EMS Leadership

Continued Professional Training

September 5, 2019

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Some Thoughts on Real Risk Management

Thanks for inviting me again to San Diego County to speak to you regarding your chosen profession, Emergency Medical Service operations. I have possibly met some of you in prior presentations, and if that is true you know my focus in life is the management of risk.

My goal today is to give you some ideas and strategies regarding the discipline of risk management and how it applies to you and your specific EMS operations. I am absolutely convinced that if more people understood the breadth and depth of real risk management we would all be a lot better off.

In 1975 I got hooked on the study of tragedies – and I have spent way too much time studying tragedies in high-risk occupations including maritime tragedies, mining tragedies, refinery tragedies, train tragedies, plane tragedies, bridge tragedies, building tragedies, power plant tragedies and tragedies in American public safety organizations.

When you take a look at any tragedy in any profession and look for "What caused it?" – it is easy to spot the proximate cause. The event that instantly precedes the tragedy is relatively easy to spot. But real risk managers do not stop their search for cause with identifying the proximate cause. Real risk managers go back in time and look for *problems lying in wait* – that people knew about or should know about – yet these problems are oftentimes ignored until the tragedy occurs.

Your role (and the role of everyone in every job in your EMS agency) is to take a daily look at your sphere of influence – your span of control – and ask these questions: Do we have *problems lying in wait* in our fleet? Do we have *problems lying in wait* in our infrastructure? Do we have *problems lying in wait* amongst our personnel? And if you identify such an issue – that needs to be addressed.

If you fail to identify and address these *problems lying in wait* sooner or later all the holes in the Swiss Cheese (the thoughts of Dr. James Reason) are going to become aligned – and when that happens the tragedy occurs – and then the lawyers take over and the problems lying in wait are then identified and addressed – after the fact.

I gave you a number of examples from a variety of professions earlier today, but my focus these days on public safety (including EMS) operations in our great nation which today face and unprecedented level of risk.

So, what can we do? Allow me to introduce you The Five Concurrent Themes for Success. I have put together this platform for success (a checklist) that may assist you in better improving your operations. This platform consists of five separate and distinct issues (themes) that when put together will allow you to analyze any of the tasks we do to better assure things get done right. Here are my Five Concurrent Themes for success.

Risk management is the cornerstone of these Five Concurrent Themes. With this in mind, we need to learn about the word "risk." Risk is part of life. You took risks coming to this class today, even if it was just a short drive or an elevator ride. You will take a risk eating dinner tonight and traveling home at the end of this program.

There is not one of you in here today who has not heard the phrase, "risk management." Unfortunately, the phrase is grossly misused, many times by people who have no clue what they are talking about. Let me assure you, the discipline of risk management is extraordinarily valuable to all of us in the high risk profession of EMS operations.

Every identifiable risk is a manageable risk. You can eliminate some risks. You can avoid some risks. You can transfer some risks. You can share some risks. All of these are forms of managing risk. Properly managing risks prevents problems. Over the years, I have spoken extensively on the management of risk, and what your role is in your EMS operations with respect to risk. This is where I would like to start our discussion.

Historically, most government operations do not take risk management seriously. Check any federal, state or local government phone directory. You will find a lot of government lawyers, but few, if any, dedicated government risk managers.

This is an important point, which will be further addressed in this and the next paragraph. Next time you see a government agency in the news negatively anyplace in the U.S., give them a phone call. Find out how many personnel they have dedicated to internal affairs (post incident) investigations, and how many are dedicated to background (pre incident) investigations.

We would be better served by excluding bad people from our profession up front, rather than firing them after they participate in some nefarious behavior. Contrary to the view of some of the loudmouths in the world, EMS organizations are not some evil cauldron that takes good people and turns them into bad people. In the news recently were some stories about sports coaches molesting young kids. These predators were bad people long before they were hired.

Along the same lines – EMS organizations - for a number of poorly thought out reasons, occasionally hires bad people who continue to be bad people. Successful private sector companies take risk management more seriously than we do in government. Why?

Time out for a paid political statement. America is a nation of laws. We have heard that statement a lot since the terrorist murders of 9-11. It is very important (particularly in the

world of government operations) that we remember this thought, as it is critical to the survival of our country. We are a nation of laws.

Unfortunately, we have also become a nation of lawyers. I do not say this as lawyer bashing. I do not bash lawyers. Lawyers are fine people with good hearts and intentions, but with an extremely limited scope of thinking. They work in a different paradigm.

