Scope of Practice Position Statement

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For The EMS Educators Association of Texas

Approved by the EMSEAT Board of Directors, Date….

Position Statements

EMSEAT is concerned that the draft National Scope of Practice would:

- significantly restrict the ability of the local Medical Director to determine the appropriate skills set and therapy for those practicing under his/her delegated practice.
- alter current practices and limit future practices based upon current community needs and future research
- prohibit skills sets and therapies that have been proven to be safe and appropriate in specific communities and EMS systems
- not ensure quality of practice or protection of the public
- negatively impact EMRs and EMTs particularly in rural and frontier areas
- create an unnecessary additional paramedic level with unsupported academic requirements

Introduction

The EMS Educators Association of Texas is open to all who are interested in the education of EMS personnel. Members represent institutions of higher education, proprietary organizations, and EMS providers. At the general membership meeting held in November 2004. The membership agreed to develop a position paper on the National EMS Scope of Practice Model. The membership unanimously agreed that this Scope of Practice Model will significantly impact EMS education in the State of Texas.

Discussion

The State of Texas has long valued the role of the EMS Medical Director within the delegated practice model. This model has allowed EMS providers in various diverse geographic areas to meet specific community needs based on their available resources. The delegated practice model allows the local EMS Medical Director to determine which skills and therapeutic practices are safe and appropriate for use by those practicing under his or her direction. This draft Scope of Practice Model restricts the ability of the Medical Director to tailor skills and therapeutic practices considering locally available

education, training, social resources, economic resources and definitive care facilities. Additionally, the draft Scope of Practice Model has the potential to alter current practices and limit future practices based upon current community needs and future research. This is particularly significant in rural and frontier communities.

We agree with the need for uniformity across the Nation. We believe that this can be accomplished by setting minimum levels. Establishing maximum skill sets does not enhance uniformity; it only ensures that providers are not authorized to perform certain skills. This minimum level allows for uniformity across the Nation and forms the basis for minimum education and training for each provider level. While we agree with the concept of permitted skills sets, we do not support the prohibitive language as defined in the draft Scope of Practice Model. Throughout the document, references are made regarding protecting the public and assurance of public safety. The limiting of specific skills does not ensure quality or safety. The draft Scope of Practice Model will not protect the public from those providers who would blatantly act outside of expected community standards. Protection of the public should be an objective of a quality assurance/ quality improvement model not the Scope of Practice Model.

We agree with the need for higher education standards for all EMS provider levels. Our concern is with the rapidly rising educational requirements that would follow implementation of the Scope of Practice Model. These increased requirements would have the greatest impact on the EMR and EMT levels. Many communities depend upon providers with limited education due to limited economic resources. We would support a phased approach to increased educational requirements at these levels.

There should only be one paramedic level. The APP scope is intended to reduce the morbidity/mortality associated with critical, emergent, and low acuity medical and traumatic conditions. We believe this scope of practice is consistent with the 1998 National Standard Curriculum for paramedics. Therefore, we disagree with a second paramedic level, especially one that requires a bachelor's degree. There are three reasons for this. First, most bachelor degree curriculum are not clinically focused, but are emphasizing operations, research, or education. Second, the need to complete upper division coursework in order to be authorized to perform a specific skill set can not be evidentially supported. Third, we believe that the additional educational requirements would be an undue hardship on areas with limited access to bachelor degree programs. We support the idea of a bachelor program that adds non clinical EMS System support. This could provide alternative non clinical pathways for advancement.

Conclusion

In summary, we agree with the concept of the National EMS Scope of Practice as it relates to professional standardization. However, we do not feel that a skills prohibitive focus is appropriate. The impact of The Scope of Practice draft 1.0 on the diverse communities of Texas will be substantial.