Australasian College of Paramedicine

# RESPONSE

SPRING 2022 www.paramedics.org


## COMMITMENT TO MĀORI HEALTH:

Equity at the heart of Hato Hone St John's new strategy **P16**

## TRAILBLAZER

Victoria's CPO forges new era for paramedicine **P14**

## BATTLE STATIONS

Life on the frontlines **P18**

## PARAMEDIC PIONEERS

New model of care for seasonal Pacifica workers **P20**


STUDY POSTGRADUATE PARAMEDICINE

**CRITICAL CARE PARAMEDICINE**
Provide advanced-level emergency care to critically ill patients.

**COMMUNITY PARAMEDICINE**
Provide high-standard urgent and primary healthcare that addresses needs of the community.

ECU offers critical care and community paramedicine courses at graduate certificate, graduate diploma and masters level. Our courses have been developed in close consultation with industry and are focused on clinical issues related to daily practice, as well as developing clinical decision-making and critical thinking skills. These courses can be completed online or on-campus and are open to those with a relevant Bachelor degree, or equivalent prior learning.

APPLY NOW FOR POSTGRADUATE PARAMEDICINE

ECUWORLDREADY.COM.AU

AUSTRALIA ECU EDITH COWAN UNIVERSITY

303ML EDCU0244 | CRICOS Provider No. 00279B


# INSIDE




**BOARD OF DIRECTORS**

Chair – Ryan Lovett
Marty Nichols
Simone Haigh ASM
Dr Bill Lord
Clive Addison
Colonel Gabrielle Follett AM
Kate Worthington
Tony Gately ASM
Angus Armour

**CHIEF EXECUTIVE OFFICER**

John Bruning
ceo@paramedics.org



**NATIONAL OFFICE**

PO Box 3229
Umina Beach NSW 2257
1300 730 450
info@paramedics.org
https://paramedics.org
ACN 636 832 061
ISSN 1836-2907

**MEMBER ENQUIRIES**

members@paramedics.org

**EDITOR**

Rob Garner
rob.garner@paramedics.org

**ADVERTISING ENQUIRIES**

Jonathon Tremain
jonathon@tremedia.com.au

**RESPONSE** is published quarterly by the Australasian College of Paramedicine. Editorial and photographic contributions are welcome and can be submitted to EditorResponse@paramedics.org. All material accepted for publication is subject to editing.



©2022. The Australasian College of Paramedicine. All rights reserved. The College and its Editor cannot be held responsible for errors or any consequences arising from the use of information contained in this publication; the views and opinions expressed do not necessarily reflect those of the College and its Editor, neither does the publication of advertisements constitute any endorsement by the College and its Editor of the products advertised.


**COVER**

Image: Dan Spearing meeting with Matua Puna Daniel Tumahai, Ngāti Whatua Ōrākei elder, at Ōrākei Marae, Tāmaki Makaurau.

The College acknowledges Aboriginal and Torres Strait Islander peoples as the traditional custodians of the land and sea in which we live and work, we recognise their continuing connection to land, sea and culture and pay our respects to Elders past, present and future.

The College acknowledges Māori as tangata whenua and Treaty of Waitangi partners in Aotearoa New Zealand.

FROM THE CHAIR

# YOUR COLLEGE, YOUR FUTURE

with **Ryan Lovett,** College Chair

THE DAYS OF OTHER PROFESSIONS DEFINING OUR SCOPE OF PRACTICE ARE COMING TO AN END

Welcome to the Spring edition of *Response*.

During the past few months, the College, via the CEO and I, have participated in various engagement activities with stakeholders from across the health and political spectrum. Some of this was organised by the College team as part of ACPIC 2022, but we were also invited by other stakeholders to attend other sessions.

As you would expect, when we met with these stakeholders there were differences in how we approach things and the outcomes we wish to achieve, but these different views and approaches are important to the success of paramedicine and our future direction. While you would expect me, as the College Chair, to tell you how important the role of the College is (and I will do that), I am also acutely aware that all key stakeholder groups, including regulators, employers, unions and universities, are also critical to the long-term sustainability of our profession.

For a long time, employers have held most of the aces in determining the role of paramedics in their respective systems and, by virtue of their relationship, our colleagues in the union movement have been instrumental in driving improvements to working conditions for paramedics in jurisdictional services while also being in a strong position to advocate for advances in practice. In more recent years, there has also been a power shift to regulators, albeit with a limited scope focused on patient safety, hence an essential balance for the profession, but not driving the future direction.

More notably, and imperative to a vibrant and mature profession, is us owning our own body of knowledge. What this means is that we, as paramedics, can propose what effective patient care means for us, and we can define how, when and where that care is provided, backed up by an extensive and robust evidence base. The days of other professions defining our scope of practice are coming to an end. To achieve this, we must have a healthy, extensive and integrated academic cohort, both pushing the bounds of paramedicine research and also, critically, as stewards of the future members of our profession.

Since 1973, the College has been ever present, providing essential leadership and support in the development of the profession up to, and including, the realisation of registration in 2018. As a College, we acknowledge and value the role of our partner organisations and have long-standing relationships, or emerging relationships, with Te Kaunihera Manapou Paramedic Council, the Paramedicine Board of Australia, the Australasian Council of Paramedicine Deans, the Council of Ambulance Authorities, and the Australasian Council of Ambulance Unions. The mutual respect that exists between us as organisations means that sometimes we will work together towards common goals, but sometimes that we can and should take different positions. A diversity of opinion is what will lead us to find the best path forward.

However, the point of differentiation for the College is that we believe that we are best placed to bring everyone together. The College's membership makes us double the size of the biggest union and at least 60% bigger than the largest ambulance service. We cover both Australia and Aotearoa New Zealand, and our work is not just for our members. We do not want to displace or take over the essential work of regulators, employers, unions or academic institutions; however, our advocacy work has a positive impact on everyone in the profession, meaning we can and will represent the whole profession like no other.

The College is consistently taking a position of representing all Australasian registered paramedics and students in paramedicine degree programs; that's 30,000+ people across paramedicine. We can challenge governments on areas that employers cannot, we can engage employers and governments in a way unions can't, we can represent students to the universities, and we can engage the regulators in a professional capacity. Ultimately, we are your College and we work every day to advance your profession. We want and need to hear from you on how you want to us to define the future for us all.

Stay safe.



FROM THE CEO

# BUSY TIMES; NOW AND AHEAD

with **John Bruning,** College CEO

The past three months have been an incredibly busy period for the College, which is normal for this time of year. We held our major event, the ACP International Conference, in Brisbane in September, during which we launched our new international peer-reviewed journal Paramedicine and announced that a consortium of academics and universities led by Dr Liz Thyer from Western Sydney University would partner with the College on our landmark Paramedicine Workforce Research. The data collected from this research will be used to inform workforce planning and key decision-making for the profession.

IT IS CLEAR WE NEED A GOOD ROADMAP TO LAY OUT THE FUTURE DIRECTION FOR PARAMEDICINE

Our conference theme this year was "Embracing Strengths, Shaping Futures", through which we explored, via presentations, discussions and workshops, the continued evolution of our profession, and reflected on the growing diversity of paramedic practice and ways to encompass the broader utilisation of the paramedic workforce in support of health systems under pressure across Australia and Aoteroa New Zealand.

In a spirit of mutual respect, we engaged with key industry stakeholders and leading health representatives to seek input on the development of a mutually affirmed and harmonious vision of the future of the profession; one that recognises the potential of paramedics to help ease health sector burdens and opens pathways for their expanded deployment as part of multidisciplinary clinical teams in the provision of new levels and dimensions of patient care. We were delighted to welcome the Paramedicine Board of Australia and Te Kaunihera Manapou Paramedic Council Chair and Registrar and enjoyed a positive exchange of ideas on some of the opportunities for the profession.

The conference also saw the Advocacy Team hold four stakeholder workshops covering the positioning of paramedicine in the health system, paramedicine clinical levels, professional development programs, and workforce requirements. These were important engagement opportunities for the College and highlighted that while there may be some variation in how we achieve our objectives, overall the profession is on the same page about the direction we are headed.

The College will undertake wider engagement with our membership and the profession on these items over the coming months, but it is clear we need a good roadmap to lay out the future direction for paramedicine. We can't address the future of paramedicine in a piecemeal way; it needs a holistic, strategic approach that considers all opportunities and challenges. We have established the Paramedicine Future Working Group looking at a range of opportunities for the College over the next 5-10 years, and the Advocacy Team is beginning work on a white paper on the future of paramedicine.

We are now in early November and coming up to the registration renewal date in Australia. This has seen a steady increase in member engagement with our new eLearning courses; clearly plenty of you are ensuring you have completed your 30 hours of CPD by 30 November. It is also an ideal time to think about the coming 12 months of CPD and, if you don't already have one, complete the professional development plan on the website to better inform the CPD you undertake. We all want better health care, and it starts with us to ensure our clinical knowledge and skills are as good as they can be.

Stay safe and well.

# ADVOCACY: BUILDING FOUNDATIONS

By **Jemma Altmeier**, College Advocacy and Government Relations Manager

With the pandemic subsiding, we were able to hold our flagship event, the ACP International Conference 2022, in a much larger face-to-face capacity in Brisbane in September, which provided the Advocacy Team with an incredible opportunity to present, connect and discuss a range of topics and ideas facing the profession with thought leaders from across Australasia.

During the course of the two-day conference, we held a number of engaging workshops exploring subjects that will help shape the paramedic profession now and into the future. Workshop participants considered paramedic-level descriptors, clinical frameworks, professional programs, clinical fellowships, workforce requirements and datasets. The perspectives, opinions and input gathered from these sessions was incredibly valuable and will strengthen our approach and position regarding the scope and career pathways for paramedics across the health care workforce.

We also we announced the partners of our landmark Paramedicine Workforce Research project, the first of its kind in Australasia. Led by Dr Liz Thyer from Western Sydney University, the project aims to establish an accurate and complete dataset of the paramedicine industry to identify trends in workforce demographics and fields of employment. This data will be used to inform workforce planning and key decision-making for the profession.

Much of what we do in advocacy happens behind-the-scenes as we work to reform legislation and build relationships with key people, groups and organisations across Australia and Aotearoa New Zealand, driven by the core goal of improving health access and outcomes for people in every community.

**Consultations:**

- The College met with Federal Member for Dobell Emma McBride, Assistant Minister for Rural and Regional Health, to discuss the role of paramedics, opportunities in urgent and primary health care, and innovative international models of care and wellbeing.
- The College discussed paramedic levels at the NSW Paramedicine Workforce Forum.
- The College had an introductory meeting with the advisor to Federal Health Minister Mark Butler to discuss the College's engagement in the Urgent Care Clinics summit.

College Advocacy and Government Relations Lead Michelle Murphy and CEO John Bruning with Federal Member for Dobell Emma McBride

**Submissions and Inquiries:**

- The College was invited to attend and provide a statement to the NSW inquiry into the impact of ambulance ramping and access block on the operation of hospital emergency departments.
- The College was invited to provide feedback to the Office of the National Rural Health Commissioner regarding the consensus statement on rural and remote multidisciplinary health care teams.

**Your voice**

Your voice is essential in progressing and developing the paramedicine profession. Through this survey, we are asking you to share your experiences and ideas, and have your voice heard on topics important to you and the wider profession. Please take a minute to complete this short five-question survey. Have your say on what is critical to you and the future of paramedicine at https://www.surveymonkey.com/r/ACPadvocacy or via the QR code

This survey will close 18 November.

**SCAN CODE TO TAKE SURVEY**





# OFFICIAL LAUNCH OF PARAMEDICINE, THE COLLEGE'S INTERNATIONAL PEER-REVIEWED JOURNAL

Manuscript submissions are now open for the Australasian College of Paramedicine's new international peer-reviewed journal Paramedicine, which was officially launched in September at the ACP International Conference 2022 by Editor-in-Chief, Associate Professor Paul Simpson.

Paramedicine, formally the Australasian Journal of Paramedicine, is a bi-monthly, open-access, peer-reviewed journal that provides an international forum for the dissemination and discussion of paramedicine research.

The journal's purpose is to advance and transform the discipline of paramedicine through high-quality evidence, and to inspire robust discussion, enable research translation, encourage innovative thinking and inform leadership. Paramedicine publishes research from any country engaged in any area of paramedicine, including but not limited to clinical care, models of practice, operations, patient safety and clinical quality, leadership, education, aeromedical and retrieval practice, tactical paramedicine, and community paramedicine.

"Our editorial team, comprised of some of the world's leading paramedicine academics and researchers, embarked on a journey to develop a world-class paramedic-led journal that will help shape the future of the profession through the provision of the highest quality research spanning all dimensions of our professional practice," Mr Simpson said. "Today we join with you in proudly launching Paramedicine, and we look forward to receiving submissions in advance of the journal's first edition in early 2023."

Paramedicine is published online in partnership with Sage Publishing. Sage brings international journal publishing experience and infrastructure that will enable Paramedicine to grow and prosper, while providing authors with a professional, high-quality publishing experience.

Paramedicine is indexed in several top databases, including the Cumulative Index of Nursing and Allied Health Literature (CINAHL), Elsevier Scopus, EMBASE, and Google Scholar, and has a Q1 "Best Quartile" in the Scimago Journal and Country Ranking (SJR). Publishing in Paramedicine will therefore increase the visibility and accessibility of researchers' work and promote greater translation and subsequent impact.

On the international team of Deputy Editors are Professor Julia Williams (UK), Associate Professor Walter Taveres (Can), Dr Alan Batt (Can) and Dr Kathryn Eastwood (Aus). Supporting the editorial leadership team is a diverse Associate Editorial Panel consisting of 28 researchers spanning nine countries.

Information on manuscript submissions is available at: www.paramedicinejournal.org

Subscribe to the newsletter to receive updates and announcements.


OUR EDITORIAL TEAM EMBARKED ON A JOURNEY TO DEVELOP A WORLD-CLASS PARAMEDIC-LED JOURNAL THAT WILL HELP SHAPE THE FUTURE OF THE PROFESSION

# THE MANY FACES OF A **PARAMEDIC**

By **Julie Johnson,** College Education Manager

Healer, carer, academic, driver, student, decision-maker, problem-solver, friend, colleague, family member, parent, partner, child and many more - but who are you? What do you want for the future, and how does your career shape your identity?

Being a paramedic is not only what we do for a job; it's much more than that. It's a lifestyle, a part of who we are. Our work life creates memories and relationships well beyond that of other jobs, and over time creates a sense of who we are. How many other jobs prescribe that you will miss important milestones in life and be required to work well beyond rostered hours, often without choice? Not occasionally but regularly.

What other job gives you the privilege of seeing into other people's lives? Being invited into their homes and workplaces in the direst circumstances and sometimes special times in their life. We meet their family and friends; we are instantly accepted and respected. Paramedicine is a community, with neighbours like the police and fire services, defence forces and health. We are all expected to be there for the general population at times of need, but then who cares for the carers?

We congregate in tribes, socialising together and informally debriefing the highs and lows of the day. Our identity becomes more and more entrenched in what we do for a job. As our skills and knowledge evolve, our roles are changing. We are no longer just the ambulance driver; we are the key to most of our patients receiving health care.

So how do we find the balance between who we are at work and who we are at home? Are we honouring our authentic selves? We digest the world around us, just like food; subconsciously internalising the conventions and expectations of the paramedic. This can have an impact on how you present yourself both at home, in your job with your colleagues, and to the world. The waters get muddy, and you become what you think the industry accepts, but being able to be authentic to ourselves is the cornerstone of our own health and wellness and that which we can provide to others.

How do I plan and adapt to the changing face of paramedicine and remain true to myself? There may be limited controls over the nature of paramedicine, but we can change and adapt while still reflecting our authentic selves. The shift to registration has and will continue to shape the future of the industry and provides us with a unique opportunity to grasp progression with both hands and plan for our individual futures.

Growth is linked to opportunity, knowledge and skill. Rather than a limited linear sequence that was ambulance work, we are now on the precipice of so many choices. How that affects each of us will be different, and how we embrace it will depend on our authentic selves; what we see we can achieve, what we plan for we can make happen.

With the plethora of continuing professional development prospects, instead of feeling overwhelmed by another layer of what is now the job, start planning. Have a conversation between your authentic self and your adaptive self.

THE SHIFT TO REGISTRATION PROVIDES US WITH A UNIQUE OPPORTUNITY TO GRASP PROGRESSION WITH BOTH HANDS AND PLAN FOR OUR INDIVIDUAL FUTURES

Investigate where you really want to be and plan for how you will get there. Authenticity matters. We often have to balance the inner and outer aspects of self in order to fit in and become more successful, but we can be authentic and successful at the same time.

I don't see learning as a burden; I see learning as a chance to further embrace my choices. As the industry starts to catch up, there are now some real opportunities for paramedics to engage and contribute more to the health of the nation. The investment in learning is a way of inquiry into what intrinsically motivates us. The paradigm of motivation is driven from within. If we are feeding our authentic selves in our careers, the opportunities are limitless.





