Leadership and Mentorship in Medicine

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Dr. Ffion Davies, President of the International Federation of Emergency Medicine (IFEM) shares her vision for training and mentorship in Medicine and lends her advice to ED physicians and the healthcare community.

Dr. Davies is passionate about mentorship and training emergency clinicians in the UK. As a dual trained clinician in adult and paediatric emergency medicine she spends most of her time as a consultant emergency physician at the University Hospital of Leicester and as a member of the Royal College of Emergency Medicine.

This year, a new hat was added to her previous roles: President of the International Federation for Emergency Medicine (IFEM). We interviewed Dr. Davies to get an insight into her views on leadership and the role that mentorship has played in her career.

MIPS: Team leadership, decision making, communication and collective self-reflection for improvement were described as the core skills to achieve success in scenarios like a 15-minute RESUS drill, but they can apply to any healthcare practitioner where they must act quickly and without error. What has been your experience teaching these drills and how you think they can help develop these non-technical skills within healthcare teams?

Dr Davies: Drill practices have been universally well received; they are a pleasure to teach. It helps to have a mental model for approaching a situation which overwhelms you and you do not see very often. My experience is that the learners often have theoretical knowledge to draw upon, but when the stakes are high, they regress into this, blind to the evolving situation. And even the theory goes to a mental blank when you are stressed. So, the first imperative is to have a realistic scenario run-through to decreasestress. On the crucial second run-through, reduced stress means that the learner starts remembering thetheory and opening their eyes towhat is happening withthe team. Half the art of managing a teamand apatient is about communication and practicalities. A good instructor uses illustrations from the first run, so it works well on the second run, and everyone feels comfortable and proud. Practice makes perfect. Making the situation time-real and involving a whole multi-professional team (such as porters or “pretend specialists”or “pretend switchboard”) truly tests this out for real-life application.

MIPS: The medical literature acknowledges that mentorship is pivotal to academic medicine and its vocation, and the role it plays role in clinicians’ training and career development. What is the role that mentorship has played in your own career and what do you think individual practitioners and organisations can do to embrace it as an evidence-based investment in their future and at the same time, an honourable endeavour?

Dr Davies: Mentorship is crucial. It can be informal (often actually unnoticed) or more clearly identified. We all hear, see, and think through our personallens. Having someone who clearly has your welfare at heart but can point out the view through a different lens, or reflect on your decisions or behaviours, is valuable. Although it can feel a bit threatening.More formal“educational supervisor” type roles often fail todeliver mentorship.I think if we talk openly about mentorship as a concept and allow flexibility in the matching system (mentor to mentee), it pays off. With open conversations it becomesreverse-mentorship and both people learn how the other thinks. Magic!

MIPS: What advice would you give to early career practitioners who would like to pursue leadership roles in the future? What type of learning opportunities, interprofessional engagement and collegial relationships would you recommend they seek to develop? Are there any hurdles or setbacks you see within emergency medicine that need overcoming?

Dr Davies: I do think you owe it to yourself and others to embark on a leadership position with more than just enthusiasm! Learn where you are in the jigsaw oftheproject. Ask carefully what’s expected of you. Considerwhoit is that is your audience, or the people affected by your project. Accept that even if youthinkyou are a natural leader (that’s a lot of us Emergency Physicians!) a short, formal course (onlinewill do) and a book or two later, you’ll have learned about your personal style, how that works and doesn’t work, and lots of other tips.Setbacks and hurdles? Well within emergency medicine practice, we are at the mercy of many external forces (public expectation, serving as the safety net for the whole social and healthcare system around us) and attempts at leadership can be very frustrating due to lack of control of the factors that affect us. We are often surrounded by either a defeatist attitude or worse, pressure for“quick fixes”. If it was that easy, we’d have solved problems like over-crowdedemergencydepartments (which is dramatically demonstrably causative of death and medicalerrors) decades ago. We are the canary in the mine of society. That sounds very deep, doesn’t it? But it’s true. Covid has shown us that in the last year.

MIPS: At MIPS, we are committed to supporting the wellbeing of all our members. How can medical defence organisations such as MIPS support emergency and non-emergency clinicians to deliver safe care while advocating for their wellbeing beyond the pandemic and in general?

Dr Davies: The first step is awareness of wellbeing and some really practical training in how to safeguard your own health, mental and physical. Defence organisations know how much physician wellbeing affects their risk of error, or worse (deliberate unprofessionalism). But what many of us are struggling with mentally at the moment is a big threat. That is the measure of acceptable care for the one patient whose care has come into question, versus the demand on the clinician’s time and attention by the overwhelming demand of the masses. Is this context in which many of us are operating being taken into account? Those of us in emergency medicine or general practice (certainlyhere in the UK) need the defence organisations to tackle this issue. Our regulatory bodies don’t seem to want to hear that you were distracted or interrupted, didn’t have enough time etc, with that patient, at that time.

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