Emergency Medicine Journal

BMJ Publishing Group

SUPPLEMENT

September 2002

Leadership: six core principles

Running an A&E department, I have had to think about leadership a great deal. Although in 1986 I had the advantage of "being the first"—for St Mary's was the last of the original 12 London teaching hospitals to appoint a trained A&E medicine consultant—A&E medicine, as a specialty, was an unknown quantity in the hospital. I needed, very quickly, to define what we were about—that is, "the importance of being there".

The nursing staff already had strong and effective leadership. Conversely the medical staff—then only five SHOs—had had little or no leadership. This is for me a lasting special interest: training successive teams of SHOs. Currently, from February 2002 this is team "32"— each six month SHO team at St Mary's having a number—team "1" starting August 1986.

I focus on the leadership required to enable successive teams of SHOs to give of their best. This is where I began and this is where I now remain. I give specific examples so what I offer is pithy, focused, and reproducible.

The first five

(1) Determination with confidence and competence

The leader must know what he is about—knowing also his limitations—and must have a focused attainable vision which he is able to communicate to the team. SHOs want two things: supervision to remove the fear, followed by education so that they will improve their skills and knowledge. A&E is frightening, whether it be multiple trauma or a full waiting room of aggressive resentful patients. We coined our motto, *Scientia vincit timorem*, knowledge conquers fear, in Latin as it initially gave gravitas, but now continued as we have become part of Imperial College whose motto is *Imperii scientia decus et tutamin* (knowledge is the shield and glory of the Empire). Thereby common identifiable goals become tradition, embedded in the department by reputation.

"Being there" sets the example: on one's own shop floor, seeing patients, being immediately available for situational teaching in real time. The rota sets the structure respected by all for being fair. The induction course over the first month helps create bonding. The on-going educational programme—compulsory, once a week—gives the development. It is quite true I sent the police to fetch a recalcitrant team "1" SHO (it was easier to do such things in 1986)! We had no more problems with lack of attendance. It demonstrated not only how vital the meetings are, but also the lengths to which I personally was prepared to go to ensure 100% attendance.

It is only practical, indeed possible, to build teams with this intensity twice a year, August and February. This is why all our SHOs start on the same day. It is also why our specialty must firmly reject SHOs rotating through A&E every four months as opposed to six.

(2) Humour with consistency

The best exponents of this core principle that I have experienced were senior NCOs in the Royal Marines. It is an art, exercising humour; one that must be used with restraint and not ever at any individual's expense. It does make for a happy work practice as quite simply happy staff makes for happy patients. Facilitating staff to give of their best willingly, because that is what they themselves want, engenders a team system of working. Of course one has to pull back when protocols are not adhered to, or when individuals become slack, or worse, perhaps start to take one for granted. Protocols must be set and explained.[1]

Let people know where they stand. By this I also mean do not become over familiar. For instance, for me, I am only comfortable—and everyone knows this and adheres to it—to be addressed by my first name by consultant colleagues, sisters (G grade), and year 5 SpRs. Over familiarity is a sign of weak leadership. Be consistent, staff will find it much easier to adapt to you when they know what is expected of them and what to expect from you.

(3) Listening, caring, and planning

To listen is to demonstrate respect for the views of others, no matter how junior. For a team of SHOs, antisocial rotas inevitably disrupt lives. Most SHOs during their six months of A&E medicine will have to survive a crisis of one sort or another. We tell our SHOs on day 1 that they will all make mistakes. We then explain the department's goal keeping necessary to minimise them.[2 3]

Our armed forces teach their officers to care for their men. Likewise, we must care for our staff. Showing an interest in their welfare and career development is vital. Appraisal and assessment are formal ways of developing this theme of caring. We tell our SHOs they are our apprentices (a good term) from the actual moment of appointment.

A day's resuscitation training—with a formal programme for the houseman to show his consultant in order to arrange the day off, as housemen do not have official study leave—for the team before it starts, no new SHO working a night shift during the first week, and an induction course are all part and parcel of caring.[1] It also helps

the team to bond and to look after one another. They will quickly learn that to help one another is stress relieving. Stress is their greatest enemy.

Correct selection of staff is of course vital. At the bottom of our introduction to the SHO job description is written, "SHOs are organised as disciplined teams, only those who welcome this structured system of working should apply".