# COLLEGE'S PARAMEDICINE RESEARCH **MENTORING PROGRAM** OFFERS NEW CAREER DIMENSION

By **Stephanie Nixon**, QAS Advanced Care Paramedic, Charleville, Bidjara Country

In 2021, I successfully applied to be a mentee in the College's 2021-2022 Paramedicine Research Mentoring Program. I had only just started thinking about what I wanted to do to further or vary my paramedicine career while living in a small rural community that I had no intention of leaving. I saw this advertised on the College's website and thought, "Why not see what this is about?"

I was very nervous about being paired with a mentor as I had less than zero knowledge of what research was, how to do it, or if I was even interested in it. We were sent an email to let us know who our mentor was and their contact information. I was fortunate to be paired with Jaimi Greenslade, who emailed me a few days later to introduce herself and start a dialogue. All our meetings except one were over the phone.

The program was semi-structured and included informal meet-ups monthly (online or in person) with our mentor and quarterly meetings where all mentors and mentees would attend an online formalised program centred on specific themes. These involved relevant speakers discussing topics such as pathways into research and the future of paramedic research.

Our first few individual monthly meetings were focused on getting to know each other and discussing Jaimi's pathway into research. During the next few months, we discussed different avenues to getting into research, such as higher degrees by research, master's degrees, and PhDs, as well as other ways such as being involved with research through employers, as a university academic or through grant applications. This is not an exhaustive list of how to become involved in research. These discussions with my mentor gave me great insight into the different pathways I might take if pursuing research was something I did indeed want to do.

SINCE COMPLETING THE PROGRAM, I HAVE FELT MORE CONFIDENT WITH NETWORKING AND PUTTING MYSELF OUT THERE, AND I AM MORE ASSURED ABOUT THE DIRECTION I WANT TO HEAD IN THE FUTURE

We also discussed different types of research, formulating research questions, and why research is needed. Around halfway through the mentoring program, I decided that furthering my clinical skills and dipping my toes into research was something I was interested in. I enrolled in a Master of Paramedicine (Extended Care) part-time that offered the final year as research with a pathway into a PhD. I still enjoy being on road and caring for my community and, personally, I wanted to continue this but with further skills.

Nonetheless, I also found the research world fascinating and something I was definitely interested in knowing more about. One of the important things Jaimi helped me with was putting myself out there and knowing that I may be a novice in the research space, but I had a lot to offer. But overall, I think the biggest take home I took from Jaimi was that research was not done alone; it was a collaboration with other researchers and academics to draw on the expertise of others.

Networking was an integral part of other researchers' success, picking the brains of someone who had already done it or could teach you how not to do it (equally as important). Since completing the program, I have felt more confident with networking and putting myself out there, and I am more assured about the direction I want to head in the future. I am grateful to the College for putting together a program that could benefit others like myself, whether to confirm the desire to pursue a research pathway or to realise that maybe this isn't the route for right now.

I look forward to seeing where this journey will take me in the future.

If you're interested in becoming a Mentee or Mentor for the 2023 Paramedicine Research Mentoring Program, please visit https://paramedics.org/research/mentoring

# ACP INTERNATIONAL CONFERENCE 2022

More than 200 people gathered in Brisbane in September for our flagship annual event, the ACP International Conference 2022 (ACPIC 2022), in our largest face-to-face gathering since the start of the pandemic.

Themed “Embracing Strengths, Shaping Futures”, and featuring more than 90 presenters and hosts from around the world, the conference was designed to inspire, educate and engage paramedics representing the spectrum of paramedics practice and paramedical research. Across the three days of the conference, delegates attended interactive workshops, innovative panel discussions, pertinent keynote and abstract presentations covering topics from obstetrics to wound care, research and sedation.

Master of Ceremonies was Dr Ben Meadley from Monash University, and keynote speakers included Associate Professor and Victoria’s Chief Paramedic Officer Alan Eade, Royal Melbourne Hospital Emergency Physician Dr Mya Cubitt, and Benasa Medical Services Director Dr John Adie, all of whom explored relevant issues facing paramedicine and the broader health care sector.

A highlight of the conference was the launch of the College’s scientific journal Paramedicine by Editor-in-Chief Paul Simpson. The journal will provide an international forum for the dissemination and discussion of paramedicine research. Submissions are now open, and the first edition will be released in early 2023.

ACP INTERNATIONAL CONFERENCE

ACPIC 2022 would not have been possible without incredible support from the organising committee, comprised of Alecka Miles (Chair), Louise Reynolds, Jessica Wissa, Andrew Odgers, Tim Andrews, Julie Johnson, Craig Campbell and Renee Guesnon, and from the College’s Conference Coordinator Georgia Coetzee.

We also extend our thanks to our event partner Zoll and event sponsors Edith Cowan University, Emergency Services Health, Guild Insurance, Cardiac Physiology in Practice, Council of Ambulance Authorities, Fortem Australia, Ferno and Laerdal, as well as all the exhibitors who came together to create a wonderful event.

Full-day recordings are available on the event pages for a limited time: https://paramedics.org/recordings

## CONFERENCE STATS

| | |
|---|---|
| **11** | WORKSHOPS |
| **78** | WORKSHOP ATTENDEES |
| **31** | WORKSHOP HOSTS AND FACILITATORS |
| **215** | F2F CONFERENCE ATTENDEES |
| **60** | PRESENTERS |
| **115** | ONLINE CONFERENCE ATTENDEES |
| **1** | CONFERENCE PARTNER |
| **8** | CONFERENCE SPONSORS |


# IT'S TIME TO PLAN FOR THE COMING YEAR'S **CPD**


As paramedic registration is again upon us, the importance of continuing professional development is at the forefront of every paramedic's mind. Professional development activities are best spaced out over the year, with planning and reflection on how your CPD can lead to better learning outcomes.

Now is the time to start thinking about your goals and objectives for the next 12 months. Learning and professional development should occur throughout your career and include a range of activities that aim to maintain safe practice, enhance competence, and improve patient outcomes.

The College's Education Team is committed to facilitating a range of activities to help you plan your professional development throughout the span of your career. We recognise the evolving nature of our industry and the changing environments in which paramedics practice. Identifying opportunities for interactive and interprofessional CPD can sometimes prove challenging with the competing priorities of shift work and work/life balance. We recognise these challenges and have planned a range of unique events in November that may assist.

At the end of November, we have a two-day live interactive online symposium consisting of eight sessions covering a range of topics. Professional education followed by reflective activities will give everyone the opportunity to engage with experts in the field. There really will be something of interest for every practice level and experience base.

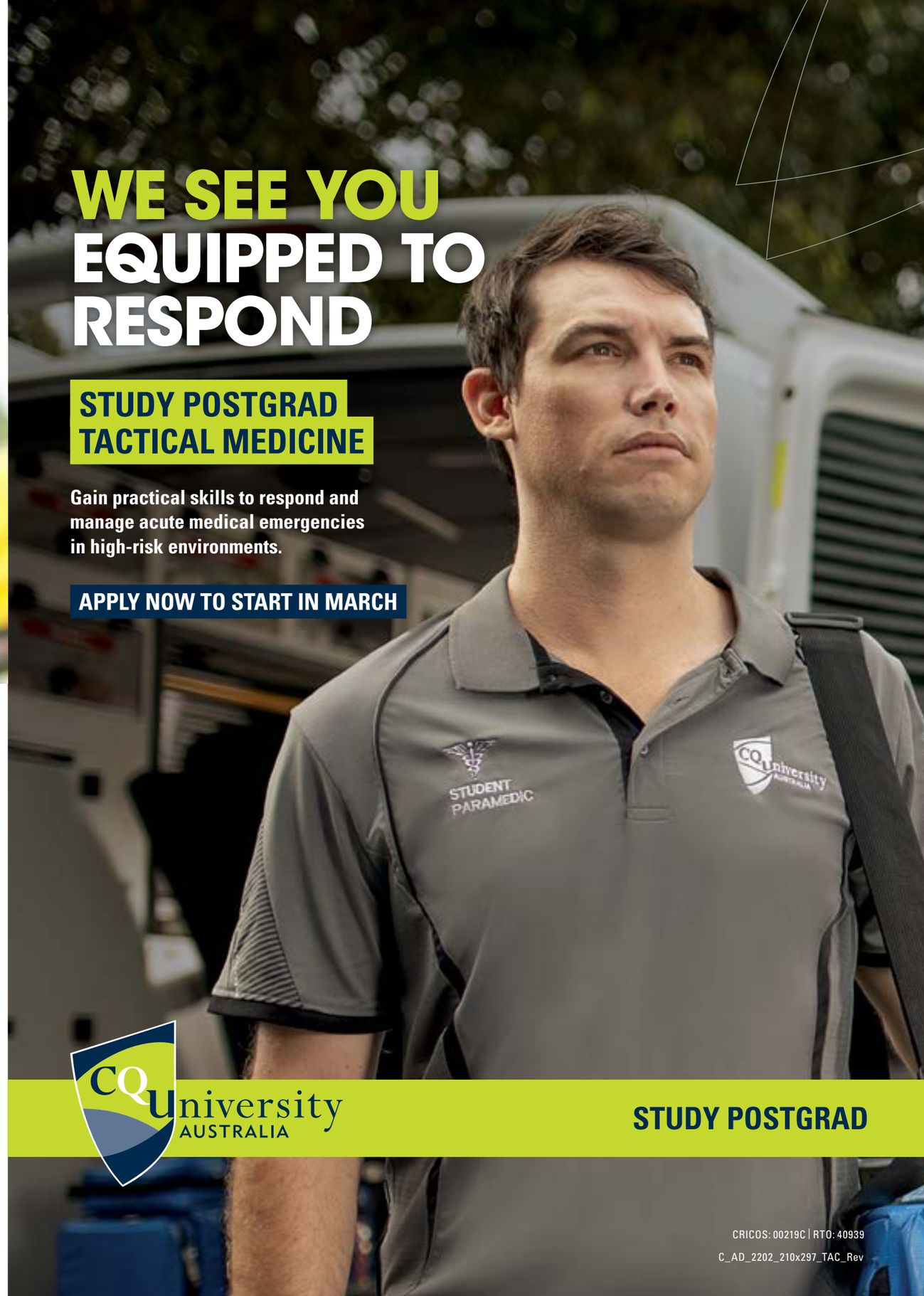
Reflecting on the last few months, we have released eLearning modules in our continuing obstetric series, with the inclusion of shoulder dystocia and optimal cord clamping coming soon.

Wound care is the first in the series and has clearly been a highly sought-after course. There is a lot more to come in this space. Advanced wound care is already in the planning stage.

We've also released the first module in Paramedic Responsibilities: Mandatory reporting. This module discusses the legal obligations that registered paramedics have, both in Australia and Aotearoa New Zealand. Guest presenter Dr Micheal Eburn delivers expert guidance, providing a legal context for this topic. It is the first in a series of modules to come in the Paramedic Responsibilities space. The second module will look at ethical conduct, duty of care and informed consent - keep an eye on our website for the announcement of this release.

Excitingly, we also published Introduction to Stroke, which was expertly and collaboratively conceived through consultation. Subsequent modules are already under way and will include clinical localisation and a review of brain anatomy.

October was a record-breaking month, with close to 1000 enrolments and still counting. Well over 4,000 members have engaged with eLearning and we truly appreciate all of the comments and feedback. If you have suggestions or some words of encouragement for our team, we would love to hear from you. All comments and suggestions are valuable, and we review each and every one of them. They contribute to our quality review process and help us ensure that the learning is a valuable experience for you, our members.



# **TRAILBLAZER:** VICTORIA'S CPO FORGES NEW ERA FOR PARAMEDICINE

In may respects, Alan Eade ASM epitomises the evolution of paramedicine in Australasia. As Australia's first and still only state or territory Chief Paramedic Officer, he's pioneered a model of professional representation in Victoria and ensured that the profession has a seat at the table and a voice to government, and in the process provided a template for the adoption of the role in other jurisdictions.

An Intensive Care Paramedic and Adjunct Associate Professor at Monash University, his appointment in April 2017 in the lead-up to national paramedic registration "came out of the blue" when Victorian Premier Daniel Andrews questioned why the state lacked a such a position.

"The fact that there was none, that there was no one else in Australasia with a similar title, was not a deterrent," Eade said. "A Chief Paramedic Officer was to be appointed. At the time we had a Chief Medical Officer and a Chief Nursing and Midwifery Officer, and the two of them had great experience in the health system but had a very limited understanding about paramedicine.

"But they welcomed me with open arms and said, tell us about yourself, and I mentioned inter-disciplinary practice and that we need to work better together. They lit up like a Christmas tree and said, 'We're going to get along just fine, because everything we do in this office is about minimising the silos and moving things across the professional groups'. And so, we were known as the Office of the Chiefs from that day on."

After initial guidance from his fellow Chiefs, it was then up to him to define and build the role. The initial challenges, some of which are still ongoing, revolved around the legislative, regulatory and policy issues impacting paramedicine tied to outdated definitions and delineations of practice.

One of the biggest hurdles was paramedics being listed in different acts

or regulations under different terms: Ambulance worker, ambulance officer, paramedic, ambulance paramedic, registered paramedic and/or operational employee of an ambulance service.

The advent of paramedic registration provided an opportunity to make the consequential amendments as part of that process. However, by the time he assumed his position, the legislative window had closed and he was unable to lend his voice and perspective to the discussion.

"That's one of the greatest challenges, because I'm still trying to fix legislative or regulatory barriers. That could have been wrapped up with the registration of paramedics if there was someone there to think about it, but nobody had any vision of the fact that it would be a problem.

ONE OF THE GREATEST CHALLENGES IS TRYING TO FIX LEGISLATIVE BARRIERS

"The reality is, if it says ambulance paramedic, that only applies if you work for the ambulance service. If you look at the definition of an ambulance officer [sic], it's an employee of the ambulance service. So there are all these paramedics who are registered and practicing in the community who were not covered by these particular acts or regulations.

"In Victoria, we've used hundreds of paramedics a week not in the ambulance service but in the broader health sector for nearly three years now. Places such as quarantine, testing, vaccinations, primary and community health, and the growing First Aid Service sector."

To address the legislative issues, he seeks out the person with responsibility for the legislation and, when legislation is open to be amended, requests the wording to be changed to reflect the contemporary reality of paramedic practice.

"They're like, 'Oh yeah, that makes sense, we'll do that. No problem'. So you just have to be patient. One example is the Public Health and Wellbeing Act came up for review because of the pandemic, and the changes I requested were made. It happened as part of a normal evolution and as a result of people being in the right positions. It's a confluence of positive things that came together at once."

However, when the changes required are impeding the effective use of the profession to support the community and health system, then advocacy is less passive. His last big hurdle, and the remaining major change that he is seeking before his tenure ends, is the omission of paramedics from drugs, poisons and controlled substances regulations, which were written nearly 40 years ago, long before there were paramedics as we know them today.

"If I can get that fixed, then I'd be extremely happy - for paramedics to be able to possess and administer medicines. To this point, what we've done is we've created workarounds rather than resolve the primary barrier. During the pandemic we've needed to use paramedics broadly and we've supported them to give vaccinations and do all sorts of things that they aren't technically supported to do in existing legislation, so we've created emergency orders (usually) under the Public Health and Wellbeing Act.

"In other acts, we've created an authorising environment to allow them to use medicines even though they don't appear in the drugs and poisons regulations, which is unusual but it's a workaround that we've had to build in that applies to the Ambulance Services Act and the Non-Emergency Patient Transport and First Aid Services Act. We have paramedics working in a lot of different environments, so we've created access to medicines as best we can.

"But we still haven't resolved the principal issue, the source regulatory instrument. Fixing this is like the Holy Grail for me because then its fixed no matter where paramedics want to work. Instead of investing all of the effort we've put into workarounds, we need to be fixing the root cause of the problem, and then it would be fixed for all contexts and forever."

THE EVOLUTION OF PARAMEDICINE INTO PRIMARY CARE IS DEFINITELY HAPPENING, AND I THINK THAT WILL BE FANTASTIC

With his term wrapping up in April 2023, Alan is focused the future of paramedicine and the opportunities that exist for further growth and development. He said the rapid evolution of the profession to date has exceeded his expectations and augured well for the coming generations.

"In four years, everything that I had considered to be a 10-year horizon we have already achieved. What we need now is consensus on a vision for the profession as a whole. If we have that, it will keep the momentum going.

"There's a cultural shift happening, and it means that we're moving beyond the emergency ambulance culture and into the broader health culture. The evolution of paramedicine into primary care is definitely happening, and I think that will be fantastic."


# COMMITMENT TO MĀORI HEALTH: EQUITY AT THE HEART OF HATO HONE ST JOHN'S NEW STRATEGY

**Tāmaki Makaurau (Auckland), Aotearoa New Zealand**


As National Operations Manager, Hauora Māori, at Hato Hone St John, Dan Spearing is on a journey to help address the inequities in Māori health and ensure ambulance operations are true to the spirit of partnership under Te Tiriti o Waitangi (Treaty of Waitangi).

