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Australasian pre-hospital care is in a unique place compared to North America, the Middle East and Europe where our education base provides the launching pad for greater involvement in the direction of the fledgling profession.

As it stands, less than half the world has formal pre-hospital care systems. In France, Germany, Austria, Greece, Malta and most of the Nordic countries the highest level of ambulance-based clinicians are physicians. These doctors staff ambulances, usually accompanied by a medical technician/paramedic. This system of delivery is generally referred to as the 'Franco-German' model of Emergency Medical Services (EMS) (1).

In contrast, Canada, the United States, the United Kingdom (UK), the Republic of Ireland, most of the Middle East and South Africa have advanced pre-hospital care systems that follow what is known as the 'Anglo-American' EMS model. This is a system in which the highest levels of ambulance-based clinicians are paramedics (1).

In the United States, parts of Canada, New Zealand, and the Middle East, paramedics are allowed by law to perform controlled medical acts because they have been delegated to do so by a physician (2). In the UK, the Republic of Ireland, parts of Canada, and South Africa, which also follow the Anglo-American model, a paramedic's authority to practice derives from their own personal licence to practice paramedicine, as authorised by the Health and Care Professions Council (UK) (3), the Pre-Hospital Emergency Care Council (Ireland) (4), the various Provincial Ministries of Health (Canada) (5) or the Health Professions Council of South Africa (6), respectively.

In Australia, the authority to practise for a state ambulance service paramedic derives not from their own licence, nor from the licence of another medical professional, or indeed from the licence of any single person, but instead from delegation by the corporate entity for which they work. It is the ambulance service itself (7) which delegates to paramedics the legal privilege of performing controlled medical acts. This is an interesting situation because most states do not prescribe how the scope and standards of practice are to be determined. Instead it is left up to the ambulance service to determine their own standards of practice and clinical practice guidelines (CPGs) as they see fit.

This model of delegation positions Australian paramedics somewhere between the Anglo-American and Franco-German EMS models and creates a unique opportunity for clinical leadership. Unlike some parts of the world where pre-hospital care services legally must have a licensed physician as a medical director, or other parts of the world where paramedics work under their own licence, Australian paramedics have the ability to assume the clinical leadership of the ambulance services for which they work. In the past, Australian paramedicine has relied heavily on physicians acting as ambulance service 'medical directors' for clinical leadership. This practice has both benefits and drawbacks. On the one hand there is no doubt about the value of the medical education and experience medical directors bring to the table. As medical experts, the medical directors are invaluable in informing clinical practice. Many of the existing state ambulance services in Australia have grown into maturity under the direction of a passionate and dedicated medical director who championed the development of paramedicine.

However, having medical directors as the lead clinician in a pre-hospital care system brings certain challenges as well; without extensive exposure to the pre-hospital setting, medical directors aren't as familiar with the subtle complexities of the pre-hospital environment as paramedics are, and they can fail to appreciate the effects of this unique clinical environment on delivering care. Additionally, without a great deal of exposure to paramedics and their practice it is easy for medical directors to under, or overestimate the capabilities of the paramedic workforce. Furthermore, the most capable physicians – the ones we want providing clinical support to pre-hospital care systems – are usually in demand for leadership roles within their own profession and therefore less available to take on the demanding role of medical director. Finally, medical school focuses on training people to be expert clinicians, and not necessarily clinical leaders of highly specialised, mobile, state-wide medical systems comprised of other healthcare professionals. Being an expert emergency physician, or one from another discipline, doesn't necessarily mean you understand how to write CPGs for paramedics, or how to work with the Medical Priority Dispatch System (MPDS).

Could paramedics fulfil the important role of clinical leadership in traditional ambulance services in Australia? Legally there is nothing to prevent it, but how do we mobilise and develop the talent pool within the ranks of paramedics to provide clinical leadership? As it stands today Australasian paramedicine appears to be in the process of consolidating the following clinical ladder:

Undergraduate degree

- Produces Advanced Life Support Paramedics focusing on the care of out-of-hospital patients

Postgraduate Diploma

- Produces Intensive Care Paramedics focusing on the care of the most acutely ill out-of-hospital patients

Master's degree

- Produces paramedic practitioners focused on practicing with enhanced autonomy in specific clinical settings that extend beyond the 'traditional ambulance service' context, specifically (8):
 - Community/extended care paramedic focusing on the extended care of out-of-hospital patients with a clinical goal to keep patients out of hospitals.
 - Retrievalist/critical care paramedic focusing on the inter-facility transport of medically complex patients at an 'intensive care unit' level.
 - Remote/disaster care paramedic, focusing on the extended care of patients in a remote or disaster setting.

