Self-regulation and Medical Direction: conflicted approaches to monitoring and improving the quality of clinical care in Paramedic Services

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Introduction

- Background and Study Aims
- Research Methods
- Preliminary Findings
- Discussion
- Conclusions
- Questions

North American Background

† In the North American context, medical direction is generally taken as a given and considered essential to a well-functioning paramedic service

- Paramedics continuing capacity to practice and remain employed is dependent on re-credentialing by the medical director
- Medical direction involves the all-encompassing roles of signing off on protocols and implementing best practice

† There is no strong evidence that medical direction makes a difference

- See our coming review paper, **O'Meara, P.** Wingrove, G. Nolan, M. 2017 Clinical leadership in paramedic services: a narrative review. *International Journal of Health Governance* 22(4)

International Background

† Those operating in systems where paramedics are recognised and practice as autonomous health practitioners find the medical direction model perplexing, while those aspiring to self-regulation find it frustrating

† In other high-income countries with highly developed paramedic services, medical officers have a role as advisors with limited formal power

- Outcomes are as good or better than the North American system
- Why might this is the case?

Study Aims

The purpose of this study was to describe and unpack paramedic service clinical monitoring and improvement systems in North America from the perspective of paramedics and paramedic managers as expert informants.

The specific aims of the study were to:

1. Describe and compare the essential elements of medical direction and clinical governance (if possible) in paramedic services
2. Determine the respective rationale and history of each approach to monitoring and managing the quality of paramedicine clinical services
3. Identify the strengths and weakness of medical direction (and if possible self-regulation and clinical governance) in the paramedicine context
4. Consider the implications of the findings, and determine how each of these approaches to quality assurance can inform the other

Methods (1 of 2)

Case study approach

†Study Sites

- The U.S. organisation was a hospital-based EMS provider that was servicing a large transient community attending an extended cultural event in a remote location over a period of two weeks. Additional personnel temporarily engaged from other parts of the U.S. and internationally for this event
- The Canadian organisation was an established, government-funded paramedic service operating in a remote location

†Participants

- Sixteen paramedics and paramedic managers were purposively recruited and interviewed - seven from the Canada and nine from the U.S. sites. Participants had trained in the US, Canada, UK and Australia
- In-depth interviews were audio-recorded and later transcribed for thematic analysis

†Ethics Approval

- The University Human Research Ethics Committee gave approval for the study. Approval for the Canadian arm of the study obtained through a local Scientists and Explorers Act. The U.S. site accepted the University Human Research Ethics Committee approval

Methods (2 of 2)

- Local investigators invited paramedics and paramedic managers to participate in the study
  - Study was explained to each participant in detail, consent obtained , and then interviews were conducted in a private setting
  - Interview times varying from 9 minutes to 46 minutes, with most taking approximately 20 minutes

- These paramedics and paramedic managers gave their expert perspective on the topic of quality monitoring and assurance
  - Each described the clinical quality monitoring and assurance system that operated in their paramedic service, outlined its essential elements, strengths and weakness

General Findings

- Wide range of issues identified that related to quality monitoring and assurance
  - The more senior and experienced participants providing more information and greater insight
  - Little evidence that quality monitoring and assurance is part of entry-level paramedic education and training in North America

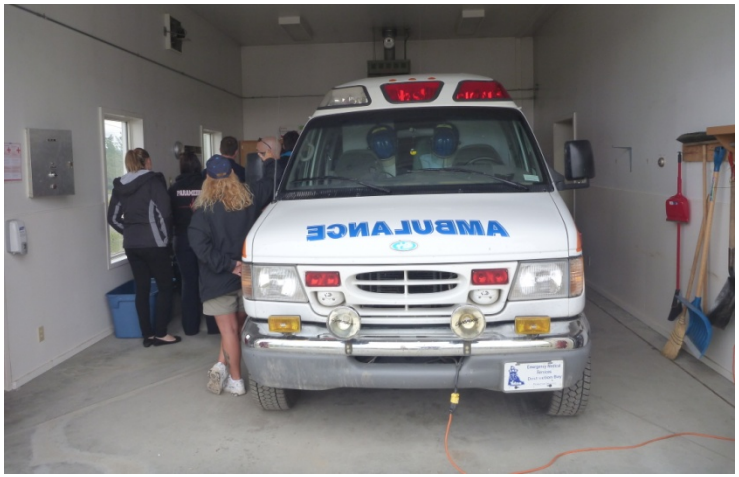
- Those participants who had trained and worked in the North America generally saw medical directors leading and implementing these processes
  - Those who had trained and worked in the U.K. and Australia identified clinical governance as the preferred approach

