PREPARING FOR THE UNTHINKABLE

EMS and fire develop guidelines for responding to active shooter scenarios.

By Jenifer Goodwin

In 2008, shortly after the Virginia Tech shootings, the Arlington County (Va.) Fire Department participated in an active shooter drill with local law enforcement. In a simulation at Marymount University, police followed the trail of dead and dying in the hunt for the shooter, who had barricaded himself inside the library.

Meanwhile, paramedics and EMTs staged in a parking lot more than 100 yards away and waited. “After about 30 minutes, police had the ‘bad guy’ and had marked the IEDs and brought out one or two injured people,” recalls E. Reed Smith, M.D., Arlington County Fire Department’s operational medical director. “Two hours later, we were still staged, and most of the injured were still inside. We could see injured people, but we couldn’t go in and get them. Myself and the special operations chief said, ‘This is ridiculous. We can’t just stand around. Why are we not moving in? The threat has been mitigated.’”

Wanting to be able to do more in real-life situations, Arlington County fire and police soon began to work together to develop a plan for responding to active shooter events that would give firefighters access to victims more quickly. Under the plan, rather than wait for police to declare a scene 100% safe, EMTs and paramedics wearing bullet-resistant vests and helmets would enter the building under police escort as soon as police determined there was no obvious threat, such as if the shooter had moved to another area of the building. Calling it Tactical Emergency Casualty Care (TECC), Smith and his team adapted their plan from the U.S. military’s strategy for taking care of the combat wounded, in which responders are trained to quickly assess the wounded, dealing on scene only with specific types of life-threatening yet treatable injuries.

“This is paradigm shifting,” Smith says. “We accept a lot of risk in the fire service when you go into a burning building or respond to a hazmat call. You mitigate those risks with proper personal protective equipment, the right tactics and the right SOPs. Why can’t we

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The laughter was spontaneous, and maybe a little nervous, as our staff sat around the conference table, reading descriptions of themselves and the people they work with. “That is so true—I am a complete freak about planning things out ahead,” one of our staffers said. “And you’re the opposite,” she noted, speaking to a colleague after reviewing his description. “No wonder you drive me crazy.” Then she had a flash of insight. “And you probably think I don’t have a spontaneous bone in my body!”

The occasion was a company-wide review of what it means to be a highly functioning team, starting with understanding how each of us is hard-wired to see the world in a certain way. If you’ve been around long enough, you’ve likely had a personality index assigned to you at some point in your career. In our case, we were using the Myers-Briggs Type Indicator (MBTI). The last time I’d done this was with a different company 20 years ago and it had the same impact—it’s as if people were seeing themselves, and their colleagues, for the first time.

We had some fun with the descriptions, but our facilitator drove home serious points: Our preferences for how we take in information, where we get our energy, how we make decisions and our lifestyle result in 16 different personality types in the MBTI lexicon. However, that doesn’t mean we’re locked into certain behaviors. Yes, our personality type dictates what is natural for us, our fallback position, but it doesn’t predetermine every action. As an INJ (MBTI speak), I am an introvert and I recharge my batteries by being by myself, but I’ve learned to be comfortable speaking in front of groups and being “on”—extroverted—when the job demands it. Understanding each other’s preferences helps build strong teams in a few ways. It fosters openness and trust. It provides a neutral way to discuss different approaches (there’s not one “right” way, there is only your way). It underscores the importance of diversity in terms of making better decisions, and it allows for alignment of strengths with team tasks.

Back to openness and trust. In his great book The Five Dysfunctions of a Team, Pat Lencioni holds out trust as the foundation that makes or breaks a team. By trust, he means not just trusting that someone will do what he says he’ll do, but having a willingness to be vulnerable—to admit you’ve made a mistake or need help, and to be confident in the knowledge that others will be sympathetic and non-judgmental. You can trust the team to “have your back.”