Their lives are focused on fixing things after they go bad. That is what they study in law school (case law) and that is what they do in their practices (clients with existing problems). Their bias is post incident correction.

Again, they are good people, but with a limited scope of vision. Many of our fine elected officials at all levels of government are lawyers. They bring this thinking of post-incident correction with them into government work.

Risk managers do not think this way. Their bias is pre-incident prevention of problems. I don't know one educated and trained risk manager in America who holds elected office. Not one!

This is not something that all of a sudden became important to me on September 11, 2001. This has been my focus over the last four decades. What will it take to wake people up? Prevention is better than correction. Small, smart expenditures of effort and money up front can prevent massive downstream problems. You can make this happen individually and organizationally.

Let's take time for a definition – and if you have been to any of my programs, you have heard this definition before including several times already today. I would like you to take a close look at this and try to remember the words. *Webster* takes a stab at defining "risk" as the "possibility of meeting danger or suffering a harm or loss" or "exposure to harm or loss." As a follow then:

Risk management is any activity that involves the evaluation of, or comparison of, risks and the development, selection and implementation of control measures that change outcomes.

Or, more simply stated, risk management is the process of looking into the future (short or long term) and asking what can go wrong and then doing something about it to prevent it from going wrong. In RM 101 you are taught the concept of **RPM**: Recognition, Prioritization, Mobilization.

First, you must recognize the risks you and your people face in your particular department. Next, you must prioritize them in terms of potential frequency, severity and available time to think prior to acting. Finally, you have to mobilize (act) to do something about the recognized and prioritized risks. This mobilization is the systems component – the second of my five concurrent themes for success.

What is a "system"? The word gets thrown around a lot, but what does it mean? According to *Webster* – "an organized or established procedure" or "an accumulation of processes." When you check under "process" and "procedure," you will find a "particular way of accomplishing something" and also "a series of steps followed in a regular definite order." Please recall that before I went to law school, I did my graduate work at the ISSM – the Institute of Safety and Systems Management.

Whenever I see a tragedy in government operations (or outside of our profession for that matter) I always do the Systems DUI Analysis. Was there a properly **designed** system in place? Was it **up to date**? Was it being **implemented**? It gets down to design, update and implementation.

Please do not subscribe to the thinking that there is nothing that can be done to prevent tragedies. I am sick of that attitude! While we have a very risky profession, we are not in the most risky profession. Timber operations, commercial fishing, aviation, structural metal workers, and long-haul drivers all have higher adjusted loss rates than we do.

But take a look at some of the leaders in those occupations and see what they are doing. Timber operations are risky, but Boise-Cascade is underrepresented in problems. Aviation is dangerous, but Southwest Airlines has a phenomenal safety record. Trucking is dangerous, but UPS has a great safety record in their long-haul operations. Chemical plant operations are dangerous, but DuPont is a vanguard in their industry. Construction work is risky but check out the lost time injury rate on Intel construction projects. They are grossly underrepresented in injuries because they understand the value of real risk management.

Well-designed systems, kept up to date and fully implemented, will never let you down. This is also true in our profession. First your agency has to build good systems (policies and procedures) and keep these policies and procedures up to date. This is the responsibility of the executive team in your EMS agency.

Why is this so important? If you take the time to study the nasty consequences we get involved in, so many of them get down to systems not being implemented. There are three principle reasons that systems are not followed. They are:

Arrogance: The rules do not apply to me.

Ignorance: I have no idea what the rules are.

Complacency: I have done it this way for a long time and will continue to do so.

More on this throughout our time together today, and this is a major concern of mine for our profession. But for right now, let me ask you this question. Does Bud (or Budette) work in your department? Let me identify Bud for you.

Our third theme is Customer Service. This is such a critical issue today, and frankly many public safety organizations (and their employees) do not quite understand the ramifications of not taking this seriously. This is not my focus today, but for right now here is a three-point guide to creating loyal customers:

Get things done right the first time.

Treat people right all the time.

Add in the WOW factor whenever possible.

Our Fourth Theme is Accountability and the increasing lack of it in society and our profession. This is a dying concept in so many organizations, with craziness abounding. Statements like "… that is not my job…" and "she doesn't work for me…" and "…we have never done it that way before…" are getting a bit tired and quite frankly customers are getting fed up with employees who are unable or unwilling to accept the fact that they need to be accountable.

