

Between Duty and Discretion: Paramedics and the Implementation of
Emergency Medical Services Policy with Older Persons in Crisis in the Community-
A Qualitative Analysis

by

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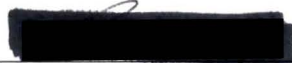
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ABSTRACT

The study inquired, “how do paramedics implement Emergency Medical Services (EMS) policy with discretion, with older persons in crisis in the community?”. The purpose of the study was to develop recommendations to reform EMS policy and practice during initiatives to regionalise health care in British Columbia. The method used was ethnography, and I rode the ambulance for ten months, in 1993. An ethical, investigative, participatory procedure was used to collect and analyse data. Sources included (a) field visits and notes, (b) interviews and focus groups, (c) EMS legislation, regulations, policy and procedure manuals, reports, memoranda, and (d) my personal journal. Findings confirmed that, in response to street-level dilemmas with older persons in crisis, paramedics implemented EMS policy with discretion. Seven discretionary decision-making processes were identified, and recommendations for EMS policy, planning, paramedic training and practice, including the implementation of guidelines and partnerships with community agencies, and future research, are discussed.

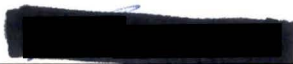
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THANKS & DEDICATION

To
Benjamin and Bethany
my children
I give all my thanks and praise
Your constant love
and joy ever present
is the greatest gift
I will love you
always.

This thesis is dedicated
to the memory
of my father
Ronald Joly James
who taught me like no other
during his life, and then
his death
the value and importance of rising to challenges
especially those we do not understand,
for the sake of community life
Thank you.

Pauline Marion James

Victoria

British Columbia

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CHAPTER 1 - OVERVIEW OF THE STUDY

This thesis is about how one group of paramedics, who work in Emergency Medical Services (EMS), interpreted and implemented EMS policy with older persons in crisis in the community. Recommendations for EMS policy, planning, paramedic education and practice, and future research are included. The thesis was written in the first person to illustrate my full participation as an active member researcher and participant in the study.

The study took place over a twelve month period from April, 1993, until April, 1994. All fieldwork was conducted with full and part-time *paramedics (*see the note below) who worked out of one inner-city ambulance station in a western Canadian city. Essentially, the study was about the full-time paramedics, however, as access to the part-time paramedics was limited to the few shifts they worked when they full-time paramedics were absent due to illness or other forms of leave. Access to the paramedics was facilitated by my concurrent placement as a co-operative education student to develop the British Columbia Ambulance Service and Emergency Mental Health Services Project (The BCAS/EMHS Project, the project). The project was carried out simultaneously with my thesis study and shared the same background described below. In the following chapter, the background to the research, the research problem, the research question and my reflections and rationale for conducting the study are presented.

Background to the Research

As background to my fieldwork, three initiatives helped clarify and launch the study. They were the Quick Response Team (QRT) pilot project, the provincial health care reform initiative called 'New Directions for a Healthy British Columbia', and the BCAS/EMHS Project. Each is described below.

*Note. Earlier, the title 'paramedic' was reserved for use only by those Emergency Medical Assistants (EMAs) trained at the EMA III level. Recently, however, the term has acquired a generic meaning and is used now to refer to any person trained as an EMA, regardless of level of training (see Appendix A).

The Quick Response Team: The Path to New Directions

I was inspired to conduct a study of paramedics and their practices with people aged 60 or older, as a result of my employment, in 1986, as a Quick Response Team liaison nurse. The Quick Response Team (QRT) began in the emergency rooms (ER) of two acute care hospitals in Victoria, British Columbia. The QRT was mandated to co-ordinate and provide short-term, community-based emergency health care and home support services to people 60 years of age or older who would have required, otherwise, admission to hospital.

When the QRT first began, potential QRT patients were recommended to physicians by the QRT liaison nurse. As a QRT liaison nurse, I was responsible for identifying, assessing, case managing and referring back to the community, those older persons who were at risk of being admitted inappropriately to hospital. I worked closely with emergency room physicians, nurses, a geriatrician, the QRT, and a nurse researcher. Together, we provided crisis intervention services to eligible seniors, within two hours of their point of entry into the ER. Potential referrals included frail, older people who resided within a selected geographic area.

In particular, eligible persons included those with acute, chronic or terminal health care conditions who required both urgent and intensive multidisciplinary support services to enable independent community living. Typical patients included those with (a) functional difficulties arising from falls, (b) care-givers who were no longer able to provide an adequate amount of care, (c) general debility secondary to acute illness and other disease processes, (d) resolving situational crises, and (e) resolving drug toxicities. It was my responsibility, also, as the QRT liaison nurse, to act as 'gatekeeper' to ensure that inappropriate referrals were found ineligible for service. Persons considered ineligible for QRT services were **older persons in crisis (**see note, below) aged 60

**Note. I first used the phrase, 'older persons in crisis', when I worked on the QRT. The phrase denoted a group of persons 60 years of age or older who identified themselves as emergency cases but later, were found ineligible for the QRT. The phrase, 'older persons in crisis' was left undefined deliberately, in this study, to help identify clinical sub-groups of patients with whom paramedics practiced discretionary decision-making.

or over who had (a) unstable physical and/or mental health conditions, (b) bizarre, pre-violent or otherwise potentially dangerous behaviours; (c) inadequate or unsuitable housing to accommodate live-in home support workers, and (d) residences beyond the geographical boundaries of the QRT.

Three needs of the health care system supported the exclusion criteria. They were to ensure that all persons received the most appropriate assessment, diagnosis and treatment in a timely and efficient manner; to provide a safe work environment for employees, and to maintain efficient utilisation of existing health care resources.

In practice, I had no difficulty excluding from service those persons who resided outside geographical boundaries or who required acute care admission for unstable physical and mental health conditions. However, I experienced ethical dilemmas and occasional verbal reprimands when QRT services were requested for marginalized older persons whose primary medical problems were complicated by secondary diagnoses of poverty or previous psychiatric diagnoses, including alcoholism, for example. One worker cited concern for her personal safety and the safety of others, and stated, “the QRT should not have to work with such individuals” (personal communication, January, 1987).

However, despite the existence of a group of older persons in crisis whom the QRT could not serve, the QRT performed a highly valuable function. Rapid mobilisation of community-based emergency support services for the frail elderly had become a reality. Consequently, media coverage drew many people to emergency departments to request QRT services. One potential patient in the ER stated to me:

I don't want to be admitted to the hospital for my problem. I came to the emergency department because I need help. I am sick and I want to stay home. I know the QRT can help me (personal communication, March, 1987).

A subsequent evaluation of the QRT by Dawson, in 1987, confirmed it was an effective service that efficiently diverted many older persons away from hospital and back to the community (LeBourdais, E. 1991, p. 1493). The issue of serving older persons in crisis who were ineligible for service, however, was unresolved. Later, when paramedics requested permission to access QRT services from the community, another issue emerged.

Paramedics, Patients and the QRT

In my role as QRT liaison nurse, I routinely encountered paramedics who had knowledge of the QRT. Frequently, they pointed out, to me, older persons in crisis whom they believed could benefit from admission to the QRT rather than to hospital. I routinely heard paramedics express frustration that they were not allowed to request QRT services directly from the community on behalf of EMS patients, even when the paramedics believed they knew when QRT services were required. With respect to the interpretation of EMS legislation by EMS bureaucrats and paramedics, one paramedic stated:

Many older EMS patients do not require ambulance transport to hospital. But according to the law, we have to take everyone there unless patients themselves refuse to go. Lots of older people who paramedics respond to need community services like the QRT instead of hospital, like old people who are depressed and lonely. They call us to put them to bed at night. If paramedics could access the QRT, many unnecessary transports could stop. A lot of money might be saved. Also, its really hard for us to bring some old people in to hospital who really need medical assessment. Often, they refuse to leave their dog or cat. Other old people refuse to come to hospital after we attend them at home. If we could work more closely with the QRT, things would be a lot better for everyone, especially the health care system (personal communication, March, 1987).

When I worked in the ER, many paramedics indicated that they knew the purpose of the QRT and the clients it strived to serve. They reported, also, that many paramedics could identify older EMS patients who did not require medical intervention from the acute care hospital ER. Paramedics expressed frustration when they saw certain older patients discharged home from the ER without home-maker or nursing care services arranged. One paramedic stated:

We know which patients will end up calling us again... then we have to bring them back to the ER in a few hours. This costs the system time and money, and the patient still doesn't get any better (personal communication, February, 1987).

This issue led me to raise two questions about paramedics and their potential ability to link older persons in crisis to other community-based services: (a) What liaison role, if any, could paramedics play in linking older persons in crisis to community-based, rather

than hospital-based, emergency services?, and (b) what did the provincial EMS legislation state about paramedics and their responsibility to transport patients to hospital, in every case?

Expansion of the QRT and the Credibility of Paramedics

The QRT expanded in 1988. The addition of more staff and a wider spectrum of short-term emergency health care services meant that additional patients with more complex problems, including younger people over the age of nineteen years with chronic illness and disabilities, could now be served. Assessments became available in the community as well as the emergency department. A telephone referral service began so that physicians and other health care professionals could refer patients to the QRT without the person having first to visit the ER. Nurses and social workers learned triage skills to identify potential patients for QRT referral by telephone. In my opinion, the expansion of the QRT presented an opportunity to include paramedics as sources of referrals.

In my position as a front-line worker, I decided to discuss my idea about paramedics as sources of referrals with the management staff of the QRT and EMS. They agreed to support a joint policy and referral protocol between the two programs, based on drafts I was requested to write. Once the final policy and protocol were developed and approved, the Regional Medical Officer of Health officially endorsed them and requested that they be implemented immediately. Paramedics were then authorised officially to refer consenting, eligible older persons in crisis to the QRT when transport to hospital was refused. Despite the official policy and protocol, however, the initiative failed.

Several months later, when I returned from a leave-of-absence, I found the policy and protocol had not been implemented. When I inquired, 'why?', I was told by one manager that, "it was too difficult to co-ordinate information sessions with the ambulance service" and, "without orientation sessions to the QRT, paramedics would not know how to make referrals to the QRT" (personal communication, May, 1990). Interestingly, EMS managers stated, "little effort was made by the QRT to deliver information sessions to ambulance personnel, even when the QRT was invited to speak at regional EMS meetings" (personal communication, May, 1990).

I was advised further that QRT front-line staff did not support the concept of accepting referrals from paramedics. The credibility of paramedics was questioned. QRT staff stated, “paramedics think they are doctors. Paramedics don’t really know anything. Paramedics are ambulance drivers” and, “paramedics will only refer schizophrenics and alcoholics to the QRT”. Others stated, “paramedics will make unreasonable demands on the QRT. They will demand that referrals be seen immediately.” These issues were not addressed and the initiative was dropped.

Upon reflection, I realised later the initiative was doomed to fail because front-line workers were neither supportive of the initiative nor had they been included in developing the policy or protocol. The gap between my experience of paramedics in the ER and the opinions of my QRT colleagues generated two more questions: (c) Do paramedics have adequate clinical knowledge and assessment skills to determine which older persons should be referred to community-based emergency services instead of being transported to hospital?, and (4) how do health care workers within mainstream community health care programs perceive, value and incorporate the work of paramedics, if at all? My four preceding questions acquired new meaning when New Directions in Health Care was proclaimed from the legislature in 1993.

New Directions: Bringing Patient Care ‘Closer to Home’

In November, 1991, the Report of the Royal Commission on Health Care and Costs: Closer to Home, (the report) was released by the province of British Columbia. The report provided a blueprint to reform the health care system. A preliminary analysis of recommendations found that the traditional medical model approach to deliver health care services was earmarked for reform. Like the priority of the QRT, the predominant theme of the report was to render health care services more effective, efficient, and ‘closer to home’ through the development and implementation of community-based multidisciplinary programs and services.

In early 1993, subsequent to the release of the report, Elizabeth Cull, the then Minister of Health and Minister Responsible for Seniors, announced the arrival of the reform initiative called ‘New Directions in Health Care: Towards a Healthy British Columbia’ (New Directions). New Directions mandated that all health programs except EMS and two physician-oriented programs be decentralised to regional health authorities.

The Mental Health Division was the first Ministry of Health division to be transferred to regional control. Concurrently in 1993, within the Mental Health Division, Emergency Mental Health Services (EMHS) was proclaimed a core service. As such, EMHS was mandated to become available province-wide. This expansion of community-based emergency services prompted me to reflect upon what role paramedics had played in the past to manage older persons in mental health emergencies, particularly those deemed ineligible for the QRT. I pursued this question with management staff from EMS and EMHS. On separate occasions each replied:

Paramedics have been responding to people of all ages in mental health emergencies for a long time because no one else has been there to do it, except police. People in mental health emergencies require specialised, co-ordinated emergency response services in the community, by workers with training in mental illness (personal communications, November, 1992).

This converging issue prompted me to discuss two issues with EMS and EMHS executives. I asked them, ‘what contributions could paramedics make, if any, based on their experiences in the community with mental health patients, to inform policy and program development and co-ordination of services, as Emergency Mental Health Services expand across the province?’, and ‘could paramedics and EMHS front-line workers together, enable co-ordinated emergency responses to ensure emergency mental health patients receive appropriate health care services when indicated?’

In January, 1993, I submitted a proposal to the Ministry of Health to conduct two research projects during my placement in the Ministry as a co-operative education student. The first project was requested by the Ministry of Health. The purpose of the project was to determine whether a working relationship could be developed and implemented between EMS paramedics and EMHS front-line workers. The report, “The BCAS/EMHS Project: Towards a Community Partnership” (James-Groom, 1994), describes the process and outcomes of the project. The second study, which forms the subject of this thesis, was my ethnographic study of paramedics. Its purpose was to analyse how paramedics made discretionary decisions with older persons in crisis in the community, and to provide recommendations for EMS policy, planning, education, practice and future research. In March, 1993, my proposal was accepted and the BCAS/EMHS Project and my thesis study, together, began in April that same year.

The Research Problem and Research Question

The Research Problem

The research problem of my study became clearer when I conducted ‘one-to-one’ interviews with street-level workers affiliated with the BCAS/EMHS Project. A pattern in the data showed that whenever we discussed the notion of paramedics being allowed to refer older people in crisis to EMHS under certain circumstances, the credibility of paramedics was questioned again. One EMHS worker stated, “ambulance drivers are nice people, but they are more like police than health care providers. Ambulance drivers don’t know anything about mental illness” (personal communication, April, 1993).

This remark returned me to my experiences in the ER when paramedics perceived they were qualified to refer EMS patients in the community to the QRT. I found that paramedics and the depth of meaning they took from their work, as I had come to know them, was at odds with the beliefs of others who saw paramedics and their work as task oriented and superficial. Thus, the research problem of my thesis study was framed:

While paramedics are experienced members of community-based emergency health services, street-level staff from other health care services perceive paramedics and their work as superficial. Much of the actual work of paramedics is unobserved. It is conducted largely behind closed doors of private homes and ambulances: the substantive portion of their work is hidden. The visible part of the work of paramedics consists of conveying stretchers and driving ambulances at high speed with blaring sirens. Little else of the work of paramedics is known to mainstream health care workers, including how paramedics make decisions to provide patient care. *Until the knowledge-base used by paramedics is identified, analysed and integrated, in terms of how decisions are actually made in the field, paramedics will continue to be excluded and under-utilised in the health care system as a whole.*

To me, it seemed that paramedics were considered ambulance drivers and marginal members of the health care community rather than as bona fide providers of health care services. When I had spoken earlier with my nursing and social worker colleagues, I found they devalued the work of paramedics due to the brevity of the EMS training program in comparison to their own, and the para-military organisation of EMS systems in general.

The Research Question

The research question of my study was clarified when I reflected on what paramedics had stated earlier, that in some cases they do not take older people to the hospital but instead, refer them to the QRT. This disclosure indicated three practices that required analysis: (a) Some paramedics practiced discretionary decision-making with older persons in crisis in the community despite EMS policy directives that apparently required them to transport patients to hospital in every case, (b) a potential performance gap, related to the skills and abilities of paramedics, as seen by others, in contrast to how paramedics viewed themselves, existed; and (c) the logic used by paramedics to practice discretionary decision-making on the street was undiscovered knowledge that, if discovered and integrated, could reform policy and practice. These issues enabled me to state my research question:

“How do paramedics implement EMS policy, with discretion, with older persons in crisis in the community, and what are the implications for EMS policy, planning, education, practice and future research?”

Having posed the research question, I then reflected upon works from the literature to provide an epistemological point of departure for the study.

My Reflections and Rationale for Conducting the Study

My Reflections on Conducting the Study

Before commencing the study, I reflected on literature by Lipsky (1980), Wharf and Callahan (1984) and Yanow (1987). Lipsky (1980) posits a theory of front-line public servants as ‘street-level bureaucrats’. Wharf and Callahan (1984) recommend

connecting policy and practice as closely as possible, while Yanow (1987) offers a theory of 'the policy culture approach to implementation' as an interpretive method to identify, collect and analyse data.

Lipsky and the Dilemmas of Street-Level Bureaucrats

Lipsky (1980) conducted policy implementation research of individuals in public service. The purpose of his research was to analyse the dilemmas experienced by street-level workers when they implemented policy during daily practice. Lipsky (1980) found that front-line workers play critical roles as interpreters, implementers and makers of policy on the front line, and that they implement policy every day by delivering programs, or goods, for public consumption. Lipsky (1980) found that the decisions of front-line workers, to control or deliver services to the people who need them, express substantive health care policy. Lipsky (1980) defined street-level bureaucrats:

[They are] public service workers who interact directly with citizens in the course of their jobs... [They] have substantial discretion in the execution of their work... [They] are teachers, police officers and other law enforcement personnel, social workers, judges, public lawyers and other court officers, health workers, and many other public employees who grant access to government programs and provide services within them... [They] tend to have much in common because they experience analytically similar conditions (p. 3 - 4).

My early background research suggested that paramedics fit the definition of street-level bureaucrat, but it remained unclear to me as to when, and how, paramedics practiced discretionary decision-making on the front-line. Thus, I turned to a contribution by Wharf and Callahan (1984).

Wharf and Callahan: Between Policy and Practice

While the research of Lipsky (1980) falls short on the topic of policy reform, the work of Wharf and Callahan (1984) poses a useful theory of implementation that influenced the proposal of my study. Their research explores connections and similarities between the work of bureaucrats and front-line workers in the daily policy-making and implementation process. Wharf and Callahan (1984) state:

... the processes of policy making and practice... are in fact, more similar than practitioners or theorists care to admit. Both confront knotty and contentious problems, both follow similar stages of development, and participants in both areas are faced with similar value dilemmas and technological gaps in attempting to implement change (p. 37).

Wharf and Callahan (1984) suggest, also, that differing vantage points within organisations determine the ways in which workers conduct and express themselves in the policy implementation process. They imply that what one sees and experiences ultimately influences what one does. From their point-of-view, to believe that only employees called policy makers develop policies would be as incorrect as saying only secretaries answer telephones.

Wharf and Callahan (1984) also discuss similarities between social policy makers and front-line practitioners in their need to involve end-users, or providers, in problem-solving. They state that workers at both levels are aware that “unless those who will be asked to support a solution are somehow involved in its creation, the action may fail” (1984, p. 41). This tenet clarified to me why the initiative to involve paramedics in the referral process of clients from the community to the QRT, failed. The QRT staff had been inadequately informed and involved in the policy making process. Wharf and Callahan (1984) found that links between policy making and practice can be strengthened through education and greater valuing of workers in daily practice.

In addition, Wharf and Callahan (1984) add to the research of Lipsky (1980) by examining the differences between programmed implementation and adaptive implementation activities. Wharf and Callahan (1984) cite Berman and state that discretionary decision-making exemplifies an adaptive approach to implementation that “requires a process that allows policies to be modified and revised... adapted according to the unfolding interaction of each policy in the institutional setting” (p. 45). In contrast, programmed implementation is described as a method to halt the practice of discretionary decision-making “by an initial decision on policy that includes an automatically executed implementation program” (p. 45). The work of Wharf and Callahan (1984) clarified, for me, that EMS policy was constructed originally to control programmed implementation activities while disallowing discretionary activities.

Together, Lipsky (1980), and Wharf and Callahan (1984) led me to develop two beliefs before my study began, that (a) EMS paramedics were street-level bureaucrats who practiced programmed and adaptive, discretionary decision-making; and (b) the method used by paramedics to practice adaptive, discretionary decision-making with older persons in the community, within a strictly regulated environment, was undiscovered knowledge. While Lipsky (1980) focuses on the front-line worker as street-level bureaucrat, and Wharf and Callahan (1980) provide a theory of policy implementation by connecting policy and practice, Yanow (1987) articulates the importance of taking a 'policy culture approach' to policy analysis (p. 110 - 112).

Yanow and the Policy Culture Approach

Yanow (1987) posits a policy culture approach to implementation and describes five lenses through which barriers to policy implementation activities can be analysed. The lenses include (a) the political lens, (b) the systems lens, (c) the structural lens, (d) the human relations lens, and (e) the policy culture lens (p. 103-109). Each lens is described as having its own characteristics. Yanow (1987) states, however, that:

the first four falsely separate implementation issues into discrete domains in which single empirically viable solutions to factual problems are sought. These four lenses rely upon the use of a rational logic of inquiry which assumes that implementation is an activity with factual characteristics which exist in the real world; since they exist as objective facts, they can be discovered (p. 108).

Yanow (1987) values these lenses but rejects the prescribed rational, logical process of analysis imposed by each lens separately, in isolation from the other. Instead, Yanow (1987) states that an interpretive approach, via the policy culture lens, should be taken:

The policy culture lens is very different from the other lenses. The policy culture approach to policy implementation analysis relies upon interpretive, rather than rational logic. It values wisdom, knowledge and experience of all persons within a chosen policy culture. Consequently, the policy culture lens includes all participants, elements and influences that are falsely separated by the other lenses. The policy culture lens shows instead, that the components of each lens are overlapping and influence one another in reality ... interpretive logic treats

implementation as a set of activities to be interpreted in which multiple meanings are expected... it asks, “how do we understand implementation?” and “what meanings did agency chiefs, legislators, front-line workers and clients make of this policy? How did these meanings shape the implementation of the policy?” The ultimate success or failure of policy implementation, from this point of view, rests on the interpretations of its policy mandate (p. 109).

In my thesis study, where health care reform was high on the agenda of the health ministry, the work of Yanow (1987) confirmed, to me, it was crucial to study the work of paramedics in the policy culture of health care reform.

Thus, the work of Lipsky (1980), Wharf and Callahan (1984), and Yanow (1987) influenced my beliefs about paramedics and their work before my study began. I believed that paramedics were (a) street-level-bureaucrats who practiced discretionary decision-making with older persons in crisis, (b) front-line workers who interpreted, developed and implemented policy-making processes using problem-solving methods similar to those used in formal policy-making processes; and (c) one group of workers within a vast, multidisciplinary health care policy culture within which policies were formed and implemented according to multiple meanings. These reflections related to my rationale for conducting the study.

My Rationale for Conducting the Study

I decided to conduct the study in order to develop achievable recommendations to reform EMS policy and practice so that older persons in crisis could receive access to the highest quality, most timely, co-ordinated and comprehensive services available. Through the study, I intended to discover a body of knowledge to describe the discretionary decision-making practices of paramedics for the purpose of informing the development and integration of community-based emergency services. It was my intent, also, that the mandate and scope of EMS, in the wider context of developing emergency health care services, might be reviewed. I believed that the process of my study might produce resolutions for activities and further research whereby the linkages between EMS policy and practice, could be identified further and strengthened. The next chapter describes the methodology I used to conduct the study.

CHAPTER 2 - METHODOLOGY

Ethnography and the Principle of Reflexivity

In this chapter, I discuss the methodology used to conduct the study. Also discussed is the principle of reflexivity, my assumptions with implications, gaining access to the paramedics and my ethical considerations. With respect to the methodology of the study, I chose ethnography. This method is a qualitative method, also called ‘participant observation’. Hammersley and Atkinson (1983) state ethnography is the most basic form of investigative, social research that can be used to (a) elicit cultural knowledge, (b) examine and detail patterns of social interaction, (c) analyse societies *in toto*, (d) describe the subject of inquiry, (e) story-tell, and (f) develop and test theory (p.2). Thus, while many ‘cultures’ of persons were present within the study such as patients, hospital personnel and the police, this thesis is about the ‘culture’ of EMS paramedics and the data, therefore, are presented from the point-of-view of paramedics.

In my study, the research question inquired, “how do paramedics implement EMS policy with older persons in crisis in the community, and what are the implications for EMS policy, planning, practice, paramedic education and future research?” Thus, an ethical analysis of the ways paramedics interpreted and implemented health care policy was central to the study. The word, ‘how’, referred the line of inquiry back to the social relationship between the meanings, values and actions taken by paramedics when they interpreted and implemented EMS policy in daily practice. Since the research question required that qualitative, descriptive data be collected from the field, ethnography was clearly the method of choice. This choice was confirmed by Hammersley and Atkinson (1983) who state, “only through ethnography can the meanings that give form and content to social processes be understood” (p.2). When I reflected on the implications of ethnography as methodology, I realised it was necessary, first, to examine my beliefs about paramedics. The principle of reflexivity guided me in this process.

According to Hammersley and Atkinson (1983), a unique feature of ethnographic research is its reflexive character. They state, “the principle of reflexivity requires the researcher to be part of the social world that is studied . . . rather than engaging in futile attempts to eliminate the effects of the researcher, we should set about understanding

them” (p. 14-17). Therefore, as a community health nurse with front-line experience in many primary health care programs including a rural ambulance service, it was crucial to identify my beliefs, values and assumptions about paramedics and EMS.

I had two beliefs about paramedics and EMS. The first was that paramedics derive meaning from their professional experiences in EMS and thus, have the potential to adapt and refine their ‘on-the-job’ assessment skills to attend to older persons in crisis. A personally-held value, related to this belief, was that the work of paramedics influences access to, and utilisation of, health care resources across the health care system by older persons in crisis. My second belief was that if the role of paramedic is expanded to include making referrals of eligible, older persons in crisis to community-based services other than acute care hospitals, then more appropriate use of acute care resources, and the co-ordination and integration of community-based emergency services, might be achieved. My assumptions, with implications, follow.

The following table (Table 1.) describes my assumptions, with implications, that were taken into the research process. They influenced how I gained access to the research setting and established rapport with the paramedics to collect and analyse data. For example, my assumptions provided epistemological points-of-departure to discover issues related to EMS policy, planning, practice and education. The findings from the data gathering and analysis process are described in chapter four. What follows now is a discussion about how I gained access to the research setting.