His efforts are part of a broader reckoning within Aotearoa New Zealand's health sector and a reconceptualisation of a Western model of health care that for generations has failed to reconcile Māori cultural identity, practice and beliefs and a traditional holistic approach to wellbeing that encompasses physical, mental, spiritual and family/social health as key components of hauora, or wellbeing.

The Hato Hone St John Aotearoa New Zealand approach, detailed in a new strategy called Manaaki Ora 2022-2027, "manaaki" meaning to take care of and "ora" meaning wellbeing, is focused on uplifting the wellbeing of all people.

## IT'S ESSENTIALLY ABOUT MOVING FROM AN AMBULANCE AT THE BOTTOM OF THE CLIFF TO THE TOP OF THE CLIFF

"To give life to Manaaki Ora means anything to do with, for example, building cultural competency within our workforce and setting up strategies and frameworks for that, and also putting an equity lens on our entire system, from our kaimahi (team) taking the calls all the way through to ambulance dispatch and front-line service delivery," said Dan, whose whakapapa (Māori lineage) hails from Hawkes Bay in the North Island.

"It's about applying an equity lens, so looking at areas of high deprivation and saying, 'Do we need to change the skill mix within these areas to ensure that we've got equitable access to the services that we can provide?', noting that in a lot of rural and isolated communities, which also coincide with high Māori populations, the inequities are very significant."

It's also about building relationships with communities, with iwi (tribes) and hapū (sub-tribes) and allowing these communities to lead and ensure we are tailoring our approach to be in line with their needs and aspirations. And it's about co-designing initiatives that use innovative technology to overcome the social determinants of health.

"As an example, this includes an initiative we are piloting in the Rotorua area where technology aids two of our frontline staff by video calling one of the clinicians from the hospital and sending through vital signs in real time. We also have a new app through software company Kiwa Digital to be released this year that is focused on raising awareness of Māori culture and building cultural competency.

"The aim is to improve health care and outcomes for Māori communities that are under-served by the health system nationally. The cause of inequities is multifaceted and therefore our approach has to also follow suit. Building knowledge, developing true relationships, and weaving an equity lens across everything.

"It's essentially about moving from an ambulance at the bottom of the cliff to the top of the cliff and identifying how can we play a part in the preventative space, things like education, health literacy skills, capturing blood pressure earlier before it leads to a stroke, for example."

Implicit in the approach is the recognition that the health system doesn't reflect a Māori world view, in which the focus is on the collective rather than the individual. That also a need to build education and health literacy, as well as ensuring that there's a better understanding of Māori culture."

## WE ARE TAKING THIS ON AS A RESPONSIBILITY TO BE A KEY PLAYER WITHIN THE SPACE OF HAUORA AND HEALTH EQUITY IN AOTEAROA NEW ZEALAND

lack of recognition coupled with low levels of cultural competency in the health sector and systemic implicit bias have bred mistrust and led to alienation and intergenerational health problems.

Compounding the inequities is the geography of Māori communities, with marae (meeting grounds and the focal point of Māori communities) generally located in rural and remote areas that are challenged with health care staff and resources. As with the location of communities, many of the challenges are systemic and cyclical, perpetuating intergenerational trauma and disadvantage leading to economic poverty and lack of access to positive educational and health outcomes.

"Poverty breeds poverty, and that's a very hard cycle to beak. As people get older, they may not understand certain conditions. What does cardiac chest pain actually mean? And because of that, they may have chest pain and not realise the seriousness of it, so they're less likely to engage with health resources or call 111 until they're really ill. So there's

Hato Hone St John's Manaaki Ora strategy is centred on five key objectives: Partnering to meet community needs to achieve health equity, committing to equity for Māori, empowering their people to deliver innovative local solutions, creating a place where everyone belongs, and building sustainability for future generations.

"We are committing ourselves to this and taking this on as a responsibility to be a key player within the space of hauora and health equity. It's not just words; we're actually getting out and making a tangible difference for the lives of people."

Paramedics have an integral role to play in delivering on the promise of health equity.

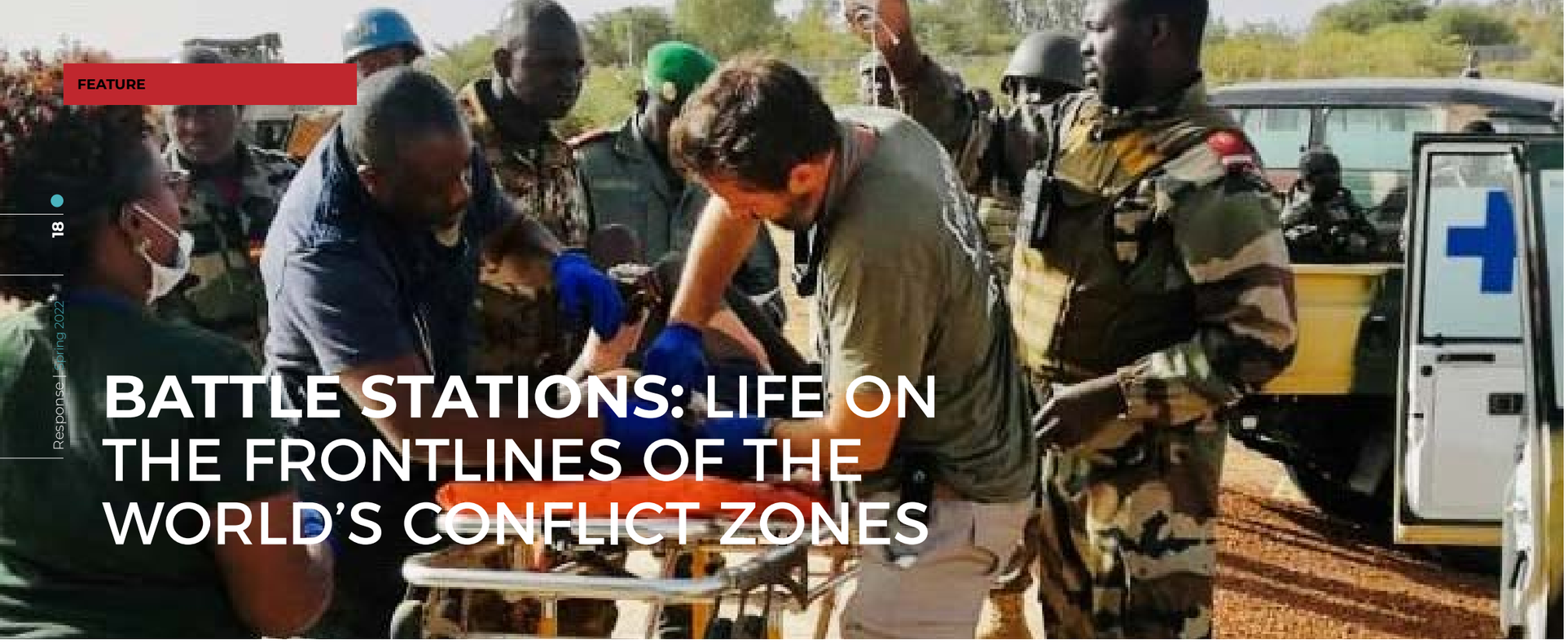
"We are in almost every community within the country, even those in rural and remote areas. We are sometimes the first point of contact within the wider health system, so it's really important that we incorporate cultural competency into our day-to-day practice.

"It's about having that cultural know-how and knowledge of how to walk in a space of Te Ao Māori (Māori world view), and that knowledge around Māori health and how they view health so we can build that connection and trust. People are more likely to venture forward and seek us out for care and they're more likely to listen to that clinical knowledge if we can do that."

Hato Hone St John has a series of projects its undertaking in this space, including a mobile wellness unit (Waka Rongoā) working alongside hauora services in high-population Māori communities to support COVID-19 vaccination uptake and the delivery of primary health care, and expanding recruitment opportunities for better Māori and Pacific representation among paramedics, which at present hovers around 7-9 percent, all of which are helping to bridge the inequity gaps.

"We want to see that our generations to come, my children, my great-grandchildren, live longer and that the gap of life expectancy narrows. For me, that's that end goal."

FEATURE



# BATTLE STATIONS: LIFE ON THE FRONTLINES OF THE WORLD'S CONFLICT ZONES

When Critical Care Flight Paramedic Shane Quick landed in Kabul, Afghanistan, in 2006 with a fellow Australian paramedic who had recently launched RMSI Rapid Deployment Medical & Rescue, the pair were equipped with just a couple of medical bags and some equipment, hoping to establish themselves as a frontline medical evacuation team.

In the space of a few years, this grew into clinics, hospitals and medical staffing throughout conflict zones in the Middle East, Africa and Eastern Europe, operating in high-risk areas, triaging high-acuity patients, and providing much-needed international medivac services transporting patients to Europe, the UK, US and Dubai.

For Shane, who began his career as a medic in the Australian Defence Force, it was "the accumulation of a lifetime of being a paramedic."

"I started out in the Army in the Medical Corp as a medic, where I spent about eight years. I was deployed to East Timor and Bougainville and travelled all over Australia. I got to practice not only as a medic in pre-hospital emergency care, but I also provided a lot of primary health care. At the time, I believed the scope of practice to be more comprehensive than most medics, nurses and other practitioners would get to do in the real world.

"It gave me the ability to operate with a lot of leeway under the supervision of doctors, so I think that's what gave me a taste for the pre-hospital world and helped prepare me to move forward from the military."

He initially transitioned to the mining industry, where he worked for two years as a site medic for BHP in the Northern Territory, before landing his dream job as a student paramedic with the Queensland Ambulance Service, where he came to understand that he knew very little about children, the elderly and numerous comorbidities in pre-hospital care.

In a rural placement, he was able to hone those skills as part of a "wonderfully steep learning curve". He worked for five years full-time with QAS and another five as a casual before "all the craziness and the amazing rollercoaster began" with RMSI.

## IT WAS THE ACCUMULATION OF A LIFETIME OF BEING A PARAMEDIC

Based in Dubai, he undertook projects in Afghanistan, Iraq, Ukraine and throughout Africa, working with the United Nations, NATO, the Organization for Security and Cooperation Europe, and the US military, in the process racking up many hours as a Critical Care Flight Paramedic and Operations Specialist on the Jet Air Ambulance. It was rewarding, challenging and often dangerous work.

"In the early days in Afghanistan and getting around Kabul, we were bright-eyed bushy-tailed paramedics from the Sunshine Coast. We both had reasonably good military experience, but that doesn't mean you don't get scared and that you don't occasionally lose your situational awareness.

"Many times in Ukraine, from 2014-2015 where we were on the eastern border, I'd be at a checkpoint and have guns pulled in my face, and we'd be detained for an hour or so, and sometimes be threatened. We were exposed to shellings, so yes, in many places I've been exposed to a lot of danger in my life. It takes its toll, but I think I've maintained a reasonable sense of sanity."

I'D BE AT A CHECKPOINT AND HAVE GUNS PULLED IN MY FACE, AND WE'D BE DETAINED FOR AN HOUR OR SO, AND SOMETIMES BE THREATENED

The challenges of responding to medical emergencies in such settings require more than good medical skills.

"It's not just about being a good clinician; it's about having situational awareness, emotional intelligence and being able to put on numerous hats at any one point.

"Initially, it was liaising with private airlines, helicopter and insurance companies and trying to establish links. There was a lot of communication involved and dealing with governments and trying to get people out of the country, forging relations with military and UN for passes/access utilising their hospitals, specifically for stabilization before flights. It wasn't just the normal life of a contract medic, but eventually we created an environment that enabled us to bring in hundreds of contract medics."

In 2018, he moved on from RMSI, which in the intervening years had been absorbed by International SOS, for whom he also worked intermittently and now works full-time, and in 2020 spent eight months in Mali in Central Africa with the United Nations Multidimensional Integrated Stabilization Mission putting in numerous hours on an Mi8 helicopter as a Critical Care Flight Paramedic with the Aeromedical Evacuation Team doing rotary wing medivacs of soldiers at the point of injury.

Since then, he has worked offshore with International SOS, predominantly on oil rigs, with the past six months spent on a rig in Equatorial Guinea off the west coast of Central Africa on a five-week on and five-week off rotation.

"Working on rigs is still a new world for me in a sense, but running a clinic and seeing patients for primary health care and providing training, it's the same template you apply whether you're on a military base in the middle of Afghanistan or in a clinic in the mountains somewhere. You're running a small clinic and seeing people that are unwell in an isolated area.

"It's a nice change of scenery. It also enables me to regroup and see where I am at this point in my life and where I'm going to go from here. I've been fortunate to work with people from all walks of life and nationalities and with different cultural beliefs and values, and this gives you so many more perspectives and so much more general life awareness, and a much better ability to work with people.

"This type of work isn't for everyone, but it's the best life for me. You don't really know until you try it, right?"

FEATURE

# PARAMEDICS PIONEER NEW MODEL OF CARE FOR SEASONAL PACIFICA WORKERS

**Heretaunga (Hastings), Aotearoa New Zealand**

Each year, thousands of Pacific Island workers descend on Aotearoa New Zealand to work in the agricultural and pastoral sectors as part of the Recognised Seasonal Employer (RSE) scheme, many of whom are placed in the fertile lands surrounding Hastings on the North Island, one of the country's leading fruit and wine-growing regions. In addition to bringing local farmers a much-needed workforce, many also bring with them a range of untreated and often undiagnosed pre-existing conditions that threaten their longer-term health.

For the paramedics at Hastings Health Centre, which looks after about 4,000 of the seasonal workers, the provision of improved treatment and ensuring better health outcomes for the Pacific Islanders is a priority, and in an initiative backed by the practice they are now running a dedicated clinic to address both their work-related injuries and their underlying health issues.

Hastings Health Centre is another of the country's clinics to have recognised the potential of paramedicine to add another dimension to community health care and to have brought paramedics into their practice as part of multidisciplinary teams working alongside doctors, nurses and other allied health professionals.

Extended Care Paramedic Steve Harkness, the driving force behind the conceptualisation and development of the seasonal workers' clinic, said initially they were primarily treating low-acuity workplace injuries.

"There's a lot of minor conditions - back pains, aches and strains - so I cut my teeth doing that. But being a paramedic, having that background, I came up with more ideas about how we could improve things. As a paramedic, you understand people and you understand what motivates them. You've been into their homes and you've seen the challenges they face. Doctors often haven't done that, not through any fault of their own - they follow a completely different model.

"We are able to form bonds with the workers and I was able to see where the gaps were in the care they were receiving."

One of the key gaps he identified was limited insurance coverage. While workers had basic health cover, which provided them with standard health care, it generally didn't extend to diagnostic procedures such as X-rays and blood tests.

"We'd have a person with a skin infection and they'd come in repeatedly for boils. We couldn't do blood tests, check for diabetes, and check for other chronic, life-changing conditions. So I tried to find different ways to address this. We lobbied our local Health Board, we lobbied Pacifica groups to try and source some funding, and while they supported our objectives, no money was forthcoming. So I said, 'Why don't we do it ourselves?', which we've done, and now, with the support and supervision of our Medical Director Raja Hingorani, Taylor Birks-Stock and I are able to lead the clinical care of this at-risk group."

WE WERE ABLE TO FORM BONDS WITH THE WORKERS AND I WAS ABLE TO SEE WHERE THE GAPS WERE IN THE CARE THEY WERE RECEIVING

A priority was securing funding for Point of Care Laboratory Testing, notably a blood analyser, as both research and the clinic's own anecdotal experience supported the fact that Pacific Islanders were less likely to receive blood screening during medical consultations despite overwhelming evidence to suggest they were at risk of increased mortality and morbidity as a result of delayed diagnosis of these conditions.

In the case of a worker in his 30s who presented with abdominal pain, non-specific weight loss and bleeding, the path to diagnosis and treatment was fraught with hurdles. While the clinician on duty ordered blood tests, the man's insurance didn't cover the costs and he was unable to foot the bill until the following week.

"When we finally got the results, he had a haemoglobin of 60, so the part of his blood that carries oxygen was about half of what it should be. When I rang his employer, I was told he was still at work. I spent the next hour tracking him down and subsequently referred him to hospital, where he was diagnosed with a perforated diverticulum and an abdominal infection. He received antibiotics and blood transfusions and was admitted to hospital for several days before making a full recovery.

"Potentially it could have been fatal. If we had the capability to test his blood at the time of consult, we could have likely picked this up at an earlier stage and made the decision to intervene early, reducing his time off work, his stay in hospital, and the overall financial burden on our hospital system that now has to be paid for."

I WOULD DESCRIBE PARAMEDICS AS THE MISSING PIECE OF THE PUZZLE

With funding from Royston Health Trust, they are now in possession of a blood analyser and cartridges for analysing blood at point of care that enables them to screen for diabetes, heart disease and infection markers at no cost to the individual. They have also streamlined processes and enhanced their tele-triaging capabilities, with employers now identifying patients that need to be seen in advance.