What comes next? Traditionally paramedics who want to further their career have either pursued a research-based PhD and gone into higher education, or pursued a Masters of Business Administration (MBA) or managerial studies and gone into operational management. But could there be another path? Could we develop the clinical ladder to prepare paramedics to assume the role of clinical leadership of formal prehospital care systems?

Enter the 'consultant paramedic'. In the UK all of the National Health Service (NHS) Health Trusts have a consultant paramedic and one service (East Midland Ambulance Service NHS Trust) has three. Qatar (in the Middle East) is actively hiring seven consultant paramedics from around the world and the National Ambulance service in Abu Dhabi is exploring creating consultant paramedic roles. It's an idea that is spreading.

Consultant paramedics are the clinical leaders of the profession, and they oversee the clinical advancement and governance of the prehospital care system in which they work. Clinical advancement is a straightforward concept but 'clinical governance' is a term that might not be as intuitively obvious, and so requires definition using a range of questions. An ambulance service can be seen to have good clinical governance if it can answer 'yes' to the following questions.

- (1) Does the service have clear, current, understandable, and reliably disseminated evidence-based CPGs?
- (2) Do all the paramedics understand the CPGs, and do they regularly demonstrate competence?
- (3) Do all paramedics appreciate and respect the role and importance of the CPGs?
- (4) Do all paramedics actually practise clinically according to the CPGs?
- (5) Does the service have a clear understanding of when and how paramedics stray from the CPGs?
- (6) Does the service understand why paramedics stray from the CPGs?
- (7) Does the service have a way of managing the consequences to patients of medical misadventures as a result of straying from the CPGs and is this regularly done? To what effect?
- (8) Does the service have a way of managing individual clinicians who stray from the CPGs and is this regularly done? To what effect?
- (9) Does the service have an understanding of the effectiveness of the CPGs when they are practised appropriately? How effective are they?
- (10) Is there a continuous quality improvement cycle in place to measure and manage the performance levels for each of the above criteria?

Consultant paramedics in the UK also take an active role in being an advocate for, and the voice of, the profession to external bodies. They represent paramedicine to other healthcare provider groups and both governmental and non-governmental agencies, including acting as expert witnesses and advisers at inquests, trials and development groups (9).

If paramedics are to attain recognition as a true profession in Australia there are still several important characteristics that need to develop in addition to becoming officially regulated (10). Among these are such important elements as developing a unique body of knowledge and having the autonomy to collectively direct the development of our own clinical practice. Consultant paramedics will contribute directly to the development of these attributes.

A consultant paramedic in the Australian context could be a paramedic practitioner who has undergone education and training at the doctorate level in order to allow them to take on clinical leadership of a prehospital care system as well as a leadership role in the development of the profession. In order to fulfil their various roles their training would likely address the following:

Professional Doctorate

- Produces consultant paramedics.
- Education would focus on a detailed and applicable understanding of areas such as:
 1. Clinical governance, encompassing such areas as evidence-based-medicine, research and evidence translation.
 2. Clinical quality assurance, focusing on such areas as performance measurement and interpretation, root cause analysis, and other 'medical misadventure' investigations.
 3. Clinical quality Improvement, focusing on such areas quality improvement systems, and human factors design.
 4. Clinical education, focusing on evidence based education, clinical simulation, field-education, and best practices in student evaluation.
 5. Clinical management and leadership, focusing on such areas as hard and soft sources of power, people skills, ethics and legalities.
 6. Research, focusing on the discovery, creation and interpretation of paramedic specific research as well as the area of evidence translation (turning the evidence into useable standard operating policy).
 7. Professionalism, understanding the evolution of professional groups, the tools of change that allow trades to evolve into professions and how to effectively utilize these tools to the advantage of paramedicine.

In the future the most appropriate individual to lead the clinical practice of paramedicine is a paramedic who has been trained specifically to be an expert in the system factors of clinical governance, advancement, and professional leadership. If the fledgling profession wants to take this next step it's time to start thinking about where we need to put our feet. Developing a training pathway for consultant paramedics will give us our first generation of dedicated clinical and professional leaders. The time has come to begin the development of the Australian consultant paramedic.

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