



City Research Online

City St George's, University of London

Citation: Goodall, A. H. & Maw, N. (2025). From clinical expertise to leadership capability: a challenge to generic and multidisciplinary leadership programmes in support of tailored leadership development. *BMJ Leader*, doi: 10.1136/leader-2025-001263

This is the accepted version of the paper.

This version of the publication may differ from the final published version. To cite this item please consult the publisher's version.

Permanent repository link: <https://openaccess.city.ac.uk/id/eprint/36742/>

Link to published version: <https://doi.org/10.1136/leader-2025-001263>

Copyright and Reuse: Copyright and Moral Rights remain with the author(s) and/or copyright holders. Copies of full items can be used for personal research or study, educational, or not-for-profit purposes without prior permission or charge, unless otherwise indicated, provided that the authors, title and full bibliographic details are credited, a hyperlink and/or URL is given for the original metadata page and the content is not changed in any way. For full details of reuse please refer to [City Research Online policy](#).

Published in BMJ Leader, January 2026. doi:10.1136/leader-2025-001263

Goodall AH, Maw N. BMJ Leader 2025;0:1–5.

Leadership in the Mirror

Received 26 February 2025. Accepted 3 December 2025.

From clinical expertise to leadership capability: a challenge to generic and multidisciplinary leadership programmes in support of tailored leadership development

Amanda H Goodall and Natasha Maw

Bayes Business School, City St Georges University of London, London, UK

Abstract

Background/Aim This article challenges the dominance of multidisciplinary and often generic leadership development programmes in healthcare. Drawing on nearly a decade of experience with the Executive Masters in Medical Leadership (EMML) at Bayes Business School—a physician-only programme—we argue that profession-specific education is not just preferable but essential.

Methods This paper reflects on our experience designing and delivering the EMML, combined with a review of evidence on physician personality traits, professional responsibilities, and the historical development of generic management education. We examine the theoretical and practical case for tailored leadership development that recognises professional differences.

Results Physicians possess distinct personality traits, undergo uniquely extensive training, carry exceptional legal and professional responsibilities, and operate within a fundamentally different professional culture than other healthcare workers or general managers. We do not believe that this is adequately recognised in the National Health Service. Our experience and EMML learning outcomes data demonstrate that physician-only programmes create psychological safety, build lasting professional networks, and deliver learning outcomes that generic, multidisciplinary courses are unlikely to replicate.

Conclusion Professional differences demand profession-specific education. The NHS champions diversity in race, gender and background. It is time to recognise cognitive, professional and situational diversity with equal vigour.

Introduction

The Executive Masters in Medical Leadership (EMML) at Bayes Business School (City St Georges, University of London) grew from research showing that there are performance advantages when hospitals and healthcare organisations have physicians (medical doctors) at

the helm, in line manager positions, and on hospital boards.^{1–7} Arguably, nurses have had opportunities to learn about leadership and management since Florence Nightingale,⁸ through courses tailored to the needs of the nursing profession. However, comparable programmes for physicians were and still are scarce.

Our considerations when setting up the new medical leadership MSc were fivefold. First, to create a tailored programme taught by research-active faculty alongside physicians in senior leadership roles. Second, to run intensive 2-day learning blocks embedding a learn-apply-learn-apply cycle enabling genuine reflection and behaviour change. Third, to create a ‘safe space’ where physicians from all specialties—NHS and independent, primary through tertiary care—could learn together with psychological safety and confidentiality. Fourth, to place behaviour awareness and behaviour change at the heart of the programme, supported by coaching and Action Learning Groups over the 2 years. Finally, to develop a well-bonded network of diverse medical leaders across all specialties and settings, that could help to melt ‘the snowy white peaks of the National Health Service’.⁹

But not everyone was enthusiastic about the new programme at the start

It was 2019 and our recently created EML had been short-listed by a top London teaching hospital in a bid to secure 10 student places. We were excited. Unfortunately, the interview did not go well. The nine-person panel, of whom only one we later discovered was a physician, seemed evidently unimpressed by the physician-only nature of our MSc programme. The not-so-hidden sentiments slipped out in a later follow-up call with the Organisational Development lead when she said, “Well we did all wonder, what’s so special about doctors?”

This Leadership in the Mirror submission draws on learning and evidence from nearly 10 years of the EML which recognises professional diversity through its tailored design. Our article challenges the seeming normalisation of generic leadership programmes and advocates substantially moving the dial towards tailored leadership development created to suit professionals in different roles and situations, thus offering physicians and others context-specific learning that reflects their psychological, experiential, cognitive and responsibility differences.

