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A Novel Trauma Leadership Model Reflective of Changing Times

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ABSTRACT

As a result of generational changes in the health care workforce, we sought to evaluate our current Trauma Medical Director Leadership model. We assessed the responsibilities, accountability, time requirements, cost, and provider satisfaction with the current leadership model. Three new providers who had recently completed fellowship training were hired, each with unique professional desires, skill sets, and experience. Our goal was to establish a comprehensive, cost-effective, accountable leadership model that enabled provider satisfaction and equalized leadership responsibilities. A 3-pronged team model was established with a Medical Director title and responsibilities rotating per the American College of Surgeons verification cycle to develop leadership skills and lessen hierarchical differences.

Key Words

Generational changes, Leadership, Organizational models, Trauma centers

We live in everchanging times in the health care industry and currently have 4 distinct generations in the workforce. Like society itself, medical practice has been evolving rapidly in the United States over the past 50 years in response to technologic, economic, and political influences that have been accelerated by the passage of the Patient Protection and Affordable Care Act. As a result of the imperative to care for more patients and provide higher perceived quality at less cost, with increased reporting and tracking demands, in an environment of high liability and contracting reimbursement, the independent, private physician practice model will be largely replaced.[1] Many physicians have been compelled to join other practitioners, become hospital employees, or align with large hospitals and health systems for capital, administrative and technical resources.[2]

Our health system is fully integrated, composed of 3 hospitals and 19 regional clinics within 19 counties in 3 states and employs 447 physician full-time equivalents. Our system is poised for the changes in health care and our providers are supported with the resources required to focus on the provision of excellent outcomes, patient satisfaction, and a work-life balance. As a large organization with more than 7000 employees, all 4 generational groups are represented in our workforce. Each generation has unique personal and professional values and management styles, based on social, economic, and famillial influences of their youth (Table 1).[3,4] The dates defining members of a generation are approximate, and there are many people who fall between 2 generations and are able to identify with both. These "cuspers" are probably the most valuable members of the workforce as they are able to bridge the divide between 2 generations and work well with both those younger and older than themselves.[3]

Our integrated health care system sought to evaluate our current Trauma Medical Director Leadership model to meet the challenges of generational changes in the workforce. In early 2011, the trauma medical director at our rural Level II American College of Surgeons (ACS)–verified tertiary trauma center left the position for a new out-of-state opportunity. This prompted us to evaluate our optimal trauma leadership structure. We assessed the responsibilities, accountability, time requirements, financial cost, and provider satisfaction with the current leadership model.

With the unique situation of rebuilding our trauma program leadership and having several of our senior providers near retirement, we hired 3 new surgeons, 1 on the cusp of generation X and 2 Millennials.[3,4] Each of the 3 providers possesses unique professional desires, skill sets, and experience, and all had recently completed fellowship training. Our goal was to establish a comprehensive, cost-effective, accountable leadership model that enabled provider satisfaction and equalized leadership responsibilities in a team environment based on matching skill sets and individual professional goals. A 3-pronged team model was developed with the Medical Director title and associated responsibilities rotating per ACS verification cycle to develop leadership skills for all 3 providers and lessen hierarchical differences of the team.

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TABLE 1 Generational Labels and Characteristics

Label and Year	Childhood Influences	Events and Leaders	Defining Traits, Management Style
Traditionalist Veterans 1900-1942	Patriotism, intact families	Great depression, WWII and Korean war Roosevelt, Patton	Loyalty, military chain of command, sacrifice for family/country, delayed gratification, respect for law and order
Baby Boomer 1943-1960	Prosperity, TV, computer	Civil rights, Space Race Vietnam and Cold War, Martin Luther King, Gandhi	Optimism, change of command, reject authority, individualism, competitive, consumer, and work placed ahead of family
Generation X 1961-1980	Divorce and single parents, latchkey children, MTV, VCR, ATM, cell phones, cable TV	AIDS, Gulf War, Exxon Valdez, fall of institutions and political scandals, limited heroes	Skepticism, self-command, independent, questioning, cynical, seek a life balance
Millennial/Generation Y 1981-1999	Doting parents, racial and ethnic diversity, mass media, technology boom, iPod, smartphones	Columbine shooting, 9/11, Princess Diana, celebrities, athletes	Realism, collaborative, work in teams, need structure, technology savvy, believe they are special

METHODS/IMPLEMENTATION

We believed that our previous traditional, hierarchal model of trauma leadership consisting of a single fellowship-trained trauma surgeon was difficult to replicate because of the increased requirements for maintenance of an ACS-verified trauma center and greater clinical responsibilities. Furthermore, with a single provider in this role, loss of the Trauma Medical Director can make it difficult to maintain all components of a system in place until a suitable replacement is found.

