Who does what in prehospital critical care? An analysis of competencies of paramedics, critical care paramedics and prehospital physicians

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ABSTRACT

Introduction Emergency medical services in the UK are facing the challenge of responding to an increasing number of calls, often for non-emergency care, while also providing critical care to the few severely ill or injured patients. In response, paramedic training in the UK has been extended and there are regional strategies to improve prehospital critical care (PHCC). We describe the clinical competencies of three groups of prehospital providers in the UK with the aim of informing future planning of the delivery of PHCC.

Methods We used a data triangulation approach to obtain lists of competencies for paramedics, critical care paramedics (CCPs) and PHCC physicians of the Great Western Ambulance Service. Data sources were professional guidance documents, equipment available to the provider, log sheets of prehospital care episodes, direct observations and a survey of providers.

Results We identified 389, 441 and 449 competencies for paramedics, CCPs and PHCC physicians, respectively. Competencies of CCPs and PHCC physicians which exceeded those of paramedics can be arranged in four distinct clusters: induction and maintenance of anaesthesia, procedural sedation, advanced cardiovascular management and complex invasive interventions.

Discussion Paramedics possess a considerable number of competencies which allow them to diagnose and treat a variety of conditions. CCPs and PHCC physicians possess a few additional critical care competencies which are potentially life-saving but are required infrequently and can carry significant risks. Concentration of training and clinical exposure for a small group of providers in critical care teams can help optimising benefits and reducing risks of PHCC.

INTRODUCTION

Emergency medical services (EMS) in England are facing two challenges relating to the skills and knowledge required from prehospital practitioners. On the one hand, emergency call volumes are increasing, in particular for non-emergency care needs. As a consequence, the traditional focus of paramedic practice, immediate treatment and transport of life-threatening illness and injuries, has shifted towards assessment and treatment for a large variety of non-life threatening conditions.

The paramedic profession has responded to this challenge with enhancement of training requirements and sub-specialisation such as emergency care practitioners with additional primary care competencies. This increased volume of urgent care episodes, however, means that the individual paramedic will only rarely encounter critical illness or injuries, with important implications for skill maintenance. On the other hand, reports over the last decade have repeatedly highlighted shortcomings in the provision of prehospital care for critically ill patients. Developments to improve the situation in the UK included increasing utilisation of physicians to deliver prehospital critical care (PHCC physicians) and training programmes for critical care paramedics (CCPs). However, considerable controversy remains about what constitutes PHCC, if it is needed in the UK and who should be providing it.

In 2008, The Great Western Ambulance Service (GWAS) established a critical care team (CCT) consisting of CCPs and PHCC physicians in Southwest England. This study examines the clinical competencies of paramedics, CCPs and PHCC doctors working within GWAS with the aim of informing future discussions and planning around prehospital critical care.

METHODS

Great Western Ambulance Service

The GWAS National Health Service (NHS) Trust provided prehospital care for the counties Wiltshire, Gloucestershire and Avon in Southwest England. The trust covered an area of 3000 square miles with a population of approximately 2.4 million people. It operated 31 ambulance stations, two emergency operations centres and two air ambulances, the Great Western Air Ambulance and Wiltshire Air Ambulance. Between 2011 and 2012, GWAS responded to approximately 273 000 emergency calls. In February 2013, it merged with the South West Ambulance Service NHS Trust; at this time, data collection for this study was completed.

Paramedics

Paramedics in the UK are registered healthcare professionals who can deliver care independently. Traditionally the route to becoming a paramedic was by working within a NHS ambulance service, moving from a transport role to a provider role with increasing experience. This system has been replaced with university or EMS-based programmes in paramedic science, approved by the Health and Care Professions Council, with the university programmes leading to foundation degrees and/or BSc honours degrees in paramedic science. The programmes last at least 2 years of full-time equivalent and include both theory and practical clinical experience, including several weeks in various hospital departments. Paramedics are able to administer certain drugs and deliver invasive interventions,
following the clinical guidelines regularly reviewed and updated by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) and their employing ambulance service.

**Prehospital CCT**

In 2008, the GWAS NHS Trust established a prehospital critical care service provided by a team of senior physicians and specially trained ‘CCPs’. The GWAS CCT attends all types of prehospital emergencies including medical, trauma and paediatric cases. The service is delivered using a combination of helicopter transport (provided by the Great Western Air Ambulance) and fast response road vehicles covering the GWAS territory. For roughly 80% of shifts, the CCT consists of one PHCC physician (senior trainee or consultant in emergency medicine, critical care or anaesthesia) and one CCP. If no physician is available, two CCPs can form the team; however, certain interventions such as rapid sequence induction are not undertaken without a physician present. To undertake prehospital work, the PHCC physicians complete a training programme with specified competencies and mentored practice, coupled with theoretical and simulation training. CCPs are experienced paramedics who have completed a university-based theory and practical training course with mentoring and supervised experience, followed by the successful completion of a comprehensive qualifying assessment.