According to Lencioni, there are five main ways in which members of a cohesive team behave:

- Trust one another.
- Engage in unfiltered conflict around ideas.
- Commit to decisions and plans of action.
- Hold one another accountable for delivering on those plans.
- Focus on achieving collective results.

How does your team measure up? [3]

WHERE’S YOUR TEAM SPIRIT?

By Keith Griffiths

RATES OF DEPRESSION, ANXIETY LOWER AMONG EMS THAN OTHER HEALTHCARE WORKERS

Researchers from North Carolina’s Mecklenburg EMS Agency and colleagues have found that rates of depression, anxiety and high levels of stress are lower among paramedics and EMTs than other healthcare workers, including nurses, physicians and med students.

The researchers analyzed the results of a questionnaire answered by more than 34,000 paramedics and EMTs renewing their national certification in 2009. About 6.8% of EMT workers reported symptoms of depression, 6% reported signs of anxiety and 5.9% reported high levels of stress. Paramedics and those with 16-24 years of experience were more likely to be depressed and stressed-out than other groups. EMT workers who rated their overall health as poor, who did little exercise and who smoked were also more likely to be stressed, anxious or depressed.

Meanwhile, married paramedics and EMTs were less likely to be depressed or anxious than the divorced, widowed or never married, and women were less likely to be depressed or anxious than the divorced, widowed or never married. Paramedics and EMTs who were 65 or older were more likely to rate their care as excellent. Other factors that affected patient ratings included teamwork among EMS staff and the availability of needed technology.

WOmen With Traumatic Injuries Less Likely To Receive Trauma Center Care

Women are less likely than men to receive care in a trauma center after severe injury, according to a recent study. Researchers in Canada analyzed records on 33,000 women and 66,000 men with an injury severity score of greater than 15, or who died of their injuries within 24 hours of hospital arrival. About 50% of women had received care at a trauma center, compared to 63% of men. Among patients 65 or older, 37.5% of women received trauma center care, compared with 50% of men.

After adjusting for clinical, demographic and socioeconomic variables, severely injured women were 23% less likely to be treated in a trauma center. Separate analyses of women with fall-related or motor vehicle-related injuries found that they were also less likely to receive trauma center care.

The study was presented at the American Thoracic Society International Conference in Philadelphia in May.

EDUCATING RESPONDERS ABOUT DEATH NOTIFICATION IMPROVES THEIR CONFIDENCE

Training EMS personnel how to deliver news of a death improves both their confidence and their ability to communicate effectively with the bereaved, research shows.

In a study from Indiana University School of Medicine, 30 paramedics participated in a 90-minute workshop that included a lecture and role-playing in simulated death notification scenarios. Responders were taught a structured death notification method known as GRIEV_ING:

G= Gather the family and ensure that all members are present.
R= Resources Call for support resources such as ministers, family and friends.
I= Identify yourself and the deceased patient by name.
E= Educate Briefly explain to the family the events that occurred.
V= Verify that the family member has died. Use clear language, such as “died” or “died.”
E = Extend support for the family member and others as appropriate.
I = Inquire Ask the family if they have questions; answer them.
G= Give them your card and contact information. Always return their calls.

After the workshop, participants said they felt more confident in their ability to discuss death with grieving families, while a post-workshop evaluation showed marked improvement in responders introducing themselves, making sure all family members were present when delivering the death notification and using clear language. The only area that didn’t show improvement was in providing organ donation information.

The study was published online June 27 in Prehospital Emergency Care.

PAIN MANAGEMENT BOOSTS PATIENT SATISFACTION... WITH A CAVEAT

Also reported in the July-September issue of Prehospital Emergency Care, EMS patients whose pain was managed effectively were 2.7 times more likely to report the overall quality of care they received was excellent—but only if responders explained the medications being used and their side effects.

Researchers from Mecklenburg EMS Agency and colleagues did a retrospective review of more than 2,700 patient satisfaction surveys collected between 2007 and 2010. Of the patients who rated their pain management as excellent, 79% rated the overall quality of care as excellent, whereas only 21% of patients rated their overall quality of care as excellent if pain management was not excellent.