Gaining Access to the Research Setting

My study was conducted in the natural setting, or everyday world, of paramedics where EMS policy was interpreted, implemented and evaluated. Gaining access to the research setting was a lengthy, but straight-forward process. Access was attributable to three different working relationships I had previously with EMS in British Columbia. The most recent was in 1993, when I was hired as a student to work on the BCAS/EMHS Project. At that time, I requested, also, to conduct an ethnographic study of paramedics. The project provided a compatible context for my thesis research to be conducted, and the EMS management staff, who were mostly former paramedics and one physician, endorsed my study. They believed useful recommendations would be produced.

Table 1.

My Assumptions, With Implications, that Influenced My Conduct in the Study

My Assumption	Implication of Assumption
1. The public expects a high standard of fair, equitable, consistent and individualised EMS to be provided by all paramedics	Persons who give informed consent to receive care from paramedics believe the best care will be given until a physician is available
2. The public expects that paramedics have adequate training and authority to provide EMS according to the needs of the patient	Persons who consent to receive EMS do so believing paramedics will provide suitable help consistent with their training and abilities
3. Some paramedics are more capable than others to provide suitable EMS to older persons in crisis, related to their abilities to synthesise professional experience with basic EMS knowledge and training	Undiscovered knowledge exists that, if found and applied, will enable all paramedics to provide suitable EMS to older persons in crisis
4. Paramedics are eager, willing learners who observe, respect and identify with other front-line emergency staff who work in the hospital and community	Paramedics will seize opportunities to learn and work with other front-line emergency staff, and EMS policies and practices will be reformed incrementally
5. My previous work with EMS gives me credibility as a health care provider who also 'understands' the work of EMS from the perspective of an 'insider'	Trust and rapport between the paramedics and I will be established easily; but they may want only favourable conclusions

Note. EMS is an abbreviation for Emergency Medical Services.

My earlier work with EMS was in 1989, when I provided occupational health services to managers and paramedics. My work included the provision of confidential counselling services, illness, disability and employee assistance services, and the organisation and administration of immunisation programs. Through these activities, I established rapport and credibility as a confidant and capable nurse clinician.

My earliest experience with EMS in British Columbia was when I worked as QRT liaison nurse, described in chapter one. In this role, I re-discovered my interest in EMS that was established earlier in Alberta, in 1976, when I helped develop and serve a rural, volunteer ambulance service. In particular, my interest in the expanded role of paramedics, in relation to the provision of community-based geriatric care, was founded. Given my experiences above and a collaboratively designed research proposal, I was granted access to the research setting with enthusiastic support. My next step was to gain access to the paramedics.

Gaining Access to the Paramedics

When the study began officially in April, 1993, I contacted a full-time paramedic at the inner-city station to request a meeting. I explained that the purpose of the meeting was to solicit the support and participation of paramedics in the BCAS/EMHS Project and my ethnographic study. With respect to my thesis research, I described my need to observe the work of paramedics on the front-line so that information could be collected and analysed to explore their abilities, or not, to work in an expanded role with older persons in crisis in the community.

Specifically, I requested permission to ride the inner-city ambulance over a ten month period to observe and interview paramedics. I stated that I wanted to learn how they provided EMS to older persons in crisis in the community. I placed my request in context by recounting favourable experiences of paramedics in the ER and their apparent, under-utilised abilities to identify potential patients for the QRT. The full-time paramedic endorsed the purpose of my research but cautioned:

Paramedics *don't* make decisions. We *have* to take everyone to the hospital. Sure, the guys who have been here a long time-- they know when somebody doesn't need to go in, but we *always* take our patients to the hospital. We have to, by law. Wait until you see some of the part-time paramedics, though. Some of them might change your mind about what great work paramedics do (personal communication, April, 1993).

My interest was piqued by the final remark. Then, I was granted unlimited access to observe paramedics in their world and I promptly booked five shifts. Descriptions of the paramedics, whom I called 'participants', to emphasise their participatory role in the collection and analysis of data in the study, are presented below.

The Participants and Their Years of Experience

The participants were all trained, licensed paramedics employed by EMS on a full-time 'career', or part-time 'call-out', basis. All were expected to comply with existing EMS policies and procedures in accordance with their levels of training and licensure, which are discussed later in this section. The participants who worked on a full-time basis worked an assigned minimum of one hundred and forty hours per month. The part-time participants worked variable hours and were paid per call, with a minimum payment of four hours per call with no guaranteed minimum number of calls per month.

At the time of the study, all EMS paramedics in British Columbia (BC), regardless of their status as full or part-time, were hired individually by the Unit Chief of a given ambulance station. During the study, 190 ambulance stations existed across the province. Paramedics from any station, regardless of status as full or part-time, were eligible to request extra work on a call-out basis in other stations pending the approval of the Unit Chief. Thus, paramedics from five different ambulance stations participated in the study. Two main groups of participants were identified: the full-time participants and the part-time participants. These groups are explained below.

The Full-Time Participants

The full-time participants were eight 'career' paramedics who worked on a full-time permanent basis out of the inner-city ambulance station. Together, they formed the core platoon of paramedics who were responsible to serve the geographical area that comprised the inner-city and two adjacent middle-class neighbourhoods. All had over ten years work experience in EMS and stated they requested to work permanently in the downtown station because of the variety and volume of EMS calls offered. Seven were male and one was female. All were between thirty and forty-five years of age.

The full-time participants worked in fixed pairs called crews. Thus, paramedics worked all assigned shifts with the same person unless one partner was absent due to illness or holiday leave. Four crews comprised the platoon of the station and each crew had worked together between one and five-and-one-half years. Of the special relationship experienced between crew members, one full-time participant stated:

Working in a crew is like being married. You go through everything together... life and death. We know, because we have been together for over five years. We know everything about each other- who we are at work, who we are at home, who our families are, what we eat for breakfast... everything (personal communication, June, 1993).

When this comment was made, the partner of the full-time participant nodded quickly in agreement and gave me pictures of his family to view.

All the full-time participants had between ten and thirteen years full-time EMS experience. With respect to the kind of experience the full-time participants had, one full-time participant stated:

All new paramedics have to do their time on the skids for at least six months after graduation. You can't get hired anywhere without it (personal communication, April, 1993).

The term, 'the skids', specifically referred to a downtown area in a large, neighbouring city where persons with medical and behavioural problems, including addictions and

persistent mental illness, congregated. All the full-time participants had experience working on the skids. One had three years experience working on the skids in Los Angeles, also. In addition, one full-time participant had two years work experience in a residential care facility where he was a care aide for the elderly and persons with developmental anomalies and/or chronic mental illness.

The Part-Time Participants

The part-time participants were seven paramedics, six males and one female, from five other sub-urban or semi-rural EMS stations. They voluntarily chose to work call-out for the inner-city station when the full-time paramedics were unavailable. Each stated they “liked working downtown to acquire more EMS experience” (personal communications, May - October, 1993).

Four of the part-time participants had no full-time EMS experience, while three had full-time EMS experience. Each of the four without full-time experience stated they “required more EMS experience before being eligible to apply for higher levels of paramedic training” (personal communications, May - October, 1993). They stated they were “ineligible to take additional training or apply for full-time employment in EMS until adequate experience was obtained first” (personal communications, May - October, 1993).

Two, of the remaining three, part-time participants had full-time EMS experience and were employed full-time in sub-urban ambulance stations. Both stated they “worked additional shifts downtown to have varied EMS experience” (personal communications, September, 1993). The remaining part-time participant with full-time experience stated he “stopped working full-time three years ago due to burn-out and to live a more relaxed lifestyle” (personal communication, July, 1993). The part-time participants were between 22 and 55 years old.

With respect to years of employment in EMS, the four part-time participants who worked call-out had less than six years experience. In addition, three of the four had full or part-time jobs outside the health care sector. The fourth relied solely on EMS call-out hours for employment. Of the remaining three of seven part-time participants, all had

full-time EMS experience. One had twenty years, one had ten years, and the third had four years part-time and four years full-time experience. The part-time participant with ten years EMS experience had two years full-time experience, also, as a care-aide in a facility for elderly patients.

The Education and Licensing Requirements of the Participants

All the participants, whether they worked part or full-time with EMS, had completed compulsory, standardised training at either the entry level of Emergency Medical Assistant I (EMA I), or the more advanced level of Emergency Medical Assistant II (EMA II) paramedic (see Appendix A). With respect to the full-time participants, all were required to be trained and licensed to practice at the EMA II level. With respect to the part-time participants, four were trained and licensed to practice at the EMA I level. The remaining three part-time participants who had full-time EMS experience were trained and licensed to practice at the higher level of EMA II. In addition, I learned that all the full-time participants were required to pass an obligatory re-certification examination every five years. One full-time participant stated to me that, “all the full-time paramedics in the downtown station passed their re-certification examinations over the years and maintained their licenses to practice without difficulty” (personal communication, June, 1993).

My Ethical Considerations

I believed strongly that the purpose and process of my ethnographic study be overt, rather than hidden from the participants. This was because the implementation of public policy by front-line workers, accountable to the public, was under ethical analysis. Thus, at the beginning of the study, I asked one full-time participant to obtain the consent or refusal of the other potential participants before I arrived at the station to ride as an observer. For example, if I requested to ride the ambulance on certain shifts and the assigned crew did not wish to be observed, I accepted the refusal of permission to ride without question.

I requested, also, that all full-time and part-time participants read the consent form provided (see Appendix B). In writing and verbally, I reinforced that the participants

could refuse to participate in the study at any time without fear of loss of job or promotions. I explained, also, that official permission had been granted by EMS managers to allow me to conduct research in the field. Appendix C provides a statement that describes how I solicited consent from the prospective participants.

With respect to my research proposal, two copies were retained by EMS. One copy was in the headquarters office of the provincial EMS, and one copy stood in the downtown ambulance station for reference. I met the requirements of the “Regulations Governing Ethical Standards for Research with Human Subjects”, as required by the University of Victoria (see Appendix D), and I was subsequently granted permission to proceed.

During the study, I advised all participants that I would make field notes and that no identifying information would be attached that could permit tracing of comments to specific individuals. When I asked the eight full-time participants to participate in interviews, I requested permission to audio-tape them also. The participants were assured they could refuse to be interviewed, without penalty, and that the tape recorder could be turned off at any time. I advised the participants that all data would be kept locked in a restricted area and that it would be destroyed upon completion of the study.

With respect to the assistance I was requested, or that I offered, to provide the participants during EMS calls, at no time was I asked to perform, nor did I offer to perform, invasive procedures with patients. All interactions with paramedics, patients and/or equipment were within my scope of practice as an active, practicing Registered Nurse. At no time was the safety of the participants, the patients, any bystanders, or me, compromised by the study. The next chapter discusses my role in the research and how data were managed.

CHAPTER 3 - HOW I CONDUCTED THE STUDY

My Role in the Research

In this chapter, my role in the research is presented. Also discussed is how the data were managed. The literature is not reviewed in this chapter, as it was re-visited only after the data collection and analysis process was complete and is therefore, discussed in chapter five. This approach to the literature enabled the inductive approach of the study to be preserved. In regard to my role in the study, I was an 'active member researcher' (AMR), as described by Adler and Adler (1987). They state:

AMRs... generally assume functional, not solely research or social roles in their settings. [They] therefore relate to members of the setting in a qualitatively different way than do researchers in peripheral membership roles. Instead of merely sharing the status of insiders, they interact as colleagues: participants in a joint endeavour... AMRs' greater degree of participation in the group's core activities accords them a higher level of trust and acceptance among setting members... AMRs' relationships with setting members may therefore be activity oriented and business-like in addition to personal in character (p. 50).

Being an AMR was consistent with my choice to be a participant in the study. My role as an AMR was confirmed by three factors, described below.

The first is that I was employed to develop the BCAS/EMHS Project with paramedics. This role placed me beside the participants of my ethnographic study in a functional capacity. For example, some participants and I attended regional health care planning meetings to explore, with others, innovative ways to deliver emergency services to patients in mental health crises in the community. The conjoint activities of the BCAS/EMHS Project and my thesis study conveyed to paramedics that I understood and valued their work. In particular, the BCAS/EMHS Project enabled the participants and me to be engaged in a productive process that facilitated me to be an AMR.

Second, as an observer in the field for ten months, I actively participated in the daily routines of paramedics. On a personal level, I experienced a high level of trust from the participants and I felt they treated me as if I were 'one of them'. For example, this was evident when we responded to large motor vehicle accidents. Some participants

asked me to assist them as they awaited the arrival of additional paramedics and ambulances. I collected demographic information from apparently non-life threatened patients and took their medical histories, pulses and blood-pressures when the participants were busy attending to patients in life-threatening emergencies. In other cases, when time was a critical factor and human resources were pushed to capacity, such as reviving victims of heroin overdose or cardiac arrest, the participants asked me to set up intravenous equipment, adjust oxygen levels on flow meters and fetch special equipment in the ambulance.

At other times, the participants asked for my interpretation of signs, symptoms and provisional diagnoses of older patients. This occurred most often when the participants found the patients to be vague historians. Occasionally, the participants asked me to supplement their report to the triage nurse in the ER, or to suggest that certain patients be assessed later by the QRT liaison nurse. In other cases, after older patients were transported to the ER, some participants asked me if I thought the patient 'really needed' the services of an acute care hospital. Finally, when EMS patients were released by the participants to the hospital, I helped them clean the ambulance and make the cot. Often, the participants invited me to choose the location for a well-deserved break.

Third, according to Adler and Adler (1987), I experienced all the potential problems AMRs can face when conducting ethnographic research. This point is discussed in detail in my conclusions in chapter five of the thesis. The following section describes how data were managed.

The Management of Data

Data were collected and analysed continuously throughout the study. In keeping with ethnographic research, the collection and analysis processes were complementary and overlapping, not distinct or separate. To collect data, four sources were used including (a) field events and my field notes, (b) formal interviews and focus groups, (c) documentary analysis of EMS legislation and regulations, EMS policy and procedure manuals, internal reports and memoranda; and (d) my personal journal.

To analyse data, an interpretive, participatory process was used. For example, themes and patterns were identified, analysed and confirmed by the participants and I when they emerged. This process ensured that the preliminary interpretation and analysis of data fit the experience of the participants. Regarding the collection and analysis of data, Hammersley and Atkinson (1983) state:

In ethnography the analysis of data is not a distinct stage of the research. It begins in the pre-fieldwork phase, in the formulation and clarification of research problems, and continues into the process of writing up. Formally, it starts to take shape in analytic notes and memoranda; informally, it is embodied in the ethnographer's ideas, hunches, and emergent concepts. In this way, the analysis of data feeds into the process of the research design... (p. 174).

The following discussion explains how data were collected and analysed according to each source. The organisation of data into sources is for ease of reading only and is not meant to imply that data were analysed separately. For example, when themes and patterns emerged from one source such as the field, they were discussed later during interviews and focus groups, and vice-versa.

Field Events and My Field Notes

My work with EMS paramedics took me into eight work sites where EMS policy was interpreted and implemented. The work sites included (a) the EMS ambulance station, (b) the interior passenger compartment in the front of the ambulance, (c) the scene of the call, (d) the interior patient compartment in the rear of the ambulance, (e) the triage desk in the ER, (f) the patient cubicle in the ER, (g) the acute care hospital breezeway where ambulances parked to deliver patients, and then prepare for the next EMS call; and (h) the place chosen for refreshment after several EMS calls were complete. These work sites were where I observed the work of EMS be conducted.

Regardless which work site I was in, I had a notebook in my pocket at all times. I recorded field events, field relations, and my observations and reflections on how paramedics made decisions with older persons in crisis. Hammersley and Atkinson (1983), who quote Spradley (1980), guided me through the process of gathering data in the field. Consequently, I observed nine features, including (a) the physical place or

places, (b) the people involved, (c) the set of related acts between people, (d) the physical things present, (e) the single actions of people, (f) the related activities that people carried out, (g) the sequencing of events over time, (h) the things people wanted to accomplish, and (i) the emotions felt and expressed (p. 156).

Specifically, I collected data that included (a) the triaged condition of the patient, the corresponding assigned *code of the EMS call upon dispatch (*see note below), and the initial response of the participants; (b) the time, location and duration of the EMS call; (c) the age and presenting problem(s) of the patient, (d) the activities of the persons present during the EMS call, (e) the questions and activities undertaken by the EMS crew to assess the patient, (f) the primary and secondary provisional diagnoses of the patient as determined by the attending paramedic, (g) the **protocols or *+therapeutic interventions given to manage the patient during the EMS call (**see note on page 27), (*+see note on page 28); (h) the assigned code of the EMS call en route to the hospital, (i) the questions or statements used by the attending paramedic to conclude the relationship with the EMS patient, (j) how the crew report was completed, and (k) the attitudes, responses and feelings of the participants and me, before, during, after and between EMS calls.

In addition, when I made my field notes, I recorded specific verbal, kinaesthetic and written behaviours of the participants and me. For example, the various meanings and functions of folk terms, technical terms, procedures and concepts used by paramedics in daily practice were analysed. This enabled identification of the beliefs, knowledge,

*Note. At the time of study, all EMS calls were assigned a code number by the EMS dispatcher when calls were given to EMS crews. The code number determined whether the call was considered emergent, as in a ‘code three’ call, or non-emergent as in a ‘code two’ call. Code three calls legitimated the use of flashing lights, sirens and high speeds. Code two calls, also known as ‘routine’ calls, did not legitimate the use of flashing lights, sirens or high speed. Once the patient was assessed by the attending paramedic, the code of the call could either be up-graded to a code three call, down-graded to a code two call, or remain the same as when dispatched, in accordance with the condition of the patient while en route to hospital.

and actions taken by the participants when they attended older persons in crisis in the community. As required by the University of Victoria, a sample list of potential questions for use in my thesis research was prepared (see Appendix E). My proposal, including the questions, was reviewed and approved by the Ministry of Health and the Department of Research Administration at the University of Victoria in March, 1993.

Formal Interviews and Focus Groups

I conducted interviews and focus groups with the participants for the purpose of acquiring new information and confirming or refuting themes and patterns in the data as they emerged. Six interviews and two focus groups were conducted. Three were on a one-to-one basis and three were on a 'one-to-two' basis, where both members of a crew were interviewed together. Five interviews were with full-time participants and one was with a part-time participant who worked full-time elsewhere in a sub-urban ambulance station.

Two of the one-to-one interviews took place in the office of the Unit Chief of the inner-city ambulance station, while the third one-to-one interview took place in the private home of the part-time participant. One of the one-to-two interviews took place in the ambulance while driving and waiting for a call, and two of the one-to-two interviews took place out-of-doors during breaks. All the interviews were audio-taped and transcribed with the permission of the participants. Consent forms were circulated prior to the beginning of interviews to provide information to the participants and to receive consent. The participants were assured before interviews began that audio-tapes and transcripts would be destroyed upon completion of the study.

**Note. At the time of study, the word 'protocols', in EMS, referred to specific regulated, invasive medical procedures which paramedics, licensed to practice at the level of EMA II or higher, were authorised to conduct, under the transfer of authority from a medical practitioner. For example, protocols existed to commence and administer intravenous drug therapy and cardiac defibrillation procedures according to the signs and symptoms of the patient.

With respect to the process of interviews and focus groups, I was guided by Hammersley and Atkinson (1983) who describe interviews and focus groups as social processes:

Interviews must be viewed as social events in which the interviewer (and for that matter the interviewee) is a participant observer. In interviews, the ethnographer can play a more dominant role than usual, and this can be capitalised upon, both in terms of when and where the interview takes place and who is present, as well as the kinds of questions asked... [W]hile it may sometimes be important to distinguish between solicited and unsolicited accounts, too much must not be made of this distinction. Rather, all accounts must be examined as social phenomena occurring in, and shaped by, particular contexts (p. 126).

I sought accounts from the participants. For example, during interviews I asked each of the participants four directive questions, with related questions, concerning their EMS experience with older persons in crisis. To remain consistent with the principle of reflexivity, I encouraged the participants to ask me questions, also, and restrictions were not placed on topics for discussion. The questions asked of all participants were:

(1) “Can you tell me about a recent, older person in crisis you responded to, who, in your opinion, did not require the services of an acute care hospital, but instead, needed something else?”

*+Note. The phrase, ‘therapeutic interventions’, was one I chose to organise my data thematically. I named as therapeutic interventions, those unregulated, voluntary practices that paramedics performed, without prompting, for the purpose of maintaining the emotional and physical comfort of patients. Such interventions, as I observed them, excluded the application of first-aid procedures and included instead (a) the initiation of appropriate conversation to establish rapport and assess the patient, (b) making contact with friends or family members to request they visit without delay, especially when safety of the patient was a concern; (c) recommending that the patient contact their physician and/or another community service for on-going assistance, and (d) assisting the patient with their activities of daily living (ADLs), including help with dressing, toileting, providing nourishment, and/or adjusting the environment to meet the needs of the person.

The following related questions were asked also: (1.a.) “What services did you think the person required instead of the ER?”, (1. b.) “What made you think the person needed that help in particular?”, and (1.c.) “How do you define a mental health emergency?”

(2) “The EMS policy and procedure manual states that unless a person capably refuses care from paramedics, the person must be transported to a physician. I understand this policy is interpreted by paramedics and EMS managers to mean that all patients *must* be taken to the hospital unless they capably refuse and sign waivers. Occasionally, I have seen paramedics make discretionary decisions with older persons by gently encouraging refusal of transport, particularly when paramedics believe a trip to the ER would be ‘a waste of time and money for all’. There seems to be a place for such encouragement, but this activity places patients and paramedics in difficult situations. Should this be solved? If so, how?”

The following related questions were asked also: (2.a.) “Can you describe a call where you encountered an older person in crisis who refused transport to hospital?”, (2.b.) “When experience tells you that an EMS policy needs changing, what role can paramedics play in such a process?”, and (2.c.) “How are policies developed or changed in your organisation?”

(3) “What educational needs, if any, do paramedics have, for their work to improve with older persons in crisis, especially mental health crises?”

The following related questions were asked also: (3.a.) “What basic EMS training in geriatrics did you receive?”, (3.b.) “What, in the training modules you now receive for continuing education, is useful or not useful, in terms of the content, delivery and writing style, in relation to what your job as a paramedic entails?” and,

(4) “Health care services are presently shifting away from the acute care hospital and back to the community. What impact, if any, is this having on EMS and your approach to patient care with older persons in crisis?”

The following related question was asked: (4.a.) “Are other options required to help older patients in crisis, in addition to the acute care hospital?”.

In addition, during interviews and focus groups, I asked the participants to reflect on, and discuss, the relationship of EMS policy and basic training to daily experience and decision-making on the front-line. Data from these discussions enabled processes of discretionary decision-making to be discovered and confirmed.

After the interviews were transcribed, I analysed them independently to identify new themes and patterns. Then, the first focus group was held to discuss and confirm the preliminary findings with four full-time participants in a quiet restaurant. A summary of the themes, issues and decision-making processes of the participants was used to stimulate discussion. Then, two months later with different participants, a second focus group was held to confirm the findings of the first group. At each focus group, the participants and I analysed the data and confirmed or refuted the findings. Pen and paper were used to record data, and the summaries of the focus groups were part of the ‘policy culture lens’ I used to interpret the documents described below.

EMS Legislation and Regulations, Policy and Procedure Manuals, Reports and Memoranda

I chose documents for analysis according to their legislative, regulatory, policy and practice-based focus. In particular, I requested copies of the Health Emergency Act (1974), the accompanying regulations, the EMS Field Operations Policy and Procedure Manual Volumes I and II, and the Crew Report Manual (1986) from the headquarters of the provincial ambulance service. Each was provided without question. In addition, I reviewed a variety of internal memoranda, reports and the chronological records of all EMS calls at the inner-city ambulance station.

I analysed the documents, above, and filtered information that pertained specifically to EMS policy and practice. Each was analysed to identify the point of view, values and beliefs within each document. I identified themes and patterns in the documents, also, in order to identify the intent of official EMS policy as it was written. Knowing this information enabled me to identify drift in the intent of policy as it was re-interpreted and implemented in the field by the participants.

My Personal Journal

I wrote entries in my personal journal after each shift worked. My journal was a repository of my personal and professional reactions to what I experienced in the highly-structured world of EMS. My journal enabled me to reflect critically on the process of my study and my part within it. For example, I analysed my journal to discover themes, patterns and shifts in my values, attitudes and behaviours toward paramedics, EMS and older persons in crisis. Tracing such shifts gave me another useful lens to collect, interpret and analyse the data of my study.

How I Maintained Rigor in the Study

To maintain rigor in the study, I invited one full-time paramedic from a semi-rural ambulance station to re-analyse and confirm the findings with me. He had over twenty years EMS experience, including being an owner/operator of a private ambulance service prior to proclamation of the Act in 1974. The work of Sandelowski (1986) guided this process. Sandelowski (1986) discusses that quantitative and qualitative researchers, alike, believe that certain activities must be undertaken to ensure that rigor in research is maintained (p. 27). Sandelowski (1986) cited the work of Guba and Lincoln and suggests that, to ensure rigor in either quantitative and qualitative research, the research must embody four values.

The four values which indicate rigor in qualitative research, according to Sandelowski (1986) are (a) truth value, achieved through 'credibility' in qualitative research, (b) applicability of findings, achieved through 'fittingness' in qualitative research, (c) consistency, achieved through 'auditability' in qualitative research, and (d) neutrality, achieved through 'confirmability' in qualitative research. When the paramedic reviewed the findings, he found them to be credible, fitting, auditable and confirmable. The paramedic stated:

This tells the story of the problems EMS has had dealing with old people ever since I joined the service. The only difference today is now, we have a lot more of them! Paramedics have been trying to solve these same problems

for years. I, personally, have been trying to tell the EMS managers and trainers in the ambulance service all of this for years so that the proper changes could be made. This is the true story all right. You have told it (personal communication, January, 1994).

The next chapter presents my ethnography of EMS paramedics and discusses the findings of my study. In particular, descriptions and analyses of the research setting, the language and vocabulary of EMS paramedics, how the work of EMS paramedics is organised, and how EMS policy was implemented by paramedics, are provided .

CHAPTER 4 - FINDINGS

This chapter synthesises the findings through sections which describe (a) the research setting: ‘fitting in’ and ‘hanging out’, (b) the language and vocabulary of EMS: learning to communicate with the participants, (c) how the work of EMS paramedics is organised, and (d) how EMS policy was implemented with older persons in crisis.

The Research Setting: ‘Fitting In’ and ‘Hanging Out’

From April, 1993 until January, 1994, I observed the participants before, during, after and between encounters with older persons in crisis. The following describes what I saw and heard when I first began ‘fitting in’ and ‘hanging out’ with EMS paramedics.