**Data collection**

Between September 2012 and January 2013, competencies were collected for three prehospital provider groups: paramedics working on GWAS ambulance and rapid response vehicles, CCPs and PHCC physicians working within the GWAS CCT. For each group, competencies were determined from five data sources to allow for triangulation:

1. Professional guidance documents or standard operating procedures (SOPs)
2. Equipment available to the provider
3. Log sheets of prehospital care episodes
4. Direct observations
5. Survey of providers of each group.

One researcher (JVVF) analysed and coded all the data.

For the paramedic group, competencies were extracted from the JRCALC’s ‘UK Ambulance Service Clinical Practice Guidelines 2006’. Equipment available on GWAS double-crewed ambulance and rapid response vehicles and the content of the GWAS paramedic drug bag represented the second source of data. GWAS ‘patient care forms’ (PCFs) were chosen from a convenient sample of paramedic care episodes and analysed until saturation was achieved. Likewise, JVVF observed paramedics working on ambulances (paired with an ambulance technician) and on rapid response vehicles. All registered paramedics working within GWAS were eligible to participate and written consent was obtained. Saturation was defined as 10 consecutive analyses of PCFs or five consecutive direct observations not revealing any new competencies. Competencies were extracted following a previously published approach and were separated into five different categories: patients’ conditions, diagnostic competencies, medications, therapeutic interventions and clinical decisions. (See table 1 for an example of competencies)

**Table 1** Example of paramedic competencies identified from the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guideline on chronic obstructive pulmonary disease (COPD) and their confirmation through the additional four data sources

| Category          | Competency          | Source | JRCALC guideline | Inventory | Patient care forms | Observation | Provider survey |
|-------------------|---------------------|--------|------------------|-----------|--------------------|-------------|-----------------|
| Condition         | COPD                | •      | •                | •         | •                  | •           | •              |
|                   | Dyspnoea            | •      | •                | •         | •                  | •           | •              |
|                   | Pneumonia           | •      | •                | •         | •                  | •           | •              |
|                   | Pneumothorax        | •      | •                | •         | •                  | •           | •              |
|                   | Heart failure       | •      | •                | •         | •                  | •           | •              |
|                   | Pulmonary embolism  | •      | •                | •         | •                  | •           | •              |
|                   | Lung cancer         | •      | •                | •         | •                  | •           | •              |
|                   | Anaphylaxis         | •      | •                | •         | •                  | •           | •              |
|                   | Airway obstruction  | •      | •                | •         | •                  | •           | •              |
|                   | Hypoxia             | •      | •                | •         | •                  | •           | •              |
| Diagnostic        | Current medication  | •      | •                | •         | •                  | •           | •              |
|                   | Past medical history| •      | •                | •         | •                  | •           | •              |
|                   | Timeline of events  | •      | •                | •         | •                  | •           | •              |
|                   | Airway patency      | •      | •                | •         | •                  | •           | •              |
|                   | Respiratory rate    | •      | •                | •         | •                  | •           | •              |
|                   | Breathing pattern   | •      | •                | •         | •                  | •           | •              |
|                   | Auscultation of lungs|    | •                | •         | •                  | •           | •              |
|                   | Cyanosis            | •      | •                | •         | •                  | •           | •              |
|                   | Pulse oxymeter monitoring| | • | • | • | • | • |
|                   | ECG monitoring      | •      | •                | •         | •                  | •           | •              |
| Medication        | Salbutamol (nebulised) | •  | • | • | • | • |
|                   | Ipratropium bromide (nebulised) | • | • | • | • | • |
|                   | High flow oxygen    | •      | •                | •         | •                  | •           | •              |
| Intervention      | Intravenous cannulation  | •  | • | • | • | • |
|                   | Oxygen (titrated to 90%–92%) | • | • | • | • | • |
| Clinical decision | Clinical response to nebulised salbutamol | • | • | • | • | • |

* a given competency was identified.
identified from the JRCALC 2006 guidelines on chronic obstructive pulmonary disease.)