A closer analysis of the data found that neither controlling pain nor explaining medications was independently associated with a statistically significant higher rating for overall care. However, when patients felt their pain was controlled and that EMS or emedics explained the medications to them, they were more likely to rate their care as excellent. Other factors that affected patient ratings included teamwork among EMS staff and the availability of needed technology.
It’s been 25 years since the EMS world started talking about quality improvement as opposed to quality assurance. During that time we’ve been preaching the importance of focusing on systems rather than individuals, gathering data and using evidence. Almost every EMS system has something with the word quality in it: a quality plan, a peer review QI committee or a quality improvement manager. Yet when you ask most EMS leaders what their “quality whatever” has made better, shoulders shrug and the subject changes. Somewhere along our path we seem to have lost the importance of part quality improvement.

Around the same time EMS started talking about QI, Don Berwick, M.D., and some colleagues founded the Institute for Healthcare Improvement. They engaged a group of rock star statisticians from Associates in Process Improvement in Austin, Texas, and adopted their Model for Improvement as the vehicle for making healthcare better across America and the rest of the world. This simple yet powerful model holds the key to making things better.

HOW THE MODEL FOR IMPROVEMENT WORKS

The first step is to write an AIM statement. Thousands of costly EMS ideas would be derailed if leaders just stopped and asked their team, “What are we trying to accomplish?”

Take my own example. A couple of years ago, some members of my clinical team wanted to change all of our cervical collars to a fancy new brand whose name shall remain anonymous. They excitedly strapped one on me in the day room exclaiming, “See how much better this is!” When I asked them, “What are you trying to accomplish?” they said, “Better cervical immobilization.” That’s when I asked the second question in the model, “How will we know that a change is an improvement?”

I asked them if they could calculate the core temperature of the sun using a nail file, a broken mirror and an out-of-juice 9-volt battery. “What is the measure of inadequate spinal immobilization?” I asked. “What percentage of patients who were able to move their arms and legs before the care for them who are now paralyzed due to something that happened during care/transit?” They looked at me as if I’d just asked them to calculate the core temperature of the sun using a nail file, a broken mirror and an out-of-juice 9-volt battery.

The first one that comes to mind is the number of patients who are now paralyzed due to something that happened during our care for the past two years. There weren’t any. In fact, no one could remember that happening in the past 20 years. How many complaints have we had from emergency physicians or nurses about inadequate spinal immobilization? None. How about from patients? None.

Management guru Peter Drucker said, “You can’t manage what you don’t measure.” Dr. Edward Deming, the father of performance improvement methods, used to say, “In God we trust, all others must bring data.” If you’re not able to measure (quantitatively or qualitatively) what you’re trying to improve, it’s impossible to know if you’ve made something better.

Let’s put this model together with a real-world example from AMR’s Ventura County, Calif., operation.

Question 1: What are we trying to accomplish?

Answer: Measurably decrease suffering for the patients we serve.

Question 2: How will we know that a change is an improvement?

Answer: A higher percentage of our patient care reports will show a decrease in suffering.

It’s important to be specific about how, exactly, measurement will happen, so we will measure this by taking a random sample of 100 patient care reports each month and evaluating them for documentation of the nature and severity of suffering (pain, nausea, shortness of breath, anxiety, etc.).

An intervention of some kind designed to decrease the suffering (CPAP, morphine, Zoferan, etc.) and a post-intervention reassessment of the suffering. The numerator will be the number of patients in the monthly sample where the PCR demonstrates a reduction or elimination of suffering.

Question 3: What changes can we make that will result in improvement?

Answer: In case of suffering reduction, improvement ideas might include:

- Adding Ondansetron to the medications carried by crews to treat nausea
- Encouraging non-pharmacologic interventions for orthopedic pain like cold compresses, elevation and splinting
- Changing the morphine dosing protocol from 2–4 mg to a weight-based 0.1 mg/kg
- Expanding the use of CPAP beyond pulmonary edema to asthma, pulmonary infections, CO poisoning, etc.
- Provide myth-busting pain management education and encourage non-pharmacologic interventions for pain

The third question is where you brainstorm ideas for improvement. By Mike Taigman

The Model for Improvement

AIM
What are we trying to accomplish?