Fitting In

When I booked shifts to ride-on-car, one full-time participant advised me, “all observers must wear black or navy pants and heavy black shoes. We will give you an EMS jacket. Bring something to eat and arrive at the station fifteen minutes early so you don’t miss the first call. It can be a long wait if you do” (personal communication, April, 1993). I complied, wearing loose navy pants, black Oxford shoes, and a long-sleeved white shirt that was topped later by a huge EMS jacket. To complete my uniform, I added a few items of my own. The principle of reflexivity reminded me it was acceptable to become part of the world being studied. So, I dressed deliberately and wore my nursing pin. After my first shift on the ambulance, called ‘riding-on-car’, I wrote in my journal:

The principle of reflexivity assures me that the influence of my presence in the research is not to be feared or avoided, but embraced. So, I am expressing myself through my attire. Having met female paramedics before, I know enough to tie my long hair back and wear no jewellery or make-up. Since I have no special EMA badges or pins, I am wearing a navy ascot, my nursing pin and a black name tag that says, “Pauline, R.N.”. If I am going to fit-in and hang-out as an observer of paramedics, then I want to look like a skilled observer with something important on her mind! (personal journal, April, 1993).

Interestingly, not once during the study did any participant comment on my attire. However, all participants casually acknowledged that I was a Registered Nurse. Occasionally, I wondered whether or not I should have worn my nursing pin but I found that the participants acknowledged I was an R.N. even before I volunteered this information myself. It was apparent to me that the participants were briefed about me and the study before I met them for the first time. Consequently, my attire and nursing pin likely reinforced whatever the participants were told before I arrived to ride-on-car.

With respect to EMS patients and my status as a 'nurse-observer', one older woman in crisis noticed me standing quietly in the background and asked the paramedic attending her, "who is that person over there?" The paramedic replied, "oh, she's the supervisor. She'll tell us later if we got it right" (personal communication, June, 1993). This comment bothered me and I asked the participant later what he meant. He stated, "we have a lot to learn from you. You know a lot about old people and being a paramedic is a lot more like being a nurse than a doctor, even though we get compared to doctors all the time. So, your time with EMS should be interesting for everybody" (personal communication, May, 1993).

Hanging Out

When my shifts to ride-on-car first began, I was told to complete three compulsory tasks. First, I had to sign a waiver of my right to claim damages from the province in the event I was injured or killed while riding as an observer. Second, I had to fasten to the outside of my EMS jacket a large plastic tag that read, 'observer' in red, block letters. Third, I had to fill my jacket pocket with latex gloves for use in the event I came in contact with body fluids. With these activities complete, I began to 'hang out'. 'Hanging out' started as the crew and I awaited our first EMS call inside the station.

The station had a combined kitchen and living room area complete with a dining/work table, two telephones, several book shelves with EMS journals, bulletin boards tacked with bulletins and social announcements, a facsimile machine, a television set and video cassette recorder, and many instructional and entertainment-oriented videos. In addition, the station had two sparsely furnished bedrooms, a bathroom, a closet for EMS jackets, a memo board to note assignments, a locked office for the unit chief, and a locked garage in front to house two ambulances, medical supplies, a bench, and exercise

equipment. The dining table held three stacks of documents. One consisted of carbon copies of completed crew reports from the current month and the previous month. Another clip-board held hand-written, chronological lists of all previous EMS calls for the month, including dates, times and provisional diagnoses of each patient seen. The third stack was memoranda and circulars. I was invited to review any material in the station whenever I chose, and often did so when the participants were too weary to talk or watched television or slept. Most importantly, two different telephone lines served the station. The white phone was an ordinary line for in-coming and out-going local calls. The second telephone was black and was used exclusively by EMS dispatchers to call the station and assign EMS calls. The participants called this telephone 'mother', and I quickly learned that when mother rang, we ran.

I took my behavioural cues from the crew I was assigned to on a given shift. If a call was not received within the first half hour of a new shift, some crews settled into watching television while others went out 'cruising' in the ambulance. When I asked the participants what they liked about cruising, some stated they felt a sense of responsibility for certain street people in the downtown area. Others said they liked to drive around selected areas of town to maintain a 'visible presence' as 'protectors of the people' and 'providers of help'. For example, some crews drove along the streets frequented by prostitutes to signal that the ambulance was an available resource. Others drove through bushy, wide pathways in the city park where homosexuals and drug dealers were known to congregate. At other times, the crews met with other crews or police officers to inquire about previous calls. I found that I preferred cruising to waiting in the station for a call. When a code three call was received, there was no greater 'thrill' than feeling the ambulance accelerate from forty kilometres an hour to eighty, in less than a minute, capped by 'feeling needed' at the end of a very 'wild' ride.

During quiet times, regardless of which crew I was with, we talked, read, watched television, completed EMS learning modules and shared meals together. Since I was hired by EMS primarily to develop the BCAS/EMHS Project which the participants supported, they discussed readily EMS calls, policies, issues, and ideas with me. Whether in the station or out on a call, I observed the participants to deepen my understanding of their interactions and conversations. This is explained next.

The Language and Vocabulary of EMS: Learning to Communicate with the Participants

Early in the study, I learned basic EMS language, including the meanings of codes and phrases used by dispatchers and paramedics. Speaking EMS language from the point-of-view of paramedics was central to my role as ethnographer. It enabled analysis of the expressions, questions, statements and practices of paramedics before, during, after and between EMS calls. For example, when participants and EMS dispatchers discussed patients during radio conversations, I comprehended and queried discussions. I formed mental pictures of patients and scenes while en route to calls and examined later, the information acquired, or not acquired, by dispatchers and the participants.

Knowing EMS language enabled me to identify the information that was retained and discarded by the participants during calls. I observed, also, which information was used to make discretionary decisions. Understanding EMS language enabled me to confirm that the participants functioned as street-level bureaucrats. For example, when the participants used different language patterns under different circumstances to describe the same patient (that is, when first in the presence of family members and later, when with other emergency personnel only), the information that was used to make decisions was identified. This finding is discussed in the section about how EMS policy was implemented by paramedics with older persons in crisis. As I became conversant in EMS language, my understanding of how the work of paramedics was organised deepened also.

How the Work of EMS Paramedics is Organised

In this section, discussions on three topics are presented, including (a) the Health Emergency Act (1974), (b) the activity domains, policy implementation processes and work sites that construct the world of EMS, and (c) the crew report and debriefings after EMS calls.

The Health Emergency Act

Early in the study, I discovered that the provincial EMS is constructed and organised by the legislation and regulations of the Health Emergency Act, 1974, (the Act). The Act (1974) was proclaimed and implemented by the province of British

Columbia (BC) the same year. Prior to proclamation of the Act, the provincial ambulance service did not exist and, according to one paramedic who owned and operated a private ambulance service in BC prior to 1974, such legislation was required desperately. The paramedic stated, “before the Act came in to force, ambulance services were little more than rapid transit rides to the hospital or the morgue. It wasn’t uncommon for the local mortician to own the only ambulance in town, too” (personal communication, December, 1993). Consequently, the major purpose of the Act (1974) was, and continued to be at the time of the study, the regulation and delivery of EMS to preserve human life, according to standards and services established by the Emergency Health Services Commission (EHSC).

According to interpretations of the Act (1974) at the time of the study, oversight of EMS was required to be provided by the Emergency Health Services Commission (EHSC) of British Columbia (BC). Delivery of EMS, on the other hand, was to be provided by the provincial ambulance service (EMS). Interestingly, at the time of the study, I found that oversight of implementation of the Act (1974) was provided, instead, by the provincial ambulance service (EMS). According to EMS executives, the EHSC now existed in name only.

When I analysed the Act (1974), its accompanying regulations, and the Field Operations Policy and Procedure Manual, Volumes I and II (Province of British Columbia, 1992), I found strong convergence existed between all documents. In particular, Section 6 of the Act (1974) was predominant and provided the basis upon which all other policies and procedures were, and continue, to be developed. For example, in regard to the “Practice of Medicine by Emergency Medical Assistant(s)”, Section 6 of the Act (1974, chapter 162) states:

6. Nothing in this Act authorises a person not registered under the Medical Practitioners Act to practice medicine; but where the unavailability of a medical practitioner is likely to result in a person’s death or deterioration of health, and *an emergency medical assistant is available, he may perform emergency procedures that he has been trained for and that he considers necessary to preserve the person’s life or health until the services of a medical practitioner are available* (italics added) (p. 4).

In the field, I found the participants continually referred to Section 6 of the Act (1974), including regulations and associated policies, as ‘the mandatory transport policy’. For example, one participant stated, “the mandatory transport policy requires us, by law, to

transport all EMS patients to hospital unless they refuse to go. When patients refuse transport, they have to sign a waiver on the crew report to prove their choice” (personal communication, April, 1993).

In addition, I found that Section 6 of the Act (1974) was interpreted by senior EMS executives and the participants alike as meaning, “all EMS patients must be transported to *an acute care hospital*”, rather than as stated in the Act (1974) that, “Emergency Medical Assistants may perform emergency procedures ... *until the services of a medical practitioner are available*” (italics added) (p. 4). When I inquired, ‘why was Section 6 interpreted that way?’, one full-time participant stated, “the Act has always been interpreted that way. In some places outside the city, paramedics take patients to doctor’s offices and even clinics, but EMS administration is afraid of lawsuits, so nothing changes, policies never loosen up” (personal communication, September, 1993).

During the study, I found that the interpretation, above, existed to structure and delimit how the services of physicians were obtained by paramedics. In the past, the original intent of such an interpretation was to ensure that patients were seen by physicians as quickly as possible. At the time of study, however, I found that such an interpretation was sometimes counter-productive. This was because ambulances could be diverted from over-crowded ERs to other hospitals, at the discretion of ER personnel, while alternative ways to access quickly, the services of physicians, remained inaccessible to paramedics and patients alike. I found that the original interpretation of Section 6 of the Act (1974) was now restricting how services of physicians could be obtained quickly, by paramedics on behalf of their patients.

For example, at the time of my study, even though physicians were required to provide medical coverage for their patients in the community at all times, and existing fee schedules permitted physicians to provide emergency services in homes and walk-in clinics, the participants were permitted only to transfer the care of EMS patients to ER physicians in the acute care hospital. Implications of this finding are discussed later in the chapter. After I understood the historic intent and interpretation of the Act (1974) more fully, and its impact upon the development EMS policy, I was able to identify with the participants, the activities, processes and work sites that constructed EMS.

The Activity Domains, Policy Implementation Processes and Work Sites of EMS

While observing the participants in the field, I identified four activity domains in the EMS policy culture that existed to achieve the mandate of the Act (1974). The activity domains arose from Section 6 of the Health Emergency Act (1974), and existed to structure and delimit the world of EMS. Within the policy culture I found, also, four implementation processes that arose from the four activity domains. The implementation processes programmed, categorised and regulated the work of EMS paramedics.

In addition, I found eight work sites where paramedics conducted the implementation processes of EMS, in accordance with EMS field policy and protocols. The interpretations of the intent of the activity domains, the implementation processes and the work sites, from the point-of-view of the participants, are presented below.

Activity Domain One: 'Waiting for the Call'

I observed the construction of EMS activity domain one by the participants when they participated in a policy implementation process to 'wait for the call'. The intent of waiting for the call, according to the participants was, "to protect and serve the public at all times during medical emergencies by ensuring the continuous availability and provision of safe, reliable, EMS by land, sea, or air" (personal communications, April - August, 1993). I found that 'waiting for the call' occurred in two work sites, including the ambulance station or place for refreshment, and the driver/passenger compartment of the ambulance.

I observed 'waiting for the call' in action when crews conferred together in the ambulance station during shift changes, in the ambulance when we cruised, and in various locations to partake refreshment. During this process, the participants shared stories of previous EMS calls, read memoranda and directives from EMS management and union personnel, watched television, slept, completed voluntary EMS training modules or discussed matters of a 'light' or personal nature.

Activity Domain Two: 'Containing the Scene and Preparing the Patient for Discharge'

I observed the construction of activity domain two when the participants participated in a policy implementation process to 'contain the scene and prepare the EMS patient for *discharge' (*see note, below). The interpretation and intent of EMS policy implementation process two, according to the participants was, "to deliver EMS to persons in medical emergencies as safely, rapidly and efficiently as possible" (personal communications, April - August, 1993). I found that activity domain two contained two or three work sites which included (a) the ambulance while en route to a scene, (b) the scene where the patient was found, attended to, stabilised and prepared for discharge; and (c) the location from where the patient was eventually discharged: either the scene, the patient compartment in the rear of the ambulance, or the acute care ER.

I observed 'containing the scene and preparing the patient for discharge' in action when we drove to the scene and then attended to the patient. Then, I observed the crew assess the patient and provide care and re-assessments of the patient in the rear of the ambulance and in the ER. Finally, I observed the participants prepare the patient to be ready for discharge. For example, I observed the participants consider the information they received about the patient from the dispatcher, and then proceed to use it as a point of departure to construct the medical history and story of the EMS patient. Then, I observed the attending paramedic conduct clinical measurements, formulate provisional medical diagnoses, and perform clinical protocols according to the condition of the patient. Next, I observed the attending paramedic discuss with the patient, what protocols or therapeutic interventions could be provided to stabilise health, prior to taking action and making decisions about disposition, or discharge.

*Note. In EMS practice, I found that the word 'discharge', was avoided by EMS paramedics and administrators, alike. Instead, the word, 'disposition', was used. I was told that, "only physicians discharge EMS patients, not paramedics, so therefore, 'discharge' is not used" (personal communication, July, 1993). In writing this thesis, however, I used the word 'discharge' to emphasise the finding that in each EMS call, the participants included 'discharge' as one discretionary option for disposition, when certain conditions were met.

Regulated and discretionary options for disposition of the patient included either (a) regulated, voluntary or involuntary transport of the patient to the ER, (b) regulated, voluntary 'capable' refusal of transport by the patient, followed by discharge to self-care or others; or (c) discretionary, solicited refusals of transport from patients by the attending paramedic, followed by discharge to self-care or the care of others.

Activity Domain Three: 'Conducting the Discharge and Telling the Tale'

I observed the construction of activity domain three when the participants participated in a policy implementation process to complete conducting the discharge of EMS patients. The interpretation and intent of this process, according to the participants, was, "to conduct the disposal, or discharge, of the EMS patient to the care of a physician, or to one's self in the community, as safely and quickly as possible" (personal communications, April - August, 1993). I found activity domain three contained one or two possible work sites, depending on where the discharge took place, and could include (a) the scene where the patient was first attended to, and/or (b) the ER triage desk and patient cubicle, for those patients who were transported to hospital.

I observed 'conducting the discharge and telling the tale' in action when I observed the crew give information to the person deemed most responsible for the care of the patient upon discharge. For example, when patients were discharged from EMS to self-care in the community, information was given either to the patient or to a family member or friend, when appropriate. When patients were transported and subsequently discharged to ER physicians, information was given via verbal and written-reports to the triage nurse and, sometimes, to ER physicians directly. Interestingly, I found that information of a clinical nature, especially when it related to EMS practices and protocols, was routinely given to ER staff. On the other hand, information about therapeutic interventions that were given to the patient by the attending paramedic, such as assistance to read labels on bottles of medication or essential help with toileting, were rarely reported. The implication of this finding is discussed later in the chapter.

Activity Domain Four: 'Getting Ready and Clearing the Call'

I observed the construction of activity domain four when the participants participated in a policy implementation process to prepare to take another EMS call.

The interpretation and intent of this process, according to the participants, was “to prepare to be ready, equipped and available at all times to protect the public, by caring first for the ambulance, EMS equipment, one’s self and one’s partner” (personal communications, April - August, 1993). I found that activity domain four contained two work sites, including the ambulance breezeway outside the ER door, and various places where ambulance crews met to socialise among themselves.

I observed ‘getting ready and clearing the call’ in action when the participants completed unfinished crew reports, laundered the cot, cleaned the ambulance, re-stocked medical supplies and debriefed with other crews who were present in the ER. Calls were cleared by radio only after the crew was ready to resume being on-call. This process took anywhere from five to thirty minutes to complete. I found that crews seldom hurried ‘clearing the call’ unless the shift was known to be extremely busy. I found that on shifts considered ‘slow’, where few EMS calls were being dispatched, crews sometimes delayed clearing calls and instead, cajoled with other crews in the ER breezeway. Later, when crews felt refreshed, they called the dispatcher by radio, a new crew report was prepared, and the ambulance was slated as being ‘in service’ to await a call once again.

The Crew Report and Debriefing After EMS Calls

The crew report that was used by the participants during the study was a legal, two-sided document on a multiple, ‘carbonless’ form that was completed only by licensed paramedics (see Appendix F). The information contained in the crew report was used by EMS paramedics and headquarters staff, alike. The participants used the crew report to record narrative and numeric details of each EMS call. Such information included the dates, times, locations of the ambulance, the demography and medical history of the patient and any protocols and measurements completed during the call. Headquarters staff used crew reports for statistical and billing purposes and to monitor the type, quality and quantity of services provided to patients.

During the study, I analysed all crew reports of calls made, which I observed, to person over the age of 60 years. I analysed the reports to learn about the values, knowledge-base, problem-solving skills and logic used by the participants. I analysed them, also, to identify patterns between provisional EMS diagnoses and discharge decisions taken by the participants with older persons in crisis. These findings are

discussed later in the chapter. I found that crew reports were completed only by the participant assigned to be the ‘attending paramedic’, rather than by the ‘driving paramedic’ on a given shift. I observed, also, that the roles of attending and driving paramedic alternated between crew members, per shift.

Most space on the crew report form was dedicated to recording the provisional diagnoses, clinical measurements and protocols administered by the attending paramedic. One form was used for each encounter with a person, regardless of the number of encounters with the same person, per shift. To ensure that high standards of EMS were maintained across the province, I was told by one participant that, “Regional EMS Medical Co-ordinators are designated by the EMS Medical Director to review all crew reports whenever protocols are administered” (personal communication, June, 1993).

With respect to completion and distribution of the crew report, I observed that when patients of any age were transported to hospital, a copy of the crew report was placed on the hospital chart by the triage nurse. In cases where the ambulance was dispatched, but the patient, regardless of age, either was not located or not transported to hospital, I found that crew reports either were not completed, or were completed in much less detail than for those patients who were transported to hospital. For example, when older patients in crisis voluntarily refused transport to hospital, their signatures to verify the refusal were requested only periodically. In addition, few, if any, details to confirm the mental status of the patient as being ‘capable’ of refusing were recorded. These findings have major legal implications, and the wider topic of ambulances that are requested, but are not used (known as “ANUs”) is discussed briefly in chapter five.

After I read each crew report, I formed questions to ask the participants during informal debriefings. I conducted myself deliberately as ‘student’ in relation to the participants as ‘my mentors’. I asked for impressions of patients and descriptions about what influenced paramedic decision-making with older patients. I asked questions that pertained specifically to processes of patient assessment, management, disposition and discharge. To be consistent with the principle of reflexivity, I shared my perspectives and answered any questions of the participants, also. When themes and patterns between debriefings were identified, I asked the participants to confirm or discard them at will. Thus, debriefings enabled clarification of the values, logic and knowledge-base used by the participants when they made decisions during EMS calls. Debriefings also enabled

discovery of the difficult questions, dilemmas, decision-making processes and critical reflections of the participants when they worked with older persons in crisis. In the next section, I discuss how paramedics implemented EMS policy with older persons in crisis.

How EMS Policy was Implemented with Older Persons in Crisis

The following section, in three parts, is an integration and analysis of the findings from all sources of data. Specifically, it examines the (a) questions and street-level dilemmas of the participants when implementing EMS policy with older persons in crisis, (b) the decision-making processes of the participants to resolve questions and dilemmas with older persons in crisis, and (c) critical reflections of the participants on EMS policy, planning, training and practice.

Questions and Street-Level Dilemmas of the Participants when Implementing EMS Policy with Older Persons in Crisis

The questions and street-level dilemmas discussed, below, were identified, analysed and confirmed during field visits, debriefings, confidential interviews and semi-structured focus groups. Questions or statements which suggested the existence of dilemmas are presented below. They are then followed by quotations or scenarios, given by various full-time participants, which reveal issues and practice-based dilemmas. The definition of ‘dilemma’ used in the study was taken from the Oxford Encyclopedic English Dictionary (1991): A dilemma is “a situation in which a choice has to be made between two equally undesirable alternatives, and/or is a state of indecision between two alternatives” (p. 403). The quotations, below, were not selected to be ‘representative’ in a quantitative sense, but rather, were chosen to describe the range of questions and dilemmas of the participants when attending to older persons in crisis.

“We are Called ‘Ambulance Drivers’ by Most People in the Health Care System”

The role of paramedic is unique and outside EMS, no-one really understands what we do. EMS work is more like nurses’ work than doctors’ work. We don’t know as much as nurses, but the things paramedics are allowed to do, like IV starts and other protocols, are like what emergency room nurses do. Even triage nurses don’t know what we do, though. We can bring a patient into the ER that we’ve been working on for half an hour to save their life, and

then some ER nurse yells out to the triage nurse, ‘tell the ambulance driver to put the patient in cubicle five!’ Other times, we bring patients to the ER when they should be going to an urgent clinic beside the ER. Most patients don’t need the ER per se. But nobody would think to ask us what would work when they make decisions to build a new ER. Its like, ‘what do paramedics know? They’re only ‘ambulance drivers’. How can we feel like we’re part of the health care team when we get treated like this? (personal communication, May, 1993).

The question, above, was asked by all the full-time participants. It was asked because the full-time participants saw themselves as unrecognised, under-utilised key health care providers within a changing, interdisciplinary health care system. During a period of health care reform, characterised by escalating demands on EMS and acute care hospital resources, the participants believed they had roles and responsibilities to work collaboratively with other disciplines, yet they felt blocked from doing so.

For example, the participants discussed how they felt excluded from sharing ideas about possible ways to improve the management and delivery of emergency response services. The participants believed their input, based on daily EMS experience, could improve the quality of decisions taken by health care bureaucrats at provincial, regional and local levels. On the street, the participants stated they felt unappreciated, overwhelmed and at times, exploited by the increasing demands placed on them by the wider health care system. They stated these feelings arose when they felt, “expected to respond constantly to the growing numbers of people who were not being served adequately by the acute care or community-based health care systems” (personal communications, April - November, 1993). Also, the participants believed they possessed valuable experiences and perspectives which, if considered by health care planners, could help resolve many of the chronic ills of the health care system. Ultimately, however, the participants believed no-one would seek the opinions of paramedics until they were seen to be more than ‘ambulance drivers’. In relation to EMS patients, however, the next scenario illustrates how the participants saw themselves instead as responsible, empowered decision-makers.

“Paramedics Decide When Someone is in an Emergency”

When a person is sick, how can they decide if it is a medical emergency?
That is why they called EMS; that is why the paramedics are there in the first

place. Deciding when and if an emergency exists is our decision. It belongs to us, not the patient (personal communication, June, 1993).

The full-time participant, above, experienced frustration and dilemmas in decision-making whenever older patients insisted to him that they were having a medical emergency, yet the paramedic could find no abnormal signs or symptoms to verify, or act on, such claims. During the study, I found that before any participant provisionally diagnosed an older person as being in a 'true medical emergency', abnormal clinical results had to be confirmed first by procedures based on the scientific method.

The position of the participant, above, was strongly defended by making reference to the mandate of the Health Emergency Act (1974) and in particular, Section 6. The participant had difficulty understanding how, or why, an emergency could be defined from the point-of-view of the patient. During the study, I found that all the participants shared a belief that was stated clearly by one participant, that "since EMS is a provincial health care program, it is our duty, as trained paramedics, to identify when, and if, a true emergency exists" (personal communication, June, 1993).

I found that interpretation of the term 'medical emergency', by the participants, was narrow and contributed to the exclusion of other forms of emergencies from being identified or managed. For example, the participants did not see a role for EMS to play in the management of patients in emergencies arising from psychiatric, psychological, developmental, social, economic or functional crises. This is described further, below.

"A Psychiatric Emergency is Only When Someone is Acting Dangerously and Can Harm Themselves or Others"

I don't think of psychiatric patients as generally needing acute care services. I don't think of psychiatric emergencies as being life-threatening unless the person is acting dangerously and can harm themselves or others. But, should we respect some older person's refusal to go to hospital, or should we force them to go by calling the police? Usually, if they want to go to the hospital, we take them to the hospital. If they decide they don't want to go, then we decide if they are mentally capable of making the appropriate decision. Then, we can't take them in unless we find them incapable and have them arrested by the police (personal communication, November, 1993).

The question, above, regarding whether or not a refusal of EMS, by an older person in crisis, should be respected, or not, was raised by all the participants. The question emphasised the difficulties and scope of legal, clinical and ethical decision-making that the participants encountered when attending to certain older persons in crisis.

When the participants and I analysed this question, we found that they tried to strike a balance between four influences that arose whenever confused, older patients in crisis were attended to. The four influences were (a) the interpretation of the Health Emergency Act (1974) and the Mental Health Act (1979) by the paramedic, (b) the interpretation of the role of paramedic as first responder, (c) the clinical knowledge of the paramedic in managing geriatric mental health emergencies, and (d) the personal commitment of the paramedic to uphold an ethic to respect the rights of the older person.

With regard to the interpretation of the phrase, 'psychiatric emergency', I found, also, that a narrow definition was used by all the participants except the full-time participant who had experience as a care aide in a residential care facility. His definition of psychiatric emergency included the concept of 'personal neglect' as a form of harm which, to him, was an indicator that a psychiatric emergency existed. The remaining participants used a definition of psychiatric emergency similar to the one cited in the quotation, above. For example, most participants believed a psychiatric emergency existed only when a patient posed a physical threat to one's self, or others, through aggressive, dangerous, wilful or violent behaviours. Messy living conditions and inadequate food supplies were not considered adequately 'dangerous' to render a provisional diagnosis of psychiatric emergency, or to cause the participant to seek emergent medical advice on behalf of the EMS patient.

During a focus group, one participant stated, "psychiatric emergencies do not exist when patients are alert and co-operative, unless they have clinical signs from inflicting harm to themselves, or from having ingested harmful substances" (personal communication, October, 1993). One other part-time participant stated emphatically, "EMS calls to older persons are bogus when social or psychiatric problems are found. People have to have medical problems to need EMS" (personal communications, July, 1993). When the notion, 'EMS calls to psychiatric patients are bogus' was explored, the participants and I found this perception existed for three reasons because the participants lacked: (a) a working definition of a psychiatric emergency for older persons in crisis, (b)

education in geriatric medicine and psychiatry and viewed the field of psychiatry as distinct from the field of medicine; and (c) skills and tools to manage older persons in crisis who appeared to not have at least one acute medical problem.