Executive accountability starts with having good systems (policies and procedures) in place.

Executive accountability continues with promoting good women and men into supervisory positions who have the guts to enforce the policies of the organization, and then to support these supervisors when they make the tough calls.

Executive accountability continues with having a discipline system in place to address those in the organizations who are convinced that rules do not apply to them.

Finally, executive accountability includes a robust audit system (both formal and informal) in place to assure what you say you are doing is in fact being done.

Next, your supervision and management team has to assure that all department personnel are doing what they are getting paid to do (i.e., following the policies of their EMS agency organization). This is what supervisor accountability is all about – enforcing the policies that were developed by your executive team.

With respect to line personnel, their accountability is to know and follow the policies and procedures of the organization and following these systems. I don't care if it is the vehicle backing policy or the seatbelt policy or the FLSA policy or the harassment policy – all personnel must follow the policies of the organization.

Everyone in the organization, up, down and around the chain of command, has accountability. There are different levels of accountability, but each of us is accountable to do our jobs correctly. When accountability is not present, you have mediocrity. Mediocrity is at the top of a slippery slope that ends up in a loss of integrity.

Here is a quote I have been using now almost 20 years. In the '90s LAPD got in a ton of trouble with the Rampart Scandal. After the fact a number of experts (mostly lawyers) analyzed what caused this tragedy. While the lawyers focused on proximate cause – one fellow identified the *problem lying in wait.*

This nugget of gold was written by Commander Ross Swope of DC PD and everyone in your EMS agency needs to understand these words and what they mean to your operations.

"The major cause in the lack of integrity in American Police Officers is mediocrity"

The following passage is taken verbatim from the LAPD report, published March 2000:

> Captain Swope went on to explain that mediocrity stems from the failure to hold officers responsible and accountable. It comes from a lack of commitment, laziness, excessive tolerance and the use of kid gloves. He felt that dealing with mediocrity is perhaps the greatest contemporary challenge to American police departments. When asked to explain how mediocrity is dangerous, Captain Swope drew an analogy of the bell curve. At the high end of the bell curve are those officers who practice all the core values: prudence, truth, courage, justice, honesty and responsibility. At the other end, are the officers with few of those values. In the large middle are those officers who have some or most of the core values. The extent of moral influence in a police department depends on the extent to which the upper and lower portions influence those in the middle. The men and women who control that influence are sergeants, lieutenants and captains. <u>The irony is that everyone within a work place knows full well which of the three categories their co-workers fall into.</u> When officers in the middle see that officers at the bottom end are not dealt with, they sometimes begin to imitate their behavior. Similarly, when those at the top end are recognized and rewarded, they become the workplace standard. *The principal, though not exclusive, agents in encouraging top end or bottom end behaviors are supervisors and middle managers. It is our sergeants, lieutenants and captains who have the daily and ongoing responsibility to ensure that appropriate workplace standards are maintained. However, that observation in no way relieves upper managers from their responsibility to ensure that proper standards are being*

maintained in their subordinate commands by providing appropriate guidance, exerting their oversight responsibility and honestly evaluating the effectiveness of the commands for which they are ultimately responsible.

Integrity is the fifth of these Five Concurrent Themes. Lose integrity and you will not be able to achieve the manifestation of integrity known as ethical behavior. Lose your ethical behavior, and you have lost the public trust. Without the public trust, we have nothing.

Maximizing public trust starts with supervisors, managers or executives in your organization. If they are just counting the days maybe they need to leave now. Putting up with a lack of integrity is a huge *problem lying in wait*. Mediocrity is a cancer that can spread quickly in an organization, and if not eliminated, it will destroy your operations.

I have this odd belief that our citizens have the right to expect that all of our personnel possess this integrity, and not just at point of hire but throughout their employment career – and I am a huge fan of ongoing background investigations. And not to be Mr. Negative here – but how much damage could one bad employee in your department do?

So, why have I wasted some time out of your life with this? Your chosen profession is extremely complex and filled with risk. I am not kissing up to you, and I do not say this when I talk to a group of real estate people, or lawyers or bankers. EMS agency operations are complex in nature, and it is getting more complex.

