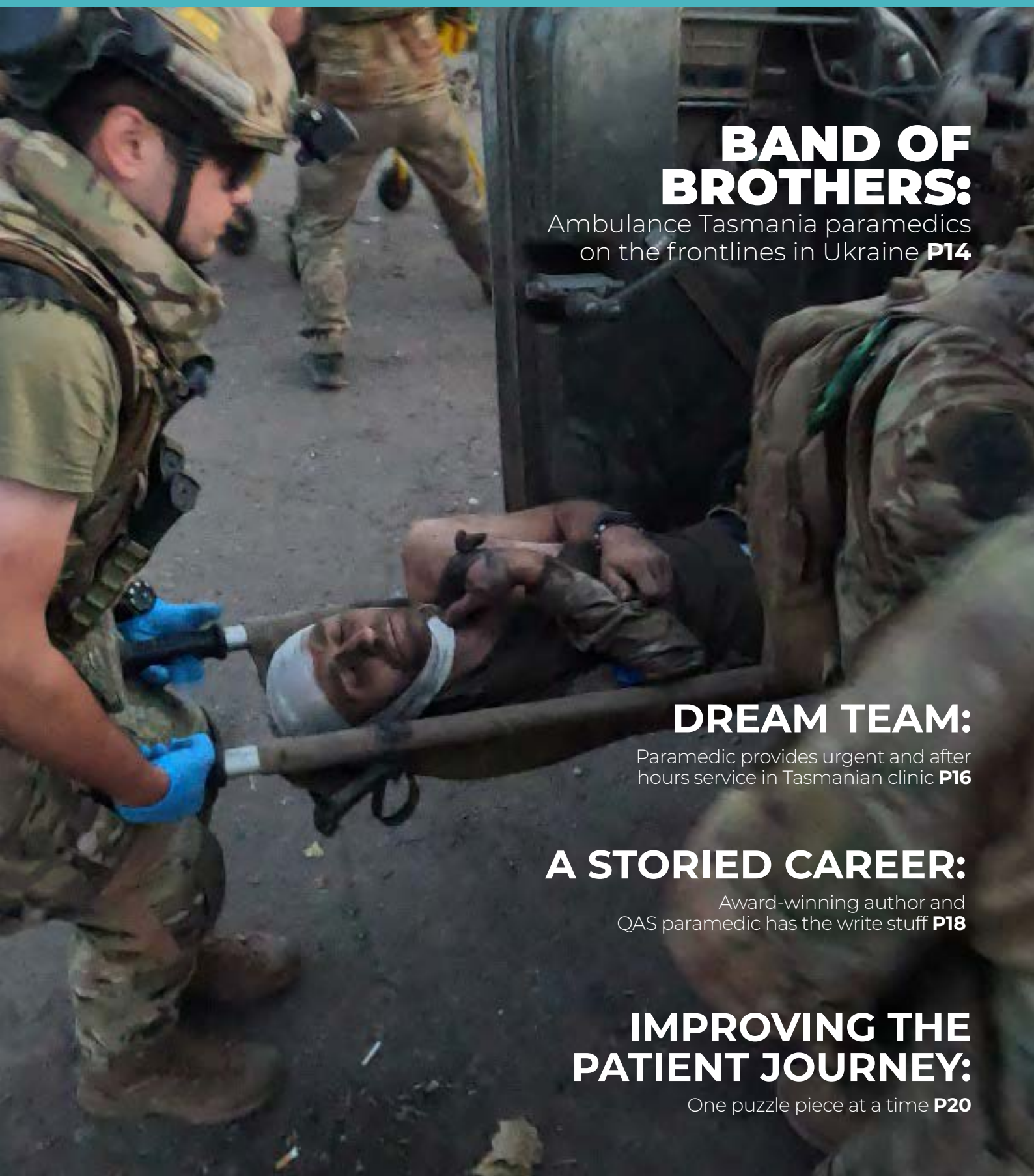
Australasian College of Paramedicine
RESPONSE
SUMMER 2024 www.paramedics.org



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One puzzle piece at a time **P20**

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COVER

Transporting wounded soldiers in the Donbas region of Ukraine.

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.

INTRODUCING OUR NEW STRATEGIC PLAN

with **Ryan Lovett,** College Chair

The past few years has been a period of establishment for the College. Our focus has been on "Foundations" to ensure the College was well placed to deliver the future that you, the profession, were telling us you wanted. The past three years have not been without their challenges, but the College has gone from strength to strength and I'm sure all members, and the wider profession, have seen the positive impact the College has had.

I am excited to present to you our new strategic plan, Evolution, covering 2024-28. As the College Chair, I am honoured to present a vision that encapsulates our commitment to advancing the field of paramedicine for the betterment of our communities.

