AN EXPLORATION OF PROGRAM DIRECTOR LEADERSHIP PRACTICES IN NATIONALLY ACCREDITED PARAMEDIC EDUCATION PROGRAMS

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by

Gordon A. Kokx

Major Professor: Laura B. Holyoke, Ph.D.

Committee Members: John G. Cannon, Ph.D.; Raymond A. Dixon, Ph.D.;

David J. Fox, Ph.D.

Department Administrator: Kathryn Canfield-Davis, Ph.D.

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Authorization to Submit Dissertation

This dissertation of Gordon A. Kokx, submitted for the degree of Doctor of Philosophy with a Major in Education and titled "An Exploration of Program Director Leadership Practices in Nationally Accredited Paramedic Education Programs," has been reviewed in final form. Permission, as indicated by the signatures and dates below, is now granted to submit final copies to the College of Graduate Studies for approval.

Major Professor _____Date_____
Laura B. Holyoke, Ph.D.

Committee Members _____Date_____
John G. Cannon, Ph.D.

_____Date_____
David J. Fox, Ph.D.

_____Date_____
Raymond A. Dixon, Ph.D.

Department Administrator

_____Date_____
Kathryn Canfield-Davis, Ph.D.

Abstract

The number of paramedic education programs participating in the national accreditation process has nearly tripled in the past several years. Although accreditation standards describe program director roles and responsibilities, nothing has been formally studied regarding their leadership practices. The purpose of this study was to explore leadership practices of program directors in nationally accredited paramedic education programs. The qualitative study explored the perceptions and observations of twelve uniquely qualified experts to determine the leadership practices of nationally accredited paramedic education program directors. Elite individuals were selected to participate based on their professional knowledge and experience in EMS education. A series of in-depth, semi-structured interviews were conducted to explore the context, challenges, and best practices of program director leadership. Participants ranked positive leadership and leadership skills approaches (human, technical, and conceptual), as important to the role of program director. Findings revealed context and best practice themes of a need for understanding and a culture of quality, while challenge themes were an EMS identity crisis and generational dissonance. Conclusions revealed a program director's leadership is responsible for 75% of a program's success, yet no formalized leadership curriculum or training exists. Subsequently, there is both a need for the development of a program director leadership curriculum as well as program director leadership training. This study adds to the research literature and identifies leadership practices that may improve paramedic education programs. Further study in the field of paramedic education program director leadership practice is recommended.

Keywords: paramedic education, national accreditation, program director, leadership practices, CAAHEP, CoAEMSP, positive leadership, authentic leadership, leadership skills

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Dedication

To my EMS and education families

who have devoted their lives

to the service of others.

“Next to creating a life the finest thing a man can do is save one”

-Abraham Lincoln

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Chapter 1

Introduction

Over 60 years ago Peter F. Drucker contrasted the concepts of management versus leadership as "Management is doing things right, leadership is doing the right things" (Drucker, 1955). Leadership is an integral characteristic of the Emergency Medical Services (EMS) profession since it is a profession built on doing the right things. The highest level of providers in the EMS profession are paramedics who are trained to provide advanced emergency care, and thus must learn to be leaders during their education. EMS instructors in paramedic education programs are assigned the task of teaching leadership principles to paramedic students based on national EMS education standards.

In order for paramedic program graduates to earn national certification, it is now mandatory for them to graduate from nationally accredited programs. To meet accreditation standards, each program is required to have a program director in a leadership position. These individuals, by position, become leaders of those entrusted to teach leaders. Over 700 programs have sought accreditation, yet leadership practices of program directors have not been studied and no formal leadership framework exists from which to learn. A resultant gap exists in practice as new and existing program directors attempt to navigate the leadership process. The purpose of this study was to explore leadership practices in program directors of nationally accredited paramedic education programs. Results from the study may possibly inform future professional development and training.

Background of the Study

Every day in the United States, a myriad of citizens experience medical emergencies and require emergency care for their illnesses and injuries. No matter what condition the patient experiences, Emergency Medical Services (EMS) personnel must be able to assess, diagnose, formulate and manage treatment plans in order to provide the patient with the greatest possible chance for survival. Their work is often done in dangerous environments and under extreme conditions (Bledsoe, Porter, & Cherry, 2012). The task is nothing less than formidable. Emergency Medical Services providers in the United States number nearly 700,000 and respond to some 30 million calls per year; totaling over 82,000 calls per day nationwide (Hertelendy, 2010). The highest level of emergency care is provided by EMS professionals called paramedics. Paramedics must complete a rigorous curriculum of education including anatomy, physiology, assessment, pharmacology, resuscitation, and in-depth medical and trauma study in preparation for what will be required of them in a moments' notice.

The level of care paramedics provide has evolved greatly over the past 40 years. Subsequently, paramedic education now requires student competencies be measured across cognitive, psychomotor, and affective domains. Graduates complete on average a total of 1,400 hours of didactic, laboratory, clinical, and field internship training (CAAHEP, 2005). Due to recent national changes, in order for a paramedic graduate to be eligible to take the national certification exam, he or she must graduate from a nationally accredited paramedic program. The intent of the accreditation requirement ensures quality standards of paramedic education with the resultant hope of improved emergency care for patients.

To become accredited, each paramedic program is required to meet established national accreditation standards. Components of sponsorship, administration, program direction, medical direction, resources, and fair practices are all measured to obtain accreditation. An integral component of meeting the standards requires each program to have a qualified program director who is responsible for the overall administration of the program. Subsequently, the individual must exemplify leadership to his or her entire sphere of influence comprised of students, graduates, faculty, advisory committee, administration, and medical director. (See *Figure 1*).

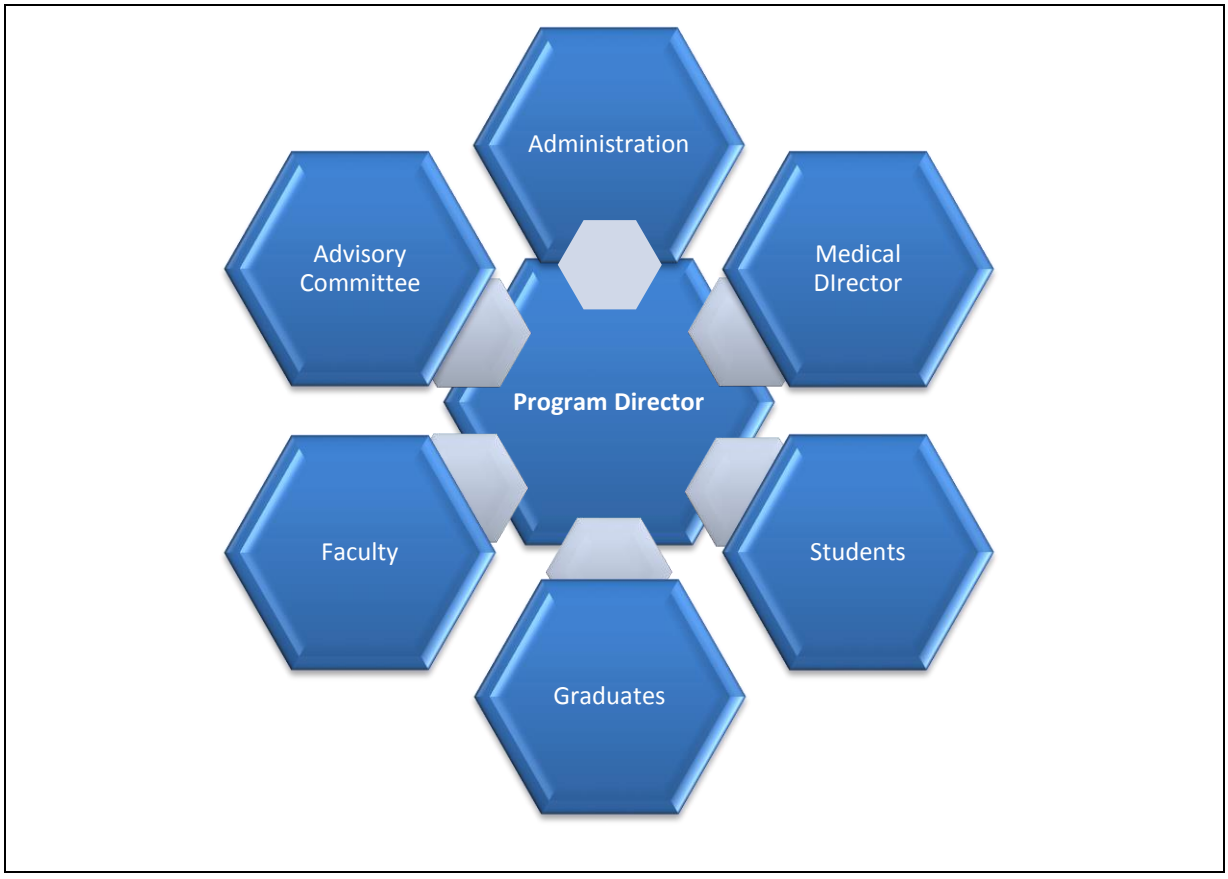

Figure 1: Program Director Sphere of Leadership based on CAAHEP Standards, 2005.

Ultimately, a program director must lead the program to the goal of successfully preparing competent, entry-level paramedics. Directors must meet specific requirements as established by national accreditation standards that include a minimum of a bachelor's

degree, experience in education, and experience in the delivery of prehospital emergency care (CAAHEP, 2005). Though the standards define required roles and responsibilities, leadership practices of program directors of paramedic education programs have not been studied.

Statement of the Problem

The concept of national programmatic accreditation for paramedic education programs in the United States began in 1978 (CAAHEP, 2005). While a seminal study showed accreditation to improve the quality of education and certification scores in paramedic education (Dickison, Hostler, Platt, & Wang, 2006), a significant number of programs have only recently begun to seek accreditation. Due to a requirement of accreditation for paramedic graduates seeking national certification, the number of accredited programs increased dramatically from 2011-2015.

As of January 1, 2013, all paramedic graduates wishing to seek National Registry of Emergency Medical Technician (NREMT) certification are required to have graduated from a nationally accredited program (National Registry of Emergency Medical Technicians [NREMT], 2013). According to accreditation standards, programs are required to have a qualified director to lead a program (CAAHEP, 2005). Program directors of nationally accredited paramedic programs are in positions of leadership. Their sphere of leadership is extensive and ultimately affects graduates who will provide emergency patient care (See *Figure 1*).

Since most states require NREMT certification as a licensure standard, many directors of EMS programs are now seeking national accreditation subsequent to the mandate. Although this requirement is perceived as a positive step towards professionalism,

no formal study of leadership practices exists to assist program directors in becoming prepared to assume successful leadership roles.

The leadership roles and responsibilities of a program director are similar to a college department chair. In fact, some program directors share the same title (NAEMSE, 2014). The need for leadership identification, research, and development is clear. In a related study entitled *Formal Leadership of Department Chairpersons,* Fattig (2013) determined a need for leadership training and further research in similar educational roles and settings:

> Additional research in the area of types of leadership training needed for future department chairpersons, to prepare them for the additional responsibilities this role entails, is essential as the need for effective department chairpersons grows. Further research should further explicate the components of positive leadership in finding an appropriate mix of traits which allow for the management of a broadened span of control which entails varied responsibilities. Further research should also be conducted to determine who will and will not be an effective leader. Identifying those individuals who would be successful, in order to provide advance training and mentoring, would be beneficial in all areas of education and corporate domains. (p. 108)

Fattig's (2013) findings mirrored several other allied health program director studies including Reiss (2000) who considered leadership styles of occupational therapy education program directors. Reiss focused specifically on leadership awareness and training of occupational therapy program directors, and like paramedic education, found a critical lack of literature in the specific field. Reiss' study was conducted through the lens of transformational leadership styles and discovered a significant need for further leadership training among existing program directors, citing implications for improvement in

occupational therapy practice and education (Reiss, 2000). Reiss determined the need for understanding one's own leadership style as well as the need for continuing leadership training. Reiss declared:

> Because transformational leadership behaviors are related to worker satisfaction and organizational effectiveness, occupational therapy practitioners would benefit from understanding their own transformational and transactional styles and use this awareness as a rationale for career decisions and as a basis for personal growth (p. 11).

Several related studies of education program directors have been conducted in allied health education. Those most similar to paramedic education including radiologic technology, respiratory therapy, allied health chairpersons, athletic training, and physician assistant programs. The studies shared common results and suggested the need for further research along with leadership development for program directors (Aaron, 2005; Weissman, 2008; Firestone, 2010; Odai, 2012; and Eifel, 2014).

Finally, (Vilkinas & Ladyshewsky, 2011) used the quantitative Integrated Competing Values Framework (ICVF) survey to study leadership among educational program directors. Among their recommendations for further research was: "Qualitative research, which explores some of the conceptual differences uncovered by the metrics in this study, may also help to deepen understanding of the pressures these Academic Program Directors [sic] face in their role…" (p. 123).

Purpose of the Study

The purpose of this study was to explore leadership practices of program directors in nationally accredited paramedic education programs. The goal was to address the problem of

a lack of identifiable leadership practices in such program directors. Accordingly, I sought to identify leadership context, challenges, and best practices of program directors of nationally accredited paramedic education programs. Although standards and guidelines of accreditation are developed by the Committee on Accreditation of Educational Programs for the EMS Professions (CoAEMSP), and published by the Commission on Accreditation of Allied Health Education Programs (CAAHEP), they do not directly inform leadership. Instead, the standards and guidelines merely establish minimum benchmarks for which to measure the process of conducting an accredited program (Commission on Accreditation of Allied Health Education Programs [CAAHEP], 2005). What remains is a dearth of leadership practices for program directors to employ in creating and maintaining quality programs.

Subject matter experts were invited to participate in semi-structured interviews to answer questions regarding leadership practices of program directors of nationally accredited paramedic program directors. The subject matter experts were asked to offer personal stories, perceptions, and professional observations to reveal rich and meaningful insights. The study focused on three areas of leadership. The first focus area was to explore the context of leadership among program directors. Accordingly, the research explored what it meant to be a leader of a program and identified relevant leadership skills as well as positive leadership practices. The second area explored challenges in leading programs, including common struggles program directors face in leading their programs. The third focus was identification of best practices of leadership among program directors of paramedic education programs. Through the exploration of the context, challenges, and practices of leadership, a groundwork of evidence emerged providing program directors with fundamentals to employ. Since no such study has ever been conducted, the contribution of this study to the field of EMS

education was expected to be significant in adding to the related leadership literature. Considering the previous literature and recommendations for further study found in the associated fields, the related purpose in the study of paramedic education program directors appeared to hold great promise.

Research Questions

The principal research question for this study was: What are the leadership practices of program directors of nationally accredited paramedic education programs?

Three supporting research questions informed the study and assisted in answering the principal question:

a. In what context do program directors practice leadership?

b. What are the challenges in program director leadership?

c. What are the leadership best practices of being a program director?

Significance of the Study

Program directors of paramedic education programs are in roles of leadership, yet no specific leadership practice foundation exists for training nationally accredited paramedic education program directors, leaving a subsequent gap in literature and in practice (Hertelendy, 2010). Other than the CoAEMSP standards and guidelines, program directors lack any kind of framework to enable them to develop their leadership. The problem is amplified by a recent mandate of accreditation and subsequent exponential growth in the number of nationally accredited programs. To further compound the issue, many participants in a joint study by the National Association of EMS Educators and the National Registry of EMT's indicated paramedic educators frequently experience excessive workloads and lack of resources (Crowe, Bentley, Carhart, & McKenna, 2015). The absence of related literature

stresses a critical need for research. Growth in the field, the accreditation mandate, excessive workloads, and a lack of resources has created a need for future leadership training for new and existing program directors alike. This study helped identify and contribute a better understanding of leadership practices for directors of paramedic education programs.

The proposed study was significant in building a formative body of knowledge concerning leadership for paramedic education program directors and in contributing to relevant leadership theory. The relevant knowledge and experience revealed by the experts in this research provided a valuable foundation of leadership information for new and existing program directors to model. The selection criteria for the experts included individuals who meet three conditions. First, each expert had to have actual program director experience in leading an accredited paramedic education program. With these lived-experiences, each selected subject matter expert was uniquely qualified to share personal and professional stories related to leadership requirements in the job. Secondly, each expert was required to have experience as a CoAEMSP/CAAHEP accreditation site visitor. Site visitor experience offered a window into the wide variety of responsibilities program directors face in preparing for and maintaining national accreditation. Finally, each expert was required to have experience serving on the CoAEMSP Board of Directors. The board of director component offered a window into the administrative roles of program directors. Board experience also provided insight into how standards and guidelines were formulated, interpreted, and executed in relation to a program director's roles and responsibilities. The three criteria required of each expert offered a layered combination of knowledge, experience, and process of program director leadership that qualified him or her as distinctly unique or elite (Marshall

& Rossman, 2006) (See *Figure 2*). Such exclusivity keenly qualified the experts to comment on the context, challenges, and best practices of program director leadership.

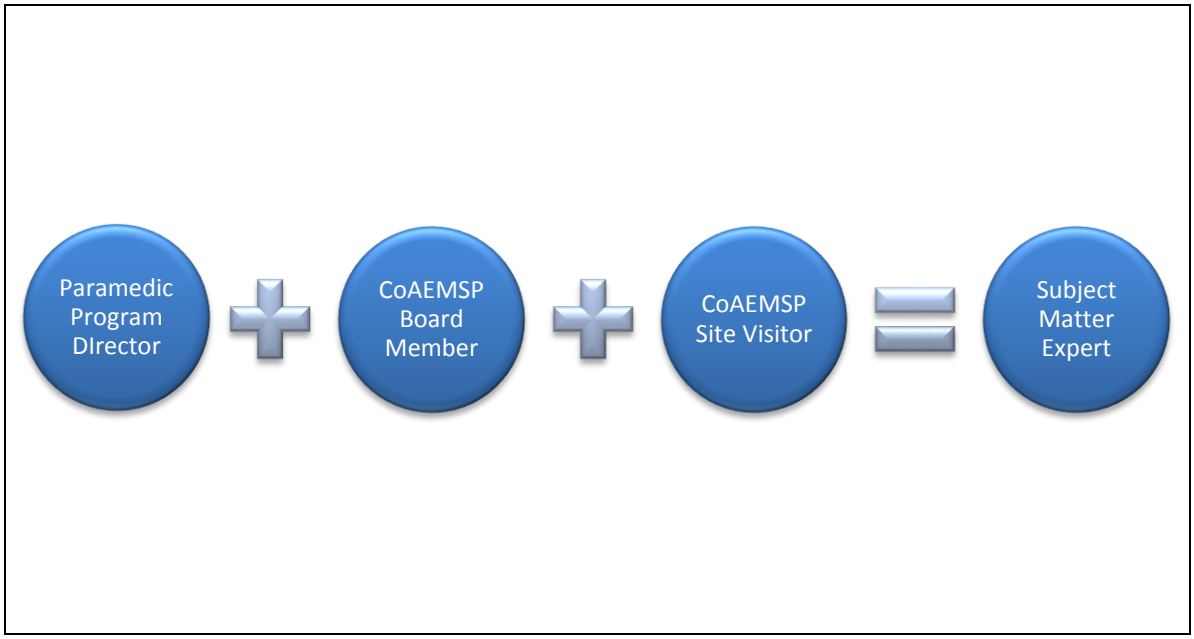

Figure 2: Subject Matter Expert Criteria

List of Abbreviations and Definitions of Terms

The field of paramedic education is filled with many acronyms most individuals outside the field would not likely comprehend. Common abbreviations and terms are provided in the following list. The abbreviations are based on publications from the Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP, 2016b), the Health Resources and Services Administration (HRSA, 2014), and the Commission on Accreditation of Allied Health Education Programs (CAAHEP, 2016a).

Accreditation: The process of assuring standards of quality; in this context related to education.

Accreditation Standards: The CAAHEP Standards and Guidelines for the Accreditation of Educational Programs in the Emergency Medical Services Professions. The minimum requirements of quality to which an accredited program is held accountable; used in accrediting programs that prepare individuals to enter the Emergency Medical Services Professions.

Accreditation Guidelines: Recommended strategies for programs to follow in order to achieve accreditation standards.

Advisory Committee: A group of community of interest members who assist both program and sponsor personnel in formulating and periodically revising appropriate goals and learning domains, monitoring needs and expectations, and ensuring program responsiveness to change. Members include physicians, faculty, administration, students, graduates, employers, police and firefighters, key governmental officials, and public representatives.

AMA: The American Medical Association. An organization that assists physicians in helping patients by addressing important medical issues.

CAAHEP: The Commission on Accreditation of Allied Health Education Programs. The organization accredits paramedic education programs upon the recommendation of CoAEMSP.

CHEA: The Council for Higher Education Accreditation. CAAHEP is recognized by CHEA in the category of "Specialized and Professional Accrediting Organization".

CoAEMSP: The Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions. The organization that recommends paramedic education programs to CAAHEP for accreditation.

HRSA: The Health Resources and Services Administration. It is the primary Federal agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable. In EMS, HRSA is especially concerned with rural, frontier and children issues.

JRC-EMTP: The Joint Review Committee on Education Programs for the EMT-Paramedic. The initial organization founded in 1978, charged with recommending paramedic education programs for accreditation.

NEMSES: The National Emergency Medical Services Education Standards. A published set of guidelines under which paramedic education programs are taught in the United States.

NHTSA: The National Highway Traffic Safety Administration. The federal organization charged with oversight of Emergency Medical Services.

NSC: The National Standard Curriculum. The curriculum under which all EMS courses were taught in the United States prior to the National Emergency Medical Services Education Standards.

Program Director: The individual charged with overal leadership and administration of the paramedic educational program.

Institutional Accreditation: General accreditation that is awarded to a school or organization of higher learning that has met specific standards of education.

Programmatic Accreditation: Specialized accreditation that is specific to education in a particular field of study or profession. In this reference, paramedic education programs.

USDHHS: The United States Department of Health and Human Services. The federal government department that protects the overall health of all Americans and determines policy for healthcare.

USDOE: The United States Department of Education. The federal government department is responsible for educational policy making and federal oversight of education in the United States.

USDOT: The United States Department of Transportation. The federal government department that is responsible for safety in transportation and oversees Emergency Medical Services.

Assumptions and Bracketing

Throughout this study, I assumed participating subject matter experts would agree to be willing to share their observations and experiences of leadership regarding program directors of nationally accredited paramedic education programs. A second assumption was each subject matter expert was able to recall his or her observations and experiences with clarity.

It was assumed the study results would serve to aid current and future program directors in improving leadership of their programs. Similarly, it was assumed the results of the study would generate discussion among EMS educators to further explore the context, challenges, and best practices of leadership among program directors of paramedic education programs. In doing so, the findings were expected to improve the overall quality of respective EMS programs and possibly serve as a motivator for further research. Finally, it was assumed the findings of the study might contain elements that may be generalizable to program directors of other allied health education disciplines.

The concept of bracketing was utilized in the study. Bracketing is often used in qualitative research and is described as “a method used by some researchers to mitigate the potential deleterious effects of unacknowledged preconceptions related to the research and

thereby to increase the rigor of the project" (Tufford & Newman, 2010, p. 81). I described my relationship and experience with the subject to trigger any potential biases. I then bracketed any presuppositions and remained aware of them during study. Bracketing or epoché was used to consciously reserve any preconceived notions and biases towards the leadership topic as much as possible (Creswell, 1998; Merriam, 2007).

At the same time, I continued to be aware throughout the study of any potential biases that may have existed. Also, I continued the bracketing process throughout the study in an effort to suspend my own assumptions and allow the subject matter experts to describe the essence of the meaning of program director leadership.

Epistemological Stance and Theoretical Framework

My epistemological stance was *a posteriori* in nature, seeking to find empirical knowledge from those with experience using inductive reasoning through a qualitative interview process (Trochim & Donnelly, 2008; Merriam, 2009). A constructivist framework helped to inform new meaning while revealing knowledge of necessary leadership practices involved in being a nationally accredited paramedic education program director. In accordance with the qualitative constructivist perspective, an end result was a "dynamic product of the interactive work of the mind made manifest in social practices and institutions" (Paul, 2005, p. 46).

As a criteria for measurement of comparison, the highest performing programs considered exemplary were defined. To define an exemplary program, "Strategies of high-performing paramedic programs" (Margolis, Romero, Fernandez, & Studnek, 2009) was used. The study was a result of a focus group which determined the key strategies programs employed to consistently score high on the National Registry paramedic certification exam.

By using a Nominal Group Technique with representatives of the high-performing programs, the researchers identified 12 such strategies based on the participants' responses. The first strategy identified on the list was to achieve and maintain national accreditation.

Positive effects of national accreditation were validated in other studies as well. Dickison, Hostler, Platt, and Wang (2006), found students who graduated from nationally accredited paramedic programs performed higher on national certification exams than students in non-accredited programs. A later multivariate study (which expanded the Dickison et al., 2006, study), also demonstrated national programmatic accreditation as a key variable in the probability of passing the national paramedic certification exam (Fernandez, Studnek, & Margolis, 2008).

Recognizing the need for accreditation was also consistent with the nationally published report: *EMS Education Agenda for the Future* which declared a need for a "single, nationally recognized accreditation" process for EMS educational programs (NHTSA, 2000). Similarly, a landmark Institute of Medicine Report titled: *Emergency Medical Services at the Crossroads* (2007) stated, "States should require national accreditation of paramedic programs" (IOM, 2007). An agreement among the principal parties regarding the need for accreditation in paramedic education is the premise for this study in examining the leadership of program directors.

A blended theoretical framework of leadership skill theory and positive leadership theory was used as a foundation for the study. Literature was drawn from multiple studies and texts from over sixty years of research (Katz, 1955; Northouse, 2007; Gardner, Avolio & Walumbwa, 2005; George, 2003; Avolio & Gardner, 2005; George & Sims, 2007, Fattig, 2013, and Kokx, 2012).

A pilot study I conducted on leadership skills and traits of EMS program directors (Kokx, 2012), revealed relevant leadership qualities to inform this study. Subsequently, Katz's three-skill approach (1955) and Avolio's and Gardner's positive leadership model (2005) emerged as most relevant theoretical frameworks for the study. Included in the positive approach was an ethical model (Fattig, 2013) and an emphasis on authentic leadership literature (George, 2003; Luthans & Avolio, 2003; Gardner, Avolio, & Walumbwa, 2005; Avolio & Gardner, 2005; Novicevic, Harvey, Ronald, & Brown-Radford, 2006; George & Sims, 2007; Endrissat, Müller, & Kaudela-Baum, 2007). Combining the above leadership approaches provided a basis to develop and determine to what extent relevant skill and positive leadership theory may be used as a practice model for current and future paramedic education program directors.

Limitations and Delimitations of the Study

Creswell (2007) described limitations as identifying "potential weaknesses in the study" (p. 148) and Simon and Goes (2013) state: "Limitations are matters and occurrences that arise in a study which are out of the researcher's control" (p. 1). The proposed study had the following limitations: (a) the field of EMS has limited published literature from which to research. Limited published literature is due largely to a lack of emphasis on research in initial EMS education; (b) most EMS research is conducted by physicians and nurses rather than paramedics (Gurchiek, 2011). The dominant physician and nurse research may be tempered by the national curriculum change in 1998, which began emphasizing research and today more EMS practitioners are participating in studies (Caroline, 2008); (c) the experts selected for interviews were part of the national accreditation board of directors and may have had a bias towards accreditation and/or an administrative lens of leadership; (d) the

experts may have had a personal bias; (e) I have fulfilled all of the requirements of a defined subject matter expert and may be biased towards questions and/or lack objectivity in some areas; (f) because of my position as the Assistant Director of Accreditation Services, there may be a perceived bias of positional power differential (Creswell, 2007). This may have potentially created a perception of researcher influence (Alvesson & Sköldberg, 2000), researcher bias (Maxwell, 2005), and/or expert response bias (Fowler, 2009). The positional power differential was reduced due to the fact my position answers to the board of directors on which most of the candidates serve and by instructing participants to consider me as a peer rather than someone in an administrative position. Due to the relatively small size of the EMS education profession and my position, the experts were all known to me through professional relationships which may have introduced further unintended researcher influence. Such influence was reduced by implementing a balanced "I-Thou" interviewer/interviewee relationship, which verged on a "We" approach during the interviews to help foster communication and gather quality data (Seidman, 2006, p. 96).

The study had delimitations. Delimitations were defined by Creswell (2007) as a narrowing of a study to specific participants or sites, or to a single type of research design (p. 148). Delimitations involve the concept of *emic*, defined as organizing "findings into schemes derived from the data themselves…from a perspective of an insider to the culture" (Merriam, 2007, p. 29). Through a basic qualitative approach and narrowing of interviews to specific subject matter experts deeply rooted in the culture; rich, lived-experiences informed the study.

Using a basic qualitative approach to focus on skills and positive leadership models through interviewing a narrow field of twelve purposely selected EMS education leader

SME, the study was not exhaustive of all EMS education leaders. Subsequently, findings may not be universal to all leadership theories selected or to the entire population of program directors. Furthermore, subsequent to the purposeful narrow selection of subject matter experts, findings were limited to views of those who met the three selection criteria of CoAEMSP-experienced: (a) board members; (b) site visitors; and (c) program directors. Lastly, this study focused specifically on practices of leaders and not practices of followers.

Summary

This basic qualitative study explores leadership practices of program directors of nationally accredited paramedic education programs. Considerations of leadership context, challenges, and best practices inform the research through a framework of positive leadership theory and leadership skill theory. Semi-structured interviews of elite subject matter experts reveal insights and perceptions of program director leadership practice.

Chapter 2 explores the relevant literature and history of EMS; EMS education; accreditation; EMS education accreditation; roles, responsibilities and qualifications of EMS program directors; and various leadership theories. Emphasis is given to positive leadership theory (i.e. authentic, ethical, servant, charismatic, spiritual and transformational), as well as leadership skills theory. A previously conducted pilot study is included to further inform the study.

Chapter 3 describes the basic qualitative research methods and process used in the study. A thorough description of the research design, methodology, analytical framework, and participants are included. Also described are data collection procedures used and a qualitative data analysis explanation.

Chapter 4 provides a comprehensive description of the findings of the study. Included are subject matter expert demographics, a description of participants and the process and analysis of findings determination. Findings include the context, challenges, and best practices of leadership practice for paramedic education program directors. Categories of internal and external factors within challenges and best practices are provided to thoroughly discuss the topics.

Chapter 5 offers emergent themes of paramedic program director leadership. Context and best practice themes include a need for understanding and cultivating quality. Challenges of program director themes include EMS identity struggle and generational dissonance. Each of the themes are discussed to consider current and future implications for program director practice and potential training.

Chapter 6 provides a summary and conclusions of the study in relation to the blended theoretical framework of positive leadership theory and leadership skill theory. Also included are a discussion of the findings relevant to leadership practice and recommendations for future research which may inform future leadership training.

Chapter 2

Review of Literature

Introduction

The purpose of this study was to explore leadership practices of program directors in nationally accredited paramedic education programs. Little evidence is available detailing leadership practices of an exemplary or even effective program director. The study focused specifically on discovery of the context, challenges, and best practices of leadership. Chapter 2 is provided as a survey of the literature including an examination of foundations and dimensions of program director leadership.

Initial topics provided in Chapter 2 include a history of Emergency Medical Services (EMS), EMS education, accreditation, EMS-education accreditation, and the role of paramedic education program directors. By understanding the history of the profession and education required to practice, the reader will appreciate the requirements of program leadership needed to influence instructors in bringing students into the profession. Similarly, the chapter contributes to understanding the dynamics of educational accreditation. An understanding of requirements and demands placed upon program directors in meeting national standards of education will emerge. Roles of program directors are also discussed to describe the many demands and opportunities of leadership that exist in the field.

A survey of various theoretical leadership models is offered to provide a basis to relate expected subject matter expert responses to leadership skills, traits, and positive leadership model practices. Having observed the EMS education profession for over 32 years in roles of a student, instructor, program director, and accreditor, I identified the most relevant subject areas I believed subject matter experts would relate to the most effective

leadership. Because of the identified gap in the existing literature, a broader net was cast in this review to capture the larger, general vision of leadership. By drawing on related fields and the broader fields of organizational leadership, a solid foundation of leadership theory and practice is offered in Chapter 2. Specific areas of skills, positive leadership models, and allied health education program director leadership studies are identified to assist in informing the reader. Finally, a pilot study is included to further focus the lens of the literature review specific to paramedic education program director leadership. The pilot study served as a "small scale version, or trial run, done in preparation for the major study" (Polit, Beck, & Hungler, 2001, p. 467). Subsequently, findings from the pilot study assisted in informing the direction of the study and the choice of leadership topics studied.

History of the Emergency Medical Services Profession

To understand leadership of paramedic education program directors, one must understand the profession of Emergency Medical Services (EMS). The original concept of EMS can be traced to ancient history. Evidence of initial patient treatment protocols are found as far back as Sumeria some 5,000 years ago (Bledsoe, Porter, & Cherry, 2010). During the French Napoleonic wars the concept of *triage* (or sorting of patients) was first used by Dr. Jean Laurie to determine severity of injuries along with the first ambulances called *ambulance volante* or “flying ambulances” pulled by horses to rush wounded soldiers from the battlefield (Brewer, 1986). Since then, many EMS treatments and protocols have come from treating casualties of wars. In the American context of reference, this included basic emergency care rendered in the American Civil War, World War I, and World War II (American Academy of Orthopaedic Surgeons (AAOS), Caroline, Elling, & Smith, 2013).

Later, helicopters were utilized in Korea and Viet Nam to evacuate injured trauma patients and transport them to mobile field hospitals (EMS Agenda for the Future, 1996).

Though much emergency care has been learned from war, EMS has a relatively short history in a civilian context. Nevertheless, EMS has enjoyed a rapid phase of growth towards a profession. The modern field of EMS began in early 1970s when it transitioned from funeral home-based ambulance attendants who provided minimal care to formalized Emergency Medical Technician training. Much of the transition was precipitated as a result of: "Accidental Death and Disability: The Neglected Disease of Modern Society" (also known as the White Paper), published in 1966. The study found accidental injuries in the United States as the "leading cause of death in the first half of life's span" and "if seriously wounded…chances of survival would be better in a zone of combat than on the average city street." (Edgerly, 2013).

Over the next 30 years, a National Standard Curriculum, national accreditation standards, and a national registration system evolved, albeit independently of one another (EMS Education Agenda, 2000). Because of the independent evolution, a system was needed to bring each component together to create a functional, comprehensive, and systematic approach. To do so, the *EMS Agenda for the Future* was authored by field experts and published in 1996. The Agenda articulated the present state of EMS as well as where experts believed the profession's direction should go. Included in the Agenda was a proposal for a national system of EMS education to make educational curriculums among states and levels of certification more consistent. An *EMS Education Agenda for the Future* followed in 2000 (NHTSA, 2000).

A vital component of the *EMS Education Agenda* was a recommendation for a single, national accreditation for paramedic education programs. The intent was to standardize the quality of paramedic education across the country and ensure minimum competency of graduates based on evidence-based research. Subsequently, the field of EMS would fall in line with other allied health education and advance itself further as a profession. The national CAAHEP accrediting body of EMS education programs has officially adopted the *EMS Agenda* description of the profession:

> The Paramedic is an allied health professional whose primary focus is to provide advanced emergency medical care for critical and emergent patients who access the emergency medical system. This individual possesses the complex knowledge and skills necessary to provide patient care and transportation. Paramedics function as part of a comprehensive EMS response, under medical oversight. Paramedics perform interventions with the basic and advanced equipment typically found on an ambulance. The Paramedic is a link from the scene into the health care system. Emergency Medical Technician-Paramedics are responsible and accountable to medical direction, the public, and their peers. Emergency Medical Technician-Paramedics recognize the importance of research and actively participate in the design, development, evaluation and publication of research. Emergency Medical Technician-Paramedics seek to take part in life-long professional development, peer evaluation, and assume an active role in professional and community organizations. (NHSTA, 2000)

In principle, paramedics are true healthcare professionals highly educated to respond day or night in often-difficult environments to treat sick and injured people during times of

greatest need. Accordingly, EMS education must be rigorous to prepare students for literally any kind of emergency situation.

History of Emergency Medical Services Education

As the EMS profession has evolved through the years, so has the education required of its providers. Subsequent to the White Paper report in 1966, the federal government granted funding for training and development which included the first standardized national standard curriculum for training Emergency Medical Technicians at the EMT-Ambulance level (EMS Agenda for the Future, 1996). The curriculum included basic assessment, trauma care, bleeding and shock control, cardiopulmonary resuscitation, and oxygen administration (Bebe, Funk & Scadden, 2010).

As the concept of EMS grew, so did the level of care that professionals believed could be offered in the prehospital setting. In the early 1970s, an EMT-Paramedic level was developed by pioneers in the field including Dr. Nancy Caroline, MD and Dr. Walt Stoy, PhD, from Pittsburgh. The curriculum was 400 hours of lecture, lab, and hospital clinical, and 100 hours of EMS field internship. All skills EMT-Ambulance providers offered as well as IV therapy, medication administration, cardiac monitoring, and advanced airway management were included in the curriculum (Edgerly, 2013).