Leadership development

The global leadership development market was projected to reach \$89.5 billion in 2025, with healthcare programmes making up the largest share.¹⁰ We have known for some time that good management practices influence organisational effectiveness in healthcare settings.^{11 12} The increased investment in health-related programmes may reflect greater awareness of the links between leadership development, improved patient care and organisational efficiency.¹³ ¹⁴ Consecutive independent NHS reviews—from Darzi’s ‘High quality care for all’ (2008) to Rose’s ‘Better leadership for tomorrow’ (2015) to Messenger’s ‘Health and social care review’ (2022) and back to Darzi’s most recent ‘Independent investigation of the NHS in England’ (2024)—have highlighted the need for improved leadership and management within

the NHS. Evidence from new research links good manager practices with the mounting problem of retaining staff in the NHS; the study shows that an increase in line manager quality by one unit (on a scale from 1 to 5) is associated with a substantial decrease in NHS employee quit intentions of 17 percentage points.¹⁵

Both reports produced by Lord Ara Darzi (2008 and 2024) called for greater medical leadership representation. This suggestion is supported by a growing body of evidence citing the benefits of ‘expert’ physician leadership found to work through improved organisational performance, employee job satisfaction, staff retention and patient safety.^{1–7} Nevertheless, there are still only around 6% physician CEOs running NHS hospitals.¹⁶ The USA has similar numbers; since 1935, physician CEOs have decreased by around 90% to running close to 5% of hospitals.¹⁷ In contrast, 61% of hospital CEOs are physicians in Israel,¹⁸ and in Italy, approximately 51% of hospital CEOs.¹⁹

Might the low number of physician CEOs be a reflection of the quantity or quality of leadership development programmes open to them? Moldoveanu and Narayandas²⁰ argue that barely 10% of the annual corporate spend on leadership development delivers concrete results, suggesting that this is because generic programmes fail to meet specific requirements.

When did leadership education become generic?

To fully understand, we must travel back and revisit two events in history: the first, in the early 20th century, saw the rise of so-called ‘scientific management’. Frederick Taylor (1856–1915) working in steel manufacturing in the 1880s to 1890s, pioneered the idea that work processes could be scientifically analysed and optimised;²¹ he believed there was ‘one best way’ to complete any task through breaking complex work into simple, repeatable operations.²² Published in 1911, his principles of scientific management facilitated mass production—most famously adopted by Henry Ford.²³ Taylorism sought to minimise the individual knowledge and skills of workers who would be supervised and monitored by managers; ‘the factory operative was to be treated as a ‘grown-up child’ and was ‘not supposed to think’’.²³ Taylor cast managers as the brains and workers as the brawn of organisations. Thus, senior managers who had no knowledge of engineering and no interest in what happened under the bonnet were running the companies.

From generic manufacturing to generic management education

The second historical event that was largely responsible for generic management education was driven by philanthropic intervention. In 1954, the Ford Foundation launched what it called a ‘revolution’ in American business education, ultimately distributing \$35million over a decade to transform the field.²⁴ Five large-scale grants created ‘centres of excellence’ at Harvard, Carnegie Mellon, Columbia, Stanford and the University of Chicago. Stirred by the Cold War,²⁵ both the Ford Foundation and Carnegie Corporation wanted business schools to become more ‘scientific’, with faculty holding PhDs and producing research grounded in economics, statistics, mathematics and psychology.^{26 27} The goal was to develop a ‘body of knowledge’ from which ‘significant generalisations about management could be made’—essentially, universal principles transcending specific industries or professions.²⁶ From the

1950s onwards, ‘the business school ideal became the general manager, equipped with a set of skills that were independent of particular industries’.²⁸ Domain knowledge education was replaced with general management training, designing curricula around a set of methodologies that could apparently apply to any field.²⁹

This philosophy still prevails in many organisations, despite mounting evidence that it fails to serve the distinctive needs of professions like medicine. Our experience with profession-specific medical leadership education directly challenges this outdated paradigm.

Why tailored leadership development?

The fundamental premise of profession-specific leadership education is that context matters. Medical professionals operate in a unique environment characterised by life-and-death decision-making, extensive regulatory oversight, high cognitive demands and distinct professional cultures that have evolved over centuries. Leadership development that ignores these contextual realities risks being ineffective at best, and potentially harmful at worst. Generic management training designed for business executives or general administrators cannot adequately address the specific challenges, ethical dilemmas and organisational dynamics that physicians face daily.