MEASURES
How will we know that a change is an improvement?

CHANGES
What changes can we make that will result in improvement?

Act
Study
Plan
Do

Adapted with permission from The Improvement Guide: A Practical Approach to Enhancing Organizational Performance, by Gerald J. Langley, Ronald D. Moen, Kevin M. Nolan, Thomas W. Reden, Clifford J. Lafferty and Lloyd P. Provost.
Q&A WITH BOO HEFFNER
President and CEO of Falck USA

A former longtime executive with Rural/Metro, Robert “Boo” Heffner made headlines in 2010 when he accused the company of cheating the city of San Diego out of revenues generated by San Diego Medical Services Enterprise (SDMSE). For years, SDMSE was cheered as an example of a public-private partnership done right, benefiting the city, the company and patients. But soon after Heffner’s charges were made public, the city auditor issued a report claiming the ambulance company had withheld millions between 1997 and 2007.

After months of investigations, negotiations and media coverage, an independent accounting firm found “no evidence” that Rural/Metro had fraudulently withheld revenue. Rural/Metro agreed in mediation to pay a $1.4 million settlement to cover Rural/Metro’s fraudulently withheld millions between 1997 and 2007.

Heffner was out of a job only briefly before being hired by Falck, the company bought Rural/Metro in March 2011. Of Falck, Heffner says, “I fell in love with the career,” he says. After graduating with a bachelor’s in science in sports medicine, he went to work for Ada County EMS as a paramedic supervising the field. He then went to private practice and in 1998, he was hired by Rural/Metro as chief operating officer and later became president of the company’s West Emergency Services Group.

Having experienced the wave of acquisitions of the mid-90s, Heffner says Falck is determined not to repeat the mistakes of the past. “The big companies snapped up ambulance services, immediately repainted ambulances with their new logo and fired long-time owners and staff,” he says. “That’s not Falck’s M.O.—the company respects local culture and believes in acquiring companies that are already well run, keeping staff and managers in place, he says. “I was working for those companies during the roll-ups. I have a saying: I will never teach as I was taught and I would never believe it was time to change the story for the future.”

Heffner was out of a job only briefly before being hired by Falck, a company based in Copenhagen, Denmark, that operates emergency, fire suppression and other services in 37 countries worldwide. During the time Heffner was with Rural/Metro, Falck held a 15% stake in that firm but sold its shares when a private equity firm bought Rural/Metro in March 2011. Of Falck, Heffner says, “Our values were 100% completely aligned. I had a close relationship with them over 10 years, and I made the decision very quickly that Falck was the company I wanted to go with.”

As the youngest of seven children growing up in Idaho, Heffner became an EMT and paramedic while in college at Boise State. “I fell in love with the career,” he says. After graduating with a bachelor’s in science in sports medicine, he went to work for Ada County EMS as a paramedic supervising the field. He then went to private practice and in 1998, he was hired by Rural/Metro as chief operating office and later became president of the company’s West Emergency Services Group.

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BP Interview

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Q What is Falck’s long-term objective?

I mean this from the deepest of our personal experiences. We are in the fabric of the community. You don’t mean this from management in place. We then acquired Caper Ambulance, a company that had been around for a very long time. We took a career firefighter in Cape Cod and made him the general manager. We then acquired American Ambulance in Florida. Over the next two years, we acquired five companies. We are now operating in 14 states. It sounds like you have some bad memories of the wave of acquisitions.

It was cultural genocide. The new bosses would come in and say, “Guys, what? We’re in charge now.” We saw a lot of great people from the industry who were basically gone. What I observed was that a lot of vendettas were set. If you were the acquirer, you got rid of some people, downsized and settled some old scores. What happened from management all the way down to the field level.