Vision: Lead the evolution of paramedicine to improve health outcomes for our communities

Our vision is an ambitious call to action, challenging us to be at the forefront of change and innovation in paramedicine. It reflects our unwavering dedication to driving positive health outcomes and ensuring the wellbeing of the communities we serve. As leaders, it is our responsibility to navigate the evolving landscape of healthcare and pave the way for paramedicine to make a lasting impact.

Purpose: Engage the profession, drive excellence, advance paramedicine

Our purpose encapsulates the core principles that define our existence - engagement, excellence, and advancement. By actively engaging paramedics, students, and the broader profession, we seek to foster a sense of unity and collaboration. Through the pursuit of excellence, we strive to set new standards for paramedicine, constantly pushing boundaries to enhance the quality of care we provide. As we advance paramedicine, we contribute to the overall improvement of healthcare systems and outcomes.

Values: Collaborative, Compassion, Inclusion, Integrity, Respect

At the heart of the College lie the values that guide our actions and decisions. We are committed to fostering a collaborative environment where the collective wisdom of our members propels us forward. Compassion underscores every interaction, reminding us of the human element in paramedicine. Inclusion ensures that diversity is celebrated, and every voice is heard. Integrity is our bedrock, and respect is the cornerstone of our relationships; with each other and with the communities we serve.

Strategic Pillars: Lead, Engage, Inspire, Enhance

The pillars of our strategic plan represent the foundational areas where we will focus our efforts to fulfill our vision and purpose.

Lead: Lead and influence change for paramedicine

As leaders, we must embrace change and actively shape the future of paramedicine. This pillar is a call to action for us to be at the forefront of policy discussions, clinical advancements, and models of care innovations. By leading, we not only elevate the status of paramedicine but also contribute to the evolution of healthcare as a whole.

Engage: Engage and connect paramedics, students, and the profession to the College

Our strength lies in our community. Through meaningful engagement, we will build a network that connects paramedics, students, and the broader profession to the College. This pillar emphasises the importance of collaboration, knowledge-sharing, and support to foster a sense of belonging and connection among our members.

Inspire: Inspire and lead excellence in paramedicine

To inspire is to ignite passion and the drive for excellence. This pillar challenges us to set the highest standards for ourselves and paramedicine. By showcasing exemplary clinical practices and scientific evidence, promoting continuous learning, and celebrating achievements, we aim to inspire a culture of excellence that permeates every facet of paramedicine.

Enhance: Enhance member experience of the College

Our members are at the core of the College, and their experience should be nothing short of exceptional. Through this pillar, we commit to continually enhancing the member experience by providing valuable resources, professional development opportunities, and a supportive community. We will invest in technologies and strategies that make interaction with the College seamless, enriching the journey for every member.

As we embark on this exciting chapter of Evolution, I invite each of you to join us in shaping the future of paramedicine. Together, we will lead, engage, inspire, and enhance; not only for paramedicine but for the communities we proudly serve.

On behalf of the Board, I commend to you the College's Strategic Plan 2024 – 2028: Evolution.

FROM THE CEO

OUR COMMITMENT TO DATA SAFETY AND CYBERSECURITY

with **John Bruning,** College CEO

The past 12 months has highlighted numerous cybersecurity breaches for various organisations, which has led to discussions within the College executive team and the Board about how we securely manage your data. We were already well placed due to several best-practice design concepts as part of our website and IT systems, but technology moves quickly and we need to continually improve our systems.

I am pleased to provide you with an update on the critical initiatives we have undertaken to fortify our digital infrastructure, ensuring the safety and security of your data. Recognising the evolving landscape of cyber threats, the College has proactively taken steps to enhance our data safety measures, reaffirming our commitment to protecting your privacy and maintaining the integrity of our digital platforms.

Website policy and terms of use updates

To lay a robust foundation for data security, we have revisited and revised our website policies and terms of use. These updates are not only in compliance with the latest legal requirements and industry standards, but are also tailored to address the unique needs of our members and website visitors. Our goal is to ensure transparency and clarity, empowering you with the knowledge of how your information is handled within our digital ecosystem.

We encourage each member to take a moment to review the updated policies, which can be found on our website's dedicated section for terms and conditions at https://paramedics.org/acp-website-subscriber-terms-and-conditions. Your understanding and adherence to these policies play a pivotal role in fortifying the security of our collective data.

Penetration testing of our website

Understanding that a proactive approach is key to cybersecurity, we engaged a reputable cybersecurity firm to conduct thorough penetration testing on the College's website. This comprehensive assessment aimed to identify potential vulnerabilities and weaknesses in our digital infrastructure, allowing us to address any potential risks before they could be exploited.

