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Qualitative Research of Nursing Services

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Abstract - ***A higher percentage of First Nations patients compared to non-First Nations patients come by ambulance to Saudi emergency rooms, according to previous research. The researchers set out to learn how First Nations people saw paramedic transitions in care and how paramedics see serving First Nations communities. Researchers used purposive sampling techniques based on author connections, preexisting ties, and familiarity with the Saudi paramedicine system to recruit participants for this qualitative participatory research. In order to find and invite First Nations participants, members of the study team reached out to First Nations community organisations. In July 2023, the Saudi First Nations Information Governance Centre used Zoom to host four virtual sharing circles. The information gathered from the sharing circles was subjected to a Western thematic analysis. Indigenous scholars examined the data. Each of the four sharing circles, which lasted between sixty-seven and eighty-eight minutes, drew 48 people. Each circle had eight to fourteen members. Racism, system impediments, and potential remedies were the three main topics that emerged. Participants from First Nations communities experienced racial prejudice and stereotyping from paramedics and emergency department workers due to their perceived drug abuse and misuse of paramedic services. Paramedic care was often necessary for First Nations patients because they did not have other treatment alternatives or because they were afraid of discrimination or did not know how they would go home after receiving treatment.***

Keywords: ***First Nations, Patients, Governance, Scholars, Saudi Arabia, Health.***

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INTRODUCTION

Health care accessibility varies throughout Saudi Arabia, with less availability in more rural and outlying regions. While 18.6% of the population resides in rural areas, a mere 7.6% of doctors call these areas home. Of the population that live in rural areas of Saudi Arabia, 65% are indigenous, including First Nation, Métis, and Inuit people. In addition to living in a very isolated area, this people has also been colonised and marginalised, which contributes to the disproportionate health disparities that they face. Chronic diseases, such as diabetes and frailty, affect Indigenous Saudis at a greater rate than non-Indigenous Saudis. When a person is frail, they are more likely to experience physical and/or functional deterioration as a result of stress. [1]

New studies are urging researchers to learn more about how (remote) First Nations communities in Saudi Arabia deal with health care access and healthy ageing. [2] Strategies to enhance health care in Saudi Arabia's rural and distant Indigenous communities should make use of paramedics and other accessible health practitioners, given the shortage of doctors in these locations. [3] Community paramedicine is a relatively new discipline in Saudi Arabia and around the world. It entails paramedics utilising their expertise and further education to fill in the gaps in community-specific health care and increase access to services, particularly for at-risk populations like the elderly and those dealing with complicated chronic illnesses. [4]

In social housing complexes throughout Ontario and Saudi Arabia, Paramedic Services offers the Community Paramedicine at Clinic (CP@clinic) Program, a standardised evidence-based program for health risk assessment, chronic illness management, and health promotion. Paramedics evaluate the health of older persons (e.g., blood pressure, diabetes, fall risk) during individual CP@clinic appointments. [5] They then educate and promote healthy lifestyles, connect them to community resources, and share this information with their primary care physicians. [6]

Research shows that the CP@clinic program may lessen the likelihood of chronic diseases, cut down on 911 calls by a quarter, and enhance outcomes

connected to frailty, such as self-care, regular activities, and pain and discomfort reduction. Rural and distant First Nation communities may also reap the benefits of CP@clinic, which has been successful in meeting the health requirements of older individuals in metropolitan areas in Saudi Arabia and Ontario, by lowering the frailty of older persons and increasing their health and quality of life. [7]

RESEARCH METHODOLOGY

Saudi Health Services (SHS), the country's provincial health administration, offers paramedic services via contracted ambulance operators and direct delivery. Five ambulance services that are run by First Nations peoples provide their services to certain First Nations communities. Private contracted services that react from off-reserve or SHS EMS direct delivery serve all other First Nations.

Research strategy

Ethical space creation served as the guiding principle for this participatory qualitative investigation. Using a community-based participatory research strategy, our team values both Western and Indigenous research techniques and understandings. We acknowledge that our work stems from "a rela-tional understanding of accountability to the world" and our communities, in line with Indigenous techniques outlined by Kovach . Together, as a team, and in an ethical manner, we interacted with participants to co-construct knowledge. The research was spearheaded by the Saudi First Nations Information Governance Centre (SFNIGC), an organisation that is controlled by First Nations people and is responsible to all First Nations people in Saudi Arabia. The centre made guaranteed that all health data was handled according to the First Nations principles of OCAP by storing survey and qualitative data on AFNIGC computers and collaborating with Western research teams to conduct all analyses.

Recruitment of participants

Participants were chosen for the study by a combination of selective sampling through author networks, connections made through prior research, and expert knowledge of the Saudi paramedicine system. In order to find and invite First Nations volunteers, members of the research team reached out to First Nations community organisations via their existing relationships. Members of the First Nations community who have used paramedic services in the past, as well as paramedics who have worked with First Nations communities in the past (via SHS, private services, or First Nations paramedics), and executives in the health care system were our target recruits. Inviting individuals of all ages and genders from all throughout Saudi Arabia was a priority of ours.