Major revisions to the national paramedic curriculum occurred in 1985 and 1998. In 2000, the *EMS Education Agenda for the Future: A System's Approach* was published which "outlined a process where the domain of practice was described (National EMS Core Content) and divided among various levels of field providers (National EMS Scope of Practice)" (Hsieh, 2014, para 10). Students must now graduate from nationally accredited programs that require completion on average of a rigorous 1,400 hour curriculum that

includes pre-requisites or demonstrated competency in medical terminology, math, English, and anatomy and physiology (CAAHEP, 2005; NHSTA, 2009). Research is emerging for prehospital practice and paramedics are beginning to practice evidence-based medicine. Such practice holds promise for maturation towards a bonafide profession based on science rather than anecdotal assumptions. Along with advancement of the profession is a need for increasing quality standards in education. In the next section, the expanded context of ensuring such standards through the process of accreditation in education are considered.

History of Educational Accreditation

The process of accreditation in education involves developing standards from which educational programs are measured to ensure quality of outcomes. In the context of paramedic education, accreditation ensures graduates have completed an approved program compliant with national standards. It also means graduates qualify to take the National Registry paramedic exam.

Educational accreditation in the United States dates back to 1787 when the University of the State of New York (Regents University) was "required by law to visit and review the work of every college in the state; register each curriculum at each institution; and report to the legislature" (Harcleroad, 1980, p. 9). The structure of accreditation process has undergone some changes over time, but in essence remains largely similar to its origins. Regional accreditation agencies formed in the 1880s focused on admission procedures and educational standards, first of which was the New England Association of Colleges and Schools in 1885 (New America Foundation, 2014). As regional standards matured, they provided a common foundation for a national framework.

Several key events during the past century impacted educational institutional accreditation on a national level. Among these included formation of the American Council on Education (ACE) in 1918, (whose purpose was to facilitate accreditation standardization); the Veteran's Readjustment Assistance Act (aka GI Bill) of 1952, (which mandated publication of federally recognized accreditation organizations); the Higher Education Act of 1965, (that formally regulated accreditation in the United States); and the formation of the Council for Higher Education Accreditation (CHEA) in 1996, (which provided an accreditation voice to congress, the American public, and international parties) (ACICS, 2014; CHEA, 2012). Historically accreditation has been primarily quantitative in nature. More recently a shift in funding has supported outcomes-based education. Accreditation played a role in validating such outcomes which have become increasingly more qualitative in nature (Lubinescu, Ratliff, & Gaffney, 2001). A byproduct of the less-prescriptive, qualitative shift is the allowance for schools to foster innovation to implement creative ways to meet the standards (Cineros-Blagg & Scanlin, 1986).

As accreditation became more expected, so did a need for programmatic or curricula-specific accreditation. Allied Health education was no exception. Congress passed the Allied Health Professions Training Act in 1966. Contained in the legislation was a requirement for ongoing assessment of allied health professional training and education needs. The legislation also empowered the American Medical Association (AMA) to grant authorization to educational institutions that sponsor and provide education to allied health professions (USDHEW, 1969).

In response to the legislation, the AMA developed a system similar to medical schools to accredit allied health education programs through the Commission on Allied

Health Education Accreditation (CAHEA). In order to accomplish this task, many allied health professions established specialized accreditation comprised of representatives from relevant physician organizations as well as professional organization to develop and assess standards of education that would lead to accreditation (Wilfong, 2009). In 1994, CAHEA dissolved and the Commission on Accreditation of Allied Health Education Programs (CAAHEP) was formed in its place. Today CAAHEP accredits over 2,100 entry-level allied health education programs across 28 different disciplines including Emergency Medical Services education (CAAHEP, 2016b).

History of Emergency Medical Services Education Accreditation

Programmatic accreditation specific to EMS education began in 1976 when the "Essentials for Paramedic Program Accreditation" was developed by the American Medical Association (AMA). Two years later in 1978, the Joint Review Committee on Education Programs for EMT-Paramedic (JRCEMT-P) adopted "Essentials" as their standards for accreditation (EMS Education Agenda, 2000). Subsequent to the 1994 AMA decision to no longer be involved in the allied health education process, the JRCEMT-P became part of CAAHEP. Then, in 2000, CAAHEP formed individual committees on accreditation for its many allied health education programs (Walz, 2010). As a result, the Committee on Accreditation of Educational Programs for the EMS Professions (CoAEMSP), was formed for the purpose of recommending EMS education programs to CAAHEP for accreditation (NAEMSE, 2013).

CAAHEP describes accreditation as "an effort to assess the quality of institutions, programs, and services, measuring them against accepted quality standards. The accreditation process is designed to evaluate and ensure that these standards are met" (CAAHEP, 2013,

para 1). Representation consisting of two appointed members from each sponsoring organization comprises the committee on accreditation's board of directors. Presently 14 sponsors serve on the CoAEMSP board of directors providing input, feedback and administrative actions for program actions (See Table 1).

Table 1: CoAEMSP Sponsors

American Ambulance Association (AAA)
American Academy of Pediatrics (AAP)
American College of Cardiology (ACC)
American College of Emergency Physicians (ACEP)
American College of Osteopathic Emergency Physicians (ACOEP)
American College of Surgeons (ACS)
American Society of Anesthesiologists (ASA)
International Association of Fire Chiefs (IAFC)
International Association of Fire Fighters (IAFF)
National Association of EMS Physicians (NAEMSP)
National Association of Emergency Medical Services Educators (NAEMSE)
National Association of Emergency Medical Technicians (NAEMT)
National Association of State Emergency Medical Services Officials (NASEMSO)
National Registry of Emergency Medical Technicians (NAEMT)

Table created by author based on CAAHEP Standards, 2005.

Together, the sponsors are charged to: "cooperate to establish, maintain and promote appropriate standards of quality for educational programs in emergency medical services professions and to provide recognition for educational programs that meet or exceed the

minimum standards outlined in these accreditation Standards and Guidelines." (CAAHEP, 2005, p. 1). Moreover, the purpose of the standards "are to be used for the development, evaluation, and self-analysis of Emergency Medical Services Professions programs" (CAAHEP, 2005, p.1).

In fulfilling its purpose, programmatic accreditation measures five broad standards including: (a) sponsorship; (b) program goals; (c) resources; (d) student and graduate evaluation/ assessment; and (e) fair practices (CAAHEP, 2005). The standards also include sponsor-approved benchmarks of education to measure overall quality of an EMS program that protect students, lead to better educational outcomes, and ultimately result in better patient care. To accomplish this, accreditation works symbiotically with professional licensure and or certification in ensuring competent paramedic providers. In other words, "Along with certification and licensure, accreditation is a tool intended to help assure a well-prepared and qualified workforce providing health care services" (CAAHEP, 2016c).

Since the genesis of EMS accreditation, some programs across the nation chose to become accredited while many others did not (Hertelendey, 2010). Thirty five years later national accreditation became mandatory for all paramedic education programs subsequent to the National Registry of EMT's landmark decision to advance the *EMS Agenda for the Future* (NREMT, 2012).

Given the cost and effort for programs to become accredited, critics may question its value. A seminal study in 2006 demonstrated the value of accreditation, indicating a positive correlation between program accreditation and subsequent success on the national certification exam. Results of the study showed 12,773 students who took the national certification in 2002, and those who graduated from nationally accredited paramedic

programs passed the National Registry paramedic exam at a higher rate than students who graduated from non-accredited programs (Dickison, Hostler, Platt, & Wang, 2006).

Anticipating the implementation of mandatory accreditation of paramedic programs, the NREMT and CoAEMSP joined forces with the National Association of State EMS Officials (NASEMSO) to determine challenges facing programs that would be seeking accreditation for the first time. Together they conducted an in-depth, survey-based study in 2009 titled, "Knowledge, Attitudes and Barriers to National Accreditation" to examine the state of affairs of EMS education accreditation across the United States. The study considered multiple angles of the accreditation issue and offered a snapshot of the state-of-the-state of paramedic education and accreditation (NREMT, 2010). The survey of programs across the country was conducted to determine if the time was right for such a mandate. An outstanding rate of return (88% of the programs surveyed) responded to the survey. The findings were significant, insofar as 68.5% indicated accreditation would improve their paramedic programs, 74% believed it would offer long-term benefits for students, 75% indicated it would promote quality improvement, 77% perceived it as a positive move, and 78% stated a single, national accreditation would benefit the profession (NREMT, 2010). The results were resounding. Clearly, the time for mandatory accreditation had come.

As the situation evolved, a common question asked by educators was: "Why should paramedic education programs become accredited?" In their 2011 article "Why accreditation – and why now?" nationally-known EMS educators Patricia Tritt and Debra Cason explored various answers to the question. Citing the 20 year national professional recommendation by *The EMS Agenda for the Future,* (which was supported by NASEMSO, NHTSA, and HRSA), a likely increase in certification exam performance, and advancing professionalism

by achieving credibility, Tritt and Cason (2011) professed the need for quality standards and the subsequent increase in quality of education for those who follow the standards. The authors argued a case for accreditation and its urgent implementation in stating, "Quality begins by evaluating ourselves against a set of industry established guidelines" (p. 10).

In a similar declaration, in their *FAQs for Implementing the EMS Education Agenda: A System's Approach*, NASEMSO (2009) stated: "Simply stated, it's more difficult for those in an organization to ignore the recommendations of an outside, independent agency that is recommending improvements in the educational process" (p. 8).

Benefits of accreditation also appear to extend beyond EMS education to other allied health fields. In a reflective observation, Jack Trufant, former Dean of Health Sciences and founding member of the CAAHEP Board of Directors stated: "The maturation and growth of many health professions over the past half-century have been accompanied in nearly every case by the initiation of an accreditation process for their educational programs" (CoAEMSP, 2010, p.1). A key resource measured in the accreditation process is a need for a qualified program director who can fulfill all responsibilities of the position. A description of the roles, responsibilities and qualifications of that type of individual is provided in the next section.

Roles, Responsibilities, and Qualifications of EMS Program Directors

Emergency Medical Services education program directors are individuals who oversee and ensure quality in paramedic educational programs. The program director is also "ultimately responsible for getting the program approved (authorized) by the institution, the state or local regulatory agencies and the accreditation body, when necessary" (NAEMSE, 2003, p. 19). According to national accreditation standards and guidelines, program directors

are required to fulfill specific responsibilities and ultimately are responsible for all aspects of the program. Specific responsibilities include, but are not limited to:

1. The administration, organization, and supervision of the educational program,
2. The continuous quality review and improvement of the educational program,
3. Long range planning and ongoing development of the program,
4. The effectiveness of the program and have systems in place to demonstrate the effectiveness of the program,
5. Cooperative involvement with the medical director, and
6. Adequate controls to assure the quality of the delegated responsibilities.

(CAAHEP, 2005, pp. 5-6)

Emergency Medical Services program directors are often individuals challenged to wear many hats. Many are full time instructors in their programs and must find a balance between teaching and administration of the program. Besides teaching, program directors are often tasked with multiple duties extending beyond the immediate classroom. Additional duties often include curriculum design, resource allocation, faculty assignments, student and faculty grievances, recruitment, retention, data collection, annual reports, accreditation self-studies and site-visits, and outcomes assessment (CAAHEP, 2005).

Though some program directors are given release time for extra duties not directly associated with teaching (NAEMSE, 2013), the challenge of finding balance between teaching, administration, and life in general is often a daunting task. A recent study suggested paramedic educators who are scheduled to work 25 hours a week actually work closer to 60 hours per week (Crowe, Bentley, Carhart, & McKenna, 2015). When comparing the challenges of an EMS program director to a modern-day college Department Chair, the

challenges are similar. Department Chairs are often charged with duties such as signing paperwork, managing adjunct instructors, coordinating assessments, and even fund raising for programs (June, 2013).

Commission on Accreditation of Allied Health Education Program standards state a paramedic Program Director must meet the following qualifications: (a) possess a minimum of a bachelor's degree from a regionally accredited institution of higher education; (b) have appropriate medical or allied health education, training, and experience; (c) be knowledgeable about methods of instruction, testing and evaluation of students; (d) have field experience in the delivery of out-of-hospital emergency care; (e) have academic training and preparation related to emergency medical services at least equivalent to that of program graduates; and (f) be knowledgeable concerning current national curricula, national accreditation, national registration, and the requirements for state certification or licensure (CAAHEP, 2005). By stipulating such qualification criteria, program directors are required to not only have field experience in the delivery of prehospital care, but also formal education and knowledge of the educational process. For example, the bachelor's degree mandate was adopted and went into effect January of 2011 (CoAEMSP, 2010).

Although expected roles and responsibilities are clearly defined, the leadership practices and skills a program director must possess in carrying out a program's mission are not. Many leadership models exist, but which is (or are) the best or most applicable for program directors to use in order to accomplish their mission? To discover an answer, this research examined several models. For purposes of this study, the vast field of leadership practices were narrowed based on a pilot study of leadership in EMS program directors (Kokx, 2012). The pilot study: *A Study of Leadership Factors in Paramedic Programs*

Moving toward National Accreditation was conducted using a conceptual framework of leadership skills (Katz, 1974) and leadership traits (Northouse, 2007). After analysis the skills category expanded to skills and abilities, whereas the traits category expanded to traits and qualities. A third category also emerged, which was called further factors.

Upon further reflection, the subject matter expert responses in the pilot study revealed less about traits and more about qualities or practices such as leadership behaviors of leaders. Examples included accountability, patience, diligence, decent human being, tenacity, and integrity. Subsequently, this study was modified to explore leadership practices of program directors, focusing on skills and positive leadership. The following section will consider relevant models of leadership based on the pilot study as well as my personal experience as a student, provider, instructor, program director, and accreditor in the field of EMS education over the past 32 years.

Leadership Models

Leadership skills. A theoretical skills approach to leadership framework is used as an initial reference for the study, drawing largely on the published work of "Skills of an Effective Administrator" by Katz (1955 & 1974), and "Leadership Skills for a Changing World: Solving Complex Social Problems" by Mumford, Zaccaro, Harding, Jacobs, & Fleishman (2000). The Katz study, initially written in 1955, held a premise that leaders do not need to be born with special traits, but rather can learn effective skills to become successful in their leadership endeavors. According to the theory, three categories of leadership skills are necessary for all leaders to possess which include technical, human, and conceptual categories (Katz, 1955). Originally, Katz thought these skills were required at

different degrees for different levels of management. After further study, Katz revised his theory to state they are actually necessary at all levels (Katz, 1974), (See *Figure 3*).

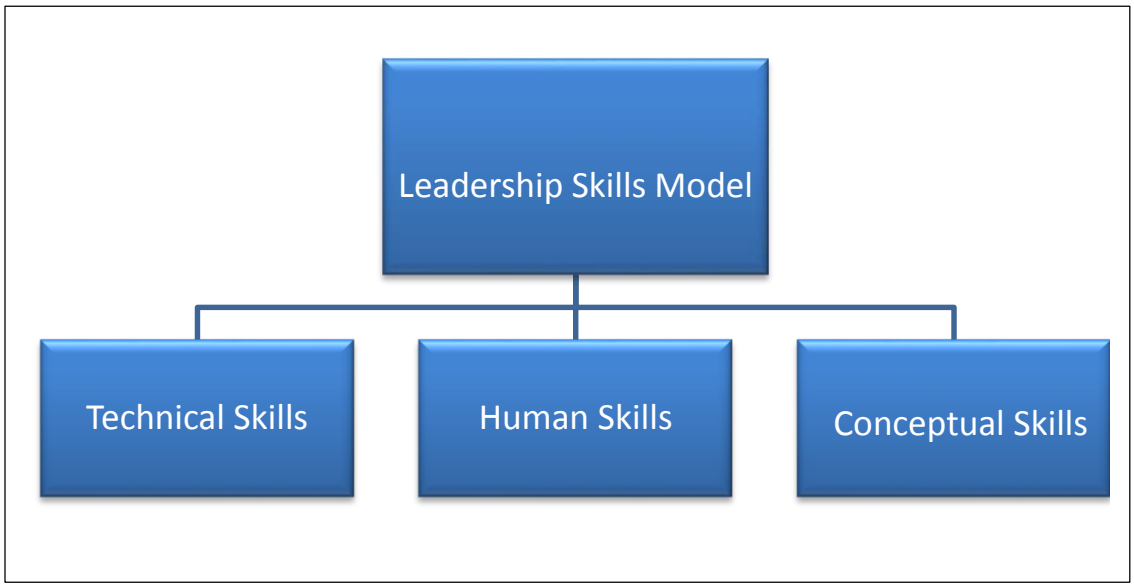

Figure 3: Leadership Skills Model based on. Katz (1974).

Human skills (i.e. the ability to relate to others) are necessary in all management positions. Technical skills are especially important for administrative positions since such administrators must be able to understand the necessary tasks to be performed by employees at all levels. Conceptual skills (i.e. the ability to formulate concepts and ideas) are important for administrators to assist in developing visions for organizations. Such skills also assist administrators in understanding how the various pieces of an organization relate to one another to achieve a greater purpose. By framing leadership skills in these categories, Katz was able to offer a conceptual framework that addressed vital components for all administrators while remaining logical and readily applicable.

Because EMS program directors align with the administrative category, they must possess a significant amount of each skill. Technically, they must complete items such as budgets, annual accreditation reports, grants, and conduct employer as well as student

surveys. Human skills required of program directors include forming and maintaining quality relationships with faculty, administrators, students, advisory committees and other communities of interest. Conceptually, program directors must be able to view their programs in an objective context that allows them to see the past, present, and future. In doing so, program directors can prepare their programs for a successful future by learning from experience.

Though largely beyond the scope of this study, Mumford et al. (2000) expanded upon Katz's framework of skill leadership by adding additional components. Their comprehensive skill-based theory of leadership was derived from a project conducted for the US Department of Defense using a sample of more than 1,800 Army officers of various rank based on problem solving skills in organizations (Northouse, 2007, p. 43). Based heavily on the concept of learning leadership skills from experiences, the theory professes that anyone can learn to become a successful leader. In short, the study considered leader capabilities through the relationship between the leader's knowledge and skills as compared to his or her performance (Mumford et al., 2000). In the study, the authors described a model containing three main components of individual practices, competencies, and leadership outcomes as well as two lesser components of career experiences and environmental influences. The "Individual Practices" category included general cognitive ability, crystallized cognitive ability, motivation, and personality. The "Competency" category comprised problem-solving skills, social judgment skills, and knowledge. Finally, the "Leadership Outcomes" component included effective problem solving and performance (Mumford et al., 2000).

Each of the three main categories Mumford et al. discovered also included elements of the technical, human, and conceptual components as noted in the Katz skill leadership

theory. The three components of leadership skill theory can clearly be linked to the key components of a paramedic program director's responsibilities specified in the accreditation Standards and Guidelines (CAAHEP, 2005).

Closely related to Katz's model of leadership skills are what Heifetz and Linsky (2002) described as recognizing and treating technical problems (routine management) versus adaptive challenges (issues of leadership). Whereas technical issues can often be remedied by authority roles and in-fact solutions, adaptive challenges require learning new ways to change behavior that are often tied to a person's identity, heritage, and values (p. 14). Since the latter is much harder to "fix," the leader must strive to understand the background and history of the problem before attempting to move towards a solution. The ability to understand the difference between technical and adaptive problems is significant. Heifetz and Linsky (2002) state: "Indeed the single most common source of leadership failure we've been able to identify – in politics, community life, business or the nonprofit sector – is that people, especially those in positions of authority, treat adaptive challenges like technical problems" (p. 14).

Because adaptive change requires individuals to lose or change something in which they are vested and/or have strong beliefs, it takes great skill to navigate. The authors describe it as taking "an extraordinary level of presence, time, and artful communication" (Heifetz & Linsky, 2002, p. 15). Effective leaders must be able to live in the disequilibrium that results from the potential loss in adaptive change and be able to help others through the process. A leader must develop the skill of ascertaining what others may be willing to give up and what must they keep. Such situations will likely present themselves to individuals serving as program directors. For example, issues of budgets, teaching loads, faculty

assignments, new curriculum implementation, and rank promotion may all arise as adaptive challenges rather than technical problems. A program director who possesses the skill to make a proper differentiation between technical and adaptive situations – and subsequently develop the appropriate solutions – may avoid serious issues and have a positive outcome on the health of his or her program.

The next section will address positive leadership models that may likely influence paramedic education program directors. Included in the positive leadership models are authentic, ethical, servant, transformational, spiritual, and charismatic approaches. Each will be considered in regards to paramedic program director leadership.

Positive leadership. Known for their research in authentic leadership, Avolio and Gardner (2005) described what they called "positive forms of leadership." In addition to authentic leadership they broadened their scope to include in their positive definition models of servant, charismatic, transformational and spiritual leadership. Using a similar approach, Fattig associated these models during her doctoral study of formal leadership of community college Department Chairs and also included an ethical leadership component (Fattig, 2013). Given the parallels of Department Chairs duties as compared to the duties of EMS Program Directors, Fattig's positive leadership model is included in this study (See *Figure 4*). Due to pilot study results (Kokx, 2012), special emphasis was given to the authentic model of leadership.

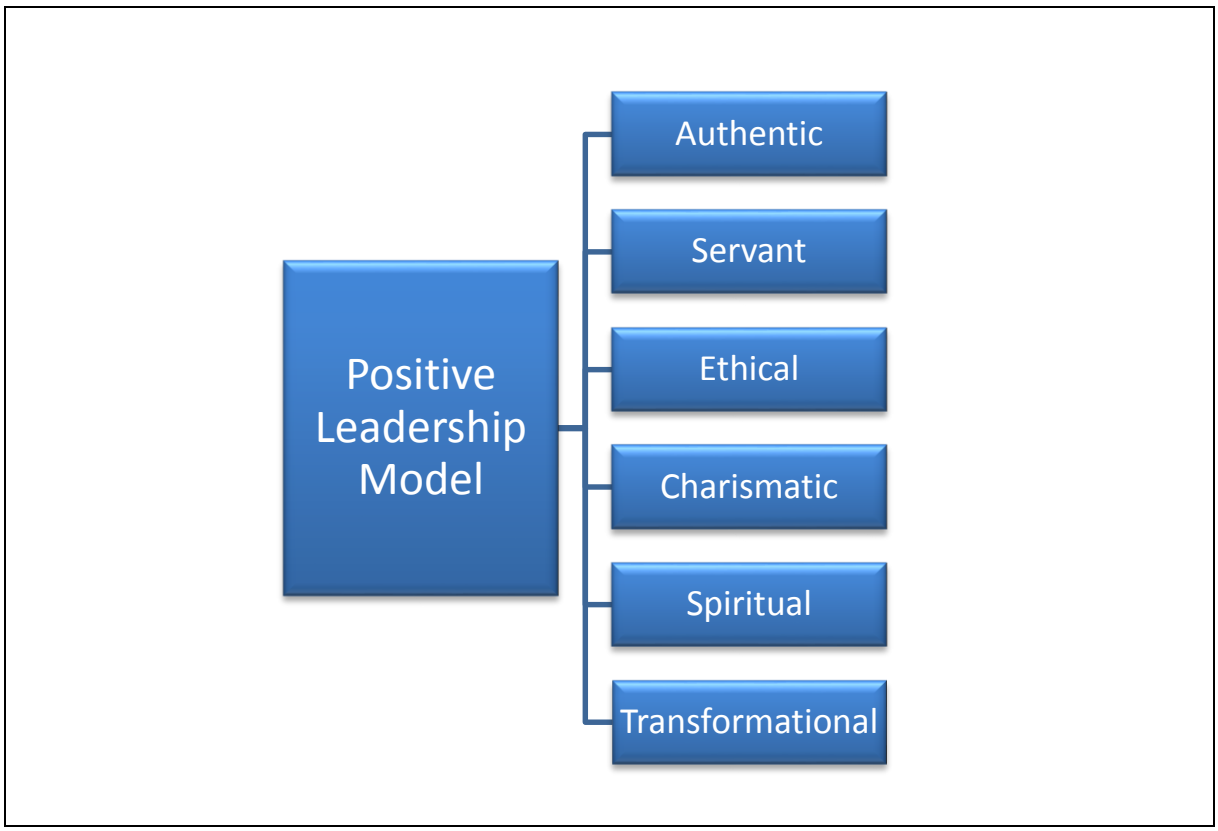

Figure 4: Positive Leadership Model based on Avolio & Gardner (2005) and Fattig (2013).

Authentic leadership. The authentic leadership model offered another angle to view EMS program director leadership that augmented the lens of the leadership skills approach (Katz, 1974) by considering leader's behaviors. Since a program director's functions involved dealing with stakeholders (i.e. students, faculty, administration, staff, advisory committee members, and one's self), authentic behavior was crucial to success. The concept of authenticity has been defined since the ancient Greeks and further conceptualized through the years by philosophers such as Heidegger, Sartre, and Kierkegaard. Although their respective philosophies differed in part, their central themes of authenticity included a keen awareness of one's self, one's emotions, and a responsibility to others (Novicevic, Harvey,

Ronald, & Brown-Radford, 2006). George (2003) defined authentic as "genuine; worthy of trust, reliance, or belief" (p. xvii).

Much of authentic leadership theory was born out of the need for genuine leaders subsequent to corporate scandals and improprieties (Cooper, Scandura, & Schriesheim, 2005). Authentic leadership theory has been validated in various cultures and nations including China, Kenya, and the United States (Walumbwa, Avolio, Gardner, Wernsing, & Peterson, 2008). In specific regards to educational administration, Begley (2006) described authentic leadership as "a metaphor for professionally effective, ethically sound, and consciously reflective practices…" (p. 570).

George (2003) asked: What does it take to become an authentic leader?

> In my experience it takes many years of personal development, experience, and just plain hard work. Although we may be born with leadership potential, all of us have to develop ourselves to become good leaders. The medium for developing into an authentic leader is not the destination but the journey itself – a journey to find your true self and purpose of your life's work. (p. 27)

Through an innate trait lens, George's answer appears to allude to skills, traits, and behaviors, whereas through a learned ability lens, one may see perseverance, self-development, devotion, and self-reflection. Moreover, his declaration of a journey provides wisdom to not seek a destination of leadership, but rather to embrace a process of constant becoming in order to align with one's talents, gifts, and strengths for the greater good.

In a recognized theory of authentic leadership, Avolio suggested a blend of skills and traits are needed to become a successful leader. Rather than referring to individuals as being born as leaders, Avolio - similar to George's "journey" - suggests leaders are in a constant

"state of becoming" (Avolio, 2005, p. 3). Echoing a similar theme, Eriksen (2011) stated the need for leaders to continuously develop "one's self-awareness of and movement toward one's ideal self" (p. 699). This is a vital concept in that no one of authenticity ever attains a place of ultimate leadership but rather is always learning, developing, and reflecting on how to become a better leader.

Luthans and Avolio (2003) described an authentic leader as "confident, hopeful, optimistic, resilient, moral/ethical, future-oriented, and gives priority to developing associates as leaders. The authentic leader is true to him/herself and the exhibited behavior positively transforms or develops associates into leaders themselves" (p. 243). Their descriptions clearly suggest a significant role of positive behaviors and a concern for others that will benefit an entire organization. In a similar works, Avolio and other researchers describe components of authentic leadership development theory that focus on the leader which include items such as possessing a positive psychological capital that includes confidence, optimism, hope and resiliency; self-awareness of values, cognitions, and emotions; self-regulation; a positive moral perspective and leadership processes/behaviors that include positive modeling and social exchanges (Avolio & Gardner, 2005; Gardner, Avolio, & Walumbwa, 2005).

Many other researchers have written about similar concepts in related, adjacent theories. Author Stephen R. Covey framed the need for principle-centered leadership that includes an internal moral compass:

> Principles are like a compass. A compass has a true north that is objective and external, that reflects natural laws or principles, as opposed to values that are subjective and internal. Because the compass represents the verities of life, we must

develop our value system with deep respect for "true north" principles (Covey, 1991, p. 94).

George and Sims (2007) suggested the metaphorical authentic leadership model of a compass with the concept of self-awareness at its center surrounded by an integrated life to the west, a support team to the south, motivations to the east and values and principles to the north (p. xxxv). With self-awareness at the center; a leader will always seek perspective of where he or she is in relation to the compass. Moreover, an individual's values and principles are the reference point or the "True North" and by possessing and utilizing such a compass, leaders can stay true to their direction no matter what internal or external disorientations may arise.

In his acclaimed book, *On Becoming a Leader*, Warren Bennis described necessary leadership practices similar to the findings of George, Avolio, and Northouse's meta-analysis. He suggested leaders need vision; passion; integrity (including self-knowledge, candor, and maturity); trust; curiosity; and a willingness to be daring (Bennis, 2009). Such a collection of practices appear to enable leaders to remain focused, motivated, and balanced while maintaining a fair and healthy environment.

Several common themes have emerged from the review of the literature including self-awareness, self-knowledge, understanding one's story, a solid moral structure, the need for strong relationships, and positive role models. Perhaps the model most closely associated with these themes is that offered by George, which he called the Dimensions of Authentic Leaders. In this model he includes the dimensions of (a) purpose; (b) values; (c) relationships; (d) self-discipline; and (e) heart (George, 2003, p. 36). As in his other writings, George emphasizes the qualities are not something that are achieved once, but rather are

sought in a continuous process throughout life. In further describing his dimensions, he states authentic leaders must understand their purpose, practice solid values, lead with their heart, establish concrete relationships and demonstrate self-discipline (George, 2003, p. 18). George's model has characteristics that are similar to those found across the authentic leadership literature, which suggest validity in comparison.

The need for a leader to have purpose is significant. Unless the leader feels he or she is contributing to something greater that has meaning, the outcomes of a leader's organization (or in this case, a paramedic program), are not likely to be positive. Once such purpose is established, the leader must develop a passion for his or her purpose. As George (2003) stated "Passion for your purpose comes when you are highly motivated by your work because you believe in its intrinsic worth, and you can use your abilities to maximize effect" (pp. 36-37).

Closely related to purpose is the need for values. As Endrissat, Müller, & Kaudela-Baum (2007) indicated, much of the impetus for the authentic leadership theory construct was born out of corporate scandals in organizations whose leaders lacked the appropriate behavior to act on adequate values. Since behaviors are often a direct manifestation of values, the role of values in leaders can have dramatic and far-reaching results for either the betterment or detriment of an organization. Kouzes and Posner (2007) espoused a similar theme in stating "Values empower…motivate… and serve as guides to action" (p. 53).

Similarly aligned to the role of values are the moral qualities of leaders. As far back as 1948, Barnard determined the need for a moral component in leadership that could be combined with a technical aspect that would guide organizations. Citing Barnard, authors Novicevic, Davis, Dorn, Buckley and Brown (2005) summarized the notion as "organizations

endure in proportion to the breadth of morality by which they are governed" (p. 1399). Though some may question the efficacy of moral development, May, Chan, Hodges, and Avolio (2003) argued with proper planning and commitment, a moral component of authentic leadership can certainly be developed as well as be sustained over time in a resilient manner across organizational levels. Furthermore, a leader's positive moral example has been found to have positive effect on followers. Conversely, a poor example can have the opposite effect. Gardner, Avolio, and Walumbwa (2005) cited an English study of the same year by Dasborough and Ashkanasy that stated "…when a leader's behavior and intentions are perceived as genuine and trustworthy, attributions of authenticity and positive emotional reactions will follow. In contrast, if follower's (sic) attribute manipulative and self-serving intentions to the leader, negative emotional reactions will arise" (p. 391).

Indeed a leader's moral example can make a difference and value decisions can be affected by tensions and conflicts. George and Sims (2007) called such situations "testing your values in the crucible of life's experiences" (p. 17). Certainly those leaders who remain true to their morals and values are more likely to succeed than those who yield to compromise. Similar wisdom was offered by Martin Luther King Jr. when he said, "The ultimate measure of a man is not where he stands in moments of comfort and convenience, but where he stands at times of challenge and controversy" (King, 1963, p. 26).

Relationships are also vital to authentic leaders. Having a solid foundation of transparency and trust among peers, colleagues, and followers allows a leader to operate in a support system of a team environment that includes all members of an organization or educational program. That said, it appears it may be an easier task for men to build such relationships within leader roles. The challenge appears greater for leaders who are women as

well as members of non-traditional outsider groups (Eagly, 2005). Though such a consideration and examination is beyond the scope of this study, the acceptance of female leaders and those of varied backgrounds will hopefully increase as the workforce diversifies.

Besides having strong relationships with others, another important relationship exists for leaders. It is vital to maintain a healthy relationship with one's perceived, actual, and ideal self. The concept of self-awareness is found consistently throughout authentic leadership literature (George, 2003; May, Chan, Hodges, & Avolio, 2003; Avolio & Gardner, 2005; Gardner, Avolio, Luthans, May, & Walumbwa, 2005; Goffee & Jones, 2005; Iles, Morgeson, & Nahrgang, 2005; Endrissat, Müller, & Kaudela-Baum, 2007; George & Sims, 2007; and Eriksen, 2009). In succinct words, "Yet, it is ultimately about knowing him- or herself, and being transparent in linking inner desires, expectations, and values to the way the leader behaves every day, in each and every interaction" (May et al., 2003, p. 248). Not only do authentic leaders practice self-knowing and transparency when it serves them best, but during every encounter. This in turn promises to optimize authenticity, relational trust, and stronger leadership.

Gardner et al. (2005) expanded the concept of self-awareness to include a leader's values, identity, emotions, motives and goals (p. 346). By seriously considering all of these components a leader can achieve a more comprehensive view of him or herself. In doing so, he or she will undoubtedly have greater self- awareness and subsequently more to offer those being led.

Ilies, Morgenson, and Nahrgang (2005) defined awareness and self-awareness as the following:

> Awareness as a component of authenticity refers to one's awareness of, and trust in, one's own personal characteristics, values, motives, feelings, and cognitions. Self-awareness includes knowledge of one's inherent contradictory self-aspects and in the role of these contradictions in influencing one's thoughts, feelings, actions and behaviors. (p. 377)

In similar fashion, Sparrowe (2005) argued an important concept of "the relationship between a leader's true self and authentic leadership" (p.420). During that same year, Gardner et al. (2005) suggested a self-awareness cause and effect "As leaders gain greater self-awareness and learn to be true to themselves, we expect them to experience greater congruence between their ideal and actual selves" (p. 354).

Aligned closely with self-awareness is the concept of self-regulation. Leaders must know when to measure their responses, especially in times of stress. Knowing when to react and especially when not to react is crucial. This knowledge involves a significant amount of courage or in other words "a mix of instant or longer emotional and cognitive states related to taking action in the face of vulnerability, risks, dangers, potential losses, and consequences to oneself" (Bass, 2008, p. 228). These traits were referred to as emotional intelligence, which also plays a vital role in self-regulation that may aid leaders in avoiding disaster. Novicevic et al. (2005) noted that as far back as 1938, Barnard recognized this in stating: "Responsible leaders are able to control their emotions in the face of moral dilemmas and avoid capricious decisions and behavior." (p.1440)

In a further progression, Erikson stated reflection was a prerequisite for self-authorship which was described by Magolda as "the ability to reflect upon one's beliefs, organize one's thoughts and feelings in the context of, but separate from, the thoughts and

feelings of others, and literally makes up one's own mind" (Magolda in Eriksen, 2009, p.749). Such skill is vital for any leader — including EMS program directors — especially in times of great challenge and stress.

Self-authorship is the ability to understand one's life story. Much like self-awareness, the theme of knowing one's story is frequent throughout authentic leadership literature (Bennis, 2009; Gardner et al., 2005; Gardner & Laskin, 2011; George & Sims, 2007; Shamir, Dayan-Horesh, & Adler, 2005; Shamir & Eilam, 2005). On the first page of their work, George and Sims (2007) asked the fundamental question of leaders: "What is your life story?" followed by "In understanding and framing the story you will find the calling to lead authentically, and you will maintain fidelity to your True North" (p.1). The assumption is if leaders have a clear understanding of who they are and from where they have come, they will be better prepared to understand their contexts of their leadership accordingly. The concept fits nicely into the continuing framework of leadership as a journey rather than a destination resulting in effective outcomes. In other words, "The ultimate impact of the leader depends most significantly on the particular story that he or she relates or embodies, and the receptions to that story on the part of the audiences (or collaborators or followers)" (Gardner & Laskin, 2011, p. 13).

Israeli scholar Boas Shamir and associates studied the relevance of leadership in knowing one's story in detail. In their approach to authentic leadership development, Shamir and Eilam (2005) stated, "Leader's life stories are self-narratives…that provide authentic leaders with a self-concept that can be expressed through the leadership role" (p. 402). By intertwining a self-concept that is based on one's story, a leader can integrate it into every

new chapter that is written as if the story is on a continuum. Such an approach has the potential to become a "novel" of solid leadership.