The talented new trauma surgeons employed at our institution represent the end cusp of generation X and the millennial generation. Members of these generations are very comfortable with technology and are accustomed to constant interactions via telephone, text messaging, and e-mail, and multitasking is second nature. This generation seeks a balance of work and life. Baby Boomers are described as the generation that lives to work, while Millennials work to live.[4]

The greatest implications of these generations to the development of the Trauma Medical Director Leadership model are the team approach. Overall, Millennials prefer to work cooperatively on projects in the absence of hierarchy.[4] Millennials are accustomed to having clearly set goals, achieving those goals, and subsequently receiving rewards as a result. In addition, they have grown up in the age of convenient and instantly available information. The combination has led to a need for clear objectives to be stated, in association with immediate feedback.[5,6]

Having an integrated health care system with provider employees and 3 new trauma surgeons, 1 a "cusper" of generation X and 2 of the Millennial generation to develop our program and leadership model, a team leadership model was chosen with support from the interim Trauma Medical Director, Department of Surgery Chair, and administration. Our goal was to establish a comprehensive, cost-effective, accountable leadership model that enabled provider satisfaction and equalized leadership responsibilities in a team environment based on individual skill sets and professional goals. The delineation of the job descriptions provides accountability to the organization and assures expectations of the providers (Appendices A-D). A 3-pronged team model was developed with each trauma surgeon assigned to 1 of 3 permanent roles and the title and associated responsibilities of the Trauma Medical Director rotating per ACS verification cycle to develop

TABLE 2 Trauma Leadership Model

Trauma Medical Director (0.1 FTE) Alternates with ACS verification cycle and added to one of the roles delineated below		
Trauma research and education director	Trauma critical care director	Trauma performance improvement director
0.2 FTE	0.2 FTE	0.2 FTE

Abbreviations: ACS, American College of Surgeons; FTE, full-time equivalent.

leadership skills for all 3 providers while lessening the hierarchical differences between them (Table 2).

CONCLUSIONS

This leadership model provides clear delineation of the Trauma Medical Director roles. It provides the organization with clear objectives for the job requirements for an ACS-verified trauma center and enables accountability to the organization. It delineates the specific responsibilities for each of the providers, which is sought by this generation. Furthermore, division of the Trauma Medical Director role into 3 individual roles assigns responsibility to allow adequate time to complete requirements effectively, fosters development of leadership opportunities for all team providers in areas of skill, education, and desired professional growth, and decreases the hierarchical nature of the previous model. It is designed to increase provider satisfaction as it enhances work-life balance for all 3 providers. The associated full-time equivalent provides appropriate allocation of compensation that is attractive to this generation as it provides a mechanism for fiscal compensation for the separate responsibilities. This model also allows modular replacement of one component of roles rather than wholesale loss of all trauma leadership if providers seek other employment opportunities.

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Appendix A

Trauma Medical Director

The Trauma Medical Director supports the mission of Gundersen Lutheran Medical Center by maintaining the dignity of the patient, enhancing the quality of human life, and providing our patients with the best medical care possible. Responsible for the overall medical management and organization of the Trauma Program at Gundersen Lutheran Medical Center at all patient care levels.

1. Primary responsibilities:
    a. Ensure quality patient care.
    b. Has the authority to remove an attending trauma surgeon from clinical responsibilities based upon performance.
    c. In conjunction with the Department of Surgery, responsible for approving the trauma surgeons who will take call.
    d. Assures that requirements are met for Residency Review Committee.
    e. Recommends and approves protocols/policies/standards governing the clinical care of the trauma patient.

II. In collaboration with the program director
    a. Monitor system trend to assure compliance with American College of Surgeons standards for trauma verification.
    b. Trauma system development and implementation through trauma operational committee.
    c. Preparation of patient cases for review at monthly trauma conferences.
    d. Evaluates participation, contributions, and performance of attending trauma surgeons.
    e. Ensures and documents dissemination of information and findings from the peer review meetings to the noncore surgeons on trauma call panel.
    f. Oversees daily operations of the trauma service.
    g. Responsible for professional and clinical evaluation of the trauma mid-level providers.
    h. Develops the monthly and holiday trauma call schedules.
    i. Takes trauma call in scheduled rotation.