"Historically, the workers would come in and would have to wait hours to see a doctor. We developed a system where the employers call or email me in the morning and I do tele-triage and schedule appointments as needed. It reduces their wait times and their time away from work, and eases the burden on our staff, ensuring an efficient health service for all parties."

His colleague Taylor, also an Extended Care Paramedic, said the seasonal workers benefited from the more direct care they were receiving, which in addition to improved health service provision also included producing translated materials on how to correctly take medications.

"I would describe paramedics as the missing piece of the puzzle," she said. "We have a level of knowledge about acute care and emergency care that a lot of doctors and nurses in primary care have no experience with and can't offer. We recognize things that need immediate intervention that others who were never taught that or exposed to it don't recognise.

"We see the workers just like any other patient, but our treatment of them tends to be a little more streamlined than a standard urgent care patient. And for Hastings Health Centre, it means we've got more staff and people don't have to wait as long to be seen, and the quality of care is proving to be just as good. Paramedics are ideally suited for this."

She said RSE employers have advised that in the next few years there is likely to be rapid growth in the number of seasonal Pacifica workers coming to New Zealand to pick fruit, but they were ideally placed as a paramedic team to meet the anticipated health demands.

"As demand grows, we also grow as clinicians in this relatively new and exciting environment for paramedics to work in."

# THE COMMUNITY PARAMEDIC: CONTINUING TO RESHAPE HEALTH CARE

**By Joshua Ferdinand**
**MCPara; Community Paramedic, St John Ambulance NSW**
**Sydney, Gadigal Country**

In the days of Nancy Caroline - the author of Emergency Care in the Streets in the 1970s that revolutionised paramedic education and training - paramedics were predominately or exclusively expected and authorised to provide emergency care or assist doctors. Our protected title stems from the Greek para (beside/alongside) and medic from the Latin medicus (physician).

Around the world, our roles and responsibilities can greatly vary. I have had the benefit of practicing on opposite sides of the globe and have thoroughly revelled in the experience of being a Community Paramedic in Sydney with St John Ambulance NSW. The position has allowed me to go above and beyond for patients and offer preventative health care services within a suburb, build relationships with patients, and in many cases be the first contact for their tentative health concerns.

The rate at which our scope of practice and our recognition within the industry has evolved has been rapid. When I was still in training nearly a decade ago, we were, frustratingly, more often than not still called “ambulance drivers” and the public perception of what we did was limited.

However, over the years, the role of paramedics has significantly expanded, and we are now a much more independent profession. We occupy primary health care centres, hospital wards, emergency rooms, control centres performing remote triage using video technology, and have developed an ever-advancing academic field of paramedical science. Due to a deficiency of specialists, the increasing demand for medical services, and gaps in the health care system, the field continues to evolve year on year.[1]

As paramedics, we are well prepared to understand community-level factors and develop enduring and trusting relationships with patients, in turn providing not only effective care but also an exemplary patient experience. And due to the nature of our training, paramedics are adeptly prepared to communicate with multidisciplinary teams and find appropriate care pathways. Thus, it is no surprise that our roles are shifting from solely emergency medical services to non-emergency calls, primary care and community paramedicine.[2]

## The increasing importance of Community Paramedics

There are many reasons why Community Paramedics are becoming vital to the health care system. Over the years, the average life expectancy of people has increased; this means not only a greater need to handle medical emergencies, but also to prevent such emergencies. In addition, the prevalence of chronic ailments and disabilities has risen significantly. These days, most adults are living with one or another chronic ailment, such as hypertension, obesity, osteoarthritis, diabetes, cardiovascular disorders, dementia, and different autoimmune and neurodegenerative disorders, to name but a few.[3]

Taking care of chronic disorders requires more engagement with patients, working at the grassroots levels, and greater patient trust. As paramedics, we are uniquely positioned to accomplish this role.[4]

## Typical presentations in the community

Similar to life within an ambulance service, there is a great amount of variability in the type of medical presentations we encounter in the community; however, in my experience the most common presentations include:

**Medical:** Allergies (from mild to anaphylaxis), asthma, abdominal discomfort/pain, arthritis, chest pain, COPD, diabetes, D&V, headaches, seizures and syncope.

**Mental Health:** Anxiety, confusion, distress, drug use, psychosis.

**Trauma:** Slips, trips and falls, fractures, sprains and dislocations, lacerations.

We are usually dealing with acute illnesses, exacerbations of chronic conditions, and social and mental health issues or trauma.

## Recent case study of a common medical complaint in the community

**Overview:** 24YoF c/o abdominal pain/discomfort, mild nausea, no vomiting.
**Complaint:** Abdominal pain | **History:** Bowel movements normal and regular, last menstrual cycle 30 days ago | **Allergies:** Nil | **Medications:** Nil | **Social Hx:** Regular partner uses barrier protection.

**Site:** Hypogastric pain | **Onset:** Started in morning at rest | **Character:** Cramping | **Radiation:** Nil | **Associated Sx:** Nil | **Time:** Comes in waves, has occurred premenstrual before | **Exacerbates/Alleviates:** Nil | **Severity:** 7/10 (subsiding to 2/10 during assessment)

**Observations: RR:** 18 | **HR:** 72 | **BP:** 125/82 | **SPO2:** 99% (A) | **ECG:** NSR |**BG:** 5.2 | PEARRL | **GCS:** 15/15 | **Bowel Sounds:** Norm | No Neuro-D

**Physical Examination:** No contusions, distension, guarding or pain on palpation.

The common complaint of abdominal pain can be quite a can of worms so to speak; fortunately, in this case it was neither a tapeworm nor anything more sinister than premenstrual cramping (dysmenorrhea). As paramedics, we must ensure we do not become complacent about these complaints; a thorough history and examination should always be performed.[5] Generally, acute abdominal pain is referred to hospital; however, in this case there were no “red flag” presentations and the patient could continue with self care and advice on worsening. Working in the community provides the opportunity for follow-up contact, and confirming the diagnosis and disposition as appropriate.

Community paramedicine is about more than metrics to better physical health; we also have a paramount role to play in mental health, ensuring that members of our community are okay, leveraging our existing relationships and compassionate nature to be a point of contact should anyone need support. Thus, I am excited to see what the next two decades brings for paramedics in the community or Community Paramedics.

In summary, paramedics are in better positions to fulfil certain roles due to higher mobility and greater interaction at the grassroots levels. We can also fill existing gaps in the way medical care is delivered, and we are better situated to provide help, not just in an emergency but also in preventing disorders and helping treat common disorders. In addition, we can play an increasingly vital role in managing chronic disorders, helping prevent future outbreaks of infectious diseases, providing palliative care, helping people with disabilities, and much more.

A flight paramedic friend of mine once paraphrased Confucius: “If you love what you do, you’ll never work a day in your life.” To my colleagues, I hope that you will find and embark on one of the ever-growing specialisations that you love in paramedicine.

THE ROLE OF PARAMEDICS HAS SIGNIFICANTLY EXPANDED, AND WE ARE NOW A MUCH MORE INDEPENDENT PROFESSION

COMMUNITY PARAMEDICINE IS ABOUT MORE THAN METRICS TO BETTER PHYSICAL HEALTH

References:

1. Morgan PA, Smith VA, Berkowitz TSZ, et al., 2019, “Impact of physicians, nurse practitioners, and physician assistants on utilization and costs for complex patients”, Health Affairs, 38(6):1028-1036. https://doi.org/10.1377/hlthaff.2019.00014
2. T. Rasku, M. Kaunonen, E. Thyer, E. Paavilainen, K. Joronen, 2021, “Community nurse-paramedics’ sphere of practice in primary care; an ethnographic study,” BMC Health Services Research, vol. 21, July, https://doi.org/10.1186/s12913-021-06691-y
3. M. Drozd et al., 2021, “Non-communicable disease, sociodemographic factors, and risk of death from infection: A UK Biobank observational cohort study”, The Lancet Infectious Diseases, vol. 21, no. 8, pp. 1184–1191, https://doi.org/10.1016/s1473-3099(20)30978-6
4. M. J. Nolan, K. E. Nolan, and S. K. Sinha, 2018, “Community paramedicine is growing in impact and potential,” CMAJ, vol. 190, no. 21, pp. E636–E637, https://doi.org/10.1503/cmaj.180642

Further Reading:

The risk of missing major abdominal pathology exists not only in the complex environment of pre-hospital care where our resources and diagnostic equipment is limited, but can also occur in hospitals with specialists, consultants, imaging and bloodwork. The UK has introduced Early Warning Scores (NEWS & PEWS) to aid decision-making around paediatric and adult care and to evaluate the level of risk associated with such patients. I believe this would benefit us as paramedics in being aware of and advocates for such systematic triage of patients in our care.

5 (a). Girl, 13, likely to have survived if moved to intensive care, coroner rules: https://www.theguardian.com/society/2022/mar/04/girl-13-likely-to-have-survived-if-moved-to-intensive-care-coroner-rules

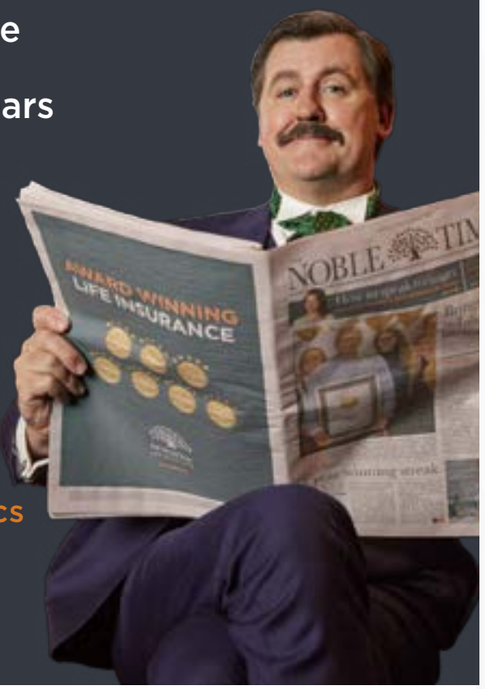
5 (b). Regulation 28: Prevention of Future Deaths report: https://www.judiciary.uk/wp-content/uploads/2022/03/Martha-Mills-Prevention-of-future-deaths-report-2022-0063_Published.pdf

3. National Early Warning Score (NEWS): https://www.england.nhs.uk/ourwork/clinical-policy/sepsis/nationalearlywarning-score/; Paediatric Early Warning Score (PEWS): https://clinicalguidelines.nhsggc.org.uk/paediatrics/intensive-and-critical-care-paediatric/paediatric-early-warning-score-pews/

# 10% LIFETIME DISCOUNT ON LIFE COVER*

with NobleOak Life Insurance

- Outstanding service – Feefo rating of 4.8/5 stars**
- Australia's most awarded Direct Life Insurer 2021^
- Claims processed in 5 days on average
- Protecting Australians for over 145 years




mozo EXPERTS CHOICE 2019 - 2022

Platinum Trusted Service Award For consistently delivering excellence ★★★★★ 2022 feefo**

CANSTAR OUTSTANDING VALUE 2016 - 2022 DIRECT LIFE INSURANCE

Get an instant quote at:
www.nobleoak.com.au/paramedics
Or call NobleOak for a quote:
1300 108 490
and mention 'PARAMEDICS' to switch.

GET A QUOTE

NOBLEOAK LIFE INSURANCE

Australasian College of Paramedicine

Important information – The Target Market Determination for NobleOak's Premium Life Direct insurance is available on our website www.nobleoak.com.au/target-market-determination

*Discount Information - Paramedics are entitled to a 10% discount (which remains for the life of the cover) on NobleOak's Premium Life Direct standard premium rates on Life Insurance cover.

**Feefo rating based on 132 service ratings over the past year (as at 24 October 2022).

^NobleOak awards information found at https://www.nobleoak.com.au/award-winning-life-insurance/

Legal statements. Premium Life Direct is issued by NobleOak Life Limited ABN 85 087 648 708 AFSL No. 247302. Address: 66 Clarence Street, Sydney NSW 2000. Phone: 1300 108 490. Email: sales@nobleoak.com.au. Cover is available to Australian residents and is subject to acceptance of the application and the terms and conditions set out in the Premium Life Direct Product Disclosure Statement (PDS). This information is of a general nature only and does not take into consideration your individual circumstances, objectives, financial situation or needs. Before you purchase an Insurance product, you should carefully consider the PDS to decide if it is right for you. The PDS is available by calling NobleOak on 1300 108 490 or from www.nobleoak.com.au. Clients should not cancel any existing Life Insurance policy until they have been informed in writing that their replacement cover is in place. NobleOak cannot provide you with personal advice, but our staff may provide general information about NobleOak Life Insurance. By supplying your contact details, you are consenting to be contacted by NobleOak, in accordance with NobleOak's Privacy Policy.



@paramedicineJ

# Paramedicine

## The international peer-reviewed journal

paramedicinejournal.org


## Scoping statement

*Paramedicine* is the official journal of the Australasian College of Paramedicine.

It is a bi-monthly, open-access, peer-reviewed journal that provides an international forum for the dissemination and discussion of paramedicine research. The Journal's purpose is to advance and transform the discipline of paramedicine through high quality evidence, and inspire robust discussion, encourage innovative thinking, inform leadership, and enable research translation. *Paramedicine* publishes research from any country investigating any area of paramedicine, including but not limited to clinical care, models of practice, operations, patient safety and clinical quality, leadership, education, aeromedical and retrieval practice, tactical paramedicine, and community paramedicine.

## Great reasons to publish with *Paramedicine*

- Open access, free to publish
- Fast editorial process; acceptance to online publication in 25 days
- Indexed in the top databases making your work discoverable
- Best Quartile Ranking = Q1 (SCImago 'EMS')
- High quality peer-review and journal governance
- Global publishing partner and international readership
- Committee of Publishing Ethics (COPE) Membership

## *Paramedicine* is open for submissions

Visit **paramedicinejournal.org** for submission and author guidelines.


## Editor-in-Chief

**Associate Professor Paul Simpson**
Intensive Care Paramedic & Associate Professor in Paramedicine, Western Sydney University (Australia)

## Deputy Editorial Team

**Professor Julia Williams**
Paramedic & Professor of Paramedicine, University of Hertfordshire (UK)

**Dr Kathryn Eastwood**
Intensive Care Paramedic & Research Fellow, Monash University (Australia)

**Assistant Professor Walter Tavares**
Paramedic & Assistant Professor in Paramedicine, University of Toronto (Canada)

**Dr Alan Batt**
Paramedic & Adjunct Senior Lecturer, Monash University (Canada)



SAGE Publishing www.sagepublishing.com

Australasian College of Paramedicine

# IMPLICIT BIAS. WHAT IS IT? **HOW CAN WE ADDRESS IT?**

By **Stephanie Nixon**, QAS Advanced Care Paramedic Charleville, Bidjara Country

The human perception of people, situations and environment are all based on previous experiences and received information (Chapman, 2013). This perception is reinforced over and over until it becomes an automatic, unconscious "known". These perceptions can form pre-existing "in-built" ideas or stereotypes about things such as ethnicity, gender, age, and socio-economic backgrounds.

These ideas can then influence our behaviour towards these preconceived stereotyped groups. No one is exempt from implicit bias. It affects everyone in some way. An example may be the child who grows up hearing that people who are homeless are dirty, lazy, and not important. This same child has these ideas reinforced over time by the movies they watch, TV shows, and even the news until it becomes an implicit bias they hold that these homeless people ARE dirty, lazy, and unimportant.

When this child becomes a paramedic, if they have not addressed or acknowledged their implicit bias, they may unintentionally treat a homeless patient less aggressively than a patient they attend in a home environment. This may seem an extreme exaggeration, but it does occur on a regular basis throughout all health care.

Clinicians have the same rate of implicit bias as the general population, making it probable for implicit bias to affect a patient's health care pathway (FitzGerald & Hurst, 2017). Patients should not receive a lower level of care because of any unchangeable characteristic. But unfortunately, health care disparities still exist.

Stigmatising a patient regardless of the reason can affect their overall health care journey (Bolton, 2012). They may be categorised as a lower priority or have physical aspects of their care neglected, such as pain relief or showering. There may be a lack of respect shown towards them, resulting in a lack of dignity. There may even be changes in their ongoing care, such as premature discharge, inappropriate referrals, or unnecessary requests for transfer.

This is a concerning prospect to consider. We are faced with the real possibility that if a clinician holds implicit bias against a patient, then that patient's care and ongoing health care pathway can be affected right from the start. Consider the above homeless patient and the paramedic who has implicit bias towards people who live in a lower socio-economic environment. Without reflection, the clinician may treat this patient in a more "hands off' manner, resulting in an incomplete physical assessment. This may then follow through to the hospital handover, where relevant information is not passed on because parts of the assessment have been skipped. Bias can also bleed through to the language used in handover, and an overly negative handover to the hospital may potentially set the patient up for less thorough assessments and premature discharge.

