PALLIATIVE MEDICINE

Palliative Medicine
2022, Vol. 36(3) 402–404

DOI: 10.1177/02692163211073263
journals.sagepub.com/home/pmj


What is the role of paramedics in palliative and end of life care?

Home is the preferred place of care for most palliative patients, and when they reach the end stage of their illness, their preferred place of death. But primary health care provision for this patient group is inconsistent and mostly provided by family, loved ones or residential care staff who feel unconfident in providing such care. These anxious carers often call emergency services for urgent help as they witness the worrying and unexpected symptoms of disease deterioration or dying, thus making paramedics and the ambulance service the patient's first point of contact in primary care. An understanding is needed of the role of paramedics in palliative and end of life care and whether paramedic attendance is appropriate in this patient group.

Paramedics providing palliative and end of life care

The ambulance service and therefore paramedics are the frontline of the emergency response to urgent palliative and end of life care. The scope of practice for paramedics in the ambulance service has radically changed in the last 20 years, with paramedics now having a high level of clinical knowledge and autonomy giving them the ability to treat patients at home rather than providing a patient transport service to hospital, this is especially true in the USA, Canada, Australia, and the UK.[1] The question that we must therefore ask is does this make paramedics a suitable solution to fill the out of hours gap in community palliative care provision? Palliative patients have an incurable underlying condition, but this does not mean that they won't experience reversible conditions such as sepsis, hypercalcemia, and other exacerbations of their illness that need acute admission, whereas an actively dying patient at the very end of their disease trajectory will be experiencing symptoms that are irreversible and would not benefit from an acute admission. Advancements in medical procedures and the many interventions now available often make the deciphering of palliative care disease trajectories complex for generalist clinicians such as paramedics.

It can be said that palliative care patients needing hospital treatment for acute reversible episodes fit better into a paramedic practice predominantly based on formulaic algorithms, guidelines and the monitoring of vital signs, whereas dying patients who do not fit into the reversibility and lifesaving paradigm may fall out of their scope of practice.[2] Research literature highlights that there is an instinctive compulsion in paramedic practice to seek hospital admissions for all patients, thus again compromising the preferred place of home for death.[3] In the context of COVID-19, the non-conveyance of patients to hospital where home is the preferred place of death is even more vital as a hospital admission may result in patients dying without their loved ones in attendance and increases the risk of the grieving process being complicated and intensified.[4]

Paramedics are often fearful of caring for dying patients in expected deaths. This fear is sometimes associated with Do Not Attempt Resuscitation orders (DNAR) as sometimes (1) the order cannot be accessed, (2) they do not understand the legal requirements associated with DNAR, or (3) whose responsibility is it to discuss the DNAR with the patient and families.[5] It has also been found that the paramedics convey dying patients to hospital despite patients having advance care plans or being known to community palliative care teams and previously expressing a wish to avoid an acute hospital admission.[6] Another hurdle for paramedics is that the patient documentation available in the home is often out of date, inconsistent and limited which can lead to lack of confidence when caring for dying patients in expected deaths. This lack of confidence may lead paramedics to a defensive clinical practice culture rather than a patient centered culture, resulting in the dying patient's conveyance to hospital.[7] An added complication is that a patient hospital conveyance is hard to criticize from a legal standpoint, whereas a paramedic's decision to leave the dying patient at home may be open to more in-depth scrutiny of the paramedic's personal clinical decision making and rationale. These conflicts, married with the bio medical culture in emergency medicine of cure and rescue, can put paramedics in an impossible moral dilemma.

Paramedics need more defined guidelines and procedures that incorporate the holistic and complex nature of end-of-life care, consisting of a social, psychological as well as a physiological assessment. Paramedics heavy reliance on algorithms and guidelines does not prepare them to interpret advance care plan and end of life

documentation.[8] There must be more recognition by the multi-disciplinary health care community team and the public of the vital role that paramedics play in end-of-life care. There is very little reference to paramedic involvement in existing international end of life guidelines and healthcare policy.[3] Paramedics and the ambulance service are in a unique position, so increased confidence of paramedics in end-of-life care could greatly benefit the relief of dying symptoms, hospital avoidance and facilitation of paramedic referral onto other healthcare providers in the community, such as the community palliative care team .