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It was cultural genocide. The new bosses would come in and say, “Guys, what? We’re in charge now.” We saw a lot of great people from the industry who were basically gone. What I observed was that a lot of vendettas were set. If you were the acquirer, you got rid of some people, downsized and settled some old scores. What happened from management all the way down to the field level.

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Fueled by a seemingly endless string of deadly shootings in schools, universities and movie theaters—as well as a growing urgency in law enforcement and the federal government to do more to thwart these tragedies—some individual agencies and large fire and EMS organizations are beginning to ask hard questions about how EMTs and medics can better respond to active shooters.

“Because of Columbine, the police community realized the tactics and the concepts were flawed,” Smith says. Police response to active shooters underwent a fundamental change. Instead of waiting for SWAT, the first patrol officers to arrive on scene are taught to enter immediately, usually in teams of four. They are trained to step over the dead and wounded, follow the sound of gunshots and pursue one objective: stop the shooter any way they can to prevent further mayhem.

The shift in police tactics took hold quickly. In the 2001 Santana High School shootings in Sanitee, Calif., officers were inside the school within moments. According to news reports at the time, they captured the 15-year-old shooter within minutes of the first shots being fired.

Yet even as police response changed, Smith says, fire and EMS largely didn’t, and continued to stage on the perimeter of such incidents. One reason EMS hasn’t changed is that no one has demanded it, he adds. “The police were faulted for what they did in Columbine. We have never been faulted for it,” Smith says. “Those are guys who are starting to hear some discourse on the EMS response, particularly involving Aurora.”

On July 20, 2012, 12 people were killed and 58 wounded when a lone gunman opened fire during a midnight screening of the film The Dark Knight Rises. According to a fire department internal review released in May, fire engines attempting to get to the injured were stuck in gridlock by parked cars, police vehicles and 1,400 fleeing moviegoers, while other engines and ambulances sat idle in a staging area. The review found that it took 17 minutes for fire dispatchers to tell EMS that there were victims inside the theater who needed medical attention, even though police officers had been telling police dispatchers they needed medical help for seven minutes before that.

ROOM FOR IMPROVEMENT

In Arlington, the basic plan for firefighter response to active shooter goes like this: During an active shooter incident, the first team of four police officers enters the building to hunt for the shooter. As additional officers arrive on scene, they, too, enter the building in teams of four, going room by room and hallway by hallway looking for additional shooters or explosive devices.

Under TEOC, a third wave—teams of two medics or EMTs—pursued a different plan. Two officers—entries after an area has been declared clear—meaning there is no obvious threat—but before police conduct the methodical search that can take hours to declare a scene safe and secure. Called a rescue task force, additional teams of police and EMTs or medics would enter depending on conditions and the number of victims.

“It can’t be a specialized team—it takes too long to get them there,” Smith says. “The people who are dying are going to be dead by the time we get there.”

Among the injuries responders treat immediately on scene: stopping bleeding using tourniquets, closing open chest wounds and treating shock. “It’s doing quick things to save the ones who are savable,” Smith says, citing research from the Vietnam era that estimates about 15% of battlefield mortalities could have been avoided by relatively simple steps such as stopping hemorrhaging with tourniquets.

Precisely what would be done on scene depends on the level of threat, according to the TECC guidelines. But generally speaking, responders move on to the next patient as soon as one is stabilized. Likewise, any injury that isn’t immediately life-threatening waits until the victim can be evacuated outside to additional EMS personnel.

In developing the plan, Smith borrowed heavily from the military’s Tactical Combat Casualty Care (TCCC) while adapting it to civilian circumstances such as law enforcement’s type of practice and medical protocols.

The IAFCS position statement will outline other key considerations for fire and EMS, including the need for joint training and using consistent terminology when developing plans so that the various responders are speaking to one another’s laws and language. “In the fire service, when you say, ‘All clear,’ it means they have searched the floor and there are no victims,” Light says. “When police say, ‘All clear,’ does that mean no victims or no shooter? There needs to be integrated planning and practical exercise of all disciplines.”