As clinicians, we need to ensure we can acknowledge our own implicit bias and address these so we can provide improved and equitable health care for all our patients. There are several strategies we can employ as clinicians to weaken the associations we have formed during our lives. These include seeing the person as an individual rather than part of a group, working consciously to address and change our implicit bias, pausing, and reflecting after interactions with patients, trying to see the patient's point of view, spending more time with people of differing backgrounds, and practicing mindfulness (Cherry, 2020).

AS CLINICIANS, WE NEED TO ENSURE WE CAN ACKNOWLEDGE OUR OWN IMPLICIT BIAS

Healy et al., suggests that as clinicians we can advocate for our patient using seven strategies (2022).

### Patient First Language

Patient first language emphasises the fact that people are more than their medical conditions. Instead of referring to John as "John the diabetic in room 4", we might say "John is in room 4 at the moment, he has diabetes". Likewise, rather than introducing Jill as "Jill's a schizophrenic", we might introduce her as "This is Jill, and she has schizophrenia".

### Eliminate Pejorative Terms

Pejorative terms are terms that position the patient as inferior to the clinician and are often derogatory in nature. These might be words such as "druggo, drug-seeker, victim, frequent flyer, or hypochondriac". Using these words can develop a perceived power difference, resulting in an increased risk of substandard health care.

### Using Inclusive Communication

Inclusive communication can go a long way in making a patient feel comfortable in the health care system. More inclusive terms such as "spouse or partner" are a simple switch that can positively affect a patient's health care journey. Likewise, confirming pronouns can not only make patients feel comfortable, they can also provide relevant medical information that may be missed if the clinician does not consider it necessary.

### Avoid Labels

Labels such as "noncompliant with medication or treatment" or "poor historian" are some examples of terminology that as clinicians we should be aiming to avoid. Rather than labelling, the focus should be on understanding why the patient might be a "poor historian" or "noncompliant". Is Sally noncompliant with her medication because she recently gave up her licence and now has no method of transport to the pharmacy? Is Bill not attending his GP appointments because they no longer bulk bill and he can't afford it, but he's embarrassed so varies his story?

### Eliminate Weaponising Quotes

Weaponising quotes are similar to labels in that they reduce the patients lived experience and, in some cases, may infer that the patient is lying. Writing in the paperwork that "Jill reported her pain to be the worst pain ever at 10/10, however the patient looked comfortable" is the kind of leading quote that may cause other health care clinicians to question the patient's integrity. We as clinicians cannot discount the patients' lived experience and how it affects them, so by opting for more neutral observations such as "Jill reported that her pain was the worst pain she had ever felt rating it 10/10 on the pain scale. Her physical observations were as follows", we can provide better holistic, unbiased care.

### Avoid Patient Blaming

Blaming the patient for their circumstances directly contradicts the understanding that, for many people, their individual circumstances are largely beyond their control. A drug or alcohol addiction may have at one point been a personal choice, but has since gone far beyond that. Homelessness is a circumstance brought on by a number of different scenarios, very few of them involving personal choice. It can be very easy as an outsider to suggest that someone "just needs to decide to leave" a domestic violence situation, but those circumstances are often multi-layered. We can't blame patients for the circumstances they find themselves in, but by advocating for them, we can empower them to seek change.

### Don't Lead with Social Identifiers

Social identifiers are identities that are a result of shared social constructs and include things such as racial identity, sexual orientation, gender identity, religious beliefs, size or weight, education level, age, belief systems, national identity, and socio-economic status. These may be important and empowering identities for our patients in their everyday lives; however, we need to consider whether this is relevant information to start with on a handover. When leading with these identifiers (John is an Englishman, or Emily is a lesbian) they will not always be medically relevant and may in fact open the door for bias. However, there are times when they will be initially relevant, for example when a patient holds a particular religious belief that may affect their health care pathway.

We all have some type of implicit bias. As clinicians, it is important that we identify and address our own implicit bias for the betterment of our patient care. This will ensure that we can align our patients with the health care pathway they need rather than the health care pathway we think they deserve based on our unaddressed implicit bias.

STIGMATISING A PATIENT REGARDLESS OF THE REASON CAN AFFECT THEIR OVERALL HEALTH CARE JOURNEY

References

Chapman, E. N., Kaatz, A. & Carnes, M. (2013). Physicians and Implicit Bias: How Doctors May Unwittingly Perpetuate Health Care Disparities. Journal General Internal Medicine 28, 1504–1510. https://doi.org/10.1007/s11606-013-2441-1

Healy, M., Richard, A., & Kidia, K. (2022). How to Reduce Stigma and Bias in Clinical Communication: A Narrative Review. Journal of General Internal Medicine. https://pubmed.ncbi.nlm.nih.gov/35524034/

FitzGerald, C., & Hurst, S (2017). Implicit bias in healthcare professionals: a systematic review. BMC Medical Ethics, 18(19). https://doi.org/10.1186/s12910-017-0179-8

Bolton, J. (2012). 'We've got another one for you!' Liaison psychiatry's experience of stigma towards patients with mental illness and mental health professionals. The Psychiatrist, 36(12), 450-454. https://doi.org/10.1192/pb.bp.112.038646

Cherry, K. (2020). How does implicit bias influence behaviour? Explanation and impacts of unconscious bias. Verywell-mind. Retrieved 19 September 2022 from https://www.verywellmind.com/implicit-bias-overview-4178401

# TRANSCUTANEOUS PACING IN THE PRE-HOSPITAL ARENA

By **Tim Bonser**
Diploma Ambulance Paramedic Studies, Grad Dip Emergency Health (MICA)
Certified Cardiac Device Specialist Heart Rhythm Society
Disclosure: Clinical Territory Manager for Boston Scientific Cardiac Rhythm Management

Transcutaneous pacing (TCP) in the setting of bradycardia with extremely poor perfusion is an accepted intervention for patients unresponsive to pharmacologic interventions.[1] It involves the application of electrodes to the thorax that allow a prescribed amount of energy to be delivered across the heart with the aim of electrically stimulating contraction. This article will examine the process, discuss key points of consideration, and look at best practices to ensure the highest levels of success.

## How does TCP work?

A pacing delivery device is designed to stimulate cardiac contraction by delivering a prescribed amount of energy over a set pulse width between two external electrodes to cause spontaneous depolarisation of all non-refractory cardiac myocytes, leading to cardiac contraction[2]. Depending on the mode of operation, the device will then set a timing cycle, and if no subsequent ventricular activity is sensed during this time, another pacing impulse will be delivered. This is referred to as demand or cardiac synchronous pacing. The alternative is fixed or asynchronous pacing, which is where the device will pace irrespective of cardiac activity. This is typically used when there are issues with cardiac sensing (poor sensing, EMI interference). This mode is typically a secondary option as there is a very small but real risk of delivering an impulse during the supernormal period of the T wave and inducing a ventricular arrhythmia. TCP is largely effective at raising perfusion through this means; however, it is extremely unpleasant for the patient, requiring sedation in many circumstances for it to be tolerated.

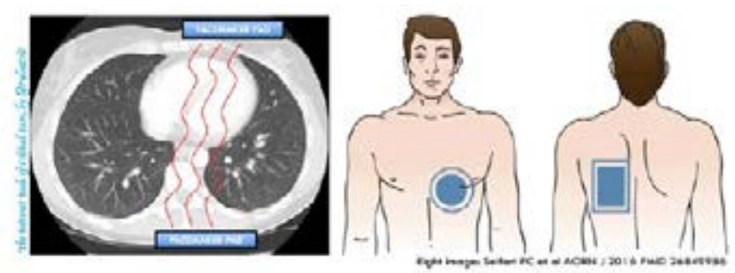


Figure 1: Pad placement and vector for energy delivery (https://emcrit.org/ibcc/bradycardia/)

## Best practices for setup and rationale

- Use new and in-date electrode pads/ECG dots: Accurate sensing is essential during demand mode. Dried pads reduce sensing capacity and increase impedance for pacing electrodes.
- Place pads/ECG dots (if required) correctly: Impedance (resistance to flow of electricity) is the enemy. The reason behind placing pads in the antero-posterior position is that it reduces the distance between the pads while still capturing the cardiac mass, hence reducing the impedance. As impedance across the circuit rises, so does the energy required to achieve depolarisation. TCP is unpleasant and at times intolerable for the patient, so minimising energy delivered is both considerate to the patient and may reduce the demand for sedation. TCP depolarises not only cardiac myocytes, but pectoral and skeletal myocytes as well. Application over dry and clipped skin, with attention paid to avoiding air bubbles, is necessary not only for ensuring impedance is minimised, but also for TCP frequently induced burns to the skin at the electrode/tissue interface over a short period of time (see Figure 2). ECG dots are critical for appropriate sensing (unless incorporated into the pacing electrode), so placement over dry, clipped skin is essential.
- Ensure that you understand how proper electrical capture is identified.

Effective TCP requires consistent electrical capture leading to cardiac contraction. Figure 3 shows discrete pacing spikes followed by broad complex QRS complexes and typically large T waves. Failure of electrical capture is demonstrated in Figure 4, showing a narrow complex high-grade junctional AV block, disassociated P waves, and arrows showing delivery of pacing spike without corresponding electrical capture.



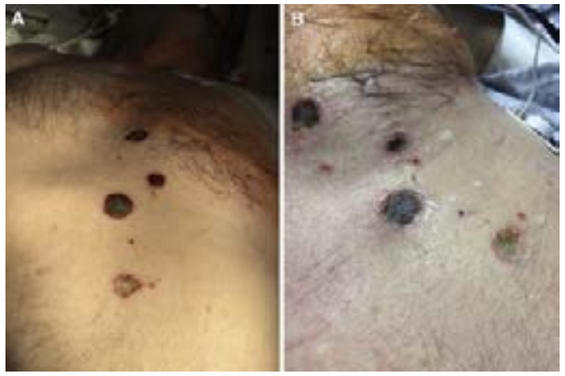



Figure 2: Burns from TCP (https://els-jbs-prod-cdn.jbs.elsevier-health.com/cms/attachment/b8603f3d-9566-4957-94c5-42fcd-c4ed11c/gr2.jpg)

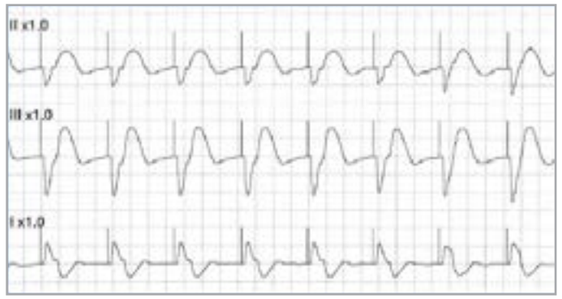



Figure 3: Consistent electrical capture with TCP (https://www.aclsmedicaltraining.com/blog/transcutaneous-pacing-tcp-without-capture/)

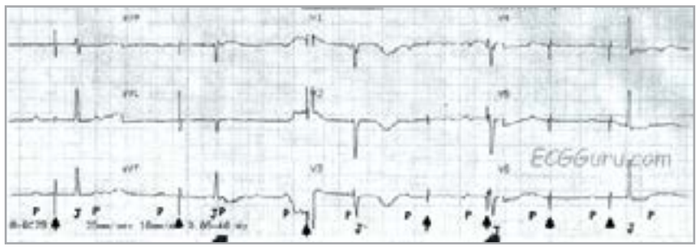



Figure 4: Failure to capture with TCP (https://www.ecgguru.com/ecg/failure-capture)

The next challenge is ensuring there is subsequent mechanical capture. A palpable pulse may not be a reliable indicator given the spasm with each delivery of pacing impulse. Check for electrical capture then incorporate other signs of perfusion status (conscious state, auscultated blood pressure, waveform on plethysmograph, skin presentation).

## Typical indications for use of TCP

Indications vary dependent on service. The aim of TCP depends on the clinical scenario. It can act to elevate cardiac rate in third degree heart block patients, raise rate during bradycardia with acute left-sided heart failure to shift volume off the left heart, increase pump function during cardiac ischaemia or protect against bradycardic induced Torsades de Pointes due to QT prolongation[3]. The likely value of Atropine as part of patient management in the heart block setting depends on the position in the conduction system where block is occurring. Broad complex low-grade block is unlikely to respond to Atropine in this circumstance, but its use is still indicated.

TCP is contraindicated in patients with severe hypothermia, largely due to the elevated risk of inducing ventricular arrhythmias[4]. The use of TCP for patients in asystolic cardiac arrest is only a consideration if the degradation into asystole in witnessed and TCP can be started immediately. The amount of energy required to induce cardiac contraction through external stimulus rises sharply due to hypoxia, hence pacing should only be considered at the very onset of asystole. TCP also requires appropriate electrode contact and its use may be difficult with severe diaphoresis. Consideration must also be given to patients with cardiac ischaemia given that a rising heart rate carries subsequent elevation of myocardial oxygen demand. This can lead to a negative sequela of events due to increasing cardiac hypoxia.

TCP is an all-or-nothing intervention. In the setting of improved perfusion secondary to external pacing, the only suggested alteration could be to reduce the rate of pacing. Reducing the delivered energy may be of some benefit to increasing tolerance; however, capture may be lost again and a higher amount of energy to restore the effect may be needed. Pay strong attention to coaching patients, metering sedation/adrenaline infusions and working on root causes.

## Summary

TCP is an accepted and valuable intervention for bradycardic and hypoperfused patients in combination with pharmacologic interventions. Success in its employment centres on ensuring best pad/ECG dot condition and placement, good understanding of electrical capture, appreciation of considerations, and adherence to guidelines.

References:

1. Sunjeet Sidhu, Joseph E, 2020, “Marine, Evaluating and managing bradycardia”, Trends in Cardiovascular Medicine, Vol 30, Issue 5, 2020, pp. 65-272. https://doi.org/10.1016/j.tcm.2019.07.001
2. Ellenbogen K, Wilkoff B, Kay G, et al., Clinical Cardiac Pacing: Defibrillation and Resynchronization Therapy, 5th edition, Elsevier. https://www.sciencedirect.com/book/9780323378048/clinical-cardiac-pacing-defibrillation-and-resynchronization-therapy
3. Agusta, L. S., Riswati, H. P., Akbar, R. R., & Rizal, A, 2018, “Bradycardia-Induced Recurrent Torsade de Pointes: When Serenity Turns into Chaosity”, International Journal of Cardiovascular Practice, 3(4), 83-86. https://doi.org/10.21859/ijcp-03045.
4. Doukky R, Bargout R, Kelly RF, Calvin JE, 2003, “Using transcutaneous cardiac pacing to best advantage: How to ensure successful capture and avoid complications”, J Crit Illn. May; 18(5): 219-225. PMID: 30774278.


LOVE YOUR COVER? TELL ANOTHER.

**Refer an eligible family member or colleague to join Emergency Services Health, and you and your referred member will have the chance to win your premiums paid, by us, for a year!***

Just ask them to mention your name as who referred them and use the code 'REFER' when joining our Fund before 31 January 2023 - we'll take care of the rest*.

*T&Cs apply, visit eshealth.com.au/winmypremiums or call it in **1300 703 703.**

Voted #1 Member Satisfaction 2021 · Voted #1 Customer Service 2021 · Voted #1 Better Claim Rebates 2021 · Voted #1 High Quality Private Health Insurance 2021 · Voted #1 Trustworthy 2021 · Voted #1 Most likely to recommend 2021

EMERGENCY SERVICES HEALTH

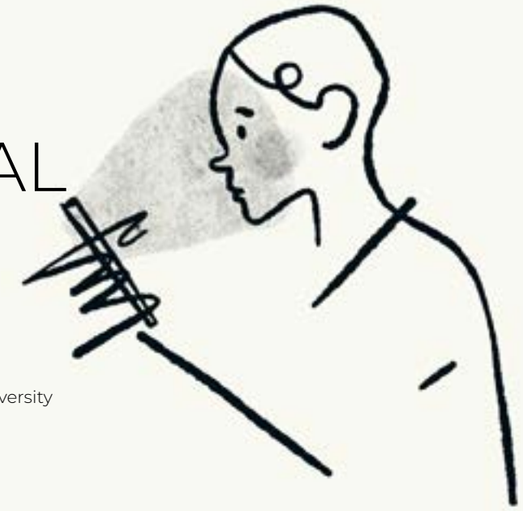
COVER LIKE NO OTHER

A Members Health Fund

Emergency Services Health Brought to you by Police Health Limited ABN 86 135 221 519. A registered, not-for-profit, restricted access private health insurer - first established in 1935. © Copyright. IPSOS Healthcare & Insurance Australia research survey conducted in 2021, and conducted every two years. *Promotion period: 1/11/22 – 31/01/23. Prizes: 2 x private health insurance policies paid for 12 consecutive months up to the value of $10,717.35 each. One random electronic draw (Permit 1224) on 17/02/23, 02:30 pm ACDT (or re-draw, if necessary, on 21/03/2023) at Police Health Limited, 320 King William Street, Adelaide SA. Winners advised by phone & email by 22/02/23 and in member Newsletter on 17/03/2023 (and any re-draw in April 2022). Permits: ACT TP 22/01880; NSW TP/00420; SA T22/1543.


