Expert Commentary

Grace Under Pressure: Leadership in Emergency Medicine

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Abstract

Physicians in general, including emergency physicians (EPs), are trained in the diagnostic, therapeutic, and administrative aspects of patient care but not so much in the theoretical and practical aspects of assuming and delivering leadership. EPs are always taught to focus on their performance, to excel and achieve, to be accountable for their own clinical decisions, and to appreciate feedback and peer-to-peer review. Currently, if there are some semblances of formal or semi-formal leadership instruction, the organized theoretical curriculum often does not formally include very structured and planned departmental leadership and management elements. Leadership is a process for a person (“the leader”) to lead, influence, and engage a group or organization to accomplish their objectives and mission. To do this, the leader must understand a variety of issues of working, interacting, and integrating with people, the environment and both, the intrinsic and extrinsic factors, and elements that have an impact on the industry or area he/she is leading in. Leadership in emergency medicine (EM) is even more challenging, with its unique focus, issues, and trajectory, moving into the new century, with new considerations. No single strategy is sufficient to ace EM leadership and no single specific leadership model is complete. This paper shares some current views on medical/EM leadership. The author shares her views and some suggested proposals for more formal and structured leadership, implementation, and succession to help nurture and groom EPs who will become leaders in EM in the near future.

Keywords: Clinical competency, emergency medicine, leadership

INTRODUCTION

Emergency medicine leadership

Leadership is a process for a person (“the leader”) to lead, influence, and engage a group or organization to accomplish their objectives and mission. To do this, the leader must understand a variety of issues of working, interacting, and integrating with people, the environment and both, the intrinsic and extrinsic factors, and elements that have an impact on the industry or area he/she is leading in. Today, the health-care environment is more complex, with health-care reforms and market forces transforming the way health care, including how emergency care, is delivered and managed. Disciplined, hardworking, effective, and visionary leaders are needed and critical to create and lead high-performance teams in these organizations.

EM is developing at an extremely rapid pace that exceeds many other specialties. The practice of EM requires a unique set of competencies to manage undifferentiated, complex conditions, 24 h a day. These conditions can be life-threatening, acute, and urgent, thus requiring capabilities for quick and accurate decision-making, timely assessment, management, and appropriate disposition.¹²

There are changes happening all the time in the ED; handling surge capacity, code black periods, need for reorganization of workforce to cope with the ever-changing demands, and hour-by-hour changes, among many other situations and challenges. Who is the individual that can lead the ED, in demonstrating both the clinical as well as administrative/management leadership? What characteristics do the individual need to have to be resilient and be able to bounce back day after day, providing emergent care, saving lives, coordinating, and leading the ED.

The ED provides a wide range of mixed conditions as well as platforms for mastering clinical and administrative/management leadership competencies. It is essentially a rich

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learning environment, with volume, variety, and the offer of a good apprenticeship model. The patients coming to the EDs are undifferentiated and unpredictable, and therein lies the robust and challenging environment for clinician leaders as well as management and administrative leadership to create and put forth the state-of-the-art and effective service.\[1,3,4\]

Health care needs excellent leadership and management personnel.

There are many definitions and views on leadership. “Leadership” represents one of the most researched terminology with a wide spectrum of meanings, parameters, and applications. Some are more generic while others tend to be specific for certain professions or disciplines. The term leadership development encompasses effort to develop individual leaders as well as build capacity for leaders within an organization. Leadership development can also promote several key functions in an organization, for example, performance improvement, succession planning, and organizational change. Thus, having proper and organized leadership development initiatives can certainly help organizations, health care, or others, advance their course, vision, and plan succession.\[4,5\]

High-quality health care increasingly relies on excellent collaboration and interdisciplinary work. Physician leaders can strategically optimize health systems’ performance if they have deep understanding of the system themselves. Physician leadership is critical in health-care institutions and many pursue a cause that they strongly believe in and are passionate about. In this aspect, more role models are certainly welcome, as they will help nurture and inspire the younger residents and leaders of tomorrow. Seniority and titles alone do not always equate leadership.\[3,5,6\]

The clinical decision-making skills and capabilities such as when to intubate a patient in respiratory distress, management of a neonate in cardiac arrest, stabilization of a multitrauma patient, or the immediate defibrillation of a life-threatening arrhythmia are indeed some of the emergent clinical tasks for an emergency physician (EP). The administrative and management skills too are crucial in the development, training, and practice of emergency medicine (EM), to ensure seamless and efficient flow of patients and staff, employed in the ED.\[5,7,8\]

