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Junior Doctors as senior clinical leaders – a reflection on my Foundation Year 2 (F2) experiences during the SARS-CoV-2 COVID-19 pandemic

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Article

It has been well documented that during the SARS-CoV-2 (coronavirus) COVID-19 pandemic (“the crisis”), junior doctors have stepped up, responding flexibly to changes in clinical responsibilities, rota patterns and working hours. However, during the crisis many junior doctors have taken on positions of leadership within both their own departments and within wider organisations. It is imperative that these efforts are recognised, not only for the hard work of the individuals involved, but also to set a precedent. Whilst their clinical responsibilities remain that of 'junior' colleagues, junior doctors have a wealth of skills they are not always empowered to use. This article is a reflection on my experiences as a Foundation Doctor, who at the start of the crisis, was implanted into senior leadership teams within a medium-sized district general hospital in the North West of England.

Clinical leadership positions are usually filled by senior consultants, sometimes appointed due to clinical seniority rather than experience for that particular role[1]. Within my Trust, junior doctors have been empowered to take on senior leadership roles, and providing them with the resources and headspace to capitalise on ideas, has reaped many benefits. The hope is that the value added by junior leaders during the pandemic will provide evidence to increase junior doctor involvement in senior management activities; further, enabling those involved to improve the National Health Service in its remit as an employer, and care provider.

As the British Medical Association trade union representative, and medical education representative, at my Trust I asked for greater representation in decisions affecting junior doctors in the hospital response to the crisis. This led to an invitation for me to attend daily Silver Command meetings, representing the interests of junior doctors, and communicating decisions made within Silver Command to junior doctors working at the hospital.

As the Trust focussed efforts on consolidating services to prepare for a surge of high-acuity COVID-19 patients, it became clear many people within the organisation would be required to work differently. Given my prior experience representing junior doctors, and my knowledge of junior doctor contractual terms and conditions, the Medical Director of the Trust asked me to lead the medical workforce restructuring. The aims of this process were:

1. To release junior medical staff to support the increasing bed capacity in critical care;

2. To release people from specialities with reduced activity to support medical specialties;
3. To build rota patterns which would increase the medical cover 24 hours a day; and
4. To build rota patterns with enough prospective cover to account for significant staff sickness.

In addition to this role, I was also asked to continue providing contemporaneous communications to, and from, the body of junior doctors to the hospital directors. Due to limitations in the absolute numbers of doctors available, it was identified that we did not have sufficient people to cover the increased service need with the current emergency systems in place. Thus, we devised a new way of working out-of-hours, to provide sufficient on-site medical cover for the Trust in light of the expected increase of both numbers and acuity of patients. The approach moved away from the traditional speciality-based allocation of doctors, to a 'whole-site' out-of-hours emergency cover system. This operated between the hours of 16:00 and 08:00 seven days a week. This was named the 'Clinical Response Team' (CRT).

The CRT encompassed all doctors into one team, allowing them to work flexibly across the site. This was a significant move from 'silo' style working, with much improved communication and coordination between members of the team. In order for this to work effectively a multi-speciality whole-site handover was implemented, this included representatives from general medical and surgical teams as well as administrative staff who are available to troubleshoot any problems with staffing.

This was complemented by a ‘hospital-at-night’ style system. This novel approach, not previously employed by the Trust was met with much apprehension from medical staff and ward staff alike. Within my own team, and other groups of junior doctors it was generally acknowledged that such a system would be positive for doctors and patients alike, however it came to my surprise that there remained considerable resistance to the implementation of significant changes.

Redeploying doctors, redesigning rota patterns, implementing a novel out-of-hours system and introducing a cross-speciality handover came with significant challenges. Whilst I was keen to utilise the can-do attitude which was evident at the start of the COVID-19 crisis, it was clear that the implementation of any changes could in no way risk patient safety. With this in mind, we sought contemporaneous formal and informal feedback from all staff groups involved.