RESEARCH

# PARAMEDIC REGULATION AND THE SOCIAL CONTRACT



By **Buck Reed**, Lecturer in Paramedicine, Western Sydney University

In 2018, paramedicine in Australia entered the National Accreditation and Registration Scheme (NRAS) for health professionals. This scheme, supported by the Health Practitioner Regulation National Law, brought Australian paramedics into a centralised regulator framework with shared regulatory responsibility between the Paramedicine Board of Australia and the Australian Health Practitioner Regulation Agency and, in some cases, state-based agencies.

Likewise, in Aotearoa New Zealand, paramedics were designated by the Health Practitioners Competence Assurance (Designation of Paramedic Services as Health Profession) Order 2019 as a health profession. As a result, on 1 January 2020 paramedics became subject to the Health Practitioners Competence Assurance Act 2003 (HCPA Act). The HCPA Act is the legislative instrument in Aotearoa New Zealand designed to provide protection to the public and establish health practitioner scope and competency. This triggered the establishment of Te Kaunihera Manapou, the New Zealand Paramedic Council, as the responsible regulatory authority for paramedics under the HCPA Act. Registration for New Zealand paramedics opened on 12 March 2021.

For both countries, the registration of paramedics has been a key area of interest. However, from the point of view of many practitioners, the purposes of regulation may not be as readily apparently. Ambulance services in both countries emerged at the end of the 19th century. The purpose of these early services was the conveyance of the sick and injured to the care of health professionals, at that time, doctors and nurses. Over time, paramedicine in both countries developed, particularly in the latter half of the 20th century, into an occupation where paramedics shifted their focus from being primarily engaged in transport to being primarily engaged with patients (Williams et al., 2009; Newton & Hodge, 2012; Pollock, 2013; Makrides et al., 2020).

## The Social Contract

The concept of the social contract emerged in the 17th and 18th centuries, most notably the work of the philosophers Thomas Hobbes, John Locke and Jean-Jacques Rousseau. Originally a political concept, the social contract outlines the relationship between populations and those who govern them.

In its original iteration, it was assumed that society was an artificial construct. The natural state of humans is unlimited freedom with no rules or order. However, for organised societies a structure needs to be created to provide order and enforce rules and customs. This takes the form of the state (Wraight, 2008). Society cedes some power and responsibility to the state to perform these functions of organisation. However, the state requires the sanction of the population for legitimacy and mandate. In this way, the needs of the state and of society are interdependent (Cruess & Cruess, 2016).

We can equally apply the social contract to professions. All professions gain legitimacy through community sanction; that is, society empowers a profession to perform its role (Greenwood, 1957; Reed, 2019). In this sense, the social contract between a profession and society creates a relationship, which may have previously existed historically (as is the case with medicine) where there are expectations and responsibilities on both the profession and the community they serve.

The social contract between medicine and the community has been increasingly explored over the past 30 years as a way to position the profession of medicine within society. Cruess (2006) outlines the mutual expectations between

Photo by visuals on Unsplash

medicine and society. The public expect doctors to be competent and able to provide the services and advice required. It is expected that doctors are trustworthy and focused on the patient's needs without self-interest. This is essential for the level of trust required for a patient to share personal information or expose themselves to intrusive procedures.

Patients expect doctors to have integrity and operate within a moral framework. The public expects doctors to work in the public good and be interested in issues of public health as well as the interests of individual patients. The public expects doctors to be transparent and clear about how they operate and the policies to which they adhere. Finally, the public expects doctors to be accountable. Given the power doctors hold over individual patients and in society in general, doctors need to be accountable to the people who grant them the status, power and privilege they enjoy. Additionally, doctors are increasingly financially accountable to ensure that they are using resources appropriately and ensuring health care is financially accessible to people.

Conversely, medicine also has expectations of the public. Firstly, doctors expect autonomy; that is, to be able to make decisions and act in a way that is in the interest of their patients. Autonomy is one of the key elements of a profession, particularly in the capacity to self-regulate (Freidson, 2001). Doctors expect trust. While there are exceptions (and thus the need for accountability), doctors work for the good of the public and their individual patients. Society should trust their decisions and allow them the latitude to make and follow policy that doctors believe is appropriate.

Medicine also seeks a monopoly over their area of professional work. As a result, laws and restrictions exist which limit a range of health care activities to doctors. Likewise, financial systems are designed to grant doctors specific domain over certain health care activities. This is combined with social structures that position medicine to perform certain types of roles in society. Medicine, like any profession, seeks status and reward. Medicine enjoys a place of respect in society for the role it plays. Equally, doctors seek reasonable compensation for the work they do, especially given its importance and the skill and training required to undertake it.

Medicine, with a complex knowledge base and extensive scope, has enjoyed self-regulation since the 19th century. This recognises the trust in the community to grant medicine the right to regulate itself within legal boundaries and guidelines. Self-regulation is both a privilege to the profession and a form of accountability, as failure of self-regulation erodes the trust in a profession by the community. Finally, medicine seeks a functional health system. It looks to society, and both the state and the market, to provide a framework in which doctors can apply their profession with sufficient resources to support their work.

Many of the same elements that underpin the status and function of medicine as a profession increasingly apply to paramedicine. In the early days of ambulance services, the focus was on providing a service, i.e., transport. The social contract was relatively simple. When people accessed an ambulance, they had an expectation it would convey them to some form of care, normally a hospital. However, as paramedics started to grow and develop, increasing their scope and training, and most importantly changing their role in health care, the social contract required redesign as paramedics became a more disruptive and innovative element in health care (Newton et al., 2020).

This also brought greater autonomy and independence. The role of paramedics moved from being one where the expectation was conveyance to one where the paramedic became a partner in the patient's health care decisions. They provided assessment, treatment, education, care planning, recommendations, etc. In this context, the social contract between paramedics and the community changes, creating a relationship between practitioners and patients rather than simply being a service provider.

Additionally, the decisions paramedics make are increasingly based on the knowledge of the practitioners supported by evidence-based guidelines and practice rather than prescriptive, algorithmic protocols created and authorised by other health professions. In this sense, by accepting more responsibility for patient care and playing a more active role in creating person-centred outcomes, paramedics accept more autonomy and more responsibility for their actions, omissions and decisions.

### Professional Regulation and the Social Contract

Regulation of a health profession is seen as one of the key elements in this shifting social contract (Cruess, 2006). Regulation of professions provides the community with a clear voice in their social contract with a health profession and provides a way of moderating this contract to ensure the profession meets its obligations (Reed, 2019). This mechanism is critical to ensuring that paramedicine recognises the sanction of the community to perform these roles and do so in a way which continues to be focused on the needs of the community and its members.

Regulation comes in many forms. These include market driven functions, title protection, licensing, and self-regulation (Freidson, 1983; Irvine, 2016). Self-regulation is predicated on the involvement of the profession itself in regulation. A self-regulated profession determines the role of itself and its membership in the social contract and sets codes, standards, and practices which support the responsible conduct of profession members in support of the social contract (O'Meara et al., 2018; Moritz, 2019).

While market regulation (status and quality are moderated by demand) and bureaucratic regulation (such as licensing) are commonly used for many occupations, self-regulation (either independently or in a co-regulatory framework such as the NRAS) is considered the most appropriate form for a highly developed profession with a complex body of knowledge. Self-regulation recognises the trust of the society in a profession to regulate itself and take responsibility for its engagement with the social contract.

Regulation is a critical mechanism in moderating the social contract between paramedics and the public they serve. Such sentiments echo Flexner's report examining medicine in 1910. One of the key observations was that unchecked, medicine's autonomy created a risk to the public as the profession had developed its professional identity in isolation (Borkan et al., 2021). Regulation presents a critical mechanism to mediate a profession's identity through reference to the safety, needs and expectations of the community it serves (Irvine, 2016). In this sense, regulation balances the autonomy and accountability of paramedicine as it evolves, and this is especially crucial given the speed at which this growth is occurring.

In this sense, the Paramedicine Board of Australia and Te Kaunihera Manapou are the moderators of the social contract for paramedicine in their respective countries. They represent society to ensure paramedics are accountable both by setting standards which underpin good and competent practice, and by issuing sanctions in cases where a practitioner has failed to meet the expectations of the social contract.

### Research Into Regulation and the Social Contract

Research into the social contract is critical for helping understand the position paramedicine holds within society and the responsibilities of practitioners. Exploring the social contract helps paramedicine meet the expectations of society and develop professional policies and norms that support the social contract. The social contract is also important in exploring the paramedic identity as it helps the profession position itself within society and understand how society views it and its members. Regulation of paramedicine and paramedicine's social contract are underexplored areas which underpin a broader understanding of the profession, its unique professional identity and its changing role in society.

Photo by visuals on Unsplash

References:

Borkan, J. M., Hammoud, M. M., Nelson, E., Oyler, J., Lawson, L., Starr, S. R., & Gonzalo, J. D. (2021). Health systems science education: The new post-Flexner professionalism for the 21st century. Med Teach, 43(sup2), S25-s31. https://doi.org/10.1080/0142159x.2021.1924366

Cruess, Sr. (2006). Professionalism and medicine's social contract with society. Clinical Orthopaedics And Related Research, 449(449), 170-176. https://doi.org/10.1097/01.blo.0000229275.66570.97

Cruess, R. L., & Cruess, S. R. (2016). Professionalism and professional identity formation: the cognitive base. In R. L. Cruess, S. R. Cruess, & Y. Steinert (Eds.), Teaching Medical Professionalism: Supporting the Development of a Professional Identity (2 ed., pp. 5-25). Cambridge University Press. https://doi.org/10.1017/CBO9781316178485.003

Freidson, E. (1983). The reorganization of the professions by regulation [journal article]. Law and Human Behavior, 7(2), 279-290. https://doi.org/10.1007/bf01044529

Freidson, E. (2001). Professionalism, the third logic: on the practice of knowledge. University of Chicago press.

Greenwood, E. (1957). Attributes of a profession. Social work, 45-55.

Irvine, S. D. (2016). Professionalism, professional identity, and licensing and accrediting bodies. In R. L. Cruess, S. R. Cruess, & Y. Steinert (Eds.), Teaching Medical Professionalism: Supporting the Development of a Professional Identity (2 ed., pp. 201-216). Cambridge University Press. https://doi.org/DOI: 10.1017/CBO9781316178485.016

Makrides, T., Ross, L., Gosling, C., & O'Meara, P. (2020). The structure and characteristics of Anglo-American paramedic systems in developed countries: A scoping review protocol. Australasian Journal Of Paramedicine, 17. https://doi.org/10.33151/ajp.17.787

Moritz, D. (2019). National Paramedic Regulation. In D. Moritz (Ed.), Paramedic Law and Regulation in Australia (pp. 127-151). Thompson Reuters.

Newton, A., & Hodge, D. (2012). The ambulance service: the past, present and future. Journal of Paramedic Practice, 4(7), 427-429. http://ezproxy.uws.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=rzh&AN=104490307&site=ehost-live&scope=site

Newton, A., Hunt, B., & Williams, J. (2020). The paramedic profession: disruptive innovation and barriers to further progress. Journal of Paramedic Practice, 12(4), 138-148.

O'Meara, P., Wingrove, G., & McKeage, M. (2018). Self-regulation and medical direction. International Journal of Health Governance, 23(3), 233-242. https://doi.org/10.1108/IJHG-02-2018-0006

Pollock, A. (2013). Ambulance services in London and Great Britain from 1860 until today: a glimpse of history gleaned mainly from the pages of contemporary journals. Emergency Medicine Journal: EMJ, 30(3), 218-273. https://doi.org/10.1136/emermed-2011-200086

Reed, B. (2019). Professions and Professionalism. In D. Moritz (Ed.), Paramedic law and regulation in Australia (First ed., pp. 107-126). Thomson Reuters (Professional) Australia.

Williams, B., Onsman, A., & Brown, T. (2009). From stretcher-bearer to paramedic: the Australian paramedics' move towards professionalisation. Australasian Journal Of Paramedicine, 7(4).

Wraight, C. D. (2008). Rousseau's' The Social Contract': A reader's guide. A&C Black.

booktopia
Australia's local bookstore

Books for students, graduates and employed paramedics

Resources for skill development, clinical placement and professional learning

SCAN TO REDEEM:

SAVE 10% OFF YOUR NEXT BOOKTOPIA ORDER.*
Scan the QR code or log in to your Australasian College of Paramedicine membership portal to redeem.

*Cannot be used in conjunction with any other offer. Offer applied at checkout. Does not apply to digital subscriptions, eBooks, magazines, Gift Certificates or the cost of shipping & handling.

NEW

eLearning portal for members

Innovative online learning relevant to paramedics of all practice levels

- All eLearning is 100% online, self-paced and specifically developed for paramedics
- Case studies and activities are based on real-world examples, encouraging the transference of skills and knowledge to real life practice
- Study areas include obstetrics, neurology, palliative care, training and mentoring and mental health

Visit paramedics.org/education to enrol in your eLearning course

@ACParamedicine

Australasian College of Paramedicine®



# SEA CHANGE: MAKING WAVES IN THE RESEARCH SPACE

**Bathurst, Wiradjuri Country**

It was surf lifesaving that piqued New South Wales Ambulance paramedic Jeremy Kuiper's interest in research and his passion for teaching.

As a 16-year-old at Wollongong's Fairy Meadow Surf Lifesaving Club, he began helping out with training courses before gaining his training and assessor certificates and ultimately being appointed Director of Education, a position he holds to this day.

"I saw that there were a limited number of educators in the club and I wanted to be involved in that, and I really enjoyed passing on what I'd learned and what I knew to other people and helping them to achieve their goals."

He went on to complete a Bachelor of Medical and Health Sciences degree at the University of Wollongong. On finishing his degree, he realised paramedicine was his calling. A move to Bathurst and a Bachelor of Clinical Practice (Paramedic) followed, where he went to work for a Registered Training Organisation conducting first aid training and assisting students in their paramedic diploma course before starting work with NSWA.

Working in the research and education space still remained a goal, and through the College he was able to start organising webinars and is now one of the College's CPD educators.

"The webinars were a good foot in the door, and then I was given the opportunity to do a case presentation on 'An Unexplained Syncope' at the College's International Conference in September. I thought that was another step in the right direction to start getting involved in higher education-level paramedicine."

Thus far, Jeremy's research has predominantly revolved around cardiology, an area in which he has a great interest, particularly in terms of his own professional growth and knowledge-building, although he hasn't yet settled on a future specialisation. And while he foresees working in the education field in the future, he wants to maintain a balance between on-road paramedicine and academia.

"I'm interested in progressing to Intensive Care Paramedic within NSWA. I think it's important to stay in that clinical space. I'll also push myself more towards education, but I don't want to lose that on-road aspect."

For other paramedics wanting to embark on a similar research/presentation trajectory, he recommended choosing a topic that was of interest and one in which they weren't necessarily proficient.

"That was a big driving force for me. I enjoyed researching, I learned along the way, and I think that's important. And pick something that is going to be relevant to your colleagues and relevant to actually working. Have a chat to your colleagues and the people around you and see if they agree.

"From there, work out what's actually relevant and what's not. There are a lot of things that are really interesting and are good to know, but they may not affect your day-to-day practice. So work out the things that are really relevant to what you do and then spend time speaking to other paramedics and educators for their perspectives.

## CHANCES ARE THAT IF YOU FOUND IT INTERESTING AND YOU LEARNED FROM IT, OTHERS WILL BENEFIT FROM IT AS WELL

"I would also advise picking something that's not part of your run-the-mill job, or something that didn't quite go to plan, something that you found challenging or something that you learned from, because chances are that if you found it interesting and you learned from it, others will benefit from it as well."

In terms of presenting, he said a good presentation made people think, kept them interested and made them want more. And importantly, less is more - less written word, more substance and engaging talk.

And while it was natural to feel nervous, particularly the first time, he said it built confidence and provided a sense of accomplishment and personal pride.

"I'd encourage those who are interested to give it a go. You've got nothing to lose and a lot to gain."

# READY, SET, FREE CARE: IMPACTFUL PARAMEDIC PLACEMENT

By **Ali Rengers**
Brisbane, Turrbal and Jagera Country


Imagine a student paramedic placement program that not only offers students the opportunity to experience frontline health care, but also provides a primary link for vulnerable people to access basic health assessments. We present a MacQuarrie pioneered student paramedic program administering health checks at a local community hub, benefiting student paramedics and clients alike.

Founded by Edith and Mal Kennedy, the Set Free Care Community Hub, located on Queensland's Gold Coast, is a drop-in centre designed to provide a supportive and safe environment for vulnerable members of the Gold Coast community. It is a charity that aims to make a difference in the lives they support through the provision of basic human necessities including meals, showers, community connections, referrals and togetherness[1].