What I am trying to do here is to give you a checklist approach (and I love checklists and I am begging you to read *Checklist Manifesto* by Dr. Atul Gawande as it has direct applicability to what you do) to getting things done right. Whatever the task is that you are doing or planning on doing, please start to analyze (if you have time) the task along these lines:

What is the risk involved in this task and how can I best manage that risk?

What is our department system (policy) and how can I best assure its implementation?

Is there a customer service component here, and if so, how can I maximize customer service on this task?

Who is accountable for what on this specific task?

What are the issues of integrity involved in this specific task?

If you try this for just a week, you will get it down to a couple of seconds per task. And if you use it regularly, you will have a higher probability of getting things done right and staying out of trouble.

And the anchor for these Five Concurrent Themes and my focus for our brief time together is the wonderful discipline of risk management.

Here are three statements that have guided me through most of my adult life. First is a quote, albeit paraphrased, from the great risk management guru of the '40s, Dr. Archand Zeller:

> The human does not change. During the period of recorded history, there is little evidence to indicate that man has changed in any major respect. Because the man does not change, the kinds of errors he commits remain constant. The errors that he will make can be predicted from the errors he has made.

What does this mean? We have not figured out any new ways to screw things up. We are making the same mistakes over and over again. Refineries have not figured out any new ways to blow up. Mines have figured out no new ways to collapse. Ships have figured out no new ways to sink. Firefighters have not figured out new ways to get in trouble. Restaurants have not figured out any new ways to poison people.

Airplanes have not figured out any new ways to be involved in accidents. This was demonstrated by Cal Rodgers in 1911 in the very first cross-country flight in the U.S. on the *Vin Fiz*! If you Google that, you will read a fascinating story.

EMS agency personnel (around California and America) have not figured out any new ways to get in trouble. To be sure, there are variations on a theme, but in reality, it is the same stuff over and over again.

The second statement important in my life thus far came from my mentor, professor and friend Chaytor Mason. He was a risk management guru in the '70s. Here is a capsulized version of his response when I accused him of being the smartest person who ever lived:

> The smartest person in the world is the woman or man who finds the fifteenth way to hold two pieces of paper together.

My instant response when I first heard this was confusion, but then I figured it out. While there are no new ways to screw things up (Zeller) there are always new ways to fine tune and revisit our existing systems to prevent bad things from happening.

Status quo (we have always done it that way – we have never done it that way) no longer works. Unfortunately, I see a lot of it in EMS agency operations. There is always a better way of doing business, the 15th way, and we must constantly be looking for it. And, the third thought…

Things that go wrong in life are predictable and predictable is preventable.

Thanks for your patience. I have been using this line since 1980 and I appreciate your indulgence. Want proof? Take a look at your newspaper today. Hopefully I will have a copy of *USA Today* with me today and we can read some of the top stories from around America and I will prove to you that…

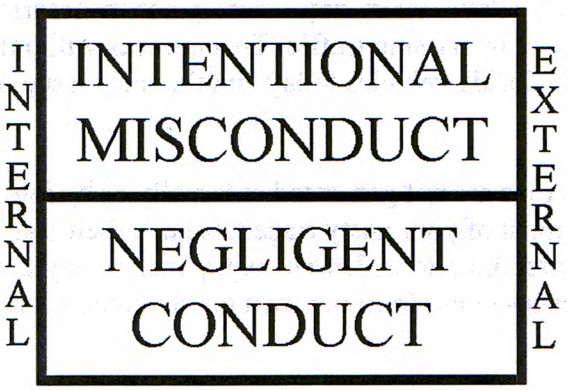
Predictable is Preventable

That wraps it up for our first topic of the day. Now let's move onto some thoughts ethical decision making.

In order to address this properly, I need to give you some preliminary thoughts. The vast majority of things your people do – they are being done right. However, when things do not go right there are significant consequences including death, injury, embarrassment, internal investigations and lawsuits. There is a reason most things go right – and there are reasons why some things go wrong.

So, where do we get started? I often speak of the value of the risk assessment. This is the "R" of RPM. Where are the problems going to occur in your EMS agency? You can get this information for your organization by using your own internal records.
You can further your assessment of risk by studying other similarly situated agencies and looking at their nasty consequences. Or you can study national and statewide trends occurring in other EMS agencies like yours around America.

Regardless of how you approach the risk assessment, you will get the same results. EMS agency personnel get in trouble for two things, and only two things. Some of your problems come from intentional misconduct, where bad people do bad things on purpose knowing what they did was bad when they did it. And some of our problems come from negligence – where good people make honest mistakes. Take a look at this graphic.