Through their research, Shamir and Eilam (2005) discovered four major themes related to life stories and their influence on leadership development: leadership development as a natural process, leadership development out of struggle or hardship, leadership development as finding a cause, and leadership development as a learning process (pp. 403-04). The natural process component revealed individuals who seem to possess leadership practices from a young age and subsequently landed in leadership roles. Those who developed out of struggle endured some sort of challenge that transformed them into leaders. Those who found a cause developed as leaders through their connection with a passionate urgency subsequent to identifying with a political agenda or ideology. The fourth and final theme was individuals who developed as leaders by seeing their self-stories as a continual learning experience of trial and errors as well as role-models that helped them connect previous learning to present leadership situations. All four components may be independent or combined as evidenced in various recognized leaders such as Martin Luther King, Jr, Eleanor Roosevelt, and Margaret Thatcher (Gardner & Laskin, 2011).

Role models played a critical role in leadership development as indicated by another study that found learning occurring from other leaders such as figures from history, literature, family members, teachers, and various other peers (Shamir et al., 2005). Shamir et al. (2005) were quick to point out however, that leaders do not simply emulate such role models, but rather use their examples to develop similar traits within themselves. Much can be learned from positive role models in becoming an effective authentic leader. Such modeling "is viewed as a primary means whereby leaders develop authentic followers" while providing

them with "a basic means whereby authentic leaders impart positive values, emotions, motives, goals and behaviors for followers to emulate" (Gardner et al., 2005, pp. 358-59).

Perhaps the leadership model that relies heaviest on emulation is the servant model. In the next section, the role of servant leadership will be considered in relation to the paramedic education program director.

Servant leadership. The theory of servant leadership was first developed by Robert Greenleaf in 1970. He posited that leaders are assigned their roles based upon their ability to serve others (Greenleaf, 1970). Northouse (2007) summarized the servant approach as leaders "should be attentive to the concerns of their followers and empathize with them; they should take care of them and nurture them." (p. 348).

Greenleaf's premise was leadership was based in the development of those being served and included a social justice component that especially considered the underserved. His questions to determine if someone is a servant leader included:

> Do those served grow as persons? Do they, while being served, become healthier, wiser, freer, more autonomous, more likely themselves to become servants? And, what is the effect on the least privileged in society; will they benefit or, at least, not be further deprived? (Greenleaf, 1970, p. 9)

Winston Churchill captured the spirit of servant leadership in his quote, "What is the use of living, if it be not to strive for noble causes and to make this muddled world a better place for those who will live in it after we are gone?" (Churchill, 1908). In essence, servant leaders are those who serve others regardless of position and provide a positive role model to inspire those being served to do the same. Examples of servant leaders in history are many and include Abraham Lincoln, Martin Luther King, Jr., Albert Schweitzer, Mother Teresa,

and the greatest example: Jesus Christ (Brown, 2013). Throughout Jesus' life he modeled a servant-leader example to His followers. This was demonstrated in multiple ways that included the act of washing His follower's feet (John 13:1-17 New International Version), engaging a despised Samaritan woman in a transformational conversation (John 4: 5-29), teaching His disciples "Greater love has no one than this: to lay down one's life for one's friends" (John 15:12-14), and ultimately in the following teaching:

> You know the rulers of the Gentiles lord it over them, and their high officials exercise authority over them. Not so with you. Instead, whoever wants to be great among you must be your servant, and whoever wants to be first must be your slave – just as the Son of Man did not come to be served, but to serve, and to give his life as a ransom for many. (Matthew 20: 25-28)

Much like transformational leaders, servant leaders enhance others by being present and inspiring those around them to serve. By nature they are viewed as individuals who are willing to work at the same jobs as their followers and subsequently earn their follower's respect as a leader. The nature of servant leadership is typified in the EMS field by providers by and large who agree to perform very difficult work in the service of people from all walks of life, especially the underserved. Such commitment is stated in the EMT Code of Ethics (originally written by Charles Gillespe and revised in 2013), which reads in part:

> Professional status as an Emergency Medical Services (EMS) Practitioner is maintained and enriched by the willingness of the individual practitioner to accept and fulfill obligations to society, other medical professionals, and the EMS profession. As an EMS practitioner, I solemnly pledge myself to the following code of professional ethics:

- To conserve life, alleviate suffering, promote health, do no harm, and encourage the quality and equal availability of emergency medical care.
- To provide services based on human need, with compassion and respect for human dignity, unrestricted by consideration of nationality, race, creed, color, or status; to not judge the merits of the patient's request for service, nor allow the patient's socioeconomic status to influence our demeanor or the care that we provide.
- To not use professional knowledge and skills in any enterprise detrimental to the public well-being.
- To respect and hold in confidence all information of a confidential nature obtained in the course of professional service unless required by law to divulge such information.
- As a citizen, to understand and uphold the law and perform the duties of citizenship; as a professional, to work with concerned citizens and other health care professionals in promoting a high standard of emergency medical care to all people.
- To maintain professional competence, striving always for clinical excellence in the delivery of patient care.
- To assume responsibility in upholding standards of professional practice and education.
- To assume responsibility for individual professional actions and judgment, both in dependent and independent emergency functions, and to know and uphold the laws which affect the practice of EMS.

- To work cooperatively with EMS associates and other allied healthcare professionals in the best interest of our patients.
- To refuse participation in unethical procedures, and assume the responsibility to expose incompetence or unethical conduct of others to the appropriate authority in a proper and professional manner. (NAEMT, 2013).

The greatest contrast to the servant leadership model is a leader motivated by self-interest. A leader whose heart is in the wrong place and bent on self-promotion will not be fully effective in serving others (Kouzes & Posner, 2009). Moreover, a heart motivated by self-interest looks at the world as a "give a little, take a lot" proposition. People with hearts motivated by self-interest put their own agenda, safety, status, and gratification ahead of that of those affected by their thoughts and actions (Blanchard & Hodges, 2005).

Ethical leadership. Closely aligned with positive leadership models is the model of ethical leadership. Based on a pilot study of program director leadership and the findings of Fattig (2013), the ethical model of leadership was included in the study. Traits and qualities listed by subject matter experts included integrity and being a decent human being (Kokx, 2012) were the reason for inclusion.

The ethical leadership model is rooted in the premise of leaders doing the right thing. This subject is vital to leadership since it deals with a leader's character and conduct, as well as relationships between leaders and followers. "There is an ethical dimension to leadership that neither leaders nor constituents should take lightly" (Kouzes & Posner, 2007, p. 345). Without good character and conduct, a leader is bound to fail while betraying those who have entrusted him or her to go the right direction. Theoretical research on the subject is limited

with some of the first ethical leadership studies of their kind dating only back to the late 1990s.

The domains of ethical theories concern themselves with a leader's conduct, character and virtues. Conduct theories range from ethical egoism (a high concern with the greatest good for one's self); utilitarianism (the greatest good for the greatest number); altruism (a high concern for the interest of others), and are either teleological (consequence- based) or deontological (duty-based) (Northouse, 2007, p. 344). Character theories consider a leader's makeup as a person and are virtue-based in ethical leadership principles. Moreover, proximate ethical leaders are more likely to engage followers in a positive way towards common goals while not veering from the organization's values (Brown & Treviño, 2006).

Several leadership researchers with overlapping theories show tangential relationships with ethical leadership. Heifetz (1998) focused on leader /follower/organizational values and how leaders help followers to resolve conflicts within the set of values. Burns' (1978) transformational leadership theory (discussed in a later section), like Heifetz, focused on the importance of the ability of leaders to help followers when their values are conflicted. The Greenleaf (1970) servant theory (discussed in the previous section), went a bit further; encouraging leaders to nurture their followers by assuming the role of a servant.

Five principles of ethical leadership date back to Aristotle. They include respect, service, justice, honesty, and community (Northouse, 2007). When followed, these foundational principles will afford leaders a strong place in their organizations by treating others in a fair manner. In pursuit of ethical leadership, Kouzes and Posner (2007) describe the need for leaders to:

> Focus on clarifying your values – on finding your authentic voice in a set of principles and ideals. These you have to find for yourself and test against others. Attending to moral values will always direct your eyes to higher purposes. As you work to become all you can be you start to let go of petty self-interests. As you give back some of what you have been given, you can reconstruct your community. As you serve the values of freedom, justice, equality, caring, and dignity, you can constantly renew the foundations of democracy. As each of us takes responsibility for creating the world of our dreams, we can all participate in leading. (p. 346)

Although I believe virtues may be enhanced by habits and or behavior, as a researcher I do not believe they are exclusively rooted in pure motives. People may choose to do nice things for others with selfish motives or for personal gain. In this case, although the act itself is virtuous, the spirit in which it is performed is not and subsequently lacks real virtue. It is possible to be motivated by the rewards of good behavior or kind acts (such as seeing joy in people who are recipients of giving), yet it is also possible to become disillusioned if recipients do not act in a way the giver hopes. My philosophical perspective is virtues are matters of the heart and a person's motivation to be virtuous results from pure, intrinsic motives. Alexander Solzhenitsyn asked, "Can a man who is warm understand one who is freezing?" (Solzhenitzen, 2005), and also observed, "Gradually it was disclosed to me that the line separating good and evil passes not through states, nor between classes, nor between political parties either — but right through every human heart — and through all human hearts" (Solzhenitzen, 1973). So it is with virtue. True leaders change hearts and subsequently inspire virtue in their followers through sharing common values and visions. In order to inspire others, leaders need to be inspirational. Perhaps the best example of such a

leader is one who has charisma. In the next section, the model of charismatic leadership will be considered regarding paramedic education program direction.

Charismatic leadership. The concept of a charisma in leadership has many definitions and re-definitions and was first applied to leadership in 1924 by Max Weber. He described one with charisma as being:

> Set apart from ordinary men and treated as endowed with supernatural, superhuman, or at least... exceptional powers and qualities ... (which) are not accessible to the ordinary person but are regarded as of divine origin or as exemplary, and on the basis of them the individual concerned is treated as a leader. (Weber, [1925] 1968, pp. 358-359)

A more formal theory of charismatic leadership was constructed by J. R. House in 1976. He included in his description of charismatic leaders as having a strong self-confidence, a robust sense of their own moral values, having a yearning to influence and dominate others, and being free of internal conflict (House, 1977). Bass (2008) described a charismatic leader as "…highly expressive, articulate, and emotionally appealing. They are self-confident, determined, active, and energetic. Their followers want to identify with them, have complete faith and confidence in them, and hold them in awe" (p. 50). Such leaders have the potential to be highly effective given their followers' attraction to them. This attraction provides a unique platform of trust and devotion. Researchers disagree on precisely how much of charismatic leadership is innate in individuals and how much is learned, though most argue charismatic leaders may have both natural and learned qualities (Riggio, 2010).

It must be noted however, not all charismatic leaders are moral and/or just in their respective roles and pursuits. Just because a leader passionately believes in a particular

ideology does not in turn make it moral. In fact, many times it can be anything but moral. Such deviant moral relativism was demonstrated throughout history through some infamous leaders who, while charismatic in behavior, did not have their followers' best interests at heart. Such was the case with individuals like Adolph Hitler, Osama Bin Laden, Jim Jones, and Charles Manson whose misguided, yet powerful charisma collectively brought devastation upon countless innocent people (Donaldson-James, 2011). Thus, charismatic leaders have been described as either socialized (positive) or personalized (negative) in nature (Lussier & Achua, 2009). A socialized charismatic leader is one who seeks the greater good for an organization, whereas a personalized charismatic leader is more likely to be driven by domination and personal gain.

A further dimension of the charismatic leadership theory is the relationship between leader and follower values. Values congruence among charismatic leadership and employees has been shown to be strong, though occupational context shows the strongest correlation to employee values (Brown & Trevino, 2009). Such a finding may be a result of individuals with certain values being attracted to professions in which those values are shared. In this setting, a charismatic leader is likely to reinforce and potentially expand the values that are already present.

Often associated with charismatic leadership is the model of spiritual leadership. Though not always directly associated, many charismatic leaders exemplify spiritual leadership that is discussed in the next section.

Spiritual leadership. The spiritual model of leadership is one of the newest approaches to understanding leadership. The theory is rooted in the notion of spirit, something Fairholm defined as "the vital or energizing force or principal in the person, the

core of the self" (Fairholm, 1996, p. 12). The theory of spiritual leadership is described by Fry and Matherly (2006) as:

> Spiritual leadership theory (SLT) is a causal theory for organizational transformation designed to create an intrinsically motivated, learning organization. Spiritual leadership comprises the values, attitudes, and behaviors required to intrinsically motivate one's self and others in order to have a sense of spiritual well-being through calling and membership, i.e., they experience meaning in their lives, have a sense of making a difference, and feel understood and appreciated. (p. 2)

Similar to ethical leadership, spiritual theory emphasizes the better nature of leaders. Moreover, the theory also describes the ability to individually and collectively inspire people to a higher purpose. In earlier writings, Fry (2003) described spiritual theory as "incorporating vision, hope/faith, and altruistic love" in order to "create vision and value congruence across strategic, empowered team, and individual levels and ultimately, to foster higher levels of organizational commitment and productivity" (p. 693). By emphasizing such an affective purpose, employees and leaders alike become focused on things greater than themselves, which in turn nurtures a community spirit for the greater good.

Spiritual leadership is often contrary to usual positions of leadership, focusing more on a higher power's direction and guidance than one's self. Or, as Barton (2008) posited from a Christian perspective, "Rather than leading from a place of intellectual striving and human strategies, I am discovering with a few others how to open the gift of discernment so that we can do God's will together" (p. 211). When such an atmosphere is created it builds community. And, as Fairholm (1996) suggested from a broader spiritual perspective, more and more individuals are finding their most significant communities in the workplace,

expecting work "to satisfy our deeply held needs for wholeness and to help provide spiritual support for our values and aspirations for personal as well as economic growth" (p. 11). Linking the need for community with the growing workplace phenomena sets the stage for an atmosphere ripe for spiritual leadership. Because the theory is in its early years, more research will need to be conducted to further define its capacities. Benefiel (2005) described it as a need for "a more robust and sophisticated understanding of the spiritual aspect of spiritual leadership" (p.724).

Related to the theme for personal growth in the spiritual model is the model of transformational leadership. The transformational model discussed in the next section focuses on developing followers' needs and inspiring leadership in others in order to achieve the mission and vision of an organization.

Transformational leadership. Transformational leadership is one of the most studied leadership models in the past 20 years. It includes characteristics of many of the positive models already considered. The concept was first defined in the 1970s by Dowton, and later expanded by James MacGregor Burns who described leadership different from power and "inseparable from followers' needs" (Northouse, 2007, p. 176). In his Pulitzer Prize-winning expansion of the theory, Burns' study of US presidents determined leaders were either transactional (i.e. followers complying with established expectations and subsequently rewarded) or transformational (i.e. focused on follower's development in order to enhance organizations as a whole) (Burns, 1978).

The concept of transformational leadership considers both leaders and followers inspiring one another to rise to a higher purpose. Burns (1978) described it further in stating: "Such leadership occurs when one or more persons engage with others in such a way that

leaders and followers raise one another to higher levels of motivation and morality" (p. 20). In other words, the primary premise of transformational leadership is leaders valuing their followers as people and desire for them to progress in their careers as leaders and as individuals in pursuit of the greater good. With time, the theory has evolved. A later study determined transformational leaders to be charismatic, inspirational, intellectually stimulating and individually considerate (Avolio, Bass, & Jung, 1999). In 2006, Bass and Riggio's study furthered the concept:

> Transformational leaders are those who stimulate and inspire followers to both achieve extraordinary outcomes and, in the process, develop their own leadership capacity… Evidence has accumulated to demonstrate that transformational leadership can move followers to exceed expected performance, as well as lead to high levels of follower satisfaction and commitment to the group and organization. (p. 3)

In the end, transformational leadership results in leaders and followers bonding together for a common purpose rather than the creation of a leader versus follower divide.

A main difference in the transformational model as compared to other models is the idea that leadership has capacity to change lives (as a very relational approach that benefits leaders and followers and calls both to a higher moral purpose), rather than transactional (role-exchange and "if – then" oriented leadership). As stated, a portion of transformational theory involves an ability of leaders to inspire their followers to do great things. Being transformational is more easily accomplished by leaders with charismatic traits that can motivate followers to believe in a purpose that links their self-concepts to the good of the organization. Transformational leaders also possess a clear vision and strong set of internal values that serve as powerful role model characteristics for their followers.

The Multifactor Leadership Questionnaire (MLQ) is the primary quantitative instrument used to assess the level of transformational leadership qualities a person may possess (Bass and Avolio, 2004). The MLQ measures transformational leadership styles through attributes, behaviors, and intellect, as well as by the ability to motivate, inspire, and be considerate of followers. Transactional leadership styles are measured through contingent reward and active management by reward (i.e. tracking mistakes). Passive/avoidant leadership styles are measured through passive management by reward (or waiting for things to go wrong before acting) and Laissez- Faire leadership styles (avoiding decisions altogether) (Bass, 1998).

A 1992 mixed-method (quantitative/qualitative) study was conducted by Kirby, Paradise, and King of transformational leadership specific to the field of education. In the quantitative component, educators surveyed believed the most effective leaders were those with the highest levels of charisma and intellectual stimulation, whereas the qualitative component revealed importance of professional development and leader behavior — rather than personality —inspires followers to greater performance (Kirby, Paradise, & King, 1992). Bass (2008) noted Abraham Lincoln, Franklin Delano Roosevelt, and John F. Kennedy were transformational leaders, yet each could effectively augment his leadership with transactional qualities when the occasion required (p. 51).

Thus far the review of literature has considered leadership in the broader terms of skills, traits, and positive leadership models. The next section refines leadership from a general context to one that is closely related to paramedic education program directors. Through consideration of the literature discovered related to the programmatic level of allied health education program directors, additional considerations will further inform the study.

Transformational leadership in allied health education fields. Although no formal studies of leadership in EMS education program directors can be identified, the previously cited allied health education studies deserve consideration. Many of the roles and responsibilities of allied health education program directors are similar to EMS education program directors and thus offer strong models for comparison.

As noted, several transformational leadership studies have been conducted in the fields of occupational therapy, radiologic technology, respiratory therapy, chairs of allied health programs, athletic training, and physician assistants (Reiss, 2000; Aaron, 2005; Weissman, 2008; Firestone, 2010; Odai, 2012; and Eifel, 2014). Each study incorporated the MLQ to measure respective leadership styles. All study results showed positive associations to transformational leadership styles of program directors and program effectiveness.

Reiss' (2008) study of Occupational Therapy education program directors determined three findings of particular interest to this proposed study. First, Reiss found transformational leadership is correlated to leadership effectiveness (p. 94). Through the MLQ survey, Reiss determined a statistical significance in transformational behaviors and perceived effectiveness. Second, Reiss found the demographic characteristics of gender and ethnicity of leaders are not a strong predictor of leadership behaviors (p. 95). This finding suggested leadership implementation and training may mitigate some demographics of educational program directors. A third finding suggested characteristics of the academic institutions or organizations are not related to leadership behavior or effectiveness (p. 96). This finding may suggest a transformational leader may be effective in his or her own program independent of educational institution's leadership structure.

Aaron (2005) studied Radiologic Technology education program directors/department chairs focusing largely on important leadership responsibilities and leadership styles. Results indicated a transformational leadership approach was positively related to overall satisfaction with program director's leadership skills with an exception of office management. Aaron also determined faculty affairs and budget/resources were the area of greatest responsibility concern. Workshops and lectures were found to be the preferred training route for leadership training. Additionally, a positive correlation of years of experience and level of higher education earned with satisfaction of leadership skills and responsibilities may suggest the more education and experience a program director has, the more comfortable he or she is with leading a program.

In a leadership style study of accredited respiratory therapy program directors, Weissman (2008), added to the literature of transformational leadership of directors of allied health education programs. Results indicated respiratory care directors tended to be largely transformational in their leadership styles and to a lesser extent transactional with faculty who are "satisfied, willing to exert extra effort, and perceive that their directors are effective" (p. 89). Weissman recommended continued research of program leadership along with variables of program outcomes in order to discover further correlations.

In a leadership styles study of allied health chairpersons, Firestone (2010) examined various leaders of allied health education programs, which included athletic training, dietetics/nutrition, occupational therapy, physical therapy, physician assistant, CLS/cytotechnology, and audiology/SLP. Firestone discovered "allied health chairpersons primarily demonstrate leadership behaviors associated with transformational leadership factors and the contingent reward factor of transactional leadership" (pp. 159-160). More

specifically, findings indicated chairs need transactional leadership in carrying out "daily administrative functions" of their position, but need transformational leadership to "be proactive in pursuing changes that meet the needs of their constituencies in a rapidly changing health care market, to have a shared vision with department colleagues, and connect the departmental vision with the goals of the institution" (p. 160). Thus, a need for both skills and behaviors was highlighted in the study and appeared significant. After determining findings, Firestone considered it a priority to develop transformational leadership behaviors in allied health department chairpersons.

In a leadership study of athletic training education program directors, Odai (2012) found very similar results as Weissman. Odai's study incorporated the Full Range Leadership Theory MLQ (Bass & Avolio, 2004), findings indicated program directors of athletic training education programs utilize transformational leadership most often, followed by transactional leadership and then passive avoidant leadership. According to Odai, "The PDs utilized transformational leadership behaviors [individual consideration, inspirational motivation, idealized influence (behaviors), idealized influence (attributes), and intellectual stimulation] to a greater extent than transactional (contingent reward and management-by-exception: active) and passive avoidant (management-by-exception: passive and laissez-faire) leadership behaviors" (Odai, 2012, p. 39).

Odai's (2012) findings inform the study's challenges to program director leadership. Respondents reported "lack of professional preparation, accreditation, administrative duties, and changing educational standards" (Odai, 2012, p. 47), as challenges to being an effective program director leader. These findings may be useful to the proposed study in determining if the same holds true for paramedic education program directors. Odai recommended further

leader training, "Transformational leadership can be learned over time and leadership training is a viable means to change a leader's behaviors in the expected direction" (p.47).

Eifel (2012) studied attributes of physician assistant education program directors. Eifel's study is important to include because physician assistants, like paramedics, often work in autonomous environments under extended supervision of physicians. Similar to paramedic education programs, "PA education programs play a unique role in training students, who upon graduation and successful completion of a national certifying exam provide many of the health care services frequently associated with physicians" (p. 2).

Like Odai (2012), Eifel used the MLQ to assess Full Range Leadership Theory in program directors included in the study. Eifel (2012) discovered "program directors use transformational leadership factors frequently in the execution of their responsibilities, and those program directors perceive favorable outcomes with these behaviors" (p. 151). These results were consistent with what was found in the studies already discussed.

To further inform the study, a graduate-level pilot study I conducted is included in the following section. The study considered leadership in EMS education program directors and contributed significantly in the design and direction of this study.

Pilot Study

In the spring of 2012, I conducted a University of Idaho IRB-exempt pilot study. The discoveries made during the pilot study served to inform the theoretical framework and literature review of this study. Accordingly, the necessary skills and positive leadership practices discovered in the pilot study were included in the framework.

Pilot study methods and design. The study was conducted using a basic qualitative pilot study research design (Merriam, 2009). The approach was chosen to allow for

interviews of subject matter experts in order to discover emerging themes of leadership factors of successful nationally accredited paramedic education programs moving towards national accreditation. The basic qualitative method was appropriate for this study as it compared the meaningful experiences of experienced nationally accredited program directors in a context relevant to leadership factors. By considering the wisdom and experience of subject matter experts using the basic qualitative format, the most important factors necessary for successful leadership in directors of programs moving towards national accreditation were determined.

A semi-structured interview format was chosen to allow participants the opportunity to answer questions directly and allow for follow-up questions by the interviewer. Questions were formulated based on both skill and trait-based leadership theories, then asked directly to purposely-selected subject matter experts. Two subject matter experts were selected to interview who were Program Directors and CoAEMSP Site visitors. Recordings of the interviews were made in order to be accessed and transcribed. After transcription, the findings were open coded. Two hundred thirty five open codes were discovered for further consideration. Next, thirty focus codes were identified from the open codes and were assigned into emergent thematic categories of "abilities," "qualities," and "further factors."

Pilot study results. Though some of the responses were very similar to those in the theoretical framework I had chosen, several were not. After analysis, the technical, human, and conceptual leadership skill categories described by Katz were further expanded with abilities, qualities, and other factors. In a similar fashion, elements of the many related theories of traits described by Northouse (Kirkpatrick & Locke, 1991; Lord, DeVader, & Alliger, 1986; Mann, 1959; Stodgill, 1948; and Stodgill 1974), appeared to be further

augmented. Strong qualities of intelligence, integrity, sociability, determination and self-confidence were reported in respondents' answers.

Other concepts also emerged falling outside of the theoretical framework. These concepts included courage, internal and external leadership factors, servant leadership, charisma, and being a decent human being. Because the concepts did not fall clearly into skills/abilities or traits/qualities, I assigned them to an emergent "Further Factors" category. Though skill and trait frameworks played a role, a greater picture was revealed. The skill category expanded to include the theme of abilities and the traits category expanded to include the theme of qualities. (See *Figure 5*).

Figure 5. Leadership factors of accredited paramedic programs directors.

As a result of the pilot study findings, the skills theory of leadership was retained and the trait theory was replaced with positive and ethical leadership theory for the proposed study. Findings indicated a connection to positive and ethical leadership theory.

Subsequently, both positive and ethical leadership theories were included in theoretical framework and literature review of this study.

Summary

A review of the literature was conducted to inform the study. Included in the review were a history of Emergency Medical Services (EMS), EMS education, accreditation, EMS-education accreditation, the role of EMS education program directors, and a survey of various theoretical leadership models. Due to the gap in EMS education leadership literature outside of the accreditation standards and guidelines, a broader net was cast to capture the larger, general vision of leadership skills and positive leadership characteristics (i.e. authentic, servant, ethical, spiritual, and transformational). To focus the lens of the study, a review of available literature regarding allied health education program directors was included as well as a pilot study specific to program director leadership in EMS education. Chapter three will focus on the methodology of how the study was designed, conducted, and analyzed to determine leadership practices in paramedic education program directors.

Chapter 3

Methodology

Chapter three addresses methodology for the study. Qualitative methods were used to help reveal leadership practice for paramedic education program directors. Semi-structured interviews of uniquely qualified subject matter experts, literature analysis, and observations were used to explore context, challenges, and best practices of paramedic education leadership.

Statement of the Problem

National programmatic accreditation for paramedic education programs in the United States has been available since 1978 (CAAHEP, 2005). Although research indicates accreditation improves the quality of education and national certification scores (Dickison, Hostler, Platt, & Wang, 2006), a significant number of programs only began seeking accreditation in 2012. The increase in programs seeking accreditation was due largely to a requirement by the National Registry of EMTs which stated "Beginning on January 1, 2013 all initial Paramedic applicants seeking National EMS Certification at the Paramedic level must have successfully completed education from an accredited program or one that has a Letter of Review (LOR)" (NREMT, 2013). Since 46 of 50 states (92%) utilize the NREMT for certification purposes (NREMT, 2016a), the total number of accredited programs has increased dramatically since 2013.

Accredited programs are required to have a qualified program director to lead a program (CAAHEP, 2005), thus program directors of nationally accredited paramedic programs assume positions of leadership. Their sphere of leadership is extensive and affects graduates who will provide direct care to emergency patients (See *Figure 3*).

Although national accreditation has become the standard for paramedic education and is perceived as a positive step towards professionalism, no formal study or foundation of leadership practices exists to prepare program directors to assume successful leadership roles. The goal of the study was to address the problem of a lack of identifiable leadership practices in program directors of nationally accredited paramedic education programs. This goal was accomplished through an exploration of subject matter expert perceptions about the context, challenges, and best practices of leadership in paramedic education program directors.

Research Questions

The principal research question for this study was: What are the leadership practices of program directors of nationally accredited paramedic education programs?

Three supporting research questions informed the study and assisted in answering the principal question:

d. In what context do program directors practice leadership?

e. What are the challenges in program director leadership?

f. What are the leadership best practices of being a program director?

Research Methodology

A qualitative research methodology was selected to explore the problem of lack of identifiable leadership practices in paramedic education program directors. Interpretive inquiry, consistent with qualitative research was utilized to gather and interpret what the researcher "sees, hears, and understands" (Creswell, 2007, p. 39). A standard method of interviewing subject matter experts resulting in "hypothetical propositions" and "theory development" (Simon, 2011, p. 86) was followed.

Interview questions were based on history of Emergency Medical Services (EMS), EMS education, accreditation, EMS-education accreditation, the role of EMS education program directors, and a literature review of various theoretical leadership models. Three leadership perspectives (leadership skills, positive leadership models, and pilot study results) informed the study regarding context, challenges, and best practices specific to program director leadership in paramedic education.

The study used what Merriam (2009) termed a basic qualitative study methodology based in constructionism, where "individuals construct reality in interaction with their social worlds" (p. 22). Crotty (1998) described the meaning construction process as "…constructed by human beings as they engage the world they are interpreting" (pp. 42-43). By its nature, a basic qualitative study methodology focuses specifically on how meaning is constructed. Merriam (2009) summarized the process as "all qualitative research is interested in how meaning is constructed, how people make sense of their lives and their worlds. The *primary* goal of a basic qualitative study is to uncover and interpret these meanings" (p. 24). Patton (2004) described the purpose of basic qualitative research as arriving at "knowledge as an end in itself; to discover truth" and whose desired result is a "contribution to theory" (p. 224). By understanding the meaning a phenomena has for those involved (in this case leadership in paramedic education program directors), new and existing program directors were afforded valuable knowledge to help them improve as leaders.

The basic qualitative methodology was appropriate for this study as it compared meaningful perceptions of experienced subject matter experts in a context relevant to leadership practices of paramedic education program directors (Merriam, 2009). By exploring knowledge and experience of such individuals through semi-structured interviews,

the goal was to determine the most important practices necessary for leadership in the field. In accordance with a basic qualitative study methodology, a deliberate step-by-step method was implemented to reveal and interpret rich, meaningful experiences of the context, challenges, and best practices of leadership for paramedic education program directors.

Theoretical/Conceptual Framework

The theoretical/conceptual framework for the study used a constructivist perspective (Crotty, 1998) and applied two theoretical/conceptual approaches. As stated in Chapter 1, the epistemological stance was *a posteriori* in nature, seeking to find empirical knowledge from those with experience through inductive reasoning and the qualitative interview process (Trochim & Donnelly, 2008; Merriam, 2009). A constructivist framework provided structure to inform new meaning while revealing knowledge of necessary leadership practices involved in being a nationally accredited paramedic education program director. From this perspective, an end result was a "dynamic product of the interactive work of the mind made manifest in social practices and institutions" (Paul, 2005, p. 46). Through ongoing data analysis of subject matter expert interviews, observations, and codes, themes were revealed that could be implemented by paramedic education leaders in programs across the nation.

Ravitch and Riggan (2012) described a conceptual framework in three different perspectives: The first was "a purely visual representation of a study's organizations or major theoretical tenets"…second, "a conceptual or theoretical framework is essentially the same thing" …and third, "a conceptual framework is a way of linking all of the elements of the research process: researcher disposition, interest and positionality; literature; and the theory and methods" (p. 6). All three of Ravitch and Riggan's (2012) descriptions were included in

this study with the most emphasis placed on the second perspective, treating the conceptual and theoretical concepts as the same. Data was analyzed from this perspective.

A blended theoretical/conceptual framework of skill and positive approaches to leadership was used for the study (See *Figure 6*). The literature review drew from multiple studies and texts from over sixty years of research including Katz's three-skill approach (1955, 1974) and positive leadership approaches (Avolio & Gardner, 2005; Fattig, 2013). A pilot study I conducted (Kokx, 2012) which supported relevant leadership approaches from an EMS program director perspective was included to guide the framework. Several allied health education program director leadership studies specific to transformational leadership (Reiss, 2000; Aaron, 2005; Weissman, 2008; Firestone, 2010; Odai, 2012; and Eifel, 2014) were also included to assist in guiding the research. As a result of the foundational nature of this study combined with the findings of the pilot study, the blended theoretical framework of positive leadership theory and leadership skills theory was deemed appropriate for a conceptual framework. The positive leadership theories addressed the common types of leadership practices required by a program director and the skill theory offered a comparison of critical skills necessary for leading programs. Together, the two theories offered a robust framework to study EMS program director leadership. Carefully constructed questions closely linked to the pilot study findings and literature review were asked of each subject matter expert.

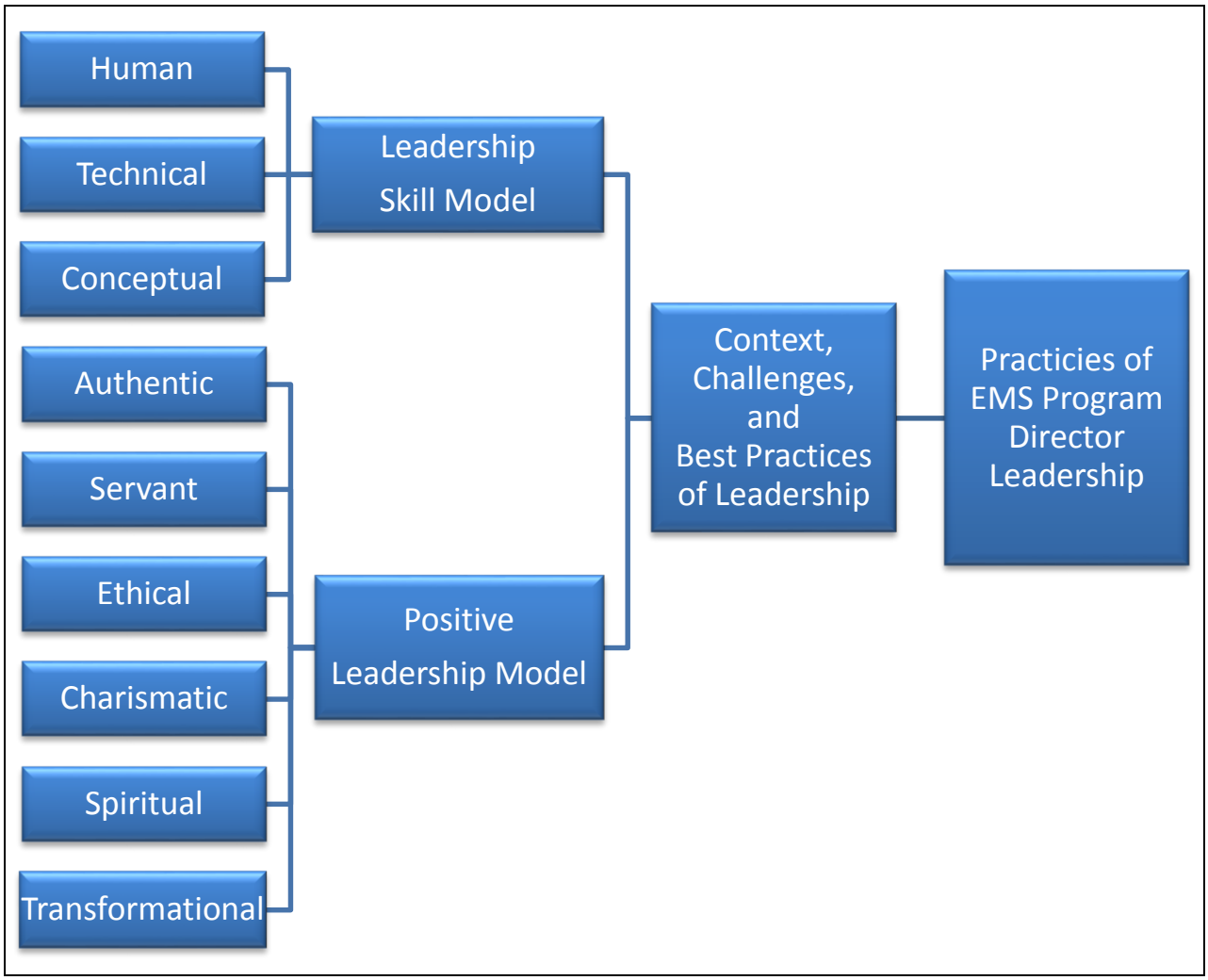

Figure 6: Blended Theoretical/Conceptual Framework of Leadership Practices

From the leadership skills and positive leadership theoretical models, the study considered the context, challenges, and best practices of leadership in program directors of nationally accredited paramedic education programs. A history of the EMS profession, EMS education, accreditation, and EMS education accreditation were also provided in the literature to inform the reader. Inclusion of the above areas focused the research lens and assisted in determining what extent relevant leadership theories should be used for possible training of current and future paramedic education program directors.

Research Design

The study used what Merriam (2009) termed a basic qualitative study design based in constructionism, where "individuals construct reality in interaction with their social worlds" (p. 22). Crotty (1998) described the meaning construction process as "…constructed by human beings as they engage the world they are interpreting" (pp. 42-43). By its nature, a basic qualitative study focuses specifically on how meaning is constructed. Merriam (2009) summarized the process as "all qualitative research is interested in how meaning is constructed, how people make sense of their lives and their worlds. The primary goal of a basic qualitative study is to uncover and interpret these meanings" (p. 24). Patton (2004) described the purpose of basic qualitative research as arriving at "knowledge as an end in itself; to discover truth" and whose desired result is a "contribution to theory" (p. 224). By understanding the meaning a phenomena has for those involved (in this case leadership in paramedic education program directors), new and existing program directors were afforded valuable knowledge to help them improve as leaders.

