Summary Report

NOMENCLATURE OF THE EMS PROFESSION

November 2020

NHTSA

INTRODUCTION

In 2017, the National EMS Advisory Council (NEMSAC) discussed the topic of emergency medical services (EMS) nomenclature at length and approved an advisory entitled "Changing the Nomenclature of Emergency Medical Services is Necessary." The council recommended adopting "the term 'paramedicine' to describe the distinct discipline and profession which has emerged within the out of hospital health care field." NEMSAC members also recommended recognizing a single generic term to describe all clinicians working within this discipline and convening a stakeholder workgroup to create a nomenclature framework.

After further engagement with the EMS community and in response to NEMSAC's third nomenclature recommendation, the National Highway Traffic Safety Administration (NHTSA) Office of EMS and the Health Resources and Safety Administration (HRSA) Maternal and Child Health Bureau EMS for Children program brought stakeholders together to further discuss the issue of nomenclature. This document describes perspectives captured from those discussions and subsequent stakeholder input.

NHTSA and HRSA convened more than two dozen organizations to participate in the Stakeholder Working Group (SWG) for this project; other organizations were also invited to name liaisons to attend the meetings (see Appendix for list of SWG members and other organizations). In March 2019, the SWG met in Silver Spring, Maryland, to discuss nomenclature in EMS. Two subsequent teleconference meetings were held for stakeholders in June and November 2019, with multiple opportunities to provide written input. Additionally, several members of the public participated in an open comment period and their feedback was reviewed and considered by the stakeholder organizations.

During the first meeting, it was clear that stakeholders were divided on whether the first two NEMSAC recommendations should be adopted and desired further discussion of those topics before addressing the third recommendation. The group focused the conversation on the use of a new term (i.e. "paramedicine") to describe the profession and everyone who practices it, and to defer any discussion about renaming the four national clinician levels (emergency medical responder, emergency medical technician, advanced EMT and paramedic).

In its 2017 advisory on EMS nomenclature, NEMSAC made three recommendations*:

Recommendation 1: Federal Interagency Committee on EMS (FICEMS) and the DOT should officially recognize and use the term "paramedicine," to describe the distinct discipline and profession which has emerged within the out of hospital health care field, moving forward. In addition, they should collaborate with the working groups on the revision of national documents such as, but not limited to, the EMS Agenda for the Future, to clearly designate the discipline.

Recommendation 2: FICEMS and the DOT should officially recognize and promulgate an all-inclusive standard generic term nationally to describe all health care providers performing within the field of paramedicine, regardless of certification or licensure. In addition, they should collaborate with the working groups on the revision of national documents such as, but not limited to, the EMS Agenda for the Future, to clearly designate the provider.

Recommendation 3: FICEMS and DOT should establish a Multidisciplinary Stakeholders Workgroup to create a nomenclature framework and develop a work plan to address the designation of provider level nomenclature.

* The National EMS Advisory Council (NEMSAC) was created in 2007 as a Federal Advisory Committee of EMS and consumer representatives. The council is authorized by Congress to provide advice and recommendations regarding EMS issues to the Department of Transportation and the Federal Interagency Committee on EMS (FICEMS).

BACKGROUND

Although ambulance services, rescue squads, mortuaries, fire departments and other organizations offered basic first aid and transport to hospitals, it was not until the 1960s that terms now associated with EMS came into use. Neither the landmark 1966 National Academy of Sciences white paper Accidental Death and Disability: The Neglected Disease of Modern Society nor the subsequent National Highway Safety Act included the terms "emergency medical services," "emergency medical technician" or "paramedic."

Over the last half-century, however, these terms have become recognized nationally. Most states and territories have encoded the terms in legislation and regulations, with many adhering exactly to the language adopted in national consensus documents and by the National Registry of EMTs.

Dozens of national organizations use these phrases in their names, from the National Association of State EMS Officials to the National Association of EMTs. Internationally, the terms are widely used as well, with many nations recognizing EMT and paramedic.