For the CCP group, documents analysed were the 2006 JRCALC guidelines and the GWAS CCT SOPs. Equipment on the helicopter and rapid response vehicle available to the CCT and the paramedic and critical care drug bags were analysed. Extraction of CCP competencies from PCFs and direct observations was undertaken as described for the paramedic group.

Documents analysed for PHCC physicians’ competencies were the Intercollegiate Board for Training in Pre-hospital Emergency Medicine’s curriculum framework for subspecialty training in prehospital emergency medicine13 and the GWAS CCT SOPs. Extraction of PHCC physicians’ competencies from PCFs and direct observations was undertaken as described for the paramedic group.

During the next step of the triangulation process, three prehospital care providers of each group were asked to review a preliminary list of all competencies accumulated from the above process. They were able to either agree or disagree to each competency being accurate for their own professional group, as well as adding free text comments and adding competencies which were deemed to be missing from the preliminary list.

Finally, competencies were considered to be accurate for each group (paramedics, CCPs or PHCC physicians) if they were identified by at least two of the five sources of data. Competencies only identified by prehospital providers were also included if at least two providers of the corresponding group agreed on the inclusion. (See table 2 for a summary of data sources for each professional group.)

RESULTS

Saturation for competencies extracted from GWAS patient care records was achieved after 93, 55 and 53 care episodes for paramedics, CCPs and PHCC physicians, respectively. For direct observations, saturation was achieved after 35, 30 and 24 care episodes, respectively.

We identified 389, 422 and 449 competencies for paramedics, CCPs and PHCC physicians, respectively. In addition, CCPs possessed 19 competencies which required discussion with a senior physician (consultant) prior to execution. (See table 3 for classification of competencies for each professional group.)

Group-specific competencies

We identified a total of seven competencies which were unique to paramedics. These were low-acuity conditions such as constipation, reduced mobility in the elderly (non-traumatic), cellulitis and wound infection, medications not used by the CCT (oral morphine and tetracaine gel) and the clinical decision of requesting CCT support.

Except for these seven competencies, CCPs’ competencies matched those of their paramedic colleagues. CCPs competencies included an additional six conditions, two diagnostics, 14 interventions, 23 medications and 14 clinical decisions. Thematically, these can be arranged into distinct clusters: maintenance of anaesthesia in patients with return of spontaneous circulation who were intubated during cardiac arrest, procedural sedation, invasive interventions and advanced cardiovascular management. (See table 4 for examples of competencies for each of the four clusters.)

PHCC physicians were able to provide all competencies identified for CCPs plus an additional eight competencies (see table 5).

DISCUSSION

Paramedic competencies

GWAS paramedics possess a considerable number of diagnostic and interventional competencies which allows them to diagnose and treat a large variety of conditions in the prehospital environment. The number of paramedic competencies found (389) is comparable with the results of a study of Dutch EMS, which used similar methods and identified 438 competencies for Dutch ambulance nurses and 500 competencies for Dutch prehospital physicians.12 While the methodology of the studies does not allow comparison between different systems, it is reassuring that the amount of provider competencies found are similar for comparably advanced EMS.1 12 Paramedics are often the first point of contact between the patient and the healthcare system for acute episodes of illness, and information at the time of dispatch is often limited.1 It is therefore essential that paramedic competencies enable them to assess and initiate treatment for conditions ranging from epistaxis or a febrile child to immediate life-threatening situations such as major trauma or cardiac arrest.

Table 3 Professional groups and number of competencies

|                        | Paramedics | CCPs  | PHCC physicians |
|------------------------|------------|-------|-----------------|
| Condition              | 187        | 189   | 189             |
| Diagnostic             | 50         | 52    | 52              |
| Medication             | 38         | 59*   | 62              |
| Intervention           | 84         | 98†   | 102             |
| Clinical decision      | 30         | 43‡   | 44              |
| Total                  | 389        | 441   | 449             |

*Of which 10 require discussion with a consultant.
†Of which four require discussion with a consultant.
‡Of which five require discussion with a consultant.

CCP, critical care paramedic; PHCC, prehospital critical care.