The basic qualitative design was appropriate for this study as it compared meaningful perceptions of experienced subject matter experts in a context relevant to leadership practices of paramedic education program directors (Merriam, 2009). By exploring knowledge and experience of such individuals through semi-structured interviews, the goal was to determine the most important practices necessary for leadership in the field. In accordance with a basic qualitative study methodology, a deliberate step-by-step design was implemented to reveal and interpret rich, meaningful experiences of the context, challenges, and best practices of leadership for paramedic education program directors.

Creswell (2007) referred to the research design process as "the entire process of research, from conceptualizing a problem to writing the narrative not simply the methods such as data collection, analysis, and report writing" (p. 249). Merriam (2009) described five necessary components of a basic qualitative study to include: (a) focus on meaning, understanding, and process; (b) use of a purposeful sample; (c) data collection via interviews, observations, and documents; (d) data analysis is inductive and comparative; (e) findings are richly descriptive and presented as themes / categories (p. 38).

To focus on meaning, understanding, and process, I concentrated on leadership context in nationally accredited paramedic education programs and understanding the practices (including the challenges) of leadership as related to program directors. Finally, I identified best practices of program director leadership in a nationally accredited paramedic education program.

The design for this study was carefully chosen based on the subject matter, population of central interest, and research questions (Ritchie & Lewis, 2003; Wilfong, 2009). A basic qualitative research model was used for the study (Merriam, 2009) augmented by the Maxwell (2005) model of qualitative research design (p. 4). The purpose of this study was to explore leadership practices of program directors in nationally accredited paramedic education programs. A history of EMS, EMS education, accreditation, and EMS education accreditation were included in a comprehensive literature review to augment a blended theoretical framework of leadership skill theory and positive leadership theory. Paramedic education program director leadership was limited to a highly specific population and necessitated a careful inquiry to determine the breadth and depth of the subject. A subsequent population of central interest — paramedic education program directors — was targeted for

the study. A purposeful sample of 12 subject matter experts was carefully selected and invited to participate. Research questions addressed the context, challenges, and best practices of program director leadership. Prior to conducting interviews, approval was sought from the University of Idaho Institutional Review Board. The University of Idaho Institutional Review Board has certified this project as exempt. Interview questions used to gather data were formulated based on the context, challenges, and best practices of leadership that used leadership skill theory, positive leadership theory, and a pilot study.

The qualitative process of semi-structured interviews assisted in determining paramedic education program director leadership practices. Pre-assigned general code categories of context, challenges, and best practices of leadership were utilized. Once the data was gathered, open, axial, and focused coding were conducted, respectively. Focused codes provided categories and themes. Accordingly, the context, challenges, and best practices of leadership were revealed through the implementation of the chosen basic qualitative research design by incorporating both "emic" (views of the participants) as well as "etic" (my own views from experience as the researcher) (Creswell, 2007, p.72). Findings were validated through triangulating observations, document analysis, inter-coder analysis (check-coding), member-checking, qualitative software analysis and expert analysis.

Participants

Participants were identified through purposeful selection (Creswell, 2007; Trochim & Donnelly, 2008). Purposeful selection of participants involved identifying and inviting subject matter experts possessing specific inclusion criteria. The use of purposeful selection assisted in yielding unique and valuable insight into the phenomena of leadership practices of nationally accredited paramedic education program directors. Paramedic education subject

matter experts agreeing to participate in the interviews were uniquely qualified to offer their perceptions of leadership in the field. Because of carefully defined inclusion criteria, only 12 individuals were qualified to offer such deep insight into the subject. Hence, a purposefully selected sample was appropriate for the proposed study. Each subject matter expert was invited to participate and asked to give consent in writing to allow his or her data to be used in anonymous fashion (See Appendix 3).

By exploring knowledge and experience of such individuals, I hoped to determine the practices necessary for program director leadership. Each subject matter expert was familiar to me from my involvement in the EMS education profession. Because interviews were conducted with experts from a preexisting relationship, the sample frame and size was closely defined to "establish particular comparisons to illuminate the reasons for differences between settings or individuals" (Maxwell, 2005, p. 90). Each selected participants was: (a) known to me from my national experience in the profession; (b) highly experienced in paramedic education; (c) considered to be an expert in the field; and (d) motivated to respond to improve the field. Subsequently, the highly defined criteria were intended to reduce erroneous responses (Fowler, 2009).

The subject matter experts' depth of knowledge and breadth of experience with the context, challenges, and best practices of leadership helped impart meaningful contributions to the qualitative inquiry. A sample size of 12 participants allowed for a keenly focused data gathering and analysis process providing thick, rich data description (Patton, 2002, p. 47).

To meet selection criteria, only individuals with the following experience were considered as subject matter experts: (a) paramedic education program director; (b) CoAEMSP Board of Directors member; and (c) CoAEMSP accreditation site visitor.

Individuals with program director experience knew the requirements of the role and demands of the position. Having functioned in the role of program director gave them insight into the lived-experience as a program director. Individuals with CoAEMSP board experience understood roles and responsibilities in light of the standards and guidelines, giving them an exclusive window into leadership required to be effective in the position. Such experience informed participants with a thorough understanding of the accreditation process, standard and policy-making, and rules of governance providing them a unique window into the leadership required to be effective in the position. Third, individuals with experience as accreditation site visitors had experience evaluating many types of programs involved in the accreditation process. Site visitors conduct on-site program compliance with accreditation standards through on-site interviews with program communities of interest. This diverse experience gave participants insight into measuring compliance with standards and guidelines of accreditation (CAAHEP, 2005), as well as insight into how program director leadership was crucial in directing a program. Through their diverse exposure, the individuals had perceptions of various types of leadership present in a vast array of programs.

Role of the Researcher

My role as the researcher in this study was to determine leadership practices of nationally accredited paramedic education program directors. Impetus for this study held both personal and professional meanings to me. I have worked in Emergency Medical Services (EMS) for 32 years. During that time I met and served with remarkable individuals who have dedicated their lives to the service of others. Through my advancement, I discovered a lack of leadership training for such loyal professionals – especially in the world of paramedic education.

From 1993 to 2014, I served as a full time faculty member at the community college level. In 2000, I accepted a position to design, implement, and direct the first public college-level paramedic program in the state of Idaho. The task was daunting and I quickly recognized no blueprint for leadership existed to guide me to become successful in my assigned endeavor. A supportive administrator allowed me to attend two national symposiums, which offered workshops that assisted me to a small extent, but nothing else provided any specific guidance.

In 2006, I was appointed by the National Association of Emergency Medical Technicians (NAEMT) to serve on the board of directors of the Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP). I served on the board's executive committee as Vice-Chair for a year and a half prior to accepting my current position as Assistant Director of Accreditation Services in the national organization.

Through my board service, I gained a strong understanding of the programmatic accreditation process by experiencing program reviews, site visits, and policy development. As a result of this experience, I hold unique insight into the problem of lack of leadership training for program directors seeking accreditation as well as those in already accredited programs. My desire to give back to a field that has provided me with a tremendous career of service to others in the clinical, educational, and administrative areas of Emergency Medical Services.

Information/Data Collection

This study primarily used data collection through the use of interviews. By conducting semi-structured interviews, subject matter experts were allowed to express their

perceptions of the meaning behind leadership practices of paramedic education program directors. Using a semi-structured format, I was able to probe and explore responses of special interest that revealed the essence of the leadership context, challenges, and best practice themes. I was careful to describe the various leadership theories in my interview questions to not overly influence participant definitions of each theory. In doing so, I was able to determine what each participant considered meaningful1 to each theory. Through inquiry of the subject matter experts' perceptions and stories (Seidman, 2006), I was also able to determine what each participant perceived to be examples of leadership successes and failures in framing the context of leadership. Additional inquiry about challenges and best practices was also solicited.

Two interviews were conducted with each participant, allowing for flexibility of direction while providing an avenue for gathering comprehensive participant perceptions. Each of the interviews lasted up to one hour in duration for each of the 12 participants. Questions were designed for subject matter experts to offer their perceptions, professional observations, and possible stories of paramedic education program director leadership. A semi-structured interview format was utilized which allowed follow-up questions by the interviewer. The interview subjects were considered *elite* in nature, because they included "individuals…considered to be influential, prominent, and/or well-informed in an organization or community…selected for interviews on the basis of their expertise in areas relevant to the research" (Marshall & Rossman, 2006, p. 105). Furthermore, a semi-structured format also allowed "the researcher to respond to the situation at hand, to the emerging worldview of the respondent, and to new ideas on the topic" (Merriam, 2009, p. 90). Data was gathered to measure demographic information of participants, context of

leadership, challenges, and best practices regarding leadership of paramedic education program directors.

Demographic questions asked during the first interview included education, healthcare certification or licensure, years of experience as a: (a) CoAEMSP board of director member; (b) accreditation site visitor; and (c) program director. The subject matter experts were assigned an androgynous pseudonym to obscure their identity to provide anonymity. Context of program director leadership (i.e. skills and positive leadership behaviors) was also explored in the first interview. Other questions included subject matter expert's perceptions of challenges to program director leadership. The audio of interview responses were digitally recorded and later transcribed using Dragon12® translation speech to text software. Because interviews were conducted with experts who had a preexisting relationship with the researcher, the sample frame and size was closely defined to "establish particular comparisons to illuminate the reasons for differences between settings or individuals" (Maxwell, 2005, p. 90). This concept was critical during the analysis phase of the study in helping determine themes and subsequent theory.

A second set of interviews helped determine best practices of program director leadership in light of findings from the first interviews. During the second interview, a series of questions were asked prompting respondents to elaborate on their perceptions of best practices of program director leadership. Examples given by experts as best practices often mirrored responses to challenge solutions given during the first interviews. Notes were made to note the reoccurring codes. Similar to the first interview, a clearly identified qualitative approach was used in the second interviews including transcription, open coding, member

checks, focused coding, and theme revelation. Identification of such themes allowed for specific identification of important leadership best practices categories (Maxwell, 2005).

My own observations as a program director, CoAEMSP board member, and CoAEMSP site visitor also added to the study. I took field notes throughout the process and kept a journal for ongoing reflection. Notes on limited document analysis, participant responses, observations of the participants, as well as my own perceptions were noted for consideration throughout the proposed study. Comparisons were then made to the notes, literature review, and observations made during the proposed research to assist in determining emergent themes. All written data collected was kept secured under lock and key. All digital audio data collected were kept under password protected computer files.

Information/Data Analysis

An important characteristic of qualitative research is its inductive and comparative nature (Merriam, 2009). Merriam specifically stated qualitative research is an "inductive process" where "researchers gather data to build concepts, hypotheses, or theories rather than deductively testing a hypotheses as in positivist research" (p. 15). Consistent with Merriam's definition, data analysis in the study was inductive. Data was gathered through the interview, observation, documents, and coding process, then analyzed for emergent themes and potential theory development.

Remaining consistent with Merriam's definition, analysis in this study was comparative in nature. Subject matter expert responses were compared for similarities and differences to identify emergent themes. A thorough comparison was also made to leadership skills and positive leadership models discussed in the literature review. Through the analysis

process a determination was made as to which leadership skills and models were most relevant to paramedic education program directors.

The digital audio recordings of the interviews were recorded, played, and transcribed. Once translated, data was analyzed manually and member checks were performed to clarify responses. Member checks verified accuracy of what each subject matter intended to communicate and increased the validity of the findings of the study (Merriam, 2009). This practice of ensuring accurate content was critical for the analysis phase of the study and contributed to precise coding. The process of coding was used in order to separate the data and "rearrange them into categories that facilitate comparisons of things in the same category and that aid in the development of theoretical concepts" (Maxwell, 2005, p. 96). Data was initially open or convergently coded (Guba, 1978) to determine regular patterns for further consideration. Open coding helped determine broad categories, followed by focus coding to reveal specific "organizational, substantive, and theoretical categories" (Maxwell, 2005, p. 97). Total time of coding was three to four hours for every hour of recorded interview. Coding was conducted using two external methods (qualitative software and human researcher) in order to enhance reliability through inter-coder analysis referred to by Miles and Huberman (1994) as "check coding." (p. 64).

Notes were written in the margins of the transcripts to identify recurrent words and/or categories for further examination and contemplation. The next step involved axial coding to connect open codes to a central emerging phenomena (Creswell, 2007). A final coding step included focused, selective, or divergent coding (Guba, 1978) to develop core categories or propositions. Finally, assignment of the focused codes into emergent thematic categories occurred to determine major themes.

Through the coding process, interview responses were analyzed to determine common themes including the context, challenges, and best practices of leadership. Identified themes were further analyzed which led to emergent themes and possible implications for further study. This practice was implemented to identify and further develop leadership practices in paramedic education program directors. Data was destroyed upon final study completion.

To increase validity of the study, the process of data triangulation was utilized. Maxwell (2005) described triangulation as:

> Collecting information from a diverse range of individuals and settings, using a variety of methods. This strategy reduces the risk of chance associations and of systemic biases due to a specific method, and allows a better assessment of the generality of the explanations that one develops. (p. 112)

Interviews conducted in different times and places from people with different perspectives, personal observations, field notes, and follow-up interviews were all triangulated and compared to test consistency of discovered data (Patton, 2002; Merriam, 2009). The results were expected to contribute to the research literature and provide an identification of leadership context, challenges, and best practices for paramedic education program directors.

Summary

Chapter 3 included a detailed account of how the study was conducted. A thorough explanation of the methodology and design were provided. In-depth descriptions of the participants, role of researcher, information/data collection and information/data analysis were also provided. Chapter 4 will provide a comprehensive discussion of the findings of the

expert interviews and categories of paramedic education program director leadership practices.

Chapter 4

Findings

The purpose of this research study was to explore leadership practices of nationally accredited paramedic education program directors. Though responsibilities and qualifications are outlined in accreditation standards, no leadership study has been done in the field of paramedic education program directors. To achieve the purpose of the study, subject matter experts were carefully identified and invited to participate in interviews. Analysis of the interviews provided findings that answered the research questions and revealed the expert's insights into the meaning of the context, challenges, and best practices of program director leadership of nationally accredited paramedic education programs.

Chapter 4 is a comprehensive discussion of the findings of the research. The chapter includes subject matter expert demographics and answers to supporting research questions which informs the principal research question of: What are the leadership practices of program directors of nationally accredited paramedic education programs? Three supporting research questions informed the study and assisted in answering the principal question:

1. In what context do program directors practice leadership?
2. What are the challenges in program director leadership?
3. What are the leadership best practices of being a program director?

Subject Matter Expert / Participant Demographics

Subject matter expert demographics included the need for experience in the following areas: (a) program director; (b) Committee on Accreditation of Educational Programs of the EMS Professions (CoAEMSP) site visitor; and (c) CoAEMSP board experience. Each of the participants was well- known in the profession on a national level and have contributed to

EMS and EMS education for many years. The subject matter experts included nine males and three females representing a diverse demographic from across the United States. Collectively, the group has vast experience in EMS education at public and private institutions that include community and technical colleges, universities, and hospital-based settings. They have written extensively (including textbooks and publications), served on national boards and committees, and have authored national curriculum and education standards. Because of familiarity of the experts among the national community of EMS educators, great care was taken to protect their identities. Accordingly, each subject matter expert was assigned a pseudonym known only to the researcher for purposes of de-identification in accordance with IRB exempt certification.

The expert's number of years of EMS education experience totaled 379 with a range of 10 to 40 years. Program director experience totaled 223 years; with a range of 4 to 36. CoAEMSP board experience tallied 87 years; with a range of 1 to 16 years. Site visitor experience totaled 149 years with a range of 1 to 32 years (See Table 6 for details). Given their unique experience, participants were keenly qualified to comment on the context, challenges, and best practices of EMS education leadership.

Table 2. Subject Matter Expert (SME) Demographics

SME Pseudonym	EMS Educator	Program Director	CoAEMSP Board	Site Visitor
Cody	**30 years**	**7 years**	**8 years**	**6 years**
Dakota	**10 years**	**9 years**	**5 years**	**3 years**
Robin	**37 years**	**36 years**	**9 years**	**15 years**
Payton	**37 years**	**30 years**	**5 years**	**32 years**
Loren	**37 years**	**35 years**	**16 years**	**28 years**
Sean	**30 years**	**25 years**	**6 years**	**12 years**
Kelly	**32 years**	**11 years**	**10 years**	**15 years**
Tracey	**35 years**	**10 years**	**4 years**	**4 years**
Ashley	**35 years**	**10 years**	**8 years**	**15 years**
Layton	**25 years**	**15 years**	**1 year**	**6 years**
Jordan	**40 years**	**31 years**	**13 years**	**12 years**
Meryle	**31 years**	**4 years**	**2 years**	**1 year**
Total	**379 years**	**223 years**	**87 years**	**149 years**
Range	**10-40 years**	**4-36 years**	**1-16 years**	**1-32 years**

Table created by author.

Descriptions of Participants

Each of the twelve expert participants was assigned randomly generated androgynous pseudonyms to provide for de-identification. The pseudonyms are purely fictitious and do not associate in any way to the participants or to any other person living or deceased. Any perceived similarities are purely coincidental. The following are descriptions of the experts who participated in the study.

Cody Melville. Cody is dually licensed as a paramedic and nurse and holds a Master's of Science degree and was a program director for 7 years. Cody has held leadership roles in the US military, National Association of State EMS Officials, and National Association of EMS Educators. The expert serves as an EMS state director and has 30 years

of experience as an EMS educator. Furthermore, Cody has served on the CoAEMSP Board for 8 years and has been a site visitor for 6 years.

Dakota Backus. Dakota is a paramedic educator and holds a Master's degree and has experience as a chief officer in the fire service and has held leadership positions with the International Association of Fire Chiefs. Dakota has published extensively in the field of EMS management and served on the CoAEMSP board for 5 years. The expert's tenure includes 9 years as an EMS program director and 3 years as a CoAEMSP site visitor.

Robin Ramos. Robin is a paramedic with 37 years of experience in EMS education and has earned a Master's in Public Health degree along with a doctorate in education. A recognized leader in EMS education, Robin has held leadership positions with the National Association of EMS educators and has authored numerous publications. Robin has 36 years of program director experience with 9 years on the CoAEMSP Board and 15 years as a site visitor.

Payton Lu. Payton has been an EMS educator for 37 years, is an emergency nurse, and holds a Master of Arts degree. Payton's service includes International Critical Incident Stress Management and extensive publishing in EMS education. Payton is a frequent speaker at national EMS conferences. Payton' experience includes 30 years of program director experience, 5 years on the CoAEMSP board, and has served 32 years as a CoAEMSP site visitor.

Loren Duncan. Loren has been a program director for 35 years and trained as both a nurse and a paramedic. Loren's experience includes having managed national EMS education curriculum revisions as well as leadership positions with the National Association of EMS Educators, National Registry of EMT's, and as Chair of the CoAEMSP board. Loren holds a

Master's degree in education and has served on the CoAEMSP board for 16 years. Loren has been a site visitor for 28 years.

Sean Runyan. Sean has been in EMS education for 30 years, is a paramedic, and holds a doctorate in education. Sean's program director experience totals 25 years and has served in leadership positions on the National Association of EMS Educators. Sean's experience includes textbook authoring and frequent speaking at national EMS conferences on EMS education. Sean has 6 years of experience on the CoAEMSP board and has been a site visitor for 12 years.

Kelly Goodwin. Kelly is a recognized EMS textbook author with 32 years of EMS education experience, is a paramedic, and holds a Master's of Arts degree. Kelly's experience includes 11 years as a program director, 10 years as a CoAEMSP board member, and leadership positions with the National Registry of EMTs as well as the CoAEMSP executive Committee. Kelly is a frequent speaker at national EMS conferences and a CoAEMSP site visitor with 15 years of experience.

Tracey Lake. Tracey is a paramedic who holds a Masters in Library Science degree and served as EMS program director for 10 years. Tracey is a high-ranking state government official with experience as a state EMS director. Tracey's leadership experience includes Chair of the National Association of State EMS Directors and Chair of the CoAEMSP board. Tracey has 35 years of EMS education experience with 4 years on the CoAEMSP board and 4 years as a site visitor.

Ashley Kaye. Ashley has 35 years of EMS education experience, is a paramedic, holds a doctorate in education, and served for 10 years as a paramedic program director. Ashley's leadership experience includes contributions to national EMS curriculum revisions

and the American Heart Association's Advanced Cardiac Life Support standards. Ashley's CoAEMSP involvement totals 8 years of board experience and 15 years as a site visitor.

Layton Finney. Layton is a paramedic, RN, and has earned a doctorate in education. Layton is a nationally known speaker in the subject areas of educational curriculum and measurement. Layton's experience includes 25 years as an EMS educator, 15 years as a program director, and leadership positions with the National Association of EMS Educators. Layton has 1 year of CoAEMSP board experience along with 6 years of site visitor experience.

Jordan Dickerson. Jordan has 40 years of experience as an EMS educator, is licensed as a paramedic specialist and served as director of a recognized EMS education program for 31 years. Jordan's leadership positions include Vice-Chair and Chair of the CoAEMSP board of directors. Jordan has served on the CoAEMSP board for 13 years and as a CoAEMSP site visitor for 12 years.

Meryle Hoppin. Meryle is a paramedic who holds a Bachelor of Science in Occupational Education and a Master's in Emergency and Disaster Management. Meryle has served in leadership and advisory roles with the US military and the National Association EMT's. Meryle's experience includes 31 years as an EMS educator, 4 years as a program director, 2 years on the CoAEMSP board, and 1 year as a site visitor.

Process and Analysis

Interviews were conducted with the 12 identified subject matter experts between May 17, 2015 and August 22, 2015. Each participant was interviewed either in-person or via telephone (Burke & Miller, 2001) at a convenient scheduled time in an environment that was comfortable for each them. Two sets of interviews were conducted with each of the twelve

subject matter experts. During the first interviews, participants answered demographic, context and challenges of leadership questions. During the second set of interviews, participants answered questions relating to program director leadership best practices and future leadership training.

Twenty-four separate interviews were digitally recorded using a Sony® digital recorder and saved in an mp3 file format. Interviews were downloaded to a password-protected personal computer for analysis. Participants were given time to respond to each question and allowed to return to previous questions if necessary for clarification throughout the interviews. No time limits placed on the interviews and participants could pause if necessary. The total time of the interviews equaled just over 19 hours. Length of interviews ranged from 19 minutes to one hour 27 minutes.

After each set of interviews was recorded, each of the audios was replayed in order to listen and dictate for transcription. Careful attention was given to subject matter expert emphasis and emotional cues regarding the various subjects. The researcher dictated the interviews verbatim using DragonSpeak12® translation software. Interview transcripts totaled 186 single-spaced pages of 11-point Calibri text. Transcripts were printed, carefully reviewed for accuracy, and compared to the recorded audio for accuracy. Notes taken during the interviews were also examined as a cross reference for clarification when needed. Each subject matter expert received an interview transcript to allow for validation of accuracy and member checking.

After member checking, the transcripts were analyzed for open codes and verified the interview questions had achieved saturation (Creswell, 2007). Important words, concepts, ideas, and quotes within the entire text were highlighted and underlined manually. Frequent

notes were also made in the margins for future reference. Open codes were identified and dictated into a new set of revised findings (Creswell, 2007). The revisions were printed and again analyzed a second time. A third and final round of dictation and analysis was conducted in the same manner, resulting in focused codes (Guba, 1978).

For validation of the reliability of the findings, Miles & Huberman's (1994) concept of "check coding" (p. 64) was implemented using two methods of external validation. First, Quirkos®, a qualitative research software was utilized for data organization and analysis. Data ranging from single words to full quotes were identified from the transcripts and inserted into the software that were relevant to the interview questions. Emergent themes arose in a visual context on the software's main canvas display which were then compared to the frequency of open and focused codes that had been determined manually by the researcher. Results were nearly exact.

Secondly, an individual with an earned doctorate who serves on the board of advisors of an international peer-reviewed publication was engaged in order to compare the interview transcripts and notes to the findings to ensure accuracy of codes and further validation of reliability. A target range of 90% of inter-coder agreement was used in the process to ensure consistency along with validity and reliability of the findings (Miles & Huberman, 1994).

Context of Leadership

The first supporting research question was: **"**In what context do program directors practice leadership?" For purposes of this study, context was defined as "the circumstances that form the setting for an event, statement, or idea, and in terms of which it can be fully understood and assessed" (Oxford, 2016a). In this case, the circumstances included the event and setting of paramedic education program director leadership practice. It was also

important to understand and assess comparative meanings of leadership, just-qualified expectations, necessary skills, and practice of various leadership theories.

To help frame the context of leadership, program directors serve in a variety of leadership roles subject to accreditation responsibilities and qualifications. Each program sponsor must "appoint sufficient faculty and staff with the necessary qualifications to perform the functions identified in documented job descriptions and to achieve the program's stated goals and outcomes" (CAAHEP, 2005, p. 5). Within the functions of the position, program directors are responsible for the: (a) administration, organization, and supervision of the educational program; (b) continuous quality review and improvement of the educational program; (c) long range planning and ongoing development of the program; (d) effectiveness of the program and have systems in place to demonstrate the effectiveness of the program; (e) cooperative involvement with the medical director; and (f) adequate controls to assure the quality of the delegated responsibilities (CAAHEP, 2005, pp. 5, 6). The responsibilities require a program director to have organizational, technical, analytical and human skills, vision, and the ability to communicate with future students, current students, graduates, faculty, administration, various medical professionals. Additional program responsibilities included in a typical job description may include:

> Scheduling courses and/or assigning instructors; preparing and distributing course announcements; processing course registration forms and supervising the student selection process; preparing, maintaining, procuring and taking inventory of all necessary training equipment; preparing exposure control plans; evaluating training programs including all course written and practical skills examination results and course evaluation forms; maintaining all training files and student records; serving as

> a student/faculty liaison; maintaining the quality of classes; overseeing and handling of financial matters; grant writing and research; coordinating with community colleges and universities as appropriate; and serving as a liaison with [postsecondary schools] as necessary. (Parvensky, 1995, p. 189)

In many programs, program directors also perform instructional duties. When this occurs, it is common for sponsors to afford program directors release time for administrative duties as articulated by NAEMSE, 2013, "Typically the program director has a reduced teaching load to address the many demands of running a program that are not associated with the direct duties of teaching" (p. 21).

The position of program director is most often a middle-management position; one that involves following administration and leading stakeholders. McClinchey (2002) described the administrator role as "the logistical engineer for a training program" (p. 271). Program directors must be uniquely prepared and according to accreditation standards, must hold the following qualifications: (a) a minimum of a Bachelor's degree for from a regionally accredited institution of higher education; (b) have appropriate medical or allied health education, training, and experience; (c) knowledge about methods of instruction, testing and evaluation of students; (d) have field experience in the delivery of out-of-hospital emergency care; (e) academic training and preparation related to emergency medical services at least equivalent to that of program graduates; and (f) be knowledgeable concerning current national curricula, national accreditation, national registration, and the requirements for state certification or licensure. (CAAHEP, 2005, p. 6)

Comparative meanings of leadership. At the beginning of the first interview, experts were asked to define leadership in general in an effort to explore the foundational premise of the context of leadership. Among their recurring definitions were concepts of creating a culture, guiding followers, and instructing and facilitating those they are charged to lead. Other components included integrity, trustworthiness, courage, people skills, and the ability to promote a positive vision for the organization. One expert stated, "It's the ability to help individuals to develop into their full potential" and another suggested, "Leaders, through their actions and their vision, create a culture of positive force within an organization. They are actively involved, making a difference in whatever they're doing. They have integrity, consistency, sound moral character, compassion, and a caring attitude." The sentiment was strongly supported by several authors (Katz, 1955; Fry, 2003, Bennis, 2009; and Firestone, 2010).

Also illustrated was the need for the leader to possess the ability to genuinely care for those with whom he or she is charged to lead, "If you care about the people below you, then you make the right decisions. You will do the things that are right based on that premise."

> Closely aligned to the positive leadership model was the following:
>
> First is credibility…you have to be competent in the community that you're trying to lead. You have to have effective verbal, written, and nonverbal communication. I believe a leader has to be ethical, that's a cornerstone. A leader has to have experience in the area that he or she is leading. I think selflessness is also a key element. It's about servant leadership. And selflessness…is the root of living in service of others.

Once experts articulated a general sense of leadership, they were asked to describe the context of leadership in EMS education. Specifically, what practices and/or qualities were involved in leading a program? In response, experts cited necessary qualities of interpersonal relations, emotional intelligence, communication, awareness, instructional and organizational skills, maintaining credibility, championing causes, and having a solid understanding of the EMS profession. Relationships with stakeholders was a recurring answer and success of a program was directly attributed to strong connection with the communities of interest:

> It's the relationships that have to do with the external factors of a program. It's the program directors that have good, strong, relationships with their clinical sites, community as a whole, and directors of the [EMS] services they serve that excel.

A similar need for quality relationships in leadership was supported across the authentic leadership literature (Heifetz & Linsky, 2002; George, 2003; Iiles, Morgenson, & Nahrgang, 2005; Eagly, 2005; Gardner, Avolio, & Walumbwa, 2005; Kouzes & Posner, 2007).

Further qualities cited were the need for mentoring followers, setting the standard for the educational process, and being the face of the program. The qualities of mentorship, modeling, and understanding the role of being the face of the program (including self-knowledge, self-awareness, and self-regulation) were also supported by the authentic leadership model posited by Avolio & Gardner (2006).

Fostering quality relationships, mentoring, self-objectivity, and setting a standard of quality were cited as important leadership components to add to a program's culture of excellence. In such environments, organizations (or, in this case, programs) can thrive (Kouzes & Posner, 2007). Another expert viewed it as:

> Creating an environment that is conducive for others to accomplish things…providing support and feedback, offering developmental opportunities, being the person that champions specific causes on behalf of the other person, runs interference, and removes barriers were necessary. It's not about a title, not about seniority, but somebody who can actually accomplish goals.

One of the experts advanced the discussion in a broader context of program director leadership requirements to include: "Leading the organization through the complex of healthcare dynamics, municipal economics, policies, and regulations…all in an effort to provide quality education."

> Another distilled program director leadership to the final outcome of patient care: Program director leadership includes remaining focused on how to improve the program, maintaining the integrity of the program, and helping to nurture your instructors and staff in moving the right direction. Ultimately…what you are as a program results in patient care.

Though attrition, certification pass-rates, and job placement are required outcome measurements of accreditation (CoAEMSP, 2016c), the ultimate outcome measure is the patient care provided to patients by the entry-level graduates of program (CAAHEP, 2005). Clearly, according to the experts, the leadership of a program's director plays a critical role in influencing this outcome.

Just qualified. To further explore the topic, experts were asked to describe what an individual with minimal qualifications for the position, (i.e. an individual who is "just qualified") should possess in order to have the greatest chance for success. Individuals come into the program director position from a variety of

backgrounds. Some come from within the educational system, but according to the experts, many individuals come without any experience in leadership or education. Accreditation standards require program directors to have appropriate medical training to at least the level of a paramedic, experience in the field of EMS, knowledge of educational practices and EMS standards, and a bachelor's degree in any field from an accredited institution of higher education (CAAHEP, 2005, p. 6). Subsequent to the required qualifications, broad knowledge of both educational process and practice was cited by experts as a vital requisite for a just-qualified program director. "How to educate and relate to students on different levels" was mentioned by one of the experts.

Another furthered the discussion of a "just qualified" program director as an individual with a critical need for education:

> If you're going to be a leader, you lead by example and you've got to have the education… knowledgeable in the field of education…not just in the field of EMS…you should really know how things work…not just, this is the way we've always done it.

Experts cited several other qualifications beyond the minimums stated in the accreditation standards. One was to know the EMS profession with great attention to detail. One expert phrased it as "Knowing the profession cold." Another framed it in a broader framework of:

> Have a material understanding, meaning competence. Clinically competent and competent in the curriculum rules and regulations of the profession…policies, procedures, curricula, regulatory environment, documentary type of things. Structure

> of the sponsoring institution including the system of finance, policy, academic curriculum, and assessment…andragogy or adult education, legal obligations and liabilities regarding patient care. Ultimately, the just qualified program director must understand the leadership context which includes the ability to engender trust, the sense of competency, and uphold the mission and vision of the organization.

Other experts voiced a need for just qualified program directors to implement objective evaluation in the development and management of a program. Such evaluation will not only measure performance, but may provide clues to the overall mission of the program. One expert described it as: "I think that the individual [program director] has to evaluate: The situation, their own context in the process of evaluation and assessment, their goals, and the individuals they work with." This concept was supported by Kouzes & Posner (2007) who stated a need to ask purposeful questions that "direct attention to the values that should be attended to and how much energy should be devoted to them" (p. 83).

The need to establish a network ranked high among the expert responses for what leadership practices a just qualified program director should understand. A successful network was described as stakeholder members such as administration, faculty, employers, as well as other program directors. One expert framed it as "A need to develop a relationship with other program directors." Another described it as "An awareness to tie in with mentors, people who've already been program directors for a while…to build a repertoire and a strong base that will push the program light-years ahead…by aligning with people who have been successful."

One set of stakeholders experts described in its own category was students. Especially important for new program directors to establish was a clearly defined line between faculty

and students. One expert stated, “You can be friendly to students, but not be their friend.” Another emphatically declared:

> You are the role model so that means your students are not your friends. You must make a clear separation. That doesn’t mean you can’t be nice, but you can’t be the students friends. You need to set standards and goals and objectives and stick to them. Once you breach the integrity of your standards and what you’ve stated the requirements are, it’s really tough to get it back.

The answers experts offered throughout the “just-qualified” context of leadership questions revealed a strong association with the leadership skill theory (Katz, 1974). Specific areas included the technical aspect which addressed tasks and duties; the human aspect which addressed relationships and personnel issues; and the conceptual aspects which addressed formulating a strategy and vision for the future of the program.

Skills. In addition to defining the meaning of leadership and the minimum “just qualified” requirements, experts were asked to describe the optimal skills of program director leadership. Skills of communication, listening, creative thinking, flexibility, empathy, and responsibility were cited as necessary for success. Among the most prevalent skills cited was the skill of service (i.e. being a servant). The model of serving others is the essence of servant leadership where leaders serve their followers, who in turn dedicate themselves to the leader and common cause of the organization (Greenleaf, 1970). One expert described being a servant in the context of EMS program direction as being “first among equals”:

> The early Romans leaders were first among equals. They never saw themselves as above one another until later… which lead to their downfall with jealousy and

> infighting. A program director is also first among equals…. given an extra responsibility…not to be all-powerful, but to help nurture others. When you [as a program director] have a servant's heart and your graduates are making a difference in patient's lives, both physically and emotionally…that is why you exist.

The spirit of servant leadership is consistent with the EMS profession in its effort to help others. In its solemn profession, the EMT Oath taken by EMS personnel proclaims "I will serve unselfishly and continuously in order to help make a better world for all mankind." (NAEMT, 2013). The parallels are strong. Servant leadership's congruence with both EMS and adult education are further supported by Northouse's (2007) description: "A servant leader focuses on the needs of followers and helps them become more knowledgeable, more free, more autonomous, and more like servants themselves. They enrich others by their presence" (p. 349).

Besides being a servant, the conceptual skill of having a vision (Katz, 1955; Fry, 2003, Bennis, 2009; and Firestone, 2010), was significant to experts. A vision was important for the present as well as the future of a program. One expert framed it as:

> A vision has clearly got to be there or else nothing is going to follow. The vision has to be sold to the people around the program director…the program director has to have a sense of what the right thing is to do and what that vision should include.

The likelihood of stakeholders subscribing to the vision is increased enormously by including them in creating the vision. When stakeholders have had a voice and were allowed to contribute to an organization's future plans, they were more likely to participate in seeing it to fruition (Covey, 1990; Kroth & Christensen, 2009; Kouzes & Posner, 2011). Researchers Ankona, Malone, Orlikowski, and Senge (2011) described the process as

"visioning that gives people a sense of meaning in their work" (p. 188). Once a vision was developed it had to be managed for progress. One expert described the process of vision implementation by a leader as a chessboard metaphor:

> Someone who is in tune with things and has a vision as to what that program is going to look like in the future…not get tied up in the day-to-day activities. I equate things from a leadership standpoint to a chessboard, looking at the whole chessboard…where all the players and where the next moves?

In addition to conceptual skills of servanthood and visioning, technical business skills also emerged as important to a program director. Because of the significant expense of programs, a director needed to possess some fundamental skills of financial management and budgeting in order to be successful. Crowe et al. (2015) found EMS educators spend numerous hours every week addressing business issues such as budget, payroll, recruitment, equipment, etc. One expert specified the need for "some good direction on finances, administration of budgets and policy manuals, working with faculty as far as personnel issues and HR issues." Similar to the other skills, experts purported paramedics coming from strictly patient care backgrounds may not have had experience in these areas and thus would find themselves in need of specific business skill training.

