NEMSPA

Breaking the Cycle

I will start the following column with a well-known quote from George Santayana (1863-1952): "Those who ignore history are bound (or doomed) to repeat it." Having been blessed to have had the opportunity to work in the air medical industry at multiple levels for almost 17 years, I can say without a doubt there is a definite cycle that plays out at every program, organization, company, and, yes, even at the industry level. How this cycle plays out over time, with its varying degrees of good and bad, is purely up to us and whether or not we have a proactive or reactive mindset and philosophy. Given that most critical care transport programs, at their very essence, are a microcosm of our industry, the following illustration is a valuable lesson to be heeded by everyone.

A few years back I had the opportunity to do an audit for a critical care transport program that has been in existence for 30-plus years. This program is and has been an excellent operation that many look to as a standard to emulate. While reviewing their records, I was intrigued by the fact that they had managed to maintain the minutes from their safety council meetings for almost the entire 30-plus years. Fortunately, I had the opportunity to spend the extra time necessary to review these documents in detail. What I discovered, hidden just below the surface, was a very interesting, repetitious cycle of history.

Throughout the many pages of this detailed collection of notes, there were multiple accounts listing the issues that had been identified and discussed in the past, including the solutions that were ultimately devised and put in place to fix them. What was not readily apparent until I read through the entire 30-year collection of documentation was that some issues seemed to be repeated at intervals of roughly 3-5years. In some cases the issues brought to the forefront at a specific time were exact duplicates of those that had occurred in the past. The interesting part was that, in many of these reoccurring cases, no references were made to these issues having come to light in the past or that they had already been addressed and fixed. When I looked at the volume of history encapsulated in these notes and the changes that occurred over those 30 years, it became readily apparent that we all have problems learning from history and, hence, seem to be destined to repeat it.

The question then becomes why? One observation that I made was that, in a number of these cases, there was a change in leadership at some level that coincided with the reemergence of some of these issues. This cycle in leadership would seem to be the natural progression most individuals experience as they further their careers through life. Hence, the 3- to 5-year cycle that seemed to be so prevalent.

The following is 1 particular case in point I discovered that I feel sums up the issue at hand quite well. I found that, early on in this program's life, they had developed a very comprehensive, efficient, and safe protocol for dealing with the hot-loading of patients into helicopters at scenes. The documentation showed a well thought-out procedure that had been vetted by every facet of the organization and included many of the first responders in the region with which they worked.

Fast forward 6 years from the implementation of that protocol to discover a period of about 5-6 months littered with close calls, angry first responders, and a program up to its neck in high drama. On closer examination I saw that, at about that same time, there had been a changing of the guard and a new leadership had been installed. With the change in leadership came a change in philosophy and hence a new protocol for hot-loading patients at scenes. While I am convinced this new leadership was concise.and well meaning, they committed 1 of the cardinal sins of our industry—they did not provide those individuals who were going to ultimately implement this procedure in the field with the same unilateral input that was provided in the past. Coupled with the fact the individuals who wrote this new protocol had little or no practical field experience in air medical transport, the program now had a phenomenal recipe for disaster.

Luckily, the program had a very strong core group of safety-minded professionals who stepped up to the plate and ensured that the old protocol was reinstated in a very expeditious manner. The issues that had plagued the program for that short 6-month period from the change in protocol ultimately disappeared and were not reported again within the historical documentation that I could see.

In this case things did ultimately work out in rather short order. The take-away lesson here is if there is a good foundation set in place at the outset of a program's birth—based on documented quality protocols, procedures, and best practices that have been vetted carefully by all of those involved—change generally will not have a huge negative affect, or at least not 1 that lasts long. If, on the other hand, a program's foundation was never firmly solidified, that program will more than likely find itself set adrift in a sea of mediocrity and drama with no one at the helm for a very long time (generally speaking, about 3-5 years).

There are two things all programs, organizations, and our industry must account for to help ensure this destructive cycle does not claim them like a lost ship on the world's reefs. First and foremost is guarding against complacency. If ever there was a true killer of programs and industry, this is it. If you don't know, ask; if you're not

sure, ask again, but for God sakes never, ever assume. Second and generally, the cause or the cure of complacency is open, timely, and documented communication. I have been quoted on many occasions as saying, "The root of all evil is poor communications." That fact has been reinforced and driven home to me with every passing day that I spend in this industry.

Communications can be the root of all things that are wrong or it can be the root of all things that are right. The role that communications plays is a choice that we as leaders make on a daily basis. Communications must be based on well-written, thoroughly vetted, and formally documented policies, procedures, and protocols that are firmly rooted in a unilateral just-culture philosophy that permeates every level of a program or industry.

In closing, to all those who do not wish to repeat history's mistakes and want to break this destructive cycle, either at their program or within their industry, I recommend the following. Be proactive, not reactive. Guard against complacency as if your life depended on it, because it does. Study and learn from history on a daily basis. Bring everyone involved to the table to thoroughly vet issues before changes are made. Never ever assume; always ask. Be wary of change, because change just for the sake of change is total folly.

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