INTRODUCTION

A leader has been defined as someone you choose to follow, to a place you would not go by yourself. One of the hard lessons for many medical directors is the realization that being the medical director does not automatically mean that you are a leader. The frontline employees in the current generation of EMS providers are not impressed with positions, titles, or degrees as they once were. In order to gain followership, medical directors must build their platform on a foundation of vision, commitment, communication, compassion, trust, integrity, and inspiration.

In 1998, psychologist Daniel Goleman published what may be the most important book on leadership in the last century, *Working with Emotional Intelligence*. Dr. Goleman and his colleagues, David McClelland and Richard Boyatzis, have collected a staggering amount of management science and analyzed it to discover what factors make the difference among average leaders, very successful leaders, and leaders who derail. They found that top executives who fail shared two traits: First, they were rigid, unable to adapt their style to changes in the organizational culture, or they were unable to take in or respond to feedback about traits they needed to change or improve. They could not listen or learn. Second, they had poor relationships, being too harshly critical, insensitive, or demanding, so that they alienated those they worked with.1

The very successful leaders and managers shared a mix of what Goleman and his colleagues have come to call emotional competencies. These competencies are clustered into five groups: self-awareness, self-regulation, motivation, social awareness, and social skills. The self-awareness cluster contains competencies like emotional self-awareness, having an accurate self-assessment, and having a strong sense of one’s self-worth and capabilities. Self-regulation is focused around managing one’s internal states, impulses, and resources. Self-control, trustworthiness, conscientiousness, adaptability, and innovation are all part of self-regulation. Motivation involves having a drive for achievement, commitment to aligning with the goals of the group or organization, initiative, and optimism. Social awareness involves having empathy, an ability to recognize feelings in others, an ability to help others develop, a bias toward service, an appreciation for the value of diversity, and awareness of the political landscape of a group. Social skills are focused around inducing desirable responses in others. This involves influence, communications, conflict management, being a change catalyst, building bonds, collaboration, cooperation, and team skills that create group synergy in pursuit of collective goals.

The information detailed in the book *Working with Emotional Intelligence* should be of particular interest to physicians in leadership positions. Much of the authors’ work is based in neuroanatomy, and is validated using methods of scientific inquiry similar to what is used in clinical research.1

FEEDBACK

Management author Ken Blanchard says, “Feedback is the breakfast of champions.” In the world of EMS, feedback from the medical director is the breakfast, lunch, dinner, and midnight snack of good clinicians.
The results of a 25-year research study involving over 80,000 managers found that the answers to these six questions determine employee turnover rate, a key factor in employee satisfaction:2

1. Do I know what's expected of me at work?
2. Do I have the materials and equipment I need to do my work right?
3. Do I have the opportunity to do what I do best every day?
4. In the last seven days, have I received recognition or praise for good work?
5. Does my supervisor, or someone at work, seem to care about me as a person?
6. Is there someone at work who encourages my development?

Medical directors who are skilled at interpersonal communications can have a powerful impact on the retention and satisfaction of clinicians in their system. No matter how scientific and academic the conversation, the vast majority of a message that is received during an interaction with another human being is emotional. Albert Marabian researched interpersonal communications in the early 1970s, and found that of the messages people receive, 7% are made up of the words they use, 38% of their tone of voice, and 55% of their body language. Therefore, how one communicates has a greater impact than what is actually said. The phrase “I love you” leaves one impression when it is delivered from a sarcastic angry person and another when it is shared in loving passion. When kindness and caring are communicated, even negative feedback can be perceived positively by the receiver.

Replace “constructive criticism” with “useful feedback.” The term constructive criticism is an oxymoron. Construct means to build; criticize means to tear down. When constructive criticism is provided, receivers are torn down; when that happens, they are not likely to improve their performance. It is very difficult to improve effectiveness when one is feeling down. Also, people react to criticism by becoming defensive and are likely to become more firmly entrenched in their belief system. On the other hand, useful feedback is like a gift that can be used to improve the future. Useful feedback is a powerful relationship-building tool.