Student paramedic involvement with Set Free Care was pioneered by Griffith University Senior Lecturer Dr Sandy MacQuarrie in January 2021. His friendship with Edith and Mal and recognition of their passion, hope and goals for Set Free Care sent his mind into action. Dr MacQuarrie believed that student paramedic involvement with the clients at Set Free Care would not only benefit the health of those individuals, but also the experience of the student paramedics, and he was prompted to set up a meeting with the founders.

On the morning of his meeting, as he stepped through the door, a Set Free Care volunteer was bitten by a dog and his skills as a paramedic were required. The patient was well taken care of and Dr MacQuarrie's case for the care that student paramedics could offer the individuals at Set Free Care was made for him. After further discussion with the founders and paramedicine program staff, and a thorough restocking of the extremely understocked Set Free Care first aid kit, Set Free Care Placement for student paramedics was born.

THE RICH INTERACTIONS BETWEEN CLIENTS AND STUDENT PARAMEDICS ARE EXTREMELY VALUABLE

Set Free Care Placement is a unique Australian paramedic educational program. Each week on Tuesday and Friday between four to six, Griffith University student paramedics meet a paramedic sessional or lecturer from Griffith University at Set Free Care. Over a period of three hours, under the supervision of the registered paramedic, the students offer free health checks to clients using the same basic diagnostic equipment they have encountered in their studies and on ambulance placements. Clients may wish to have a student paramedic capture an ECG of their heart, check their blood sugar levels, or may prefer to have a discussion about the difficulties they are facing in their life. It's up to the clients.

Dr MacQuarrie believes the rich interactions between clients and student paramedics and the ability for these students to talk with someone who is "travelling rough" are extremely valuable. As one of those student paramedics who was fortunate to be involved since 2021, I can attest to the richness of the interactions between myself and the clients.

While classroom learning is necessary to acquire the skills required to be a paramedic, it can never truly prepare you to talk with someone from a completely different background or walk of life. Assessing a non-speaking, non-moving plastic mannequin during a university scenario is planets away from discussing and treating a laceration on a client's foot at Set Free Care Placement. Working in the operational environment that is Set Free Care Placement fosters responsibility and independence, both qualities that are required in paramedic professional roles[2].

INTERACTIONS WITH REAL PATIENTS ENABLES STUDENTS TO TRANSITION THEIR CLASSROOM LEARNING TO THE REAL WORLD

Studies have shown that student clinical skills improved significantly during clinical placements in a supportive atmosphere with positive student-instructor relationships[2]. The program is conducted to make you feel that the client you are talking to or assessing is in your care while the supervising registered paramedic sessional or lecturer is there to assist when required or asked. Interactions with real patients who have health issues and problems enables students to transition their classroom learning to the real world, preparing them for ambulance placement and their future careers.

Clients of Set Free Care benefit from the student paramedic-client interaction as they have their medical needs more easily assessed and met in the security of the familiar space that is the Set Free Care Community Hub. A table with some basic monitoring and diagnostic equipment is set up in a corner of the community hub with chairs placed around it to encourage clients to sit down if they wish to be assessed. Student paramedics are encouraged to introduce themselves and not turn the monitor on or open a medical kit until they have explored what has brought the client to visit them. This ensures that the clients are listened to by the student paramedics to help build rapport and foster trust between the two parties before any clinical work takes place.

The Set Free Care Placements I have attended as a student paramedic during my degree have had personal benefit. In one instance, I talked with a tense client about her current living situation, and she shared with me her concerns regarding her mental health. Her willingness to open up to me meant I was able to refer her to a phone counselling service that was both convenient and accessible. To me, providing a phone number for a referral is no huge feat; however, to her it was the world and she gave me a huge hug when leaving the community hub that day.

During the debrief of the placement session, I realised her delight over the phone number was really relief at having unburdened herself of her concerns and her gratefulness that someone was willing to listen and try to help her. It is well known that big actions such getting an IV in or putting a pelvic binder on a patient can make a life-or-death difference. However, in this fast-moving, unpredictable and sometimes callous pre-hospital setting, it is imperative to remember that small actions, such as actively listening and acknowledging a patient, can make a world of difference to their receptiveness to receive healthcare and trust health care providers.

The future of paramedicine is and will always be changing. Pioneering programs such as the Set Free Care Placement designed and implemented by Dr Sandy MacQuarrie benefit students and clients alike. More work to replicate similar support programs, and more research to improve such programs, can only improve health outcomes for people and better prepare our future paramedics.

Reprinted from The Shift Extension.

References

1. Set Free Care. About set free care: A demonstration of love and good will [Internet]. Australia: Set Free Care; [updated 2022; cited 2022 Aug 03]. Available from: https://www.setfreecare.org/about-us

2. Brewster L. Effects of clinical placements on paramedic students' learning outcomes. Asia Pac. J. Health Manag. [Internet]. 2017 [cited 2022 Aug 3];12(3):24-31. Available from: https://www.researchgate.net/publication/326436933_Effects_of_Clinical_Placements_on_Paramedic_Students'_Learning_Outcomes

# WAYS TO LOSE YOUR JOB...

## PART 2

By **Michael Eburn**

In *Ways to lose your job*... Part 1 (published in the last issue of Response), I discussed how challenging public health programs – and COVID 19 vaccination requirements in particular – has cost paramedics both their registration and their jobs. Today I continue looking at how paramedics can self-destruct their careers with an analysis of reported unfair dismissal cases.

The value in this exercise is to identify the type of behaviour that has seen paramedics dismissed, as well as the circumstances where that dismissal has been "unfair". Identifying the circumstances that have led to a dismissal and whether it was or was not unfair will help guide current paramedics in their understanding of what is and is not acceptable in the workplace and what they can expect from their employer.

### What is unfair dismissal?

Legislation provides remedies for people who are subject to "unfair dismissal". Remedies are provided for in the Fair Work Act 2009 (Cth) and in state legislation, for example the Industrial Relations Act 1996 (NSW).

Dismissal is unfair if, in the opinion of the relevant Commission or Tribunal, it was "harsh, unjust or unreasonable".[1] That is a very broad set of criteria and gives the decision-maker wide discretion. In considering whether a decision to dismiss an employee was unfair, the decision-maker looks at the employee's conduct and also at the employer's processes - was the employee given adequate notice of the employer's concerns, were they given a chance to respond, where the issue is poor performance, were efforts made to assist the employee to perform to the employer's expectations, etc.[2]

### Identifying the cases

The method for identifying cases for discussion was to conduct a search on the publicly available case law databases hosted by the Australian Legal Information Institution (AustLII). The search was a Boolean search for "((paramedic or ambulance) near "unfair dismissal")". The search identified 60 cases.

Twenty-four cases were identified by coincidence; that is, they were unfair dismissal cases that may have cited an ambulance case or for some reasons the term "ambulance" or "paramedic" was used, but the case was not about the dismissal of a paramedic.

Of the remaining thirty-six cases, five involved paramedics who filed an application for unfair dismissal but then took no further part in proceedings; that is, they did not file supporting evidence or appear at any hearing. These cases were dismissed without discussing the behaviour that had caused their employer to terminate their employment.

In one case, the Industrial Relations Commission of Western Australia determined that there was no jurisdiction to hear the matter. The application was dismissed without any discussion of what the applicant was alleged to have done to warrant his dismissal.

With 29 cases left, a number involved multiple hearings, for example an application for procedural orders or a decision at first instance and then an appeal, and perhaps a further hearing if the appeal ordered the case back to the relevant tribunal. Reducing those to single cases there were applications by 16 individual paramedics. A very small number given the cases range over 24 years from 1998 to 2022.

It is recognised that the paramedics who are the subject of this discussion may still be working in the field or known to readers of this blog. While reporting on judicial decisions cannot be defamatory,[3] we recognise that the publication of names may cause embarrassment and is not strictly necessary to identify the lessons from the cases. Accordingly, in the discussion below, the names of the paramedics have been redacted and the citation of the cases omitted. The list of authorities is held by the author and can be made available on request.

We can now consider the reason these paramedics were dismissed varied across a range of behaviours.

### Failing to comply with COVID or influenza vaccinations

Three paramedics were dismissed for failing to comply with directions to obtain a COVID-19 or influenza vaccination. In each case, the relevant tribunal noted that the obligation to ensure staff were vaccinated came from the relevant health department. The employing ambulance services were required to comply with the direction. In each case, the decision to terminate the paramedics employment was confirmed. As the court said in one matter:

> The applicant exercised her free will and chose not to receive the influenza vaccination. She did so in the full knowledge that she would consequently be dismissed.
>
> The dismissal of the applicant was neither harsh, nor unjust, nor was it unreasonable.

### Work performance

Five paramedics were dismissed over behaviour at work or their work performance, including failure to follow lawful directions (other than with respect to vaccinations).

Mr G was dismissed from a private ambulance provider for failing to report to a different station and for refusing to use electronic time-recording services.

Mr M was dismissed for being absent from work or leaving work early to complete secondary employment, as well as allegations regarding his behaviour during the inquiry process.

Mr B was dismissed over his behaviour at a motor vehicle accident. He was alleged to have assaulted another paramedic and this was held to be sufficient to show he was not a fit and proper person to remain with NSW Ambulance. At the time, he was attending the accident as a member of the volunteer rescue squad and not the ambulance service.

Ms L's conduct necessitated her relocation on the basis of operational requirements. She refused to perform work in accordance with roster. This unreasonable conduct on the part of the applicant justified summary dismissal.

Finally, Mr K took training material home and was using it in his own training business. Police were called. The tribunal said, "I consider that both his taking of the material and his actions in misleading Mr Harvey [an investigator] are valid reasons for his dismissal".

### Clinical performance

Four paramedics were dismissed over issues of clinical care and performance.

Ms Ha, the most senior MICA paramedic treating a 15-year-old in cardiac arrest, directed other paramedics to withhold resuscitation in circumstances contrary to the relevant clinical practice guideline. An ALS Paramedic Educator pointed out that "the patient's ECG rhythm had changed (Sinus Bradycardia and Accelerated Idioventricular) and was associated with significant improvement in ETCO2 / patient skin colour". She was also found to have said "words to the effect of continuing resuscitation is 'flogging a dead horse'", and when told about the clinical indications in favour of resuscitation she said "words to the effect of 'I'm not going to fuck with the family'". Finally, she was also found to have lied to investigators reviewing the event.

Ms Ho was employed by a private contractor working at a BHP mine site. Staff from BHP complained about "... aspects of the applicant's conduct at work. These complaints included what could be described as allegations that the applicant conducted certain drug and alcohol testing procedures in an officious and unnecessarily insensitive manner". BHP in turn referred the complaints to Ms Ho's employer. Ms Ho also raised issue about her employment conditions with her employer and copied BHP into the correspondence. BHP exercised its right to exclude Ms Ho from the mine site with the result that she could not attend to perform her job, in which case her employment was terminated.

Mr R was alleged to have administered the drug fentanyl intravenously rather than intranasally as required by the Ambulance Services procedures.

Mr W, a flight paramedic with Ambulance Victoria, was found to have failed to respond to an urgent call in a timely manner in order to wait for the next crew to arrive so that he could hand over to the incoming crew rather than respond to the job.

### Drug use

Two paramedics were dismissed for drug use.

Mr C was dismissed for self-administering methoxyflurane while at work. The Industrial Relations Commission found that Mr C's continued denial of the conduct and the potential risk to patients justified his dismissal.

Mr M suffered an injury during his prior service in the Navy. He "self-administered intramuscular pain relief using midazolam and morphine. He admitted taking and self-administering the midazolam and morphine, and removing pages and falsifying entries in the Drug Register".

### Drug use

Two paramedics were dismissed for drug use.

Mr C was dismissed for self-administering methoxyflurane while at work. The Industrial Relations Commission found that Mr C's continued denial of the conduct and the potential risk to patients justified his dismissal.

### Fit for duty

Finally, two paramedics were dismissed on the basis that their employer thought they were no longer fit for duty.

Ms V was involved in a serious motor vehicle accident while driving an ambulance. Four years later, she applied to return to work; there were then delays while Ambulance Victoria had her assessed, etc. They determined she could not return to her duties. By the time it came before the tribunal, she had not worked for seven years.

Ms A suffered a back injury. She was taken "off road" and was working at the ambulance education centre. Although she had been working there for some time, she was not offered a permanent position due to her physical limitations. Although she had not been dismissed, she had been asked to show cause why her employment should not be terminated. Even without actual dismissal, the Industrial Relations Commission was prepared to hear the matter and determine if her dismissal would be unfair.

### The outcomes

The description of the facts, above, identifies why the paramedics were dismissed, but it does not say whether or not those dismissals were "unfair" or the allegations were made out. In fact, the various tribunals found that the decisions to dismiss the paramedics were "unfair" in half the cases, that is in eight out of the 16 applications, although that finding may have brought little comfort to the applicants.

### Unfair process

In most cases, the dismissal was found to be unfair because of the process that had been followed, not because the circumstances did not warrant dismissal. In Ms Ho's case, the tribunal found that her employer failed to make any inquiry about whether the complaints made could be established.

> ... the dismissal of the applicant was without valid reason involving established misconduct or capacity inadequacy. Further, the dismissal involved an entirely unjust and unreasonable process, including the complete absence of any opportunity for the applicant to be heard before the decision to dismiss was made.

By the time the matter was finalised, Ms Ho had found alternative employment, so she was awarded compensation.

In the matter of Mr W, the Fair Work Commission found that the conduct of Ambulance Victoria was unfair as they invited Mr W to respond to the allegation that he had been guilty of serious and wilful misconduct. They received and considered his submissions, found the offence established, and then proceeded to dismiss him without first inviting him to make any submissions that he might care to make on what would be the appropriate penalty - there was no "opportunity to address the range of possible outcomes available". Mr W did not get his job back. He, too, was awarded compensation, but given the statutory limits, the amount awarded was much lower than his projected loss of income.

The Industrial Court of Queensland upheld Mr C's appeal and found that his dismissal was unfair. Mr C had not been provided with all the evidence relied upon before the hearing, and that the ambulance service failed to comply with its own policy to refer officers for drug rehabilitation. The court did not make any final order; it was left to the parties to consider what the outcome should be given the Court's reasoning.

In MS L's case, Queensland Ambulance had begun the disciplinary process to determine if the allegations were made out, but then moved to summarily dismiss Ms L rather than follow the procedures to the end. The conduct by QAS was unfair as it denied her the opportunity to respond to the allegations even though the inevitable outcome would have been her termination. Although finding that there had been unfairness, there was no compensation ordered.

### Disproportionate response

In three cases, it was not the process that was found to be unfair but the determination by the employer that dismissal was the appropriate remedy; that is, dismissal itself was seen as too harsh or not warranted. In Mr G's case the tribunal said:

> In this case I am satisfied that the termination of Mr G's employment was a disproportionate response to his misconduct. Mr G mistakenly considered that he was entitled to notice of the change of location. Mr Douglas Dawson knew that this was the only reason Mr G did not comply with the direction. There was no evidence to suggest that had this issue been resolved, Mr G would have refused to comply with the direction. Further, there is no evidence that had Mr G's concerns about the Time Management System been responded to or if he had been given a direction that he would have not complied with a direction to enrol.

In the cases of both Ms V and Ms A, the relevant commission determined that the applicants should not have been dismissed because it was not established that they were not fit for duty. In the case of Ms V, the commission said:

> Before any ambulance paramedic, who has had an extended period of leave, resumes normal operational duties, they must undergo a knowledge gap analysis and receive any relevant training. Further, there can be no doubt that a community aim is to assist people who have been the subject of illness or injury to return to work if that is possible. Ms V wishes to return to work and both independent medical practitioners have not said that this is not possible. Ms V should be given this opportunity.

In Ms A's case, it was found that the decision to dismiss her was unfair given that she had been working well in the ambulance education centre and had been successful in her application for a permanent position save for her physical limitations. The Commission said:

> .. the applicant's threatened dismissal is harsh, unreasonable and unjust, and that the Commission should order the respondent not to dismiss the applicant. Moreover, the applicant should in my view return to work as an educator, this being a role well-suited to her professional capabilities, and the only role in employment with the respondent, on the evidence, which would presently seem suitable in conjunction with the return to work as a corollary of the order not to dismiss.

### Insufficient evidence

The dismissal of Mr R was unfair because the allegations were not and could not be proved to "comfortable satisfaction". The Commission ordered Mr R's reinstatement.

In the other cases, the dismissal was upheld with one anomaly. In Mr B's case, the decision at first instance was that the allegation of assault had not been established so the dismissal was unfair. This was set aside on appeal, where the full bench of the Commission held the Commissioner had fallen into error by failing to explain their reasoning and to resolve conflicting evidence as to what happened. The appeal bench took the view that the evidence was sufficient to show the assault had occurred. This was an unusual case as it was the only one where a first-instance decision in favour of the applicant was set aside on appeal.

