Scope is not the problem: why governance is the real risk for advanced practice by paramedics in Canada – policy commentary

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Across Canada, paramedicine is at the centre of conversations about advanced practice. The Career Framework for Paramedics[1] proposes specialist and practitioner roles for paramedics across multiple contexts. These are what we refer to as advanced practice roles. Expanded clinical roles, community-based models, and integration into primary and urgent care are increasingly positioned as actual and potential solutions to healthcare access pressures, emergency department congestion, and workforce shortages.[2–5] In many areas, the debate has become intensely focused on scope and skillset: how far paramedics can, or should, practice. This focus is understandable…but it is also misplaced.

The most significant risk facing advanced practice in paramedicine is not the breadth of scope (e.g., expanded clinical examination and procedural skills, increased autonomy), but the absence of clear, coherent, profession-led governance to support it. When roles evolve faster than accountability, decision rights, and regulatory structures, the result is not innovation but system fragility.[6] Advanced practice will succeed or fail not on what paramedics are 'allowed' to do, but on who is accountable when they do it, under what authority, and within what governance framework.

The persistent myth: scope as the primary constraint

Much of the discourse around advanced practice assumes that scope expansion is the critical bottleneck. The logic is relatively straightforward: if paramedics are permitted to assess, diagnose, prescribe, refer, or discharge independently, then as a result access to care will improve and systems will become more efficient. When these outcomes do not materialise, the default explanation is often that scope has not been expanded far enough.[7]

This framing misses the point. Scope describes what a clinician may do; governance determines how, when, why, and under whose authority that work occurs. In the absence of robust profession-led governance, broader scope can increase risk by creating ambiguity around accountability, escalation, and clinical responsibility. In practice, many advanced roles operate in a grey zone: clinically capable, operationally relied upon, but structurally unsupported. Paramedics are asked to make higher-stakes decisions without corresponding clarity about decision rights, liability, clinical oversight, or system integration. This is not empowerment, but rather exposure to increased risk.

Advanced practice without governance

Advanced practice roles are often introduced through pilots, exemptions, or local agreements rather than deliberate system design.[8] While this approach allows innovation to move quickly, it frequently bypasses the governance questions that ultimately determine sustainability. A common failure point includes unclear clinical accountability, where responsibility is diffused between medical directors, employers, regulators, and partner organisations. Decision-making authority may be informally delegated but not formally recognised, leaving advanced clinicians responsible for outcomes without clear organisational backing. Oversight arrangements are often inconsistent, relying on legacy medical-dominant models that were never designed for highly qualified autonomous paramedic practice.

The consequences of such models are predictable. Risk is shifted downward to individual clinicians. Employers struggle to defend roles that lack formal governance. Regulators are left reacting after the fact, often by applying inappropriate standards to new roles to 'make them fit' within existing structures. Most importantly, patients experience variable care depending on local interpretations of authority rather than consistent system standards. Then when problems emerge, scope expansion is blamed, even though scope was never the root cause.

Governance is clinical infrastructure

In paramedicine, governance is too often treated as an administrative or regulatory concern, separate from “real” clinical work. In reality, governance is clinical infrastructure. It is what allows advanced practice to function safely, consistently, and at scale. Effective governance clarifies decision rights: which decisions advanced practitioners can make independently, which should be done in consultation, and which remain outside their authority. It establishes lines of accountability that are visible, defensible, and aligned across organisations. It ensures that clinical oversight evolves alongside role complexity, rather than remaining anchored to outdated supervisory or medically dominant models. Without this infrastructure, advanced practice roles become dependent on individual relationships, local goodwill, and informal workarounds. That may sustain a pilot, but it will not support a system.

The accountability gap

One of the most under-examined issues in advanced paramedicine is accountability. As roles expand, accountability often becomes fragmented rather than clarified. A paramedic may be clinically autonomous in practice but legally tethered to an authority that has limited visibility into day-to-day decision-making. Or they may accept delegation from an authority lacking true insight into the realities of paramedic clinical practice, or who are unknown to them. Employers may rely on advanced practice roles to deliver services that fall outside traditional ambulance service mandates, while distancing themselves from clinical responsibility. Regulators may approve competencies or roles without corresponding reform or changes to regulatory standards, practice standards, or complaints processes.