When a crisis occurs, the EPs take care of the casualties. The EPs have to lead the ED through the “chaos” and manage patient after patient objectively, despite all the commotion and distractions going on. They have to lead their teams during the incident or crisis and afterward, through debriefing and the healing process. These EPs are the leaders in the EDs and they are at the forefront, being the influencers and change agents. Leadership such as this is also about handling “chaos,” viewing and giving orders, and adding structure to that “chaos.” The handling of simultaneous emergencies with oversight of a very busy resuscitation room, simplifying an overwhelming, complex (clinical) situation into systematic, manageable steps, and many more tasks, make up each day for an EP. Nothing tests the leadership capabilities more than a crisis situation where orders must be established, needs assessed, resources allocated effectively, and emotions managed.\[1,7,9\]

In many settings, the purview of EM may even extend beyond the ED itself. It may involve the prehospital setting, continuity of care downstream after the ED phase of management, and liaising with interdisciplinary teams and caregivers. There is also involvement in injury prevention, different types of advocacy, teaching, research, and knowledge translation.\[2,7,8\]

It is also increasingly common to see EPs being involved in institution or hospitals’ leadership and governance roles, which might be a reflection of their visibility as an integral and respected member of the medical community and institution. One of the many reasons for this could also be that EPs are extremely familiar with the critical and time-sensitive issues facing health care, hospital personnel, and the hospital itself. Another reason could be because EPs work at the frontline in receiving and treating patients which often enable them to work in partnership and collaboration with other specialties and disciplines. Thus, they are familiar with administrative issues, challenges, the “positive” practices, and the “need improvement” areas, from a bigger and wider perspective. After all, leadership in a complex organization is often distributed and collective rather than individualized.\[4,9\]

In fact, in many places, these days, it is becoming more frequent that both the medical and lay communities are looking toward EPs for answers to issues such as disaster management, trauma, bioterrorism, and medical urgencies, when these were formerly being directed to other specialists.

**Leadership: The Training, The Experience, and The Exposure**

The ED is a unique environment, whereby the trained can flourish and the novice can develop their capabilities. As clinical proficiency is foundational in the development of an EP, administrative and management leadership skills development may at times be downplayed or be a blind spot, in terms of adequate and deeper training. Some of the assumptions that are often made in this context include:

a. That leadership skills will “automatically” be present as an EP gets more senior
b. Leadership skills will develop over time in EPs and the longer they work in the ED, the more leadership skills they will have
c. Leadership is a hidden curriculum. It is assumed that there is really no need for dedicated time to train and EPs may tend to just assume the role, when called upon
d. Faculty, who may not be consciously looking out for younger leaders among EPs, may themselves not be aware of the traits they should be looking out for in the more junior colleagues.

Thus, there needs to be a deliberate focus.
A recent meta-analysis of leadership interventions across all health-care settings and disciplines showed that participation in leadership training programs accounted for a third of the variance outcomes. It was concluded that leadership training is important for leaders’ performance and overall team effectiveness. Another systematic review by Frich et al. noted the lack of programs that integrate new physicians and physician–professionals, limited use of more interactive learning and feedback to develop greater self-awareness, and a narrow focus on individual level rather than systems’ level outcomes.

No single learning strategy is sufficient to ace EM leadership training. Experiential learning is valuable in enabling leaders to develop their skills, coupled with the guidance in a supportive environment. There is a variety of complex, unpredictable stressors, which can pop up at any time of the day or night, singly or in groups. Chaos and complexity are words commonly used to describe the environment. EM leaders and managers must be able to handle, negotiate, and provide oversight. This is also where EPs and ED leadership can learn from other industries which have multifaceted, high-load workflow, which needs to be integrated seamlessly. In such environments, it requires a more discerning pair of eyes to understand and see how to take the department or organization from “here” to “there” and how to effect change in a robust fashion. This is where the ED provides the experiential breadth and depth of leadership development.

Physicians in general, including EPs, are trained in the diagnostics, therapeutic, and administrative aspects of patient care but not so much in the theoretical and practical aspects of assuming and delivery of leadership. EPs are always taught to focus on their performance, to excel and achieve, to be accountable for their own clinical decisions, and to appreciate feedback and peer-to-peer review. If there are some semblances of formal or semi-formal leadership instruction, the organized theoretical curriculum often does not formally include very structured and planned departmental leadership and management elements. Medicine, in general, does tend to underinvest in formal administrative leadership and management training.