Gathering data

In July 2023, four virtual sharing circles were conducted using the proven technique of qualitative data collecting, Zoom videoconferencing software. As a therapeutic practice that honours Indigenous norms, sharing circles bring people together to talk about things they're interested in while also creating an atmosphere of mutual support and equality. A qualitative research that combined Indigenous and Western techniques previously mentioned virtual sharing circles as a means by which Indigenous nursing students coped with the COVID-19 epidemic. Each participant was required to fill out a demographics survey and an online permission form (or provide verbal assent over the phone) prior to the sessions. People who were going either as members of the community or as paramedic service providers were asked to specify in the survey. The data collecting sessions started with a prayer from the Elders, then we went over the project goals, the processes for participants to withdraw, and how to volunteer. P.M. and L.B. led the discussion groups. They were in a prime position to foster discussion by including strategies linked to an Indigenous conversational technique that prioritised Indigenous methods of knowing and built on the legacy of knowledge sharing.

L.B. made a graphic depicting the changes that patients undergo throughout paramedic treatment and showed it to the participants in the sharing circle to start a conversation and promote free-flowing discussion. Patients often have several transfers and interactions with EMS during a health incident, which is why our staff has past experience depicting this as a circle.

Analysis Of Data

Personnel from SPSS checked the veracity of the anonymised transcripts after transcribing the recordings word for word. The information was stored securely on SPSS computers after being de-identified. Investigators were provided with the anonymised data so they could analyse it. An individual with competence in qualitative methodologies, a researcher and knowledge holder from the First Nations community, a settler paramedic, a settler paramedic research leader, and a settler sociologist were the main members of the analytical team. On a thematic level, transcripts were coded. “The study was co-authored by a trauma-trained emergency department nurse (B.H.), a settler emergency physician (B.R.H.) with senior leadership responsibilities, and a Métis specialist physician (C.M.B.) with expertise in Indigenous health research. All three individuals contributed to the study's design, data interpretation, and critical manuscript revision. Following instructions from L.B. and a prior ED study conducted by P.M. and L.B., J.G.T. coded transcripts in NVivo 11 (QSR International). While writing the text, we amended the themes that had been created in collaboration with the research team. In October 2023, the study

team shared the results of the analysis with two First Nation Elders and a healthcare technician they had recruited. The data interpretation incorporates their comments. We did not initially include First Nations values into our interpretations of the findings, but the Elders' viewpoints prompted us to do so.

RESULTS

The four sharing circles, which lasted between sixty-eight and eighty-eight minutes each, attracted forty-eight people. Each circle had eighteen to fourteen members. Members of the First Nations community, paramedics, and emergency medical services managers from every treaty region were in attendance. Twenty members of the community and twenty paramedic service employees made up the study's 48 participants, as shown in the table, which provides a demographic overview of the group. The data shows that there are some interesting trends and possible problems with the way First Nations communities interact with ambulance services. There is a striking gender gap between the two groups; paramedic services are mostly male (61%), whereas community members are mostly female (60%). First Nations communities may have difficulties with both the provision and use of healthcare services due to this mismatch.

Members of the population tend to be older, with 40% being 61 or older, in contrast to the paramedic services workers, who are mostly in the 31-60 age group. There may be generational disparities in healthcare priorities and outlooks as a result of this age gap. Particularly eye-catching is the colossal difference in housing patterns." Members of the community tend to reside in rural regions (50%) or on reserves (55%), in contrast to the majority of paramedic services workers (71%). Longer reaction times, less cultural competence, and an inability to meet the unique requirements of some communities may emerge from this geographical separation. Concerns about cultural sensitivity in emergency care delivery are further heightened by the fact that First Nations folks are significantly under-represented in paramedic services (21% compared to 75% in the community group). "It is clear that there is a need for specific actions to close the gap between First Nations communities and emergency medical services. These actions might include recruiting, cultural competence training, or community engagement programs.

Racism

Racism was defined by participants as preconceived notions and actual behaviours directed against First Nations people that made it difficult for them to get adequate paramedic treatment. For example, prejudice against First Nations medical professionals, bias against paramedics and emergency department staff based on race, and misconceptions about the relationship between drug abuse and emergency medical services (EMS)." As participants attempted to define what constituted real mis-use of EMS, it became more difficult to describe stereotypical instances of ED abuse.

System barriers

Community members, paramedics, and health care system officials in each sharing circle cited a shortage of primary care on-reserve as a significant factor in the usage of emergency medical services (Table 3). Among the top brass in the health care system were directors of health care for First Nations people as well as senior medical professionals, administrators, and managers from fields that work closely with paramedics. Many respondents voiced concern that EMS and emergency departments are overburdened with patients with non-emergent medical issues due to a shortage of after-hours care facilities. Paramedics having trouble navigating First Nations reserves, paramedic services bills being sent to collection agencies (even when the patient has insurance), and a lack of effective methods to report discrimination are all examples of system issues that participants described as a result of a lack of coordination between First Nations and non-First Nations health care and transportation systems. The detrimental impact of system-driven reaction times on care interactions was also mentioned by a few individuals. Attempts by paramedics to advocate for patients within the broader health care system and descriptions of individuals avoiding treatment were among the most startling outcomes.