I found, also, that all participants used the phrase, “we can’t force older people to go to hospital unless they are a danger to themselves or others” (personal communication, June, 1993). The phrase was used to justify leaving older persons in crisis alone without support or follow-up when transport to hospital was ‘capably’ refused. The next quotation describes how older persons in crisis were labelled ‘repeaters’ and ‘abusers’ when the participants felt unequipped and unable to provide the help that was required.

“Lots of Old People are ‘Repeaters’ and ‘Abusers’ of EMS”

Old people who call EMS repeatedly are seldom in life-threatening emergencies. They can be real problems for EMS. They are abusers of the service, especially the ones who are depressed and lonely, or those that drink too much. Often, they don’t need to go to hospital. When we do take them in, nothing is really done. So, the system is paying for EMS and acute care for someone when, in the end, nothing is really done to stop the problem that the old person called us for in the first place. We responded to a call six weeks ago where a gentleman was complaining of shortness of breath. On arrival at the scene, he was not acutely short of breath, but he had been drinking quite a bit. Apparently, he uses the ambulance weekly, if not daily. We assessed him and he was not short of breath. We took all his vital signs and found them normal. We gave him some oxygen to keep him relaxed. We also did a chemical strip test to measure his blood sugar, which was normal. We decided to transport him to hospital because it would be quicker than waiting for the police to take him to the detoxification centre. He did not need hospital services because he was not short of breath. He wasn’t a serious patient. A lot of times, people like him are just lonely and need people to talk to. They are cold and hungry and need food and a place to lie down. When we take them to hospital, they are usually discharged within an hour of arrival. Then we get another call later by someone requesting that we take him in again (personal communication, June, 1993).

The full-time and part-time participants, alike, expressed high levels of occupational frustration and role conflict when they felt required to transport to hospital, older persons in non-life-threatening emergencies. The participants referred to older persons with chronic lifestyle and/or mental health problems as being most problematic. Dilemmas in

decision-making with such individuals were encountered because, on the one hand, the participants were trained and equipped to respond to older persons with life threatening illness. On the other hand, however, the participants were not trained or equipped to respond to older persons in non-life threatening emergencies that arose from chronic lifestyle and/or mental health problems. Consequently, an unintended impact of this performance gap in policy, training and practice was that certain older persons in crisis were unofficially classified as ‘repeaters’ and ‘abusers’ of EMS.

The folk terms, ‘repeaters’ and ‘abusers of EMS’, were used by all participants without hesitation. The terms were used to refer to those older persons in crisis who (a) had unmanaged substance abuse problems, (b) lived alone and needed home support or other health care services on a regular basis, and (c) called EMS daily, weekly or monthly for ‘apparently non-life threatening’ problems. In the field, I heard the terms used to preface remarks like, “EMS has nothing to offer these old people to improve their daily lives” and “what these old people need is more home care, not EMS” (personal communications, June - November, 1993).

During the study, I observed the participants work conscientiously to deliver EMS to persons in life threatened crises, in accordance with the prevailing interpretation of the Health Emergency Act (1974) (the Act). At the same time, however, I heard the participants criticise the operative interpretation of ‘the mandatory transport policy’, as discussed previously. One full-time participant concluded,

The mandatory transport policy should be changed to make sure that older people get the help they need, where and when they need it. EMS isn’t the service to provide it and we don’t have enough training to even begin to know what to do with all these old people. The whole system is getting backed up and it is EMS who they call. So we just keep taking them in to the ER. Give us the policies and training we need so we know what to do with them (personal communication, June - December, 1993).

The next question illustrates further, the need for EMS policy and educational reform.

“Confused Geriatric Patients are Hard to Assess. How Do We Know What is Wrong?”

We see two elderly sisters on a regular basis. Its become an abuse of EMS. Several doctors have tried to get these two women into a nursing home because their quality of life is going down, their house is dirty, they are not eating properly. Who knows why the one sister is confused, whether its a combination of a psychiatric problem, dementia, Alzheimer’s disease... they have fired several doctors. Our first call there was for a collapse. The woman was alert but couldn’t answer the questions. She said she was fine. But the sister is giving us another story. One of the good clues with older people when they have real confusion is they don’t know their medical history. They say they are fine but they are on all these medications for a cardiac problem, hypertension, diabetes. Well, with this patient, we couldn’t find out what was wrong. We checked her vitals, her blood sugar, we put her on a monitor. That time I just had to go with my guts and listen to what my intuition told me. We transported her that time, but most of the time we don’t, unless there’s an obvious reason. So, what are we supposed to do? (personal communication, June, 1993).

All the full-time participants asked the same question, above, and expressed dilemmas in decision-making when confused, apparently non-life threatened patients were found.

The scenario, above, posed a dilemma for the participant because he wanted to accurately assess his patient to the best of his ability but felt unable to do so, related to limitations of training and EMS policy to curb expenditures of resources and time. Consequently, the participant felt obligated to rely on other sources of information for decision-making, including intuition and friends or family of the older person in crisis, whenever this dilemma arose.

All the full-time and part-time participants except for one, stated they “had left older, confused patients at home alone or with other care-givers” when no apparent medical problem was found to justify transport. One part-time participant emphasised, however, “I always transport confused older patients to hospital regardless of the base-line measures, because I strongly dislike wasting my time with confused geriatric patients” (personal communication, June, 1993). The next quotation illustrates how the decision-making processes of the participants, with older persons with chronic lifestyle and mental health problems, were challenged and influenced by ER staff and conditions.

“The Triage Nurse Gets Fed Up and Asks, ‘Why Did You Bring that Old Guy Here Again?’ ”

There’s just not enough room for everybody. I get told off by the triage nurse when I take skid row types in to the ER, especially when the nurse tells me the same guy has been in thirteen times that week already. I have to make a choice. As for the other old patients who had falls or something and nothing seems broken, when I know the ER is really busy and the person is probably going to be sent home at four in the morning, or worse, be stuck on a stretcher all night, I encourage them to stay home and call us later if there’s a problem. This is better for the patient and for the system (personal communication, December, 1993).

The full-time and part-time participants all referred to a sense of obligation, or duty, to provide appropriate services to patients, versus the need to protect the resources of EMS and the ER. One full-time participant stated, “our peers teach us on the skids who to take in and who to leave. We have to learn this. . . the system can’t handle all the people who want to go to hospital” (personal communication, June, 1993). In particular, people with chronic problems of substance abuse, mental health problems, and other apparently non-life threatening illnesses, such as “bad colds” were cited as potential persons to not transport to hospital, “unless a really obvious medical problem is found, too” (personal communication, June, 1993).

When the full-time participants felt required to make decisions with such persons as those described, above, the participants stated they felt obligated to choose between two options, either (a) to obey the mandatory transport policy and be chastised by the ER staff for having brought the person to hospital, or (b) to disregard the mandatory transport policy and leave the person in the community, to preserve social relations with the ER staff. One call I observed illustrated the first option in action. I wrote in my field notes:

We made a call to a mobile, moderately inebriated, sixty-year old male who was known by EMS to have a severe alcohol problem. He requested to be taken to the ER to see a doctor for treatment of his harsh, productive cough. The call demonstrated to me just how important it is to the paramedics that they maintain social relations with the ER staff, even at the expense of the physical and emotional comfort of their patient. When we arrived at the scene, within a minute I saw the attending paramedic, who was usually very gentle and caring, assume a defensive posture and use a loud, impatient tone of voice.

After what sounded like verbal jousting between the man and the paramedic, the man climbed in the back of the ambulance. In three minutes we were at the ER. Once in front of the triage desk, I heard the triage nurse say, “this is the worst guy I’ve seen in a long time. Give him a kleenex. Oh my God, that cough, its gross”. I couldn’t believe what I was seeing or hearing because it was so disrespectful. Then the attending paramedic said, “Ya, what can you do with guys like this? He has chronic chest pain, too, but we already know he’ll be non-compliant with his meds.” The triage nurse added, “he’s here all the time with the same complaint. Wheel him into the waiting room. He’ll probably leave before we call him to see the doctor.” Then, the man shouted, “I have a f---ing right to be here! Why are you saying that about me? Just let me see the g-d--- doctor!” The man was taken to the waiting room and left alone to wait. The call was cleared in ten minutes, but the rawness of the encounter, three hours later, is still evident in my head (field note, August, 1993).

When I reflected on the call, I recalled that the unsupportive behaviour of the participant and nurse preceded the agitated behaviour of the man. I wondered whether the participants would have brought the man to the ER at all, had it not been for my presence and interest in all older persons in crisis. The call led me to conclude that the participant valued maintaining amicable relations with the ER staff as much as, or more, than providing adequate care to an impoverished, older, mobile EMS patient with an obvious alcohol problem. Responding to such persons clearly created dilemmas for the participant. When the call was debriefed later, the participant stated:

Old drunks like him need help from community services other than EMS and the ER. Why didn’t he just go to his doctor’s office? He’s an abuser. We need more detoxification centres, urgent psychiatric clinics and access to emergency mental health services for men like that. We shouldn’t be tying up an ambulance with somebody like that (personal communication, July, 1993).

I found the participants occupied a voluntary, gatekeeper role to exclude certain older persons in crisis from utilising EMS, for example, persons whose most active problem appeared to be chronic alcoholism. The next quotation captures a common dilemma of the participants, where they either felt obligated to transport a person ‘unnecessarily’ to hospital, or to leave a person alone in the community, without support or follow-up, when refusals of transport were received.

“At Three O’Clock in the Morning, Who Do We Call?”

Since the arrival of more community support programs, EMS is getting more calls from elderly people who want to be put back to bed. Medic Alert systems have really increased EMS calls, and as paramedics, we have to decide whether or not the person needs to be seen in the ER and whether or not the person has adequate services in place. But the problem is, at three o'clock in the morning when the person refuses EMS, who do we call? If we leave the person at home, we just hope they have an assessment the next day by someone in the community. For EMS, there is no way to access the home support system without a doctor’s order. And when we get called to see a confused person and they aren’t acutely sick and we know the hospital can’t do anything more for the person and its three a.m., what are we supposed to do? (personal communication, May, 1993).

The question, above, illustrates the conflict and potential jeopardy that arose for several of the full-time participants and their patients after a working knowledge of community geriatric services was acquired, without a concomitant granting of access to such services.

Specifically, the conflict was between the professional and ethical commitment of the participants to provide the most appropriate emergency response for their patients who refused transport, and the work place reality that the most appropriate services were either inaccessible or unavailable to paramedics. The next statement illustrates how geriatric patients, by virtue of age alone, have created ‘problems’ for the participants.

“Old People are Not the Reason Most People Become Paramedics. When Paramedics Respond to Old People Who have Fallen out of Bed, They Ask Themselves, ‘What Do I Have to Do to Clear the Call Quickly So I Can Get the Next Code Three Call?’ ”

All paramedics know about meals-on-wheels and home care support services because we do so many ‘old folks calls’ where people stay at home to the bitter end. A lot of times, though, we just put them back to bed. Some folks are unable to get up once they fall out of bed. They can’t get back in, so they call EMS. Some crews who have been on the job a long time clean people up after they soil themselves, make the bed and make the person comfortable. Other crews wouldn’t give the time of day. For some reason, those paramedics think that giving that kind of care is not their job. They say, ‘that’s not why I became a paramedic. Its the blood and guts that I’m here for, none of this social stuff’. The EMA program has no training in geriatric care to even encourage a change in attitude. I work with two paramedics who are really

terrific with old people. They are socially minded when it comes to old folks and their needs. Other paramedics are more aggressive. Their interests do not lie in making a really good discharge happen for an older person. Those paramedics are more interested in airway management techniques. When that kind of training is offered, they are first to sign up. Some paramedics don't see our role as including looking after the mental aspects of the patient's well-being. Instead, they think of the patient in terms of, 'either you're hurt or you're not hurt. If you aren't hurt, then my time is wasted here and I can get a better call where I'm really needed. Sign the crew report. I'm leaving'. That's what a lot of paramedics think and do with older folks (personal communication, June, 1993).

One participant stated the root of the problem was the basic curriculum for paramedic training. He suggested it emphasised the performance of invasive medical protocols to sustain life rather than the acquisition of medical knowledge to enhance the provision of care for apparently non-life threatened patients of any age. When I examined selected EMS training documents I found the perspective of the participant, above, was strongly reinforced. I found only five lines of text allocated to describe the needs and management techniques of the elderly patient (Justice Institute of BC, chapter 17, p. 4).

When the participants and I analysed the questions and statements, above, and the dilemmas that often arose in practice, one predominant issue of EMS policy and practice converged. The participants and I found that paramedics as a group, believe that when older persons in crisis are found to be in life threatening emergencies, a wide range of EMS clinical services can be provided without conflict. On the other hand, when older persons in crisis are found to be in apparently non-life threatening emergencies, paramedics have only one choice to make between two conflicting alternatives. Paramedics can either (a) take the time necessary to assess and manage the older person, while reducing the availability of EMS to respond to potentially life threatened persons; or (b) manage the older person in a non-life threatening emergency as quickly as possible, in order to be available to respond to other potentially life threatened patients. The next section is a description and analysis of the discretionary decision-making processes practiced by the participants, as they tried to resolve the questions and dilemmas, above.

Decision-Making Processes to Resolve Questions and Dilemmas

The discretionary decision-making processes were discovered, analysed and confirmed during an eight month period. They were found by identifying patterns of responses to the questions and dilemmas of the participants when they attended older persons in crisis. To enhance my ability to analyse the decision-making processes with the participants, within the EMS policy culture, I examined, also, a clinical text about EMS by Caroline (1991). The text was recommended and used by the provincial paramedic training institute and provided me with an understanding of the five stages of pre-hospital care that all EMS paramedics were expected to conduct, without discretion. The stages of pre-hospital care are presented below, followed by a description and analysis of seven discretionary decision-making processes.

All participants in the study learned to conduct the five stages of pre-hospital care according to their level of license to practice, as either an EMA I or EMA II paramedic. I found that the stages of pre-hospital care related to how the policy activity domains and policy implementation processes of EMS, discussed earlier, should be carried out. Caroline (1991) describes the stages of pre-hospital care:

Stage one of pre-hospital care [EMS] is to survey the scene, including checking for and eliminating hazards, determining if back-up help is required and identifying special equipment that may be required to gain access to the patient.

Stage two is to conduct the primary survey, which includes the rapid assessment and treatment of conditions that involve an immediate threat to life. Specifically, paramedics are to (a) initiate airway management, (b) ensure the patient is breathing, and (c) check the adequacy of circulation and start cardio-pulmonary resuscitation for cardiac arrest; control haemorrhage and start treatment of shock; and continue reassessment and management of airway, breathing and circulation.

Stage three is to conduct the secondary survey, which includes looking at the scene for the mechanisms of injury, obtaining a more detailed history, and conducting a head-to-toe physical assessment of the patient.

Stage four is to conduct definitive field management of the patient, including wound care, stabilisation of fractures and packaging the patient for transport.

Stage five includes the ongoing re-evaluation of the condition of the patient (bold and italics added) (Caroline, 1991, p. 50).

When I examined the aforementioned questions and dilemmas to determine where problems occurred and difficult decisions were required to be made during the pre-hospital care process, I found problems and decisions arose during stages three, four and five. No problems, dilemmas and discretionary decisions arose during implementation of stages one or two of the pre-hospital care process where EMS activities are highly programmed to sustain life and where acute, physical problems must be quickly diagnosed.

The following story below, as told by a full-time participant, illustrates a call where the stages of pre-hospital care were followed without difficulty. The story recounts a call to an older woman with a fractured leg. No discretionary decision-making was required and the story illustrates how EMS policy was converted, through practice, into five task-oriented, clinical stages of care based on scientific logic.

Stage 1. Survey of scene: note hazards, request back-up, get equipment.

We arrived at the scene in three minutes and took the stretcher up. It was a small three story apartment building with an elevator, and the lady lived on the top floor in a one bedroom place by herself. I scanned it and saw the lady lying on her side, alert, in the middle of the floor. She was in obvious pain. The place was neat, clean and quiet. Nobody else was there. There was one way out, through the front door. Oh, there was a small balcony too, but it was blocked.

Stage 2. Primary survey: do ABC's.

The lady said she fell off a chair while she was cleaning. She said she crawled ten feet to phone us. She was breathing and talking to me without distress. There was no bleeding, but her right ankle looked broken. Her colouring was good. She spoke real quietly and politely. She made sense.

Stage 3. Secondary survey: closer look at scene; do medical history, head-to-toe assessment.

She could tell us what medications she was taking and she didn't seem confused at all. Then I checked her from top-to-toe and took her medical history and vital signs as I went along. There was nothing out of the ordinary but her ankle. She was in good shape for her age. She was around eighty-five. I knew she needed a full leg splint because when I looked closer, the break looked like it was at the base of her leg rather than her ankle. I knew she needed to go to the ER for an x-ray and a cast. She probably needed surgery. It was nasty. You could see the end of the bone pushing her skin up, but it wasn't bleeding.

Stage 4. Definitive management: wound care, stabilise fractures, package patient for transport.

I sent my partner to fetch the splint. While I was putting it on, I told her we were taking her to the hospital for a doctor to check her leg. She didn't question that. We loaded her in the car and I filled out the crew report as we drove to the ER.

Stage 5. Ongoing re-evaluation of the patient's condition.

When we got to the ER, I checked that the lady was still okay and that the splint hadn't moved. Then we unloaded her and I told the triage nurse what was up. That was a pretty good call (personal communication, May, 1993).

The stages of pre-hospital care were conducted smoothly in the scenario, above, because the patient had only one acute medical problem, without chronic social, mental or functional problems to pose difficult questions or dilemmas to the participant. The knowledge-base of the participant was sufficient to manage the situation and hence, the policy implementation and decision-making processes were not impeded.

In the field, with respect to EMS calls where questions and dilemmas in decision-making occurred, however, I asked the full-time participants, "how do you implement EMS policy and make decisions about what to do with your patients when there are no protocols or policies to guide you?" One participant stated:

Paramedics don't make decisions. We do the primary survey and look after the ABC's. Then we do the secondary survey and find out if any protocols are required. If none are required, we just do whatever else is needed and transport the patient. If the patient refuses, we either force them to go in or leave them at home and clear the call. That's it. We only have policies and protocols to direct care when invasive procedures like intra-venous drugs or special treatments are needed. If the patient doesn't need protocols, we just do the best we can. (personal communications, April - November, 1993).

Despite the participants stating they did not make decisions, however, I observed them make continuous decisions during implementation of the stages of pre-hospital care. For example, when the patient was being prepared for transport, I heard crew members ask each other, "should we take the patient out on the cot or in the chair?", and, "should we get the police to accompany her-- what do you think?" When the participants were leaving an older woman in the community, when she refused transport to hospital, the attending paramedic asked his partner, "I think we should get a family member here to stay and watch her-- what do you think?" I had difficulty understanding why the

participants did not recognise these events as critical decision points in the policy implementation process which had impacts on subsequent actions taken.

When I analysed the Field Operations Policy and Procedure Manual (1992), to confirm what the participant stated in the quotation, above, I found no EMS policies or protocols to resolve the questions and dilemmas described earlier, or to guide paramedic decision-making. What I did discover, however, was that when the participants implemented stages three, four and five of pre-hospital care to non-life threatened older persons in crisis, the participants were obliged to practice adaptive, discretionary decision-making without policies or guidelines to do so. Seven discretionary decision-making processes were used.

The seven discretionary decision-making processes to adapt EMS policy fell into three groups, including (a) processes to manage ‘repeat users’ and ‘abusers’ of EMS, (b) processes to manage ‘adamant refusers’ of EMS, and (c) processes to solicit patient refusals of transport. Each group is discussed below, followed by a brief discussion later about the common characteristics of the decision-making processes.

Processes to Manage ‘Repeaters’ and ‘Abusers’ of EMS

The first story, below, describes how the participants tried to extinguish repeat calls to EMS by an elderly, ‘repeat user’ of the ambulance service. Although no formal definition of ‘repeat user’ existed, I found that older persons were called repeat users if interventions from EMS were requested more than twice within the same calendar month.

The “Give the Patient Tea and Cookies to Stop the Calls to EMS” Process

There are lots of little old ladies who phone EMS with a medical complaint yet, when you arrive at their home, there really is no problem other than they are alone and lonely. We had one house we were called to everyday. Just after this person went to bed, she would become short of breath and call EMS. After awhile, we found that if we went to her home about ten p.m. and gave her a cup of tea and cookies and put her to bed properly, she never phoned. She was just lonely. Now, its nice when we can help a woman like that, but there are calls waiting and we really can’t do that (personal communication, June, 1993).

The discretionary decision-making process, above, illustrates how paramedics sometimes responded to repeat users of EMS. This process was practiced only rarely by one crew of the full-time participants. They stated that, “it is common for paramedics to help old people out, especially when the person is known and liked by a lot of people” (personal communication, June, 1993). I found that older persons who reputedly received such assistance from paramedics were described as “lonely” and “suffering from problems getting around, problems getting enough to eat and increasing memory loss” (personal communication, June, 1993). Use of the discretionary decision-making process, above, indicated the participants were asking the question, “what actions do we need to take to prevent repeat users of EMS from calling in future?” While it was beyond the scope of the study to explore this question, further research on the topic of repeat users is required.

Interestingly, I found the other full-time participants stated they all knew paramedics who responded to repeat users in ways similar to those in the story above, but, the participants clarified they “did not provide such services” themselves. Instead, two participants stated, “if we find some fellow who has soiled himself, of course we will wash him up and change his bed before we go. That’s the proper thing to do for somebody when we find them like that” (personal communication, June, 1993). Two other part-time participants felt differently, however, and stated, “no, I would never prolong a call by staying to clean patients up. Some of the older paramedics are getting mellow about that kind of stuff with old folks, but I would never waste my time on that. What about the child that is choking across town? We always have to be available for code three calls” (personal communication, August, 1993).

At the time, I noted in my journal that when the full-time participants discussed providing personal care to older persons in crisis, their voices dropped and they spoke in hushed tones, as if such information was secret. When I asked the participants if use of the discretionary decision-making process, above, could unintentionally increase the number of calls to EMS by repeaters and abusers, they stated, “it might, but it has also prevented some for sure” (personal communications, June, 1993). The next story, as told by one of the full-time participants, illustrates how one entire station of paramedics, of which he was a member, discretely decided to co-ordinate their efforts to ‘case-manage’ one older, repeat user of EMS.

The “Paramedics-as-Case-Managers” Process

We had this one fellow, a retired university professor who was alcoholic. He was always drunk whenever we were called, and he would throw things, strike out and be very belligerent. When he was sober he was a great guy. The local hospital had had it with him. They treated him with disgust and disdain right through from the nurses to the doctors. They didn't have the time of day for this guy. He always complained that his ulcer was acting up whenever we took him in to the ER. Many times we just put him back to bed, but when we did that, often he would start crying and have big fits if we didn't pay attention to him. Eventually we learned to stop fighting with him.

We had a station meeting about him with all the paramedics collectively, part-timers and full-time alike. We decided, 'enough!' and that on the next call we had to his house, the paramedics would tell him they would not take him to the local hospital any more because he was not receiving the care he needed to stop his problems. So, we said to him, 'let's take you to a hospital where they don't know you and let's start you off with the proper resources'. We did that. We took him to another hospital in a neighbouring district. He had worn his family resources down to zero. The hospital people who knew him before were not treating him properly . . . Well, this man got better treatment at the other hospital.. He was put into an alcohol rehabilitation program. He was sent to the regional mental health facility for assessment. It worked for a short time, then the cycle of him calling EMS all the time began again.

Eventually, the second hospital became tired of him, too. They had offered him the programs, gone through the steps with him, walked the walk, but he was unable to continue on the program. Eventually, he just moved out of our district. Now he is someone else's problem (personal communication, June, 1993).

The participant who contributed the story, above, responded to this older EMS patient when he was based as a paramedic in a semi-rural station elsewhere in BC. This decision-making process illustrates that with certain repeat users of EMS, paramedics are capable of delivering EMS according to selected principles of case management.

For example, the paramedics collaboratively identified several issues in need of resolution. First, they identified that the man was a repeat user of EMS and second, that regardless of the number of times he was taken to the ER, he was discharged quickly without a plan of care to resolve his presenting problems. Third, the paramedics found they had been 'fighting' with the man, rather than taking supportive action on his behalf.

Fourth, the paramedics collectively assessed the problems of the patient, and decided with the patient that he required intervention from a different ER. Fifth, the entire station of paramedics worked as a team, on behalf of the patient, and decided to respond to him consistently, according to a patient-focused plan of care.

The call, above, highlights that the participant and his peers chose to deliver EMS as a deliberate process to resolve a specific problem with a patient, rather than as a series of tasks to address separate problems. Such a shift in practice indicated that ‘action learning’ occurred among the paramedics. In a text by Meziro (1990), Marsick states:

Action learning is highly compatible with many of the premises on which adult education is built. It is driven by peers, focused on immediate problems, based on learner experience, and is highly participatory. Because action learning is built around real life problems with real life consequences, learners are usually motivated to deal with issues that arise that block understanding and solution of the problem. . . learners are not inclined to evade issues, because they see how relevant they are to effective action. This is particularly true when participants work in teams (chapter 4, p. 44).

The story above, and the collective decision of the group of paramedics to provide a pre-structured, consistent response to a repeat user, has implications for how EMS can be delivered in future. Next, discretionary decision-making processes to manage ‘adamant refusers’ of EMS are presented.

Processes to Manage ‘Adamant Refusers’ of EMS

The story below illustrates a discretionary decision-making processes to manage an older man in crisis who ‘adamantly refused’ transport to hospital.

The “Patient Refused and I Let Him Be” Process

A gentleman I responded to recently wanted to stay at home. He would not go to the hospital. He had a medic alert tag on. He had fallen; that is why we were called. He was lucid and told us he was not going to leave his home. He said that if his lot in life was to die, then he would die at home. As soon as I arrived in his home, I walked around and looked at his social conditions. I wondered, ‘does the place smell like urine? Is the floor sticky? What’s in the cupboards? What is this man eating? Has he got good food in the place? Who’s

coming in? What kind of social services are already coming in? Does he have meals-on-wheels? Who is doing the grocery shopping? Has he got family support in town? Are the relatives coming in every day, or is he totally relying on support services in the community?’

This particular man never left his house. He had meals-on-wheels daily and twice a week somebody came in to straighten the house up. Also, a male nurse came in and gave him a bath as well. His house was neat; it had a bit of a urine odour to it. He had no cardiac problem at all. He was really shaky, had fallen many times at home and I wondered how he got around at all. He was basically fairly healthy, on no medications at all, just getting on in age. And of course, he was forgetful. I ask all those social questions to make a decision.