(4) Praise of others, but with self awareness.

Advanced life support courses have transformed standards of care for the seriously ill and injured in A&E. They also teach us the art of critiquing: always to say what is done well, before suggesting areas for attention. It is all too easy to forget when annoyed, or even plain cross!

Raise morale by praising individuals right from the start. Make it clear to each SHO that even if they have only undertaken two house jobs they will bring to the department individual skills and knowledge. These will help keep their consultants up to date.

As consultants we must all be aware of, and have insight to, our own weaknesses and biases. What we want most are our potential weaknesses.

However, in 1986 I was only too well aware of the rugby tradition at St Mary's. I played on this to help develop teams of SHOs that developed their own *esprit de corps* in order to raise morale. Each team is told that they are Mary's finest (the "Brigade of Guards" of the hospital). This helps to keep the service going under adversity—for example, asking an SHO to work an extra shift at short notice because of another's absence. Our greatest fear as consultants, when on-call at weekends, is the night doctor calling in sick. We all have our own tricks to make this threshold high. The healthiest is to generate SHO self respect, respect for their own team and for its members.

(5) Respect

This must be mentioned in its own right. For most of us working in under-resourced environments to make the system work one does sometimes have to be strict. This is acceptable providing it is fair and consistent. The easiest way to generate respect is to respect those below you who you lead. The second easiest way to generate respect is to work on the shop floor alongside "the team" picking up the card at the top of the pile. You then are doing what they do and experiencing what they experience. It is also good for interacting with the on-take teams. St Mary's has its own "medical standing guidelines". These define a consistent service from the on-take teams and are signed by a number of senior consultants across a range of specialties.

We in A&E have the advantage of not being seduced by private practice; medicolegal work should be done in one's own time—for example, on one's half day, programmed and accepted. The very best leaders are loved but this either happens or it does not. Certainly it will not happen for all the "teams" that you train. You must never seek it; this weakness will be spotted at once.

Conclusion

I have not specified charisma: the capacity to inspire enthusiasm and devotion. The six core principles of leadership in A&E engender this, but in a much more subtle way than is possible in the military. Our work as A&E consultants must be sustainable. Charismatic leadership for most carries a price, the risk of burnout because of the need to lead by example. There is also the risk of becoming idiosyncratic and outliving one's usefulness to the department.

Being effective as The Leader—The Captain—invites, indeed necessitates, a degree of loneliness; much less now though, in our multiconsultant departments.

Leadership in 2002—as opposed to 1986–91 when I was single handed—is now tested in different ways: rotation of the departmental "directorship", structured consultant clinical session systems of working and responding to directives from above—for example, that no patient stays in your department for longer than four hours.

It makes for departmental happiness and cohesiveness to rotate the the directorship among the consultants (say every three to five years), while each retains their own specific departmental tasks and duties—for example, coordinating successive teams of SHOs. But what is right for one department may not be right for another.

Therefore, to the above five principles of leadership must now be added the vital sixth facilitating longevity: *adaptability*.

Our specialty—more so than any other—offers such rich diversity of opportunity facilitating self development; but beware of taking on special interests completely outside of your department. This diminishes your leadership ability within it. Centre your own special interests on your own department—for example, undergraduate teaching and research and innovation.

This is my prescription for remaining a leader throughout ones consultant career:

- Determination with confidence and competence.
- Humour with consistency.
- Listening, caring, and planning.
- Praise of others, but with self awareness.
- Respect.
- Adaptability.

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References

1 **Touquet R**, Fothergill J, Henry JA, *et al.* Accident and emergency medicine. In: Powers MJ, Harris NH, eds. *Clinical negligence.* London: Butterworths, 2000.
2 **Touquet R**, Fothergill J, Fertleman M, *et al.* Ten clinical governance safeguards for accident and emergency departments. *Clinical Risk* 1999;**1**:44–9.
3 **Touquet R**, Driscoll P, Nicholson D. Teaching in accident and emergency medicine: 10 commandments of accident and emergency radiology. *BMJ* 1995;**310**:642–5.

Reforming Emergency Care

EMJ is planning a themed edition relating to reforming emergency care systems, including innovations in the provision of clinical care, reduction of waiting times, and organisation of systems.

Original research in this area should be submitted before 1 November 2002 for consideration for inclusion in the themed issue.