Many members of the public are not able to define the acronyms EMS or EMT—in a survey conducted by NHTSA in 2007, 42% of respondents aged 16 or older answered correctly when asked what "EMS" stands for. At the same time, even those members of the public who don't know what the letters stand for likely know they refer to the people who show up when 911 is called and cardiopulmonary resuscitation (CPR) or other immediate care is needed.

In its advisory, NEMSAC pointed out the numerous ways EMS agencies identify themselves (e.g., mobile intensive care, medical transport, emergency medical services, ambulance services, fire and rescue, etc.). Much of the public cannot differentiate between paramedics, EMTs and other certification levels, and often use the terms interchangeably. When communicating about themselves, members of the profession struggle to use one unifying term, instead choosing phrases like EMS providers, medics, EMS clinicians or EMS practitioners when trying to speak generically about the EMS professionals certified at varying levels. Some stakeholders have compared this to the terms "nurse" and "nursing," which they have argued are used by nurses at all different licensure levels and are generally understood by the public.

In recent years, both before and after NEMSAC made its formal recommendations, several organizations representing different aspects of the EMS profession released statements or otherwise endorsed positions related to this topic. These include:

- The National EMS Management Association approved a position statement in 2017 in support of "the term 'paramedicine' to describe the discipline and profession within which traditional prehospital medicine is performed." The organization contended, "We will serve ourselves and our profession best by uniting under one flag. The flag of Paramedicine."

- The International Association of Fire Chiefs Board of Directors adopted a position in 2017 stating opposition to "any efforts to change the name of EMS to 'paramedicine' and to call all EMS providers 'paramedics.'" "It is the position of the International Association of Fire Chiefs (IAFC) that the common term 'Emergency Medical Services' (EMS) is the term recognized by the public to define out-of-hospital care provided by the current four levels of EMS providers," according to the statement.

- The International Association of Firefighters adopted a resolution opposing any efforts to replace the term "emergency medical services" with another term or to change the current naming structure of the four national levels of EMS clinician certification.

Although the available data are limited, recent surveys indicate that individual members of the profession are divided on the issue of nomenclature as well. In a 2018 survey of more than 1300 of its members, the National Association of EMTs (NAEMT) found that 75% of them agreed or strongly agreed with the statement that "We should continue to use the term 'EMS' to describe our profession." However, in the same survey, more than 40% of respondents also agreed or strongly agreed with adopting the term "paramedicine," meaning some respondents may see a need for both terms. Two-thirds of the respondents supported conducting a study to further identify the potential benefits and challenges of nomenclature change and using the term "paramedicine."

Similarly, in the 2019 EMS Trend Report published by EMS1.com and Fitch & Associates, which surveyed nearly 3,000 self-selected EMS professionals, two-thirds of field providers said the term "EMS" should continue to be used to describe the profession. "Paramedicine" had less support, with approximately one-fifth of all respondents preferring the term.

WHAT ARE WE NAMING?

Early on in the stakeholder discussions, it became clear that the disagreements among stakeholders about which terms to use stemmed from different visions of what, exactly, those terms defined. For example, even defining "emergency medical services" is not simple. To some stakeholders, it means the organizations that respond to medical emergencies in ambulances, fire engines, law enforcement cruisers and other "first response" vehicles. To others, EMS includes the entire system of care: the first responders and transport agencies, hospitals, trauma systems and even post-acute care facilities.

The same is true for labeling the individuals who are part of EMS. "EMS clinician" can mean the four national levels of certification typically associated with EMS—EMR, EMT, AEMT and paramedic.

It could also potentially refer to other providers who are part of an EMS "system," including nurses practicing on ambulances and in helicopters, to physicians, trauma surgeons, and other levels of healthcare practitioners caring for the acutely ill and injured.

As many traditional EMS organizations and clinicians expand their services to include community paramedicine and other "non-emergent" activities, defining "EMS" appears more difficult for many members of the profession.