The penetration testing process involved more than just testing for weaknesses; it involved a full review of our website code, providing us with valuable insights into our system's resilience. Rest assured, the testing was conducted ethically and with the highest regard for the confidentiality of our members' information.

WE WANT YOU TO FEEL CONFIDENT IN THE MEASURES WE ARE TAKING TO PROTECT YOUR DATA

Updates and enhancements post-penetration testing

Following the completion of the penetration testing, our team has worked to implement necessary updates and enhancements to address the identified vulnerabilities. These enhancements cover various aspects of our digital presence, from server configurations to encryption protocols, ensuring a holistic and robust defence against potential threats. The initial tranche of updates has occurred, with a second and final tranche due to be undertaken shortly.

We know we can never rest, and we have a commitment to continual improvement, ensuring that the College remains at the forefront of cybersecurity best practices.

Your trust is of high importance to us, and we want you to feel confident in the measures we are taking to protect your data. As we navigate the complexities of the digital age, your support and cooperation are invaluable. Together, we can build a resilient and secure digital community that mirrors the strength and unity of our paramedic family.

Stay safe and well.

Strategic Plan | Mahere Rautaki

Our Vision / Moemoeā

Lead the evolution of paramedicine to improve health outcomes for our communities

Our Purpose / Kaupapa

Engage the profession, drive excellence, advance paramedicine

Strategic Pillars

Lead

Lead and influence change for paramedicine

Engage

Engage and connect paramedics, students, and the profession to the College

Objectives

Increase the impact of the College through advocacy, policy and thought leadership

Create and deliver framework and vision for paramedicine that drives a better future

Deliver exceptional and highly valued member and stakeholder experiences

Engage and connect paramedics and students to the College

2024–2028

EVOLUTION

Our Values / Whanonga pono

We Collaborate

We work together, sharing and fostering information and ideas, to achieve our objectives

We act with Integrity

We engage openly and honestly, take appropriate action, and own our outcomes

We are Compassionate

We provide a culture of care where we listen to, acknowledge, and support each other

We are Respectful

We recognise our diversity and value each other's perspective and contribution

We are Inclusive

We welcome, include, value, and engage equitably with all people and ideas

Inspire

Inspire and lead excellence in paramedicine

Create high-quality professional programs that lifts professional and clinical practice

Establish and implement standards, credentialling and accreditation for advance practice

Enhance

Enhance member experience of the College

Enhance the member experience through personalised member services and connections

Grow digital capability and improve user experience

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Australasian College of Paramedicine

ADVOCACY: DEDICATED TO MEANINGFUL HEALTHCARE REFORMS

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

The College made a lot of progress in our pursuit for the recognition of paramedicine across Australasian health contexts last year, and while there is still much work to do, we head into 2024 with great energy and a positive outlook for meaningful healthcare reforms that will advance the profession.

Key activities to kickstart the year include ongoing consultation with the major Australian Government, Health and Aged Care primary care review led by Prof. Mark Cormack, Unleashing the potential of our health workforce: Scope of practice review. The review team has promised to release the first report, which we look forward to sharing with our members. Members will also be pleased to learn that the review team invited the College to join the Expert Review Committee, for which Alan Eade ASM is our representative.

Members following the major Australian New Zealand Standard Classification of Occupations consultation will have seen the Preliminary Proposed Changes released in late-December 2023. Despite the disappointment, the College is committed to an ongoing collaborative effort with key stakeholders and partners to have paramedicine appropriately recognised in ANZSCO, and we will continue to share updates with our members.

Always a focus for us is our commitment to keeping College members connected, engaged and informed about advocacy projects and activities. This year, as well as utilising newsletters, social media and the website, we have a big line up of Advocacy in Conversation guests planned and more consultation opportunities for members to share their voice and be heard.

We encourage you to visit our website and follow us on social media to stay up to date with the issues that matter for the profession.

Quarterly highlights: Advocacy in action

5 December 2023:
BBC - The Conversation broadcast an interview featuring College Advocacy and Government Relations Lead Michelle Murphy ASM. You can listen to the interview at https://www.bbc.co.uk/sounds/play/w3ct4twd

18 December 2023:
Paramedicine was recognised in a major report: Australian Government releases Final Report MTR NHRAA 2020-2025: https://paramedics.org/news/mr-paramedicine-reognised-in-major-report-MTR-2023

18 December 2023:
The Australian Government, Health and Aged Care added paramedics to the list of health professions eligible under the Workforce Incentive Program: Provider stream, a major step forward for the profession.