Leadership behavior that directly helps the leader and his team accomplish results include also coordinating action, monitoring, and surveillance of the teams and staff, educating and empowering them accordingly as well as coaching and evaluating can be shared. Training in interpersonal skills and action processes such as communications and conflict management are also important.

Leaders must learn to shift away from just being the “individual expert” to a model that leverages cross-disciplinary and interprofessional groups, whereby they will be able to integrate knowledge, anticipate, and solve unprecedented challenges together, and at the same time, deliver efficient, high-quality, and compassionate care. Leadership in EM and in the ED requires stepping back and examining problems at a higher level, thus requiring the ability to view issues broadly and systemically. This kind of leadership demands understanding and recognition of the actual needs and the resources available for utilization. Another unique feature is the need to be able to analyze complex situations in a timely fashion and make informed decision expeditiously, while at the same time, each EP needs to be able to do the introspection, self-assessment, and reflection, as well as, onward adaptation and customization.

In the ED, EPs have to practice “adaptive unconsciousness,” i.e. the ability to quickly and systematically process a lot of data and information that we need to keep functional. This decision-making apparatus is highly capable of making a judgment based on very little initial information. This power of knowing in the first 5 s or a very short span of time is something EPs have to cultivate.

They are also taught to focus on performance and measurement, teamwork, high degree of accountability, and even peer-to-peer review and feedback.

EM leadership training is a journey and a long-term process. Usually training can be incorporated at a more senior level, and these days, it is also becoming a requirement in many administrative tracks in EM residency training. These programs should incorporate gradual experiential acquisition of skills and capabilities, on the job training as well as some classroom didactic sessions. In the paper by Goldman et al., EM residents identified nine leadership skills for ED practice: prioritizing, organizing, managing, multitasking, communicating, decision-making, being adaptable, being assertive, and having emotional resilience. EM residents felt that the “hardest thing they had to learn” was leadership in the ED because it was “not really explicitly taught at any one point, and it is an environment where you are suddenly entrusted into the position whereby you are managing people.” There were also comments that learning leadership was often by trial and error, through eliciting feedback from nurses, and dialog with friends and colleagues and through “reflection on action” by self or with their attending and senior nurses.

Therefore, a roadmap or framework for nurturing and developing leaders and utilizing the appropriate, relevant tools and platforms are critical. There will then be greater opportunities to turn EPs into ED and hospital leaders.

**Emergency Medicine Leadership Framework: Suggested Curriculum**

A comprehensive and coherent leadership training program curriculum may take into account certain broad principles such as those in Table 1. Once the proposal is customized, its relevance will have to be assessed and mapped to institution standards. The embedding process which is highly relevant for experiential learning is the next stage. In some institution, the curriculum is fitted into an existing framework such as the EM residency training. Whatever the process, it is important to
realize the curriculum has to be dynamic, with some degrees of flexibility.

Leadership training programs are as good as their practical applications. One of the misperceptions that can hurt leaders and leadership is the notion that they only need to learn a set of 10–12 skills and these would enable them to work through any situation. However, health-care leadership is about a variety of skills and styles that need to be accommodated with a broad mindset and perspective. The best staff or employee may not necessarily be the best leaders.[20–22]

Individual and team leadership training vary widely across EM training and residency programs. The EP must be trained to handle a high degree of stress and “chaos,” with a multitude of broad-spectrum issues and challenges which require a bird’s eye perspective. Many of these issues can be unpredictable and arise acutely, requiring level-headed management and oversight. The ED poses complicated and intricate issues and being prepared in handling them is crucial.[7,10–12,14] The training curriculum and framework must incorporate elements of experiential learning exposure that will help turn EPs into ED leaders. Besides the hardcore technical EM topics and systems topics, the other important topics that should be covered are cognitive and social psychology as well as the human elements of communications, interaction, mentoring, collaboration, and networking.

EM leadership training should strive to make EP more conscious and be able to step up their ability to regulate behavior. It is necessary for them to understand that it is not enough to just have the best ideas, but it is also about the practical applications. They must appreciate the early difficulties and challenges of trying and testing something new. After all, transformation is never easy nor straightforward and can be complex and multifaceted. Thus, the ability to manage mindsets and be able to reframe initial resistance as a potential positive force of support is critical.[22] Even the effective execution of ED leadership is more complex than the routine patient–doctor relationship. More so in an environment where emergencies and uncertainties are happening every minute and these require assessment and level-headed handling.