We wanted to take him to hospital because he looked like he wasn’t getting enough support. I actually phoned the Quick Response Team and they said they were swamped and couldn’t get anyone there. He had been found by his homemaker who was concerned about him. He was unshaven and a little smelly. He had had many falls, bruising on his body a little bit, nothing broken, no open wounds of any kind. The home-maker thought he was getting a little more senile and that he should have twenty-four hour care. A lot of times the family members are frustrated by trying to place the person in a nursing home because the person refuses to go. [The older person] knows its a one-way street to the nursing home. Dignity is lost right away. Independent care is lost and these are very independent people. So, in the end, I decided to just let him be (personal communication, June, 1993).

This discretionary decision-making process illustrates how interpretive and scientific knowledge was integrated by the participant to mediate the medical, social, functional and ethical concerns that had been identified on behalf of the patient. The participant who told this story stated he used this decision-making process, “fairly often with older persons when they are in non-life threatening, social emergencies” (personal communication, August, 1993). Interestingly, the participant had two years work experience as a care aide in a residential facility that provided cared to older persons with chronic medical and psychiatric problems. The participant stated this previous experience “really helped make my work, as a paramedic, be better with old people” (personal communication, August, 1993).

The discretionary decision-making process, above, incorporated discrete observations and questions to provide the participant with additional information to

assess the medical, psychological, social and functional abilities of the patient. The participant implemented the process, above, to achieve two purposes, (a) to confirm whether or not the refusal of transport by the patient should be accepted or not, and (b) to decide whether the patient required urgent follow-up or not, by another community-based health care service. The next story illustrates how some older persons in crisis, when they ‘adamantly refused’ EMS, were threatened with arrest by police under Section 24 of the Mental Health Act (1979), to force transport to hospital.

The “Threaten Section 24 Until They Give Up and Go” Process

I used the threat of Section 24 lately with two little old ladies. One had smoke inhalation from a fire that was smouldering in her apartment. She had been trying to put it out for four hours. Four hours! Why would anyone do that and not call the fire department? Her nostrils were black, but she still kept refusing to go to the hospital. Threatening her with the police was the only way to get her to go. The other time was with an older lady who was staying at a downtown motel. She looked like she was having a heart attack. She was pale, diaphoretic and very weak. She was really scared but she wouldn’t go in. We talked to her for fifteen minutes and finally got some oxygen on her but still she wouldn’t go in. She was afraid her children would come and then force her into a nursing home. When I threatened her that I would have her arrested and the police would take her in, it was only then that she agreed to go (personal communication, September, 1993).

This discretionary decision-making process illustrates how the participants responded to older persons in crisis, with acute medical problems, when they ‘adamantly refused’ EMS. When I asked the participants about the usefulness of Section 24 of the Mental Health Act (1979), and when it should be implemented, one participant stated:

I have never really seen a proper Section 24 done. It is used more as a ploy to get a person to agree to go to hospital-- to make the person think, ‘Ok, if that is the way it is, if I am going to be arrested, then so be it, I will go’. Paramedics use Section 24 as a persuasive tool to limit the options of the patient. I use my own experience and common sense to dictate my decision on whether or not to call the police in. I ask myself, ‘what would I be doing in this situation versus what I see my patient doing?’ If I decide the person has to go to hospital and the person keeps refusing, then I say to the person, “either you come with me now or I am going to have the police come down here and arrest you”. If that doesn’t work, I bring the cops in. I don’t know what it is, its another uniform presence or again the power of their uniform, or status within the community, but

in most cases the person will say, 'Ok, I give up'. That's saying, 'I'm coming in'. Paramedics have to have a tool like this for some old people-- its the only way we can help some of them (personal communication, July, 1993).

While all participants valued Section 24 as a back-up tool to manage elderly patients, I found it was implemented with great reluctance.

When the participants and I reflected on previous calls made to older persons where Section 24 was implemented, or threatened to be implemented, we found that all the patients had provisionally diagnosed, acute, unstable medical problems or were becoming physically aggressive or violent. Interestingly, in calls where the functional status and safety of the older person was of concern to the paramedics, but no unstable medical problems were provisionally diagnosed and the person remained co-operative, the participants stated they "usually did not threaten to call the police to force transport" (personal communications, November, 1993). The next story illustrates the difficulties faced by one participant when he tried to assess and manage an older man in crisis who 'adamantly refused' transport to hospital.

The "Just Try and Get Them in the System" Process

Some old people who live on the streets refuse to go to hospital with us. We were called by city workers once to go down to get this older fellow. He was a nice man who spoke real quiet, real soft. He was a very well behaved, well mannered gentleman, but he just stank and was in just wretched condition. He was in his sixties and appeared fit. He even had his own apartment. He had a place, a home to go to. He had collapsed in front of city hall and was adamantly refusing to go to hospital. I looked at him and said to my partner, 'well, we have to do something. We just can't leave this guy and let him be'.

Well, we called the police and talked to them and said, 'listen, this guy is well within his rights to not come to the hospital with us, he is totally lucid, but look at him-- something needs to be done here. We can't let this guy live on the street and just stay like this. Arrest him for vagrancy or whatever you want to do, but get him into the system. Somehow try to get him into the system where he can be looked after'. He agreed to go with the police in the back of the paddy wagon to the hospital.

The triage nurse put him in the waiting room of the ER on a particularly busy day. He never got looked at. He was taken to the waiting room and of course, he was a mess. So he was put in a wheelchair off to the side... they saw him as a social

problem as opposed to a medical problem, although he looked very ill and bad. He was not complaining of anything in particular. Medically, he was lucid and very shaky. There was no way we were going to leave him.

The outcome of this case was that this gentleman walked away. He had the strength to walk out of the ER. He crawled under a tree just outside the hospital and was discovered the next morning by a passing ambulance. They saw part of his body hanging out from underneath the tree. He was unconscious at that point. They took him into the hospital suspecting maybe hypothermia from being out on the street, from sleeping outside the previous night. There was a frost that morning. Upon re-warming him and bathing him, his level of consciousness never rose very high. So, now they were looking for medical reasons to explain why this man is not one hundred percent. He goes for a 'cat scan', and the scan showed that a quarter of his brain had been taken over by maggots. When they shaved the back of his head, they found the entrance way. A hole in the back of his head. The maggots had moved in there and eaten away part of his brain. He subsequently died that day.

It just stinks like there's no tomorrow that these people can speak quite calmly about what day it is and their orientation to place and person is perfectly fine, but yet they can refuse to come to hospital. It is not taught in any of the EMS courses to get the police involved or to refer these people to other services. What can EMS do with these people? There is no liaison between the ambulance service and suitable services that can be provided for people who refuse to go to hospital.

In cases like this one, EMS needs a policy, a way, a system where paramedics can phone someone to come out and make clinical decisions for patient management. These decisions shouldn't be the paramedic's alone, because our skills and training in geriatrics isn't there. I suspect that many cases of older patients who are left in the community have serious, untreated medical problems. They keep falling through the cracks. When we do this, its like talking to our patients on the phone and hanging up. But some paramedics think, 'oh well, I'll never see that person again'. In three days its out of their head and they think, 'well, for heaven's sake, someone somewhere else must have looked after him' (personal communication, June, 1993).

In the decision-making process, above, the participant in the story practiced four behaviours. First, without success, due to lack of co-operation by the patient, he tried to complete the primary and secondary surveys of the patient. Second, he received, and decided to reject, an adamant refusal of transport from the patient. Third, the participant

decided to call the police without delay to force transport of the patient to hospital, via Section 24 of the Mental Health Act (1979). Fourth, during subsequent visits with ER and EMS staff, he inquired and reflected upon the outcome of the patient.

In the story above, the participant recognised his limitations to assess the man and instead, used what biological, social, psychological, functional and intuitive information he had to justify transport to hospital under Section 24 of the Mental Health Act (1979). The inadequate knowledge of the participant, to provisionally diagnose an acute confusional state, or delirium, however, may have contributed, in part, to the low priority assigned to the patient at the triage desk. In addition, based on earlier findings in this study, the man was ‘high risk’ to be sent to the waiting room by the triage nurse. A provisional diagnosis of delirium by the participant, had it been recognised and communicated to the triage nurse, may have enabled the man to have been triaged as a higher priority and thus, treated more quickly upon arrival in the ER. The next decision-making process illustrates how refusals of transport, called ‘soft code X’ing’ and ‘hard code X’ing’, were solicited by the participants from certain older persons in crisis.

Processes to Solicit Patient Refusals of Transport

The anecdote, below, stated by a full-time, female participant, describes the discretionary decision-making processes called, ‘soft code X’ing’ and ‘hard code X’ing’. I found that soft and hard code X’ing were used by the participants with EMS patients of all ages, including older persons in crisis.

The “Soft Code X” and the “Hard Code X” Processes

The soft code X is when the paramedic puts the words in the patient’s mouth. The paramedic spends fifteen minutes convincing the person that ‘no, you don’t really think you need to go to the hospital, do you? What do you think?’ And the patients all say to the paramedics at that point, ‘no, no. I think I will be all right. What do you think?’ Then the paramedic says, ‘well, I am not allowed to make a decision about this for you, but if you think its something that maybe could wait . . . I think maybe it could wait, but I am not telling you what to do. You tell me that you don’t want to go to the hospital . . .’.

That kind of scenario would be a nice soft-sell code X. Some paramedics lie about the hospital being busy, or they convince the person they don't need to go, even when the person wants to go. Although the person is the one who phoned EMS and the paramedic is actually refusing them, through their street-smarts the paramedic manipulates the person's words to the point where the person says, 'ok, this is why I do not need to go to the hospital now, so its all right if you leave me here'. A hard code X is when the paramedic gets the person frustrated enough to say the words, 'fuck you!' Now that is the ultimate refusal of service, and then the paramedics just leave (personal communication, June, 1993).

I observed soft code X'ing and hard code X'ing in practice when the participants encountered certain older persons in crisis. I found that both types of code X'ing were constructed and conducted invisibly by the participants, and the patients always gave the impression of 'voluntarily participating in the decision' to terminate the EMS call.

All the full-time participants stated they learned to practice code X'ing from their EMS peers in the downtown core of a large, neighbouring city. The participants stated they practiced soft code X'ing when the presenting complaint was non-life threatening, and especially of a social nature. In particular, I observed soft code X'ing with older patients who had (a) fallen without apparent injury, (b) non-specific complaints and functional disabilities that were complicated by living alone and chronic alcohol abuse, (c) requested EMS for companionship and/or assistance with the activities of daily living. I observed hard code X'ing in practice by two crews when they responded to older, single men with symptoms of alcohol abuse in the presence of normal vital signs. When I asked one participant why code X'ing was used so widely to terminate calls, he stated:

Chronic abusers want to go to the hospital. They phone EMS a dozen times and when we arrive, they have their bags in-hand. Some have chronic mental health problems and they tell us all their medical problems to convince us to transport them to hospital. Many paramedics just code X them when they call over and over again (personal communication, September, 1993).

I found that all participants, except one with full-time EMS experience who worked part-time during the study, stated code X'ing was an acceptable practice. The part-time participant who did not practice code X'ing stated:

To save my own time and energy, I just decided to follow the rules. I no longer spend fifteen minutes at a scene trying to convince someone they do not need to go to hospital. I have come to the conclusion that there are a lot of abusers out there, more of them than me, and if I get myself all upset every

single time these people want to go to hospital when I think they don't need it, and we argue, I will exhaust myself, I'll drain myself and become embittered and won't like my job any more. I try to tell that to the young paramedics, too. I say, 'don't bother going on and on with people to try and get a refusal of transport from them. Just take them in, the chronic abusers. Just throw your hands up and say, come on! let's go! (personal communication, June, 1993).

The part-time participant, above, had come 'full circle' in his choice of decision-making processes. He chose to implement EMS policy and the five stages of pre-hospital care as programmed policy, independent of his years of experience in EMS and a residential care facility and without regard for his education or ethical beliefs. Interestingly, in the eyes of his peers, this participant was considered 'burned-out' and 'uncaring'. In his own mind, however, he believed 'compliance with policy' meant practicing 'self-preservation' skills.

During interviews, focus groups and in the field, it was clear, to me, that the practice of code X'ing was a hidden process which had, and continues to have, critical implications for EMS policy, planning, training and practice. This is discussed further in chapter five. Next, is a brief discussion about four characteristics that I found were common to all the discretionary decision-making processes.

Four Characteristics of the Discretionary Decision-Making Processes

The first common characteristic of the decision-making processes, above, was that each process was intended (a) to maintain the availability of EMS paramedics and ambulances to respond to code three calls, and (b) to protect EMS paramedics from being found negligent or practicing medicine without a license. The second common characteristic was that each decision-making process contained multiple, invisible discrete decision-points. The decision points related directly to specific events where paramedics departed from programmed implementation of EMS policy and the five stages of pre-hospital care. Identification of the decision points showed how, when and for what purpose, discretionary decision-making processes were implemented in practice.

Third, the discretionary decision-making processes incorporated scientific and interpretive knowledge that was acquired on the job, either through critical reflection of previous EMS calls, or through assimilation of discrete behaviours modelled by others. Fourth, the participants matched and implemented the discretionary decision-making

processes to older persons in crisis for one of two reasons, either (a) to provide or seek ‘better care’ for the older patient in crisis, or (b) to terminate quickly, ‘bogus calls to repeaters and abusers’, in order to keep EMS resources available to respond to code three calls. By virtue of existence, the discretionary decision-making processes revealed the education, experience and ethical standpoints of the participants that lay hidden ‘between duty and discretion’ in the implementation of EMS policy and practice. In part 3 below, the critical reflections of the participants are presented.

Critical Reflections of the Participants on EMS Policy, Planning, Training and Practice

The critical reflections, below, are quotations from the interviews that I conducted with the full-time participants. The reflections were selected for their depth of analysis of the predominant issues concerning the implementation of EMS policy with older persons in crisis. The reflections are categorised according to (a) reflections on EMS policy and planning, (b) reflections on paramedic education, and (c) reflections on EMS practice. My own brief analysis follows each reflection.

A Reflection on EMS Policy and Planning

During the study, a recurrent theme was that paramedics were, as a group, excluded from effecting policy change, both within and beyond EMS, and that decisions to change policy were reactive rather than pro-active, and imposed ‘from the top, down’.

“Policies Get Changed When People Die and the Coroner Found it was a Paramedic’s Fault”

When people die and a concern or complaint is lodged, the case is reviewed. Then policies are made accordingly. For example, one older man was in a hotel room across the street from a large downtown hospital. He had a nose bleed and the ambulance took twenty minutes to get there, nice and quietly without sirens. The person was asked by the paramedic, ‘do you have any other medical problems?’ And the person replied, ‘no’. So the attendant asked, ‘how long have you been bleeding?’ The answer was, ‘five minutes’. The person was asked, ‘how much?’ and they said, ‘not much’. The end of the scenario is that the patient died. Bled out, because the patient had a blood disorder. The patient died from a nose bleed. So, now every

patient with a nose bleed is transported code three with lights and sirens, to hospital. That is totally inappropriate. Its overkill, an overreaction. But it covers EMS. It prevents us from being sued (personal communication, June, 1993).

In this reflection, the participant described a relationship between the life and death of EMS patients on the one hand, and the subsequent revision of EMS policies on the other. The foremost role of the paramedic in this reflection, in relation to policy, was to be a guardian of policy for the purpose of preventing wrongful death and unwanted litigation with EMS patients. The next reflection relates to paramedic education in geriatrics.

Reflections on Paramedic Education

All the participants commented upon their need for basic, and continuing education in topics relevant to daily EMS practice. The following reflection captured the main themes of the participants when they spoke of their need for education in geriatrics.

“Paramedics Need Education in Geriatrics”

If paramedics are going to become monitors for old people who refuse to go to hospital, with responsibilities to link them to services they could benefit from, then certainly paramedics need to be educated in geriatrics and what services are available. This is especially true for the EMA I's-- they hardly know anything. If paramedics don't have a community resource book in the stations or ambulances that can be used in daily practice, then I fear that many older people will be left in the lurch. Very little actually gets done for older people who refuse to go to hospital, certainly not by EMS. New paramedic training modules come out five or six times a year. Who decides on the topic of the module? Well, has someone gotten in trouble for something? or has a coroner's inquiry said, 'paramedics had better know this' or, 'look at this! doctoring on an ambulance call!' When this happens, someone makes a suggestion down the line to management. Then management asks, 'what are the priorities? Are people falling through the cracks? Paramedics ourselves have to go to the executive director, the EMS medical director, the regional medical co-ordinators, and the people in charge of paramedic education if we want our needs to be met (personal communication, September, 1993).

In this reflection, the participant reinforced that 'very little actually gets done for old people who refuse to go to the hospital'. He also raised the issue that a large performance gap existed between EMA II paramedics and those trained at the lower level of EMA I.

Since the downtown station where I was assigned was staffed entirely by EMA II paramedics, and EMA I paramedics worked there on a 'call-out' basis only, I had inadequate data to confirm this observation.

The reflection, above, also described how decisions were made within EMS in regard to topics in continuing education for paramedics. In addition, the reflection highlighted the hierarchical relationship between the administrative and educational staff. Thus, to connect policy and practice better, a role for paramedics to promote their own agenda for continuing education programs, based on their experience and the needs of EMS patients on the street, is suggested. The next reflection illustrates how paramedics can be reflective and therefore must be encouraged, through practice, to recognise the limits, as well as the possibilities, of their knowledge-base.

"Paramedics Think They Know More Than They Really Do"

I'm finding that in the last few years particularly, where some of my earlier decisions were based on what I thought was up-to-date knowledge, in reality, I was ignorant of the side effects or risks involved. In EMS, this can cause the patient to not get proper care and die. This can translate into heavy lawsuits for EMS and job losses for paramedics (personal communication, October, 1993).

This reflection demonstrated the ability of the participant to reflect critically on his past EMS experiences while integrating an important objective of EMS administrators: that paramedics provide 'proper' care in order to prevent lawsuits and job losses for EMS and paramedics, alike. In addition, the reflection identifies the need for paramedics to have formal audit processes to evaluate the impact of discretionary decisions on patients, especially those where refusals of transport are either received, or solicited, by paramedics. The next part examines reflections on EMS practice.

Reflections on EMS Practice

This part examines reflections about the 'kinds' of paramedics who practice EMS, their 'need' for discretion, and that EMS has become a 'catch-all' service.

“There are Two Kinds of Paramedic. Those Who Follow Rules, and Those Who Don’t”

There are two types of paramedics in EMS. Paramedics that look at the policy that says, ‘all patients must be transported to hospital’, and instead they think, ‘I will make the judgement whether or not the person needs to be taken to hospital’. The second type of paramedic is incapable of judging a black and white situation. Rather than risk their jobs, they think they might be fired, so they stick to the policy that all patients must be transported. They say to the patient, ‘you called an ambulance, say no more, get in, let’s go’, versus someone like me who would say, ‘let’s screen the ER first. I do that a little bit, not too much, I don’t think I have overstepped my bounds, but I know I do it and a lot of paramedics do it. We come to the scene and make decisions for people. We say, ‘well, no, I don’t think you need to go to the ER. I think this is a matter that can be dealt with through other channels rather than by taking you to the ER at this late hour when its over-flowing, and you will have to lie on a stretcher for five hours and then be sent home at four a.m. And those paramedics will, having made the decision for the person, call the person up later to make sure the person is looked after.

Other paramedics are paranoid about making decisions this way. They say, ‘its not in my jurisdiction. I don’t get paid enough to make a decision on behalf of the patient or the ER’. Maybe these paramedics don’t feel trained or qualified to work this way. They say, ‘I don’t know what services are available or what the options are. I haven’t been trained to do this and I’m not going to do extra reading on my own’ (personal communication, June, 1993).

In this reflection, the participant valued the practice of discretionary decision-making over ‘complying with the rules’, with the intention of making ‘better’ decisions for patients. In particular, the participant was critical of his peers who complied with EMS policy as it was intended originally. The participant referred to the mandatory transport policy, in particular, because he believed his experience enabled him to make discretionary decisions, whereas the mandatory transport policy did not.

In addition, this reflection clarified, for me, that my study was an ethical analysis of those paramedics who *chose not* to follow the rules and that I had gathered insufficient data to describe those paramedics who *did choose* to follow the rules. The reflection illustrated to me, also, that a relationship exists between the increasing informal education, experience and ethical questions of paramedics on the one hand, and a growing urge to make discrete decisions, on the other. Further study of this relationship is warranted since the education, experiences, and ethical standpoints of paramedics, are, in

theory, strictly controlled by physicians. The next reflection addresses the ‘need’ of EMS paramedics to practice discretionary decision-making in daily practice.

“Paramedics Need to Exercise Discretion”

Paramedics need some discretion. Every day is different, every patient is different, every scenario is different. The nature of our work demands that there be some flexibility. I might make a different decision with two similar patients because of a gut instinct or feeling, when something doesn’t quite fit, you don’t know what, its just that something is missing. Science is not always definite, things are always changing. Intuition is a big big thing in this work (personal communication, June, 1993).

This reflection confirmed the analysis in previous reflections, that the needs of patients and paramedics within EMS have been, and are, evolving. In addition, the reflection acknowledged that the participants in the study used knowledge and informal education derived from experience and intuition, as well as science, to implement EMS policy. The next reflection illustrates the maturing view-point and growing discontentment among EMS paramedics when they analyse their role in the wider policy culture of EMS.

“EMS has Become a Catch-All Service”

We transport people who simply do not have enough money for a cab, we transport people with toothaches to the emergency ward. Its a place to get quick treatment instead of going and waiting in line for a doctor at the doctor’s office. I think people in Canada really do not know what the word ‘emergency’ means, period. A true emergency constitutes the use of lights and sirens. EMS cannot be based on every call being potentially life threatening because the flu could be considered life threatening. That’s our problem now. If that is what the government wants, fine, but the government has to decide which service it wants to provide. Either an emergency service only, or like now, where service is given to anyone, for any reason, without refusal. Well, if that’s what the government wants, that’s fine, but then the EMS budget can’t be limited (personal communication, June, 1993).

The participant who contributed this reflection perceived that a major conflict exists between the vision of ‘government’, as expressed through the EMS mandate and policies, and the street-level realities of paramedics.

At the same time, the participant identified that major economic consequences arise from the conflict. He placed the conflict squarely on the shoulders of 'government' for resolution. Given the historical, hierarchical and conflicted relationship between EMS management and union staff that I noted in memoranda in the ambulance station, intervention by a third party and further research about the mandate of EMS now seems appropriate. The next reflection addresses how EMS is 'stuck in the revolving door'.

"EMS is Stuck in the Revolving Door"

Because of the mandatory transport policy, everybody goes to hospital unless they refuse. Even that is not cut and dried, though, because if people refuse, we can still transport them to hospital under the Mental Health Act. Paramedics have to be very conscientious about what patients require. We assess the patient and we see immediately whether they need medical care or not. If they need it, they get it. If they do not need medical care, then we know they don't need it, but still, if they want to go to hospital, we take them. Its like a revolving door, and EMS gets stuck in it. There's a need for a middle-option, like for someone who can come into the home and assess the person on our request. For some people it's better than going to hospital. Without a middle option, EMS will stay stuck in the revolving door (personal communication, June, 1993).

Throughout the study, I heard several full-time participants use the phrase, 'EMS is stuck in the revolving door'. To me, the reflection, above, illustrated the ability of the participant to consider EMS in the wider policy culture, while reflecting, also, on past experience to inform the future.

In summary, two unspoken questions pervaded the process and findings of the study. The questions were, "is anyone in the health care system really listening to paramedics, and if so, are they willing to integrate the experiences and recommendations of paramedics as health care undergoes reform?" As an ethnographer of paramedics, I can only state at this time, 'I am unsure'. Given the growing maturity of full-time EMS paramedics, however, one thing is certain: additional action-oriented research is indicated to demonstrate how paramedics, and older persons in crisis, together, can pioneer new ways to deliver 'better' emergency health care for all. In the next chapter, the literature is re-visited and the conclusions and recommendations of the study are summarised.

CHAPTER 5 - Reflections, Conclusions, Recommendations, and My Developing Model of Health Care Reform

This chapter has three sections, including (a) reflections on the literature, with conclusions and recommendations; (b) final conclusions and recommendations, including recommendations for future research; and (c) my developing model of health care reform.

Reflections on the Literature, with Conclusions and Recommendations

In this section, I re-visit the work of Lipsky (1980), Wharf and Callahan (1984), and Yanow (1987). Then, I reflect upon selected literature that was collected during the study and reviewed after the findings were written. I used this process of reflecting on the literature, at the end of the study, for the purpose of synthesising my conclusions and recommendations and to include the reader as a participant and auditor of the study. I believed that such a process would invite readers to synthesise their own conclusions and recommendations arising from the study, also.

Re-Visiting Lipsky, Wharf and Callahan, and Yanow

In the part below, I reflect further on the literature of Lipsky (1980), Wharf and Callahan (1984), and Yanow (1987). To conduct this process of reflection, first I reviewed my beliefs at the beginning of the study and then, I re-examined the literature in the wider context of the findings of the study. What follows are my beliefs and conclusions about (a) paramedics as street-level bureaucrats who practice EMS with discretion, (b) connections between policy and practice, and (c) the role of ‘the policy culture approach’ in conducting an ethical analysis of policy implementation.

At the beginning of the study, based on accounts I received from paramedics when I worked with the QRT and in accordance with Lipsky (1980), I believed that EMS paramedics were street-level bureaucrats who implemented EMS policy with discretion (see chapter one, page 10). I was unsure, however, as to how, when and why such discretion was exercised within the highly regulated environment of EMS. Upon returning to the literature, I found a discussion by Lipsky (1980) about the role of public services and the categorisation of ‘emergencies’ which supported my findings:

. . . the category of emergency in public services is organizationally and situationally determined. A condition is emergent in public services only if it is called so by an authoritative agent. Patterns usually emerge to give shape to emergency practice, so that by convention one can often tell when a condition is likely to be regarded as an emergency. However, an emergency does not exist outside the organizational needs of the agency and the relationship between the bureaucracy and the clients. . . Street-level bureaucracies . . . create the emergency categories and determine when clients or cases fit those categories. . . they assign priorities but also determine the reach and limits of their own flexibility. By determining which cases are emergencies they allocate bureaucratic resources *with respect to formally relevant and nonrelevant attributes of the case* (italics added) (p. 137, 138).