Table 2 Professional groups and respective data sources

|                        | Paramedics          | CCPs               | PHCC physicians       |
|------------------------|---------------------|--------------------|-----------------------|
| Professional guidance and SOPs | JRCALC guidelines | JRCALC guidelines | IBTPHEM curriculum |
| Equipment              | DCA and RRV;        | CCT RRV and helicopter; | CCT RRV and helicopter; |
|                        | paramedic drug bag  | CCP drug bag       | CCT drug bag          |
| Log sheets             | GWAS PCFs          | GWAS PCFs         | GWAS PCFs             |
| Direct observation     | Paramedics on DCAs and RRVs | CCPs on RRVs | PHCC physicians on RRVs |
| Provider survey        | Three paramedics    | Three CCPs        | Three PHCC physicians |

CCP, critical care paramedic; CCT, critical care team; DCA, double-crewed ambulance; GWAS, Great Western Ambulance Service; IBTPHEM, Intercollegiate Board for Training in Pre-hospital Emergency Medicine; JRCALC, Joint Royal Colleges Ambulance Liaison Committee; PCF, patient care form; PHCC, prehospital critical care; RRV, rapid response vehicle; SOP, standard operating procedure.
Critical care competencies

CCPs and PHCC physicians of the GWAS CCT possess a relatively small number of additional competencies which relate to induction and maintenance of prehospital anaesthesia, procedural sedation, advanced cardiovascular management and complex invasive interventions. While only a small majority of patients for whom EMS are activated will require this level of support,1 2 3 4 5 6 the National Confidential Enquiry into Patient Outcome and Death 2007 report identified the lack of these skills in the prehospital care of major trauma patients as an important contributor to unfavourable outcomes.7 Further research indicates that severely ill or injured patients benefit from competently delivered prehospital critical care.8 9 10 11 12 13 Views on how to best provide this level of care for a small fraction of patients differ.14 Attempts to introduce critical care skills to the general paramedic provider were made in San Diego, but showed unfavourable outcomes for paramedic rapid sequence induction of anaesthesia.15 This is likely due to the inherent complexity of critical care interventions, which require extensive training, regular exposure and effective clinical governance to maximise benefits and minimise associated risks.16 17 18 An alternative approach, which has been adopted within GWAS and other ambulance services in the UK and internationally, is the concentration of training and clinical exposure for a small group of prehospital providers in CCTs.9 10 11 Dedicated dispatch of CCTs to severely injured patients, often covering large geographic areas by helicopter, has been shown to improve outcomes for trauma patients.12

Paramedics versus physicians in prehospital critical care

While the benefits of prehospital critical care, if applied judiciously, are generally accepted,19 20 21 controversy remains regarding which prehospital providers should be delivering it.22 23 The CCPs in this study possessed the same critical care competencies as the PHCC physicians with the exception of those needed for rapid sequence induction of anaesthesia, fascia iliaca nerve block, thoracotomy and peri-mortem caesar-ean section. To attain these competencies, GWAS CCPs receive initial practical and theoretical training, undergo a sign-off process during work-based placements and participate in regular audit and clinical governance activity. They regularly work alongside senior PHCC physicians and attend hospital shifts with the chance to get clinical feedback. In addition, 19 of the 59 CCP-specific competencies require the CCP to discuss the case and treatment plan with the senior consultant on-call. We believe that this combination of training, exposure and supervision allows successful paramedic-delivered prehospital critical care.20 PHCC physicians play a vital role in pre-hospital critical care; their experience from hospital-based critical care allows them to undertake interventions that are currently beyond the scope of CCP training. In addition, physician supervision of CCP practice has been shown to be beneficial.24

LIMITATIONS

The methods of data extraction from the different data sources in this study depend to a certain degree on subjective interpretation. It is therefore entirely feasible that the findings of another research would differ at least marginally.12 We therefore cannot view the presented competencies as absolute findings which can be used to compare between EMS. However, comparison between the groups in this study remains valid, as data for all groups have been reviewed by the same investigator. Also, this study does not evaluate the quality of performance for any given competence nor does it investigate complex interactions such as leadership, teamwork or non-medical aspects of prehospital care such as patient extrication.

CONCLUSIONS

Paramedics in the UK possess a considerable number of diagnostic and interventional competencies. CCPs and PHCC physicians possess additional competencies enabling them to undertake prehospital anaesthesia, procedural sedation, advanced cardiovascular management and complex invasive interventions. The optimal training, skill maintenance and delivery to the scene of these competencies need to be considered by ambulance services to provide effective prehospital critical care.
Prehospital care

Acknowledgements We like to thank all the paramedics, critical care paramedics and prehospital physicians of the Great Western Ambulance Service who have helped with the data collection process.

Contributors JVVF designed the data collection tool, extracted all data, analysed the data and drafted and revised the paper. He is the guarantor. JB supervised the research planning and execution and revised the draft paper.

Ethics approval South-West—Cornwall and Plymouth Research Ethics Committee.