The necessary skill of communication was cited repeatedly by the experts. A large amount of communication is necessary to keep stakeholders informed of program changes. The concept of articulating one's thoughts was important, but just as important was the ability to listen. This was supported by Covey (1990) who stated, "Communication…is not so much a matter of intellect as it is of trust and acceptance of others, of their ideas and feelings, acceptance of the fact that they're different and from their point of view they are

right" (p. 117). Similarly, one expert framed communication as the need for a measured approach: "I think somebody needs to be in control…that doesn't raise their voice, doesn't yell at people…once yelling starts communication stops. A clear communicator [who] gives directions that are clearly understood by staff and students." Another expert summarized the communication discussion, simply stating: "Effective communication: written, verbal, all forms of communication."

To juxtapose what skills were needed, experts were queried regarding what leadership skills were missing in struggling programs. Participants identified several key components that included a lack of program director vision, education, resources, and passion. Program directors lacking vision were described as unable to see beyond the daily tasks required to run a program and were constantly near-sighted in their focus. On the contrary, those with vision were able to anticipate needs for the program:

> The [successful] program director has a vision for the future…[with the ability to say] this is what the paramedic program looks like today, but five years from now we may need other things, so what will it take for us to get to those areas?

A new program director may have been trying hard to simply survive in the position and not concerned with a vision for the program. Clearly the risk in this was becoming buried in day-to-day technical challenges (Heifetz & Linsky, 2002) that consumed time and stifled creativity.

Experts cited several other missing leadership components in struggling programs. Among them were a lack of trust, organizational ability, professional development, and management experience prior to becoming a program director. Lack of trust was a critical issue. Bennis (2009) described it as:

> Trust is vital. People trust you when you don't play games with them, when you put everything on the table and speak honestly with them. Even if you aren't very articulate, your intellectual honesty comes through, and people recognize that and respond positively (p. 161).

One expert offered an example of EMS education programs that had suffered a failure of trust. No amount of other resources or skills could counter the issue:

> I've seen programs with absolutely top-of-the-line equipment, classrooms, instructional methodologies, materials, clinical affiliates and internships, but missing quality program leadership and they are extremely distressed programs…all the best bells and whistles of the world will still create a problem for a distressed program without that level of trust. I've seen that happen in programs that have gone from the very best, highest peaks, to the very worst because of poor leadership coming in. A real problematic program director creates a terrible level of mischief that creates a bad internal reputation, in-fighting, and cliques…in this case everything that could go wrong did go wrong, with self-interest and fighting for territory and pushing off work.

Organizational skills were also cited as important, with a lack thereof creating a culture of disarray. One expert described it as: "I think organizational skills is often the one that stands out [for me]. I think the organizational piece is huge and oftentimes what is missing." Without organization, program components such as reports, meetings, communications, and deadlines all begin to suffer and in turn affect the health of the program.

Other missing skills mentioned were a lack of professional development for program directors. Every paramedic must complete required continuing education every two to three years for National Registry and/or state recertification. For example, paramedics must complete 72 hours every two years for National Registry (NREMT, 2016b). Few states however, require instructors to have continuing education to maintain their status and fewer (if any) offer program-director specific professional development. The need is tremendous and demonstrates a critical lack in the system of EMS education.

The expert's responses such as these are supported in the literature in regards to leader self-structure and its influence on positive leadership. Hannah, Woolfolk and Lord (2009), proposed "having greater content and complex structuring of positive attributes in leaders' self-constructs promotes positive organizational leadership…" (p. 270). This was especially in the realm of educational preparation and in the evolution of educational standards. One expert offered:

> The educational understanding of how. It's no longer here's your curriculum and go teach, it's here's your standards now develop your curriculum. The result is program directors don't have the skills to develop the program and the program suffers because they don't understand the content of what they're supposed to be doing.

Related issues may be exacerbated by frequent practice of promoting strong paramedics into the educational then administrative role of program director without proper preparation. The end result is often an overwhelmed individual lacking passion. One expert described the phenomena in a struggling program:

> There's something fundamentally wrong. Their attrition is high, their output is poor, and their communities of interest are not interested in their graduates. So lack of

> education, motivation, oversight, foresight, and insight about themselves, how the industry operates, and fundamentally how students learn. Folks are struggling because they don't have the additional tools from gaining education…which gives personal insight to ask: "How can I grow…as a human being, schoolteacher, and practitioner?"

The missing leadership components cited by the experts clearly emphasized the critical need for a leadership curriculum that would inform and enhance program director practice.

Practicing leadership theory in context. To finalize the discussion of leadership context, experts were asked to provide their insights on the theoretical constructs chosen for the study. The purpose of this study was to explore leadership practices of program directors in nationally accredited paramedic education programs, thus it was important to determine which leadership theories may be transferrable to practice. The theories included in the discussion were positive leadership theory (Avolio & Gardner, 2005, Fattig, 2013) and leadership skill theory (Katz, 1974). Experts were asked to describe the significance (if any) of each theory or approach and rank them in their importance.

The six leadership approaches included in the positive model were authentic, servant, ethical, charismatic, spiritual, and transformational. The leadership skills model used considered technical, human, and conceptual components of leading a program (Katz, 1974). Technical components of leadership were queried to help determine how program directors lead through performance of daily duties. Examples included completion of required documentation, administrative tasks, and accreditation responsibilities. Second, necessary human components of leadership were explored to assist in identifying relational skills. Examples of human skills included interpersonal and communication skills a program

director uses with a program's various communities of interest. Third, the conceptual component of the leadership skills model was probed to help determine the ability to see the program on many levels. Examples of conceptual skills included the importance of a program director's capacity to recognize and relate a past, present, and future vision for a program.

The findings showed all of the experts believed in the merits of each of the leadership approaches considered. They ranked authentic, ethical and servant highest followed by transformational, charismatic, and spiritual, respectively. Leadership skills (i.e. technical, human, and conceptual) were emphasized by experts throughout the interview responses. Similar to Katz's (1974) findings of executives, such skills were cited as important in being an effective administrator of a program.

Begley (2006) described authentic leadership as "a metaphor for professionally effective, ethically sound, and consciously reflective practices…" (p. 570). The authentic leadership approach takes time to be developed in an individual or as George (2003) articulated:

> In my experience it takes many years of personal development, experience, and just plain hard work. Although we may be born with leadership potential, all of us have to develop ourselves to become good leaders. The medium for developing into an authentic leader is not the destination but the journey itself – a journey to find your true self and purpose of your life's work. (p. 27)

Authentic leadership considerations include some higher order exploration of the value of a program director's self-awareness, moral principles, and responsibility to others. Examples may include the need to recognize one's limitations, having a moral compass, and demonstrating responsiveness to the communities of interest. Experts believed in the

importance of each of the higher order concepts, yet voiced concern over competition from daily duties and tasks.

The need to be authentic was ranked highest among the theoretical approaches, with participants indicating the need for program directors to both possess and exhibit values, morals, and transparency. “This is at the very top, it’s essential” stated one expert. Another declared:

> Personally, I ranked authentic as number 1. I think sometimes too many of us are not authentic in what we do. We have a work face, director face, home face, and parental face; when you have so many faces the problem is you forget which one is the real face. You have to be authentic…to be who you are enough to understand that not everyone’s going to love you, but you’ve always got to be willing to stand for your principles.

Another expert described program directors displaying authentic leadership as individuals who: “Have values and morals, strong in knowing who they are, what they stand for; know and admit when they’re wrong…it is okay to say I don’t know everything.” Much of the leadership literature considered in the study conferred these sentiments in supporting the need for authenticity in every area of a leader’s life (Heifetz & Linsky, 2002; Avolio & Gardner, 2005; Shamir & Eliam, 2005; George & Sims, 2007; Kouzes & Posner, 2007).

Other qualities of authentic leadership for an EMS education program director were described as very important by the experts included characteristics of maintaining consistency, being ethical, and having a core belief system. One of the experts summed up authenticity as:

> If you're not [authentic] people can see through you and if you're not true to your word or are lying, your values are not where they should be. People will not go to you. They will tend to avoid you unless they only need to absolutely get to you. And that's not a good thing.

In a broader context, it was clear from the findings the authentic leadership model was supported by the experts. Their responses closely mirrored George (2003), who suggested authentic leaders must understand their purpose, practice solid values, lead with their heart, establish concrete relationships and demonstrate self-discipline (p. 18). Furthermore, the findings were also supported by the philosophy of authenticity to include the awareness of one's self, one's emotions, and a responsibility to others (Novicevic, Harvey, Ronald, & Brown-Radford, 2006).

In addition to the authentic model, the servant leadership model was also considered as part of the positive leadership construct. Closely aligned with the EMT Code of Ethics (NAEMT, 2013), the servant model was originally developed by Greenleaf (1970) who qualified the approach by asking if the leader's impact on those served caused them to develop as individuals and as servants. Also important to the theory was the degree of impact the servant leader had on the least privileged in society (Greenleaf, 1970).

Besides being part of the positive leadership framework, servant leadership was explored to help determine the degree of importance of a program director in being a model of service to others. Instances of service to communities of interest and embodying the EMT Oath were considered as examples of servant leadership.

The servant model ranked high among the experts in considering the positive leadership models. Experts stated it was "most definitely needed, valued highly, very

important, and absolutely critical." Descriptions included qualities of being a public servant role model, a founding principle of the profession, placing others before self, paramount, providing for program continuity, in the overarching purpose of serving students. One expert described servant leadership in the positional power (Bass, 2008) context of being a role model as a teacher:

> We are on a pedestal and being watched at all times. If we teach, we are a role model to others. That's all there is to it. Part of being that service model, is to serve others and that's what we are training them to do. I think we have a generation that comes to us that doesn't always understand the model of service to others…we've got to teach them servanthood.

Experts described the importance of being an example and modeling behavior in regards to the servant model. One stated the example of service flowed from the program director position all the way to down to patient care:

> Servant leadership [to me] is where there is a servant sense of the job and being a patient advocate…everything from you need to be out ensuring the public understands EMS; perhaps doing screenings for the public, education programs, going to the medical director and making a change in your protocols, [all] falls into the servant perspective. You are a public servant and you need to act like one...and be the patient's advocate and always do what's right.

Having a sober understanding of one's role and position is important to a leader. By appointment, program directors assume roles of positional power, yet the servant model of leadership lends itself more towards a personal realm of power. As a leader it is a critical to understand the difference to be effective in practice. As Heifetz and Linsky (2002)

counseled, “the authority you gain is a product of social expectations. To believe it comes from you is an illusion” (p. 168).

The close association with the servant model and EMS profession allow for an easy understanding of the approach. This connection translated to an exponential effect of education on the general public in which EMS is called to serve. One expert summarized it as:

> Ultimately, it’s the [service to] people you are never going to be meeting that graduates are going to be tending to on the side of the road, in the middle of the night, or in someone’s home under very, very, adverse circumstances.

Also included in the positive leadership model was the ethical leadership approach. Aristotle described ethics as including principles of respect, service, justice, honesty, and community (Northouse, 2007). Ethical leadership in turn is rooted in the areas of conduct, character, and virtues (Brown & Treviño, 2006).

The ethical leadership component was explored to help determine the relevant importance of program directors in doing what is right. Examples of ethical leadership included treating all communities of interest fairly with integrity and consistency.

Experts agreed ethical leadership was important in a program director. One stated, “I think that authentic and ethical are very much tied together. You have moral principles and values and you have ethics.” Ethical leadership’s implications are far-reaching as furthered by another expert, “Ethical leadership is unquestionable. It fits right in with authentic and trustworthiness. If you are unethical that just corrupts at the core.” The need for morality, values, honesty, and truth were all described as critical in being a program director. The results of each help in developing the program, teaching students, providing a foundation that

is monumental, as well as providing a role model and setting the tone for a course. Still, being ethical can be a stressful charge in positions of leadership:

> Sometimes being ethical will put you into great jeopardy. To speak the truth. Whenever something has happened in my life where I had to stand up and do the right thing and I was sometimes slaughtered down…I rose up and did a better job, and in the end, got even more respect.

The impact of ethical leadership consistent with being a role model was articulated by one expert: "You are a role model and you are setting the tone. So how can you expect students to behave ethically if you are not [behaving ethically]?" The concept was further described: "Ethical leadership for what we do is monumentally important. We are working with patients and people in their most vulnerable circumstances...in someone's home, largely unsupervised with a great deal of autonomy…"

Charismatic leadership was also included in the study's construct. The model suggests certain individuals have the ability to lead based on their attractiveness and personalities. Bass (2008) described such individuals as "highly expressive, articulate, and emotionally appealing. They are self-confident, determined, active, and energetic. Their followers want to identify with them, have complete faith and confidence in them, and hold them in awe" (p. 50).

Consideration of charismatic factors of leadership addressed significance (if any) of a program director having qualities of charisma. Conger & Kanungo (1987) defined leadership charisma as "the power of a leader's personal abilities and talents to influence followers in profound, extraordinary, and transformative ways" (as cited in Norhria & Khurana, 2010, p. 125).

The charismatic leadership model provided the most contentious discussion among the experts. Most of the subject matter experts were hesitant to rank charismatic leadership highly. The positive impact of charismatic leadership was building relationships, being an outgoing role model, and providing a personal augmentation to the role of program director. One expert suggested:

> You have to build relationships. You need to reach out and have the ability to reach out to show that you're excited about your program and that you want program input and value what your communities of interest have to say.

Another expert stated, "Charismatic leadership is extremely important because of the program director's role as a role model." In a similar vein, another offered, "Having charismatic qualities can certainly benefit a leader to help gain attention and support of others." The concept was advocated by another expert:

> My own leadership style is charisma and that is something unique. I think the strongest paramedic program directors are very, very charismatic. They could have been in sales, religion, principles of high schools, or superintendents of high schools. A person with charisma has something that people want to listen to. They want to listen this person…I think charisma is a good thing.

In contrast, subject matter experts were critical in saying charismatic leadership should not be a substitute for substance, "If you don't have the substance, you're not ethical, you don't have the moral components…the charismatic components can only go so far." Another expert offered a similar sentiment, noting an observed fondness of EMS professionals towards charismatic individuals:

> I believe that students and other people in our profession look to folks that are particularly charismatic. My concern is that oftentimes people allow that to be a substitute for substance…we need to be careful about that. It's important for us to realize charisma is not a replacement for requisite abilities, skills, leadership traits or characteristics we need to have in order to be effective. Sometimes people who have charisma are lacking in other aspects and are probably not as effective as they otherwise could be.

The proclivity of attraction to charismatic individuals could serve as a detriment if the intentions of the leaders are not completely pure. Accordingly, charismatic leaders must be moral whereas some are misleading. Another expert described this as:

> It is possible for a leader to be charismatic and mislead people without underlying principles of placing others [or the mission of the organization] before oneself. If you're not authentic then the charismatic leader is just creating mischief by taking people down a hedonistic role. That's self-serving for one's own advancement.

Charismatic leaders must also have competency. Oftentimes stakeholders are not in position to judge this in a leader until it is too late. One expert declared:

> Everybody loves a charismatic individual and I think self-confidence is good. I sometimes though tend to be little more on the skeptical side. I'm more concerned about authenticity and competency as opposed to being charismatic. Charismatic people may be good leaders, but not for the good…Adolph Hitler and Jim Jones were charismatic but not for the good. Oftentimes in EMS we get drawn to instructors who are charismatic and yet I've seen some of those do presentations and give wrong information because they never bothered to update their information. And yet people

> love them but don't realize they are not getting good information. So charismatic is not as important to me.

According to the experts, it is not a critical factor for leaders to have charisma. It is also not a replacement for ability, skills, or traits. Leaders can have too much charisma to the point of not being taken seriously. One expert stated: "Charismatic leadership is often superficial in so many ways" and another expert offered the most critical critique, saying:

> I think you can be a real loser and use charisma in a negative way. I've seen it done. I've even seen it with people who teach ethics and I think that's very unethical because they are very charismatic and they are not related. So it's not deal breaker if you're not highly outgoing and high-energy.

Though Avolio, Bass, & Jung (1999) reported charisma as a necessary component for transformational leadership, ten of the twelve experts in this study did not rank it as important for paramedic education program directors.

The fifth positive leadership approach considered in the study was spiritual leadership. Spiritual leadership is based on the premise of appealing to intrinsic motivation for direction. Fry and Matherly (2006) described the spiritual leadership model as appealing to a greater power:

> Spiritual leadership comprises the values, attitudes, and behaviors required to intrinsically motivate one's self and others in order to have a sense of spiritual well-being through calling and membership, i.e., they experience meaning in their lives, have a sense of making a difference, and feel understood and appreciated (p. 2).

Spiritual leadership was considered in determining a need (if any) for program directors to possess a supernatural dimension that values a power higher than themselves.

The spiritual dimension of leadership for this study considered a program director's personal faith in God (if any) that assists him or her in the role of leading a program.

Four of the participants ranked spiritual leadership as high on their list of the qualities to possess. "Sometimes you have so many problems or challenges that you have to turn to someone else to help give you the strength to continue" stated one participant. Another regarded spiritual leadership highly and defined it as focusing "on creating people who really live to serve others in an ethical way, providing service to their community, not worrying about personal recognition, but worrying about what happens for the right reasons to patients."

A personal reflection of spirituality was offered by another participant in regards to leadership:

> I have a faith there is a higher power. I am not the only one at a patient's bedside who has all the knowledge in my head, in my hands, or in my heart. I truly believe that there is a God and my job is to help realize what God has given me to be able to help serve others. So I absolutely think that people that I've dealt with that are really truly strong leaders have a sense of spirituality that transcends everything. It doesn't matter whatever the faith is…I think people that really have that sense of who they are, who God is, how all it fits into the universe, and certainly in the emergency healthcare and teaching business…I think they're very strong.

Another participant suggested a leader who possess a sense of spiritual leadership can relate to others on many levels which may include counseling people with problems to motivating people to a higher purpose. On a personal level, spirituality may also have benefits for a program director as it "gives you a better background and a general approach to

how you're going to look at people. You're going to be more forgiving, willing to help people more, and just a whole gamut of things."

Two participants listed spiritual leadership as very low on their list with the six others in the middle. Participants defined spiritual leadership in a broad context, with one framing it as, "It means more about order in the universe" while another cautioned against trying "to push it on somebody in a public institution." All agreed it was a very personal subject and potentially one that would not be witnessed by site visitors or board members in enough capacity that would allow for expert comment.

One participant's comments seemingly attempted to bridge the gamut of views by offering the following regarding the role of spiritual leadership in EMS education:

> Spiritual leadership is important…especially for us. Our students are going to be involved with patients that have spiritual things going on with them. Too many programs have missed the boat of not having those conversations that lend themselves easily to the content we are preparing the students to engage themselves in the real world. They need to be able to be respectful of alternative viewpoints and patients they will interact with…circumstances arise with end-of-life decisions, birth control, you name it and the list can go on and on. We are missing a huge opportunity and not adequately preparing our students for what they are ultimately going to do if we don't insist that those conversations take place. It's important for us to engage as a group to develop respectful attitudes about different people's spiritual beliefs…and the way we learn about those is to engage in a dialogue and some academic programs they don't want to go there. It is [also] important for leaders to be able to relate to the spiritual needs of the individual students.

According to the participants, spiritual leadership responses were mixed and may or may not directly relate to program directors on a professional level; however on an individual level it may prove beneficial. Regardless of personal beliefs, as a role model, program directors must respect the spiritual persuasions of all of the communities of interest — especially the students — to remain consistent with the EMT Code of Ethics (NAEMT, 2013). It is also important for faculty to impress upon students the significance of spiritual beliefs in the patients they may encounter and moreover the need to respect those beliefs in providing optimal patient care.

The transformational leadership approach was included in the study's construct. The concept of transformational leadership considers both leaders and followers inspiring one another to rise to a higher purpose. Burns (1978) described it as: "Such leadership occurs when one or more persons engage with others in such a way that leaders and followers raise one another to higher levels of motivation and morality" (p. 20). Additional studies determined transformational leaders to be charismatic, inspirational, intellectually stimulating and individually considerate (Avolio, Bass, & Jung, 1999).

Transformational leadership questions were asked to help address to what degree program directors should inspire their communities of interest for the betterment of themselves and the programs they serve. Illustrations of transformational leadership in program directors included fostering faculty and students in professional development as well as building leadership capacity in members of the various communities of interest.

The participants agreed that transformational leadership encompasses many of the other positive leadership models. It helps by "building relationships with people and in teaching your students to be leaders within their communities" according to one participant.

Transformational leadership is highly desirable and offers the essence of leadership according to another participant, as it is sustainable and "continues to inspire others after a leader's is no longer there…resulting in something of quality that will be just as good the day after you retire as when you built it."

Transformational leadership is leadership that creates a personal, lasting change, is the highest peak of leadership. Through its implementation it can inspire interest, foster vision, and encourage ethical behavior. According to participants, keys to transformational leadership were growing replacements to take the place of the present program director as well as future faculty to serve a program.

The biggest threat to transformational leadership is the tendency to be transactional in nature:

> We oftentimes are transactional in our form of leadership because a lot of what we do [in education] is, if you do this you'll get this grade and that's good. So in education there's a significant reward incentive [for grades]. I also think it's important to be conveyed to paramedic students that nobody will ask you what your grade was in paramedic school when they are laying on the gurney in front of you. They want to know that you care about them and you're going to do the best job you possibly can…it's not the grade it's about doing things to the best of your innate ability so you do have the knowledge and skill and ability to perform for the patient whose lying in front you. And that takes it beyond simple transaction that if you do this then you get this score, you get an A…rather it's I'm learning this because somebody's life might depend upon me at the end of the day. That's where transformational leadership becomes so important rather than just deep down transactions. So you are successful

with X number of endotracheal tubes, good for you. Does it make a difference in the patient's outcome?

Transformational leadership encompasses many of the previously mentioned models such as servant, authentic, ethical, and provides for a healthy organization that invests itself and its stakeholders as well as the mission and vision of the program. Such leadership calls leaders and followers to "rise to a higher purpose through motivation and morality" (Burns, 1978, p. 20). A discussion of transformational leadership theory to include its use in other allied health education fields is also necessary to include in the curriculum to demonstrate its usefulness to program directors.

None of the participants discussed topics related what George (2007) termed in his authentic leadership model as an integrated life (see Figure 5). The need for leaders to have a balanced life outside of work is important in fostering creativity and sustainability. Perhaps because the subject of formal leadership is new to the field of EMS program directors or the ever-present "do it at all costs" attitude of EMS professionals, the subject was not addressed by the participants. As the leadership discussion evolves however, further study of how program directors balance their personal lives with their professional lives may be of value in decreasing turnover and fostering longevity.

The importance of all of the leadership theories should not be understated in EMS program director leadership. Though the various theories may not be familiar to many EMS educational leaders, the applications to practice appear to be many. When asked how much of a program's success (if any) was due to the best practices of a program director leadership, participants responded with a range of 60% to 100% and an overall average of 75.44%. The high percentage emphasizes the significant role a program director plays in the success of a

program. Through positive leadership and skill integration a program can thrive, but without them a program appears destined to struggle.

Challenges and Best Practices of Leadership

Two final supporting research questions were presented to participants in regards to challenges and best practices of leadership. The second supporting research question was: "What are the challenges in program director leadership?" Participants were asked specifically about challenges with stakeholders or communities of interest, accreditation, and future issues. The third and final supporting research question included in the study was: "What are the leadership best practices of being a program director?" To answer the question, participants were asked about leadership concerning personal and professional practices, stakeholders, retention, placement, certification, placement, recruitment, accreditation, student practices and future issues. At the conclusion of the interview, participants were allowed to elaborate on other leadership issues they felt were important. Two categories (internal and external factors) resulted from the analysis relating to challenges and best practices. Each of the factors was derived from the data gathered during the interviews which answered the supporting research questions.

Figure 7. Challenges and Best Practices of Leadership

Internal factors. The first category, "Internal Factors" included core aspects of leadership that influenced a program internally. These factors included personal and

professional leadership practices, resources, student recruitment, retention, and certification (See *Figure 7*). Each of the internal factors falls largely within a program director's immediate span of control.

Internal factors: Professional and personal leadership. To determine the leadership practices of program directors, participants were asked which professional and personal leadership practices and skills were important for program directors to have. They were also asked about which leadership practices were missing in struggling programs.

Participants indicated 75% of a paramedic program's success is directly attributed to a program director's best practices of leadership. Accordingly, professional priorities for a program director included being a role model to all of the stakeholders including faculty, students, medical director, graduates, advisory committee, and administration. Even beyond the stakeholders, it was important for a program director to recognize that he or she is a role model to the surrounding EMS community. The role model is far-reaching, comes with significant responsibility, and impacts the program in tremendous ways. One participant phrased it as, "I have a responsibility to not only be a good role model for the students but I have a responsibility to uphold the very best ideals of our profession because other programs look up to me."

Graduates are impacted through the fact that the program director is the face of the program and is the individual who becomes the default contact for employers when hiring occurs. The program director is a role model to faculty when educational challenges occur and through integrity the program director is a role model who can be trusted and confided in when necessary. The program director is a role model to administration in the context that he or she is transparent, forthright, and not overly needy. Trust is imperative in the relationship

with administration and thus the program directors role model is vital in that situation. The role model also to the advisory committee members by doing things the right way, not taking shortcuts, and creating a product of value members can believe in the trust. Finally, and perhaps most importantly, the program director is a role model to students. Students will practice the way they are taught and if the program director who is the leader of the program has displayed an attitude of professionalism and built a culture of excellence, students will practice the same way throughout their career. One participant described the charge of being a role model as "a weight of responsibility" in a spiritual context:

> Being a program director really made me feel the great weight of responsibility and so I take it very seriously. My wife and I pray each morning for God's grace that I will always be that role model and have integrity…and that people will be able to see that within me. I say that's a responsibility I bear and an important part of being a program director.

Understanding the magnitude of being a role model in the leadership role as a program director is paramount. This is not only limited to the individual, but also the organization he or she represents. As Heifetz, Grashow, and Linsky (2009) advanced, "In addition to your own values, priorities, and sensitivities, you embody your organization's values, priorities, and sensitivities…the roles you play and your behavior in those roles depends on the values and context of any given situation" (p.209).

Personal and professional leadership practices identified included a need for effective communication including the ability to listen as well as speak and write effectively. Communication is a critical element in the context of leadership (Covey, 1991; Drucker, 2003; Kouzes & Posner, 2007). For program directors, communication must occur with each

of the stakeholders of the program. Frequent communication with the medical director regarding student progress, examination performance, medical questions of practice, and integration of oversight of the program are crucial to accreditation standards as well as overall success of the program. Communication with faculty is vital to ensure the message of the vision and mission of the program are carried out to the level of success. It is important to remain measured in such communication as one participant advised:

> I think [a good leader is] somebody in control and I guess what I mean by that is someone that doesn't raise their voice, doesn't yell at people, they're always cool, calm, and collected. Once yelling starts, communication stops. I think that they need to be a clear communicator and give direction that is clearly understood by the staff and students.

Developing critical skills relates to the technical skill component of Katz's skill theory (1955). By possessing such skills, program directors will be more likely to navigate the day-to-day requirements of leading a program. The skill of regular communication with the program's communities of interest is vital. For example, regular communication with advisory committee members outside of the scheduled annual or biannual meetings is important to sustain clinical sites, and understand the needs of the communities the program serves. Communication with administration is vital in order to convey what it is the program needs, as well as understand what administration's limitations may be an intern communicate those to them faculty, medical director, and students of the program. Communication with graduates is important. Program directors must solicit feedback from graduates to determine how well they were prepared for the workforce and to make necessary improvements. Graduates can also be a valued resource to the program has preceptors, role models to

students, and key players in building a culture of EMS practice excellence. Regular communication with students is important throughout the educational process. From applications to orientations throughout the time as a student until graduation, the program director must stay in close communication with students to understand their needs, concerns, and celebrate their achievements.

Also critical to participants was the ability for a program director to be adept in the skill of reflection. Through reflection, a program director can "objectively assess a situation in order to formulate a solution to both foster and maintain success in a program." One participant articulated the importance of the skill of reflection as: "A program director needs to know what is going on at the organization…the policies and procedures so that they don't walk into a minefield and find things the hard way."

Remaining credible in clinical and educational practice were also cited as important to leadership practice. To achieve this, participants believed in the practice of staying abreast of local, regional, state, and national issues within the EMS education field. The need to maintain integrity was also cited as vital to ensure trust and build relationships among the stakeholders. Keeping self-composure which aids the program director in being a role model was also cited as a very important personal leadership practice.

To contrast desired professional and personal practices, participants were also asked which leadership practices were missing in struggling programs. Answers included the practice of communication, the inability to secure institutional support, and a lack of vision. A lack of training or preparation for the role was also noted along with program director apathy or lack of effort.

One participant summarized:

> Program directors who truly care about the students and the graduates their program…I think will make the right decisions. There are a lot of program directors who need help in getting to the point of making the right decisions, simply because they just don't have the background…being a program director is becoming more and more and more challenging because it becomes more and more and more demanding on the program director to become a lot of things that they weren't necessarily in the past. They're going to need help.

The need for help emphasizes a need for a leadership curriculum and training program tailored specifically for paramedic program directors which will include vital skills identified by the participants. Those skills include the ability to be effective in the workplace (Drucker, 2001). Also imperative was the skill of being relational with the stakeholders in order to form relationships built on trust, integrity, and authenticity. Such values directly point to "True North" in the authentic model of leadership where "leadership principles are values translated into action" (George, 2007, p.85).

Flexibility is another skill that is vital in the sound practice of EMS education. Understanding that education of paramedic students must be conducted with flexibility and not in a binary context is important. One participant stated, "Leadership is what allows us to confront a challenge head-on and come up with creative solutions to make things better." Since students and stakeholders have varied needs, a program director must assess and apply leadership in a large context of flexibility in order to achieve positive outcomes.

Organization is also a critical skill for a program director. There are many moving parts to each program and the program director must be able to manage those multiple moving parts at one time. The skill of organization becomes critical when doing so, and in

meeting the many demands of accreditation, student admissions, grading, managing budgets, recruitment, placement, in preparation for certification exams. Program directors must possess the skill of allowing the stakeholders the freedom to be creative while allowing them to make mistakes and learn from those mistakes. Adequate oversight is necessary, however micromanaging is a bad practice of leadership. The program director must have the skill of recognition of the components necessary for good education and value the various communities of interest involved with the program such as the advisory committee members, graduates, faculty, students, administration, and the medical director.

According to participants interviewed for the study, any type of formal program director leadership training is virtually nonexistent. With the advent of so many new programs being led by new directors combined with the high turnover amongst existing program directors, the need for leadership training is momentous. The participants emphasized the need for mentorship and a leadership curriculum to enhance program director practice. Kouzes and Posner (2007) described this as a culture of strengthening others. One of the participants framed this in relation to program directors as:

> It's all our responsibility [as program directors] to make sure that we are helping to train and educate the next generation, that we are mentoring them. If we are not doing that, then we're doing pretty poor service to the profession. We have to find the right people to help, mentor, and groom them so that they can take over programs.

Another component of professional development is for program directors to learn they are expendable. One participant described it as:

> We are getting older. There are not a whole lot of people lining up to take our place. So I think you better start looking long-term at how do you grow your replacement.

> And not just bringing in some new kid off the block, this person's got to have the gravitas and got a have the skills, so you've got have a little bit of an eye for what that talent pool looks like.

The transformational practice of 'growing your successor" is supported by the Edmar Soriano notion of "Great leaders grow their constituents into leaders themselves" (Sornario as quoted in Kouzes and Posner, 2007, p. 248). For the health of the program, directors must always be thinking of a succession plan.

Internal factors: Resources. Every paramedic program must have adequate resources to remain operative. According to accreditation standards, resources must be "sufficient to ensure the achievement of the program's goals and outcomes. Resources include… faculty, clerical/support staff, curriculum, finances, classroom/laboratory facilities, ancillary student facilities, hospital/clinical affiliations, field/internship affiliations, equipment/supplies, computer resources, instructional reference materials, and faculty/staff continuing education" (CAAHEP, 2005, p. 5). A program director must ensure the program has enough resources to not only meet the standards of accreditation, but also to provide for an optimal educational environment for students. Thus, additional resources beyond those required by accreditation may be required in some programs.

The issue of resources emerged as a significant challenge for program directors with a national trend appearing to be fewer resources with more work requirements (Crowe et al., 2015). Budgets appear to be shrinking while costs of education are rising:

> Shrinking budgets, increasing cost, the demand or pressure to take more students, more students because it generates more revenue obviously. And having smaller pools of students. So the program director from the top is hearing you need to take

> more students, generate more money, because our budgets are shrinking and I can't give as much money. But from the bottom coming up, the field sites are saying you're taking students that should not be in this program. Why are you taking so many students? You can't manage them! And that clinical sites are saying you can't send us so many students, so it's kind of like the program directors being pressured from several different sides. So I would say the biggest challenge is to maintain high numbers or take larger numbers and reduce costs at the same time. And I think that's really, really tough to do.

Balancing budget reductions, rising costs, and student enrollment pressures has been further compounded by new federal guidelines which limit the amount of financial aid for students who have previously completed college coursework. Programs are also being held to higher standards of graduation and placement rates (CoAEMSP, 2015a). Though these criteria appear to be improving the overall quality of education, the demand on resources becomes significant.

Another resource challenge for paramedic programs is the problem of high program director turnover. The phenomena was described by one participant as:

> Paramedic program directors are constantly turning over. We are turning over a bunch of them. I'm not sure what the reason is, I don't know if it's whether they don't make a lot of money, or if it's a crappy job, or if it's because they got fired, or they got sick, or if they decided they wouldn't do the job anymore because it's tough. I don't know what all the reasons are, but paramedic program directors are turning over.

Subsequently, finding a qualified and sustainable program director is a resource challenge for programs. The minimum requirement of a bachelor's degree combined with the allure of more pay in the patient care setting were cited as challenges in finding qualified individuals. Moreover, without a quality leader as program director who can navigate inevitable challenges, a program is likely to suffer. One participant described it as:

> It really takes a unique set of skills. There are so many [program directors] out there that have none of these skills and it's a problem. You can take a great program and put it in the hands of somebody who is very unskilled and in 2 or 3 years, boom , they are having really, really, serious problems.

Another participant continued the theme in stating even programs who have sound leadership are in danger if a successor is not identified prior to a program director leaving a program:

> I think that many of these paramedic programs are either excellent or doing very, very, well. But any of them are one paramedic program director away from a train wreck. So you could be running a stellar program and have been there for 25 years, then you retire or die. At that point the administration decides to transition someone else into the leadership role. It may only take two years, but there can be situations where leadership changes in a stellar program results in a marginal program or non-exemplary program.

Finally, an identified resource issue was in some areas caused by the result of a paramedic shortage. Shortages of paramedics can create the phenomena of employment urgency, or pressure on programs whose employers in their community of interest are eager

to find staff for their vacant positions. If a paramedic student's education occurs too quickly, it can create students who may become sub-standard graduates:

I think most people have seen programs that just crank out numbers [of graduates] and such programs are not paying a lot of attention to what the students know; it's just "get that body out and get them on the truck"…it can negatively affect things.

Another participant candidly expanded this premise:

> Some people want a quick, easy, cheap program and that is not always possible. In other words they want to put their people in a program and get them out "if they pay the fee they want a "B". Everyone. There seems to be that perception from private to public. I think program directors have this constant pressure from the community side to produce these people, passing them to get them out on the ambulance. I think from an administrative side it's probably budgetary. It's about running a program very efficiently and I agree to that being frugal is good, but sometimes it can all cross the line to "we don't want to pay for this, we just want to crank them out." That's a problem the program directors have to face. We are constantly being compared to nursing, PA, medical programs, so are we truly a medical program? Or are we a kind of a fly-by-night program?

Some of the issue may be that employers do not understand the educational process combined with the economics of the position. This may hold especially true if the employer completed a program years ago when the curriculum was a fraction of what it is today. One participant articulated the problem as:

> Sometimes they [employers] don't understand completely the educational process. I think they say "Why can't you train a paramedic in 6 months instead of year?" For

> them it's all about having access to warm bodies and recruits to run an ambulance. Sometimes I also don't think employers always appreciate that an entry-level competent paramedic is not a finished product. There is still time, energy, money that has to be invested in them in order to allow them to be highly effective in their new role. A physician goes to [medical] school in most cases for 4 years plus a residency (depending on what their specialty is) for a reason.

The amount of resources required to operate a paramedic program are many. Resource categories are outlined in accreditation standards, yet in a time of shifting political, administrative, and employer attitudes towards education, program directors find themselves surrounded by many resource challenges which may likely continue.

Internal factors: Recruitment, retention, and certification. Internal program issues of recruitment, retention and certification are important areas a program director must consider. As part of a program director's leadership role, he or she must attract, retain, and adequately prepare paramedic students for certification, registry, and/or licensure. Recruitment is significant for program directors to attract high caliber, well-prepared student who will be successful in the program. The accreditation body requires program directors to report retention and certification on an annual basis. The threshold for each category is 70% (i.e. 70% of enrolled students must graduate and 70% of graduates must be successful at certification) (CoAEMSP, 2016c).