Another key point is getting support and cooperation from police. With one fire and one police department serving an area spanning 26 square miles, Arlington was able to get law enforcement buy-in quickly. But in areas where various jurisdictions overlap, that can be more complicated. In Prince George’s County, Md., for example, the fire department covers an area that’s served by 21 police departments.

saying, meaning there will be lots of legwork to do to get to the next page of an active shooter response plan.

Another consideration is making sure firefighters or EMS responders don’t get mis- taken or excluded. Smith and his team worked out a system of communications in which police would use one channel to relay information about the scene and the shooter to the command center, while fire would use a second channel to communicate medical information, making sure that everyone is using the same terminology, and that command knows exactly where everyone is in the building at all times.

PREPARING FOR THE UNTHINKABLE

As fire and EMS grapple with how best to respond to active shooter incidents, one central question is just how much risk responders should be expected to take on. While many Arlington firefighters eagerly embraced the active shooter guidelines, some were afraid they would be put in harm’s way, according to Smith.

But by entering only “warm” zones, going in with police and wearing protective gear, Smith believes the risk is minimal—especially when compared to other risks that firefighters face on the job, such as the fire and EMS personnel who would be in harm’s way, according to Smith.

instead, Fitch recommends a third plan, called “CARES,” or Community-wide Alignment of Resources for Efficiency and Service, which suggests minor tweaks to put a lid on costs. Under Fitch’s Plan, even fire-based rescue vehicles would have their shifts cut from 24 to 14 hours, eliminating excess capacity in the middle of the night, Moore says.

A second part of the Fitch plan suggests trimming costs by changing how they respond to 24,000 annual low-acuity calls, which is overkill, Fitch says. “It’s doing Quick things to save the oncs who are savable.”

One thing is unfortunately clear: Active shooter killing sprees will likely continue. Between 2006 and 2012, there was an average of 15 incidents in the U.S. annually in which two or three people were killed, according to a study by the New York City Police Department. And although these incidents are relatively rare, they can happen anywhere, anytime, in big communities and small, Light says. He likens preparing for active shooters to the firefighters who respond to the recent 777 crash at San Francisco Airport. “That will hopefully be the only large-body jet they will ever see crash,” he says. “But some of them trained their entire career, 20 or 25 years for that.”

NAME CHANGE FOR EMSC, NEW CEO FOR AMR

Emergency Medical Services Corporation, the parent company of American Medical Response (AMR) and other health-related services, recently changed its name to Envisio Healthcare Corporation.

“The new name better represents our service lines and offerings,” says Ron Cunningham, director of marketing communications for Envisio Healthcare Corp., which is based in Greenwood Village, Colo. “Emergency care is still a very important part of our service offerings, but it is no longer the only service we offer.”

Also in June, Edward “Ted” Van Horne became AMRC’s new president, replacing Mark Bruning, who left in January. Van Horne began his career in EMS 24 years ago and has served in senior management positions at AMR since 2003. He holds a bachelor’s of science degree from Rochester Institute of Technology and an MBA from the University of Phoenix.

— Jenifer Goodwin

The Fitch report, a draft of which was released March, recommended against the earlier consul- tant’s proposal and the fire depart- ment’s proposal. Cutting 25 rescue vehicles and laying off five firefighters was too extreme, the Fitch report says. “Pinellas County fire and EMS are not in a state of disrepair that would require such a drastic cut,” the report reads. Nor would the fire agencies’ proposal work, according to Fitch, as that plan would lead to “unrealistically high and danger- ous” crewworkloads and unit hour utilizations on fire agencies’ trans- port units.

Instead, Fitch recommends a third plan, called “CARES,” or Community-wide Alignment of Resources for Efficiency and Service, which suggests minor tweaks to put a lid on costs. Under the Fitch plan, fire-based rescue vehicles would have their shifts cut from 24 to 14 hours, eliminating excess capacity in the middle of the night, Moore says. A second part of the Fitch plan suggests trimming costs by chang- ing how they respond to 24,000 annual low-acuity calls and Omega calls. Last year, county staff had proposed having only Sunstar respond to low-acuity calls, the rationale being that it was overkill to send both a fire truck and an ambulance to minor medical issues.