During the 2019 stakeholder meetings, there were attempts to describe exactly what "emergency medical services" means. Some suggested it is an umbrella term that includes all the services potentially provided by EMRs, EMTs, AEMTs and paramedics, while others felt it was more specific to activities related to emergency response.

Others reasoned that while EMS is the "core" of the profession, it does not necessarily include services such as interfacility transport, community paramedicine or service delivered by EMTs and paramedics who work in a hospital or clinic setting.

Many stakeholders felt those roles outside the traditional EMS system will continue to expand as healthcare evolves, with these practitioners possibly serving as "physician extenders" for primary care physicians or specialists.

This question—exactly what proponents of terms such as "paramedicine" or "mobile integrated healthcare" are trying to name—is at the heart of the EMS nomenclature debate. Most, if not all, stakeholders who participated in this discussion agreed that the core skills of the profession are and should remain the provision of emergency medical care in the out-of-hospital setting. However, several members of the SWG feel there is a need for terminology that refers to the entire domain of practice for these clinicians and distinguishes them from other providers, including nurses and physicians, who might also provide care as part of the EMS system.

These supporters of adopting the term "paramedicine" advocated for using the word to describe the practice of EMRs, EMTs, AEMTs and paramedics who provide protocolized health and medical care under the direction of a physician. "EMS" could still be used to specifically describe the system that prepares for and responds to emergency medical incidents.

That the terms EMS and paramedicine could live side-by-side seemed generally acceptable to the SWG, but whether they should—and whether there was any need for "new" or additional terminology—remained a point of disagreement.

THE CASE FOR A NEW TERM

One argument favoring adoption of a term other than "EMS" held that future roles of EMS clinicians could expand, making the term "emergency" less relevant. Examples could include paramedics and EMTs serving as "physician extenders" for primary care and other specialties, especially if the movement to divert people from the hospital continues influencing healthcare. At the stakeholder meeting, for example, some paramedic representatives who perform interfacility transports, both ground and flight, pointed out that the term "EMS" is often used to refer to the system activated by a 911 call, not the roles that people licensed as paramedics and EMTs may also play in healthcare outside of the prehospital EMS system.

Frequent comparisons are made to nurses and physicians. No matter where nurses practice, they are practicing nursing—in a doctor's office, a helicopter or an intensive care unit. Physicians practice medicine, whether on an ambulance, deployed with a military unit or in the operating room. Do paramedics and EMTs practice EMS? Are they practicing EMS even in another setting, such as a physicians' office or urgent care clinic? Proponents of using the word "paramedicine" say it is necessary to help define and advance the profession of the specific individuals certified as paramedics, EMTs, AEMTs and EMRs.

Advocates for a new term also point to moves by the profession in other countries, including Canada, the United Kingdom and Australia, to introduce new terminology as part of an effort to rebrand and professionalize the role of the EMS clinician.

For example, the EMS Chiefs of Canada, an organization representing leadership of EMS agencies across the country, changed its name to the Paramedic Chiefs of Canada several years ago. Canada now has two levels of paramedic, the primary care paramedic (PCP) and the advanced care paramedic (ACP), and the country also maintains the emergency medical responder (EMR) designation. The largest EMS conference in Canada is known as the Paramedicine Across Canada Expo.

THE CASE AGAINST A NEW TERM

Emergency medical care continues to be at the core of EMR, EMT, AEMT and paramedic training and practice. Many who participated in the stakeholder meetings said that as long as that remains the case, the term "emergency medical services" remains an appropriate way to describe the practice of these clinicians. In fact, using a term that doesn't acknowledge that core service could distance the profession from the public's expectations, potentially damaging the work the EMS community has done to earn the public's trust and support over the last half-century.