23 January 2024:
The College was invited to present at the Tasmanian Parliament Committee Hearing into the Transfer of Care Delay (ambulance ramping).

We also continue to meet with, and submit consultations to, advisors, governments, stakeholders and collaborators to change policy and legislation with the aim of improving health outcomes for individuals and communities across Australasia.

WHAT'S NEW FROM THE COLLEGE'S RESEARCH COMMITTEE

Talking Research Webinar

The Research Advisory Committee is thrilled to announce the final instalment of our Talking Research webinar series for 2023: "How to Choose a Higher Degree Research (HDR) Supervisor". Hosted by committee member A/Prof Scott Devenish, our guest speakers delved into the critical aspects of finding the ideal HDR supervisor for your individual research journey.

During this session, Prof Brett Williams shared his insights into understanding doctoral supervision in paramedicine from the perspective of the supervisor, and covered the essential skills supervisors need to support and guide paramedicine HDR students to successful completion. A/Prof Paul Simpson spoke from the perspective of the HDR student, highlighting the importance of choosing the right supervisor, providing guidance on what questions to ask and what qualities to look out for. Prof Peter O'Meara concluded the session, discussing other aspects to consider during your HDR journey, including supervisory styles, strategies for handling conflicts with your supervisory team, and valuable insight into the resources and facilities available to HDR students.

If you are contemplating starting an HDR journey, this is a must-see Talking Research event! It is available at https://paramedics.org/recordings/talking_research_HDR_supervisor. All our Talking Research webinars are recorded and accessible on the College website under the research tab at https://paramedics.org/research and counting towards 1.5 hours of interactive CPD.

The ACP Research Advisory Committee is excited to continue with the Talking Research webinar series in 2024, presenting a fresh array of engaging topics relevant to paramedicine research.

Paramedicine Research Mentorship Program

The Paramedic Research Mentoring Program (PRMP) was envisioned by the Research Committee as a pathway for registered paramedics to learn about research directly from experienced paramedic academics.

In November last year, we held our third and final workshop for 2023, focusing on "The Impact of Paramedicine Research". This wonderful event featured guest speakers who generously shared their insights into translating research to improve paramedic policy and practice.

We were joined by A/Prof Belinda Flanagan, who delivered a fantastic introduction to the significance of research, why impact is important, and the crucial role of implementing evidence-based knowledge in the paramedicine profession. Following her insightful presentation, A/Prof Sonja Maria, Sarah Ashover and Tanya Milburn each shared their personal research experiences, shedding light on the practicalities and complexities involved in translating research and evidence-based knowledge into practice.

We have concluded the PRMP for 2023 and are delighted to announce the following mentees who successfully completed the program: Mackenzie Kwort, Sherlynn Hii, Richard Jones, Troy Pan, Angela Arlotta, Matthew Cook, Joshua Ferdinand, Felix Tan, Pia Salenga and Aleisha Webster.

Peer Review Mentoring Program

We are pleased to announce that the highly successful Peer Review Mentoring Program will be running again in 2024 under the guidance of the Research Advisory Committee. Originally established as part of the Paramedicine journal, this program aims to foster and develop peer-review capacity, enhancing the quality of the peer-review process. We will be taking applications soon and look forward to welcoming the next cohort of mentees for 2024.

Meet the Researcher: Laura Hirello

Laura Hirello is a Canadian paramedic from Halifax, Nova Scotia. She moved to Melbourne in February 2023 to pursue a PhD from Monash University. Laura's research study is called Assessing the impact of Shiftwork in Australian Paramedics (ASAP). It looks at how shift work and the resulting circadian rhythm disruption impacts paramedics, their work performance, and their decision-making. Read more about the ASAP project at: https://sites.google.com/monash.edu/projectasap/home. Prior to moving to Australia, Laura worked as an ambulance paramedic for nine years before moving into project management and process improvement at a large women's and children's hospital. In her free time, Laura and her partner are attempting to explore and experience as much of Australia as they possibly can.

REVOLUTIONISING PROFESSIONAL LEARNING IN 2024: EMBRACING INNOVATION FOR ENHANCED LEARNING

By **Julie Johnson,** College Education Manager

In the ever-evolving landscape of paramedic professional learning, 2024 promises a paradigm shift with the integration of immersive technologies and a renewed focus on tailored resources for paramedics.

As the field of eLearning continues to mature, the upcoming year is set to introduce new and engaging experiences that will revolutionise the way paramedics meet their CPD requirements, ensuring they are better equipped to handle the challenges of the future.

Immersive learning takes centre stage

One of the most exciting developments in paramedic education is the incorporation of immersive experiences. Augmented Reality (AR), Virtual Reality (VR), and 3D graphics are set to become integral components of the learning journey for paramedics. Imagine stepping into a simulated emergency scenario from the comfort of your own home! Aim for stars and let's make this possible, that's our education motto.