Moldoveanu and Narayandas²⁰ suggest the existence of a giant skills transfer gap—three in particular: a motivation gap between company and individual interests, a skills gap between what is taught and what is needed, and a transfer gap when there is difficulty applying classroom learning to real work. In other words, the learning is not suitable for the context into which it should be applied.

We often hear the following retorts about physicians: first, it is suggested that physicians are not interested in leadership, that they only care about their clinical work. But this is wrong. In a survey of Danish physicians that assessed their motivation to go into leadership, 70% of the 3500 respondents reported a strong interest.³⁰ Their key motivation, the physicians stated, was to make a difference in their organisation. Respondents also recognised the need for training and development prior to entering any form of leadership.

A second oft-heard comment is ‘physicians should focus on their patients and leave the managers to run healthcare organisations’. This goes against the research evidence as suggested previously.^{1 31 32} The Mayo and Cleveland Clinics are consistently ranked at No. 1 and No. 2 in global league tables (eg, U.S. News & World Report Best Hospitals, Newsweek’s World’s Best Hospitals.) Both Mayo and Cleveland Clinics are not-for-profits. Both have approximately 80000 staff with similar operating revenues of around US\$16billion; and notably, both have since their inception been led only by physicians.

Finally, incredibly, it is not uncommon for NHS managers or journalists to publicly claim (with no evidence) that physicians make terrible leaders and are the last group to be given power. This has always shocked us. It is rude and inaccurate, and frankly, if such a statement were made about any other healthcare group, heads would roll.

Naturally, physicians like all professionals who have intensively focused on their vocation really need leadership and management training to help them widen their lens. This is a prerequisite. Success in one area can also lead to over-confidence about one's skills in other areas. On day 1 of the EMMML, we have a stock statement: 'we can give you the skills you need in strategy, innovation, health analytics, finance, etc, but if you behave like an a**hole, you will fail at the first hurdle in your bid to lead'.

Importantly, leadership development is not just for those who wish to progress upwards; it also helps physicians to be more effective in their clinical practice—in other words, to become better physicians. This point is made repeatedly by EMMML students and their line managers in interviews held three times a year as part of the apprenticeship levy learning assessment process.

What does the research say about single versus multi-professional programme composition?

A helpful place to start is to establish what good looks like when measuring success in leadership development. Lyons¹³ suggests, in his extensive study, that effective programme evaluation requires assessment to be integrated into programme design from the outset, explicitly clarifying objectives with key stakeholders, and consulting primary users about how they will use evaluation data. He recommends that quality should be maintained by using established checklists, employing multiple methods to capture diverse outcomes, developing longitudinal evaluation plans and identifying appropriate control groups. Future research, Lyons suggests, should explore common intended outcomes across stakeholder groups, map existing methods to specific outcomes, develop new evaluation methods where gaps exist and investigate relationships between programme design and outcomes. Currently, few studies come close to achieving this standard.³³ In addition, we are not aware of any research that robustly examines the pros and cons of single and/or multi-professional leadership development in healthcare.

When we advocate for physician-only tailored leadership development, we hear the following: physicians work in multidisciplinary teams; therefore, they should also undertake leadership development with the same groups. While this suggestion might seem simplistic, it has common-sense appeal; and arguably, there is a strong case for the inclusion of some cross-disciplinary team-based learning.

Two systematic review articles^{13 34} examine the evidence base for leadership development in healthcare. Lyons et al examine 117 studies, of which 28 (25%) are rated as high reliability using validated appraisal tools.¹³ Of the 117 studies, 89 (76%) included physicians-only, while 26 (24%) were multidisciplinary, including nurses, managers and allied health professionals; however, it is unclear whether these multidisciplinary studies are represented in the high-reliability category.¹³ Phillipson et al synthesise evidence from 86 reviews covering at least 1659 unique studies, but do not report specific numbers of single-profession versus multidisciplinary programmes.³⁴ A fair test of the relative effectiveness of leadership development would compare single-profession with multi-professional programmes; however, neither review conducts this direct comparison. Lyons et al found that programmes

with mixed internal and external faculty were significantly more likely to report organisational outcomes than those with external faculty only ($p=0.049$), and that organisational outcomes were more frequently reported in programmes with senior physicians than residents, but did not test whether physician-only programmes differed from multidisciplinary programmes.¹³ Phillipson et al noted that interprofessional education was associated with fostering teamwork and clinical outcomes, and that programmes tailored to participants' needs and organisational contexts showed better outcomes, but again did not directly compare single-profession versus multi-professional programme effectiveness.¹⁴ Both reviews identify educational methods—including experiential learning, mentoring, project work and contextual tailoring—as more consistently associated with positive outcomes than specific curriculum content or professional composition.^{13 14}