Best practices of recruitment are program reputation, having high standards, and recognition that word-of-mouth advertising is likely the most effective form of recruitment. A program director's behavior will also be important in attracting potential students to the program:

> I think the standards you uphold for the program are your best recruitment. Your behavior as a program director to gain the respect of people is also critical, but it really comes down to the reputation of the program that outweighs everything else.

Another leadership best practice identified was to seek out the best students for the program and recognize dynamics in the field that exist in order to attract such students. Employers from the advisory committee were described as excellent resources to determine field dynamics and job availability for graduates. Integration of the program with the healthcare community is also vital, as well as informing students early of the requirements of being a paramedic. Informing advisory committee members of the application process, having a vibrant program website, and distributing accurate information were also cited as best practices of recruitment.

Participants had much to say about student retention including recognizing the need to choose the right students. It is crucial to reveal to the students the commitment necessary to be successful in a paramedic program as early as possible. Some programs utilize interviews to determine affective responses prior to admission. Others require entrance testing to assess reading and mathematics scores. One participant emphasized the need to ensure all program publications are accurate, up-to-date, and reflect current requirements for the program. Another participant expressed a similar need for full disclosure with the following comments:

> So having an avenue for a conversation with students before they ever get into class, whether it is part of screening or it's just a face-to-face. I know those are time-consuming, but to sit down and say here's our program, here's what we're doing, and these are the expectations…this is what you can expect to study, and this is what your

> average day is going to look like. I don't think you can beat that in terms of getting somebody prepared. And talking frankly with them…asking what are your personal challenges? Are there any big life changes coming up [for you]? How many hours are you planning a working during the program? Those things help folks get grounded…some programs have a process where they will have graduates available to mentor or somebody the students can contact who are recent students to assist them. They will tell them this is what it was like…what I thought going in and what it really was … if you're in an academic institution you know what resources are available.

Student retention can also be impacted by offering tutoring and study resources as well as understanding various learning styles of students who come to the program. Participants stated students must be valued as well as engaged and must have a realistic view of the profession of which they hope to take part. A recognition of demographics is also important with special attention given to factors students may have with personal are academic challenges.

As students near the end of a program, they must be prepared to take a certification, registry or licensure exam. As mentioned, graduate performance on these exams were measured annually as an accreditation benchmark. Best practice strategies in preparing students for certification include providing testing immediately upon course completion along with the integration of high level/critical thinking questions throughout the program (Margolis, et. al, 2009). Program directors may consider utilizing commercial products with predictive value to increase certification success. Such examinations have shown up to 97% predictability of passing the national registry written exam on the first attempt (Page et al.,

2003). Program directors must also understand success on certification exams is a responsibility of the program director:

> Teaching students to think critically and in terms of scenarios, to think in terms of problem solving is really important as opposed to memorization of information. We need to avoid lower-level memorization questions. And the evaluation piece is huge in terms of developing items, evaluating your items, comparing how students are doing on your items versus National Registry [or state certification] items. I know programs are successfully using commercial products as some benchmarks. And some use predictive instruments students must pass in order to take Registry. Those are all good things.

Participants also indicated program directors must also reflect on the process of the program that prepares the student along the way to take a certification exam. Moreover, program directors should never use a certification exam as a final valid reliable measure of the program. Throughout the program, directors should counsel faculty on the use of using realistic scenarios as well as the integration of valid, reliable questions of different degrees of difficulty throughout the curriculum. Such measures are supported by previous research (Margolis et al., 2009; Dickison et al., 2006; Fernandez et al., 2008).

Student recruitment, retention, and certification are important are important practices in ensuring a quality paramedic program. Programs must attract and choose students who are motivated to learn and willing to participate in high standards of education. As a program develops a strong reputation, future students are drawn to it based on word of mouth. Students usually have a higher chance of success in programs that require admission standards, practice full disclosure early regarding program requirements, and have access to

academic resources. Student certification success depends largely on a program offering predictive examinations that include high-level questions throughout the program followed by reflection on performance.

Internal factors included core aspects of leadership that influenced a program internally. The aspects fell largely under the direct purvey of a program's control. Factors included personal and professional leadership practices, student recruitment, retention, certification practices. Participants believe by implementing sound internal factor practices, a program director can improve a program's quality and outcomes. Additional observations regarding internal factors are offered in the conclusion section of Chapter 6.

Another way a program director can influence a program through leadership is by recognizing and addressing external factors. The next section addresses a second category of leadership aspects titled "External Factors."

External Factors

External factors identified were core aspects of leadership that impact a program externally. Those factors were identified as stakeholders, accreditation, the EMS profession and patient care, future and other considerations (See *Figure 9*). Though external factors are often beyond a program director's internal span of control, they may nonetheless be impacted by strong leadership.

External factors: Stakeholders. Every paramedic program has key communities of interest or stakeholders that fall under the program director's sphere of influence as defined by the accreditation standards (CAAHEP, 2005). The ability to lead stakeholders encompasses a large amount of the roles and responsibilities of the program director. The various communities of interest of a paramedic program must be led effectively

and harmoniously if the program is to be successful. The stakeholders include the medical director, students, advisory committee, faculty, administration, and graduates. Each of the stakeholders has a critical role in the success of a program. Leadership challenges with the program stakeholders can be formidable and it is the program director's role to interact with each of the stakeholders in a positive way to foster success for the program. Each of the six stakeholder categories will be discussed in the next section.

Program directors are guides who must communicate with, educate, and mentor the various stakeholders or communities of interest that fall under their leadership sphere of influence. The program director serves as "the face" of the program to these entities and subsequently must have a healthy relationship with each. Leadership inspires, is organized, and is responsive to the communities of interest. The following is a description of how program director leadership influences the context, challenges, and best practices of each of the stakeholders.

External factors: Faculty. Program director leadership affects faculty in significant ways through the creation of trust and providing a role model for employees to believe in a vision. One participant articulated, "If the program director is not a good leader, then faculty usually are not. He or she sets the tone, has good moral and ethical values, and is a good role model." When dealing with faculty, participants said program director leadership builds camaraderie and respect in the program. It does not hand out edicts and mandates, nor is it overbearing or micromanaging. Leadership rather fosters communities of creativity and advancement to ensure success.

The program director must also provide clarity and direction to faculty in an organized fashion. As one participant posited, "If the program director does not demonstrate

good leadership or has some issues, it affects the faculty very quickly. The program director must be clear on direction and goals." Another added, "A program director must be highly organized with the ability to be analytical and politically savvy." In as much, he or she will be more likely to recognize challenges early on and be able to negotiate issues for the benefit of faculty.

It is important to choose qualified faculty the program director can trust. This includes clinically sound individuals with a good reputation as individuals who possess a passion for education. Many situations arise in the course of paramedic education and the program director must be able to believe in faculty members to carry out the mission and vision of the program using sound judgment. One participant phrased it as, "You have to have faculty you can trust. You then have to guide faculty and find those still working in the field."

Leadership also includes respecting individuality of faculty members. Each faculty member has unique gifts and talents. In order for their attributes to thrive, leaders must offer faculty a safe environment that fosters their creativity. This involves avoiding the opposite behavior, or as another participant described it, "Program directors must never be stern, overbearing, micromanagers that stifle creativity. They must build camaraderie and respect."

Several challenges exist with leadership of programs regarding faculty. One is transitioning faculty from a curriculum-based instruction model to one of education standards. These standards are less prescriptive and thus require educators to be more knowledgeable about conceptual issues rather than only reiterating what is stated in the curriculum. Another key element is the education of educators; specifically their ability to receive their own education in the practices of education. According to the participants, there

also appears to be a lack of qualified faculty nationwide. Finding such individuals is becoming more challenging. This may create difficult personnel issues when hiring individuals who only meet the minimum qualifications and do not understand the educational process or culture. One participant described it as, "There are examples of faculty that engage in the worst types of behaviors such as exchanging interpersonal favors for grades or otherwise or socialization that's improper in some instances."

Some more recent generation faculty do not appear to be committed to growing and learning themselves whereas others have been inappropriate with students. Challenges continue with faculty not remaining current on the latest science of medicine and overall possess a lack of commitment, prioritization, and accountability. Faculty who suffer from personal or professional behavioral issues pose personnel management issues for program directors. Some are not willing to work the long hours required of the job, whereas others view their outside lives is much more important than their positions. Still others may want to act in a controlling or micromanaging fashion towards their students. There is also a challenge to grow replacements for faculty as many existing faculty are aging. Participants cite faculty challenges that include maintaining their credibility, autonomy, and education.

> Faculty need to know they are allowed to have a sense of autonomy in their classrooms - and the program director - while being responsible for the program, is not micromanaging them. Faculty members know their stuff, that's why you hired them in the first place. So they should have some autonomy to teach within the program director's guidelines and feel the freedom to be creative.

Best practices in dealing with faculty include regular and effective communication and a recognition by the program director that faculty are a sacred resource. It is vital to

mentor, educate, and train faculty to achieve high performing and well-versed professionals. Faculty must be empowered, engaged, and recognized for their hard work and successful efforts. It is also important to know when to part ways with difficult or poor performing faculty. It takes careful monitoring and keep your finger on the pulse of the program. Student evaluations, faculty evaluations, employer surveys, graduate surveys and certification performance may all yield valuable indicators of faculty performance. One participant shared a difficult experience:

> Greater than half the class failed a national registry test twice in a row. I had to take an action and make a determination…it cost me a loyal faculty member, but I could not tolerate such a high failure rate. It turned out that the program was not being well supervised, the faculty had gone feral, and from a lack of supervision drifted away from preparing students for the national registry.

Faculty may also fall into a routine of teaching what they believe are best practices of field care based on their own experiences. This can be valuable when the content they are teaching is consistent with the national standard, but dangerous when they begin teaching their personal practices based on anecdotal evidence. According to participants, some faculty members declared "Your book says a lot of things, but this is how we do it in the field." To complicate matters, students are impressionable and often willing to follow their instructors who are actively providing patient care. Not knowing the difference, students may learn incorrect or outdated material and then perform poorly on their certification exams. One participant faced this issue with an instructor that resulted in termination of the employee:

> My instructor was doing best practices, but doing what he believed best in the profession. That was an example of having to make an administrative change that

> may not have been popular but was essential. So you don't go for popularity, you go for what the standards are in the program.

Faculty members are important stakeholders in any paramedic education program. Program directors must monitor faculty performance and provide them with opportunities to foster their professional development.

External factors: Students. Leadership affects students by providing them with good working knowledge and ensuring competent entry-level paramedic graduates. Leaders must understand the characteristics of students and understand that there are unique types of students. This is especially important given ever-evolving generational dynamics.

> Some of program directors' difficulty [with students] is generational. He or she must understand how students learn, how to communicate, and how they respond to supervision and rules. Much of the issues involve behavioral or affective domain issues. We have to be careful not to judge them based on the way they are, but rather work with them. So we need to change in order to have a different mindset on that, not just consider what the students need to change.

The point is well taken, program directors must avoid the false dichotomy of exclusive thinking which often creates a "my way is the only way" mindset between educational staff and students. Similarly, it is important to continually recognize the need to understand student perspectives and expectations to provide them with the best education.

> I think the expectations of students today are so much different than they were. Then again, I'm in my early 60s so I don't get the idea of "payout" or "I want to have a job so I can have fun." It is such a different mindset than my generation as a boomer. But I think that's going to be to remain relevant to the students. Subsequently, it will be

imperative to keep those communication pathways open and I think it's always going to be a challenge.

Program directors need to be approachable, but also need to be in an authority or boss role. Leaders set expectations and through their influence affect all of the communities of interest including the students. Ultimately they must mirror professionalism and energize students they are entrusted to lead. This is done best by being a positive role model and teaching students how to think: "What I think it is truly about is we are really teaching them critical thinking, teaching them to do good assessments, and then to be able to apply what they've learned."

Student challenges to leadership are many. Most of the participants interviewed described current students as possessing different mindsets and skill sets from years ago. Participants cited attitudes of entitlement and poor reading abilities as the greatest challenges. Some programs have an obligation to accept students, many of whom lack responsibility and don't know how to study. One participant believed open enrollment was a significant contributor to attrition: "We look at our program attrition and we have a high attrition rate. We are a public access institution and that's one of the reasons."

Additional student challenges to program director leadership are communicating with students on a regular basis to keep them apprised of their progress and sometimes sharing the reality of failure. Program directors must communicate to students the concept of education being a lifelong journey, not just the narrow time they are in a paramedic program. Program directors must inspire learning in students and find ways to engage them to help them be successful.

Participant responses to leadership best practices related to students largely centered on affective or behavioral challenges. Professional behaviors of "integrity, empathy, self-motivation, appearance and personal hygiene, self-confidence, communications, time management, teamwork and diplomacy, respect, and careful delivery of service" have been measured in paramedic students since the 1998 major paramedic curriculum change and remain in effect in the latest version of national EMS education standards (NHTSA, 2009). The concept was supported and furthered by Kanarian (2010) who stated: "Students should be exposed to the values of integrity, compassion, empathy, caring, listening and dedication through self-sacrifice" (p. 25).

Participants also identified the need for a handbook and a policy manual that clearly states agreed-upon rules and expected behaviors was imperative to the expectations and evaluation of the affective domain. Consistency of administration of the program was also noted as vital, especially in regards to the affective domain. There must also be explicit expectations of faculty and students.

One participant described it as:

> Regarding the affective domain, evaluating the students on a frequent basis is key. Obviously, having the program director's input, but also having faculty involved in the discussion on a frequent basis to determine a common grade. Sometimes folks say you can't grade people affectively, but you can! It's very different than grading somebody in the cognitive domain. By having a faculty discussion you can get a better review and a better evaluation. For example, I might say I saw a student during simulations who was really rude whereas another faculty member may say that's not my perspective…so we can sort out the differences. Because we all see people at

> different places and in different scenarios. So a collective evaluation…certainly using the [National EMS Education Standard's] counseling review form to sit down together and use a collective approach.

The program director must also model professionalism at all times and live up to the role and essence of the EMS profession. The participant's sentiments were supported by Touchstone (2011) who stated, "All EMS educators, instructors and adjuncts must demonstrate professional behavior; treat students with respect, know the material they will teach, arrive on time for whatever role they will be filling, and pay attention to hygiene and appearance" (p. 26). Kanarian (2010) further suggested, "By establishing the right values and attitudes in our students we can help them prepare for the reality of EMS" (p. 25). In doing so, stakeholders will witness first-hand the expected standard for professionalism.

Students are the lifeblood of any paramedic educational program. They must be chosen wisely, valued, and held to high standards. As leaders, program directors must strive to understand student needs while ensuring they receive a fair and rigorous education.

External factors: Graduates. At the completion of each course, students are approved for graduation. According to accreditation standards, each student must successfully complete a "summative comprehensive evaluation [that includes] cognitive, psychomotor, and affective domains" (CAAHEP, 2015, p. 13). The program director and medical director must also complete a terminal competency form to attest to the individual competency of each graduate. After graduation, the program is measured on how many graduates found gainful employment. A 70% threshold of graduates who become certified as paramedics are expected to be employed, continue their education, or be active in the military (CoAEMSP, 2016c).

Graduates are affected by program director leadership to the degree of culture a leader has built. It is important for program directors to be an example that fosters others and grows future leaders: "The best program directors teach students how to go forward and mentor and develop others."

A major program graduate challenge includes securing responses to surveys six to twelve months after graduation. It is a vital component of accredited programs to solicit feedback from graduates regarding how well they were prepared for the professional field practice. It is often challenging to maintain ongoing connections with graduates to collect such surveys.

> Their experiences will dictate future classes…if you have one graduate that says the program sucks, it can really affect the perception…people who have bad experiences are much more vocal and it skews the information the wrong way. It's important for graduates to have a mechanism to communicate the strengths and weaknesses of the course with the program director. If students have issues has an issue, even though they passed, they [know the] program is not ignoring them, but rather trying to determine if it's something can be changed. So it's making sure the graduates know that that mechanism is in place.

Upon graduation, graduates should be proud of the program they attended. "Graduates become a reflection of the program" and "students who become graduates become advertisements for future courses." A program's graduates may also become future preceptors and adjunct faculty for the paramedic program. By experiencing a positive culture during their own education, graduates will understand what is expected of future students when they mature into instructional roles. To accomplish this, one participant said a program

director must be “approachable, communicative, and offer good direction.” Another participant described it as offering students “good traits from leaders to mimic and mirror.”

Program director best practices for graduates include remaining connected to them after they leave the program. Inevitably, graduates become advertisements for the program with either positive or negative connotations. Program directors may offer letters of recommendation to help graduates gain employment and advance their career. Ultimately, graduates will seek employment and thus placement becomes a challenge for program directors. To address the placement challenge, best practices include program director recognition that clinical and field time act as informal job interviews for students. Accordingly, student behavior and performance while attending scheduled clinical and field experiences are significant previews of how they will function as employees. Some of the participants suggested student acquisition of EMT experience by encouraging students to seek out volunteer positions while still enrolled in a paramedic program. The advisory committee should be utilized to notify the program director of current job openings. Feedback should be solicited from employers that serve on the advisory committee to determine their needs for future employees. One of the participants focused on a comprehensive program approach to placement, stating:

If the program director is consistent with best practices such as interviewing the students, having entry requirements, teaching them appropriately, securing the resources that are needed to support the program, and if your medical director is involved in testing them fairly and you are measuring written, psychomotor, and affective behavior objectives and the students pass their certification exams, graduates from your program are going to be sought after because they know they will be ready to work.

Knowing the community and what is required, inviting employers to the school and possibly hosting a job fair for students can all increase student placement upon graduation. Above all else if the program produces a quality product, employers will seek out graduates of the program based on its reputation. One participant articulated it as, "To be honest with you, if your program does well, if your program produces and you are receptive to your advisory committee, I don't think your students have a problem with finding a job."

Program directors also provide graduates with a lifelong resource of connectivity to the profession. Through their leadership role, program directors need to be friendly to students, but not be their friend until after graduation. A goal of the program director should be to have graduates display a positive image of the program and the profession. Accordingly, graduates should be pleased with the educational product they received, or as one participant articulated, "They should be proud of program." In order to achieve graduate pride, the program director must build a positive culture within the program.

As a result, the program director will become a lifelong resource and positive role model for the graduates. In essence, practicing such is making an investment in the student's futures. One participant suggested, "If the program director is engaged with them while a student, [he or she] will remain engaged after graduation."

Finally, graduates must also be viewed as an instructional resource. A program director invests in the graduates while they are students and shares with them the culture of the profession. As the graduate matures in his or her career, the investment can provide large returns to the program when graduates return to be preceptors and potential instructional faculty. By hiring individuals who have "grown up" in the program, a program director can be assured the culture he or she has built will continue to be propagated.

Graduates are important stakeholders of a program. Their knowledge base and professionalism are on display each day in the workforce as a reflection of the educational program they attended. Program directors must remember the impact graduates have on their programs.

External factors: Medical Director. Program director leadership must have a relationship with the medical director of the program. This builds trust and fosters involvement as well as cooperation to advance the mission and vision of the program. Through his or her leadership, the program director must guide the medical director in fulfilling required roles and responsibilities. A program medical director must fulfill six key responsibilities which include but are not limited to:

> (a) review and approval of the educational content of the program curriculum to certify its ongoing appropriateness and medical accuracy; (b) review and approval of the quality of medical instruction, supervision, and evaluation of the students in all areas of the program; (c) review and approval of the progress of each student throughout the program and assist in the development of appropriate corrective measures when a student does not show adequate progress; (d) assurance of the competence of each graduate of the program in the cognitive, psychomotor, and affective domains; (e) responsibility for cooperative involvement with the program director; and (f) adequate controls to assure the quality of the delegated responsibilities. (CAAHEP, 2005, p 6)

It is crucial for the medical director to understand the responsibilities in the program. This may require the program director to orient the medical director to his or her role which may take some time and patience. Understanding that most medical directors do not come to

the position with the requisite knowledge or experience is important. The program director must also realize he or she will likely need to do some training of the new medical director.

One participant articulated it as:

> You have an old master sergeant who is out there, combat worn, savvy and has run the operation for years. In comes a brand-new, young, 2nd Lieutenant who is in charge of everything and wants people to polish their shoes and brass in the battlefield. So the sergeant has to break the lieutenant in and it's that way sometimes with the medical director because they come to the program and now they get to be a medical director of an EMS service and they come in and run the shop…you do not have respect simply by title or by aura, but by earning the respect. So when I get a new medical director my job is to earn their respect and appreciate them so we can establish a good, strong relationship and work towards our goals together.

The medical director must be active and is considered an integral part of the program in a complementary capacity. This includes playing an active role throughout the duration of the program. One participant described this comprehensive involvement as, "Not only involvement in the classroom, but involvement on the advisory board, involvement with the administrators, involvement with the communities of interest, involvement with helping do special projects including community projects that are part of the affective domain."

Another participant described the needed involvement as:

> What is most important is an engaged physician that's passionate and wants to be involved with the program…they must learn what's involved with being a medical director. It's not as simple as taking care of patients, there's a skill set and a knowledge and a background that comes with disciplinary matters as it pertains to

> students, valid and reliable exam instruments, and everything else that comes with an educational program. So [the medical director has] to be armed with the appropriate skills or knowledge in order to know that a program is functioning the way it should.

Many participants saw the greatest challenge with medical directors was helping them understand their role. The medical director must have a solid understanding of what is expected of the role and a willingness to be involved in the program. Involvement does not have to be limited to lecturing, but can be manifested several ways. One participant offered, "I scheduled the students with my medical director when she was in the ER. She would involve students by teaching them how to assess, diagnose, and manage patients and that's a good role for the medical director."

Some medical directors have very little understanding of paramedic practice and need to be educated to what it entails. Another challenges may also include the inability for programs to pay ta medical director. A minimal stipend a school can afford cannot compete with a usual physician salary. It's also a challenge for medical directors to spend sufficient time with a program for student interaction and documentation of student progress.

Other medical director challenges include cooperative involvement with various stakeholders or community of interest, including clinical and field areas that are vital to education. It is imperative to find the right person to be the medical director who can dedicate enough time and resource to the program. In doing so, the medical director and program director will likely develop trust and subsequently buy into the vision of the program.

According to the participants interviewed, program directors need to lead medical directors by "keeping them engaged, satisfied, and happy; not overwhelming them or

working them beyond capacity." Another leadership challenge a program director faces regarding the program medical director is constantly being mindful of a replacement. Recognizing that medical director's lives and schedules can abruptly change, an identified replacement is good to have in reserve. Frequent communication with the medical director may be useful in recognizing potential issues as well as identifying replacements.

Sometimes the program director plays a role of intermediary between the medical director and the students in ensuring optimal learning. Program directors must use medical directors wisely, keeping them involved but not overwhelming them with things that are not necessary. It is important to compensate the medical director either monetarily or with benefits of the school (i.e. library and/or sports access, bookstore discounts, clinical professor appointments, etc.).

One participant candidly summarized the challenges and stresses associated with a program medical director by stating:

> I think the main challenges with the medical director are finding one that is willing to commit the time to the program and understanding accreditation is requiring more and more and more of medical directors…the demands are going up and at the same time you are getting a shrinking pool of physicians who are even remotely interested in the position. You're always fearful that if my medical director leaves, who will I get? So I think it's a huge stressor for the program director. Because you always have got that in the back your mind what if your medical director leaves? What am I going to do? Who am I going to get to do all this work?

Best practices in dealing with challenges with the medical director are similar to the advisory committee in they must be chosen wisely. Someone who likes to teach students and as passionate about EMS education is very important.

> Finding [a program director] who really wants to be involved in the education of the prehospital care provider is the key. Finding someone who really wants to educate and not just a figurehead who wants to sign off on paperwork for you. You've got to find somebody who really is dedicated in helping you develop a positive program…come in and work with students, faculty, and administration to make the program what it needs to be. The challenge therein is finding the individual that has the time to make the commitment.

Medical directors must be involved, engaged, and act as advocates on behalf of the program. Clearly it is a best practice to articulate clear expectations of the position, establish a healthy relationship and use them efficiently in their service to the program:

> The program director has to establish a relationship and state what expectations exist for the medical director including what's expected of the job. It's important for the program director to become streamlined so when the medical director is on campus you don't waste his time or her time…make sure you have things that need to get done so the Medical Director is not just sitting…feeling like you're wasting his or her time…have everything structured and have all the steps laid out. It's an efficient use of the doctor's time because it's such a vital commodity.

Program medical directors are an integral part of any program, yet according to the participants are often underused. Participants believed it was vital that he or she understood the role and were active in the program as required by accreditation. Also according to the

participants, a medical director who shared a healthy professional relationship with the program director that was augmented by frequent communication was strong.

External factors: Advisory Committee. Advisory committees are comprised of communities of interest or stakeholders that include at least the following individuals: Current student, graduate, physician(s), employer(s), key governmental official(s), police and fire services, public member, hospital / clinical Representative(s), faculty, medical director, program director, and sponsor administration (CoAEMSP, 2016a). The committee plays a vital role in guiding and directing programs to ensure graduates are competent, entry-level paramedics (CAAHEP, 2005). Examples of committee participation are through program goal endorsement, clinical and field access facilitation, advising current scope of practice, equipment acquisition, and employer feedback.

In leading the Advisory Committee, the program director must first choose the right people to serve. This may not mean someone who agrees with everything, but an individual who is willing to offer candid advice. Choosing the wrong individuals will hamper the ability of the advisory committee to function. As one participant suggested, "It is crucial to have the right people. The wrong people can be destructive to a committee and the program as well."

Participants describe program director leadership of the advisory committee as someone who fosters a functional relationship. It is also very important to communicate needs and listen to constituents in order to advance the program. The advisory committee relationship must include expectations of the program and be built on authenticity as well as respect. Also vital is the need for members to practice ethical behaviors and the willingness to trust one another. The leader sets the tone and must choose the right people to be involved with the program to foster a professional relationship and provide for healthy discussion.

Some advisory committees suffer from an identity struggle. Members do not know their role and can even feel marginalized. One of the participants articulated this as "[members] struggle with who they are what they're supposed to do." They are often underutilized and thus a resource that often goes untapped.

Advisory committee challenges may be significant. According to one participant, an advisory committee is: "One the most powerful parts of a program, but it is either underutilized or sometimes not at all utilized. They just become signatures." Subsequently, an advisory committee can play an integral role in a program or contribute to its demise. Participants add it is crucial for advisory committee members to understand the concept of vocation versus profession. In doing so, members can guide the program into the future as it moves forward towards a true profession. Program directors and other school leadership must emphasize the need for input from the advisory committee and implement their suggestions as they are offered.

Program directors must also recognize advisory committee members are often the best source for current professional information from the field. They also provide wisdom to aid in decision making to help accomplish things. As a result, it is crucial to keep committee members involved in the program and clear in their understanding of the role they play. Some of the challenge that exists with advisory committee members is keeping them involved in decisions and not allow them to feel marginalized. One participant described advisory committee challenges as:

> Getting them to come. That's probably the most difficult challenge. It's not that they don't want to come [or] participate, but when you look across every organization in the US, everybody is being asked to do more with less and that includes people from

> all walks of life. People are busy… really busy…we think it's just an hour or two meeting…surely they have that to give. Accreditation requires at least one [meeting] a year…people get busy and have priorities for their own operation…it can be a challenge to get them to recognize how valuable their participation is when their primary goals or responsibilities are for their own job. We have discovered if we feed them, they will be more likely to come. Then we need to keep them engaged; doing employer surveys and graduate surveys and all those kinds of things. Advisory committee members are incredibly valuable stakeholders and sometimes we just have to remember to thank them and let them know that we can't do this without them. They need to feel part of something special so they're more likely to feel valued and stay engaged…they have expertise and insight that you would otherwise never have on your committee.

Other advisory committee challenges may also include the integration of technology (such as computer access to medical reporting). Another common challenge is soliciting help from members to secure access to patient care clinical and field sites.

Advisory committee best practices for engaging in addressing challenges of advisory committee members include feeding them at meetings to promote camaraderie and attendance as well as engaging them outside of meetings on a regular basis to help them feel valued. Advisory committees must be utilized to achieve a strong fully functioning healthy program. Subsequently, advisory committee members must be involved and must recognize the role on the committee is a valuable resource as clinical liaisons, employment scouts, and advisors of the changing healthcare model. One of the participants offered an advisory committee best practice specific to clinical issues:

> If you're having problems in a clinical area, invite those people to sit on the advisory committee. They will be pressured into seeing what are other people doing, [and realize] they're not holding up their end of the deal. An example may be when you are struggling to access a unit like labor and delivery, to include them on the advisory committee and say…Look, paramedics are not going to stop delivering babies field…so either you can do a better job of making them better prepared or run into a lot of problems because you will not give them that opportunity. So I engage them in the advisory committee. After they attend, a lot of times they'll talk to us and say we really need to fix the problem. So they become a big part of the solution and are no longer the problem. It's usually effective to use them as your mechanism in fixing your clinical and field internship problems.

Advisory committee members must also be strong advocates for the program, willing to use their network to advance the program's mission, able to freely advise the program, and fulfill the role of mentors. They must be surveyed on a regular basis for feedback of their perceptions of the program. Members must also feel appreciated for their service to the committee in order for them to maintain interest.

Like medical directors, advisory committees are often not fully utilized in paramedic education programs. By representing the field, they offer critical insight into current practice and the educational process in preparing students for the workforce. Members must be chosen wisely to optimize their contributions. Regular communication with the stakeholders fosters relationships and advances the mission of the program. Providing meals at meetings increases attendance and surveying members affords them a voice in guiding the program.

External factors: Administration. Programmatic accreditation requires every paramedic program has an administrative structure. At a minimum, programs must have a president and/or Chief Executive Officer and a Dean or comparable administrator (CoAEMSP, 2015b). Administration, according to participants is an integral part of any program. Administration is often made up of chairs, deans, vice presidents, chief financial officers, presidents and/ or chief executive officers. Program director leadership must focus on communicating program requirements and future programs needs to members of the administrative team. In doing so, program directors must recognize potential political implications of interacting with administration. This may include knowing what one participant said was the best way to make requests for resources and or informing administration of needs:

> You have to be politically astute and know when it's a good day to go talk to the Dean or college president...I had weekly meetings with my Dean and I was on a first name basis with the president. So if there was something going on, I kept them involved. Bosses don't like surprises…keeping them in the loop bonds administration and lets them know what they can do to improve things.

Participants explained administrators like to be kept in the loop and do not like surprises. They must work with many other individuals, including directors of other programs. As a result, they need to be kept informed of what's going on in the EMS program. Program directors are in positions of leadership and must understand there are often limited amounts of resources that must be shared among many allied health education programs. This includes recognition of the administration's role in balancing needs of the various

programs. Subsequently, EMS program directors must be willing to possess a give-and-take outlook, realizing other programs may have more pressing needs.

At the same time, the EMS program director must be an advocate for the program, communicating with administration its status, described by one participant as:

> Being transparent…frequent communication is very important. Nobody likes to be blindsided. Whomever you report to, make sure they're aware of all the parameters of the program…enrollment numbers, attrition rates, success rates on whatever your credentialing exam is, your evaluations. Make sure you have some type of schedule that you keep folks informed.

Challenges with administration were some of the most passionately stated by the participants during the interviews. All agreed that it is the program director's responsibility to inform administration and continually educate them so they can understand the program and what is required. Many administrators simply do not understand the dynamics and requirements of a paramedic program as articulated by one of the participants:

> We had a multimillion dollar contract we dealt with and the people in our administration all the way up to the Chancellor of the system didn't understand our program. We were only eclipsed by one other academic program in our entire college system in terms of numbers of students, but the folks in the administration did not understand that. They were in leadership positions in schools, but that didn't necessarily mean they understood what we were trying to accomplish… paramedic program directors that are going to be effective leaders have to advocate for their program and find champions in the administration that want to champion what they do.

This advocacy may include requests for extra budget and staff due to the nature of the program. Administration must understand the process and the need for extra (often expensive), equipment requiring the program director to be savvy in their presentations and wise in timing. One participant phrased it as:

> I don't know if administration always understands how expensive it is or how much stuff is involved in what we do. Cardiac monitors that are pretty standard equipment now that are the [cost] equivalent of a car. They don't get that. There is somewhat of a disconnect and really a lack of understanding of what EMS education is really all about and how we do it…but at the end of the day, most realize the value of what such programs do in bettering communities.

While understanding resource needs of other related allied health programs, the program director must continually advocate on behalf of the program to the administration. It is also important to possess business leadership skills to constantly watch budgets and monitor cost requirements of the program. Many programs are seeing decreases in budgets with increases in costs, which compounds the severity of the challenge. The need to stay positive and understand limitations is also important to program directors when dealing with administrative challenges. Creativity also plays a part in finding alternative solutions when resources are simply not there. Communication and feedback to administration is imperative and needs to occur to inform administration of needs and future needs.

Best practices for working successfully with administration include the need to continually inform the principals (i.e. Chairs, Deans, Vice Presidents, Presidents, and/or Chief Executive Officers) to the nature and process of paramedic education. This includes

conveying a thorough understanding of the expectations of accreditation requirements. Another best practice is to always advocate to the administration on behalf of the program:

> A common theme in programs is the administration never fully funds the program so you have aging equipment and a lack of space…you really learn how to advocate for your program and balance the ability to make quick proposals, good arguments, and using your advisory committee make a case using the leverage of accreditation. Ultimately it's advocating at every level of your program; understanding funding constraints, capital budgets, programmatic budgets, and organizations with many, many, financial demands is one of the skills in building best practices you can really exercise in the areas of experience, savvy informal training, and leadership.

It is also vital to be transparent with the administration. The responsibility of informing administration of program needs and or issues rests on the program director. Accordingly, the program director must keep the administration informed appropriately. One participant claimed this is best accomplished through frequent and succinct communication:

> First and foremost it's always about keeping communicative relationships with your administrators and making sure they know the good and the bad in your program. You have an obligation help them understand [especially] the technical part of what we are doing. Medicine is confusing whether it's nursing school, paramedic school, or respiratory therapy school. It's a skill to let the administration know your needs and benefit to the organization without killing them with details…just tell them what you need and why you need it. And don't assume they're going to be impressed because EMS is America's heroes…you still have to compete with everybody else.

An understanding of administration is imperative. Administration has a job to do just like the program director. Recognizing that administration is not necessarily an adversary, but rather an important entity that must manage budgets and promote quality (much like a program director). Heifetz (1994) warned against looking to administration to solve every problem in saying, "Habitually seeking solutions from people in authority is maladaptive behavior. Indeed, it is perhaps the essence of maladaptive behavior; the use of a response appropriate to one situation in another where it does not apply" (p. 73).

Subsequently, program directors must realize their roles; especially in the context of adaptive problems (Heifitz & Linsky, 2002), to seek broader solutions beyond whatever necessary limitations may be placed on them by administration. This can be aided by what the participants described as understanding administrative roles and functions for the health and success of a program. Still, by the nature of the relationship, potential conflicts exist as articulated by one of the participants:

> Administration is pressuring you to take more students to generate more money, then as you take more students your attrition rates are going higher and higher and higher and then accreditation is stepping in and saying your attrition rates are too high. So it's kind of like a vicious circle that is created that program directors have to deal with as they are being pressured from all angles on different sides.

Many program directors must balance their time between teaching and program administration (Crowe et al., 2015). Executing two roles simultaneously makes external accreditation, governmental political and/or the administrative pressures of academia even more difficult to navigate. One participant described the pressure as:

> In an academic institution…they are increasing the general education requirements. Accreditation is saying you need to spend more time on technical coursework and the states are saying you need to reduce the number of credit hours it takes [in order to] graduate people faster. And administration is saying you better take more students to generate more money and all of a sudden the program director is being pressured from all these opposing forces. So if I take more students I am going to have to have higher attrition, the accreditors are going to cite me because I have such high attrition, administration is telling me I don't have enough students, and I have to cut our coursework to meet general education requirements. I have all these pressures coming from all these different places as the program director I must manage.

It is important for program directors to remember every program has an administration. A program director has the prerogative to determine how he or she will approach the administrative relationship. According to the majority of the participants in this study, a relationship is best forged through collaboration and mutual respect for one another's positions. Pursuing such a relationship may increase the likelihood of successful navigation of the many pressures a program director will certainly face.

External factors: Accreditation. The process of accreditation involves an application, fee, self-study review, site visit, and annual reporting of outcomes (CoAEMSP, 2016d). As of January 1, 2013, programmatic accreditation is mandatory for paramedic education programs whose graduates seek national registration. There are presently over 700 programs in the United States that are involved in the accreditation process. Forty nine states have at least one accredited program and one state (without an accredited program) has a program in the initial stage of Letter of Review (LOR) process (CAAHEP, 2016d).