These technologies are not merely gimmicks but powerful tools that replicate the complex and urgency of real-life scenarios. From navigating complex trauma cases to dealing with paediatric emergencies, paramedics will have the opportunity to immerse themselves in life-like scenarios, enhancing their ability to make critical decisions under pressure.

Tailored resources for specialised needs

We listen to you and understand the unique needs of paramedics. Professional learning initiatives in 2024 will focus on tailoring resources to address specific challenges. A dedicated effort is underway to provide comprehensive resources on a range of topics recognising the HALO (high acuity, low occurrence) skills as critical areas that demand specialised knowledge and skills.

Additionally, a groundbreaking project is in the works specifically designed for advanced practice clinicians, Intensive Care Paramedics and Critical Care Paramedics. This initiative aims to elevate the skill set of these specialised professionals, ensuring they are at the forefront of patient care, particularly in high-stakes situations.

Empowering students and graduates

The significance of fostering a continuous learning culture is vital for career success. 2024 will see an increased focus on resources catered to students and recent paramedic graduates. A series covering relevant and contemporary topics will be rolled out, ensuring that those entering the field are well-supported to take their knowledge into the work environment.

This initiative not only aims to bridge the gap between theoretical knowledge and practical application, but also strives to instil a sense of confidence in newly minted paramedics as they embark on their careers. The educational landscape is evolving, and so too should the tools and resources available to those entering the profession.

Case-based inquiry learning: A glimpse into the future

Perhaps the most exciting prospect on the horizon is the introduction of case-based inquiry learning. This innovative approach places paramedics at the centre of complex scenarios, encouraging them to analyse, critique and problem-solve in a dynamic learning environment. It's not just about following protocols, but understanding the reasoning behind each decision.

The power of case-based inquiry learning lies in its ability to replicate the unpredictable nature of out-of-hospital healthcare. As the saying goes, "practice makes perfect", and case-based inquiry learning aims to provide paramedics with a level of supported practice that is not always included in online learning.

The landscape of paramedic professional learning is on the brink of a transformative year in 2024. It is more than just CPD. The infusion of immersive technologies, specialised resources, and innovative learning methodologies is set to redefine how paramedics engage with learning, ensuring they are not only competent but adaptable in the face of the unpredictable challenges they may encounter. Buckle up, embrace the change, and get ready for an educational journey that is as dynamic and diverse as the profession itself.

THE COLLEGE EDUCATION TEAM

Julie Johnson, Education Manager:
Julie is a seasoned healthcare professional. Holding qualifications as a Registered Paramedic, Nurse, and educator, she began her journey in nursing and teaching before transitioning to the fast-paced world of Jurisdictional Ambulance Services. Now, she stands as a focused educator with an avid passion for fostering inclusivity in the learning environment. Her paramedic experience spans private practice, specialist healthcare, sporting medicine, and event medical management. As a nurse, she spent many years in midwifery, women's health, and primary healthcare. In addition to clinical experience, she holds qualifications in tertiary and higher education, training and development, management, leadership, and community services.

Jonas Ogonowski, Learning and Development Officer: Jonas has a background in coaching, psychology, counselling, community education, learning, and development spanning more than a decade. He develops people's capability through facilitation, coaching and learning design.

Dan O'Brien, Clinical Education Officer: Dan is a Registered Paramedic based in Queensland. He has been with the College for almost two years and enjoys working with the Education Team. His professional interests include primary care and community paramedicine, patient safety and human factors, as well as clinical education.

Jeremy Kuiper, Clinical Education Officer: Jeremy is a registered paramedic working for a state ambulance service in regional NSW. Jeremy is the current Director of Education for his local Surf Lifesaving Club and has extensive experience working for private registered training organisations in the past six years. Jeremy has presented at ACPIC in the past two years and joined the College Education Team in October 2023.

THE COLLEGE'S 2024 CONFERENCE CALENDAR

By **Georgia Coetzee**, College Conference and Events Manager

The College is thrilled to build on the success of last year's conferences as we unveil a dynamic calendar for 2024. Brace yourselves for an engaging line-up featuring the inaugural Primary Care Conference, the Research Symposium, and the much-anticipated Australasian College of Paramedicine International Conference. Additionally, we are in the process of finalising smaller, locally focused events to better connect with our members. Let's dive into the details of each conference and what they have in store for attendees.

PRIMARY CARE CONFERENCE

Primary Care Conference 2024: A groundbreaking conference focused on primary care

Kicking off the conference schedule this year is the inaugural Primary Care Conference 2024, set to take place in picturesque Hobart, Tasmania, in May. This two-day event welcomes clinicians currently working or interested in the primary care sector.