Some of these intentional acts may be generated by people outside of your operations – murderers, rapists, arsonists or even terrorists who want to further their nefarious schemes in trying to hurt Americans. While this in not my focus today, I would like to remind you of the importance of being vigilant – and also quickly comment on the value of random irregularity.

Continuing on, some of these intentional events are generated by our own personnel. Certainly, we have witnessed a number of these in EMS agency operations around America – and you have had a number of these right here in San Diego County where our own people light arson fires for fun or profit, sexually assault patients or suspects in their care, those who steal from co-workers and storeowners, steal dope from drug dealers, perjure themselves in court and on written reports, or falsify evidence.

What can we do about this? I think most of this could be prevented if we did a better job of screening out losers up front – prior to hire. EMS agencies are not evil cauldrons that hire good people and turn them into bad people.

My belief is that you occasionally hire bad people and put them in a position of public trust and they continue to perpetrate their bad behaviors. I could give you examples of this from around America, but you are acutely aware of this. This is not a class on Background Investigations today – but please take them seriously. Spending wisely up front on this process will pay off handsomely in the future.

Let's move to the bottom section in the above chart. Some of our problems come from external negligence. This is where otherwise good people do stupid things that end up causing us grief. A citizen bringing a gun he found on the street into a police station without calling first to ask how to do this correctly is a form of external negligence.

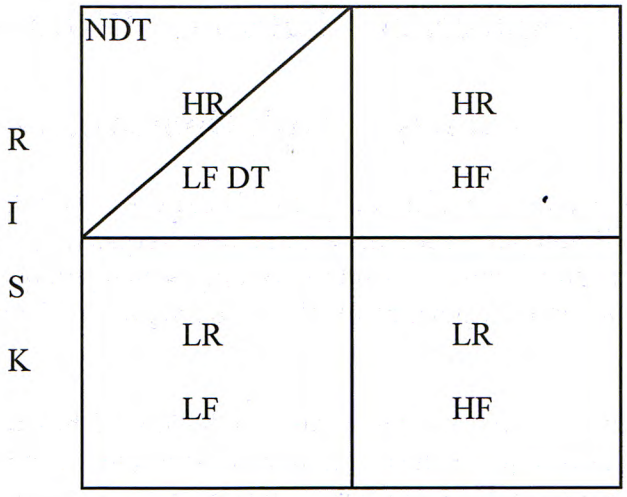
And too many of our tragedies occur when otherwise good people make mistakes while driving. Please be aware of this risk and talk to your people regularly about the risks involved in vehicle operations – including the dangers of roadway incursions. If you have never visited the website www.respondersafety.com - please do so.

Also recognize that every day – every day – someplace in America a cop, firefighter or EMS operator gets struck by passing traffic. This number will only get worse over time with all the distractions inside vehicles today and the huge issue of sleep deprivation in our nation.

But most of your tragedies are not generated externally or by internal intentional misconduct. Frankly, most of your nasty tragedies have their start with internal error. You can call them errors, omissions, lapses, negligence or anything else – but too many of our nasty consequences come from our own good people making honest (sometimes stupid) mistakes.

Where do errors occur? There is a chart on the top of the next page that summarizes my thoughts on internal error. And please do not give me credit for inventing this chart – I

did not. I learned about this in 1975 in grad school and even then, I wondered why I did not see this in high school, college or at the CHP Academy.



This chart is known as the risk/frequency analysis. Everything that gets done in every job in your operations (and specifically in your job description) can be put into one of these four boxes. And if you understand this chart, you can predict where most mistakes will occur. And please remember that mistakes are the cause of too many EMS agency tragedies.

The good news is that most of the things you and your people do in your organization are High Frequency, and your past experience will show you how to do it right the first time. This brings up the topic of **RPDM** or Recognition Primed Decision-Making.

If you want to read all about this, please pick up a book by Dr. Gary Klein, *Sources of Power* and read all about it. The principals of **RPDM** are as follows.

Consider your mind as a hard drive or, for those of you over 50, a slide tray. Your daily experiences help load this drive. Everything you do and experience is loaded into your hard drive.

When you get involved in any task or incident, your magnificent brain quickly scans your hard drive and looks for a close match or what Dr. Laurence Gonzales calls a "memory marker" or "mental model" or a "behavioral script."