Whilst much of the feedback was positive, it became clear that further action would be required to generate buy-in from all of the stakeholder staff groups. With this aim, we identified leaders within those groups who both shared the vision of what we were aiming to achieve, and had a sufficient position of leadership to instruct and motivate their colleagues. In this instance, this was the Associate Director of Nursing, who had oversight over both the ward-based nursing teams and night manager team. In addition to colleagues working within both Trust operations and finance, we created a so-called ‘guiding coalition’. This group was instrumental in engaging all of the different groups crucial to the success of this project[2].

Lesson learned

Whilst there were many successes in the project I was involved in, there are also many areas of improvement to be learned from. Initially, my key objective was to improve the communication between management groups and the body of junior doctors, acting as an intermediary to both communicate junior related issues to management teams and communicate management decisions back to junior doctors. My primary means of communication downstream were by social media channels including WhatsApp groups and a private ‘Doctors Mess’ Facebook group. The reasons for this were largely due to unreliable formal communication systems in place within the Trust. Email distribution lists were often incomplete, Trust email accounts were not accessible from personal devices and medical staff often found it very difficult to check emails during working hours due to lack of IT availability or work pressures. Due to the rapid pace of change many of the communications sent out by me were not followed by formal notification from the Trust directors. This led to significant confusion as to the validity of communications. Without a formal role other than my junior doctor representative position, the legitimacy of my communications was rightly questioned by colleagues.

Whilst social media channels were effective in disseminating information quickly, this also came with significant drawbacks. The first being a question of formality as many doctors felt that important changes to working patterns and policy should be communicated via more formal channels. This was further complicated by a lack of formal communication from Trust leadership, often leading to the only communication of significant changes being from me.

The second issue arose from using my personal phone number and social media account to disseminate information. This led to a blurring of the boundaries between colleagues, meaning I was frequently contacted during anti-social hours to troubleshoot and explain policy. This included phone calls from colleagues on night shifts and requests for information late into the evenings. This degree of accessibility also led to me often being the first point of contact for problems beyond my remit, including requests for additional zero days, requests for e-portfolio tutorials and annual leave applications.

On reflection there are several areas of this communication model which could be improved. Whilst in the infant phases of the pandemic, the focus was rightly on disseminating information quickly, this model was unsustainable in the medium and long-term. The first change would be the establishment of a generic email inbox and a work mobile phone. Not only would this add legitimacy to communications, but it would also allow for setting of boundaries. Ensuring that queries and communications are only responded to within working hours would allow for defined boundaries, reducing the chance of a constant state of ‘on-call’.

The second, and perhaps more important change, would be ensuring every communication regarding significant changes is followed by a formal communication from an appropriate member of the management team. This would both provide authenticity to the information sent out via social media channels, but also provide junior doctors the security of recorded documentation of decision affecting them.

Conflicting roles

A significant challenge during the pandemic was the interaction between my different roles, and the conflict of interest which arose as a result of this. As mentioned previously, I am an active junior doctor representative for the British Medical Association Trade Union. Within this role I often find myself negotiating with management teams for improved working conditions and terms and conditions of service for junior doctors. Within my new role, I spent a significant amount of time working on projects under the direct supervision of the medical director, director of workforce, and associate director of medical education. Initially, this closer relationship was very positive. Local negotiations were productive, with improvements agreed for junior doctors in:

- the taking of annual leave when scheduled to work night and weekend shifts;
- protecting the pay of doctors moving into lower paying rota patterns; and
- improvements to the doctors' rest facilities.

Unfortunately, the frequently changing working patterns dictated by the pandemic, lead to many doctors being underpaid for the hours they had worked. This was undoubtedly within my remit as a trade union representative to challenge the trust on. This caused significant personal difficulty for two reasons. As a conduit for all information from Trust management to junior doctors, it had become unclear which side of the proverbial negotiating table I was sat on. As a result of this, many colleagues contacted me, not asking for support in obtaining their salary, but suggesting that it was my personal error that had led to this situation.

Furthermore, when challenging the directors, and their respective teams to resolve underpayments, it created strained working relationships with individuals I worked with daily.