The College is collaborating with various groups to ensure the success of this inaugural conference, emphasising comprehensive coverage of primary care topics. Attendees can expect insightful discussions, networking opportunities, and a social event on the evening of the first day.

This Primary Care Conference will be held biennially, alternating with the College's Critical Care Summit. Pre-registration for this event is now open, offering interested participants a chance to receive timely updates as more information becomes available. Visit https://paramedics.org/events/PCC24

Research SYMPOSIUM

Research Symposium 2024: Nurturing novice researchers

The Research Symposium returns in July 2024, promising two days of enriching content aimed at novice researchers. While the location is yet to be confirmed, attendees can anticipate a stimulating environment fostering the growth of budding researchers.

Pre-registration is open, enabling those interested to stay informed as details unfold. https://paramedics.org/events/RS24

ACPIC SYDNEY 2024

Australasian College of Paramedicine International Conference 2024: ACPIC returns

The highlight of September will be the return of the Australasian College of Paramedicine International Conference (ACPIC24), to be held from the 11- 13 September at the Sydney Masonic Centre.

Immerse yourself in the latest advancements, hands-on workshops, and dynamic networking opportunities at ACPIC24. We bring together industry leaders, showcase groundbreaking techniques, and celebrate a community dedicated to taking paramedicine to new heights.

ACPIC24 follows the established schedule with pre-conference workshops and welcome drinks on September 11 and conference Day One and a gala dinner on September 12, concluding with the second day of the conference on September 13.

As with the other conferences, pre-registration for ACPIC24 is available online, allowing prospective attendees to stay in the loop as details emerge: https://paramedics.org/events/ACPIC24

Local connections: Smaller events in the pipeline

Recognising the importance of local engagement, the College is diligently working on planning smaller, single-day events in various jurisdictions, including in Aotearoa New Zealand. The goal is to ensure accessibility and relevance to meet specific regional needs. The College's Member Engagement Team, Education Team, and dedicated Member Committees are involved in delivering local Continuing Professional Development (CPD) events, webinars, and podcasts. The College extends our sincere gratitude to these teams for their outstanding contributions throughout 2023.

As we eagerly anticipate an exciting year ahead, we invite you to mark your calendars and pre-register for these enriching conferences. Whether you are a seasoned professional or a novice researcher, our diverse calendar offers something for everyone.

We look forward to fostering collaboration, sharing knowledge, and creating memorable experiences at each event. See you at one of our upcoming conferences in 2024!

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BAND OF BROTHERS: AMBULANCE TASMANIA PARAMEDICS ON THE FRONTLINES IN UKRAINE

On the frontlines in the war-torn Donbas region of eastern Ukraine, the first target of Russian attacks are tanks and the second are medics.

"If you can destroy their chain of evacuation, it means that more soldiers die in the battle," said Ambulance Tasmania paramedic Matt Pickering, who alongside fellow AT paramedics David Brown and Daniel Tree each spent between four and six weeks less than two kilometres from the Russian front.

The three operated in an unmarked ex-Amsterdam ambulance, one of many donated to the war effort by countries throughout Europe. It was rudimentary vehicle, equipped with just a spare tyre, a backpack and a stretcher. Pockmarked with bullet holes in its windows and chassis, the vehicle bore witness to the ever-present danger facing medical personnel operating in an unrelenting war zone.

THE EXPECTATION OF WORKING IN A FUNCTIONING AMBULANCE WAS VERY NAIVE OF US

When not being used, the ambulance was fully camouflaged and hidden under trees. With the exception of a small red cross in the vehicle, when being driven it was devoid of the large, universally recognisable red crosses and flags that typically offer medics a degree of protection against attack.

It was a world away from their lives in Tasmania, and a baptism of fire in what has become a protracted and brutal two-year military campaign since Russia's invasion of Ukraine in 2022, thus far claiming an estimated 100,000 Ukrainian soldiers' lives and more than 20,000 civilian deaths and casualties.

Each had a similar motivation for heading to Ukraine – a burning desire to help the war effort and to use their professional skills and capacities in a different and more challenging environment. All three had initially begun their journey individually, but word of mouth among paramedics soon brought them together.

"It just so happened that all three of us were going to be there around the same time. We found out about each other's plans through the grapevine at work. Dan had already headed over. Dave and I had been in touch for a while and worked out our plans, so we decided to dial in the dates and go there together," Matt said. "Right up until literally the week of leaving, as far as I was concerned I was going on my own."