Bottom line: Give me a good woman or man and put them in a high-frequency event, and there is a darn high probability that they will do the task right this time.

There are exceptions to this rule. Occasionally you will find that errors occur on high-frequency events. When this occurs and you look for what caused the tragedy, there are five issues that keep on popping up.

They are:

Complacency Fatigue Distractions

Hubris Risk Homeostasis

But even when you factor these in, rarely do mistakes occur on the high-frequency events. However, if you put a good person in a low-frequency event – particularly one that is high risk in nature, and I hear trains coming. When you get back to work later this week, I want you to start the practice of RPM – Recognition, Prioritization, and Mobilization.

First, you must recognize the tasks that fall into the top left box in the job description(s) that you manage. This requires the actuarial risk assessment I spoke of earlier. Now you must prioritize these risks. Here are some thoughts on this process.

Please recognize that this top left box has been divided into two areas. Some tasks need to be done immediately (Non-Discretionary Time - NDT), and some give us time to think (Discretionary Time - DT). The top left portion of the top left box scares me a lot, as these tasks truly give you no time to think.

Included here are workplace violence incidents, chemical spills, bomb threats, building evacuations in an emergency, responding to an active shooter, structure fires, earthquakes and other natural disasters, and similar events. These are the tasks that have higher priority in my way of thinking, as they have a higher probability of getting you in trouble. These are the events (tasks) that need the regular and ongoing training.

This is the mobilization component of RPM and it is very important that every day is a training day and you must focus your efforts on the *core critical tasks* – those tasks in the top left portion of the top left box.

The good news here is that in an average career of 30 years, less than one shift is really spent on this type of task. The bad news here is that in an average career of 30 years, less than one shift is really spent on this type of task.

With this in mind, and because of the high level of risk involved in the given task that falls into the top left corner of the top left box, these need to be covered regularly to make sure people know what to do if they ever get involved in the HR/LF/NDT family of tasks.

The excellent news is that most of the tasks in the top left box are not NDT, but rather DT meaning that you have time to think before you act. That may include asking someone who does the task at a higher frequency (and that may mean only once more than you) how to do it so it gets done right.

EMS operations can be very complex. However, **most** of the incidents you get involved in are ones that you have done a lot (high frequency) or ones that give us **total discretionary time**. If you have the time to think, please use it. Failure to use discretionary time when available is over-represented in subsequent problems.

Blink vs. Think

> Your role as a leader in Emergency Medical Service operations is making sure that you and all of your people in each and every job description in your department are fully and adequately trained for the tasks that give you no time to think (the *core critical tasks* that are present in every job in your agency), and that you (and they) understand the value of thinking things through when they are involved in a discretionary time task.

So, what do you do with this discretionary time to think things through prior to taking action? Simply stated, you use this time to think so that the proper decision is made to assure that things get done right. Good decisions are an essential component of getting things done right.

And every task, incident or event encountered by your personnel requires the making of a decision. So, how many of your people have had a class on how to make a decision? If 5% of the hands go up in any given class I am speaking to, I am surprised. So here we are in the most complex profession in America with no training on how to make decisions. I hear a train coming!

Some people think this is not an issue because most decisions we make are good ones. Very true, primarily because most decisions you make you make on a regular basis, meaning you do the underlying event at high frequency. In this situation, your friend and ally **RPDM** kicks in and things get done right.

I am not worried about how you make high-frequency decisions, as you do so all the time and if you were not doing it correctly, you would know about it by now. I am very concerned about how you and your people make low-frequency decisions.

How do you make decisions? Do you have a systematic approach to this process, or do you use the whatever-sounds-right-at-the-time approach? Hastily made or poorly thought out decisions can have dramatic and permanent consequences.

I never received a decision-making process until I got to law school – and there I was taught IRAC. What is the ISSUE? What is the RULE of law regarding this issue? How can you APPLY the rule to this issue? How can you reach a logical CONCLUSION based on the application of the rule to the involved issue?

I am not intimately familiar with all that goes on here in your specific EMS operations, but in so many initial training programs, we train our personnel how to do specific tasks, but we do not teach them how to think. So how can IRAC be of assistance to you? I expanded it slightly and made it more specific to what we do so here is my ten-step decision making process.