A second helpful review article by Geerts³⁵ reports that some studies—on the topic of whether participant composition should be profession-specific or mixed—show benefits of mixed samples (such as 20% higher team performance outcomes when teams train together vs individually). Other studies indicate that designation-specific cohorts may be more effective due to shared professional contexts and psychological safety among similar peers. The author notes that some programmes reportedly fail partly due to mixed samples (citing an example where senior participants felt that the impact was diluted by the inclusion of junior-level participants), while others gain from diverse perspectives and cross-professional collaboration. Geerts concludes that both approaches have merit.³⁵

Are physicians different?

This question lies at the heart of the debate around tailored versus generic leadership education, because it may have implications for how physicians learn, lead and respond to leadership development interventions.

Three studies that assess physicians' personalities^{36–38} claim they seek to understand these traits for the following reasons: (1) select and guide medical students into appropriate careers and specialties,^{37 38} (2) explain and improve physician-patient interactions by recognising personality mismatches that may affect treatment adherence and communication,³⁶ (3) enhance interprofessional teamwork and tailor medical education to different personality types^{37 38} and (4) predict and prevent burnout by identifying personality-related vulnerabilities in medical practice.³⁷

Across all three studies, physicians are found to demonstrate a distinctive personality profile characterised by consistently elevated conscientiousness, with physicians scoring higher than both the general population and other professional groups on traits associated with reliability, efficiency and thoroughness.^{36–38} Physicians also exhibited significantly higher agreeableness and extraversion compared with the general population,^{36 38} alongside distinctive traits of dominance, perfectionism, reasoning ability and reward-dependence, while showing lower levels of narcissism, abstractedness and social boldness.³⁷

When compared specifically to other health professionals, physicians differed from nurses despite sharing some traits: while both groups demonstrated dominance and conscientiousness, physicians exhibited higher perfectionism, reasoning and shrewdness, whereas nurses showed greater assertiveness and hardiness.³⁷ Compared with allied health professionals, who demonstrated high cooperativeness, self-directedness and persistence, physicians displayed more instrumental and reasoning-oriented traits alongside their reward-dependence.³⁷ Within medicine itself, surgeons differed from internists by showing higher extraversion and openness to experience, though both surgical and medical specialties shared similar levels of conscientiousness and agreeableness.³⁸ More significant were the differences between the general population and physicians of all specialties. Indeed, Stienen et al suggest ‘the existence of a distinct and consistent average ‘physician personality’’.³⁸ These personality differences were observed not only in qualified physicians but also reproduced across medical students and residents, suggesting they may represent selection factors influencing career choice rather than solely being shaped by professional training.³⁸

The findings are based on reasonably robust studies published in peer-reviewed journals, with large sample sizes (over 112000 participants across the systematic review) and validated personality assessment tools. However, all studies relied on self-reported personality measures which are vulnerable to social desirability bias; Louwen et al’s systematic review found that only 68% of included studies achieved high methodological quality, and the use of 153 different assessment tools across studies makes direct comparisons challenging. The cross-sectional designs cannot distinguish whether personality traits lead people to choose medicine or whether medical training shapes personality. Nevertheless, the most consistent finding—elevated conscientiousness in physicians—appears robust across different populations, measurement tools and countries, suggesting genuine personality differences exist between physicians and the general population, though these represent small average differences between large groups rather than definitive individual profiles.

What about physicians’ responsibilities?

Beyond personality differences and cognitive characteristics, physicians carry a unique burden of legal and professional responsibilities that further distinguish them from other healthcare workers.