Implications for paramedic practice in end-of-life care

Paramedics are willing to care for dying patients in expected death and see this aspect of patient care as a vital part of their practice, but consistently express an overwhelming need to receive more palliative and end of life care education as part of their undergraduate education and continual professional updating. This education should incorporate communication skills in end-of-life care, the exploration of advance care planning documentation and instruction in the writing of care plans, as well as an in-depth exploration of the care goals of symptom control in dying patients.[8,9] Simulation training has been found to be very useful in end-of-life care education as it allows paramedics to work through realistic clinical scenarios in a protected environment and ask questions of palliative specialists and explore issues which are not easily or readily explored in the traditional classroom setting, such as cultural differences in dying and the pressure of time critical practice.[10]

The need for further in-depth research in paramedic practice and end of life care

There is a need for further research into the personal experiences and perspectives of paramedics providing end of life care, not only to improve the care their patients and carers receive, but also to support the essential role that paramedics play in the care of the dying in the community. Paramedics are currently in a position of extreme pressure and their resources stretched at times to breaking point. The COVID-19 pandemic has highlighted gaps in both ambulance and palliative care provision.

With the undervalued and sometimes misunderstood speciality of palliative and end of life care meeting the equally undervalued and misunderstood profession of paramedic science, could the reliance on paramedics to provide urgent response to end-of-life patients be an example of a perfect storm? For this to be addressed there needs to be a substantial mind shift in international healthcare policy to recognize the value of paramedic clinical decision making, together with the importance of palliative and end of life care to achieve the best care for dying patients in primary care.

If primary healthcare provision is going to increasingly rely on the ambulance service to care for the dying patients in the community, then we need to equip paramedics with the resources to do so. There is a long-standing practice in the ambulance services to employ specialists in specific areas such as midwifery and mental health to advise paramedics on scene. Unfortunately this is not the case for palliative and end of life care, with only a few ambulance services employing specialist palliative and end of life practitioners.

There are currently mounting concerns about the mental welfare of paramedics on the frontline of healthcare and we need to understand how this burnout is correlated with paramedic perception of their role, their views on organizational structure, education, and guidelines. It is not a sufficient response to just implement end of life interventions, such as policies and guidelines, without first seeking the views of the paramedics who must implement them. It is now time for research to gain a greater understanding of the experience and perspectives of paramedics caring for dying patients in expected deaths to provide paramedics with the evidence they need to reinforce their practice.

Declaration of conflicting interests

The author declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author received no financial support for the research, authorship, and/or publication of this article.

ORCID iD


Tania Anne Blackmore https://orcid.org/0000-0002-8610-3849

References

1. Givati A, Markham C and Street K. The bargaining of professionalism in emergency care practice: NHS paramedics and higher education. *Adv Health Sci Educ Theory Pract* 2018; 23(2): 353–369.
2. Waldrop DP, Clemency B, Lindstrom HA, et al. "We are strangers walking into their life-changing event": how prehospital providers manage emergency calls at the end of life. *J Pain Symptom Manage* 2015; 50(3): 328–334.
3. Hoare S, Kelly MP, Prothero L, et al. Ambulance staff and end-of-life hospital admissions: a qualitative interview study. *Palliat Med* 2018; 32(9): 1465–1473.
4. Mayland CR, Harding AJE, Preston N, et al. Supporting adults bereaved through COVID-19: a rapid review of the

impact of previous pandemics on grief and bereavement. *J Pain Symptom Manage* 2020; 60(2): e33–e39.
5. Cameron C, Lunn TM, Lanos C, et al. Dealing with dying – progressing paramedics' role in grief support. *Prog Palliat Care* 2021; 29(2): 91–97.
6. Murphy-Jones G, Laverty D and Stonehouse J. Infusing the palliative into paramedicine: inter-professional collaboration to improve the end of life care response of UK ambulance services. *Prog Palliat Care* 2021;29(2): 66–71.
7. Kirk A. Advanced care planning in end-of-life care: the key role of ambulance services. *J Paramed Pract* 2018; 10(9): 1–4.
8. Patterson R, Standing H, Lee M, et al. Paramedic information needs in end-of-life care: a qualitative interview study exploring access to a shared electronic record as a potential solution. *BMC Palliat Care* 2019; 18(1): 108.
9. Higginson IJ, Daveson BA, Morrison RS, et al. Social and clinical determinants of preferences and their achievement at the end of life: prospective cohort study of older adults receiving palliative care in three countries. *BMC Geriatr*. 2017; 17(1): 271.
10. Anderson NE, Robinson J, Moeke-Maxwell T, et al. Paramedic care of the dying, deceased and bereaved in Aotearoa, New Zealand. *Prog Palliat Care* 2021; 29(2): 84–90.

Tania Anne Blackmore
Lancaster University, Lancaster, England, UK

Corresponding author:
Tania Anne Blackmore, Lancaster University, Bailrigg, Lancaster, England LA1 4YW, UK.
Email: t.blackmore@lancaster.ac.uk