A couple of linguistic constructs can improve the chance that a receiver will actually be able to integrate feedback without becoming defensive. The first is to construct feedback in the form of an “I statement.” An “I statement” comes across as a request for assistance. Almost everyone in EMS likes helping people, and it is a useful way to engage their energy. Effective “I statements” have four parts: your emotional state, their action, your interpretation of their action, and a request. For example, “I get frustrated when you bring in patients with only their head immobilized to the back board, because my interpretation is that you don’t understand the damage that can occur if you have to roll the patient to clear their airway. My request is that whenever you immobilize a patient’s spine that you secure the head, shoulders, chest, and hips to the board.”

Another trick for providing effective feedback is to replace the word “but” with the word “and.” “You are a really good EMT but . . .” has a much different impact than “You are a really good EMT and . . .” When most people hear “but” used like this, it sends the message that everything said before the word is a lie and it signals that an attack will immediately follow. Immediately a psychological defensive wall flies up. Of course, what this wall blocks is the very message that was to be delivered in the first place. When people hear a compliment followed by “and,” their ears tend to perk up expecting more good news: “You are a really good paramedic, and if you were more aggressive with your airway management this patient would not be hypoxic.” When they hear useful feedback tied to a compliment, they are more likely to put the message to use.

Most customer service literature suggests that people treat others the way they have been treated. Medical directors who are kind and caring in their interactions with paramedics are likely to have paramedics who are kind and caring toward their patients. Conversely, paramedics who have been abused are more likely to become abusive. How paramedics feel when they leave an interaction with their medical director has a direct impact on the way their next few patients are treated.

Similarly, meaningful feedback should be provided in private. Even if the feedback is not likely to embarrass or stress the receiver, it should be given in private. This approach increases respect for the leader; it also is more effective, as demonstrated in the following case. A medical director dressed down a paramedic in front of the emergency department staff and the patient; the paramedic had made a potentially dangerous mistake. Following the interaction, the physician felt that he had been effective in his communication. He also felt that it was an added benefit for the rest of the staff to hear the feedback, so they would not make the same mistake. However, all
the paramedic and the staff who witnessed the event could focus on was what a jerk the medical director was. They felt that he acted inappropriately, and they totally missed the feedback he provided. The general consensus was that in the future they needed to be more careful not to get caught.

A similar situation occurred in another city. However, this medical director chose to wait until the patient was cared for and his anger had lessened. He then asked the paramedic to step into a private room to discuss what happened. After the physician communicated his concern in the form of an “I statement” he asked the paramedic how she perceived the situation, and she was allowed to explain her thought process and decision making. Only then did the medical director point out the cognitive flaws and provide remedial education. After the interaction the medical director felt that she had been effective in communicating the message; more important, the paramedic felt the medical director really cared about the treatment that patients received. Feeling supported, the paramedic provided as many of her peers who would listen with the details, so they would not make the same mistake. Now, paramedics in this system bring their mistakes to their medical director before she hears about them from another source. In addition, she is regularly sought out as a consultant for retrospective review and advice about challenging calls.

It is important that the field personnel provide a reality check for the medical director. The reality, that medical directors care enough to ask how they are doing and then listen to the feedback, builds both their position and the team.

EMS team members generally have positive intentions; however, those intentions may be difficult to discern. Few providers wake up in the morning thinking, “I wonder how many patients I can harm today?” If the provider has a positive intent during a discussion, then education and information will probably solve the problem. If providers do not have a beneficial motive for their incorrect actions, they may have chosen the wrong profession.

COMMUNICATION AMONG TEAM MEMBERS

In order to lead effectively it is necessary to have access to accurate and timely information. One of the challenges facing medical directors is managing from the “top.” Communication often does not flow freely up through an organization to its leaders. In fact, information is often distorted or intentionally changed as it progresses from the bottom of the organization to the top. This distortion can be caused by bureaucratic pressures, errors, and a general desire to present information to leaders that is well received.

Effective leaders are the ones that get the bad news. But to make this happen it is necessary to take proactive steps to ensure that the messenger is not shot. It is easy for a leader to express anger or frustration when receiving bad news. But directing that at the messenger discourages followers from sharing bad news with the leader.

Although problems like this plague all organizations, those where decisions have life or death consequences have received more scrutiny than others. These organizations include the airline industry, the military, and medicine. Some of these communication failures have resulted in dramatic changes in the industries in which they occurred.