Medical physicians (who are registered with the General Medical Council in the UK) have unique responsibilities which are distinct and that set them apart from other healthcare professionals and managers. These include prescribing rights for all medicines, including controlled drugs; legal responsibilities, for example, signing death certificates and cremation forms; issuing sick notes; mental health sectioning under the Mental Health Act; providing medical reports for legal proceedings; and driver medical fitness certificates for the Driver and Vehicle Licensing Agency. They hold specific clinical leadership responsibilities, including acting as the named responsible clinician for patients, making final decisions about treatment escalation and withdrawal, leading ward rounds and having overall responsibility for patient management plans and supervising resident physicians and medical students. Their professional obligations include a responsibility to be registered with and follow General

Medical Council guidance, a duty to maintain their licence to practise through revalidation every 5 years, an obligation to provide or arrange emergency care, even when off-duty, and a requirement to have specific levels of professional indemnity insurance. Importantly, many of these responsibilities begin when they are young and still in medical school.

Because of the situational power bestowed on physicians by virtue of their training and responsibilities, the need for evidence-based leadership development seems even more important.

Arguably, different population groups differ in their tolerance for learning. The length of physicians' education dwarfs most other professions, including those elsewhere in healthcare. Starting with 5–6 years undergraduate medical degree (or 4 years graduate entry), then 2 years Foundation Training (F1 and F2), 5–8 years specialty training (depending on specialty) making the minimum training time 10–15 years to become a Consultant or general practitioner. It takes 3–5 years to become a registered nurse, 5 years for pharmacists to registration, physician associates train for 5–6 years, as do solicitors and school teachers (both 5–6 years, excluding Teach First). With regard to cognitive abilities, to study medicine requires consistently high grades across all universities, often combined with additional aptitude tests and top grades at both General Certificate of Secondary Education (GCSE) and A-level.

Conclusion

Our experience with the EMLL demonstrates that profession-specific education can deliver compelling results: strong peer networks, effective learning transfer to clinical contexts, psychological safety for personal development and more relevant skill-building tailored to medical leadership challenges. These learning outcomes are evidenced in data we have collected from EMLL students and their direct line managers (a study is forthcoming).

Physicians differ measurably from the general population in personality, cognitive abilities and professional orientation. They carry unique legal responsibilities that begin in medical school and intensify throughout their careers. They undergo training that is longer and more demanding than virtually any other profession. They work in contexts where decisions have immediate life-or-death consequences, where regulatory oversight is intense, and where professional cultures have evolved over centuries to manage extraordinary complexity and risk. And, importantly, the power that physicians' training and position extols should be balanced with learning that establishes the right behaviours to execute those powers effectively and reflectively.

While not all leadership development for healthcare professionals needs to be single-profession, we should question the default assumption that generic and multidisciplinary is better. For physicians, as for other distinct professional groups, tailored education that respects and responds to professional differences may not just be desirable, but essential. Management consultants in the major firms, who trade on the idea of fixing any problem

despite being professionally far from the context, have benefited greatly from the generalist paradigm. Business schools too have played their part, though the trend is arguably reversing.

Diversity has been a priority for the NHS and other healthcare providers. It is therefore counterintuitive not to recognise cognitive, professional and situational diversity also. The path forward, we believe, for leadership development in healthcare is to embrace, not resist, the reality of professional difference.