III. Committees
    a. Attends Trauma Operational Committee.
    b. Attends Trauma PIPR Committee.
    c. Attends Surgical and Trauma Morbidity and Mortality conference.
    d. Attends Surgery Committee.
    e. Attends Trauma Care Path meeting.

Appendix B

Trauma Performance Improvement Director

Performance Improvement Director supports the mission of Gundersen Lutheran Medical Center by maintaining the dignity of the patients, enhancing the quality of human life, and providing our patients with the best medical care possible. Responsible for the overall trauma performance improvement process, associated education, and regional and state trauma system development to ensure the best quality outcomes for the trauma patients of Gundersen Lutheran Medical Center and the region.

I. Primary responsibilities
    a. Ensure quality patient care.
    b. Takes trauma call in scheduled rotation.
    c. Recommends and approves protocols/policies/standards governing the clinical care of the trauma patient.

II. In conjunction with administrative staff
    a. Collaborates in the preparation of patient cases for monthly trauma conferences.
    b. Communicates performance improvement issues and recommendations of the Trauma PIPR Committee with Referring institutions and facilities.
    c. Maintains American College of Surgeons Standards.
    d. NTRACs and TQIP Medical leadership.
    e. Participates in regional and state trauma system involvement.

III. Committees
    a. Chair of Trauma PIPR Committee.
    b. Attends Surgical and Trauma Morbidity and Mortality conference.

Appendix C

Trauma Critical Care Medical Director

The Trauma Critical Care Medical Director supports the mission of Gundersen Lutheran Medical Center by maintaining the dignity of the patients, enhancing the quality of human life, and providing our patients with the best medical care possible. In collaboration with the Trauma Medical Director is responsible for organizing and planning the systematic delivery of care to trauma patients and ensuring continual evaluation of the quality of care delivered to the critically injured trauma patients at all patient care levels.

I. Primary responsibilities:
    a. Ensures quality patient care.
    b. Works in a collaborative fashion with the other specialists involved in the delivery of critical care to develop protocols for patient management as well as to devise the most effective system for surgical critical care.
    c. Participates in critical care unit operational and strategic planning decisions.
    d. Supervises trauma bed utilization in the critical care unit and recommends trauma patient triage decisions.
    e. Recommends protocols/policies/standards governing the clinical care of the trauma critical care program.
    f. Responsible for the didactic education in surgical critical care for surgery and oral surgery residents.
    g. Establishes and carries out continuing education activities for critical care unit staff.
    h. Participates in evaluation and review of equipment and makes recommendations.
    i. Takes trauma call in scheduled rotation.

II. In conjunction with administrative staff
    a. Conducts quality assurance activities to ensure quality of care of the trauma patient in critical unit.
    b. Collaborates in the preparation of patient cases for monthly trauma conferences.
    c. Maintains ACS Standards.

III. Committees
    a. Attends Trauma PIPR Committee.
    b. Attends Surgical and Trauma Morbidity and Mortality conference.
    c. Attends Critical Care Joint Practice Committee.
    d. Attends Massive Transfusion Committee.

Appendix D

Trauma Research and Education Director

The Trauma Research and Education Medical Director supports the mission of Gundersen Lutheran Medical Center by maintaining the dignity of the patients, enhancing the quality of human life, and providing our patients with the best medical care possible. In collaboration with the Trauma Medical Director is responsible for organizing and planning the systematic delivery of care to trauma patients and ensuring continual evaluation of the quality of care delivered to the critically injured trauma patients at all patient care levels.

I. Primary responsibilities
   a. Ensure quality patient care.
   b. Takes trauma call in scheduled rotation.

II. Education
   a. Coordinates with the surgery residency program director and coordinator to develop annual trauma lecture series and simulation laboratory experience.
   b. Coordinates and administrates the ATLS/ATCN Provider, ATLS Renewal Courses, and the RTTDC regional courses in collaboration with trauma medical director and administrative staff.
   c. Participates in annual Wisconsin state ATLS instructor course.
   d. Provides trauma education to Gundersen and regional providers through lectures and participation in regional conferences.

III. In conjunction with administrative staff
   a. Collaborates in the preparation of patient cases for monthly trauma conferences.
   b. Maintains ACS Standards.

IV. Research
   a. Directs Trauma Research Program.

V. Committees
   a. Attends trauma PIPR committee.
   b. Attends surgical and trauma morbidity and mortality conference.