In my study, I found that the participants demonstrated the characteristics, above, during the implementation and adaptation of the stages of pre-hospital care. For example, after scanning the scene, the priority of the attending paramedic was to conduct the primary and secondary surveys in order to identify whether a ‘true medical emergency’ existed or not. Then, decisions were taken either to follow, or adapt with discretion, EMS policy in accordance with the presenting problems of the patient.

Discretionary decisions were taken when the participants chose to adapt their actions to counter contradictions with EMS policy, particularly Section 6 of the Health Emergency Act (the Act). Discretionary actions were justified by participants according to the rationale that current interpretations of Section 6 of the Act were outmoded, and the belief that ‘patients should not be transported to hospital in every case when true medical emergencies are not found’. Consequently, the contradiction between policy and practice became manifest when the terms, ‘repeaters’ and ‘abusers’ of EMS were used to refer to those older persons in crisis who were perceived to not require transport to hospital.

As stated earlier in this thesis, the terms, abusers and repeaters, were used most often with older persons who (a) experienced frequent falls without apparent injury and had normal vital/neurological signs, (b) lived in extreme poverty and/or required urgent, non-medical assistance with the activities of daily living; (c) had chronic problems of untreated alcoholism and/or drug abuse, (d) had ‘stable’ mild confusion without other apparent, acute medical problems; (e) had pre-violent and aggressive behaviours without

posing an apparent danger to self or others, or (f) capably refused transport with, or without, EMS encouragement once the presenting problem appeared to be resolved. Such signs and symptoms were perceived to be 'non-relevant attributes' as stated by Lipsky (1980, p. 138), above, and consequently, refusals of transport were sometimes solicited. From the point-of-view of Lipsky (1980), the existence of terms like abuser and repeater confirmed that persons were categorised and excluded from service through discretionary practices. The categorisation of persons by institutionalised, bureaucratic processes led me to reflect upon the work of Ng (1988).

In her investigation of the politics of community services, with a focus upon 'immigrant women', class and state, Ng (1988) inquired, 'how are immigrant women organised into the positions they occupied in the labour market hierarchy?' Although the question posed by Ng (1988) and the research question of my study were different, both sought to identify invisible processes used by workers to construct specific outcomes for particular client groups. As researchers, our methodologies and stand-points were different, but related. While my study used ethnography to examine how policy was implemented by workers from the stand-point of front-line paramedics, Ng (1988) used institutional ethnography to analyse the relations of power between the state, community agencies and immigrant women from the stand-point of a front-line counsellor.

In view of the finding of my study that older persons in crisis were categorised and apparently under-served, the work of Ng (1988) led me to ask another question: "How do community emergency services construct older persons in crisis to become 'abusers and repeat users' of such services?" I believe that answering this question, by using institutional ethnographic methods, would contribute to the field of gerontological policy research. With respect to the role of the policy analyst, Ng (1988) states:

As I see it, the analyst's responsibility is to make visible the structural constraints within which [consumer] groups have to operate. In identifying existing sources of contradictions, the analyst can help groups to develop an on-going analysis of new areas of struggles and change. . . Ultimately, analyses of these contradictory processes enable us to discover how the state works to constrain and limit the actions of working people. More importantly, they can help us assess the strengths and weaknesses of various community actions and movements, so that we may work more effectively to transform the conditions of our lives (p. 99).

Thus, the work of Ng (1988) drew me to examine, more closely, institutional ethnography as method. This examination has led me to recommend now that an investigation be undertaken to analyse how community emergency services in general, are organised to construct older persons in crisis to become 'abusers' and 'repeat users of the system'.

On a related topic, my study illustrated that discretionary decision- making was practiced with 'abusers' and 'repeaters', either to ration or re-direct service (with the intention of finding 'more appropriate' service), or to cope with personal occupational stress. In his formulation of the street-level bureaucrat, Lipsky (1980) posits:

[C]ertain clientele are mentally discounted by workers to reduce the tension resulting from their inability to deal with citizens according to ideal service models. . . street-level bureaucrats develop conceptions of their jobs, and of clients, that reduce the strain between capabilities and goals, thereby making their jobs psychologically easier to manage (p. 141).

During the study, I observed the selective 'discounting' of older persons in crisis by paramedics and found that such practices were justified for altruistic reasons as well as to benefit paramedics themselves. However, unlike Ng (1988) who concluded that the state institutionalised the classification and oppression of clients, in-part by requiring workers to comply with agency policy and objectives, I concluded that the participants in my study voluntarily used their 'wits' and practice-based knowledge to circumvent policy in effort to reconcile contradictions in practice. For example, discretionary decision-making processes were used not only to ration service and divert older persons in crisis away from physicians, but to reinforce that in some cases, multidisciplinary services, rather than medical services, were more appropriate to attain better outcomes.

With regard to contradictions between policy and practice, Lipsky (1980) states that the medical model is used (a) to impose restrictions on the scope of powers held by street-level bureaucrats, (b) to free workers from the perceived responsibility for outcomes, and (c) to reduce strains between resources and objectives (p. 148-149). In my study, while I found that the medical model was dominant in policy, planning and education, I found another emerging contradiction in daily practice: as paramedics continued to integrate their experience to manage patients with discretion, the

knowledge-base of paramedics was expanding also. One is left to query whether the practice of EMS will evolve to become an autonomous profession either overtly with, or covertly without, the sanctioned approval of physicians. To that end, a theory of Lipsky (1980) offers both a forecast and a warning about the potential future of EMS in BC:

[P]atterns of practice, conceptions of the job, and conceptions of the clients must fit together if street-level bureaucrats are to resolve work contradictions successfully. [If they do not], [p]rivate conceptions of the clientele will be developed in proportion to the need to come to a private resolution of the contradictions in the work (p. 155).

After re-visiting Lipsky (1980), I believed that valuing the discretionary practices of workers was, and is, essential to researchers and policy analysts who are concerned about connections between policy and practice. I believe that discretionary practices, if discovered and embraced, can be re-shaped where appropriate to transform contradictions of policy into innovative practice. This awareness led me to reflect, again, upon Wharf and Callahan (1987) and the connections between policy and practice.

When my study began, research by Wharf and Callahan (1984) alerted me to observe how policy and practice in EMS were connected, especially in regard to education and the valuing of workers in daily practice (see chapter one, p. 11-12). With these thoughts in mind, during the study I observed the meaning and importance of paramedic training, including basic and continuing education and how the participants perceived their contributions were valued, or not, by bureaucrats in daily practice. I observed, also, how the problem-solving processes of the participants were similar to the problem-solving processes used by other groups including nurses and EMS bureaucrats. The latter concept is explored more fully in the report, *The BCAS/EMHS Project: toward a community partnership* (James-Groom, 1994).

The work of Wharf and Callahan (1984) guided me through the study to discern how paramedics made decisions in practice. For example, I sought to identify the concepts and problem-solving steps used by the participants when they constructed their decision-making processes to implement established governing policy. This approach revealed to me that experienced paramedics implemented the stages of pre-hospital care as adapted, discretionary processes rather than as sequential steps, as taught to 'rookie'

paramedics in training. This knowledge led me to conclude that the role and importance of experience in EMS policy, education and practice has been largely ignored, to date.

As my study evolved, I discovered that education, experience and ethics were inseparable connections between policy and practice. For example, the full-time participants with EMA II level education and experience were able to articulate ethical positions about patient management while acknowledging how their educational deficits made implementation of policy more difficult. On the other hand, the same participants stated their experience enabled them to make responsible, discretionary decisions on a routine basis with confidence. Interestingly, the full-time participant with two years experience in a residential care facility chose to make discretionary decisions ‘routinely’ while the part-time participant, also with two years experience in a similar facility, chose not to make discretionary decisions due to “burnout”. This finding has critical implications for policy and practice.

The work of Yanow (1987) inspired me to employ ‘a policy culture approach’ to implementation analysis. Such an approach required that policy be interpreted according to multiple meanings within an historical, multi-dimensional context rather than in a rational, technical manner that separates people and services from policies and processes. In my study, I found that the policy culture approach was highly useful to analyse how policy was implemented on the front-line. Also, the approach ensured that an ethical analysis was conducted because, by nature, the lens of the policy culture required the participants and I to consider the moral principles which underlie our community and wider society. While the policy culture approach did not prescribe a format or process to ‘make’ the participants and I seek out violations of moral principles related to policy, the approach did require that we identify and value the wisdom, knowledge and experience of participants and others in the policy culture. To that extent, the ‘policy culture approach’ was useful to manage data and complemented the ethnographic method of the study.

Ethnography and ‘a policy culture approach to implementation analysis’ were complementary because they required that I respect and seek to understand, rather than categorise or criticise, the wisdom of others in the study. In contrast, an institutional ethnographic method would have required that I discount the ‘wisdom’ and spirit of the participants and instead, according to Ng (1988), interpret and classify the behaviours of

workers as constructions created by the impersonal social relations of various extra-local governing bodies. To that end, a policy culture approach supported ethnography as method to answer the research question and I would use such an approach in future. Next, I discuss selected literature that was collected during the study.

A Discussion of Selected Literature

I reflected critically upon the selected literature, below, once the findings were written. Instead of conducting a traditional review of the literature, I chose to collect literature during the study when new concepts arose and when new themes and patterns in the data emerged. I reflected upon the literature and wrote my conclusions and recommendations in the context of my findings as they related to the literature and reality of EMS in BC. This approach preserved the qualitative, ethnographic method of the study while maintaining rigor and credibility, also. This approach enabled the literature to contribute neutral findings which supported and expanded upon my findings.

All the applicable literature found was American, or Canadian, in origin. Key words and phrases used to select literature included ‘ambulance services’, ‘emergency medical assistants’, ‘emergency medical technicians’, ‘emergency medical services’ (EMS) and ‘paramedics’. The key words and phrases were then cross-referenced with such topics as (a) the ‘non-transport’ of patients, including older persons in crisis; (b) EMS and co-ordinated community emergency response services for older persons in crisis, (c) the education of paramedics in geriatric and behavioural emergencies, and the process of skill acquisition; and (d) the development and implementation of Emergency Medical Services policy. In addition, I reflected upon other literature to clarify my role in the study as policy analyst and nurse. Selected topics included (e) methods of policy implementation analysis, and (f) the environment and community as foci of critical nursing research. My reflections on the subjects, above, now follow.

Paramedics and the ‘Non-Transport’ of Patients, Including Older Persons in Crisis

Early in the study, I observed that most participants experienced occupational stress and frustration when they encountered older persons who either apparently did not require transport to hospital, or who were found to be very ill, yet despite illness, refused

transport to hospital. Thus, I acquired literature on related topics. I found three studies that described issues and concerns related to 'non-transport' and refusals of transport.

I found the term, 'non-transport', was used consistently in the literature by EMS physicians and administrators, alike, to refer to those patients who were not transported to hospital, either related to voluntary refusals of transport by the patients themselves, or to decisions to not transport by EMS paramedics. The importance of the meaning of the term, 'non-transport', lies in the assumption that all persons who require EMS require, also, transport to the care of physicians without exception unless verifiable reasons are found to explain otherwise. Thus, several studies were found which indicated that some patients were not transported to hospital by paramedics, and of those, some were related to discretionary decision-making (Seldon, Schnotzer, Nolan, and Veronesi, 1991; Sucov, Verdile, Garetson and Paris, 1992; and Zachariah, Bryan, Pepe and Griffin, 1992).

The study by Seldon, Schnotzer, Nolan and Veronesi (1991) was a quantitative, retrospective descriptive study of 2, 698 patients of all ages in Alaska who were evaluated by paramedics and subsequently not transported to hospital. The purpose of the study was to establish a demographic profile and disposition of persons seen, but not transported, by EMS and to provide a model for policy development and further research. The study did not identify how decisions were made to not transport patients. The study did find, however, that non-transports were a result of either (a) paramedic decisions to not transport, (b) patient refusals, or (c) dispositions of patients by paramedics to other agencies (1991, p. 139).

With respect to the elderly, Seldon et al. (1991) found that people over the age of seventy years, regardless of gender, were more likely to be transported than persons between the ages of forty and fifty years (p. 135). The researchers found, also, that no guidelines existed to govern paramedic decision-making when non-transport was practiced. In addition, Seldon et al. (1991) found that the proportion of non-transports conducted by paramedics increased significantly in the late evening and early morning hours (p. 137). They found that patients were discharged most often (a) to friends and relatives, (b) to self-care, (c) to police officers who took the person home, (d) to a mental hospital or jail; (e) to detoxification unit personnel, (f) to physicians in offices, or (g) to nursing homes (p. 138).

My findings confirmed and expanded upon those of Seldon et al. (1991, p. 137) because the participants in my study identified certain older persons whom they tended to not transport during the night, including (a) old people who were lonely or alcoholic, (b) persons who had fallen without apparent injury, and (c) persons who needed help going back to bed, only. This finding supports the argument of Seldon et al. (1991) that the use of non-transport guidelines are required to keep paramedic decision-making accountable while increasing the likelihood that older EMS patients receive the interventions they require. Such guidelines would aim to reduce incidents of litigation where EMS is found liable for wrongful death, especially in cases where paramedics have been found to have not contacted physicians for advice from the field before choosing to not transport certain older persons in crisis.

Interestingly, Seldon et al. (1991) found that physicians were contacted for medical advice by paramedics in the field in only 4.2 % of the cases which involved persons over the age of sixty-five years. In my study, at no time did I observe the participants contact any physicians from the field for medical advice regardless of the age, gender, symptoms or apparent needs of the patients in care. This finding suggests that the participants in my study either conducted their duties with higher degrees of autonomy and with less direct accountability for their work than paramedics elsewhere, or, it may be that the levels of education and licensing of the participants in my study were higher than paramedics elsewhere.

In contrast to studies that examined the non-transport of persons initiated by paramedics, Sucov, Verdile, Garrettson and Paris (1992) conducted a retrospective, quasi-qualitative study that examined the outcome of patients who refused pre-hospital transportation (N= 188). As method, reviews of crew reports and telephone follow-up to patients were conducted within five days of the EMS encounter. The researchers wanted to elicit information about what type of additional medical help, including hospitalisation, the former patients may have sought or required. One-half of the patients were successfully contacted and of these, 'some' subsequently required hospitalisation. Although the data was sensitive to age and gender, quantifications, implications and conclusions based on such parameters were not stated. Although Sucov et al. (1992)

concluded their method of study was inadequate, a discussion about the medico-legal ethics of refusals was provided. Sucof et al. (1991) concluded:

The determination of competency for the patients who refused transportation was not well-documented . . . All EMS systems should develop medically sound protocols for the management of pre-hospital patients who refuse treatment and/or transportation. Ongoing quality assurance measures and continuing education for the pre-hospital providers must focus on this subset of patients (p. 370).

The conclusions from the studies, above, support the credibility of the findings of my study and fit with the requests of the participants to receive (a) education in geriatrics, (b) legal authority, with policies and guidelines, to conduct non-transport of older persons in crisis, and (c) legal authority, with policies and guidelines, to refer older persons in non-life-threatening crises to other more suitable, community-based services.

The study by Zachariah, Bryan, Pepe and Griffin (1992) was a quantitative, retrospective review of 158 EMS incidents where an ambulance was called but the patient was not transported to the care of a physician. The purpose of the study was to document the outcomes of patients who were not transported as a result of paramedic discretion alone. The review took place within a volunteer, sub-urban EMS service with indirect medical control where the discretionary non-transport of patients was seen as a necessary practice to ration ambulance resources in a densely populated area.

Zachariah et al. (1992) found that refusals of transport happened one of two ways (a) either the patients refused transport, regardless of the advice of the paramedic; or (b) the pre-hospital care providers refused transport of the patient. Zachariah et al. (1992) found that, “the situations in which EMS personnel either denied transport or mutually agreed with the patient to not transport by ambulance, were twice as likely to result in hospitalisation than were those cases in which the patients declined transportation against the advice of EMS personnel” (p. 359). In addition, Zachariah et al. (1992) found that paramedic decision-making to not transport patients was based on initial training and rote learning only and that no criteria, policies or guidelines existed to help paramedics make such decisions (p. 360).

My study supported the findings of Zachariah et al. (1992) although the full-time participants in my study identified additional tools, in the absence of basic geriatric education and non-transport guidelines, which they used to make discretionary decisions with older persons in crisis. For example, the participants cited as useful (a) discussing difficult cases with others, including paramedics, ER physicians and nurses; (b) learning from past experience, (c) relying upon intuition, and (d) knowing what you don't know, as ways to improve the quality of discretionary decisions made. Further research is warranted to determine if such 'tools' actually relate to better outcomes for older persons in crisis. Such research is important, especially since Zachariah et al. (1992) found:

A hospital admission was twice as likely to ensue if EMS [and not the patient] made the decision to not transport to a receiving facility. . . . [Therefore] further prospective study is necessary to assist in the development of appropriate guidelines for the non-transportation of patients (p. 363).

This finding is important because the full-time participants in my study were found to practice discretionary decision-making routinely without benefit of basic geriatric education, supporting EMS policies and guidelines, or follow-up mechanisms to evaluate the outcomes of patients. The relationship of the elements, above, to the quality of paramedic decision-making remains unclear, however, and further study is warranted. At the same time, the known relationship of the absence of non-transport guidelines to subsequent hospitalisations and even death, of some EMS patients must be closely regarded (Seldon et al., 1991; Sucov et al., 1992; and Zachariah et al., 1992). In addition, none of the studies above suggested that patient refusals of service were solicited by paramedics, as my study found. This finding has critical implications for future policy and research.

EMS and Co-ordinated Community Emergency Response Services for Older Persons in Crisis

As my study proceeded, the participants voluntarily identified certain older persons, in non-life threatened crises, whom they thought required community support services rather than transport to hospital. I sought research to explore this topic further.

Two articles (Latessa & Kainrad, 1988; and Gerson, Schelble & Wilson, 1992) were found that described demonstration projects where paramedics linked older, non-life threatened EMS patients to community support services. Neither article discussed policies, guidelines or how paramedics made decisions with older persons in crisis and the basic training levels of paramedics were not described.

In Lee County, Florida, Latessa and Kainrad (1988) established a project called “Age Link” which empowered paramedics to make official decisions to not transport certain older persons in crisis. Instead, certain older persons in non-life threatened crisis were referred to local community-support services. The role of the paramedic was expanded through training and guidelines so that older persons ‘in social emergencies’ could be served better. For example, instead of being transported to hospital in every case, older persons in crisis who repeatedly called EMS were assessed by paramedics, instead, for possible linkage to community-support services.

Characteristics of the population served by Age Link included (a) frail older persons who lived alone or with a spouse and who had physical and/or mental deterioration; (b) older people with medical and/or psychiatric conditions who required social service intervention rather than EMS; and (c) older persons with financial burdens and restrictions which impeded their ability to receive medical help (Latessa & Kainrad, 1988, p. 12). In a telephone interview, Kainrad reported to me that, “one hundred percent of repeat calls to EMS have ceased since the Age Link Program began” (personal communication, June, 1994).

Although Latessa and Kainrad (1988) did not conduct a formal evaluation of the Age Link program, they provided guidelines for paramedics in other EMS services to respond more appropriately to older persons in non-life threatened crisis. For example, definitions of ‘urgent’ and ‘non-urgent’ referrals were developed with criteria to govern paramedic decision-making during the assessment and referral process (p. 12-13). A formal evaluation of the Age Link program, similar to that conducted to evaluate the QRT, would be useful to demonstrate the impact of the program on the utilisation of acute care hospitals and EMS. Such data would likely encourage other EMS systems to develop similar programs to respond more appropriately to older persons in non-life

threatened crisis. In view of the apparent success of Age Link, to do less for older persons in non-life threatening crisis when assistance, but not hospitalisation, is urgently required could be viewed as abandonment of the patient at the scene. In relation to my study, the existence of Age Link supports the findings and confirms that paramedics are capable of working in expanded roles when EMS leadership is motivated to provide innovations in pre-hospital care.

Gerson, Schelble and Wilson (1992) conducted a prospective, non-randomised open trial in Ohio within a pilot project to evaluate the ability of paramedics to act as 'gatekeepers' to identify older persons at risk and then refer them appropriately for assessment and service. At the beginning of the project, 130 fire-fighter paramedics received basic education in geriatrics. The training included a review of the available community services and procedures to identify elderly at-risk. Then, over a nine month period, the paramedics used new procedures and a special form to identify 197 older persons who had apparent problems in need of evaluation by a trained geriatric assessor. The problems were categorised by the paramedics as being environmental, social, medical and/or mental in origin.

Problems were confirmed by the assessor in 121 of the 124 older persons located. While the project was found to be useful, it was found to be not useful for older persons who (a) refused EMS, (b) attended nursing homes and long term rehabilitation, (c) whose problems were related to medical emergencies, and (d) who refused all help or who were ineligible for service (Gerson et al., 1992, p. 35). Gerson et al. (1992) concluded that paramedics can serve as case finders for at-risk elderly and that referrals to community service agencies can occur (p. 33).

Unfortunately, implications for EMS policy were not discussed, nor were the changes required to implement the program. At the end of the study, when the paramedics were asked to comment on the usefulness of the program, all but four stated the program was useful and should be retained. No discussion was given to explain why four paramedics believed the program should end. In relation to my study, the project by Gerson et al (1992) supported the observations of the participants that certain older persons in crisis require assistance for environmental, social, medical and mental health problems. Further, the study of Gerson et al. (1992) emphasised that EMS paramedics

have not only a role, but a responsibility to report their observations to agencies who can provide the most appropriate service to the elderly in need.

The Education of Paramedics in Geriatric and Behavioural Emergencies, and the Process of Skill Acquisition

I sought literature on paramedic education in geriatric and behavioural emergencies when I learned the participants had no formal education or skills in these areas. I sought literature, also, on the process of skill acquisition of emergency workers after I observed some of the full-time participants conduct spontaneous assessments of the environmental, social and mental health of older persons without policies, training or guidelines to do so. In addition, I sought literature to explain current theories and philosophies of paramedic education, although none were found.

I found seven articles that addressed the topic of paramedic education in geriatric and behavioural emergencies (Bassuk, Apsler & Jacobs, 1983; Butcher, 1990; Hoge & Hirschman, 1984; Moss, 1994; Rubens, 1990; Shybut & Carter, 1983; and Spaite, Criss, Valenzuela, Meislin & Ross, 1990). Two other studies (Dreyfus & Dreyfus, 1979; and Dreyfus & Dreyfus, 1980) were found which described models to explain the process of skill acquisition in aircraft pilots as they performed emergency response behaviours.

Three studies (Bassuk, Apsler & Jacobs, 1983; Hoge and Hirschman, 1984; and Shybut & Carter, 1983) were quantitative evaluations of paramedics and their needs and abilities to learn about behavioural emergencies with persons of all ages. Each study (Bassuk, Apsler & Jacobs, 1983; Hoge and Hirschman, 1984; and Shybut & Carter, 1983) found that paramedics lacked training in behavioural emergencies and that when such training was provided, the abilities of paramedics to respond appropriately to persons in psychological and psychiatric crises was enhanced. Bassuk et al. (1983) and Shybut and Carter (1983) also noted that appropriate interventions by paramedics included making decisions about whether or not to transport patients, and whether or not to refer patients to other community services. Both studies (Bassuk et al., 1983; and Shybut & Carter, 1983) emphasised the need for research to measure the impact of

training in behavioural emergencies on paramedic decision-making and patient outcomes. In addition, Shybut and Carter (1983) cited the findings of Frazier and Cannon:

A considerably lower percentage of [EMS] patients with concomitantly demonstrated psychiatric, drug use or alcohol-related diagnoses received mandated treatment as compared to a group of laceration patients . . . Inadequate treatment of patients with these concomitant conditions may be related to a perceived 'abuse' of the ambulance service (p. 45).

The finding above reminded me of the theme in my study, that some older persons in crisis were 'abusers' of the ambulance service. The finding of Frazier and Canyon, cited in Shybut and Carter (1983) was consistent with my findings. In addition, Shybut and Carter (1983) and Seldon et al. (1991, p. 140) supported that older patients who have consumed alcohol may be less likely to be transported by paramedics when education and guidelines to manage such older persons are lacking.

Four articles (Butcher, 1990; Moss, 1994; Rubens, 1990; and Spaite, Criss, Valenzuela, Meislin & Ross, 1990), described the need for paramedics to learn about the elderly as a distinct group of patients who require specialised approaches to ensure that appropriate and complete pre-hospital care is provided. In particular, Rubens (1990) stated specific questions to assess the mental status of the elderly (p. 71), while Butcher (1990) discussed clinical methods to assess and manage the older EMS patient (pp. 56-74). Moss (1994) described the "Carpe Diem" program that is taught to all new emergency medical technicians (EMTs) at Acadian Ambulance Services in Lafayette, Louisiana. The Carpe Diem program uses principles of experiential learning to teach EMTs to use empathy when responding to older persons in crisis.

In contrast, Spaite et al. (1990) conducted a quantitative analysis of the EMS files of patients aged 70 and older to evaluate the pre-hospital demographics, mechanisms of injury and assessments conducted by EMS personnel, including physicians. The purpose of the study was to provide data to inform the development of preventive, administrative and pre-hospital educational programs. Spaite et al. (1990) found that 83% of EMS transports to hospital were elderly persons over the age of 70 years (p. 94), and 10% presented with falls that were likely secondary to an undiagnosed, primary medical

problem (p. 93). In addition, Spaite et al. stated, “. . . the tendency for elderly patients to use the EMS system more efficiently than younger ones was also indicated by a much lower false alarm rate . . .” (p. 93). The researchers concluded that nearly 90% of all geriatric injuries resulted from falls and motor vehicle accidents.

The conclusion above highlights the need for EMS paramedics everywhere to receive adequate education in geriatric medicine in order to ensure that older patients, especially those who present with falls (Spaite et al., 1990) and/or ethanol abuse (Shybut & Carter, 1983; and Seldon et al., 1991) are assessed and managed appropriately. Such education might enable paramedics to respond inclusively to older persons in crisis instead of labelling them as ‘abusers’ and ‘lonely old people who don’t need help’.

Dreyfus and Dreyfus (1979; 1980) posited models and theories of skill acquisition to explain aircraft pilot emergency response behaviours and decision-making. In their first study (1979), three *models* of skill acquisition were discussed, including (a) the non-situational model, (b) the intermediate model, and (c) the situational model. In the non-situational model, Dreyfus and Dreyfus (1979) explain that trainees are taught to comply with specific rules under specific conditions, where each decision taken is triggered by a state-response rule that has pre-determined the response for each state (p. 1-2). This model of skill acquisition parallels the method of instruction and stages of pre-hospital care, including the administration of protocols, that EMS paramedics are expected to conduct regardless of levels of licensure or years of experience. Interestingly, Dreyfus and Dreyfus (1979) state that, “only the behaviour of a rank beginner would accord completely with the non-situational model” (p. 6-7).