When facing a ***low-frequency*** task, and the setting of this task does not matter, please analyze as follows:

#1. Identify and clarify the issue. If there is a preservation of life issue, immediately act and move to step eight (do something to preserve life) of this process. Otherwise, ask, what is going on in this event and what am I being asked to do? You cannot make the right decision if you are addressing the wrong problem. Listen to what is being communicated to you and ask clarifying questions as necessary. Don't let RPDM get in the way. RPDM can generate "cognitive lock."

This is a nasty phenomenon where we make up our mind based on little information. This is a problem area. Study after study has demonstrated that the more time you spend identifying what is really going on, the higher the probability you will make a good decision.

Check out www.theinvisiblegorilla.com for some interesting thoughts about this issue – and how it applies to your EMS agency operations.

One last thought: I worry that someone in here today will view this request to think as an opportunity to excessively delay performance of given tasks, incidents and events. Please do not do this. You have a job where things need to get done – so please do your job.

#2. Is there discretionary time or not? This is so, so important. If you have it on a low-frequency event, then use it to think the issue through using the next five steps of this process.

Failure to utilize DT when available is overrepresented in subsequent problems. There is no excuse for a poor decision when there is time to think the decision through.

Those tasks that are truly NDT need the regular and ongoing training. You are responsible to make sure you are fully capable of handling these events should they ever occur.

But most things give us time to think – and if you have that time, the next five steps are the core of the decision-making process.

#3.* Am I able to address this issue? If yes, then handle it now by moving on to #4. If it is not within your current job description, then get the issue to someone who can handle it now and follow up to make sure it got handled.

If it is a police department issue, get it to them. If it is a CHP issue, then get it to them. If it is a public works issue, get it to them. And whenever possible – follow through to make sure the need was taken care of.

This is called "closing the loop" in the customer service world and is an excellent technique for creating loyal customers.

#4. * What is our current department policy regarding the involved issue? What does our policy manual say about this task? I am presupposing that you have good policies in place. If there is a written rule, it has to be followed!

And when your boy and girl wonders come up to you and inquire as to how to do something, rather than dazzling them with your significantly loaded hard drive of past experience, the smartest thing you can do for them is to teach them how to look it up.

And if you do not have a policy specific to the task, incident or event in which you are involved – please

remember the Mission Statement or the values and vision of your department.

#5. * What is our past practice regarding this issue? You may have never experienced this event before, but someone else in your agency may have some memory markers as to how it needs to be handled. Use this discretionary time to ask someone who has done this incident before so that your behavior today is consistent with past practice.

Failure to treat people as others in similar situations were treated or performing a task in a manner inconsistent with past performance is the easiest way to really make people angry.

If you are going to deviate from the norm, you have to have specific, articulable facts to justify this deviation from the way you normally do this type of task.

And for those of you who serve as supervisors and managers in your department, you have a key role in being consistent in the way you do your job.

#6. * Is it the right thing to do under the circumstances? What are the ethical considerations of this event? Every task we get involved in has an ethical concern, so every decision we make has got to include the ethical analysis.

#7. * What are the potential consequences of my decision? This is a generational-specific concept. You have got to make sure that you understand and analyze potential consequences in advance of our decision.

Consequences include intended, unintended, short term, and long-term issues. What is the impact on the customer, your co-workers, your organization and our profession is something we need to ask before we do anything.

This is a huge issue with the newer employees, as they have grown up in a world devoid of consequences and thus many not understand the gravity of what they are doing.

And not to beat this to death, but there is not a month that goes by that I don't have someone in my law office in big trouble for not considering consequences prior to acting.

And with the huge under employment and economic issues our nation faces today, getting fired would be a life-changing event.

So, with this in mind, if you are involved in an ethical dilemma please, please do not try to make the call by yourself. Ask a co-worker or supervisor for their advice.

And if you don't feel comfortable talking about your planned behavior with others – then perhaps you are headed in the wrong direction with your thinking.

#8. Act! And if this is a preservation of life issue, act quickly. Make and implement your decision. If not a preservation of life issue, recognize that it is not too late to go back to number one of this process to assure that you are still headed in the right direction. It is much easier to start over than it is to attempt to undo something that was done incorrectly.

#9. Document as necessary (this is the lawyer in me). Record keeping and report writing are essential components in this process and must be done as incidents develop. Don't think that you will remember why you did what you did when you did it three years from now.