Leadership in the ED also involves stepping back and examining problems at a higher level; thus, the need to be able to view issues broadly and systemically. Critical self-assessment and reflection must be developed as an integral portion of professional life and are highly pertinent to developing leaders and maximizing their potential.

There must be recognition of needs, organized learning, and demonstration of leadership with an energized vision, which is directive and yet still participatory. The ED leadership, as in other models, also needs empowerment of others. Only then can high-performance teams sprout in EDs.

Research has shown that certain values are critical in a successful leader. In general, these include:[23–29] (Table 2).

Besides these examples, the ability to organize teams and staff, articulate their objectives clearly and in a practical way, decision-making through collective inputs, empowerment of others and even skills in conflict, and differences resolution are important. Specific leadership skills also include training in the use of authority and assertiveness, maintaining and improving standards, coordination, and continuity of processes.[23,26,27] The ED leaders should be able to maintain and strengthen team structures and communications. The person must be able to promote excellent teamwork and collaborative practice. Factors such as knowledge sharing and mutual respect are also what others will be looking out for in their leaders. Developing a relationship with people is the first step in developing trust, so they will willingly and positively invest in one’s leadership. This may even mean picking up the phone to call and clarify or just talk to any of the team members and staff, rather than just writing the monologue of an E-mail.

Of course, these can vary according to the context and situation encountered.

The methodologies of the ED leadership training can comprise of a variety of ways and techniques, which can add variety and make the approach very interesting. Embedment and experiential exposure are critical in this aspect.

Table 3 shares a sample of the possible training methods that can be considered.

Besides the above, the ability to self-reflect is also something which is encouraged and highly useful. ED leadership needs to be present and to show presence. This is an important part of staff and people engagement as well. They must ensure that the voice of their staff and patients is heard and expressed. The concerns and experience, needs as well as feedback must be handled with fairness and compassion, empathy, and respect.

### Table 1: Curriculum proposal

| Integration of different theories and concepts of leaders and leadership |
| Linkage of concepts to experiences |
| Coursework and learning activities |
| Frame around the principles of adult learning, which links the theory and practical meaningfully |
| Incorporation of evidence and research-based standards |

### Table 2: Examples of characteristics of a successful leader

| Excellent core subject knowledge |
| Passion |
| Decisiveness |
| Conviction |
| Integrity |
| Adaptability |
| Emotional toughness |
| Emotional resonance |
| Self-knowledge |
| Humility |
| Lifelong learner |
These leaders hold the key to setting the departmental culture and strategic directions, for example, just culture, open culture, transparency, and open communications can all be set by themselves by being practitioners of these themselves and showcasing their importance.

Table 4 below summarizes a very basic outline of the job scope of an ED leader. This is not exhaustive and the repertoire can be so much wider and broader, depending on the person in the leadership role, the approach, and principles he/she pushes for or focuses on for the department.[4,6,9,16,18]

ED leadership can lead one to become involved in a higher level of leadership such as hospital and institution leadership. Here, the individual must be familiar with the organization structure, governance, and regulations. ED leaders can take on hospital leadership roles in whatever capacity is available, to start making a greater impact. Examples may include hospital patient safety committee, information technology adoption committee, infection control committee, and others. Networking within the hospital committees, management, and leadership can assist the EP to build relationship, understanding, and collaboration. Once the position of the EP in these committees and groups become established and strong, they are able to influence, showcase, and project the appropriate voice for EM in the institution, the community, and even the nation.[19,24]

**Leadership in Crisis**

The leadership of EDs must preferably be those who are familiar and able to handle critical and crisis situations. Thus, the concept of Leadership in Crisis or also known as meta-leadership is a useful one to understand. This model originated from the Harvard School of Public health and The Kennedy School of Government. It stresses on the importance to view leadership and its training from five dimensions:[30]

1. The person: Leaders, in general and especially those facing and handling crises, need to have a high degree of emotional intelligence, self-awareness, and self-regulation
2. The situation: Crises are usually large scale, very complex situations and require an organized and structured way to be managed and to sort out the solutions
3. “Leading your silo.” Good leaders are able to gain respect and take command and lead their staff and department. They have the respect of everyone and can inspire their people to excellence
4. “Leading Up”: Leaders, can at the appropriate time, also lead their bosses and superiors.
5. “Leading across”: ED leaders especially should be able to connect with teams from other disciplines and departments. This also has something to do with the work that is done in the ED, where patients who present cuts across all disciplines of medicine and surgery.