References

- 1 Goodall AH. Physician-leaders and hospital performance: is there an association? *Soc Sci Med* 2011;73:535–9.
- 2 Veronesi G, Kirkpatrick I, Vallasca F. Clinicians on the board: what difference does it make? *Soc Sci Med* 2013;77:147–55.
- 3 Sarto F, Veronesi G. Clinical leadership and hospital performance: assessing the evidence base. *BMC Health Serv Res* 2016;16 Suppl 2:169.
- 4 Tasi MC, Keswani A, Bozic KJ. Does physician leadership affect hospital quality, operational efficiency, and financial performance? *Health Care Manage Rev* 2019;44:256–62.
- 5 Bäker A, Goodall AH. Do expert clinicians make the best managers? Evidence from hospitals in Denmark, Australia and Switzerland. *Leader* 2021;5:161–6.
- 6 Kirkpatrick I, Altanlar A, Veronesi G. Doctors in leadership roles: consequences for quality and safety. *Public Money Manag* 2024;44:515–22.
- 7 Darzi A. Independent investigation of the NHS in England. London Department of Health and Social Care; 2024.
- 8 Nightingale F. Notes on nursing: what it is and what it is not. London: Harrison, 1859.
- 9 Kline R. The snowy white peaks of the NHS: a survey of discrimination in governance and leadership. London Middlesex University; 2014.
- 10 Future Market Insights. Leadership development program market size & trends 2025-2035. 2025. Available: <https://www.futuremarketinsights.com/reports/leadership-development-program-market>
- 11 Bloom N, Sadun R, Reenen J. Does management matter in healthcare. Boston, MA: Harvard Business School, 2014.
- 12 Veronesi G, Kirkpatrick I, Altanlar A. Are Public Sector Managers a “Bureaucratic Burden”? The Case of English Public Hospitals. *J Public Adm Res Theory* 2019;29:193–209.
- 13 Lyons O, George R, Galante JR, et al. Evidence-based medical leadership development: a systematic review. *BMJ Lead* 2021;5:206–13.
- 14 Restivo V, Minutolo G, Battaglini A, et al. Leadership Effectiveness in Healthcare Settings: A Systematic Review and Meta-Analysis of Cross-Sectional and Before-After Studies. *Int J Environ Res Public Health* 2022;19:10995.
- 15 Bäker A, Goodall AH, Serra-Sastre V. Managing to stay: does line-manager quality affect employees’ intention to quit in the NHS?. *British Journal of Industrial Relations*, Wiley, 2025
- 16 Trinchese D, Veronesi G, Kirkpatrick I. Board faultlines and employee turnover: the moderating effect of the CEO-board interface. working paper. 2025
- 17 Angood P, Birk S. The value of physician leadership. *Physician Exec* 2014;40:6–20.
- 18 Angel Y, Goldshtein H, Barel N, et al. Trends in Israel’s Medical Administration subspecialty, 1987-2022. *Isr J Health Policy Res* 2025;14:3.
- 19 Rossi D, Bizzarro A, Affanni P, et al. The educational background of the top managers of Italian health authorities. *Acta Biomed* 2019;90:87–91.
- 20 Moldoveanu M, Narayandas D. The future of leadership development. *Harv Bus Rev* 2019;97:40–8.
- 21 Taylor FW. The principles of scientific management. New York: Harper & Brothers, 1911.

- 22 Kanigel R. *The one best way: Frederick Winslow Taylor and the enigma of efficiency*. New York: Viking, 1997.
- 23 Hounshell DA. *From the American system to mass production, 1800-1932*. Baltimore: Johns Hopkins University Press, 1984.
- 24 Howell JE. *The ford foundation and the revolution in business education*. New York Ford Foundation; 1966.
- 25 Khurana R, Kimura K, Fourcade M. *How foundations think: the ford foundation as a dominating institution*. Harvard business school working paper 11-070. 2011
- 26 Gordon RA, Howell JE. *Higher education for business*. New York: Columbia University Press, 1959.
- 27 Pierson FC. *The education of American businessmen*. New York: McGraw-Hill, 1959.
- 28 Muller JZ. *The tyranny of metrics*. Princeton, NJ: Princeton University Press, 2019.
- 29 Goodall AH. *Credible: the power of expert leaders*. London: John Murray Press, 2023.
- 30 Bäker A, Bech M, Geerts J, et al. Motivating doctors into leadership and management: a cross-sectional survey. *Leader* 2020;4:196–200.
- 31 Mustafa S, Farver CF, Bierer SB, et al. Impact of a leadership development programme for healthcare executives: the Cleveland Clinic experience. *J Health Adm Educ* 2019;36:77–91.
- 32 Mustafa S, Stoller JK, Bierer SB, et al. Effectiveness of a Leadership Development Course for Chief Residents: A Longitudinal Evaluation. *J Grad Med Educ* 2020;12:193–202.
- 33 Geerts JM, Goodall AH, Agius S. Evidence-based leadership development for physicians: A systematic literature review. *Soc Sci Med* 2020;246:112709.
- 34 Phillipson J, Pinto AC, Kingsley-Smith H, et al. Leadership training in healthcare: a systematic umbrella review. *BMJ Lead* 2025;0:1–11.
- 35 Geerts JM. Maximizing the Impact and ROI of Leadership Development: A Theory- and Evidence-Informed Framework. *Behav Sci (Basel)* 2024;14:955.
- 36 Ammi M, Fookien J, Klein J, et al. Does doctors' personality differ from those of patients, the highly educated and other caring professions? An observational study using two nationally representative Australian surveys. *BMJ Open* 2023;13:e069850.
- 37 Louwen C, Reidlinger D, Milne N. Profiling health professionals' personality traits, behaviour styles and emotional intelligence: a systematic review. *BMC Med Educ* 2023;23:120.
- 38 Stienen MN, Scholtes F, Samuel R, et al. Different but similar: personality traits of surgeons and internists—results of a cross-sectional observational study. *BMJ Open* 2018;8:e021310.