#10. Learn from and share your experiences (this is the risk manager in me). If you learn something, share this new memory marker it with your peers so all can benefit from your new knowledge.

And I recognize that there are many other approaches to making good solid decisions, and I do not care which one you use, but get a structured approach to thinking things through. Also, share this with your people, as it will allow them to make better calls.

With respect to #6 above, "Is it the right thing to do under the circumstances?" this query raises the ethics issue. More and more people, both inside and outside of EMS operations are looking at your profession and raising the ethics question. What is "ethics" all about?

Webster defines "ethics" as follows:

1. The discipline of dealing with what is good and bad and with moral duty and obligation.

2. A set of moral principles or values.

Further, "ethical" is defined as "conforming to accepted professional standards of conduct."

America has been sliding down the slippery slope of decreasing ethics and integrity for decades. Not taking this seriously has eroded public confidence. We have got to rethink how ethical behavior is achieved and sending people to a class (this is lawyer thinking) on ethics is not the total answer.

Many organizations use it as a crutch to show that they care and that they have a piece of paper saying that someone went to a class. Having a piece of paper saying that some paramedic or other EMS operator has been to ethics training does not mean much to me.

What we should do regarding ethics training is to employ the principals of risk management.

First, if we truly want to maximize ethical behavior, we have to start by hiring people who have integrity. This requires comprehensive background investigations. Spending wisely on the background investigation process is absolutely necessary. Past habits will become future habits. The best predictor of future behavior is past behavior. You cannot train the immoral to be moral, so do not waste your time on them.

Second, after hiring, we have to train our good new people regarding ethics. And if you are taking a close look at the next generation of employees coming on board, they have substantially different values than you do, so some re-tuning of the hard drive may be necessary. Classes on ethics during initial training are essential, but again not the total answer.

Third, recognize that every incident encountered by EMS personnel has ethical considerations. With this in mind, <u>each</u> class we instruct needs to have a discussion regarding the ethical considerations of this particular task or incident. It will cost you nothing to do make ethics a part of every class taught.

Finally, when rules are not being followed, there needs to be action. When supervisor or managers ignore wrongful behavior, they have encouraged future wrongful behavior. You who serve as the supervisors or managers must be out and about and taking a look at what is going on in your workplace – and if you see something that is not right, you must act.

It is not the intent of this class to give the right thing to do in any given situation, for your job is complex, and the number of permutations of possible incidents is innumerable. It is the intent of this class to maximize the level of interest in the concept of ethics and to instill in each attendee that ethics plays a role in each decision you make.

It is also my intent to again stress the value of systems thinking and to give you a structured approach to determining if what you are doing is the right thing to do. Here are some ideas for you to consider:

1. Always obey the law and follow the policy. If you have the law and policy on your side, you are probably in good shape.

2. If it smells bad, it probably is bad. Even if your planned behavior is consistent with law and policy, it might not be the right thing to do. It is essential that we give it the smell test, both personally and externally. "How will it read in the paper tomorrow?" is a necessary consideration.

   However, this only applies if you have discretion in what you are doing. In the world of EMS operations, some of your functions are mandatory meaning <u>shall</u> and further meaning you <u>have</u> to do the task a certain way. If you are involved in such a matter, follow the letter of the law or policy regardless of the smell.

3. When questioned after the fact, always be up front and honest. America and Americans are very forgiving, but only if you are up front and honest about what really happened. This is the most complex job in the world and mistakes are going to happen. Don't compound the mistake with a cover up.

4. Ethical actions speak louder than ethical words. You are the leaders in your department and our profession, and you must set the proper example. EMS work is a noble endeavor. Please take it seriously. We all need to act like the professionals we are even when no one is looking and there is no chance our behavior will be noticed.

Well, that wraps it up for our afternoon together. Thanks for coming back after the break and for your attention. I came here with several goals to help you better do your job.

My program over our time together was a broad discussion of risk management concepts. I do not undertake to provide specific recommendations as to best practices in a particular scenario and nothing in this presentation should be construed as legal advice or a recommendation by me to follow a specific course of conduct when presented with a particular risk or situation.

Please recognize that any hypotheticals or examples provided in the program are to encourage understanding of broad risk topics and are not to be interpreted as any recommendation to modify the existing practice you have in your operations.

Before you make any changes to the way you currently do your job, please contact your organization's attorney.

Again, thanks for coming to the program today. I wish you continued success in all you are doing.