These five elements and comments come from extensive research and observations of leaders in many settings, encountering many high stakes and high-stress situations. It is also the core of the work done by the National Preparedness Leadership Institute.[30]

**Leadership Models**

There are many definitions of leadership. No single description can fully encompass the concept. The ED leader will usually have to utilize a variety of leadership styles during the course of his work. Certain types of leadership model or behavior are more suited for certain situations. In the ED, these situations can be many and varied. This is something that it is known as the situational view of leadership or the contingency theory of leadership.[9,17,21,25,26,31]

Some examples of the leadership models commonly used either singly or in combination in the ED include:

**Directive leadership**

Directive leadership is a rather instructional, managerial style of leadership. This is suitable for leaders who are supervising more junior staff, new recruits, and perhaps also nonclinical type personnel in the ED, whereby they require more directions and oversight in performing certain expected tasks.

**Participative leadership**

This involves the leader working together and side by side with the staff and colleagues, whether in goal setting, problem-solving, or day-to-day running and operations. The final decision often is still left to the leader to make and execute.

**Empowering leadership**

This is practiced by leaders who believe in engaging and empowering staff and giving them the opportunity to

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**Table 3: Different training methods**

| Method                                      |
|---------------------------------------------|
| Didactic teaching                           |
| Interactive teaching                        |
| Immersive and embedded learning            |
| Mentoring                                   |
| Partnership formation to impart knowledge and experience |
| Hands-on projects and trials                |
| Observations                                |
| Case-based learning and discussions        |
| Sharing platforms                           |

**Table 4: Capabilities recommended for leaders in healthcare**

| Capabilities                                                                 |
|------------------------------------------------------------------------------|
| Oversight and overview, maintaining mission, vision, and strategic direction forward. At the same time have build-in capacity for handling innovation, complexities, and change management |
| Collaboration and partnership formation. This involves spanning borders and influencing systemically |
| Recruitment, retention, and transformation of talent in the department |
| Employee engagement, welfare, and wellbeing, including awareness of work-life balance |
| Ensuring educational environment that supports learning agility and state of the art training |
| Resource stewardship with integrity, transparency, and accountability |
| Ensuring business strategy alignment with compassionate care |
contribute, to perform, to innovate, or to create. There are benefits in this style as it can unleash latent talents, and in this way, the grooming of the new generation leaders can also take place. Leaders practicing this style of leadership usually would want to see the staff be nurtured and grow and develop their skills and capabilities.

**Distributed leadership**
This helps spread and distribute decision-making throughout the team. For example, the Chairman of the department may empower others to lead subcommittees and subgroups to make a decision pertaining to certain challenges or issues. It is about allowing small teams or individuals to also make the decision on how to accomplish certain objectives. All the individuals and team members must also have a shared purpose.

**Diplomatic leadership**
This style involves usually people or teams of relatively the same caliber and capabilities and it involves negotiation, solving challenges, and conflicts but at the same time being conscious that the relationship needs to be maintained and preserved. It also involved dealing with resilience and trust of the leader/s.

Shared leadership is more dynamic and interactive, influencing processes among individuals, groups, and teams, where the objective is to lead and challenge each other to achieve common group goals.

There are many factors which determine which type of leadership style is the most effectiveness, and when to draw on a different or a combination of leadership models. There are also other leadership models in action. Thus, an experienced ED leader will be able to use these models in various combination and permutation to handle, negotiate through, and plan strategic directions and action for certain tasks, initiatives, and proposals.

**The Final Word….**
Not everyone may feel they are leaders in the true sense, but everyone in the ED can contribute to the leadership process by demonstrating positive personal capabilities, working with other members of the team, and managing resources prudently. The action on every individual’s part can improve and enhance service and help set the direction forward for the ED. Team leadership and performance skills are important and have a direct impact on patient safety.

High performing health-care system requires high-performance leaders and staff who are engaged, with a high level of ownership. Their focus is clear, their communications are focused and open, and the collaboration is proactive. Compassion and empathy are evident, and the leaders’ decisions are characteristically strategic and spot on. High-performance health-care organizations are systems of interacting, inter-related, and inter-linked as well as interdependent clinical microsystems. Considering the development, evolution, direction forwards, and also challenges in EM, the leadership training for its future leaders cannot be left to chance. It needs to be based on evidence, robust theory, and lots of experiential learning. These leaders will be taking EM and EDs into the future to deliver high quality, patient-centric, and compassionate care and at the same time continue to attract the best to be nurtured as EPs of the future.

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