One failure with far reaching impact was the crash of a United Airlines passenger jet in Portland, Oregon, in 1978. The jet crashed after running out of fuel while the crew investigated a faulty reading on a warning light. The National Transportation Safety Board (NTSB) investigation identified the communication between the pilot and crew as one of the contributing factors to the crash, which killed 10 persons.

Research conducted by NASA at the time had revealed that human error was the cause of over 70% of civilian airline accidents. And significantly, these errors were the results of “failures in communication, teamwork, and decision making.” The training interventions undertaken by the aviation industry to address these failures are collectively known as “Crew Resource Management” (CRM) and emphasize teamwork and open communication among team members. These concepts have also been applied in medicine with success.

Not only is communication vital to success but so is creating an organizational culture in which team members, including subordinates, feel free to voice their opinions and ideas. When the submarine USS Greeneville struck and sank a Japanese fishing vessel off the coast of Hawaii in 2001, a number of safety and operational failures were identified by the National Transportation Safety Board (NTSB) and Naval Board of Inquiry that investigated the accident. One of the contributing factors to the accident was the failure of the sonar operator to advise the captain.
that he had plotted the position of the fishing vessel as being nearby. After the captain announced he had not seen any vessels with the periscope, the sonar operator, an enlisted man, revised his plot to coincide with the captain’s conclusion even though there were no data to support that revision. The NTSB found that a contributing factor to the accident was the leadership style used by the captain: “The teamwork problems demonstrated on the day of the collision were due in part to the CO’s overly directive style.”7

How easy is it for a physician with the title of “Medical Director” to become “overly directive” with prehospital subordinates? Emergency physicians are trained to make decisions and aggressively implement them, because hesitation can result in adverse consequences in life and death emergencies. Yet these decision-making styles can result in failure when directing subordinates in administration and management where relevant facts are unknown or not communicated to decision makers. Improving the flow of information to the top of the organization improves the quality of data on which decisions are made.

**PROTOCOLS**

Rules, regulations, policies, protocols, and procedures have strengths and limitations. Very little of the strength resides in the written document. The ability of policies or protocols to guide and improve care comes from the process of their preparation, implementation, and daily use. Protocols need to be flexible and dynamic in their ability to evolve and adapt with the changing needs of the system. Ideally, changes in the protocols should be driven by scientific research, and choreographed by the local practice of medicine. Provider involvement in the development and implementation of protocols is essential. Protocols are best followed when providers understand the rationales supporting them; one of the best ways to understand them is to participate in their creation.

The education in the implementation phases of protocol revisions is critical to the ability of clinicians to use the protocols successfully in the care of patients. Communication and education about the new information are best accomplished with an eye toward developing new competencies in clinicians. The most effective systems use multiple mechanisms (classes, newsletters, audio education, computer-based training) to ensure that everyone practicing in the system understands and can activate the new information. It is an absolute mistake to deliver a new protocol in every mailbox and expect instantaneous compliance. The effectiveness of training can be assessed at four possible levels:

- **Level 1:** Post-training participant satisfaction assessment. This is designed to fine-tune the delivery mechanism for training to best meet the needs of the learner.
- **Level 2:** Knowledge retention assessment (post-training test). This is designed to see how well students remember the information that is presented in the training programs.
- **Level 3:** Behavior change assessment. This is designed to see if the new knowledge translates into a change in action by crews when taking care of patients.
- **Level 4:** Clinical outcome assessment. This is the most difficult level of training effectiveness assessment and can only be accomplished in certain clinical conditions.

The primary weakness of protocols is the inability of anyone to write a protocol for good judgment. Systems attempting to promulgate protocols that account for every variable of the EMS equation have paradoxically produced huge monoliths that are incomprehensible, impossible to remember, and ineffective in supporting good clinical care.

A “values-based” leadership style is more effective than a “rules-based” style. Because the practice of prehospital clinical care is an extension of the practice of the system’s medical director, everyone practicing under his or her oversight should know the medical director’s values. It influences the decisions made and actions taken by prehospital care providers if their medical director believes that the only real stabilization of patients occurs in the emergency department, or if they believe that whenever possible, patient choice should drive clinical decision making. In most systems, the only time the policy manual, protocol manual, or union contract is consulted by management is when something did not go well.

