Trauma – Leading, Following, Getting It Right!

Jason W. Lang MD,
Anesthesiology Resident, PGY-2
Department of Anesthesia and
Perioperative Care
University of California, San Francisco

Benn Lancman MBBS MHumFac
FANZCA
Visiting Clinical Instructor
Department of Anesthesia and Perioperative Care
University of California, San Francisco

Date for publication: April 14, 2016

Paramount to providing safe and efficient care for patients is effective communication. Communication is important regardless of the context; however, its importance is magnified in critical situations such as during trauma activations and arrests whether respiratory or cardiac. In fact, communication has been deemed so important that ACLS and ATLS guidelines recommend techniques such as closed-loop communication to improve outcomes. Nonetheless, communication is often suboptimal despite being such an important component to providing the best care for patients. One study found that communication during trauma activations was inaudible approximately 50% of the time, and was not understandable greater than 50% of the time.[1] Trauma bays are often chaotic. Because the interplay between multiple clinicians and ancillary staff occurs in such a highly dynamic environment, it is understandable that communication will be suboptimal without specific attention and training. Poor communication can lead to adverse consequences for patients.[2] While keeping in mind the ultimate goal of providing the safest and highest quality care for patients, it is important to understand that effective communication becomes every team member's obligation – effective communication is not solely the obligation of the team leader. Communication is also important for the anesthesiologist's role in a resuscitation team - both as a leader and as a follower.

Followership is a rarely discussed skill in the healthcare space. The role of a good follower is not that of a blind autonomous sheep, but rather that of a skilled and competent colleague who helps to support a leader make correct clinical decisions. A good follower conveys the most pertinent and accurate information in a timely fashion. They are also acutely aware of their personal skills and limitations. This allows followers to assist the leader in appropriate resource allocation to essential tasks. As anesthesiologists we are rarely in a position to take a 30,000 foot view of the situation in an acute major trauma. Our clinical expertise is needed elsewhere. Anesthesiologists are performing essential life saving interventions such as airway management or vascular access. We are best positioned to support the leader in making assessments about the most appropriate time to intubate a patient, obtaining sufficient vascular access, and the management of hemodynamic instability. Having a good follower in the team means the leader is able to focus on broader questions of disposition and diagnosis, rather than micromanaging complex physical tasks.

Great followers have many other qualities including judgment, work ethic, competence, honesty, courage, discretion, loyalty, and ego management.[3] Putting "followership" into context for an anesthesiologist on a resuscitation team could be as follows: use your clinical judgment to help the leader (e.g., is patient stable for imaging prior to going to OR?); work hard for the benefit of the team and team efficiency. However, for the benefit of the patient; the anesthesiologist needs to check their ego at the door and remain loyal to the patient and the team; be honest about competence with assigned tasks from the leader (e.g., do you feel comfortable with obtaining a certain type of vascular access, or do you need help?);

have the courage to challenge the leader based on your clinical judgment, but use discretion (i.e., don't disparage the leader in the process). Having the courage to challenge the leader is sometimes the most important role of a good follower. Such a challenge can be a daunting barrier created by hierarchy within the medical system. It is important to be aware of different strategies to enhance communication in order to combat these challenges.

One method is graded assertiveness which provides a guide of how to express concern in an escalating fashion, yet in a respectful, discretionary manner. Graded assertiveness is based on four levels of inquiry using the acronym PACE: Probe, Alert, Challenge, Emergency Action. A probe assumes that the leader has not noticed an abnormality, and is a non-confrontational way to begin dialogue about the issue (e.g., "What are your blood pressure targets in trauma?"). The next step is an alert, which assumes the Leader has either not noticed the abnormality or is dealing with other pressing issues. An alert draws direct attention to the abnormality and includes an offer to help solve the issue (e.g., "Did you notice that the blood pressure is very low? Would you like me to give some fluid?"). Continuing to the next grade is a challenge. A challenge assumes that the leader has a good reason for the perceived abnormal behavior, and thus requires an explanation for the deviation from what is deemed normal (e.g., "Is there a reason you're happy with such a low blood pressure?"). The most assertive step is the last step, which involves taking emergency action after prior attempts to address concerns did not work and the patient continues to be at immediate risk (e.g., "The blood pressure is dangerously low and I am going to treat it now.") The graded assertiveness technique can be used by any team member, and is useful whether or not the person raising the concern is correct in assuming there is an abnormality to begin with. When put into practice, graded assertiveness not only results in an explanation to the person raising the concern, but it also informs the leader of possibly unrecognized issues, thereby enhancing situational awareness of all team members.

In conclusion, our current teaching around leadership needs to evolve to incorporate a more robust understanding of "followership". We need to leave the days of leaders as micromanagers behind us. Leaders do not have all the answers, nor should they. The job (and teaching) of leaders should be focused on addressing issues such as optimal team performance, resource allocation (e.g., Crisis Resource Management), and the synthesis of information. For those of us working in teaching institutions, we can provide some guidance to the next generation of clinicians by modeling these behaviors. By developing these skills, we can take great strides towards improving the functionality of our teams in the complex and challenging environment of major trauma.

References

1. Bergs EA, Rutten FL, Tadros T, Krijnen P, Schipper IB. Communication during trauma resuscitation: do we know what is happening? Injury. 2005 Aug;36(8):905-11.
2. Williams RG, Silverman R, Schwind C, et al. Surgeon Information Transfer and Communication: Factors Affecting Quality and Efficiency of Inpatient Care. Annals of Surgery. 2007;245(2):159-169.
3. McCallum JS. Followership: The Other Side of Leadership. Ivey Business Journal. September / October 2013.