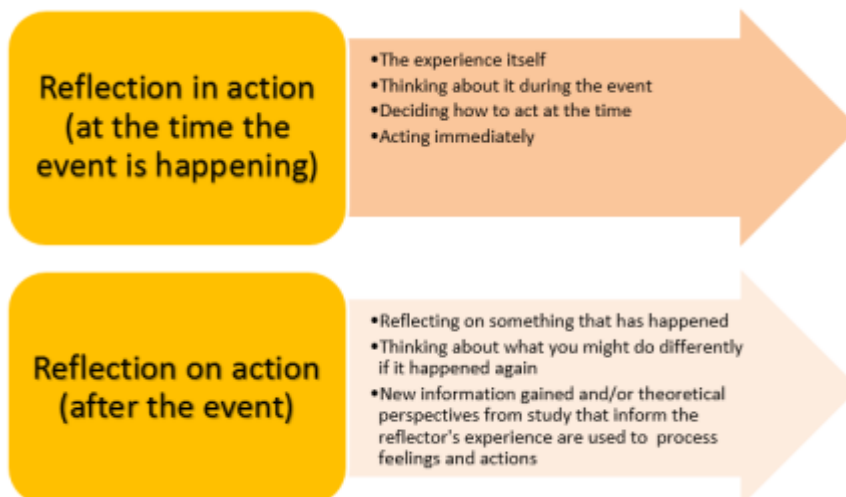
- The Myers-Briggs Company (no year) *MBTI Step I*. Available at: <https://eu.themyersbriggs.com/en/tools/MBTI/MBTI-Step-I> (Accessed 1st April 2019)
- Timms, H. and Heimans, J. (2019) *#newpower: Why Outsiders are Winning, Institutions are Failing, and how the Rest of us can Keep Up in the Age of Mass Participation*. London: Picador
- Totem Consulting (2016) *Identifying Your Drivers: Questionnaire*. Available at <http://www.totem-consulting.com/wp-content/uploads/2016/02/Drivers-Questionnaire-1.pdf> (Accessed 3rd November 2019)
- Tucker, D. (2018) *Self-doubt in medicine and the imposter syndrome*. Available at: <https://www.linkedin.com/pulse/self-doubt-medicine-imposter-syndrome-danny-tucker> (Accessed 11th November 2019)
- West, M. (2013) *Developing Cultures of High Quality Care*. Available at: <https://www.kingsfund.org.uk/sites/default/files/michael-west-developing-cultures-%20high-quality-care-kingsfund-feb13.pdf> (Accessed 10th July 2019)
- Wickware, C. (2018) *Bawa-Garba: What happens next*. Available at: <http://www.pulsetoday.co.uk/news/hot-topics/bawa-garba/bawa-garba-what-happens-next/20037297.article> (Accessed: 11th April 2019)

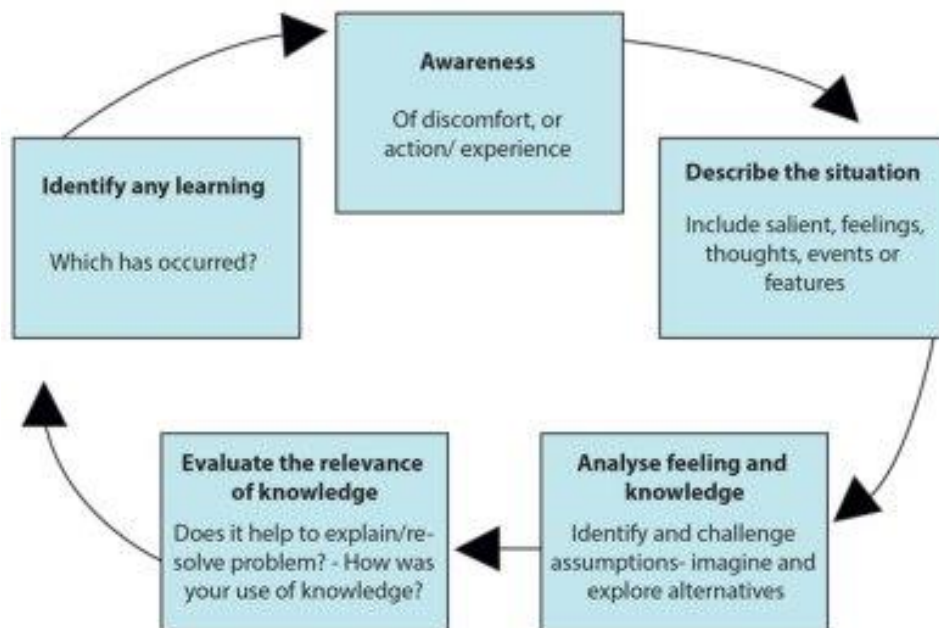
Appendices

Appendix 1: Kolb's Reflective Cycle (OT MSc Student, 2016)



Appendix 2: Schön Model (OT MSc Student, 2016)



Appendix 3: Atkins and Murphy Model (OT MSc Student, 2016)**Appendix 4: Rolfe (OT MSc Student, 2016)**

Descriptive level of reflection	Theory - and knowledge - building level of reflection	Action-orientated (reflexive) level of reflection
What ...	So what ...	Now what ...
... is the problem/difficulty/ reason for being stuck/reason for feeling bad/reason we don't get on/etc., etc.? ... was my role in the situation? ... was I trying to achieve? ... actions did I take? ... was the response of others? ... were the consequences - for the patient? - for myself? - for others? ... feelings did it evoke - in the patient? - in myself? - in others? ... was good/bad about the experience?	... does this tell me/teach me/imply/mean about me/my patient/others/our relationship/my patient's care/the model of care I am using/my attitudes/my patient's attitudes/etc., etc.? ... was going through my mind as I acted? ... did I base my actions on? ... other knowledge can I bring to the situation? - experiential - personal - scientific ... could/should I have done to make it better? ... is my new understanding of the situation? ... broader issues arise from the situation?	... do I need to do in order to make things better/stop being stuck/improve my patient's care/resolve the situation/feel better/get on better/etc., etc.? ... broader issues need to be considered if this action is to be successful? ... might be the consequences of this action?

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