A core problem with management by rules is that it allows people to quit thinking. All providers know of cases in which the supervisor intensely studies the rulebook until something that fits the situation at hand is found. Instantly, the supervisor relaxes when the rule that applies is located. If unsuccessful in the search for a rule, the supervisor quickly begins the process of writing. The results of these endeavors in reactionary
rule making are often ridiculous. The following are a few real-life examples:

1. “Starting June 15th there will be no slouching in the ambulance.”
2. “Forthwith employees are required to follow the following eight-step process for washing their hands after every patient contact or handling of equipment. Violators will be subject to the progressive disciplinary process.”
3. “All employees are required to adhere to everything in the Book-O-Memos.” (This book has every memo written in the organization since 1981; it is expanded to four volumes, and is full of contradictory information.)

EMS leaders and medical directors who rely only on memos and addenda to the protocol manual for leadership rarely get their messages to the team.

Some rules do help lead and build the EMS team. The key to developing a new rule effectively is to avoid overreacting to the current situation. A good strategy is to write the new rule or protocol and lock it away for 30 days. If at the end of the waiting period it still makes sense to implement, put it in place. Many leaders who use this strategy find that 80% end up in the shredder. There are of course some protocols that must be implemented immediately. A successful medical director knows which problems are best addressed with immediate protocol revision, and which are not.

**SETTING THE DIRECTION FOR THE EMS SYSTEM**

One of the most important contributions a medical director may make to an EMS organization is to insist that the answers to the following questions reflect patient care as the highest priority of the organization. The answers to these questions provide a useful framework for setting a clear direction for an organization. They are based on strategic planning principles first described by Peter Drucker and since expanded on by others.8

- What business are you in? (What is your purpose or mission?)
- Where are you going? (What is your vision?)
- What guides you? (What are your values?)
- How are you doing? (What are your performance indicators?)
- What are you doing to improve? (What are your improvement projects?)

A medical director can bring a patient-oriented focus to these discussions and emphasize the importance to any EMS organization of providing quality patient care. It is easy for managers to become distracted by pressing political or economic concerns. The Star Care principles discussed in the following section provide an excellent basis for developing patient-centered mission, vision, and values statements for an EMS organization.

**STAR CARE**

An organization should be led with a simple set of values and principles, that is, a shared paradigm. Paramedic and author Thom Dick wrote such a set of guiding principles, which has been adapted widely since its introduction at Bay Star Medical Services in San Mateo County, California, in 1990. Personnel use this “Star Care” checklist to ensure they cover all the important aspects of each call. Medical directors and system leaders use the checklist to evaluate programs, policies, protocols, and improvements in their systems.

- Safe—Were my actions safe for me, my colleagues, other professionals, and the public?
- Team-based—Were my actions taken with due regard for the opinions and feelings of my co-workers, including those from other agencies?
- Attentive to human needs—Did I treat my patient as a person? Did I keep the patient warm? Was I gentle? Did I use the individual’s name throughout the call? Did I tell the patient what to expect in advance? Did I treat the patient’s family and friends with the kind of respect that I would have wanted to receive myself?
- Customer accountable—If I were face-to-face right now with the customers I dealt with on this response, could I look them in the eye and say, “I did my very best for you”?
- Reasonable—Did my actions make sense? Would a reasonable colleague of my experience have acted similarly under the same circumstances?
- Ethical—Were my actions fair and honest in every way? Are my answers to these questions?

One of the challenging parts of using the Star Care system is deciding if a particular action was or is ethical or not. An easy way to get through this difficulty is to imagine how you would feel if what you are
about to do were to be featured as the headline story in tomorrow’s newspaper. If you and the people in your system would be proud of the article, it is probably an ethical decision. If not, then it is probably not.

This Star Care checklist can be printed on wallet-sized cards and carried by everyone in the system. It provides a very simple yet powerful method to recognize, reward, and reinforce strong performance. It also provides a template to work through any improvement opportunities. (This checklist may be reprinted freely with credit given to Thom Dick and Bay Star.)

REFERENCES