Please submit your article on our online manuscript tracking system, Bench>Press, at http://submit-emj.bmjjournals.com/ indicating in your cover letter that this is for the reforming emergency care issue.

Presidential pearls

- The 9th International Conference on Emergency Medicine was hosted by BAEM in Edinburgh in June. Despite concerns following 9/11 almost 1000 delegates from 45 countries attended—a truly world wide coming together of emergency medicine. The scientific programme was excellent, with many outstanding contributions reflecting the international nature of our specialty. Edinburgh lived up to its reputation as the perfect conference venue and the overseas visitors, in particular, were overwhelmed by the unique ambience of the city. And the sun shone—a meteorological metaphor without question! The social programme included an opening reception in the magnificence of Edinburgh Castle, a superb International Federation dinner at the Royal College of Surgeons of Edinburgh, and the final banquet at Dynamic Earth. The Scottish theme prevailed, prominently featuring haggis and pipers, the former being greeted with varying enthusiasm by our international guests! The competitions running during the week reflected the ICEM concept with the Fun Run winners being from New Zealand (men) and Spain (women), the golf competition at Gleneagles being won by a colleague from Hong Kong, and the OSCE competition won by our own John Thurston.

The organisation of the conference was a quintessential team event with immense contributions from all the committee—Roger Evans, Gautam Bodiwala, Steve McCabe, Peter Burdett-Smith, Ed Glucksman, Tom Beattie, and Brodie Paterson. Thank you.

The unmissable 10th International Conference will be held in Cairns, Australia in June 2004.

- As a result of the post Byers reshuffle, Hazel Blears, the Minister of Health with responsibility for emergency care, was promoted and replaced by David Lammy.

The President of the Faculty and I met him at the Department of Health on 22 July 2002. This was an extremely encouraging and positive meeting. The Minister expressed his belief in the key role of our specialty in providing emergency care and that this view was shared by senior Government colleagues, including No 10. We emphasised the commitment of our specialty in delivering the principles contained in the *Reforming Emergency Care* document, despite some reservations regarding detail. However, action by Government to demonstrate their commitment to supporting our specialty in delivering the strategy is urgently required.

The absolute need for urgent investment in our specialty was reinforced, particularly given the chronic under investment over a period of many years. The details of healthcare funding following the spending review are imminent. We stated the importance of ensuring that funding for emergency care is identified specifically and not allowed to be absorbed in local Trust debts or allocated to other competing specialties. Such funding could then make a real difference when invested in initiatives in our departments, including medical and nursing staffing, clinical decision units etc, etc.

We expressed our continuing concerns with regard to the quality of data submitted to the Department of Health with creative interpretation of definitions allowing a far more satisfactory impression of the current state of play to be conveyed, in contrast to day-to-day reality in many of our departments. New guidance is imminent from the Department of Health regarding definitions of admission, waiting time measurement, etc. We were reassured that the Minister is under no illusion regarding the current difficulties facing our departments and that urgent action is required. The Minister clearly understands that some pressures, for example trolley waits for admission, lie outside our immediate control but we have a major role to play in developing new and innovative practice to deal with the true emergency department workload given adequate resources.

- The Government has appointed a "tsar" to direct emergency care strategies. The appointee is Professor Sir George Alberti, immediate past president of the Royal College of Physicians in London. We welcomed this initiative and emphasised the vital importance of the early involvement of our specialty with the tsar to ensure that there is full awareness of the current issues and the opportunities for our specialty to fulfil its true potential are realised.

JOHN HEYWORTH

Consultant appointments, June – September 2002. The information for the consultant appointments is provided by the Faculty and any errors should be notified to them and not the journal

Name	Hospital	Previous post
Kashmi Ajula	Princess Margaret Hospital, Swindon	SpR, Aberdeen
Abhijit Bose	William Harvey Hospital	Locum consultant, Ipswich Hospital
Kilian A Hynes	Barnet Hospital	Locum consultant, London
Kees P Ketting	Dewsbury and District Hospital	SpR, Leicester
Rachel Landau	Whittington Hospital	Locum consultant
Andy Lockey	Calderdale Royal Hospital	SpR, Leeds General Infirmary
Jason L Louis	Taunton and Somerset Hospital	SpR, North Bristol
David P Mbamalu	Barnet Hospital	SpR, London
Amjid Mohammed	Calderdale Royal Hospital	SpR, Leeds General Infirmary
Clifford G Reid	North Hampshire Hospital	SpR, Australia
Magdy Sakr	Walsgrave Hospital	Locum consultant, West Midlands
Beverley L Watts	North Hampshire Hospital	SpR, North Hampshire
Suzanne Wyatt	Glanrhyd Hospital (Princess of Wales Hospital)	Locum consultant, Prince Charles Hospital, Bridgend