According to the participants interviewed in this study, the accreditation process is a definite leadership challenge. Programs have had to adopt new attitudes and formulate action plans to meet the challenge of mandatory accreditation as articulated in a study from North Carolina (Wilfong, 2009). "The challenge of accreditation is getting the program director to look internally at his or her program in an objective fashion" cited one participant. "As a program director, you must be self-reflective," added another. A vital understanding of the process must occur in order to accept a need to change and thus become better. Challenges of accreditation described by participants included "being organized, understanding the process, recording and performing analysis of data…paperwork, developing action plans, and keeping stakeholders informed." Participants described accreditation as "a challenge to achieve a vision for a program by using the process [of accreditation] as a framework." Similarly, participants stated it was important to view accreditation as a tool for improvement rather than regulation. Participants also reported the need to "embrace the concept of accreditation in order to make changes so that EMS can evolve and get to the same level as nursing." In the end accreditation is a challenge, but program directors must believe in the process to be the most successful.

To address leadership challenges of accreditation with best practices, participants cited "learning the accreditation process, staying current with changes to the standards and interpretations, and being creative in achieving the standards." An additional best practice mentioned included being "objective and honest with oneself in the program in order to see things clearly." Participants also described the need to "be self-reflective as to what has been done and what needs to be done in the future for success." Attendance at accreditation workshops and willingness to be an accreditation site visitor were strongly recommended

from the participants regarding best practices related to accreditation. One of the participants provided an in-depth summary of the accreditation process as:

> You have to understand what the rules and regulations are and if you don't have the resources [the education process is designed to have], you have to educate your administration and others [to what is needed]. Part of the process is to get paramedic education program directors educated as to how the accreditation process works. We've seen places where people have been very resistant to a voluntary standard of accreditation and now it has become mandatory.

The accreditation process can be scary for program directors who have never been through the process. Many times a program director's job can hinge on becoming accredited and the fear of a third party conducting the process can be overwhelming. Subsequently, the need for a program director to be continually educated regarding the accreditation process is paramount.

> It's like the analogy of the well-woman well-man physical. At some point your doctor is going to see you naked to do a physical exam head to toe. Accreditation is that well-man or well-woman paramedic program director physical exam. The accreditation process is going to strip away all the other stuff and really what it gets down to is "How you do you do it?" And there's not a single right or wrong answer.

A significant key to being successful in the accreditation endeavor appears to be in the approach a program director takes towards process. If the program director is resistant or views the process as adversarial, it often does not go well. Conversely, if the process is welcomed, it often yields positive results. One participant framed it as:

> Most importantly is the mindset of the program director [whose program] is being accredited. If it is negative, it has to change. And I think we are seeing that. I think over time people are saying, "Hey that wasn't as bad as I thought it was going to be. The accreditors really are facilitators and they really are trying to help. They really are giving me the resources I needed." Even so, I think it's a constant re-education process.

Sometimes program directors can use the accreditation process in their favor as a way to explain to administration and other stakeholders their need for additional resources. If a program director through his or her leadership, can show administration a clearly defined need related to the accreditation standards, he or she may be able to secure additional resource. One participant framed it as:

> Accreditation is our collegial way of the rising tide raising all ships. We are all in this together and accreditation is the agreed upon professional standard. The program directors need to utilize accreditation standards as leverage with the sponsoring agency to get the resources they need for justification for what they are doing. Standards [are rationale] for why you have the admission and retention policies, ratios for instruction, etc., so accreditation is absolutely critically important. Upholding the accreditation standards offers integrity to the process.

Further professional development cited by participants included attending workshops, webinars, and national meetings regarding accreditation is also helpful in maintaining a solid understanding of what is required.

The need to network with peers and other program directors across the country was described by participants to frequently document assessments and outcomes of the program

were also noted as important best practices for program directors. “The recognition that accreditation is a constant process of continuous quality improvement is something program directors must integrate,” stated one participant.

By its nature, any discussion of accreditation includes at least a tangential discussion of leadership context, challenges, and best practices. The participant’s responses to the interview questions were no exception. As the profession moves forward, a creation of a culture of quality that includes accreditation will be important.

External factors: The EMS profession, patient care, and the future. A program’s students, faculty, and graduates all must be worthy of trust in the public eye. Participants believed the servanthood and ethical behavior a program director models is what earns such trust. Similarly, the values espoused by a program director move throughout a program to create a culture for the greater good. When asked if program director leadership affects the profession, one participant stated, “You know I’ve always said, you know all the wonderful things I’ve gotten to do in life, with 40 years in the [EMS] business, the most noble thing I ever did was teach.” The impact a program has through education can provide a lifelong role model to students, teachers, and society. Program directors must realize they are forming future professionals and allow them to mature, grow, adapt, and change in their pursuit of professionalism. “Graduates are direct reflection of the program and have a direct influence on the reputation of the program,” stated another participant.

Program director leadership may affect patient care by providing a social role model from which faculty, students, and graduates will emulate. This is clearly supported by the EMS Code of Ethics (NAEMT, 2013). One participant stated program directors may also model professionalism “through their teaching, their scholarship, and their service.” Leaders

set the bar and set the standard in building a culture of excellence in meeting the expectations of the stakeholders. Their example of fairness and critical thinking are displayed to all their constituents. If a program director is energized and enjoying his or her position, the end result will be an improvement in patient care as evidenced by the practice of the program's graduates.

Participants were asked, "Moving forward, what leadership best practices will be important to paramedic education programs?" They answered accordingly with the idea that paramedics may be expected to have an associate degree as a minimum education requirement in the future. Subsequently, program directors will need additional education, likely a master's degree. Program directors will also need to be consistent in their practice and recognize their place as a role model to the greater profession.

> I think we have to mature as a profession more into the allied health model of degree-based education. I know that's not the popular view. I hear all the time that EMS is struggling, especially with the [new] healthcare reimbursement issue processes. They're not getting all of the reimbursement like other allied health professions…maybe because there is a lack of understanding of what it takes to operate a service at the federal level…there's a decline in qualified [EMS employee] applications and people working. There is not a decline in the number of licensees or licensing, but paramedics are finding jobs in other areas that pay more than what an ambulance service pays. We've got to understand this and move forward with the degree [requirement] so payment structures will be consistent. If not, I don't see how we are going to survive.

Not only will program directors need formal education, but participants also expressed the need for professional development with a limited candidate pool. One participant articulated this as: “Meeting employment standards and understanding program director best practices. This may only be achieved through leadership training and is complicated by high program director turnover and a small group of qualified individuals from which to draw.” A leadership course that includes the basics of directing a program was cited by all of the participants. A similar finding was discovered in a study of occupational therapy assistants (Reiss, 2000).

As dynamics continue to change, program directors will need to be resilient and understand they will likely be called upon to do more with less resource. Further understanding will be necessary of their role in the healthcare system and thus and understanding of all parts of the healthcare system will be vital. Technology will also play an important role and its integration will increase as we move forward. Finally the development of a leadership training curriculum will be imperative if program directors are to advance in their roles within the profession.

At the end of each of the interviews, participants were also offered the chance to expand on any other leadership factors they believed to be important. Participants indicated the need to review results on a regular basis and look at themselves objectively. “To always think of how they made be willing and able to improve themselves and their programs, to look outside their area for innovative and different ways of doing things and consider leadership in other disciplines that may land outside of healthcare or education” is how one participant articulated it. Networking will also continue to be important. One of the participants suggested:

> You have to be involved in the group whether it's a local group, whether it's the county, whether it's a state, whether it's the national level, the program director has to be involved in their profession. You are an EMS professional, but you also have to be an educator. You need to be involved, so you need to be a member of the National Association's educator group and the statewide educator group or whatever. You have to be involved in the various groups so you have someone else to bounce ideas off of and then you're keeping yourself active.

In addition to being connected to a network, it also appears a formalized leadership curriculum for program director training is needed. Having a presence with all of the stakeholders throughout the program and understanding the concept of leaving a legacy was also noted as crucial to successful program director leadership. One of the participants articulated this as:

> Everything we do and everything we say will lead to a legacy, whether it be good or bad. It's going to define us…so the question becomes: How do we build our legacy and what do we want it to be?

An additional concern was the changing national healthcare model that one of the participants posited "will present challenges that may impact the scope and direction of the profession." This will likely affect how EMS is taught, practiced and funded. Closely related to the funding issue are rising tuition costs and the pattern of program directors being asked to "do more with less" in an environment of decreased state funding for educational programs. One participant passionately articulated this as:

> Resources are tied directly to funding [which is] shifting away from higher education. When I first started thirty-one years ago about 65% or 70% of our entire budget at the

> University came from state subsidy and we are down now to about 19%. Here's the problem: Because we are a public institution, the state said we are going to cut 10% of the state subsidy next year, yet would only allow a raise in tuition by 1%. So you may have been at $5 million, but by raising tuition by 1% you recovered 2.2 million, so you still had a gap of probably 2.8 million that you never made up. The next year they cut again and they capped tuition, so you never made up what you lost or continued to lose over time. Now we are so lean at our institution…people don't understand…they say you raised tuition, but you never make in tuition what you lost in state subsidy. Then the elected officials say a college education costs too much. Well, I wonder how it got that way! And I look at these jackasses and I say you know you guys, seriously? You guys are making education so expensive because you are defunding education. So I think the biggest challenge administratively is resources and resources all way around.

A need for program director leadership training was also made clear. When asked if future program director leadership training is necessary, participants unanimously said yes. Components of teaching, leadership skills, accreditation, and standards interpretations all were emphasized as to what should be included in such a curriculum. All of the participants agreed ongoing education for program directors should be included to maintain professional competency. Evidence-based education should be offered at the initial and eventually the continuing education level. Participants believe a human component is necessary that could only be achieved only through face-to-face training. Still, an online or hybrid component may increase access for a greater number of participants. Facilitation of student networking during the leadership program would be important to include in order to build rapport and

camaraderie amongst the participants. According to the participants, concepts of "shared problem-solving, budgets, objectives, lesson plans, clinicals, tracking devices, and mentoring" would all be important to include. Further topics of "local assessment, evaluation, item writing, and addressing student challenges" may also be of value in a leadership curriculum.

Participants indicated such a curriculum may also be beneficial in combating the problem of program director turnover. Leadership training may be a "two-day workshop, a weekend, or college semester course," but regardless was perceived as necessary for the profession. Additional comments regarding leadership and accreditation included "exam review and awareness of the profession beyond the local level." Questioning if a program is cost-effective and its sustainability, as well as recognizing increased demands in the role and profession. Participants believe it is vital to keep a current assessment of their programs as well as an understanding of local, state, regional, and national EMS education issues. The willingness to change was vital as a program leader as well as the ability to adjust to change and improve one's self as well as the program. The factors stated by the participants were largely supported in the limited EMS education professional development literature (Rayonovich, 2012; Hsieh, 2012).

Some participants discussed multiple leadership styles that all included "values, morals, ethical duties and servant relationships." The need to "not micromanage" and the need to "allow for mistakes" were reiterated. Some said good alumni relations were vital along with the need for a comprehensive exit interview of students to gather feedback on strengths and weaknesses of the program. Communication with graduates is also important to determine how well graduates were prepared for the workforce.

Several participants discussed the need for program directors to have mentors and a need for a playbook to help new program directors move forward. All agreed that integrity and vision were vital to success as a leader. Many of the participants suggested program directors implement a community service component in their programs. In doing so, EMS will enhance their visibility in healthcare and foster relationships with other allied health providers. Similarly, a need for "collaboration with other allied health programs to promote a sense of teamwork amongst various health professions to foster an environment of teamwork when dealing with actual patients in the workplace."

External Factors discussed were considered core elements of a program that impact leadership externally. Elements included stakeholders, accreditation, the EMS profession and patient care, and future and other considerations. Participants believe each of the external factors are greatly affected by program director leadership. Additional observations regarding external factors are offered in the conclusion section of Chapter 6.

In review, participants offered a variety of responses when queried about external factors of leadership challenges and related best practices. Generational issues with students and faculty were cited with respect to behavioral issues. Others determined resources (such as equipment, facilities, and faculty budgets) as leadership challenges. Still others spoke of understanding the difference between curriculums and educational standards as well as how EMS ultimately fits in healthcare system. The need to remain current with science was also an issue, along with the need to keep up with rapidly changing evidence-based medicine. Noted was the struggle of EMS in defining itself; either as a profession or a vocation. Accreditation issues were also cited as being challenges, yet overcoming them as vital to

future success. Finally, it was agreed that program directors have no leadership framework from which to follow during their career.

Summary

Findings of this qualitative research study were presented in Chapter 4. Based on 24 interviews, the exploration of leadership practices was presented to include participant's demographics and insights into the exploration of leadership of nationally accredited paramedic education program directors. Participants provided answers to the main research question of leadership practices as well as the supporting questions of context, challenges, and best practices of program director leadership. Leadership context included definitions, skills, positive approaches, stakeholder considerations, the EMS profession and patient care. Responses regarding challenges and best practices were divided into two main categories that included internal and external factors. Internal factors included professional and personal leadership, resources, recruitment, retention, and certification. External factors included stakeholders, accreditation, EMS profession and patient care, and future and other considerations. Chapter 5 will discuss the emerging themes found during the research analysis process.

Chapter 5

Emergent Themes of Program Director Leadership

Four themes emerged from the analysis of the data and are covered in this chapter. Emergent themes are a product of what Creswell (2007) described as the analysis of themes in which "the researcher analyzes the data for specific themes, aggregating information into large clusters of ideas providing details that support the themes" (p. 244). The themes emerged from the lens of context, challenges and best practices of paramedic education program director leadership and included (a) a need for understanding; (b) cultivating quality; (c) EMS identity crisis; and (d) generational dissonance.

Context and Best Practices Themes

In answering the questions in what context program directors practice leadership and what are the leadership best practices of being a program director, participants revealed two key themes: (a) a need for understanding and (b) a culture of quality (See *Figure 8*).

Figure 8: Context and Best Practices of Leadership Themes

A need for understanding. The first theme identified was for program directors to possess understanding. The need for understanding was multidimensional and, at its center, included knowing one's self as a leader as well as all aspects of a paramedic education program. Broad understanding is supported by Bennis (2009) who stated "Clearly, to become a leader, one must know the world as well as one knows one's self" (p. 68). To begin, a program director must be willing to be objective and self-reflective or as Heifetz and Linsky (2002) described it, having the ability to "get on the balcony" (p. 51). Getting on the balcony allows a leader to gain perspective regardless the situation in order to determine the best course of action. It is vital however, as a leader gains perspective that he or she not forget to see him or herself among the participants. The authors noted, "Perhaps this is the hardest task of all — to see one's self objectively" (Heifetz and Linsky, 2002, p. 54). The self-objective concept was further supported in the authentic leadership literature and described as including "knowledge of one's inherent contradictory self-aspects and the role of these contradictions in influencing one's thoughts, feelings, actions, and behaviors" (Iles, Morgeson, & Nahrgang, 2005, p. 377). Participants reinforced the literature, stating a need for remaining open-minded with an ability to see one's self objectively as a strong premise from which a program director should operate. A self-objective outlook also enhanced a program director's need for understanding the many facets of their programs. Educating paramedic students was described as a sometimes arduous duty, summarized by one participant as:

> Look, training a paramedic from the time they walk in the door to the time they go out to be a competent entry-level provider is a lot of hard work. It takes a lot of

> people to come together to do that. Sometimes I don't think we often realize just how much effort actually goes into accomplishing that goal.

As part of the need to understand all of the aspects of a paramedic education program, a program director must embrace many roles. First, the program director must possess a firm understanding of the practice of education related to EMS education. Being in tune with the latest instructional techniques in lecture, lab, clinical, and field practice settings as well as keeping up-to-date with local, state, and national scope of practice regulations is critical to delivering a quality product. A program director also must understand the proper practice of what it means to be a program director of an educational program. To achieve understanding of practice, it optimally requires the program director to have his or her own formal education in addition to experience in the EMS field. For example, a minimum qualification of a bachelor's degree is required by the programmatic accreditation Standards (CoAEMSP, 2015c).

Understanding the business aspects of running a program surfaced during analysis. Business facets included understanding areas of full time equivalents, budgets, personnel, and human resource issues. One of the participants described it as:

> It's also being able to understand that for most program directors it's a business. You have to have some good direction on finances, administration of budgets and policy manuals, working with faculty as far as personnel issues and HR issues, I think having all those qualities can help a lot when it comes to leadership. I should treat everybody the same, no favoritism and those sorts of things that will go long way to help you.

Also included in the business aspect of directing a program was understanding enrollment and retention issues as well as workforce needs. Awareness of local, state, and national trends in student interest, academic requirements, and employment availability were all important in balancing program outcomes and student needs.

Understanding accreditation also arose during analysis since accreditation is mandated as a requirement for paramedic education programs if its graduates seek national certification (NREMT, 2013). Accordingly, the need to understand accreditation standards, guidelines, and process were vital. Of special significance to accreditation are components of equipment, enrollment, retention, certification, placement, and workforce needs. Furthermore, analysis showed a need for program directors to stay current on all accreditation publications, webinars, and attendance at accreditation workshops when possible.

There was also a need to fully understand the EMS profession. With changing healthcare dynamics, scope of practice issues, and searching for an identity as a profession, the program director must comprehend the different facets. Involvement in related healthcare organizations at local, state, and national levels was also recommended by the participants.

An understanding of the need to mentor others also emerged. Once program directors understood the process it was imperative they possessed a willingness to share their knowledge and experience with others. In doing so, their wisdom would help those who were less qualified and less experienced. Given the highly specialized area of EMS education, participants believed the process of mentorship was critical to the profession in training and sustaining new program directors.

The critical need to understand the role of the EMS program director materialized during analysis. Although the role has been defined in the accreditation standards (CoAEMSP, 2015b), many program directors find themselves performing many other duties in addition to those outlined in the standards (Crowe et al., 2015). An ability to prioritize work flow and the need to understand what was imperative to complete (versus what was optional) was important to both program and program director sustainability.

Emergency Medical Services must navigate its current identity crisis in defining whether or not it is exclusively a healthcare provider profession or a public safety profession, or both. Many models exist suggesting it is all of the above, but a program director must understand each model in order to be successful; especially at a local level. Knowing the local culture of EMS was critical since the communities of interest serve on the advisory committee and steer the direction of the program. Accordingly, analysis revealed the need for a program director to know his or her communities of interest and establish relationships with those organizations and the individuals who lead them. In doing so, programs better serve their constituents and provide the needed workforce for the agencies in their service areas. Finally, it was important for EMS program directors to understand the spiritual component of the nature of the EMS field. Regardless of a program directors' spiritual persuasion, he or she needed a cognizant respect for the spiritual perspectives of others; especially those involved in the program (i.e. communities of interest, co-workers, students, and even patients).

Each of the identified needs for understanding can be related to the conceptual component of the skill model of leadership (Katz, 1955) as well as the positive leadership model (Avolio & Gardner, 2005; Fattig, 2013). By cultivating a need for understanding, program directors will be more likely to conceptualize and thereby anticipate what is best for

their programs. Moreover, by seeking to learn about the many facets and dimensions of a program, directors heed Bennis' (2009) leadership advice of experiencing "broad and continuing education" as well as "developing key associations with mentors and groups" (p. 68).

The recognition of the need for understanding the many aspects of a program and the learning that follows influences the degree to which a program director is informed. Analysis of the data clearly revealed directors who were more informed offered a higher quality paramedic program. The next theme expands on the need to cultivate a culture of quality.

Cultivating quality. The critical theme of a need to cultivate a culture of quality also emerged from the findings. A quality culture is centered in stakeholder development or as Kroth and Christensen (2009) described it, "A development-minded culture in any company cannot emerge unless developing others and helping them reach their potential becomes a deeply felt shared value and vision for the organization and its leaders" (p. 7). The participants stated relationships were critical in the context of quality leadership culture for paramedic education program directors. Kouzes and Posner (2007) stated "Leadership is a relationship…and a relationship characterized by mutual respect and confidence will overcome the greatest adversities and leave a legacy of significance" (p. 24). Building rapport, trust, and a culture of excellence with various stakeholders and other program directors is important for sustainability as well as the future development of a program. George (2007) described this as building a support team:

> Leaders do not succeed on their own. The loneliness of leadership has been well documented, but the remedies have not. Everyone has insecurities; some are just more open about them than others. Even the most outwardly assured executives need

> support and appreciation. Authentic leaders build support teams that will counsel them in times of uncertainty, be there in times of difficulty, and celebrate with them in times of success. (p. 118)

Katz (1955) described the need for relationships as the human component of his skill theory. By connecting and relating to an organization's communities of interest, relationships are formed and trust is built. Throughout all aspects of a paramedic education program, key communities will work with program directors more readily when they are in a trusting relationship with the individual leading the program. Part of being in a healthy relationship involves self-awareness and generosity, including knowing one's own limitations (George, 2007) and possessing a willingness to share with others. As one participant stated, "It seems to me that the folks that run really good programs are the ones that are always willing to share what they're doing with new people."

The strongest relationships were best built through networking with other program directors. Relationship building may occur at the local, regional, state, and national level. Several participants cited a need to establish a network in which to belong. One participant suggested, "It may be a conference, a blog, or online community." Another described it as, "Perhaps a structured or even un-structured place where program directors can come in and talk with their peers; certainly to hear what other people are doing." The modality may be face-to-face or electronic, "[Establishing] a network for collaboration…to have discussions with others nationally and share information we have learned."

Through such relationships, program directors can learn new ways to approach common problems and have a resource to confide in during challenging situations. In furthering the discussion, another participant stated the importance of relationships as:

> One of the ways a program director develops his ability to be effective is through relationships with other program directors from across the country. It's about being engaged and involved in your profession, reading current literature, engaging in research, going to conferences, collaborating with one another, breaking down barriers, and realizing they are not in this alone. There are lots of ideas that have been very effective and maybe [sharing them] will help other program directors develop a strategy for their own programs.

Program directors can also learn from others the reality they do not know everything there is to know about being a program director, "The minute you think you know it all, you're in trouble. We all learn from others and we need to get out of our area in order to learn from the best practices of colleagues wherever they may be."

In addition to building quality relationships, creating a culture of quality requires program directors to deliberately make good, selective choices. Following a careful plan of selection can prevent many future problems in directing a paramedic education program. This practice was profoundly evidenced in the choice of those included in the communities of interest or stakeholders. Participants indicated advisory committee members needed be chosen carefully, including those who advocate on behalf of the program. "You must find the right people…the wrong people can be destructive" stated one participant. Specifically, individuals selected needed to be willing to be actively engaged in the advisory process, facilitate external clinical and field education, and be an intermediary between the field and clinical settings in the program.

Medical directors must be chosen carefully as well. Individuals who are passionate about EMS education, engaged in the educational process, involved in the EMS field and

those willing to have a relationship with all stakeholders in the program are critical. One participant described it as: “Someone who will practice cooperative involvement, [who can] find the right balance of the right relationship of education and remediation.” Medical directors who value education and recognize the importance of quality education are certainly those most desired.

Selection of students was also important. Applicants with solid academic skills such as math, English, and reading were more likely predictive of success. Students who exhibited professional behaviors and demonstrated an ability to perform the cognitive, psychomotor, and affective requirements necessary for being a paramedic were desired. Program directors could ensure good choices of students by having a, “Good working knowledge of entry-level competent people and understanding the characteristics of good students.”

The choice of faculty members was also crucial to the success of the program. Much like the medical director, those who were willing to be engaged, study, and willing to stay abreast of current, evidence-based practice were crucial to the health and future of the program. Faculty who were role models to students were “iconic images” to students and able to mentor them throughout the educational process. Faculty contributed to a strong culture of quality, “set the tone of class” and served as a positive reflection of the EMS profession.

Peter Drucker (2003) paralleled the good, selective choices theme in describing his five principles to follow when carefully selecting candidates for positions: (a) Think through the assignment; (b) Look at a number of highly qualified people; (c) Think hard about how to look at these candidates; (d) Discuss each of the candidates with several people who have worked with them; and (e) Make sure the appointee understands the job (pp.129-131). The

same principles apply to program directors in their selection of students, faculty, medical directors, and advisory committee members. If quality candidates are selected, they will likely contribute to a program's culture of quality.

After analysis, the need for program directors to have a vision and a future plan for the program was clear. One participant summarized it as: "Every program director must have a vision and create a culture that is a positive force within an organization." Though each day requires many tasks consuming a program director's time that can distract from a larger picture, it is important to not lose sight of the long range plan for the program. The need for vision was supported across the leadership literature (Katz, 1955; Fry, 2003, Northouse, 2007; Bennis, 2009; Kroth and Christensen, 2009; Firestone, 2010).

In summary, two best practice themes (a) a need for understanding and (b) cultivating quality emerged during analysis. Program directors need to fully understand many components and intentionally build a culture of quality in order to be successful in leading their programs. The next section will consider the themes of program director leadership challenges.

Challenges of program director leadership themes. Participant descriptions of challenges in program director leadership resulted in an emergence of two distinct themes: (a) EMS identity struggle and (b) generational dissonance (See *Figure 9*). Identification of challenges also shed additional light on leadership context as well as best practices.

Figure 9: Challenges of Program Director Leadership Themes

EMS identity struggle. "Struggling to find our identity" is how one participant described the present state of the EMS profession. One of the most concerning challenges for program directors is the idea that the emergency medical services profession faces a professional identity crisis. Another participant articulated it as:

> One of the challenges being fought globally is an understanding of EMS, what EMS is, and what EMS does. Not just within healthcare or medicine, but in communities. People still don't understand different provider levels…one ambulance shows up and they think it's what happens on TV. We have not always done a good job in educating the public about what EMS is and why we do it.

Beyond the public's confusion of what EMS is and does is the confusion at the educational level. Even in a college setting, paramedic programs can be found in academic education, technical education, continuing education, and workforce training. Without a common identification point within academic structure, it is tough to send a consistent message of where EMS should reside. A participant elaborated on the issue:

> The folks in higher education don't always know where to put us. Many of the programs function better in academic-based programs…very much like professional or graduate school types of programs…rather than an undergraduate major. That can create some challenges as far as where we should be housed and who oversees what we do and how we do it within the scope of medicine.

Nohira and Khurana (2010) quoted Markus and Nurius (1986) who stated, "Identities are not only historical constructions, nor are they limited to the social negotiations of current roles; identities are also projections about the future" (p. 659). Accordingly, the future of the profession is hard to predict with the lack of agreement regarding whether EMS should reside in healthcare, public safety (i.e. fire or law enforcement), or should it be a combination which allows for it to live in either or both places. When educating students, it is important to prepare them for the role in which they will be expected to perform. Without a clear identity, knowing which role to prepare them for becomes a complex challenge. If a program is largely centered in a fire-based EMS region, it may need to lean towards the public safety model. If it is located in a hospital-based ambulance service model it may need to emphasize the health care provider role. Regardless, the competency of graduates and their understanding of evidence-based practice must not waver.

The struggle continues for program directors whose programs reside in colleges as to whether their programs should be vocational or academic in nature. One of the participants described the struggle in a university as:

> We are still viewed largely as a vocational-technical program which is a fight that a program director may have to fight through as we transition to a larger profession…if

> you're viewed as a vocational-technical profession, you are often [unfairly] looked down upon by the academic, scholarly programs.

It must be noted the participants' tone in the interviews did not paint vocational education in an inferior light, but rather denoted a perceived superiority of some academics towards them. The great irony in the discussion, according to the participants, is the rigor of education required for paramedic training is often equal to that of traditional academic programs. Still, the perceptual divide remains. Some of the challenge in resolving the identity crisis resides in communicating a consistent message of who we are, what we do, and informing our communities of interest.

Program directors must understand their community's needs and guide faculty and the other stakeholders in the educational process to ensure positive outcomes that include a well-prepared EMS workforce. Maintaining a focus and awareness of the program's mission in the presence of the identity struggle is vital. Outside pressures can be especially challenging during shifting cultural and generational norms, which may result in compromising to a point personal identity crisis for program directors themselves. One of the participants summarized it as:

> I think we are a very caring profession…somewhere along the line some folks forgot that…a lot of people lack integrity and are selling out their values. Administration says…we need to get them [the graduates] on the trucks [ambulances] as soon as possible…we need to make cuts in the amount of educational hours, the tests are too hard, [the students are] doing far too many clinicals… The first thing to go is integrity. You kind of sellout a little bit…the next thing you know you don't even recognize yourself anymore. There is a real danger out there for program directors.

The identity crisis shows no sign of immediate resolution. A new and concomitant challenge before the EMS profession is the changing national healthcare model. Rather than functioning as independent units, healthcare is becoming more integrated in approach. The same is true of EMS or as one participant described it, "EMS has lived the last 40 years in a silo. It's got one foot in healthcare one foot in public safety…our educators [need to] integrate EMS into the healthcare system."

The implications for changes to the EMS structure and delivery may be significant. Time appears of the essence in regards to EMS determining its place as a future profession. According to one participant, EMS leaders will need to be involved in charting the future or be faced with an assigned alternative:

> With the Affordable Health Care Act, the system is changing quickly…I don't think [the EMS Community] realizes how fast it's changing…we could end up with EMS as we know it redesigned out from under us if we are not careful. We have not been integrating well with nursing and with hospitals and with assisted living and nursing homes for the last 40 years because we really didn't need to. Well now we need to…and leaders that are good at playing that game are going to be the ones that become successful. Our days are numbered sending paramedic graduates out of classroom to only run 911 "hero stuff." There may be 3 or 4 roles [for future] paramedics.

Gardner and Laskin (2011) described how psychologist Erik Erikson framed an identity crisis from the individual, psychosocial perspective:

> All individuals are involved in working out aspects of their psychosocial identity; who they are, where they come from, what is going to happen to them. It sometimes

> happens that individuals in the throes of an "identity crisis" arrive at solutions that work out not only for them but also seem to hold a key to a wider problem, one that is besetting a significant portion of their society (p. 240).

Moving forward, the EMS profession can hope to generalize the same. And though the future of the profession as well as its eventual identity are not clear, one thing remains most important for the role of program director as articulated by one participant, "You must have a positive impact on patient care. If that's not the focus, then I don't know why we would be program directors."

A tangential challenge for program directors included in the identity struggle is the challenge of promotion of good clinicians to educators. Many participants described promotion of good clinicians to educators as a significant challenge. To simply assume good clinicians will automatically make good instructors is a mistake. Similarly, to simply assume good instructors will automatically make good program directors is a similar error. The skill sets are different and program directors must address this challenge by selecting faculty and directors that will identify with the educational role. George (2007) described this challenge as finding individuals who know themselves well enough to choose the right role. Individuals must express a passion for the principles and practice of education rather than exclusive criteria of simply being a good clinician. One of the participants described this professional role change as:

> We have to educate program directors because we have individuals who are lacking knowledge of how to perform. It's the one profession I know where they look at you and say you're a great clinician you've got to be a great educator. And that does not correlate often times, but so many of our paramedic program directors and faculty

> members are where they are because somebody thought they were a good clinician and they would be a good teacher.

Another participant echoed the danger of simply promoting high quality patient care providers into educational roles and the economic challenges that result in stating, “We have this nasty habit… we always promote great clinicians who don’t have the slightest clue how to manage a budget or understand how the education system is paid for.” Another participant suggested newly promoted program directors often lack an understanding of the role and relational expectations of the position: “They are still clinicians at heart and haven’t progressed towards becoming a leader or figured out their needed relationships…there’s a failure to communicate with stakeholders to determine what their needs are and how to involve them in their program.”

A lack of educational experience was cited as common threat to a program. By not understanding the principles and process of education, a program director is poised to perpetuate the identity crisis. One participant stated lack of educational experience may often be the main impediment or reason for programs to struggle and added the problem may not be isolated only to EMS education:

> The struggling programs I’ve seen seem to be for lack of experience. Whether it is classroom experience for the instructors or lack of leadership and management experience for the program directors…medicine is guilty of a lot of things and I’ve seen [the lack of experience] all over in virtually every part of the profession.

In similar fashion, another participant elaborated on the issue, citing a lack of education and lack of educational practice knowledge:

> I think what we do is we take good clinicians and say you were a great clinician so you are really a great program director…they know nothing about budget, education for evaluation, item writing, test item analysis, validity or reliability. We have chosen people with no education background, no education with no sense of the discipline of education and now have an expectation that they are writing reliable and valid exams! We have an expectation that they are managing their budgets, we have an expectation that they are ensuring interrater reliability, and a lot of times all they were was a good paramedic.

A third area of significant challenge within the identity struggle was the concept I identified as "Habit Think." Participants reported the phenomena of program directors doing things simply because of the way they have always done them. Though such thinking may be beneficial in some routine circumstances such as following policies or protocols, participants reported the approach in a negative context. Such thinking is restrictive, often squelching creativity and impeding progress by perpetuating a "one way to do things" philosophy. Covey (1991) suggested, "Old habits exert a powerful pull [and] forces like appetites, passions, pride, pretension, aspiration and ambition" (pp. 74-75). Habit Think can blind individuals from seeing new solutions and propagate mediocrity. Specific examples of the challenge include it as the root cause for the failure to remain current, failure to adopt new curriculums, and failure to embrace the changes of the greater healthcare system. One participant stated:

> One of the big challenges that EMS confronts is the notion of we've always done it this way. If we want to mature and grow and be a recognized healthcare profession, we have to be willing to adapt and change along the way. All too often there are too

> many people in leadership roles that want to keep things the way they are in the interest of tradition or because we've always done it that way. We can't do that. If we do, somebody or something else is going to come in and replace us. There can be programs, program directors, others in our profession that hold us back and prevent us from moving forward.

Sometimes the practice of Habit Think can slow progress of a program or even create a paralysis of advancement. One participant related this to a program director refusing to think in new ways (even after recognizing poor practice) stating, "They are stuck in the 1980's and don't want to move forward…they know their students are not performing at the level they want them to perform, but they're not making any changes." The "Habit Think" problem is often exacerbated by regional isolation. Many educators "grew up" in the particular system in which they trained, practiced as a paramedic, and now are assuming an educational role in the very same system. They have not been out of their region and are only familiar with local practices. One of the participants articulated it as:

> Some program directors lack the bigger worldview…communities are very insular, very incestuous…people have never been outside a practice area…they don't know anything else. They think they are a state-of-the-art EMS system and they're not. [The ability] to get the broader view…including an appreciation for the educational components and the importance of accreditation are really huge.

Hsieh (2014) supports both the need to recognize and address identity crisis in stating "Systems will need to depend on not only a well-trained workforce, but well-educated EMS professional to provide increasingly sophisticated medical services in this dynamic environment. In this regard, EMS education is at a crossroads" (para. 3). If the profession is

to actualize its potential, it will need to face its present identity challenges and wisely choose the road ahead.

Generational dissonance. Generational dissonance emerged as the second challenge theme. Dissonance is "a tension or clash resulting from the combination of two disharmonious or unsuitable elements" (Oxford, 2016b). In this case, tension or clash of dissonance arises between generations and their respective approaches to work and academics. Nearly all of the participants commented on an overall change in student attitude and behavior. One described it as:

> Kids have priorities that are a bit misaligned. They say I can't come back next semester because I just don't have the money…in the next breath they say I just bought a brand-new Ford Quad-cab pickup truck. And I say are you kidding me?! You couldn't drive a Chevy Cobalt for another year to get through school? So all of a sudden they're driving a $50,000 truck with payments of $800 a month and have to work [to pay for it]. So I think a lot of it is priorities and a lot of the non-academic attrition is due to poor prioritization and instant gratification. I want the truck, [so I will] go get it.

One meta-analysis of student behavior supported the perceptions of the majority of participants in this study concerning the latest generation of students (i.e. Generation Me), finding they "score higher on assertiveness, self-liking, narcissistic traits, high expectations, and some measures of stress, anxiety, and poor mental health, and lower on self-reliance" (Twenge, 2009, p. 398). Twenge suggested the combination of traits present in Generation Me students deserve attention by educators. Together, the generational traits may lead to

overconfidence, a lack of empathy and an expectation of higher scores without truly learning the material; which in the field of medicine may be dangerous (Twenge, 2009).

Several participants believed the issue rests in a lack of understanding the servant model that is expected in the field of EMS. One voiced it as, "I think we have a generation that comes to us that doesn't always understand the model of service to others. And so we've got to teach them about servanthood and how to live it." The lack of servanthood quality appears to be compounded by a lack of academic preparation prior to coming to paramedic school. Another participant described it as:

> I think the biggest challenge has been the impact of No Child Left Behind. It was the worst idea…it promoted the idea of standardized testing and did not teach students to read or do math. We used the HOBET® [Health Occupations Basic Entrance Test] for a number of years. The average adult reads at 200 words a minute. I had newer generation students coming in who read at 20 words per minute…reading at less than a fourth grade level.

Generational challenges were also noted in new faculty, specifically in their attitudes and behaviors. The former commonly possess a "work until the job is done" philosophy that does not always appear to transfer to newer generations. Though not exclusively, it was noted that new generation individuals appear to be more concerned with their lives outside of work than their roles in the workplace. The following example was offered by one of the participants in comparing senior and junior faculty:

> The priorities [between senior and junior faculty] are totally different. The senior faculty view their priorities and their job as their students. So here's the difference: I have to get my nails done because I'm going to some banquet tonight: The senior

> faculty are going to get all their work done, make their appointment at 6 PM, and cancel their appointment if they have to, because they believe they have to get everything done. The junior faculty are going to make their appointment for 10 AM, not show up to work, then all of a sudden have a crisis because they can't get everything done that day because they elected to get their nails done or go to the spa rather than do their work! There's a totally different level of commitment by the younger faculty. It's a lack of commitment, prioritization, and accountability…priorities have changed where their outside commitments have taken precedence over their commitment to the program.