The trio all went via the Road to Relief NGO, a Ukrainian-registered humanitarian NGO established in March 2022 with the purpose of helping civilian populations most affected by the Russian invasion. Its work has since expanded to include casualty and medical evacuations and emergency treatment of injured soldiers in coordination with the Armed Forces of Ukraine.

David said the first 24 hours in the capital, Kyiv, were "discombobulating" amid the sounds of sirens signalling incoming missiles.

WHERE YOU'RE GOING IS WELL WITHIN SMALL ARMS RANGE OF THE RUSSIANS, HUNDREDS OF METRES AT POINTS

"I remember feeling that sort of tightness in the belly," he said. "It was the first and only time I went to a bomb shelter. I looked in a few, but I didn't actually go and seek any kind of refuge. There were only a couple of people in there; the rest were still going about their business. It was really strange - this is a country at war and I was expecting bombs to fall all the time. It was quite discombobulating, not stressful, just really uncertain what the rules were in this place. It's amazing how quickly you get used to it within 24 hours. It was almost like I'd been there a month."

"And then we're sitting in a cafe while the alarms go off and we just continue with our lunch and there'd be artillery landing nearby. In the first few days you'd be like, 'oh'; a week in, you hear them and you're like, 'oh yeah, that's a bit close'. You lose any fear. It just becomes completely normal."

As they moved closer to the frontlines, the same pattern of initial uneasiness followed by rapid adaptability became the norm. It's a psychological behaviour known as "risk creep" in which people progressively push their boundaries.

"This concept was relayed to us about war zones where you move a bit closer and it feels fine," Matt said. "So we're apprehensive about crossing the border into Ukraine. We get to Kyiv, there's an alert, nothing happens, and you're like, 'ok, this is fine'. So within a day you're switching your alerts app off and going with the flow. And then you move to Donbas and you're like, 'oh, this is a starting to feel a bit real', and then nothing happens and you and go, 'ok'.

"So you move up towards the frontline and you hear artillery and things blowing up next to you but you don't get hurt. And you're like, 'this is fine'. It's the creep - you move closer and closer until, which is what unfortunately happened with our NGO guys, the creep caught up with them in the end because they found that point at which reality occurs and you've crept a little bit too far."

Road to Relief Director Emma Igual and her colleague Anthony "Tonko" Ihnat were killed last September when the vehicle they were driving towards Bakhmut came under artillery fire. Two others travelling with them suffered serious shrapnel injuries.

Daniel said that prior to arriving in the Donbas, he expected to operate in much the same manner as in Australia in terms of emergency response, but with limited equipment, a landscape littered with land mines, horrific injuries, and constant close proximity to Russian troops, the situation on the ground proved vastly different.

"The expectation of working in a functioning ambulance was very naive of us," he said. "We rolled up and the vehicle that we were going to work in was damaged and so we were relegated to basically a postal van with a stretcher and a backpack in it. It put us into a different mindset."

And while Ukrainian soldiers had rudimentary knowledge of Tactical Casualty Combat Care that enabled them to administer basic first aid, many had to endure long waits for retrieval.

"A lot of these patients are heavily shocked because they've been sitting at the zero line waiting for extraction for sometimes eight or nine hours," Daniel said. "We'd get a radio call saying we've got five casualties coming in. By the time they organised a vehicle so that we can get our hands on them, there might be 20 casualties, and they've been lying there losing blood for many hours. Some have had tourniquets on for hours.

"Dave did a lot of the clinic work, which by and large was much more dangerous than the medivac work that we were doing although they all come with risks. When you're doing the medical clinics, you're going in blind, and there were times where we had to sit down and have conversations and say, where you're going is well within small arms range of the Russians, hundreds of metres at points."

Time was always of the essence. When retrieving patients, they had at most 15 minutes to pick up wounded soldiers and take them to a stabilisation point. Higher-level interventions weren't possible, so the focus was on pain relief, bandaging and applying torniquets. Once they reached the safer "green zone" away from the fighting, they were able to administer more advanced treatment.

It was a sobering experience for all three, but each left Ukraine feeling frustrated that they hadn't done enough.

"Until Russia withdraws and this war's over, enough is never enough," Daniel said.

Ben Smith with nurse practitioners Kerrie Duggan (left) and Samantha Beattie

DREAM TEAM: PARAMEDIC PROVIDES URGENT AND AFTER HOURS SERVICE IN TASMANIAN CLINIC

Cygnet, Tasmania, Muwinina and Palawa Country

After 15 years on road with New South Wales Ambulance, paramedic Ben Smith was looking for a change of professional pace. The night shifts had become increasingly taxing and the enjoyment and satisfaction he had previously derived from his work had waned.

