In Perspective

Title: Developing leadership in emergency medicine

Leadership in emergency medicine is a routine part of day-to-day practice. Being a trauma-team-leader, emergency physician in charge, or clinical lead all look very different and require a range of skills but are all certainly forms of leadership that have significant impact on the running of an emergency department, patient outcomes and, as is increasingly being recognised, staff wellbeing [1].

The EMLeaders programme was launched in 2018 as a collaboration between RCEM, Health Education England, and NHS England as a structured approach to leadership development of emergency physicians in training. Although professional societies and colleges offer leadership courses, these usually focus on those who have completed training. A critical aspect of EMLeaders is that learning is not confined to the course, but continues on the shopfloor with the involvement of emergency department consultants.

In their multi-method evaluation of the EMLeaders programme, published recently in EMJ, Kneafsey et al. provided an insightful and pragmatic evaluation of the EMLeaders programme [2]. They surveyed a broad selection of clinicians associated with RCEM asking open ended questions about their experience of leadership training. In total, they surveyed 417 clinicians of which 177 had participated in the EMLeaders programme. From this group they recruited 26 clinicians for semi-structured interviews in which they were able to expand on participants experience of the EMLeaders programme, what they learned from it, and how they may have implemented this into practice. Their analysis develops insights that can inform emergency medicine focused leadership training and practice more broadly.

There was a strong preference for face-to-face leadership teaching, and this warrants unpicking. It is not that training delivered online, either via e-learning modules or teaching sessions via videoconferencing sessions lack utility. Indeed there are many settings where the increased accessibility and flexibility, combined with considered use of technology-enhanced learning, facilitate high-quality education[3,4]. It is more that, in the context of leadership training for emergency medicine, face-to-face training adds something. Face-to-face training, particularly when it involves reflection on challenging aspects of work, facilitates building a community of practice[3]. The importance of peer-learning, interpersonal connectedness, and time and space away from the workplace to allow reflection, should not be underestimated. These are not concepts that just add value to face-to-face leadership training. They are central to the learning, particularly at the level of behaviour change, that occurs in these settings[5].

The frequent use of the term “compassion” in the evaluation by Kneafsey et al mirrors an increasing recognition of the importance of compassion in leadership. The King’s Fund state that “compassionate leadership involves a focus on relationships through careful listening to, understanding, empathising with and supporting other people, enabling those we lead to feel valued, respected and cared for, so they can reach their

potential and do their best work[6].” This reflects what I think one participant was getting at:
“Is the leadership training going to make the NHS better? No, it's not. It's probably going to allow us to survive in the system. …being kind to each other being compassionate and civil and putting the patient first. It’s about having effective communication when you have conflict.” In the emergency department, where uncertainty is the norm, disagreements amongst clinicians and between those with different priorities, for example an individual patient versus the running of an entire department, are routine. Leadership skills are what allows these occasions to be positive and constructive and not degrade into conflict or incivility.

The EMLeaders programme not only teaches valuing and respect as leadership attributes, it is a way of demonstrating to learners that they are valued and their professional development respected. This is important as, in their extensive qualitative study of emergency departments in the UK, Daniels and colleagues found that “compromised leadership” was seen as a barrier to improving working conditions and staff retention [1] and professional development has a central role in retaining staff [7].

Part of the success of the EMLeaders programme may be down to its design. In particular, the central involvement of trainees in ensuring relevance of both content and delivery. This process of co-design, well established in research [8], is still in its relative infancy in education[9] and almost entirely absent from the health professions education literature. Kneafsey and colleagues do a good job of exploring the limitation of their study, but I see the failure to interview those involved in the development of the programme as a missed opportunity as it may have helped garner a more holistic understanding of the programme and benefit those planning something similar in other countries.

As a doctor in emergency medicine training who undertook the EMLeaders programme while participating in leadership activities from the shopfloor to national level with RCEM, the Emergency Medicine Trainees’ Association, and beyond, I feel well placed to recognise the importance of structured leadership training at an early stage for our professional development. The programme reminds us that leadership is a day-to-day activity and the remit of all emergency physicians. Getting better at it can be conceptualised as a means of helping yourself and your colleagues provide high-quality, sustainable care, in a challenging environment.

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