Provenance and peer review Not commissioned; externally peer reviewed.

REFERENCES

1 National Audit Office. Transforming NHS ambulance services. London: The Stationery Office, 2011.
2 College of Paramedics. Curriculum Guidance & Competence Framework, 2nd edn. London: British Paramedic Association, 2008.
3 Black JJ, Davies GD. International EMS systems: United Kingdom. Resuscitation 2005;64:21–9.
4 O’Hara R, O’Keeffe C, Mason S, et al. Quality and safety of care provided by emergency care practitioners. Emerg Med J 2012;29:327–32.
5 Deakin CD, King P, Thompson F. Prehospital advanced airway management by ambulance technicians and paramedics: is clinical practice sufficient to maintain skills? Emerg Med J 2009;26:888–91.
6 Findlay G, Martin I, Smith M. Trauma: Who Cares? A report of the National Confidential Enquiry into Patient Outcome and Death 2007 29/03/2012. http://www.ncepod.org.uk/2007report2/Downloads/SIP_summary.pdf
7 Hyde P, Mackenzie R, Ng G, et al. Availability and utilisation of physician-based pre-hospital critical care support to the NHS ambulance service in England, Wales and Northern Ireland. Emerg Med J 2012;29:177–81.
8 Jashapar A. Clinical Innovation in pre-hospital care: an introduction to Critical Care Paramedics in the United Kingdom. London: The Economic and Social Research Council, 2011.
9 Mackenzie R, Steel A, French J, et al. Views regarding the provision of prehospital critical care in the UK. Emerg Med J 2009;26:365–70.
10 von Vopelius-Feldt J, Benjer J. Prehospital anaesthesia by a physician and paramedic critical care team in Southwest England. Eur J Emerg Med Published Online First: 31 October 2012. doi:10.1097/MEJ.0b013e32835b8b7
11 Joint Royal Colleges Ambulance Liaison Committee (JRCALC). UK ambulance service clinical practice guidelines. London: Ambulance Service Association, 2006.
12 van Schuppen H, Bierens J. Understanding the prehospital physician controversy. Step 1: comparing competencies of ambulance nurses and prehospital physicians. Eur J Emerg Med 2011;18:322–7.
13 Intercollegiate Board for Training in Pre-hospital Emergency Medicine (IBTPHEM). Sub-speciality Training in Pre-hospital Emergency Medicine. Curriculum Framework and Assessment Blueprint. London: College of Emergency Medicine, 2012.
14 Gibson JM, Bullock M, Ford GA, et al. ‘Is he awake?’: dialogues between callers and call handlers about consciousness during emergency calls for suspected acute stroke. Emerg Med J 2013;30:414–8.
15 Duchateau FX, Burnod A, Sapir D, et al. Frequency of critical care techniques in the French prehospital critical care. Ann Fr Anesth Reanim 2007;26:612–3.
16 Gamer A, Crooks J, Lee A, et al. Efficacy of prehospital critical care teams for severe blunt head injury in the Australian setting. Injury 2001;32:455–60.
17 Bernard SA, Nguyen V, Cameron P, et al. Prehospital rapid sequence intubation improves functional outcome for patients with severe traumatic brain injury in a randomized controlled trial. Ann Surg 2010;252:959–65.
18 Botker MT, Bakke SA, Christensen EF. A systematic review of controlled studies: do physicians increase survival with prehospital treatment? Scand J Trauma Resusc Emerg Med 2009;17:8.
19 Davis DP, Hoyt DB, Ochs M, et al. The effect of paramedic rapid sequence intubation on outcome in patients with severe traumatic brain injury. J Trauma 2003;54:444–53.
20 Fakhry SM, Scanlon JM, Robinson L, et al. Prehospital rapid sequence intubation for head trauma: Conditions for a successful program. J Trauma 2006;60:997–1001.
21 Butler DP, Anwar I, Willett K. Is it the H or the EMS in HEMS that has an impact on trauma patient mortality? A systematic review of the evidence. Emerg Med J 2010;27:692–701.
22 Lossius HM, Soreide E, Hotvedt R, et al. Prehospital advanced life support provided by specially trained physicians: is there a benefit in terms of life years gained? Acta Anaesthesiol Scand 2002;46:771–8.
23 Stone CK. The air medical crew: is a flight physician necessary? J Air Med Transp 1991;10:7–10.
24 Cushman J, Hettinger A, Famey A, et al. Effect of intensive physician oversight on a prehospital rapid-sequence intubation program. Prehosp Emerg Care 2010;14:310–6.