### Conclusion

This analysis is intended to demonstrate the range of conduct that constitutes ways for a paramedic to lose their job. The data is of course limited. Only cases where an applicant has sought a remedy for unfair dismissal have been identified. It is likely that many more paramedics have been dismissed but they have not sought a remedy. They may have believed that the dismissal was fair, that the cost and effort of seeking a remedy exceeded any potential benefit, if the employer wants to sack them and do it unfairly they may no longer want to work there and/or they would rather leave quietly rather than bring proceedings in a public forum where all the facts are disclosed and are open to reporting in articles such as this.

Another limitation is that these are unfair dismissal cases. Other cases that would be relevant to identifying "ways to lose your job" would be public service appeals, where paramedics seek to appeal against disciplinary, for example, appeals against a finding of misconduct but before a decision on the penalty to be applied has been made, or where the penalty is something other than dismissal. Other relevant cases would be professional discipline decisions, particularly where paramedic registration is suspended or cancelled.

Even with those limitations, this analysis shows the range of conduct that can lead to dismissal - failure to follow an employer's lawful directions, inappropriate clinical care, drug misuse and questions of fitness for duty. This probably comes as no surprise, but putting it into context with specific examples hopefully confirms the lesson on "ways to lose your job". This analysis also demonstrates issues that must be considered by employers and employees when considering whether a dismissal is or is not "unfair". It is important for employers to apply their own disciplinary processes, to ensure that employees are given appropriate notice and the chance to respond, and that all options are considered.

References:

1. Fair Work Act 2009 (Cth) ss 385; Industrial Relations Act 1996 (NSW) s 84.
2. Fair Work Act 2009 (Cth) s 387; Industrial Relations Act 1996 (NSW) s 88.
3. Defamation Act 2005 (NSW) s 29.




**PBS Information:** Emergency Drug (Doctor's Bag) Supply only.

**Please review Product Information before prescribing. Product information is available from 1800 PENTHROX (1800 736 847) and medicaldev.com/penthrox-pi**

**MINIMUM PRODUCT INFORMATION – Penthrox® (methoxyflurane) Inhalation.**

**INDICATIONS:** For emergency relief of pain by self administration in conscious haemodynamically stable patients with trauma and associated pain, under supervision of personnel trained in its use and for the relief of pain in monitored conscious patients who require analgesia for surgical procedures such as the change of dressings. **CONTRAINDICATIONS:** Use as an anaesthetic agent; renal impairment; renal failure; hypersensitivity to fluorinated anaesthetics (including familial history of hypersensitivity) or any ingredients in Penthrox®; cardiovascular instability; respiratory depression; head injury or loss of consciousness; malignant hyperthermia. **PRECAUTIONS:** Not to be used as an anaesthetic agent; liver disease and liver damage after previous methoxyflurane or halothane anaesthesia; diabetic patients (may have an increased likelihood of developing nephropathy); paediatric patients (minimum effective dose should be administered); use in pregnancy and lactation, the elderly and regular exposure to health workers. **INTERACTIONS:** Antibiotics including tetracycline, gentamicin, kanamycin, colistin, polymyxin B, cephaloridine and amphotericin B; subsequent narcotics administration; concomitant use with CNS depressants (e.g opioids); treatment with enzyme inducing drugs (e.g. barbiturates); cautious use of adrenaline or nor-adrenaline during methoxyflurane administration; β-blockers. **ADVERSE EFFECTS:** Very common: Dizziness, headache; Common: Dry mouth, nausea, toothache, vomiting, feeling drunk, influenza, nasopharyngitis, viral infection, fall, joint sprain, increase alanine aminotransferase, increase aspartate aminotransferase, increase blood lactate dehydrogenase, back pain, amnesia, dysarthria, migraine, somnolence, dysmenorrhoea, cough, oropharyngeal pain, rash, hypotension, euphoria, diaphoresis, dysgeusia, flushing, hypertension, anxiety, depression, sensory neuropathy, confusion, musculoskeletal. **DOSAGE AND ADMINISTRATION:** One 3 mL bottle vaporised in a Penthrox® Inhaler. Up to 6 mL may be administered per day. The total weekly dose should not exceed 15 mL. Administration on consecutive days is not recommended. PI amended 13 December 2019.

**References: 1.** Penthrox® (methoxyflurane). Product Information. Australia. December 2019.
**2.** Coffey F, *et al. Emerg Med J* 2014;31(8):613-8.

Penthrox® is a registered trademark of Medical Developments International Limited. ABN 14 106 340 667.
4 Caribbean Drive, Scoresby, Victoria 3179. www.medicaldev.com. MDI0017. September 2022.

Penthrox® Methoxyflurane




# 60 YEARS OF THE **COUNCIL OF AMBULANCE AUTHORITIES**

If you were to take a look back at ambulance services 60 years ago, you would see absolutely no standardisation and an industry run by dedicated, yet untrained, staff. You'd see impractical vehicles working solely as delivery services, merely undertaking the task of transporting the sick and injured to hospital without any medical intervention along the way. Luckily, ambulance services today are enormously different than they were 60 years ago, but how did it happen?

For the past 60 years, The Council of Ambulance Authorities (CAA) has been facilitating fundamental collaboration in and beyond the Australasian pre-hospital sector. From working with telecommunications companies to making Triple Zero (000) the common number to be called for emergencies around Australia, to introducing national specifications for ambulances, we've facilitated change and transformation that has turned the sector into what it is today.

As the pre-hospital sector has grown and transformed, so has CAA. Our organisation is made up of a board consisting of the chief executives of the 11 statutory ambulance services in Australia, New Zealand and Papua New Guinea who are supported by a dedicated full-time secretariat - a vast change to the simple annual meeting that CAA solely functioned to host 60 years ago. A range of working groups, committees and forums function year round with ambulance service representatives collaborating on topical issues.

Each year, CAA runs multiple campaigns that are born out of these groups to raise awareness in the sector and create action on particular areas, including the Me First mental health and wellbeing campaign, Sustainable Ambulance, Take Five for Hand Hygiene, and the much-anticipated Women in Ambulance Awards. This year, the Women in Leadership working group launched the Women in Leadership Scholarship, which provided the well-deserving recipient with an AUD $7,000 fully funded leadership and personal development course.

The much anticipated and internationally renowned CAA Awards for Excellence were another initiative created 10 years ago to encourage and foster a collegiate sense of community alongside a healthy sense of competition and achievement. We continue to run the Awards for Excellence, with our member services looking forward to the Gala Dinner that comes along with the awards every year as a part of CAA Congress, the Australasian ambulance sector's premiere event.

Through all this, we also managed to find a way for CAA and member services to keep track of what we were doing. We introduced the Patient Experience Survey back in 2002 in Australia and 2007 in New Zealand and started contributing ambulance data to the Australian Report on Government Services. Both the survey and data have changed the ambulance sector into the evidence-based industry that it is today.

We're sure you'll agree that over the last 60 years, CAA, member services, and all within the sector have accomplished so much together. On November 17, CAA will be hosting a 60th Anniversary Gala to celebrate every achievement, milestone, and challenge from the past 60 years. The night will feature delectable cuisine, elegant black-tie attire, and exclusive entertainment, including a silent and live auction. The Gala will also play host to the launch of the "60 Years of CAA" anniversary book that features some of the biggest and most impactful stories from CAA and member services in the past 60 years.

We could not have accomplished all that we have without the collaboration and support from a range of diverse organisations that have worked so dedicatedly to elevate the industry. If you would like to get in touch with CAA about collaborations, partnerships, or sponsorships, please contact partnerships@caa.net.au. To learn more about CAA, it's members services and their output visit caa.net.au.

Here's to what another 60 years might bring!

# SKY'S THE LIMIT FOR **SAAS** VOLUNTEERS


Robert Furber, Patrick and Ashleigh

Volunteering with SAAS is a great opportunity for individuals to enrich their own lives while saving the lives of others. With more ambulance volunteers needed, it's a perfect way to gain skills that can be used in everyday life, as well as contributing to your own personal development.

Ashleigh and Patrick, who previously volunteered with the Kadina station, and Port Broughton station volunteer Robert can attest to this after their experiences as volunteers led them to take on further career opportunities with SAAS.

Graduate Paramedic Pathway recruit Ashleigh said volunteering provided a great knowledge base to start her learning journey and gave her a love for pre-hospital care.

"Very shortly after starting my volunteering career, I knew I wanted to be a paramedic and work full-time for SAAS. The more I learnt, the more I knew I wanted it as a career."

While Ashleigh confirmed her takeaways from volunteering were abundant, she credits the on-the-job skills that were irreplaceable.

"I had the opportunity to be the Volunteer Training Coordinator for Kadina. This has taught me a lot about education. I am now able to confidently talk in front of groups of people and share my experiences and knowledge. This is a skill that will stay with me forever, and really helped during my interview for my career position."

Patrick is also going from strength to strength and has commenced his paramedic Internship after initially signing up with SAAS as a school leaver.

"Joining SAAS straight out of school meant that I lacked a lot of life experience when compared to my colleagues, but arguably one of the most valuable things is the diverse and unique experiences. Anything from working with different groups of people of all ages to working with patients from all backgrounds has allowed me to develop more life experience than possible anywhere else."

Meanwhile, after four years of training and shifts at stations from Peterborough to Yorketown, Robert starts his next chapter as a Career Remote Ambulance Officer and couldn't be prouder.

"I could not have anticipated how much this type of work would appeal to me, and my life has changed for the better. I applied for a Remote Ambulance Officer job at Ceduna and through some hard work, great training, motivation and encouragement from all around me, I was lucky enough to get a career job with SAAS."

Upper Yorke Peninsula Regional Team Leader Daniel Kenny said, it had been a privilege to work alongside these three highly motivated and dedicated volunteers and it was rewarding to see them progress into the career stream.

"Having started as a volunteer myself like so many other paramedics have, it is amazing to see how many volunteers continue to move across into making their passion a career."





# AMBULANCE TASMANIA LAUNCHES COMMUNITY PARAMEDICINE MODEL

On August 3, Ambulance Tasmania took another significant step towards improving community care by commencing its Community Paramedic model.

Twelve Community Paramedics received specialised training in patient assessment, clinical decision-making, and specific clinical skills to care for patients in the community without necessarily needing to visit emergency departments.

Community Paramedics are valuable resources to care for patients who present with minor illness or injury and can typically wait longer periods of time for an ambulance when more critical cases are prioritised.

The team is rostered on to provide 16 hours of coverage a day across Tasmania's North, North West and South.

This Community Paramedic model is new to Tasmania but successfully operates in Canada, the United Kingdom and the US.

In a substantial move for Ambulance Tasmania, the service launched its immediate and long-term commitment to build safe and supportive work environments for all staff.

A Culture Improvement Action Plan was released to staff and the wider public in mid-August, which revealed a comprehensive list of goals and actions to improve and update policies, procedures, staff communication, leadership styles, career development, management support, decision-making processes, and mental health and wellbeing support.

Unfortunately, like other ambulance services across the country, Ambulance Tasmania has faced many challenges that have negatively impacted workplace culture, which were all highlighted in an anonymous staff survey called a "Resilience Scan", as well as staff consultations.

Progress of all actions is being tracked and a second Resilience Scan was undertaken in early September to continue this journey.

Women in Ambulance is a key focus area of the Council of Ambulance Authorities.

In June, Ambulance Tasmania's inaugural Women in Ambulance Steering Committee held its first meeting, with 12 members appointed from many areas of the service, all across the state.

Going forward, the members will focus on collaborating and leading solutions to address issues women face in the organisation and address issues raised in the Resilience Scan.

The Committee will support Ambulance Tasmania to be more inclusive, increase gender diversity, recommend changes to the Executive Committee, and celebrate achievements of women in Ambulance Tasmania.

Ambulance Tasmania also marked a major milestone for one of its newer joint services that is providing care to patients experiencing mental health distress.

More than 1,000 Tasmanians experiencing mental ill health have now been supported by our Police, Ambulance, and Clinician Early Response (PACER) southern trial since it launched in January this year.

In the first 32 weeks, nearly 80% of PACER patients have remained in the community and avoided the stressful environment of a hospital. The team is made up of paramedics, police officers and mental health clinicians who are trained to manage complex presentations and refer some of the most vulnerable community members to the right services and care.

Due to the success of this trial, the tri-agency PACER initiative will be funded as a permanent service in Tasmania's south, with a trial expected to begin in the North West early next year.

And Ambulance Tasmania awarded a little champion for his bravery after calling triple-zero for his mum who had a seizure at their Launceston home.

Four-year-old Monty Cocker was taught how to unlock his mum's phone and how to call triple-zero only the day before the incident.

The two paramedics who attended were amazed that Monty knew what to do, that he followed all instructions really well, and how calm he was during the incident.

Monty has been telling people he isn't a superhero, just a hero.

"I'm so proud, he's my little hero, he certainly has saved the day," mum Wendy said.

For all the latest news from the Ahpra Paramedicine Board, visit: Paramedicine Board https://www.paramedicineboard.gov.au/

### Online renewal for paramedics is now open

Paramedics have until 30 November 2022 to renew their general or non-practising registration on time. We encourage you to renew early to avoid delays during the busy renewal period. Renewing on time also means you'll avoid late fees which apply after 30 November 2022.

Find out more: https://www.paramedicineboard.gov.au/News/2022-10-04-practitioner-renewal-open.aspx

### Registration now open for graduates set to finish study in next three months

Graduates set to complete their course in the next three months can take the first step in their new health career by applying for registration now. Applying before you finish studying means we can start assessing your application while we wait for your graduate results. Registration with the Paramedicine Board of Australia is required before you can start working as a paramedic - once you're registered you can work anywhere in Australia.

Find out more: Paramedicine Board of Australia - Registration now open for graduates set to finish study in next three months

### Paramedicine Board releases latest registrant data June 2022

The latest registrant data is now available. Find out more at: https://www.paramedicineboard.gov.au/News/2022-07-28--Report-Registrant-Data.aspx

### Extension: Temporary acceptance of additional English language tests

National Boards are now accepting the TOEFL iBT® Home Edition test for applications received until 21 February 2023.

Find out more: https://www.paramedicineboard.gov.au/News/2022-07-22-Extension-temporary-acceptance-additional-English-language-tests.aspx

## KAUNIHERA MANAPOU PARAMEDIC COUNCIL

The latest newsletter by Kaunihera Manapou Paramedic Council New Zealand is packed with useful information for paramedics practising in Aotearoa New Zealand. Visit the website to read full articles: https://www.paramediccouncil.org.nz/

Newsletter updates include:

- Meet Te Kaunihera whānau - Bernadette Pereira and Craig Barraclough
- Te Wiki o te Reo Māori | Māori language week
- Consultation outcome - Naming policy
- Recent report by the Health and Disability Commissioner
- Overseas-qualified paramedics
- What do you do if you become aware that a colleague may be practising in a way that could pose a risk of harm to patients?
- Medsafe reminder
- Non-Fatal Strangulation Research Project
- Updates to MyPMC
- 2022 – 2023 Kaunihera hui/meeting dates: 24 February 2023, 28 April 2023, 30 June 2023, 17, 18 August 2023, 13 October 2023, 1 December 2023.

## THE NATIONAL CLINICAL EVIDENCE TASKFORCE

Keep up to date with National Clinical Evidence Taskforce updates by visiting: https://clinicalevidence.net.au/

We know we must be prepared for new challenges in COVID-19 and beyond, and the COVID-19 Clinical Evidence Taskforce (the Taskforce) is committed to supporting Australian clinicians with up-to-date evidence-based guidance as new data emerges.

The Taskforce and its National Steering Committee has been considering how we can best extend the success of this living guidelines model, and the pioneering multidisciplinary collaboration between our 35-member organisations.

Our members have unanimously agreed to continue the Taskforce's remarkable alliance and provide evidence-based guidance for urgent and emerging diseases. This means that we have a new name - the National Clinical Evidence Taskforce - and a new-look logo.

The Taskforce will continue to develop and update COVID-19 guidance for both acute and long COVID as new evidence emerges, recognising the need for clear and trusted national advice in these uncertain times.


# Love the College?

Refer your friends and be rewarded!



Current College members who refer three new employed members will receive a **complimentary Leatherman Raptor Folding Shears** valued at $179.95.

Visit **paramedics.org/membership** for more information.

www.paramedics.org

@ACParamedicine

Australasian College of Paramedicine

# Advancing paramedicine.

The College is the peak professional body representing and supporting paramedics across Australia and Aotearoa New Zealand through knowledge, events, research, advocacy, networking and much more.

**Leading the profession for paramedics across Australasia**

**Evidence-based education, research opportunities and grants**


**Supporting paramedics through every stage of their careers**

**Promoting paramedic health and wellbeing**

Belong to the College.
Join today **paramedics.org/membership**

@ACParamedicine

Australasian College of Paramedicine