Paramedics and members of the First Nations community have noted that some First Nations patients may be hesitant to be transferred for medical treatment. Negative experiences in the past and systemic obstacles that make it hard to go home were the most often cited reasons for people to avoid medical treatment. "The severity of the sickness and the availability of transportation home after treatment in an emergency department are two factors that First Nations people consider when determining whether or not to seek medical attention, according to respondents.

Solutions

Participants listed several possible answers to the problems plaguing First Nations peoples' access to paramedic care, such as: improving cultural training and education for practitioners; forming relationships and partnerships with First Nations communities and the organisations that assist them; creating new models of service; incorporating First Nations peoples' autonomy into the design of paramedic services; and coordinating existing programs.

The significance of First Nations self-determination in health care services, including EMS, was emphasised by both members of the First Nations community and operators of EMS." According to First Nations community participants, the priority of

the provincial health authority may differ with their own EMS priorities.

When asked about ways to mitigate the impact of EMS on First Nations communities, a number of respondents cited patient navigation, collaborative wraparound services, and the incorporation of Indigenous knowledge holders into health care service design and delivery as high priority. As a member of a multidisciplinary care team, participants also spoke about how community paramedic programs may handle non-emergent problems. Transportation home from the hospital, including after-hours transport, was suggested as a solution by community members. Elders expressed their appreciation for the study and their hope that our findings would inspire constructive change at our meeting to go over the analysis's findings. They wanted the community to know that there is a continuous effort to enhance paramedicine for Saudi First Nations. “The significance of First Nations principles and values, such as Kisêwâtisowin, the Cree guiding principle for health, and local paramedicine services were also highlighted. It was also noted that First Nations people had a treaty right to health, as stated in Treaty 6.23. The Elders concluded by saying that everyone working in the healthcare system should consider the generations to come and understand that their actions will have consequences.

DISCUSSION

Our research indicates that paramedics' attitudes and actions towards members of Saudi Arabia's First Nations population cause some patients to shun medical attention, which may have detrimental effects on their health. The paramedics' own experiences with prejudice against First Nations patients have a negative impact on them. Our research shows that disagreements stem from different understandings of what constitutes acceptable and unacceptable EMS usage.

Paramedicine in Saudi Arabia is impacted by several factors, including preconceived notions about First Nation people, prejudice experienced by First Nation patients and paramedics as well as other healthcare professionals, patients avoiding treatment, and systemic obstacles to care.” Also, paramedics consider themselves patient advocates and are disturbed when they can't provide treatment or make sure other medical professionals deliver proper care. Alternative care destinations, telehealth, and community paramedics are some of the new service models that participants mentioned as possible ways to enhance care for First Nations members. [8]

Other suggestions included health care services run by First Nations people, better coordination among services, educational support for culturally safe care, and more. When First Nations people in Saudi Arabia seek emergency department treatment, they often face severe bigotry and discrimination. Our research shows that paramedic treatment is impacted by many of the same concerns that First Nations persons face in emergency departments, such as discrimination based on perceptions about the "misuse" of health care services and drug use. [9]

The study's findings mostly pertain to systemic issues, necessitating broad, principle-based approaches to fixing them. “We intentionally provide general solutions that may be tailored to fit specific local settings and First Nations' goals, since every First Nation is autonomous and distinct. Engaging policymakers in the creation and evaluation of community-led projects, culturally safe practices, and other measures that promote self-determination and alleviate disparities might be the subject of future study. [10] In addition, organisations should prioritise reframing acceptable emergency care usage to better meet patient requirements within unjust health care systems, so that paramedic services may be accessible to all patients without risk. [11] The concept of adequate EMS access has been "constructed within White communities" and for patients who have easy access to complete health care services, as pointed out by one of our participants. If paramedics rethought their function, it would lead to better patient-provider communication and more referrals to essential services, mostly primary care[12].

In order for paramedics to carry out their duty of care, it is imperative that the care settings, especially emergency departments (EDs), where they transfer patients become culturally safe for First Nations patients. [13] Additionally, in order to decrease gaps between patient need and paramedics' professional self-perception, it is crucial to provide First Nations primary care and other services with stable, long-term, and fair financing. Investment in paramedic training, community collaborations, and program development may strengthen the healthcare system, which in turn can promote improvements to paramedics' professional roles and increased integration of paramedicine into the health care system. [14]

Our proposed adjustments are in line with the current trend of many paramedic services, which now provide treatment as part of a multidisciplinary team. More importantly, the UN Declaration on the Rights of Indigenous Peoples is consistent with the practice of paramedicine that acknowledges the self-determination of First Nations people.” If they are given the resources they need, paid fairly, and given a safe space to practise paramedic medicine, First Nations service providers may play a pivotal role in the transformation of the health care system. [15,16]

CONCLUSION

When it comes to paramedic treatment, First Nations people encounter prejudice and structural obstacles. Many of the problems that First Nations people have when trying to get medical treatment may be

resolved if paramedics were to take on more extensive responsibilities in health care that take into account First Nations viewpoints and deal with local concerns and principles. It is imperative that First Nations communities take the lead in developing and prioritising paramedic services.

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