Tampa Bay EMS Journal
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Volume 1, Number 4
April - June, 1988

Editorial

Organizational Culture as a Medical Control Instrument

The topic of medical control and one of its components, retrospective quality assurance, has been getting more attention lately by the EMS community. This is a very positive trend. However, I am concerned about how EMS systems approach this very important issue.

There is tendency, particularly in bureaucracies (like EMS agencies), to inadvertently emphasize form instead of function. In most cases, form is easier to deal with. Function can be rather difficult to define and therefore difficult to assess.

In the case of EMS medical control, quality assurance programs have focused on review of the field report or "run ticket." While that is perfectly legitimate and worthwhile, investing an agency's entire medical control effort in it can satisfy the "bean counters" of the bureaucracy in doing something tangible and generating lots of paperwork, but it can also lead to a very false sense of security about the quality of care delivered in the system.

To illustrate the point of potentially misplaced emphisis on field report audits, consider the all too common case of large multiple victim scenes where things were totally out of control, disorganized, and very poor patient care was delivered as a direct result. Occasionally, I have had opportunity to see the reports that were filed on such calls. Some of them depicted the scene and events with little or no resemblance to the actual situation. These "buffed" reports portrayed the scene as the perfect picture of order, control, efficiency and exemplary patient care.

The term "buffing a chart" was popularized in a not so fictional novel about medical residency training where the quality of care was not judged by patient outcome, patient satisfaction, or direct observation of clinical performance - it was judged solely on the basis of documentation in the charts, even though the charts did not reflect the actual condition or treatment of their patients.

In real life, a good paramedic, in the terms of an errant medical control system based primarily on field report audits, is one who can write a "clean" report. A clean report can be a realistic account of a well managed call. Or, it can be a more contrived representation of what should have happened, but maybe did not in reality - It has been "buffed clean." Buffing is learned skill. The buffer learns what the medical auditors are looking for, regardless if the auditor is a paramedic supervisor or a physician medical director. A skilled buffer can present the facts in such a way that appeases the known sensitivities of the auditors. They may even stroke the auditors by including things they know the auditor likes to see in the report. The line between buffing and outright falsification of medical records is very thin. Some techniques for buffing avoid the falsification issue. By not keeping track of times and events as they occur during the call, one can simply call the dispatcher to get on-scene times and extrapolate times and events with literary license to the best of one's recollection. This allows the buffer freedom to recall things in a way that looks good on paper. If a q5m epinephrine schedule was to be maintained during a code, a sly buffer will recall times with several 5 and a few 4 or 6 and even a rare 7 minute interval between doses.

I do not mean to imply that this is a common phenomenon. I hope it isn't. I have no way of knowing how widespread it is or isn't. Retrospective review of field reports is necessary. My point is that retrospective review of field reports is only one component of good quality assurance and comprehensive EMS medical control program. Don't allow your medical control program to rely too heavily on the written reports just because they are the primary documentation of the incident. Form is important, but only as much as it is an accurate reflection of function. The buffers can exploit a misdirected medical control effort, such that the paramedic you think is your best may indeed be your worst in terms of actual patient care. Even in the case of paramedics who are not intentionally buffing their reports, the typical approaches to documentation of field care are grossly inadequate and can result in very misleading impressions.

The solution? One could start by looking to technology by which documentation in a field environment could become more practical. Verification by direct observation of field operations by paramedic supervisors and medical directors with notation of the events taking place and comparing them to the reports that are filed may be a step in the right direction. However, in practical terms, the technology for making documentation easier can probably be manipulated by the intentional buffer. If the buffer is aware of observers, their tracks will be hidden from view. Besides, only a small percentage of calls can possibly be monitored by such third party observers.

What I think may be the most effective measure may also be the slowest and most difficult to implement. Nonetheless, it would be very worthwhile. It is bringing the influence of the medical control system and the medical director to bear on the professional attitudes of the paramedics. Medical directors for EMT and paramedic training programs must make sure that a deep sense of ethics, professionalism and personal accountability becomes instilled into each student. That doesn't happen now. The organizational "culture" of the EMS agency should be developed in such a way that buffing or anything else short of total professionalism and clinical excellence is not acceptable to the standards of the medical director, or perhaps more influential, one's colleagues. The higher quality of care cannot be mandated, it must be inspired. That also doesn't happen now. This approach might be very effective when coupled with a peer review medical audit program. By peer review, I do not refer to paramedic supervisors, but to the direct participation of field paramedics in the audit process.

The organizational culture, by shaping the basic attitudes of field personnel towards their own self-image as professionals, fostering professional growth and self-actualization, encouraging traits of compassion and a sincere desire to clinically perform to the best of one's potential ability, is perhaps the best instrument for effective medical control. Unfortunately, its the most neglected one.

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Editor