As a trade union representative there is always a degree of conflict; the body you negotiate with is your employer and can be your opponent. However, in this circumstance, this was heightened significantly. After reflecting on this situation there are a number of methods to mitigate against the difficulties I have described.

The first and most obvious solution would be stepping down from one position, which would negate any conflict of interest. However, this would not only leave me and my colleagues underrepresented, but would also fail to make any appreciation of the fact that having someone with a trade union background, at the centre of transformative change, has many positives for the people they represent.

With hindsight, perhaps the most useful intervention to mitigate against conflicts of interest would be to have definitive and openly published job descriptions, including responsibilities for each different role. In addition to this, specific discrete communication channels for each distinctive role would help to distinguish in what context an individual is communicating. Without this in place, it is easy for lines to be blurred to which role any person is speaking to, or who they are representing at a particular point in time.

Moving forward

Following the positive feedback from staff groups, the executive team have chosen to continue many of the changes implemented into the recovery from the COVID-19 crisis. These include:

1. **Cross-speciality handover.**

This will be continued into the future. There has been significantly good feedback around the interaction between surgical teams and medical teams. It allows senior decision makers from both specialties to raise concerns over patients, staffing levels or other system-wide safety concerns. These are often resolved during the handover. Additionally, representatives from the directorate administration teams now attend handover. This allows for trouble shooting between junior doctors and management including sickness, absences and rota issues.

2. **Whole site on call team with central coordinator role.**

The new out-of-hours work structure has received globally positive feedback, with junior doctors feeling safer at work, with more manageable workloads. Ward teams have also submitted feedback suggesting they feel their requests for attendance are answered faster. Both of these leads to quicker patient care, by a more rested clinician. Both of which have been shown to improve patient outcomes.

3. **Inclusion of junior doctors within senior leadership teams and decisions.**

Following reviews of this process by the executive team, it was recognised that doctor's clinical seniority should not be used as a measure of ability to make senior

leadership decisions. It was also recognised there is a tangible benefit from incorporating junior doctors into senior decision making in operations and strategy. Not only does this give the director team insight into some of the challenges on the clinical coal-face, but it also allows better ownership of decisions by one of the staff groups it impacts. Additionally, the Trust saw the added value of placing juniors at the centre of decision making and have created a permanent post for a management-facing clinical fellow.

Conclusion

As a Foundation Year doctor, opportunities to involve oneself in non-clinical opportunities and projects are often rare. Whilst clinical learning is no doubt the main objective in completing the Foundation programme, the impact junior doctors can have if given the opportunity should not be underestimated. The evidence of this perceived value by my Trust is in the permanent full-time management fellow post. This year long post, without clinical component, will focus on transformation and COVID-19 recovery projects across the Trust. In addition to these projects the fellow will also have access to system-wide strategy and policy development, with as much emphasis placed on the candidate's personal development as their contribution to the Trust themselves.

From a personal development point of view, working on transformational projects during the COVID-19 period has taught me a significant amount, about both the process of instigating lasting change at an NHS Trust and barriers to it. The lessons learned between balancing enthusiasm in new projects, with ensuring appropriate protective measures are in place are essential for personal longevity within each

role. It came as a surprise early on that a ‘good idea’ is not enough to start, complete, or sustain major change within an organisation. The concepts of early stakeholder engagement, creation of a guiding coalition and sustained evaluation of changes are vital to creating lasting change.

Key considerations such as setting personal boundaries and separating professional from personal relationships are both areas I foresee as continuing challenges as a manager and leader in the future.

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[1] Stanley, D., 2006. In command of care: Toward the theory of congruent leadership. *Journal of Research in Nursing*, 11(2), pp.132-144.

[2] Kotter, J., 2012. *Leading Change*. Boston, Massachusetts: Harvard Business Review Press.

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Author Biography

Dr Joseph Home is a Junior Doctor working in a medium sized District General Hospital in the United Kingdom. He has an interest in healthcare leadership and policy, having previously studied a post-graduate degree in medical law. He is also currently an Honorary Research Fellow at the University of Salford.

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