News from BAETA

Conference season is upon us again. The 9th International Conference on Emergency Medicine, held in Edinburgh in June, was extremely well attended by trainees who represented the UK with numerous posters and presentations that reinforced the growing reputation of the specialty in this country and abroad. Congratulations to all those who won recognition for their efforts. The traditional BAETA excursion broke all records with 100 trainees making it a night to remember.

The main issue of discussion during the week was the proposed new consultant contract, which can be viewed on the BMA web site at www.bma.org.uk.

The general feeling at both the BAEM AGM and the BAETA meeting was of unanimous concern and rejection of the proposals as they stand. It is difficult to reconcile these proposals with the vision for the future of emergency care laid out in other recent documents. The trainees' main point of contention was that specialist registrars will not be included in a referendum planned to gauge response to the proposals. This is clearly unacceptable, as we are the consultants of the future and should have a say in the development of contracts under which we will be working. A letter outlining the points raised at the meeting has been sent to the President of BAEM and Chairman of the Central Consultants Committee on behalf of trainees.

On a final note, several BAETA officers are due for a change around in the near future. In order to enact a smooth and seamless handover, it has been suggested that we stagger these changes, and institute a shadow period when the new can gain advice and experience from the old. Elections will be held during the AGM in Bristol (during the BAETA Conference) for the new president, who will be able to shadow the current incumbent for six months. Next April at the BAEM conference, elections will be held for the new trainee representative to the BAEM Executive, and between these two postal elections will be held for the trainee representative to the Faculty Board. Hopefully this system will ensure that there are no unnecessary disruptions to issues in progress at the present time. Please contact the current officers if you have any inquiries about these positions.

We hope to see you all at the BAETA conference in Bristol.

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Round up of "Forum" news from FASSGEM

Portsmouth Conference

The programme for the conference is coming together very nicely and all the indications are that it will be an exciting and thought provoking few days. For those who have not booked their study leave yet this is a reminder to get on and do so. The venue is the Holiday Inn in Portsmouth and the conference will run from the evening of Tuesday 12 November to the afternoon of Friday 15 November. To book download a booking form from the BAEM web site or contact the secretary by email (chargreaves@doctors.org.uk) or by post to A&E Department, Queen Alexandra Hospital, Cosham, Portsmouth, Hants PO6 3LY.

One session of the conference will be given over to papers and audit presentations by FASSGEM members—if you have material you wish to present then it is important to let the conference organiser (Carolyn Hargreaves) know as soon as possible so that scheduling can be completed.

Pay

The thorny issue of pay remains as a major problem. Chances of an early resolution have (in all probability) been worsened rather than helped by the draft proposals for the new consultant contract.

I was fortunate to be invited to meet the new Minister for Health (David Lammy) and to present some of the issues concerning NCCG staff in emergency medicine (I was able to emphasise the problems with remuneration and the consequential effects in respect of recruitment and retention and therefore the implications for the successful implementation of *Reforming Emergency Care*). The Minister was clearly surprised to hear of some of the challenges facing NCCG staff and is going to investigate the situation as part of his remit to bring about the implementation of *Reforming Emergency Care*.

Policy document

The BAEM policy document (available on the BAEM web site) has now been widely distributed. All NCOs are advised to ensure that it has been noted by their heads of department, medical staffing departments, and medical executive directors.

This document is intended to evolve and with that in mind, discussions are underway with the Faculty to address some of the academic issues within the remit of the document (with the intention of producing a joint BAEM/Faculty publication as soon as possible).

The proposed new consultant contract has implications for what hours are considered "social" and what hours are "unsocial"—once it is clearer what elements of that proposed contract are accepted and what elements are rejected then further revisions to the current policy document may be needed (the conference in Portsmouth offers an ideal forum for this to be undertaken).

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