In the intermediate model, Dreyfus and Dreyfus (1979) state that emergency response behaviours incorporate four abilities. The first ability is to recognise situations in the ways below.

- (1) to recognise situations using memories and paradigms,
- (2) to perceive the current situation as similar to a remembered paradigm,
- (3) to notice when the current paradigm is no longer adequate to explain the current situation, and
- (4) to then experience the current situation as similar to a different and more appropriate, remembered paradigm (p. 3).

In relation to the first ability, above, Dreyfus and Dreyfus (1979) define ‘paradigm’ as a series of pictures of a particular situation that is synthesised from past experience which is then remembered and used in future to solve problems in similar situations (p. 4).

The second ability noted by Dreyfus and Dreyfus (1979), in the intermediate model of skill acquisition, is to identify characteristics which stand out in each remembered situation (p. 7). The third ability is to remember a sizeable set of aspects, or signs and symptoms as in the case of paramedics, that enable the observer to formulate conclusions about what is seen. The fourth ability is to remember and use maxims, or procedures, that fit the situation, as opposed to simply following the rules regardless of the context (p. 7). The four abilities, above, are similar to the abilities I observed the participants demonstrate when they practiced discretionary decision-making processes.

The situational model described by Dreyfus and Dreyfus (1979) incorporates five abilities to demonstrate ‘successful’ emergency response behaviour. They include:

- (1) The ability to remember a large set of paradigms . . . ,
- (2) the ability to perceive the present situation as similar to a remembered paradigm . . . ,
- (3) the ability to identify when the current paradigm is not adequate for perceiving the current situation . . . ,
- (4) the ability to experience the current situation as similar to a different and more remembered paradigm . . . and
- (5) the ability to remember with each paradigm, an appropriate action (pp. 3-4).

Dreyfus and Dreyfus (1979) concluded that the situational model enables a “pronounced shift to more flexible and rapid performance in the real world environment” whereas the non-institutional model of skill acquisition does not (p. 33). Given the finding of my study, that the participants learned to practice soft and hard code X’ing from peers and have no policies or guidelines to support adaptive decision-making on the front-line, then current EMS policies and methods of paramedic education should be reformed to incorporate the impact of experience on EMS policy and practice.

With respect to philosophies and theories of paramedic education, no literature was found. In a telephone interview with Dr. A. T. Williams, Director of the Paramedic Academy of the Justice Institute of British Columbia, however, he stated, “since EMS is a relatively new profession where paramedics are granted specific, limited authority by

physicians to practice medical procedures until the services of a physician are available, there is a tendency to use educational philosophies and models similar to those used for medical students in university medical schools. That is what we do in BC” (personal communication, January 1995).

In research later by Dreyfus and Dreyfus (1980) to discover the *process* of skill acquisition in aircraft pilots who conducted emergency response activities, they found that students pass through five stages of skill acquisition, including (a) novice, (b) competence, (c) proficient, (d) expert, and (e) mastery. Dreyfus and Dreyfus (1980) concluded that, “as the student becomes skilled, he depends less on abstract principles and more on experience. . . [therefore] any skill-training procedure must be based on some model of skill acquisition so that it can address the appropriate issues involved in facilitating advancement” (p. iii).

Although it was beyond the scope of this study to evaluate the appropriateness of the model of basic and continuing education used by the participants, my findings suggested that the skill levels of some of the full-time participants were at the level of expert and master. This finding suggests that a situational model of instruction, as described by Dreyfus and Dreyfus (1980), would be appropriate. This is an important consideration in view of the fact that some of the participants made discretionary decisions to ration and even withhold pre-hospital care. With respect to the finding that one participant chose to ‘just follow the rules’ despite having practiced discretionary decision-making in the past, his voluntary choice to not use acquired skills could not be explained by the work of Dreyfus and Dreyfus (1980).

The Development and Implementation of Emergency Medical Services Policy

Related to the research question, literature was sought that discussed how EMS policy was implemented by EMS paramedics. I sought literature that recommended ways to evaluate the impact of the implementation of EMS policy. Five articles were found that discussed these topics from clinical, legal, policy and practice standpoints (Bassuk, Minden, & Apsler, 1983; Fitzpatrick, 1989; Garza, 1992; Griffiths, 1990; and Thompson and Curry, 1993).

Bassuk, Minden and Apsler (1983) conducted a retrospective, quantitative clinical study to assess how older persons used the ER of an American, urban general hospital. Bassuk et al. (1983) found that despite co-existing medical and psychiatric problems, the chief complaint of older persons was somatic in origin rather than psychiatric. Bassuk et al. (1983) found, also, that once psychiatric problems were identified and treated in the elderly, they stopped using emergency services (pp. 540-541). Bassuk et al. (1983) concluded that a holistic approach to diagnosis of the elderly is required and team management should be of prime importance for all concerned (p. 542).

In his position paper about ambulance services and the law, Fitzpatrick (1989), a Canadian lawyer, argued that ambulance law is still evolving in Canadian provinces (pp. 39-41). Fitzpatrick (1989) states:

Ideally, the laws and regulations which govern the provision of ambulance services should fulfil both protective and preventive functions. To do this, they should clearly circumscribe the role of ambulance workers and accurately reflect the level of care which is actually provided to the public. Legislation should also lay down predictable standards and rules which permit ambulance workers to keep their conduct within the limits defined by the law. Finally, to remain effective, provincial legislation must keep pace with changes in the services it is supposed to regulate. Knowing what type of action may be taken, by whom and under what circumstances is vitally important both to the legal security of workers and to the efficient delivery of quality of care. When provincial laws do not deliver enough information or do so inadequately, ambulance workers are left unsure of how to best guide their conduct. This is especially worrisome in light of the fact that ambulance operations are raising increasing numbers of delicate issues to which present laws do not always provide a ready response (p. 40).

A review of EMS systems and laws in Canada by Garza (1992) found that EMS in British Columbia (BC) is “state-of-the-art” compared to EMS in other provinces (p. 44). However, given the findings of my study, that EMS policy in BC is interpreted conservatively and implemented with broad discretion as well as full compliance, one must conclude that even in BC the interpretation and implementation of EMS laws and policies have not kept pace with the realities of daily practice.

A qualitative, investigative study conducted by Griffiths (1990) posed two questions to a variety of American leaders of EMS. The questions were (a) “what lessons of the 80’s are most important for EMS?” and, (b) “how can we use what we have learned to deliver improved care in the 1990’s?” (p. 67). In reply, Dr. Kathleen A. Handal stated:

Now that our industry is established with a recognised presence, Emergency Medical Services must not only be responsible for developing the profession’s goals, but must look at the trends in health care and be responsive to community-health care planning and needs... If sufficient primary care existed, EMS, including the Emergency Department would see only true emergencies, thus decreasing call volume and the number of professionals needed ... All aspects of the health-care delivery system are in a process of re-configuration. It is no simple task to define, establish and present EMS... This challenge has been hurled upon all of us in the health care system, and those who don’t accept it are still responsible for the outcome (p. 81).

In another vein, with regard to the role of the pre-hospital worker, Griffiths (1990) quoted Forbuss, who stated:

It is my belief that the role of the pre-hospital worker could be dramatically increased to provide services now only provided in the hospital setting. As overcrowding of emergency rooms becomes more pervasive in the 90’s and ambulance diversion becomes the password, pre-hospital workers will be providing more services without patient transport. Virtually one-half of the patients transported to hospital by ambulance check out within 24 hours. Many of the services now being performed by overburdened emergency rooms can be provided in the field (p. 76).

In the article by Griffiths (1990), Handal and Forbuss each suggest that EMS systems in the 1990’s will have to consider the needs of the community and expand the role of paramedics to respond to shifting population demographics amid limited acute care resources. If the visions above formulate a blue-print for action, including responding to the fact that nearly one-half of all transported patients are discharged from ERs within twenty-four hours of admission, then three things must happen.

First, EMS laws, policies, protocols and guidelines in BC must delineate the mandate and scope of EMS in accordance with the needs of the population and in balance with the abilities of EMS paramedics to manage those needs. Second, EMS paramedics must be adequately empowered in law, via their roles, education and organisation of practice, to fulfil the mandate of EMS. Third, the option of non-transport of certain older patients, with back-up referrals to other services, must become a legal reality. To that end, suitable guidelines and alternatives to acute care ERs must be provided to ensure that standards of pre-hospital care and patient outcomes are not compromised, while, at the same time, enhancing the abilities of paramedics to practice discretionary decision-making in daily practice. The findings of my study support the vision of Forbuss with one cautionary note. Changes to EMS law, policy and the roles of paramedics should be evaluated continuously to identify and rectify any adverse, unintended impacts on all patients, regardless of age or status.

In another article, Thompson and Curry (1993), two Canadian EMS physicians and instructors, conducted a survey to describe the extent to which physicians are involved in the ‘medical direction’ and ‘control’ of EMS in Canada. Respondents included 56 physicians and government bureaucrats involved in various EMS systems in Canada. Questions were asked about the role of physicians in the medical direction and control of EMS according to the legislation, regulations, organisation, administration and practice of EMS in each Canadian province.

Thompson and Curry (1993) found that great diversity exists in physician involvement in EMS across Canada. For example, at the time of study, legislation in BC provided for the medical direction and control of EMS by physicians whereas the Northwest Territories had no legislation or medical direction to oversee the delivery of EMS at all. Interestingly, however, local physicians in the Northwest Territories were found to be routinely active in the delivery of pre-hospital care in the field. Thompson and Curry (1993) concluded that, “the level of physician involvement in EMS across Canada is inconsistent and insufficient . . . compared with accepted principles” (p. 1945).

It must be noted that Thompson and Curry (1993) assumed unquestioningly that physicians are the only health care professionals who should provide direction to the delivery of EMS. I question this assumption now since my study found that many

services provided by the participants to older persons in crisis were not purely 'medical'. Rather, I observed the participants use knowledge that was more multi-disciplinary in origin than purely 'medical' alone. For example, this was evident when assessments of the environment, social-support network and mental health of the patient were made, or therapeutic interventions were given, prior to the initiation of discrete requests for help from others, including the family or friends of the patient and the Quick Response Team.

The finding, above, raised critical questions for me as to how, when and by whom, direction of EMS should be provided. In addition, when discussing barriers to physician involvement, Thompson and Curry (1993) stated that, "some EMT's psychologically resist medical direction because they are trying to establish their role" (p. 1952). The major finding of my study, that some of the full-time, highly-experienced participants made discrete decisions of non-transport without guidelines or clearance from physicians, suggests the participants had distanced themselves already from medical control. Further research about the discretionary practices of paramedics, preferences for clinical direction, and outcomes of older persons who are not transported by paramedic choice, could answer these questions.

Selected Methods of Policy Implementation Analysis

I reviewed methods of policy implementation analysis for two purposes: (a) I wished to help identify limitations in my study, and (b) I wanted guidance as I formed my conclusions and recommendations. In particular, five works were chosen, including works by Berman (1980, in Ingram, H. & Mann, D., Eds.), Etzioni (1967), Ottoson and Green (1987), Pal (1987), and Wharf (1984). The following definition from Pal (1987), who quotes Jenkins, fits the definition of public policy I embraced when conducting the study.

[Public policy is] a set of interrelated decisions taken by a political actor or group of actors concerning the selection of goals and the means of achieving them within a specified situation where these decisions should, in principle, be within the power of these actors to achieve (p. 3).

This definition was compatible with the research question and methodology because I conceptualised public policy as a set of decisions that, when taken, contribute to the

achievement of goals by workers empowered adequately to pursue them. From my stand-point as a nurse-researcher doing ethical analysis, my study queried how policy was implemented by front-line workers.

With respect to ethical analysis, Pal (1987) states, “Ethical evaluation of policy may in principle, be divorced from empirical assessment of impact. More usually, ethical evaluation is combined with an analysis of impact to demonstrate that the effects of policy violate moral principles” (p. 37). In my study, where the research question asked, “how do paramedics implement EMS policy with older persons in crisis in the community?”, it was essential that I examine discretionary decision-making processes. It was important, also, to investigate whether the participants were adequately empowered to achieve the mandate of EMS and whether or not any unethical outcomes occurred.

In light of the definition and my stand-point above, therefore, I asked one question based on the Health Emergency Act (1974): “Were the participants empowered adequately to perform emergency procedures they were trained for and that are considered necessary to preserve the person’s life or health until the services of a medical practitioner are available?” (1974, Section 6). This thorny question produced two answers. On the one hand, for those participants who interpreted the mandate of EMS and the role of paramedic conservatively, that is, to be a technician who performs protocols on persons in life-threatening emergencies, the answer was ‘yes’. On the other hand, for those full-time participants who interpreted the mandate and role broadly and experienced dilemmas when they felt morally obliged to assist all older persons in crisis, the answer was ‘no’. This method of analysis led me to examine the work of Ottoson and Green (1997).

Ottoson and Green (1987) offered a theory of implementation which included a discussion of the dilemma of the practitioner:

McGowan (1976) captured some of the elements of the practitioner’s dilemma in what she described as the paradox central to the implementation of social innovations: programs that are likely to appeal to varied constituencies are often broad and vague, but this imprecision makes the programs less workable and more problematic for executive agencies. As a result, implementers feel caught: on the one hand they have their own weak grasp of the ideas, looseness of the developmental process, and limited control; on the other hand, they have their own accountability to concept developers,

oversight agencies and frequently their own ideas for social reform. This dilemma, combined with a passion for rationality, produces a series of mismatches between innovative ideas and the policy maker's influence, and between each of these and rational management (p. 354).

The remarks above inspired two reflections. First, the issues and dilemmas of the participants in the study arose, in-part, from feeling powerless about delivering EMS in the wider health care sector related to the authority and power vested in EMS executives and physicians in general. Second, in my role as ethnographer and nurse, I may have reinforced certain issues or dilemmas of the participants unintentionally, especially if they felt 'accountable' to me, as a nurse, when responding to older persons in crisis.

Etzioni (1967) offered another way to conceptualise dilemmas in policy implementation. In his discussion about mixed-scanning as a third approach to decision-making, the relationship between fundamental and incremental policies was described:

Thus while actors make both kinds of decisions [fundamental and incremental], the number and type of fundamental decisions are significantly greater than incrementalists state, and when the fundamental ones are missing, incremental decision-making amounts to drift . . . without direction (p. 93).

In Section 6 of the Health Emergency Act (1974), the empowerment of paramedics "to perform emergency procedures . . . necessary to preserve the person's life or health until the services of a medical practitioner are available" (p. 4) was a fundamental public policy decision. With regard to implementation of EMS policy with non-life threatened older persons in crisis, however, policy-drift occurred because no guidelines existed to chart the course for implementation of incremental decisions by paramedics.

Wharf (1984) conceptualised policy drift differently and related changes in policy to worker discretion. In a study of line-staff to determine whether front-line staff influenced policy outcomes through the exercise of discretion, Wharf (1984) found that "line-staff attempt to change existing procedures, programs and policies more often than they try to initiate. . . line staff are not simply passive creatures who deliver policies as enacted but rather, change them to meet the realities of practice" (p. 26). Thus, the work of Etzioni (1967) and Wharf (1984) influenced my final conclusions and

recommendations because I believe now that the policy implementation process cannot be analysed without considering first, the intent of fundamental policy in its wider context while examining, also, the needs of workers and clients. Therefore, critical features of the policy culture include the experience and ethical commitment, or not, of workers, to implement policy as intended on behalf of clients. To reconcile conflict between policy and practice through the valuing of workers, Wharf (1984) quotes Gilmore and Nelson:

Unclear lines of responsibility are endemic in large and complex organisations. One way of sorting out the confusion is to identify decisions in which there are ambiguities, bring these difficulties out into the open and resolve them through the participation of the people affected (p. 67).

This conclusion suggested to me that the participants in my study should have a role in developing future EMS policy and guidelines about non-transport. In particular, close attention should be paid to the issue of non-transport of those older persons in crisis whom paramedics perceive do not require the services of the acute care ER. At the same time, the reality that paramedics will always exercise discretion in practice should be embraced and enhanced to enable development of policy that will match the roles and abilities of workers to the needs of clients and society.

With respect to the formation and ‘fit’ of policy in accordance with the intent of governments, workers and clients, Berman (1980) emphasised there is no one ‘right way’ to develop or implement policy. Berman (1980) states:

There is no universally best way to implement policy. Either programmed or adaptive implementation can be effective if applied to the appropriate policy situation, but a mismatch between approach and situation aggravates the very implementation problems these approaches seek to overcome. . . First, policy implementers need to develop more effective implementation techniques for both programmed and adaptive strategies. Second, they need to recognise different types of situations intrinsic to the context within which a policy is implemented. Third, they need to learn to match strategies to the situation . . . [for example] It is difficult for a programmed approach to build in the contingency plans needed to cope with environmental changes . . . a programmed approach seems suitable to stable environments and an adaptive strategy seems appropriate for unstable conditions (p. 206, 220).

Thus, the work of Berman (1980), Etzioni (1967) and Wharf (1984) confirmed and expanded my reflections in chapter one and guided the formation of my final conclusions and recommendations which follow. First, a brief discussion of how my role as a nurse contributed to my study of EMS and paramedics, follows.

The Environment and Community as Foci of Critical Nursing Research

I selected two articles (Kleffel, 1991; and Stevens & Hall, 1992) that situated my study within the domain of contemporary nursing research. The articles were chosen because the authors, leading community health nurses (CHNs), researchers, activists and theorists, espouse practice standpoints similar to my own. In particular, Kleffel (1991), and Stevens and Hall (1992), are committed to redefine the practice of community health nursing by moving beyond the traditional epidemiological model of disease in order to empower CHNs to confront the socio-political influences which contribute to the development of illness and disease.

For example, in her article about “re-thinking the environment as a domain of nursing knowledge”, Kleffel (1991) reviews the environmental perspectives of the major nurse theorists to analyse the environmental foci within nursing. She aligns the paradigmatic origins of theories with views of the environment, according to categories of need theorists, interaction theorists and outcome theorists. Kleffel (1991) found that the epidemiologic model of the environment is concerned more with the incidence and seriousness of problems of disease than the examination of related social or cultural forces (p. 44). On the other hand, Kleffel (1991) found that ‘ecological, ‘upstream and ‘critical social nursing’ models of nursing practice embrace a paradigm shift that enables nurses “to examine the relationships of social, political, economic and cultural conditions that produce health and illness” (p. 49). Kleffel (1991) concludes, “upstream nursing scholars are providing non-traditional investigations that will lead the profession to a new level of practice” (p. 49). In my study, I examined how one group of workers whose base of practice was primarily ‘medical’, implemented selected health care policy with discretion in society. I queried, also, the ethical implications of such actions in relation to program delivery and health care reform. Discovering such knowledge enabled formation of my conclusions and recommendations which are discussed later in the chapter.

In a position paper about the relationship of ‘critical theories’ to community nursing, Stevens and Hall (1992) ask, “What theories can best guide our nursing care with communities?”, “how can nursing theories be relevant to the everyday realities experienced by the communities we serve?”, and “is the primary allegiance of the nursing profession owed to consumers or administrators and institutions who control health care budgets?” (pp. 2-3). To answer these questions, Stevens and Hall (1992) posit that critical theories are empowering processes for nurses to use which enable nurses to empower communities to gain control over threatening conditions (p. 3). Stevens and Hall (1992) describe critical theories:

Critical theories are not abstractions. Their basis is a living process created in the everyday struggles of a group of people. It is grounded in the historical context of a concrete oppressive condition experienced by a particular group. Thus, it avoids the oppressive split between theory and practice, and academia and real life, since the theories affirm the oppressed as subjects of their own struggle, rather than as objects of study or manipulation . . . [A] critical perspective begins with actualities rather than ideals (p. 3, 5).

Stevens and Hall (1992) reminded me that while the purpose of my thesis study was to discover how EMS paramedics implemented EMS policy with older persons in crisis, the origin of my research question was rooted in my nursing experience in the emergency room of an acute care hospital.

My work with the QRT exposed me to the ways that paramedics and certain older persons in crisis were excluded from service by front-line workers, in relation to how policy was interpreted and implemented in practice. Consequently, a critical nursing theory approach enabled me to conceptualise and propose my thesis research for the purpose of identifying better ways for paramedics, and others, to provide emergency response services to older persons in crisis. The final conclusions and recommendations which follow are a synthesis of my reflections on the methodology of the study, the findings of the study, and my reflections on the literature. They are followed by a statement of my developing model of health care reform.

Final Conclusions and Recommendations

This section has two parts, including my (a) final conclusions about the methodology used to conduct the study, and (b) final conclusions and recommendations for EMS policy, practice, education and future research.

Final Conclusions About the Methodology Used to Conduct the Study

In their monograph, “Membership roles in field research”, Adler and Adler (1987) identified the role of active member researcher (AMR). They state:

With active membership, the researcher moves clearly away from the marginally involved role of the traditional participant observer and assumes a more central position in the setting. Researchers who adopt active membership roles do more than participate in the social activities of the group members; they take part in the core activities of the group . . . they assume functional, not solely research or social roles in their settings. . . Instead of merely sharing the status of insiders, they interact as colleagues: participants in a joint endeavour . . . relationships with setting members may be business-like in addition to personal in character (p. 50).

Because I was a trusted confidant of most of the participants from my previous work as an occupational health nurse and Quick Response Team liaison nurse, and was working as a student with the BCAS/EMHS Project, the participants welcomed me as a peer and colleague. Thus, I became an AMR quickly.

With respect to the potential problems faced by AMRs, Adler and Adler (1987) identified four escape routes, and a fifth consideration, that AMRs must take to ensure they do not ‘go native’ and forget their greater commitment to their academic role. The first escape route is that, “AMRs must periodically withdraw from the setting to nourish their outside interests and limit their involvement” (1987, p. 51). When I read this, I realised that during my study I nourished my outside interests too little. During my study, my world consisted of working with EMS balanced with caring for my family. Even my family became involved, peripherally, in the setting of my study. For example, when my

children saw an ambulance zoom by, they would ask, “Mum! Is that your ambulance?” The excitement and lure of EMS had hooked us all.

The second escape route stated by Adler and Adler (1987) is that, “AMRs must periodically realign their perspective with outsiders in order to analyse the setting critically and maintain the theoretical stance” (p. 51). When I reflected on this, I realised that I remained too isolated from my academic nursing peers during the conduct of my study. Consequently, I did not share or appreciate my insights and reflections adequately to wring from them every ounce of analysis they were capable of producing.

The third escape route stated by Adler and Adler (1987) is that, “AMRs must retain sight of the fact that, ultimately, their participation in the research will be temporary in scope, and that their personal and career commitments, unlike their fellow participants, lie elsewhere” (p. 51). When I reflected on this, I realised that during the study I had hoped to pursue a career, later, in EMS. For example, although I saw my study as temporary, my enjoyment of EMS and my need for gainful employment in a competitive work environment, led me to ponder twice, applying for basic EMA training. If it had not been for the requirement to write the findings of this study and the remote locale of the training centre in a distant city, I might have seriously considered doing so.

The fourth escape route stated by Adler and Adler (1987) is that, “AMRs with greater involvement in the core activities of the group make them more likely to use overt approaches, since the AMR role is more demanding of one’s time and self. AMRs are less likely to feel the need for secrecy and inconspicuousness associated with the covert role, as their participation and active membership status can generate great trust among group members” (p. 52). This escape route confirmed to me that I had made the right decision to conduct an overt study. The EMS executives and participants supported the purpose and method of the study, and all the available full-time and part-time participants consented to participate.

The fifth point made by Adler and Adler (1987) is that AMRs must be prepared to experience difficulties when they write their research report. They stated, “fulfilling the expectations of the participants that they be portrayed entirely favourably is often problematic, as the process of analysis involves focusing a critical or multiperspectival

lens on the group and examining them from a theoretic stance” (p. 56). This point caused me to evaluate the degree to which I had been truthful and open with the participants when I observed behaviours that challenged my personal and professional ethic and the purpose of the study. In the final analysis, I believe I was as truthful and open as possible while not compromising the integrity or reporting of the study.

My greatest difficulty in conducting the study was being in a concurrent role as a student worker on another EMS project, since knowledge from the BCAS/EMHS Project made writing of the study reported here more difficult. To that end, in future I will conduct only one study at a time! In summary, the five points, above, were missing links that guided me to complete the circle of interpretation, reflection, disengagement and final writing of my study. My final conclusions and recommendations concerning EMS policy, practice, education and future research now follow.

Final Conclusions and Recommendations for EMS Policy, Practice, Education and Future Research

The following conclusions and recommendations concern EMS policy, practice, education and future research. My first recommendation arises from an early finding of the study, that the Emergency Health Services Commission (EHSC) exists now in name only and provides oversight only to EMS, despite the existence of other multi-disciplinary emergency response services across BC that fall under the legal authority of the Health Emergency Act (1974). I believe, therefore, that the EHSC should be revitalised and reformed to incorporate, also, multi-disciplinary emergency response programs and perspectives. Such reform would ensure that a governing body would oversee the development of all community-based, multi-disciplinary emergency response services which could then match policies and workers more closely to programs and clients. To argue against taking such actions to appease those who subscribe to the medical model only and who wish to ‘control’ EMS entirely within the domain of medicine, would be tantamount to ignoring the therapeutic interventions done by paramedics and others in the community, with persons who require emergency assistance but not medical protocols.

My second recommendation is that a review of EMS legislation, policy and guidelines be conducted. The purpose of such a review would be to reinterpret and

realign policy to incorporate, where appropriate, the discretionary practices of paramedics to match the needs of the geriatric population as a whole. Since the study confirmed that the full-time participants practiced discretionary decision-making, either by initiating unofficial referrals to other community-based services or by soliciting refusals, a review would create a forum for bureaucrats and paramedics to work together to change EMS policy. Such policy is already in place in other EMS systems. For example, the literature demonstrated that other EMS systems are recognising shifting population demographics and the needs of non-life threatened older persons in crisis through new EMS policies and programs (Gerson, Schelble & Wilson, 1992; and Latessa & Kainrad, 1988). Such programs have converted discretionary decision-making practices into safe innovations to reduce or eliminate calls from 'abusers' and 'repeat users' of EMS. Without such changes to EMS in BC, where every second call is to a person over 60 years, the threat of economic and social disaster will continue to loom (Ministry of Health, 1994, p. 6).

My third recommendation concerns the practice of discretionary decision-making by paramedics. As Lipsky (1980) and Wharf and Callahan (1980) discussed, discretion will always be practiced by front-line workers charged with administering (and withholding) the benefits of public policy. One must conclude therefore, that as the experience and education of paramedics expand over time, their repertoire of discretionary practices will expand, also. The objective of EMS guidelines, therefore, should not be to diminish or regulate discretionary decision-making but to embrace and enhance the growing abilities of paramedics to serve patients to the best of their abilities.