- A smaller number of participants identified self-regulation as a way forward

Thematic Findings

†The participants identified three inter-related themes clustered around:

- Resourcing, fragmentation and regulatory frameworks
- Independent practice facilitators and barriers
- Paramedic roles and professionalization



Resourcing, fragmentation and regulatory frameworks (1 of 2)

† Smaller paramedic services often relied upon ‘personality driven’ quality assurance systems, with the medical director being the key to action

> *It’s a small, small organisation …, so I can actually email the medical director when we have one and make suggestions directly and things like that, and get feedback almost immediately via email or face to face conversations and things like that because you run into those people, so there is personal sort of affect there as well. (Participant 4)*

† Paramedic services operating in larger geographic, often at state or provincial levels, had more access to the resources and infrastructure required to implement and maintain effective and sustainable quality assurance systems

Resourcing, fragmentation and regulatory frameworks (2 of 2)

† One of the challenges in the United States is a fragmented system design where there are many different providers, and each region has the ability to set its own clinical standards, credentialing standards and critical protocols

We have a service where three different medical control areas that each have their own independent medical protocols, their own medical independent medical oversight and credentialing process, and their own independent quality review processes. (Participant 12)

I think that having one medical director creates a subjective bias that changes the whole view over the service and that is one, one of the things that I think has created a huge disparity between EMS services across the United States. (Participant 11)

Independent practice facilitators and barriers (1 of 3)

† One perspective was that medical direction provides a level of safety because paramedics are not clinicians in their own right

Self governance, you know I think we're treading on thin ice there. You know the doctors are the trained professionals and we're like one of their hands or we're their eyes or something okay. We don't have all of the stuff that we need for self evidence and I think that a doctor is always going to need to be there, a medical director somebody who can, who can see what's needed and can twist things and move them a little bit right or left to, to fit the exact situation. (Participant 9)

† Others felt that Clinical Practice Guidelines would allow paramedic practitioners to practice the best quality of care, rather than be dependent on medical director oversight

The education system (paramedic) has evolved over the years, however the power of the doctor has not. (Participant 2)

International Perspective

… the graduating paramedic should have the core foundation elements to practice under supervision, and that, at the end of the graduate induction period of up to one year, the paramedic should be ready to practice independently. (CAA Professional Competency Standards)

Independent practice facilitators and barriers (2 of 3)

† There was considerable deference given to doctors that bordered on 'doctor worship' borne of an apparent professional inferiority complex that might be explained as a result of having gone through a paramedic education system based on skill acquisition and rote learning rather than critical thinking and independent decision-making

† There were strong calls for improved education systems that would lead to better regulatory systems and a stronger knowledge base for the profession

If I was going to create a new system I would do one of two things, I'd make sure that everybody went through a college education or a professional education that they were certified, that they were licensed not certified, licensed at a minimal level same as nurses, same as physicians. (Participant 11)

Independent practice facilitators and barriers (3 of 3)

† Perhaps because of uncertainty about paramedics' willingness to professionalise, some participants conveniently singled out for criticism those doctors who had been paramedics