Such behavior is supported by a study of generational differences in work values comparing Generation X to Baby Boomers. Smola and Sutton (2002) found a decline in work values between 1974 and 1999, a stronger desire for faster promotion, and Generation X member's jobs less likely to be associated with their self-worth as compared to a strong sense of job self-worth in the previous Baby Boomer generation.

In recognizing generational change, a similar sentiment was echoed by another participant in the study:

> We have generation of young men and women…who want to get their education quickly, and immediately make 50, 60, 70, or 80 thousand dollars a year. It's just not realistic. They don't pay the dues that generations before them have paid. I had to start at the bottom and work my way up. They want to graduate and immediately be respected…their education is just an obstacle to move to the next step. It's a real challenge.

Although findings in this study indicated perceived changes in generational differences in attitudes and work ethics, the finding may not be universal to all populations. Generational differences have been noted for hundreds of years. Socrates is attributed to having stated: “The children now love luxury. They have bad manners, contempt for authority; they show disrespect for elders and love chatter in place of exercise.” (Goodreads, 2016). In a more modern example, Parry and Urwin (2011) found mixed empirical evidence and cautioned against making generalizations in their meta-analysis of the published generational research; stating “generations cannot be defined purely on age of birth” but rather “their formation is based on a more complex combination of birth cohort and a shared experience of historical and political events, collective culture and the competition for resources” (p. 92). Accordingly, it is imperative program directors understand their own generational perspective and the need to communicate beyond it. Indeed, vigorous communication appears vital in bridging generational gaps, yet it may be a challenge for some older program directors who have not experienced any generational culture but their own. One participant admittedly summarized it as:

> Expectations of students today are so much different than they were…then again I’m in my early 60’s, so I really don’t get this idea of payout or wanting to have a job in order to have fun. That mindset is very different from my generation’s mindset as a boomer. I think that concept is going to remain relevant to the students and to keep those communication pathways open I think it’s always going to be a challenge.

Program directors must also strive to understand and serve individuals (whether students, faculty, or whomever) from a broader context rather than simply a generational category. One participant warned:

> I think program directors need to be aware they never want to pigeonhole students based on a Generation X or Generation Y lecture that they've heard. It doesn't mean an individual student will respond the way a generational category is supposed to respond…we have to be open-minded to look at the person independently and know how to coach as well as discipline...Sometimes it's coaching these individuals and understanding they may have the skills, they just never have been developed.

In doing so, program directors will be better prepared to carry out what one participant described as "all our responsibility to make sure that we are helping to train and educate the next generation" in order to optimize productivity amongst stakeholders regardless of their age. Being successful in training multiple generations may require different techniques and include program director professional development in how to understand and relate to individuals from various generations. Such approaches may include recognition of what one participant framed as: "personality types and generational differences like Generation X. It doesn't mean they are bad… just different, so they must adapt to the type of students that they're seeing. It might mean incorporating different teaching techniques like hybrid delivery."

Another participant summarized the need for program directors to approach future generational dissonance with a need for a new set of skills in order to: "deal with the generation of today…instructors whose priorities are really different than ours…today's students who are coming in potentially less prepared with different priorities and expectations…with needs of instant gratification." It may also require program directors to: "show them they need to be lifelong learners…you never stop learning…it's going to be a lifelong journey."

This sentiment appears supported by at least one study in the medical education literature. Twenge, (2009) states it is vital to understand generational differences since "students are a reflection of contemporary culture" [and educators must] break lectures into short chunks, using videos, and promote hands-on learning…without compromising content" (p. 404). Based on the answers offered by the participants in the study, the Twenge study's findings may offer a reasonable course to follow.

Summary

Chapter 5 discussed the emergent themes revealed from the research. Four total themes of leadership were identified through the lens of context, challenges, and best practices. Context and best practices themes included: A need for understanding and cultivating quality. Challenge themes included identity struggle and generational dissonance. Chapter 6 will offer the summary, discussion, and recommendations of the research.

Chapter 6

Summary, Conclusions, Discussion, and Recommendations

Summary

Although national accreditation became the standard for nearly all paramedic education and was generally perceived as a positive step towards professionalism (Wilfong, 2009; Hseih, 2014), until now no formal study of leadership practices has been conducted to prepare program directors to assume successful leadership roles. The purpose of this study was to explore leadership practices of program directors in nationally accredited paramedic education programs. By identifying relevant leadership practices, the study filled the gap in knowledge. This goal was accomplished through an exploration of expert perceptions regarding the context, challenges, and best practices of leadership in paramedic education program directors.

The project met its aims in collecting over 19 hours of participant interviews regarding paramedic education program director leadership practices. After detailed analysis, leadership practice is important in the role of a paramedic education program director. The practice of leadership also has a broad impact on educational programs. Analysis revealed 75% of a program's success is due to the best practices of program director leadership, yet a lack of leadership training exists in the program director community. Positive leadership approaches of authentic, ethical, and servant leadership along with relevant leadership skills are the most important in the program director role. The span of leadership includes all program stakeholders or communities of interest (i.e. students, faculty, graduates, employers, administration, and advisory committee members). A program director needs to be willing to

invest in relationships, build trust, and display integrity in order to earn the respect of the communities of interest.

Within the leadership context, a program director needs to understand the need for leadership practice in a program. Importantly, he or she needs to practice excellence in communication along with human, technical, and conceptual leadership skills. It is also important for a program director to possess a need for a comprehensive understanding of the educational process and have the ability to make good, selective choices regarding all aspects of the program. Lastly, program directors need to be a role model for everyone involved with the program and cultivate a culture of quality which includes a vision and plan for the future.

Specific challenges impacting a program director's ability to lead a program include promotion of clinicians to educators, generational dissonance with students and faculty, securing adequate resources, balancing charisma with content, and advocating to the administration on behalf of the paramedic education program. Future challenges for program director leadership include cultivating mentors, maintaining clinical competency, understanding the nature of the job, staying current with a changing healthcare environment, and the need to grow a successor.

Best practices for a program director are associated with the roles and responsibilities outlined in the accreditation standards (CAAHEP, 2005). They include professional and personal development, being sensitive to affective situations, and informing the communities of interest; especially administration. Other program director best practices involve student retention and recruitment, certification and placement, and accreditation concerns.

Conclusions

A national certification mandate of national accreditation for paramedic education programs has greatly expanded the number of accredited programs in recent years. Though accreditation standards exist, very little has been known about the leadership practices of the individuals who direct the programs. The purpose of the study was to explore leadership practices of nationally accredited paramedic education program directors. The principal research question for this study was: What are the leadership practices of program directors of nationally accredited paramedic education programs? Three supporting research questions addressing the context, challenges and best practices of program director leadership informed the study to answer the principal question. Below are highlights of the conclusions of the study (See *Figure 10*).

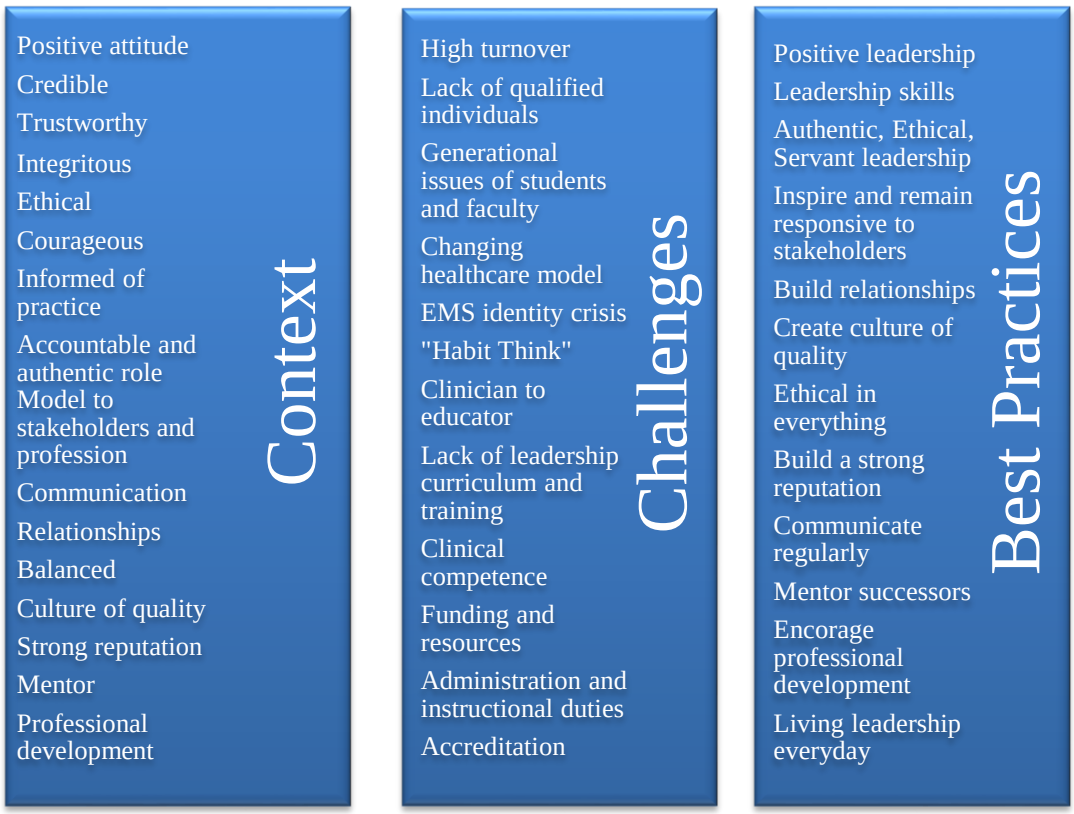

Figure 10: Highlights of Leadership Practices Conclusions

Context of program director leadership practice. Program directors must function within accreditation standards and guidelines, meeting specific minimum qualifications to be eligible for the position. Once in place, the director is held responsible for all aspects of the program (CAAHEP, 2005). An EMS program director guides a program through leadership practice. The greatest leaders of paramedic programs are positive, trustworthy individuals of credibility, integrity, courage, and are worthy of trust. They are informed of practice, accountable to their stakeholders, active in their profession, and cultivate both a vision and culture of excellence in their programs. Program directors recognize themselves as authentic role models to their communities of interest and to their profession as a whole.

Relevant positive leadership and leadership skill theory literature support the practice of paramedic education program directors. Among the positive approaches, authentic, ethical, and servant leadership are most important and are all consistent with the EMT Code of Ethics (NAEMT, 2007). Transformational, spiritual and charismatic leadership, although valuable in part, play lesser roles. Transformational leadership is especially important for growing successors within programs, spiritual leadership for recognizing spirituality in others, and charismatic for fostering relationships. Charismatic leadership can be effective, but should be considered with caution since it is often perceived as short on substance.

The context of program director leadership shows a strong association with the leadership skill theory whereas leadership skills required of program directors include organizational, technical, analytical and human skills. Areas include the technical aspect of leadership skill theory (Katz, 1974) involving tasks and duties, or in this case the expected responsibilities of a program director outlined in the CAAHEP standards. The human aspect of skill theory is also significant which involves relationships with stakeholders and other

program directors as well as personnel or human resource issues. The conceptual aspects of leadership skill theory are important for a program director when formulating a strategy and vision for the future of the program. A need for a strong vision is significant in a program and strongly supported across the literature review (Katz, 1955; Fry, 2003, Northouse, 2007; Bennis, 2009; Kroth & Christensen, 2009; Firestone, 2010).

In the context of leadership, program directors must fully understand the roles and responsibilities of their positions and be able to communicate with their stakeholders on a frequent basis. This includes future students, current students, graduates, faculty, administration, and various medical professionals. Frequent communication results in building trust among stakeholders, which in turn fosters integrity and builds relationships (Bennis, 2009). Relationships are further enhanced if a program director is of sound moral character, is consistent in behavior, and demonstrates a caring attitude. Because program directors often perform instructional duties, they must also be able to balance their time appropriately. This includes possessing an ability to prioritize work flow and assessing the importance of situations requiring immediate attention.

Through an expansive lens, the context of program director leadership includes possessing a thorough understanding of the role of program director; creating a culture of quality throughout the program that leads to excellence in patient care; networking with other program directors to share best practices; and guiding, instructing, and facilitating the communities of interest. By demonstrating such qualities and implementing such practices, program directors gain credibility in the eyes of their stakeholders which fosters confidence in their programs.

Challenges in program director leadership. Perhaps the greatest challenge is a lack of a leadership training for the position. Limited accreditation workshops are available, but only to programs that can afford travel. Such workshops offer participants how to meet accreditation standards and guidelines, but do not directly address leadership of programs. Subsequently, no leadership curriculum or training exists for paramedic program directors.

Another challenge is program directors must often fulfill instructional duties in addition to their administrative roles. They must also remain clinically competent which often means working as a paramedic on nights and or weekends. Increased workloads, diminishing state funding, and pressure from employers for accelerated courses to address paramedic shortages are significant challenges. These multiple factors may result in high turnover of program directors which often leads to a disruption in the continuity of a program. High turnover with a lack of qualified applicants to fill vacant program director positions often results in replacement candidates being selected simply because they were good clinicians. Just because an individual excels in patient care does not guarantee he or she will make a good educator or administrator and new program directors without proper education and training for the position may be doomed to fail. Another challenge for program directors is the phenomena of Habit Think, or doing things the way they have always been done while ignoring new possibilities.

Securing adequate resources is critical to a program and often a challenge. Program directors must have strong relationships with advisory committee members as well as their administrations to secure and maintain adequate resources. Recruitment of qualified and competent students is often a program director challenge. Low performing students, low pay for paramedics, and pressure from administration to admit every student add to the challenge.

Future and other leadership considerations include the need for a program director leadership curriculum as well as leadership training. In designing and offering such, existing and future program directors will be better prepared to understand their positions, handle challenges, and implement best practices of leadership. Other concerns are the recognition of the coming impact of the changing national healthcare model on the EMS profession and the need for program directors to network together, thus sharing creative solutions to common problems.

Best practices in program director leadership. Leadership is inspirational, organized, and responsive to the stakeholders or communities of interest. Though each group of stakeholders is unique, all require frequent communication, education for their respective roles, and mentorship. The program director serves as the face of the program and a role model to each stakeholder, and thus is required to have a healthy relationship with each. Such a relationship is based on credibility, respect, and frequent communication. It is imperative to have a comprehensive and ongoing knowledge of the accreditation process. This is best achieved by attending workshops and webinars, staying abreast of CoAEMSP and CAAHEP publications, and networking with other accredited program directors. The EMS profession (and in a larger sense, patient care) is impacted by program director leadership. A program director's modeling of ethical behavior and servanthood are the biggest behavioral factors in preparing graduates worthy of the profession and the public trust. Similarly, when a program director is a positive social role model through teaching, scholarship, and service, the program's faculty, students, and graduates are more likely to be committed to excellent patient care.

Best practices for recruiting students ranked as building a strong reputation for the program, followed by seeking highly qualified candidates, and maintaining a high visibility in the community. Retention is best accomplished through selective admission standards, full disclosure of what to expect in the program, and offering academic support throughout the program. Success in certification is best accomplished through student preparation. The best form of preparation is accomplished through valid and reliable exams that include a significant number of application and problem-solving level questions. It is also helpful to encourage students to take their certification exams immediately after graduation.

It is clear from the results of study that program director leadership practices are crucial in the success of a paramedic education program. Unfortunately no framework or curriculum exists from which program directors may learn to become better leaders. Without such a curriculum, advancement of leadership practice is unlikely. Subsequently, both an EMS program director-specific leadership curriculum and training program are needed for paramedic education program directors to allow for the learning and practice of leadership. Such training may consist of an introductory one or two-day workshop up to an advanced graduate certificate in leadership.

Discussion

The field of paramedic education is constantly evolving. Changes in curriculums, teaching modalities, policies, procedures, regulations, certification, accreditation, and the changing national healthcare dynamic all greatly impact leaders in the field. Though responsibilities and qualifications are outlined in accreditation standards, a leadership framework for program directors does not exist. This study explored various leadership practices of nationally accredited paramedic education program directors whose findings may

begin to inform such a framework. Among the topics included in this study were context, challenges, and best practices of leadership. Findings from the study indicate each of the topics would be important to include as part of a curriculum in a leadership training framework. Leadership practices for comparison were considered based on previous research of department chairs given the close similarities of the roles, responsibilities, and duties as compared to paramedic program directors. In context, theories were chosen based on Wolcott's (2009) definition, "Theory is a way of asking (inquiring) that is guided by a reasonable answer" (p. 75). The chosen theoretical framework for this study was based on a blended construct of the leadership skills (technical, human, and conceptual) model (Katz, 1955) and positive leadership (authentic, servant, ethical, charismatic, spiritual, and transformational) model (Avolio & Gardner, 2005; Fattig, 2013).

It is clear from the findings the authentic leadership model is supported for paramedic program directors. The findings closely mirror the work of George (2003), who articulated authentic leaders must understand their purpose, practice solid values, lead with their heart, establish concrete relationships and demonstrate self-discipline (p. 18). It is also clear an individual development component (George, 2003) is required of program director leaders. Professional development to learn and sustain the role of program director is critical. Also significant is the self-reflection concept (Gardner, 2005), along with the need to be a positive role model (Shamir, 2005). Finally, relationships built on trust and integrity are significant to authentic leadership theory as described by Gardner, Avolio, and Walumbwa (2005). A paramedic program director must strive to be authentic in each of these respects to effectively lead his or her program.

Servant leadership qualities including the spirit and nature of servant leadership (Greenleaf, 1970) are important to program directors. Behaviors of servant leadership parallel the EMT code of ethics, originally written by Gillespie and revised by the NAEMT in 2013. Ethical leadership is crucial in regards to program director leadership which assists in building trust that leads to healthy relationships (Kouze & Posner, 2007). By its nature, EMS relies on the public's trust which expects none other than the highest degree of ethical behavior.

The subject of charismatic leadership provides a wide array of discussion. A surprising discovery from the study showed charismatic individuals believe strongly in the approach, whereas less charismatic individuals tend to be skeptical of its motives. These findings are consistent with (Lussier & Achua, 2009) which determined charismatic leadership to be socialized (in the interest of others) or personalized (in the interest of self). In paramedic program leadership, program director charisma may be useful in fostering relationships but must be accompanied by credible knowledge and sound character. Otherwise, an impression is made on the communities of interest that suggests the program is focused on the individual rather than the program.

Spiritual leadership is significant in that there is a recognized need for it, but it is deeply personal. Subsequently, individuals may not feel comfortable in sharing their feelings regarding spiritual leadership which makes it difficult to study. A challenge discovered in the study is spiritual leadership is not often discussed among peers which prohibits an adequate understanding of the subject. Regardless, an acknowledgement of human spirituality must be taught to faculty and students in order for them to respect the spiritual dimension in others.

The transformational leadership model shows strong alignment with authentic, servant, and ethical theories which correlates to inspiring the EMS program communities of interest or stakeholders to collectively achieve a higher purpose (Burns, 1978). A prime example of this is program directors investing in faculty to grow their successors and thereby build sustainability in their programs.

Significant associations with leadership skill theory offers insight into successful leadership in dealing with various communities of interest of a paramedic program. The importance of building and maintaining relationships with each stakeholder through human elements of trust and regular communication is paramount. Technical skills of compiling data and reports for accreditation, tracking students and graduates, and practicing regular communication with stakeholders are all important skills for program directors. In practicing regular communication, program directors lay a foundation to create a culture of excellence from which stakeholders will benefit both personally and professionally. Such a culture will foster a vision for the program and advance the skill of conceptualization. Moving forward, the need to learn and practice leadership in leading programs will be significant as the profession matures. The implications of program director leadership promise to impact the EMS profession and patient care in a positive manner.

Themes of leadership context and best practices and challenges emerged from the findings and are discussed in the next section. Of special interest in the context and best practices categories are the need for program directors to be fully educated in regards to their positions and the need to cultivate a culture of quality. In the challenge categories, themes of an EMS profession identity crisis and generational dissonance emerged. Both areas will need significant attention if the profession is to move forward in the future.

Emerging Themes of Leadership Context and Best Practices

Two distinct themes emerged from the study in regards to context and best practices of program director leadership. They included the following:

- A Need for Understanding
- Culture of Quality

First, it is imperative for a program director to possess a comprehensive understanding of expectations of the role of program director. Knowing what is required of the position including job functions, state and national regulations, educational process (i.e. andragogy), accreditation, and current field practice are critical in leading a program forward. Program directors must understand the best leaders of paramedic education programs are positive, trustworthy individuals with qualities of credibility, integrity, and courage. They must also understand they will not be in their positions forever and subsequently be actively mentoring a successor. Leading a program also involves understanding a need to encourage stakeholders in their own professional development which invests in the program and furthers the educational mission. Program directors must understand the need to be ethical in everything they do, informed of practice, accountable to stakeholders, and active in their profession. Finally, the best leaders foster a vision as well as a culture of excellence.

Directly related to a positive culture and vision was the second emergent theme of cultivating a culture of quality. The program director must include the stakeholders in the creation of the program's vision in order to develop a shared common goal and mission. Also important to the culture of quality is the ability of the program director to possess a self-knowledge of leadership, recognizing him or herself as an authentic role model of professionalism to the communities of interest and profession as a whole. The importance of

living such leadership on a daily basis cannot be overstated. Leading a program in a culture of quality also involves balancing time and workflow, being organized, and building quality relationships with stakeholders by seeking to inspire them through regular communication. In creating such a culture, program directors will establish a strong reputation for their programs and thus be more likely recruit quality students to enroll their programs. Moreover, students enrolled in programs with a culture of quality will be more likely to complete their paramedic education, become certified, and find employment.

Emerging Themes of Leadership Challenges

Two clear themes of challenges emerged during analysis of the data. They included:

- EMS Identity Crisis
- Generational Dissonance

Similar to the context and best practices themes, each were surprising to discover and may shed light on developing solutions to move the profession forward. The first theme is the field of EMS is in an identity struggle somewhere between healthcare and public safety. It is not clear whether EMS professionals should function exclusively in one environment, another, or both. The present model suggests there is room to practice in both environments, yet given the changing healthcare model it remains to be seen if it is sustainable. A phenomena of "Habit Think" or doing things a certain way because of tradition or not wanting to change is a challenge to programs. Because the field of EMS education is constantly evolving, such a practice is detrimental to progress of the program. Program directors must be willing to adapt to changes to remain relevant. Such an identity struggle may impact program directors in their program's philosophy, funding, and clinical access.

The identity of the environment in which EMS education should reside is presently uncertain among participants, albeit vocational or academic. Similar to the public safety / healthcare debate, programs currently reside in vocational and in academic settings. Regardless of the program's location, many program directors must fulfill instructor, administrator, and clinical roles as part of their positions which creates a significant time challenge. Funding and resources are ongoing challenges for program directors as enrollment pressures, lack of state funding, and increased scrutiny of federal financial aid pose serious threats to program finance.

Another significant challenge is employer urgency or pressure from employers for programs to offer fast-paced courses to fill high-turnover paramedic vacancies. Many paramedic education programs also experience high-turnover in program director positions, which combined with a lack of qualified candidates, creates a challenge for programs. A phenomena of promoting good clinicians to educators and good educators to program directors exists. The assumption of competency for each role creates a challenge since skill sets of the various positions vary widely.

The second emergent challenge theme discovered was one of generational dissonance. Student issues include being poorly prepared in basic academic skills such as reading and mathematics, attitudes of entitlement, and an unwillingness to work hard for the goal of a paramedic education.

Future measures may need to be implemented for program directors and faculty to understand the needs of newer generation students in order to better serve them. Recommended approaches may include structured classrooms, interactive learning, specific instructions with frequent feedback, strictly followed rules to combat entitlement, and an

emphasis on work ethic to balance the present generation's substantial yearning for leisure (Twenge, 2009).

Challenges among generations exist not only in students, but also in newer faculty. Many newer faculty mirror similar behaviors of newer generation students. Issues identified by Smola and Sutton (2002) surrounding lackluster "desirability of work outcomes, pride in craftsmanship, and moral importance of work" (p. 376) appear present in many newer generation faculty. Just as in dealing with students, future measures may need to be implemented for program directors to understand the needs of newer generation faculty in order to better serve them. Also important will be for program directors to realize there may be more than one way for a program to be successful, and thus remain flexible and adaptable in their approach. Clear communication of expectations among all parties will be critical.

Limitations

The study had several limitations or "potential weaknesses" (Creswell, 2007, p. 148): (a) the field of EMS had very little published literature to research. Subsequently, a broader literature search was conducted to include a wider array of fields. (b) Most EMS research has been quantitative and conducted by physicians and nurses rather than paramedics (Gurchiek, 2011). Though valuable, such research has been largely in the clinical realm and may have introduced a level of professional perspective bias. While I have fulfilled all of the requirements of an expert participant as defined in the study, it was important for this study to be conducted by a paramedic educator who fully understood the roles and responsibilities of a program director. Every effort was made to practice bracketing and epoché to suspend bias or preconceived judgement. (c) The participants selected for interviews were part of the national accreditation board of directors and may have had a bias towards accreditation

and/or an administrative lens of leadership as well as personal bias. Efforts were made to instruct participants to bracket and suspend potential bias. (d) Because of my position as the Assistant Director of Accreditation Services, there may have been a perceived bias of positional power differential (Creswell, 2007). This may have potentially created a perception of researcher influence (Alvesson & Sköldberg, 2000), researcher bias (Maxwell, 2005), and/or expert response bias (Fowler, 2009). The bias was reduced however, due to the fact my position answered to the board of directors on which most of the candidates served. Further influence was reduced by implementing a balanced "I-Thou" interviewer/interviewee relationship which verged on a "We" approach during the interviews (Seidman, 2006, p. 96). e) Finally, due to the relatively small size of the EMS education profession and my respective position, the participants were all known to me through professional relationships. This may have introduced an unintended bias in answering questions and interpreting answers. Once more, bias was intentionally reduced through bracketing and epoché.

Delimitations

The study also had delimitations. The study was narrowed to specific participants and to a basic qualitative design (Creswell, 2007, p. 148). Through the process, participants who were deeply rooted in the culture of EMS education offered rich perceptions of their experiences to inform the study. Since the study was not exhaustive of all EMS education leaders, findings may not be assumed to be universally generalizable to all leadership theories selected or to the entire population of program directors. Furthermore, because of the purposeful narrow selection of participants, findings are limited to views of those who met the three selection criteria of CoAEMSP-experienced: (a) board members; (b) site visitors; and (c) program directors. Lastly, the study focused specifically on practices of leaders and

not practices of followers. Still, the findings of the study will add to the gap of EMS education leadership literature and provide several recommendations.

Recommendations

Six recommendations for research are identified. Topic areas include:

- Amount and type of education program directors receive.
- Study of value of situational leadership in program direction.
- Program director-specific workload study (inform curriculum and turnover variables).
- Program director perceptions of leadership challenges.
- Applicability of study to conclusions to other allied health education program directors.
- Program director leadership curriculum and training development.

The need for further research is recommended regarding the amount and type of education program directors are receiving in the field of education. Data for the study would likely include program director completion of: (a) basic instructor course; (b) amount of higher education; and (c) type of higher education. Determining the amount and type of education program directors have earned would provide a baseline for the study. Once data is gathered, it would then allow for a comparison to accreditation citations and national registry certification success rates, thereby revealing any potential correlation to knowledge of education as well as potential recommendations for professional development.

The need for situational leadership awareness may be indicated. Situational leadership was described by Northouse (2007), who stated:

> The essence of situational leadership demands that a leader match his or her style to the competence and commitment of the subordinates. Effective leaders are those who can

> recognize what employees need, and then adapt their own style to meet those needs (p. 92).

Knowing when to adapt different leadership approaches to various situations may be important for success. Accordingly, further study of situational leadership in the context of program director leadership may be beneficial in future leadership development and practice. It may also be valuable to add situational leadership theory to the theoretical/conceptual framework if a study similar to this is repeated. Such an inclusion may provide an additional element of robustness for further leadership practice consideration.

Also recommended is a program director-specific workload study. A program director workload study of the correlation of the amount of hours worked per week to program outcomes would be valuable. Although the Crowe et al. (2015) study offered a general study of lead paramedic educators, program directors were not the specific focus. The study found most EMS education program directors work in excess of fulltime, with some working other jobs. Findings of such a study may aid in determining which leadership practices could be valuable in informing a future leadership curriculum and helping to identify factors of high program director turnover.

A national survey of program directors to determine their perceptions of the greatest challenges compared to the conclusions made in this study may be beneficial. Such information would be a critical component in further development of professional development training to be included in a program director-specific leadership curriculum.

Further study is also recommended to determine if the conclusions of this study can be transferrable to program directors of other allied health education programs. Previous findings from other allied health and department chair leadership studies suggest similarities

(Reiss, 2000; Aaron, 2005; Weissman, 2008; Firestone, 2010; Odai, 2012; Fattig, 2013; and Eifel, 2014), but further study specific to the context, challenges, and best practices of leadership is recommended to determine potential value in those areas of academia.

The final recommendation is a need for program director leadership training. In order to provide such training, a leadership curriculum will be necessary to developed. Such training may be designed and offered at different levels, including an entry-level workshop, a college-level course, or graduate certificate in leadership. It would likely be best initiated with an initial entry-level workshop and expand it as needs are identified.

In the final analysis, this study provided an exploration of program director leadership practices of nationally accredited programs. To determine such practices, the context, challenges, and best practices of program director leadership were explored. The conclusions add to the body of scholarship of relevant leadership practice, offer immediate-use models of leadership best practice, and begin to inform further research.

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Appendix A

Pilot Interview Questions

Project Title: A Study of Leadership Factors of Paramedic Programs Moving Towards National Accreditation.

Interview Questions*:
Note* Given the qualitative nature of the study and questions, other questions may arise as follow-up questions from the following questions.

1. How long have you been in EMS education?

2. How long have you been a program director?

3. How long has your program been nationally accredited?

4. What is your highest degree of education?

5. Are you currently seeking a higher degree? If yes, which degree?

6. How do you define leadership in program director (PD) terms?

7. What leadership traits are important to being a PD of a nationally accredited paramedic program?

8. What leadership skills are important to being a PD of a nationally accredited paramedic program?

9. What personal qualities are necessary in being a successful PD of a nationally accredited paramedic program?

10. What kind of support is needed to become a nationally accredited paramedic program?

11. What barriers to leadership exist in moving a paramedic program towards national accreditation?

12. Are there any additional comments you wish to add regarding leadership and accreditation of nationally accredited paramedic programs?

Appendix B

Interview #1 Questions

The following interview questions are in reference to the leadership context of program directors of nationally accredited paramedic education programs.

Context Questions*:

1. How long have you served as:

   An EMS educator?

   A program director?

   A CoAESMP board of director?

   An accreditation site visitor?

2. How do you define leadership in general and what elements or components do you perceive are most important?

3. Can you describe the context of program director leadership? Please explain.

4. What leadership practices does a just qualified program director need to know?

5. Tell me about an exemplary paramedic program. How much of its quality is due to internal (program director leadership) vs. external (program) factors? Please explain.

6. Describe what you think are optimal skills of program director leadership:

7. Are program director leadership skills missing in struggling programs? Please explain.

8. Are any of the following leadership characteristics important for program directors? Please rank and explain.

   Authentic: (i.e. capacity for self-awareness, moral principles, and values).

   Servant: (i.e. model of service to others).

   Ethical: (i.e. doing what is right).

   Charismatic: (i.e. self-confidence, an outgoing personality, and a high energy level).

   Spiritual: (i.e. need for faith in a higher power).

Transformational: (i.e. inspiring leadership in communities of interest for the betterment of themselves and the programs they serve.

9. How does program director leadership affect the following stakeholders: (i.e. faculty, students, graduates, medical director, advisory committee, administration, the EMS profession and ultimately patient care)?

10. From your perspective, what else is important to consider about the context of program director leadership?

Challenges Questions*:

The following interview questions are in reference to the leadership challenges of program directors of nationally accredited paramedic education programs.

1. What leadership challenges do you perceive program directors face in leading paramedic education programs?

2. What leadership challenges (if any) may be faced by program directors in dealing with the following stakeholders? Please explain.

    Program Medical Director

    Students

    Administration

    Faculty

    Advisory Committee

    Graduates

3. How is the accreditation process a leadership challenge to program directors?

4. Do you perceive any future challenges to program director leadership? If so, explain.

5. Do you foresee a need for future program director leadership training? If so, describe.

6. Are there any additional comments you wish to add regarding leadership and accreditation of nationally accredited paramedic programs?

Note* Given the qualitative nature of the study and semi-structured format of the questions, other questions may arise as follow-up questions from the following questions.

Appendix C

Interview #2 Questions

The following interview questions are in reference to the leadership best practices of program directors of nationally accredited paramedic education programs.
Best Practices Questions*:

1. How much of a program's success (if any) is due to best practices of program director leadership? Are there other contributing variables or factors? Please explain.

2. What professional leadership practices are priorities in being a program director of an exemplary nationally accredited paramedic program?

3. What personal leadership practices are priorities in being a program director of an exemplary nationally accredited paramedic program?

4. What leadership practices are missing in struggling programs?

Using a story or example, describe leadership best practices you have observed for the following:

5. Student affective or behavior challenges

6. Administrative challenges

7. Faculty challenges

8. Advisory Committee challenges

9. Medical Director challenges

10. Student retention

11. Student placement

12. Student certification

13. Recruitment

14. Accreditation

15. Moving forward, what leadership best practices will be important to paramedic education programs?

16. Are there any additional comments you wish to add regarding leadership best practices of nationally accredited paramedic programs?

Note* Given the qualitative nature of the study and semi-structured format of the questions, other questions may arise as follow-up questions from the following questions.

Appendix D

Consent Form

An Exploration of Program Director Leadership Practices in Nationally Accredited Paramedic Education Programs

1. The University of Idaho Institutional Review Board has certified this project as exempt.

2. The purpose of this study is to determine the context, challenges and best practices of program director leadership of nationally accredited paramedic education programs.

3. The study will take place between May 2015 and September 2015.

4. There are no identifiable risks associated with the project. Any disclosure of your responses outside of this research will not reasonably place you at risk of criminal or civil liability or be damaging to your financial standing, employability, or reputation.

5. You personally and society in general will benefit from this project by helping us understand the leadership context, challenges, and best practices of program directors of nationally accredited paramedic programs.

6. Although you will be interviewed individually, other subject matter experts will be interviewed at other times whose data will be compared to yours.

7. If we find the interview is creating undue stress or emotional difficulty for you, we will stop the interview.

8. All information you provide will be kept confidential at all times. Interviews will be tape recorded and analyzed for comparison to other participant's answers. Your information and subsequent data will be locked in a file cabinet and stored electronically in a password-protected file accessible only by myself or Dr. Holyoke.

9. If you have questions about the study, you may ask the investigator at any time during the course of the study.

10. Investigator
Gordon A. Kokx
Ph.D. Student
University of Idaho

Faculty Sponsor
Dr. Laura Holyoke
Associate Professor of AOLL
University of Idaho

11. During the course of this study, you may stop at any time.

12. If you do stop your participation in the study, there will be no penalties associated with your withdrawal. All you need to say is: "I no longer wish to participate in the study."

13. I have reviewed this consent form and understand and agree to its contents.

Participant Name _____ Date _____

Researcher Name_____ Date_____

Appendix E

Interview Guide

Hello. My name is Gordon Kokx and I am conducting a study of leadership practices of program directors of paramedic education programs. For the study, I will be interviewing other subject matter experts in the field. You were selected because you meet the specific criteria of having experience as a: (a) CoAEMSP-Accredited Program Director; (b) CoAEMSP Site Visitor; and (c) CoAEMSP Board of Directors member.

If you agree to participate in the study I will ask you a number of questions about leadership practices involved being a program director of a nationally accredited paramedic program. You will not be paid for the interview, nor will you benefit directly in any other way. There will be no identifiable risks to you as a participant in the study. Your identity will be kept confidential and a pseudonym will be assigned to you ensure further anonymity. Your participation will be beneficial to future and existing paramedic program directors of nationally accredited paramedic programs.

You may ask questions at any time during the interview and you may withdraw from the study at any time for any reason. Your participation in the interview is completely voluntary. If any questions arise after the interview, please feel free to contact me.

Do you have any questions?

Are you interested in participating in the study?

If no, thank you for your consideration. I appreciate your time.

If yes, thank you for your consideration. To ensure effectiveness of the interview, I have a few thoughts for you.

1. Since this is a qualitative study, please remember your answers are important regardless of your opinion or perspective. In short, since there are no "right answers" or "wrong answers," please answer what you believe the answer to be.
2. My purpose is to learn your thoughts, ideas, and insights into the questions I ask of you. Subsequently, I will be listening intently and moving from topic to topic to keep us on time.
3. For this interview I would like for you to consider me as a peer, not someone in a position of authority or an employee of the CoAEMSP.
4. If you need to pause for any reason please let me know.
5. Are you ready to begin?