This diffusion of accountability creates risk for everyone involved. Paramedics bear professional and moral responsibility without commensurate authority. Physicians may be

nominally accountable for care they do not directly oversee or have expertise in. Organisations struggle to manage risk that is structurally embedded rather than operationally controllable. Advanced practice cannot thrive in this environment. Clear accountability is not a constraint on practice; it is what makes higher-level practice possible.

Why paramedicine feels this tension acutely

Paramedicine experiences governance gaps more sharply than many other professions because it sits at the intersection of multiple systems: emergency response, primary care, public health, and social services. Advanced practice roles often cross organisational and sectoral boundaries, exposing misalignments that remain hidden in more siloed models of care. In rural, remote, and underserved communities, these tensions are magnified. Advanced practice paramedics may be the most clinically capable (and accessible) provider available yet operate within outdated regulatory and governance structures designed solely for episodic emergency response in narrowed contexts. Scope expansion is frequently justified based on necessity, but governance and regulatory frameworks rarely evolve at the same pace to allow this to happen safely.[6] The result is a paradox: the settings that most need and stand to benefit most from advanced practice roles are often those least equipped structurally to support it safely.

Lessons from international experiences

International experience reinforces this point. In jurisdictions such as the United Kingdom and Australia, advanced practice paramedic roles have expanded significantly, including independent prescribing and consultant-level practice. Where these roles are embedded within clear governance structures (e.g., defined accountability, recognised decision authority, and integration into broader care pathways), they have demonstrated system value.[9,10] Where governance has lagged, however, similar problems emerge: role ambiguity, professional tension, and inconsistent outcomes. The lesson is not that advanced practice is inherently risky, but that governance is the determining factor between resilience and fragility. Canada is not unique in facing this challenge, but it can learn from these experiences rather than repeating them.

Reframing the question

The most important question facing advanced practice in paramedicine is not “how far should scope and skills expand?” but “what governance must exist for this role to be safe, sustainable, and accountable?” That question forces a different set of conversations. It requires clarity about where advanced practice sits within the health system, not just within a profession. It demands alignment between regulation, funding, employer responsibility, and clinical oversight. It shifts the focus from individual capability to system design. This reframing also changes how success is measured. Rather than counting tasks or procedures, system leaders must assess whether advanced roles reduce risk (note: it is not possible for such roles to be risk free), improve continuity of care, and enhance equity of access outcomes that depend on governance far more than scope.

Implications for the profession

For paramedicine, this moment presents both risk and opportunity. Continuing to frame advanced practice primarily as a ‘scope issue’ risks reinforcing the very conditions that undermine its success. It positions paramedics as pushing boundaries rather than as partners in system stewardship. Alternatively, leading with governance allows the profession to demonstrate maturity, credibility, and readiness for expanded roles. It signals that paramedicine understands that authority and accountability must evolve together, and that safe innovation requires more than permission, it requires structure, such as reform of regulatory models, higher-education preparation, and collaborative consultation resources. Advanced practice will not be secured by arguing for ever-broader scopes in systems that remain poorly designed to regulate such scope. It will be secured by insisting that governance keeps pace with professional capability and practice realities.

Conclusion

Advanced practice in paramedicine is not a question of ambition or competence. Paramedics have repeatedly demonstrated the clinical capability to take on expanded roles across Canada. The real test now is whether health systems are willing to build the governance infrastructure those roles require. Scope is not the problem; governance is. Until accountability, decision rights, and oversight are made explicit and coherent, scope expansion will continue to generate risk rather than resilience. If advanced practice is to fulfil its promise for patients, communities, and the profession it must be designed as a system function, not an exception. For paramedicine, that means shifting the conversation.

The future of advanced practice will be decided not by how much we are allowed to do, but by how well the system is designed to support us when we do it.

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