My fourth recommendation concerns referral processes between EMS and partnership agencies. To illustrate, I refer now to existing referral processes between the police and mental health workers in BC. Recently, Panagabko, the Provincial Co-ordinator of Emergency Mental Health Services (EMHS) for the Province of British Columbia, found that administrative policies and guidelines alone were insufficient to guarantee implementation successes of referral guidelines on the street (personal communication, September, 1993). Instead, to achieve success in policy implementation, Panagabko found that 'service agreements' between referring and responding agencies constructed meaningful partnerships between groups that fostered trust and goodwill with effective outcomes. Unfortunately, a written evaluation of such agreements was not available at the time of writing. Panagabko defines service agreements as mutually

negotiated community protocols that articulate the terms, mechanisms, expectations, responsibilities and modes of evaluation that are agreed upon to conduct referrals:

Service agreements are typically not legally-binding but rather, serve as tools to confirm and clarify what each party has agreed to. They are highly useful in situations where levels of trust between groups are low, or when certain professional groups fear the demand on resources may exceed capabilities to deliver. Conversely, service agreements help parties with a shared vision to merge their enthusiasm in partnerships that cost little more than the time and paper they are written on and the client benefits (personal communication, Panagabko, 1994).

Given the apparent usefulness of service agreements between the police and mental health programs and physicians in BC, I recommend now that such agreements be implemented between EMS and the agencies with whom EMS enters into partnership. Such agreements would enable pre-hospital care to be delivered efficiently and in a more caring manner, while, at the same time, allowing paramedics to make discretionary decisions within a safer, more stable environment for patients.

My fifth recommendation concerns the practice of leaving ill, 'adamant refusers' alone in the community when transport to hospital is refused. It is well-known that this group of individuals is often the most difficult for many health care professionals, not only paramedics, to assist. However, when one's personal 'alarm bell' rings after an older person in crisis provides a capable refusal and transport to hospital under Section 24 of the Mental Health Act (1979) is therefore not possible, I recommend strongly that the family physician, a family member or a friend of the person be summoned to visit the person within one or two hours of the EMS encounter. Such follow-up could make a difference between the ill, older person accepting medical help later, or for some, not dying alone.

My sixth recommendation concerns paramedic training and education. My findings indicated that with respect to basic and continuing EMS instruction and the needs of older persons in crisis, the full-time participants were not satisfied with the subject matter or the models of instruction used. Instead, the full-time participants stated they relied on past experience, intuition, debriefing with others and information from ER nurses and physicians to expand their clinical knowledge of older people. To that end,

and to achieve the other recommendations, above, I recommend now that paramedics in BC receive basic and continuing education in geriatric medicine and psychiatry, taught from the point-of-view and knowledge-base of experienced paramedics, not physicians. The intent of such education would be to impart knowledge and skills about assessing and managing illness in older people, particularly those older persons found to be at-risk of inadequate assessment and treatment or non-transport (see chapter five, p. 76-77).

In addition, educational programs in geriatrics should be designed to assist paramedics to reflect critically upon their knowledge and experience while, at the same time, providing them with adequate information to support older persons in crisis to seek assistance from suitable community programs to resolve urgent crises. The use of a multi-disciplinary, team-teaching model would be highly useful and would possibly ameliorate, to some extent, the concern that 'no-one understands EMS or the work that paramedics do'. For example, one paramedic and one geriatric social worker or nurse could co-present information based on experience, from complementary, but different points-of-view. Such a teaching method, where each co-instructor is situated to complement the strengths of the other, would build bridges between EMS and the other health care professions where presently, none exist.

My seventh recommendation concerns topics for future research. Many have been stated in chapters four and five thus far. Research that is most urgent concerns matters of quality assurance and decisions surrounding solicitations of 'non-transport'. For example, all cases of non-transport should be audited for one month to identify patient outcomes, especially when refusals are solicited from 'abusers' and 'repeaters' with or without referrals to physicians, family members and/or alternate programs. Such research would inform policy and practice within, and beyond, EMS.

In addition, as discussed before, calls to older persons in crisis were terminated quickly, often without transport or follow-up, when paramedics believed either the older person (a) had frequent falls without apparent injury and had normal vital/neurological signs, (b) lived in extreme poverty and/or required urgent, non-medical assistance with the activities of daily living; (c) had chronic problems of untreated alcoholism and/or drug abuse, (d) had 'stable' mild confusion without other medical problems present, (e) had aggressive or pre-violent behaviours without posing an apparent danger to self or

others, and (f) capably refused transport, with or without EMS encouragement to do so once the presenting problem appeared to be resolved (Ministry of Health, 1994). Therefore, further research is required to examine these groups further to determine clinical outcomes and implications for policy and practice.

In summary, it is critical that further research be conducted to examine who older persons in crisis are, especially those in the groups above, in order to learn the outcomes of such patients when refusals of EMS are solicited or volunteered. On the one hand, it may be found that failure to provide medical care or request follow-up in the community runs dangerously close to negligence. On the other hand, additional research may find that permissible discretionary practices of non-transport, followed by referrals to alternate programs, are the missing links in a chain of care that is becoming visible only now.

My Developing Model of Health Care Reform

This section begins with a question: “What have I learned from conducting this study?” Upon reflection of my experiences in EMS and as an AMR, I discovered that I have begun to develop a model for a process to achieve health care reform. The principal component of the process is an ethical analysis of policy implementation from the point-of-view of the street-level worker. In practical terms, my developing model posits:

If the discretionary-decision making practices of street-level workers are analysed ethically, from the stand-point of the workers, with the new knowledge converted into policy and educational initiatives which are endorsed and team-taught by multidisciplinary staff, then policies and practices can be reformed, also, by the discovery and application of such knowledge.

My developing model, therefore, posits that policy and practice can be evaluated and reformed through one overt process that examines the connections between ‘duty and discretion’ in policy and practice.

The process of reform includes (a) a participatory ethical analysis of the discretionary decision-making practices of street-level workers, and (b) the integration and application of new knowledge through educational and policy-making initiatives

which include street-level and multidisciplinary staff together. I believe such activities would create a mutually respectful process whereby the critical reflections of workers on their experience and education, from an ethical stand-point, will reform policy and practice. An epistemological point of departure to develop my model further would be to examine the interrelationship of experience, education and ethics in the daily practice of front-line workers.

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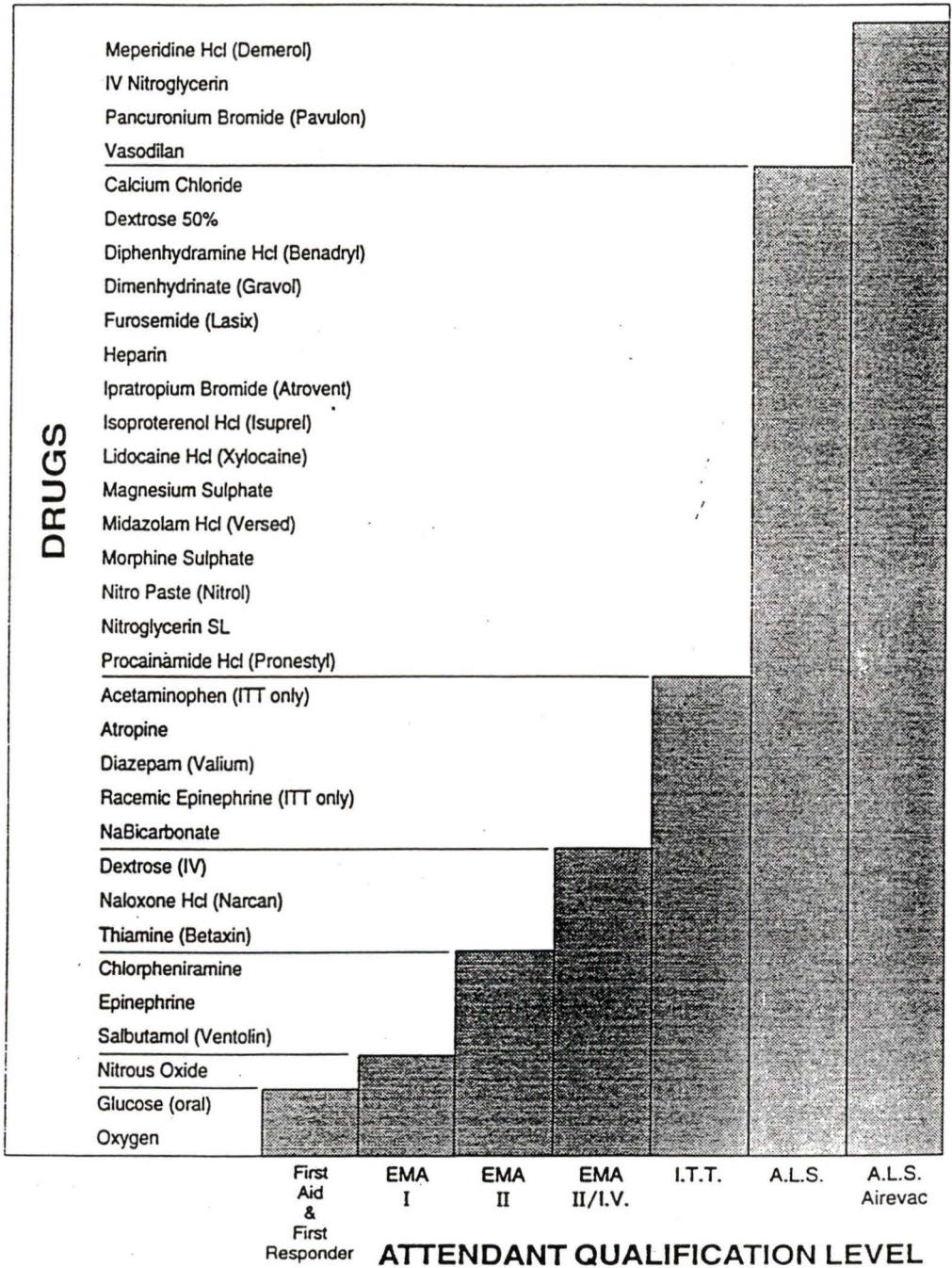
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GUIDE TO ATTENDANT QUALIFICATION



Letter of Informed Consent

To Participate in the Study, “Between Duty and Discretion: Paramedics and the Implementation of EMS Policy with Older Persons in Crisis in the Community”

Researcher: Pauline James-Groom, RN, BSN, Masters Candidate, (Ph: 385-9456)

Supervisor: Dr. J. Isobel Dawson, RN, Ph.D., (Ph: 721-7965)

I, _____, give voluntary consent to participate in the above-titled study. I understand that in volunteering, I will be observed in my work as a paramedic and will be asked to participate in confidential ‘one-to-one interviews’ with the researcher. I understand that I will be asked questions about my professional practice preferences and opinions concerning the delivery of emergency health care services to older persons in crisis in the community. I understand that I will also be asked to voluntarily participate in one or more confidential focus groups at a later date with the researcher and other volunteers for the purpose of discussing the findings of the interviews and their implications for policy and practice.

I understand that my choice to participate in the study is completely voluntary and confidential. I further understand and agree that neither my employer nor I will receive payment or gratuities for participating in the study. I understand that the researcher will endeavour to hold interviews and group meetings during my hours of work, however, I acknowledge that any meetings which I choose to attend that are held outside my regularly scheduled hours of work may be at my own expense unless otherwise negotiated with my employer.

I understand that I may refuse to answer questions, written or verbal, at any time and that I may withdraw from the research study at any time of my own choosing without penalty or risk of loss of job or status.

... 2.

APPENDIX B.

I understand that all information provided by me to the researcher during the study will be collected and treated as 'strictly confidential'. I understand further that interviews and group meetings may be electronically recorded if consents are given by all participants. I know that I may request and expect the tape recorder to be turned off at any time without offer of explanation.

I understand that, at all times, data will be kept secure by the researcher in a locked filing cabinet without names of persons or agencies attached which could permit tracing of data to individuals or groups. I understand that all data, once transcribed, will be destroyed by the researcher. If I have questions or concerns about participating in the study, I know I can call the researcher or supervisor of the study for clarification.

Signed _____ Witness _____ Date _____

How I Solicited Consent from the Prospective Participants

The following statement is an approximation of what I stated, in casual conversation, to prospective participants of my ethnographic study.

“I am a Registered Nurse and master’s degree student who is interested in learning more about paramedics, their work, and how they actually do it when they provide assistance to older people in crisis in the community. I am interested in studying this because I believe that paramedics have untapped knowledge and skills to do things for old people that are not necessarily part of current EMS policy or practice. Changes to policy cannot occur without research that discovers how things are done, and then recommends the way things could be improved. I need your help to do this” (Pauline James-Groom, personal communication, April, 1993).

REQUEST FOR APPROVAL OF PROPOSED RESEARCH
INVOLVING HUMAN SUBJECTS

Please type this and all accompanying information. Please submit original plus 3 copies of application form and accompanying documents.

TO: Committee on Research and Other Activities Involving Human Subjects
Office of Research Administration, Room B115, Sedgewick Building

FROM: Pauline M. James-Groom March 10, 1993
(Name) (Date)
F.H.S.D. Graduate Student Home: 385-9456
(Department) (Position) (Phone Number or Local)
NOTE: Position = ie. Student, Grad Student, Research Assistant, Faculty

1. Short title of proposed research: Shifting Models of Emergency Health Care
Services for Older Persons with Psychiatric
Illness: An Implementation Analysis

Please attach an outline of the proposed research, with emphasis on the procedures involving human subjects. That is, what are the subjects going to be doing? Include copies of questionnaires, tests, interview schedule, Letter of Informed Consent, etc.

2. Who are the subjects?
The subjects will be a variety of professional workers engaged in front-line service delivery of emergency health care services to consumers with acute psychiatric problems within the Victoria region.
3. How will the subjects be obtained?
The subjects will be obtained on a voluntary basis through the use of convenience sampling techniques. Advertisements and visits to worksites by the researcher to discuss the research and seek volunteers will be conducted. At no time will coercion or bribes be used.
4. To what extent is the participation of the subjects voluntary? How is this assured, procedurally?
Advertisements, discussions about the research to prospective participants, and the letter of consent will each specify the voluntary nature of participation in the research project. Incentives will not be provided nor will employers be informed about which persons are participating. How is the subject's right to withdraw at any time assured?
The Right to Withdraw will be stated on all advertisements for participants. It will also be included on the letter of consent and will be further discussed with participants prior to and during the conduct of the research, so that participants may withdraw at any time.
5. To what extent are appropriate guarantees of anonymity or confidentiality given to the subjects? How is this implemented (e.g., will data records contain names or other means of identifying individuals)?
Anonymity and confidentiality of participants will be assured at all times throughout the study. Names and other personal identifying information will not be used on any surveys, field notes, tapes or documents. Codes will be used to identify data. All data will be destroyed in detail, on a separate page; include the necessity for this risk or hazard and the potential value of the research justifying it.
6. Is there any possibility of physical, psychological, or other risk in the research? If so, explain in detail, on a separate page; include the necessity for this risk or hazard and the potential value of the research justifying it.
No risk to anyone, of a physical or psychological nature is expected during the conduct of the proposed research.

What safeguards for the subjects, the researcher, and the University are part of the research plan?

Interviews and groups will be held in secure, professional offices. During the course of normal work for the voluntary subjects, certain safeguards are already practised. These include attending to patients in pairs of two staff or more. All staff are equipped with either pagers and cellular telephones or C.B. radios which are monitored by trained professional personnel. The researcher will not visit the front-line without

- 7. When, and to what extent, is the nature and purpose of the research or study explained to the subjects?

During the recruitment of volunteers phase, posted Advertisements and scheduled site visits will allow full explanation of the research. Full explanations will accompany all interviews, preface focus groups to insure consent. Considering this question and question 4, when and how is informed consent obtained? is informed

- 8. Please list any institutions or organizations involved in the research (e.g., by providing subjects, facilities, or access to data). Also indicate whether their written permission is attached or is to be forwarded to the Committee.

- 1. Emergency Psychiatric Response Team, Ministry of Health > DR. Barry Morrison
- 2. Intensive Community Support Team, Ministry of Health
- 3. British Columbia Ambulance Service, Emergency Health Services Commission - MR. Mick Hazen

- 9. Person designating him/herself as in charge of the research:

Pauline M. James-Groom

 (Name)

Pauline M. James-Groom

 (Signature)

Supervisor (if any):

Dr. J. Isobel Dawson, RN, PhD.

 (Name)

Isobel Dawson

 (Signature)

Chair/Director of Department or School:

Dr. Michael J. Prince
~~Dr. Jim McDavid~~ PhD.

 (Name)

Michael J. Prince

 (Signature)

March 24, 1993

 (Date)

- 10. Additional information, required before final approval can be issued:

Approximate starting and termination dates:

April 15, 1993 through March 31, 1994

Name(s) and position of all person(s) who will be conducting the research:
 NOTE: Position = ie. Student, Grad Student, Research Assistant, Faculty

- 1. Pauline M. James-Groom, Grad. Student
- 2.
- 3.

APPROVED BY COMMITTEE ON RESEARCH AND OTHER ACTIVITIES INVOLVING HUMAN SUBJECTS:

J. Humboldt

 (Chair's Signature)

April 8/93

 (Date)

DATES: From To

APPENDIX E.

Sample Interview Questions from Research Proposal

The following note and questions were prepared for inclusion in my research proposal for review and approval by the University of Victoria, Department of Research Administration, and the Ministry of Health, province of British Columbia.

1. Can you please tell me about your job? I would like to know what your title and job description are, and what duties you actually perform.
2. What training or qualifications do you require to be placed in this position?
3. Why did you decide to work in this position and how long have you done this kind of work?
4. What is it about your work that keeps you in this field of practice?
5. Can you tell me about an emergency call or urgent case which you have had recently where the patient was an older person in crisis and you believed they did not require the services of an acute care hospital?
6. What is it about the call which makes it memorable?
7. What exactly did you do for, with, or to the patient on that call?
8. Did you experience any dilemmas as you provided care to the patient?
9. As a professional who exercises discretion in administering patient care, will you tell me about the choices or options for care you had for the patient and how you decided to do what exactly it was that you did?
10. In your opinion, could a visit to acute care have been avoided if a particular resource had been available at the time for you to refer the patient to, for immediate attention and/or support?
12. Can you think of a repeat call you had where you believed the older person required urgent, additional or different attention but did not require an acute care admission to the emergency department or a ward?

13. Can you tell me about the mandate of your organisation and the policies you work with everyday which would have influenced the choices you made to deliver care to the patient we have been talking about?
14. Can you tell me about the ways in which you perceive policies are developed in your organisation?
15. In your opinion, how are policies in your organisation implemented?
16. What is your role within your organisation as an implementer of policy?
17. Can you tell me about the ways you perceive that policy changes in your organisation?
18. In your opinion, how do policies change in your organisation?
19. What is your role with respect to changing policy in your organisation?
20. Are there any policies you work with everyday that, in your experience, conflict with the mandate of the program within which you work?
21. It is acknowledged that certain patients use emergency services repeatedly. What factors, in your opinion, contribute to this?
22. In your opinion, what is needed to assist older persons in crisis in the community who do not require a visit to the emergency department, yet do require intervention and support?
23. Are there any roles or tasks which you carry out in your job with patients which you perceive are unrecognized by your employer?
24. Please think about your own philosophy and approach to health care practice which you apply on the front-line. Now think about those ways in which you are required to demonstrate accountability to your employer. In what ways are they compatible or incompatible ?
25. When you are on a call and the patient refuses the services you offer, yet you are particularly concerned about the safety and well-being of the patient, do you do anything differently or in addition to what you have already offered or done?

26. Current health care initiatives aim to make programs and services ‘closer to home’ and more ‘effective and efficient’. As a front-line care provider, what does this mean to you in terms of your present job duties and the ways you think older persons in crisis ought to be responded to?
27. One researcher named front-line workers in the human services, ‘street-level bureaucrats’, meaning that policy is made on the front-line through the interpretation and implementation of policies by workers with their clients. Do you see yourself as a policy maker in this way?
28. If emergency services for mental health patients could be organised and implemented according to your interpretation of what older patients in crisis in the community need, what would need to change?
29. Many of the ways that health care is organised is based on the medical model. Many aspects of health care, however, are conducted by personnel other than physicians. Paramedics, nurses and para-medical staff are frequently allowed to perform assessments and treatments via a ‘transfer of function’ authorisation from physicians to non-physician health care workers, for example. As a health professional, how do you see your work in relation to, or separate from, work conducted by physicians?
30. From your standpoint as a health care provider who is working during a transition in the organisation of health care, from a bureaucratic model to a regionalized model, in your opinion, how should emergency mental health services be organised and implemented for older persons in crisis in the community?
31. Based on your experience, what needs do older persons in crisis in the community express to you, and how are these similar or different from needs identified by the emergency health care system?

Note. A maximum of 10 to 15 questions will be chosen from the list above for interview purposes. Questions may be worded differently from those shown, as they will be derived and adapted from the content as it flows between the researcher and the interviewee. At all times, questions will be respectful of the participant’s right to privacy. Cues to the researcher that questions are perceived to be intrusive by the interviewee will result in re-wording or dropping of those questions by the researcher.



Province of British Columbia and Ministry Responsible for Seniors
EMERGENCY HEALTH SERVICES COMMISSION

CREW REPORT
COMMISSION COPY

HLTH 2402
REV 8705

32. REG. N. STATION SHIFT 33. DATE OF SERVICE DO MM YY 34. VEH. #

1. PATIENT'S SURNAME				TIME KM:		35. SPECIAL CODE ① ② ③ ④ ⑤ ⑥ ⑦ ⑧		36. PROV. RESPONSE # P-		37. RESPONSE # 122	
2. PATIENT'S GIVEN NAME INITIAL				20. CALL RECEIVED		38. AMBULANCE RESPONDED TO PATIENT'S ADDRESS ①					
3. POSTAL ADDRESS				21. START		40. PATIENT CARRIED TO 41. HOSP					
4. CITY		5. PROVINCE		6. POSTAL CODE		22. CODE ② ③		42. DRIVER # NAME			
7. PATIENT'S PHONE #		8. BIRTHDATE DO MM YY		9. AGE		10. SEX ① M ② F		43. ATTENDANT # NAME			
11. M.S.P. I.D. #				12. S.I.N. #		23. CODE ② ③		44. ESCORT NAME			
13. PATIENT'S PHYSICIAN				24. AT SCENE		45. UNIT QUALIFICATION ① EMA ③ EMA I.V. ⑤ ALS I ⑦ ITT ② EMA II ④ EMA-D ⑥ ALS II					
14. BILL TO: (NAME IF NOT ALREADY INDICATED)				25. TO DESTINATION		46. LAYERED RESPONSE ① EMA I/II ③ ALS ⑤ ALS not available ② EMA-D ④ F. Dept Initials					
15. POSTAL ADDRESS		16. CITY		17. PROVINCE		18. POSTAL CODE		47. HOSPITAL CONTACTED			
19. BILL TO / IDENTIFICATION ① Patient ⑦ Standby ⑬ Sheriff ⑲ Other ② M.H.R. ⑧ Parent ⑭ A.G., B.C. ⑲ M.H.A. Trans. ③ W.C.B. ⑨ D.I.A. ⑮ Home Care ⑳ Cont. Call ④ I.C.B.C. ⑩ D.N.D. ⑯ Police ㉑ Cancelled ⑤ Non resident ⑪ A.G. Canada ⑰ I.H.T./T.R. ㉒ Pt. refused ⑥ Employer ⑫ Coroner ⑱ M.H.A. ㉓ A.N.U.				26. CODE ② ③		27. CODE ② ③		48. PHYSICIAN ORDERING			
29. CLEAR				30. BASE		31. AMBULANCE IN PAST 24 HRS. Y N Unknown ① ② ③		49. POLICE DEPT. / CONSTABLE #		50. VEH. LIC # IF M.V.	

51. CHIEF COMPLAINT	56. VITAL SIGNS				57. COMA SCORE				64. DISPATCHED AS DIAGN																							
	TIME	SYS	B.P.	DIA	PULSE	RESP RATE	RESP EFFORT	CAP REFILL	E	V	M	TOTAL																				
52. MECHANISM OF INJURY - HISTORY OF ILLNESS	58. EXAM				60. TS 1				61. TS 2				62. PUPILS																			
	State of consciousness				H & N				Chest				C.V.S.																			
53. RELEVANT PAST HISTORY	59. DIAGNOSTIC AND ADDITIONAL COMMENTS				63. SKIN				65. AIRWAY CONTROL				66. OXYGEN																			
	Blood Loss				Normal ① Cyanotic ② Pale ③ Flushed ④ Diaph. ⑤				① DSW ② D10W ③ NS ④ R/L ⑤ Other				① Cleared ② Positioned ③ Suctioned ④ Ventilated ⑤ Oral Airway # ⑥ Intubated #				① Cannula ② Mask ③ Venturi O ₂ at _____ % O ₂ at _____ lpm															
54. MEDICATIONS	67. CARE GIVEN				68. I.V.				69. PROTOCOL CODES				70. PATIENT FOUND																			
	① Control Bleed ② Dress wound ③ Splint ④ Traction ⑤ Back Board ⑥ Neck Immobil. ⑦ Transport only				ATTEND ATTS SUCC DRIVER ATTS SUCC TIME SIZE SOLUTION TOTAL VOL. (ml) BLOOD DRAWN				① DSW ② D10W ③ NS ④ R/L ⑤ Other				① ② ③ ④ ⑤				① ② ③ ④ ⑤															
55. ALLERGIES	74. TIME				75. MEDICATIONS AND PROCEDURES				76. RESP. RATE				77. PULSE				78. B.P. SYS. DIA.				79. CARDIAC RHYTHM				80. RESULT				INITIAL			

81. ADDITIONAL REPORTS				82. U.C. - LMC INITIAL				83. DRIVER'S SIGNATURE				ATTENDANT'S SIGNATURE				84. M.D. REQUEST REVIEW				85. RECEIVING PHYSICIAN'S SIGNATURE			
2ND TREAT				AIR-VAC				OCCUR															

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Brocklehurst, J. C., Robertson, D. & James-Groom, P. (1982). Clinical correlates of sway in old age- sensory modalities. Age and Ageing, Vol. 11, No. 2, pp. 1-10.

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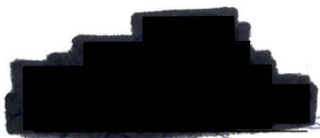
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Author



Pauline Marion James

April 21, 1997