But in something of a surprise, the Fitch analysis says that fire agencies are better positioned to serve as first responders for Alpha and Omega calls and should call for Sunstar only if the patient needs transport. “Here in Pinellas County, we all agree that fire and EMS don’t do both need to go to those calls—we just didn’t agree on who should,” Moore says. “The county said Sunstar should go. Intuitively that made a lot of sense, but when Fitch did its study, they had a surprising finding. They said that Paramedics Plus was very, very efficient, and they don’t have much excess capacity, but the fire departments do. Fitch said the fire department should go because they have the capacity.”

Fitch, which was paid about $300,000 for its analysis, estimates its plan would save a modest 6.3 million annually, or about 5.5% of the overall $112 million EMS bud- get, without jeopardizing clinical excellence. The plan was approved by the county board of commis- sioners, which also serves as the county EMS authority, at the begin- ning of August.
SOme clarity about Leadership Development

By John Becknell

Last month I wrote about a smart and talented young EMS supervisor named Jason who has little interest in leadership. He sees little he wants to emulate in the bosses running his agency and the so-called leaders at the forefront of the industry. I concluded that we need to do a better job of guiding a new generation of young people into leadership. Getting clear about what leadership is—and is not—and reflecting on our own leadership may illuminate some needed changes.

The term leadership gets thrown around a lot these days. From NEMSMA to NAEMT, IAFC, NASEMSO and the AAA, there is much talk about the need for leadership development in EMS. But here is where the confusion starts: If you listen closely, there is wide variation in what’s being talked about. Some are talking about the knowledge and skills needed to manage an EMS operation such as budgeting, deployment strategies and human resource management. Some are talking about mastering a set of officer competencies. Others are talking about creating a ladder where field providers can move from the field to supervision to management and so on. But there is little clarity about what leadership is—and, consequently, little clarity about how to develop leadership in others.

To stir the pot around this topic, consider the following questions: Does calling someone a leader make them a leader? Can someone manage an EMS agency without providing leadership? Does the title of director, administrator, manager, supervisor, executive or chief guarantee leadership? Are most EMS agencies truly led or simply managed? Is your state EMS director providing leadership of EMS in your state? Are the people tasked with leading EMS in the federal government exercising leadership? Is the head of your association actually leading the members somewhere? Is that charismatic speaker at the national conference a model of leadership?

Many are called leaders, but there is often a wide gap between the title and the actual practice of leadership.

The need for leadership shows up when there is a need for a group of people to collectively move toward a goal or destination. The acute need for leadership is often most visible in crisis. But the need for leadership shows up daily when something impacting a group needs group action to change, be different, be improved, be created or be stopped. Leadership then is a process of identifying a goal or destination coupled with a process of influencing others to action toward the achievement of the goal or destination. At its most basic level, leadership is about seeing ahead; it’s also about social influence.

Most of us would agree that EMS would benefit from having more people who actually see ahead, describe a compelling vision of the future and inspire others to put their best efforts toward achieving that vision. We especially need leadership that is not self-serving and has more than a personal career at its center. We need leadership that serves the basic missions of the organizations and groups being led and leadership that is benevolent and fully engaging to followers.

The development of leadership requires learning, but it also requires modeling and mentoring—which means those of us who would develop leaders need to reflect on how we personally show up as leaders.

So I end this with some personal questions. If a young EMS millennial came to you wanting to learn more about leadership, could you adequately define leadership for him or her? Could you help them clearly distinguish leadership from management? Is your own practice of leadership a model worthy of followership? If you were to mentor someone in leadership, could you point to your own successes in influencing others toward a destination?

In answering these questions we will discover how we might better lead a new generation into a positive and compelling view of leadership.

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