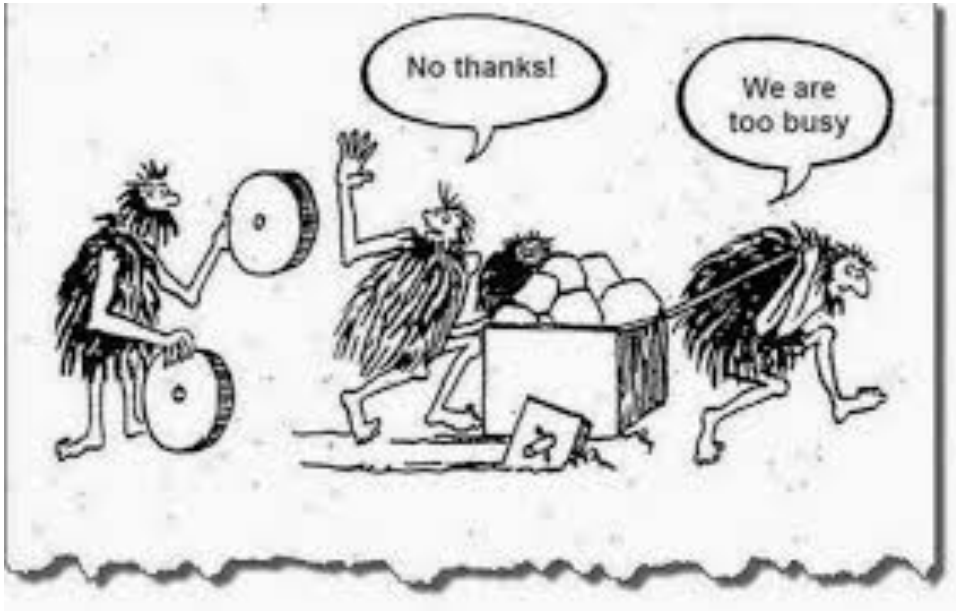
I get concerned about a lot of doctors who used to be paramedics who think that they're just like the paramedic on steroids now because they're a doctor. They really have no current understanding of paramedicine and what it takes, because it's more than just the just the skills, it's the everything that goes with the package that provides the skills. But they still think of it as skills. … There are people out there that people practically worship … it just blows my mind because they have done nothing to progress our profession, if they had we wouldn't be in the position we are right now. (Participant 15)

Paramedic roles and professionalization (1 of 3)

† Participants were keen to argue that change was required, and they could see new roles emerging such as community paramedicine

† Prospects for self-regulation were mixed, with some optimistic, while others expressed the view that paramedicine lacked the maturity to take this step toward autonomous practice

† Some were critical of existing professional associations who currently lack the traction to change the status quo



Paramedic roles and professionalization (2 of 3)

† At an individual level, the participants expressed aspirations to improve the EMS system and their own paramedic services in particular. Some felt that self-regulation and professional pride were linked concepts.

In the ideal world in the US, Paramedics would take personal responsibility and accountability for everything that they did clinically or otherwise and would always be looking for opportunities for improvement of themselves, so by improving one-self you raise the whole system up. So kind of one grain of sand at a time, building that up and you would have no need for management to come around with a big hammer. (Participant 15)

Paramedic roles and professionalization (3 of 3)

† Broader knowledge and understanding of how self-regulation and clinical governance could have an impact on quality and safety was scant
  - There was a cry for better monitoring and improvement systems that would make a difference to paramedic practice and improve patient outcomes

† Limited understanding of the distinction between governance, management and practice
  - Participants often saw little alternative to the all-encompassing medical director role where these roles are often blurred (not best governance practice)
  - This fall back to embracing ‘personality driven systems of quality monitoring and improvement seems to stand in the way of consistent and sustainable improvement in paramedic practice, greater levels of professionalization and self-regulation

Discussion

- Medical direction has a strong hold over paramedicine in North America
  - Paramedics have little power to change the system and often know little about the alternatives such as self-regulation and clinical governance
- The lack of adequate resourcing for paramedic services and paramedicine as a discipline makes any change challenging
  - Incremental change is happening with paramedic roles and scopes of practice expanding in both depth and breadth
  - In Canada the push toward self-regulation is advancing rapidly despite opposition
- Participants had their own visions for the future that varied from maintaining the status quo to the professionalization of paramedicine through research and education, professional self-regulation and the development of a paramedicine professional identity
  - Few considered changes that might enable paramedics to be a self-regulating health profession working in collaboration with other health professionals, rather than as a companion profession to medicine

Conclusions

- Prospect of change or melding of medical direction and clinical governance depends on:
  - Taking a long term approach
  - Building a professional identity, underpinned by paramedic research and education that matches independent paramedic practitioner roles and scope of practice
  - Reducing fragmentation and encouraging paramedic leadership
  - Improving sustainability through adequate resourcing and regulatory frameworks

One can choose to go back toward safety or forward toward growth. Growth must be chosen again and again; fear must be overcome again and again.

~Abraham Maslow~

Thank you

Questions?

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