Because of this, using a new term to describe the discipline practiced by EMS clinicians would mean educating the profession and, eventually, the rest of healthcare, public safety and the public. "EMS" has become a well-known term, even if people don't understand exactly what it means—and the "brand" could evolve without losing the name, much like AT&T or IBM. Few people know what those abbreviations mean, or that they no longer describe the work those companies do, yet they know what they "stand for" as a brand. There was discussion about how the fire service and law enforcement brands have existed for hundreds of years; that EMS was relatively new and needed time to become as familiar to the public. Opponents of introducing any new terminology said that the debate itself was about an identity crisis that doesn't exist. They also contended that terminology used in other countries was irrelevant to the conversation about what terms should be used in the United States.

With other pressing issues facing the profession, introducing new terminology, they concluded, was only a distraction from the more significant challenges facing local EMS systems across the country.

THE LOGISTICAL CHALLENGES OF CHANGE

Many stakeholders represented in the Nomenclature of the EMS Profession meetings agree that introducing new terms could potentially present logistical challenges and would not be easy. The extent of those challenges was where opinions differed.

Stakeholders disagreed on whether regulatory or legislative change would be required to adopt a new term such as "paramedicine" to describe the domain of practice, for example. Already, some national organizations are using the term, without any obvious legal or regulatory consequences. However, more extensive adoption and use by local services or organizations could potentially raise concerns. Any changes to provider-level nomenclature (e.g., "paramedic," "EMT") would clearly require legislative and regulatory changes in most, if not all, States.

Opponents also contended that other logistical and financial hurdles existed, some as basic—yet costly—as changing labels on apparatus and uniforms or amending policies.

Advocates for adopting new terminology stated that a new phrase to describe the domain would not require immediate changes at the local level, where agencies could still describe their services as EMS. Instead, they said, the new term would fill a void to describe something that has no appropriate term currently. In addition, any changes could be phased in over many years. Advocates for changing the terminology used to describe the domain of practice and individuals who practice it said that logistical challenges should not prevent the profession from preparing for its future, and that putting off the conversation any longer would only reinforce the status quo.

PUBLIC FEEDBACK

Comments were received from more than 30 members of the public. Members of the SWG were given the opportunity to review the comments and they were each considered during the group's discussions and the development of this summary.

Generally, the public comments reflected the SWG's conversations in their diversity of opinion and lack of consensus on nomenclature and on the definition of "emergency medical services." They were also mixed on whether the public does or does not understand the current terminology.

CONCLUSION

The Nomenclature of the EMS Profession SWG meetings and additional stakeholder input facilitated vigorous discussion of issues that strike at the heart of what the profession is, and what it will become. No consensus was generated around the need for new nomenclature nor a framework, workplan, or policy analysis regarding effects potentially caused by use of new nomenclature.

During the final teleconference, one participant suggested further research would help shed light on the issue, including what the potential costs—both financial and others—would be of adopting new terminology. Another participant disagreed, arguing that the lack of consensus or a clear mandate from the profession was enough of a reason to stop debating the topic and focus on other things. Stakeholders did agree, though, that regardless of terminology, members of the EMS community should find ways to work together to ensure our partners in healthcare and public safety, as well as the public, better understand what EMS is and the value it provides.

In the end, the lack of consensus likely means the issue is not going to be set aside but will remain a topic of discussion among members of the profession. It will be critical for Stakeholders to find ways to examine the multiple facets of the nomenclature discussion as objectively as possible, focusing on the future of the profession and not current assumptions or constraints. While the right answer for the profession may or may not be the current terminology, that decision should not be based merely on tradition, conjecture or a reluctance to change, but rather on a true effort to determine what is best for clinicians, patients and communities.

PROJECT PARTICIPANTS

Stakeholder Working Group

The project team asked several organizations to participate in the Stakeholder Working Group for the Nomenclature of the EMS Profession project. Invited organizations and the individuals they designated to participate are listed here.

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Organizational Liaison Group

Dozens of organizations not included in the Stakeholder Working Group were invited to attend meetings and participate at certain points in the conversation. Organizations who participated and their designated liaisons are listed here.

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