In a bid to reignite his passion and achieve a better work/life balance, he scaled back his hours from full-time to part-time and then to casual. To no avail. "I felt paramedicine wasn't for me any more," he said.

While working in the interim as a landscaper, he came across an advertisement for casual employment as a paramedic with the Australian Defence Force (ADF) through a private contractor to support an army training exercise in Queensland

"I'm like, 'Oh, I've got some spare time off, I'll give that a go'. And I loved it. It was the patient contact side of things; it was clinical, but it wasn't the grind that on-road ambulance service had become for me. I came back from that contract thinking, 'I can still do this'."

I DON'T THINK I'VE EVER GOTTEN SO MANY 'THANK YOUS' IN MY ENTIRE CAREER

What followed was a series of paramedic placements with the ADF, civil construction sites such as the Snowy Hydro Scheme and mining operations, and later with the National Aboriginal Health Service in Wiluna in Western Australia and the WA Community Country Health Service's Kimberley Ambulance Service working in Indigenous communities. What became apparent after his stints in WA was his passion for working in primary healthcare and the level of patient contact and engagement that it involved.

"I really enjoyed it; this is exactly what I was after. I've got the primary healthcare side of it, I've got the in-clinic side of it, but I still get to go out and on occasion use those critical care skills."

Following his passion, in October last year he joined Cygnet Family Practice in southern Tasmania, the sole paramedic working as part of a multidisciplinary team comprised of nurses and nurse practitioners.

"I saw the Cygnet job come up in Tasmania, and it was a lot of what I'd already done. I was confident that I could do the primary healthcare work. And it was a roster; no night shifts, three days on, four days off, so I knew I'd be able to build a community and have that balance again, a life again."

Cygnet is the only urgent and after-hours service currently operating in the town, serving a population of 4,800. For residents, the ability to access urgent and after-hours services has spared many the 110km return trips to Hobart for emergency treatment.

In a recent incident, a woman who dislocated her finger at 7pm in the evening had no way of getting to and from Hobart. Working alongside his after-hours nurse practitioner colleague, he administered a ring block and realigned the finger. The nurse practitioner wrote a referral for an X-ray that enabled the patient to avoid an emergency department presentation. She was back home with her family an hour later, with a functioning digit and significantly less pain.

Cygnet's urgent and after-hours service has proved enormously popular, and word of mouth has fuelled a booming practice.

"People are happy about it. I don't think I've ever gotten so many 'thank yous' in my entire career. The local population is genuinely appreciative and grateful that there is an urgent after-hours service. They're telling other people in the community, 'Call Cygnet, they've got urgent and after hours; you'll be able to get in and see them'. A lot of them are pretty reluctant to make the drive to Hobart, so if I can suture someone up and our nurse practitioner can order antibiotics, they avoid that trip."

At present, Ben works from Thursday to Saturday, from 9.30am to 9.30pm, and has a consultation room next to his nurse practitioner colleagues. During normal business hours, he sees patients who are unable to secure a booking with other GPs in the town as well as handling emergency call-outs under a memorandum of understanding with Ambulance Tasmania.

"If they can't get in to see their GP and they're not a patient of Cygnet Family Practice, they can still get in to see the urgent and after hours team. A lot of the time I can deal with it on my own. If I can't, then the nurse practitioner is practicing in another consult room.

"A couple times a week, a community call comes in, so that might be police on scene or a person who has a medical issue. It may be someone who's called the clinic saying that they're physically not capable of coming up to the clinic or they want someone to come out and tell them if they need to go to hospital or not. I go out for that."

IT'S ABOUT MY COMPETENCIES, WHAT I'M TRAINED IN, WHAT I'M CONFIDENT ABOUT

It's while on community calls that he comes across sicker patients and people with more severe injuries who require ambulance transport. While the nearest Tasmanian Ambulance station is located in Huonville about 20 minutes aways, their geographic range means it can sometimes take an hour to arrive on scene. Equipped with treatment and kit bags, his role is to assess the patient on scene, administer urgent medical assistance as required, and stabilise the patient until the ambulance arrives.

Cygnet's multidisciplinary model of team-based care is one that is gradually being adopted in Australia in primary and urgent care health environments as a growing number of health services realise the value and utility of paramedics' capabilities and experience in providing more responsive and holistic patient care.

For Ben, it's a steep learning curve, but one that is continually building confidence and trust in his knowledge and skills.

"It's about my competencies, what I'm trained in and what I'm confident about. I like that the responsibility's on me. It's not predetermined - this is what you've got to do or this is what you can't exceed. It's up to me within my skills, knowledge and experience. A lot of the time I can deal with things on my own. If I can't, then I consult with my nurse practitioner colleague.

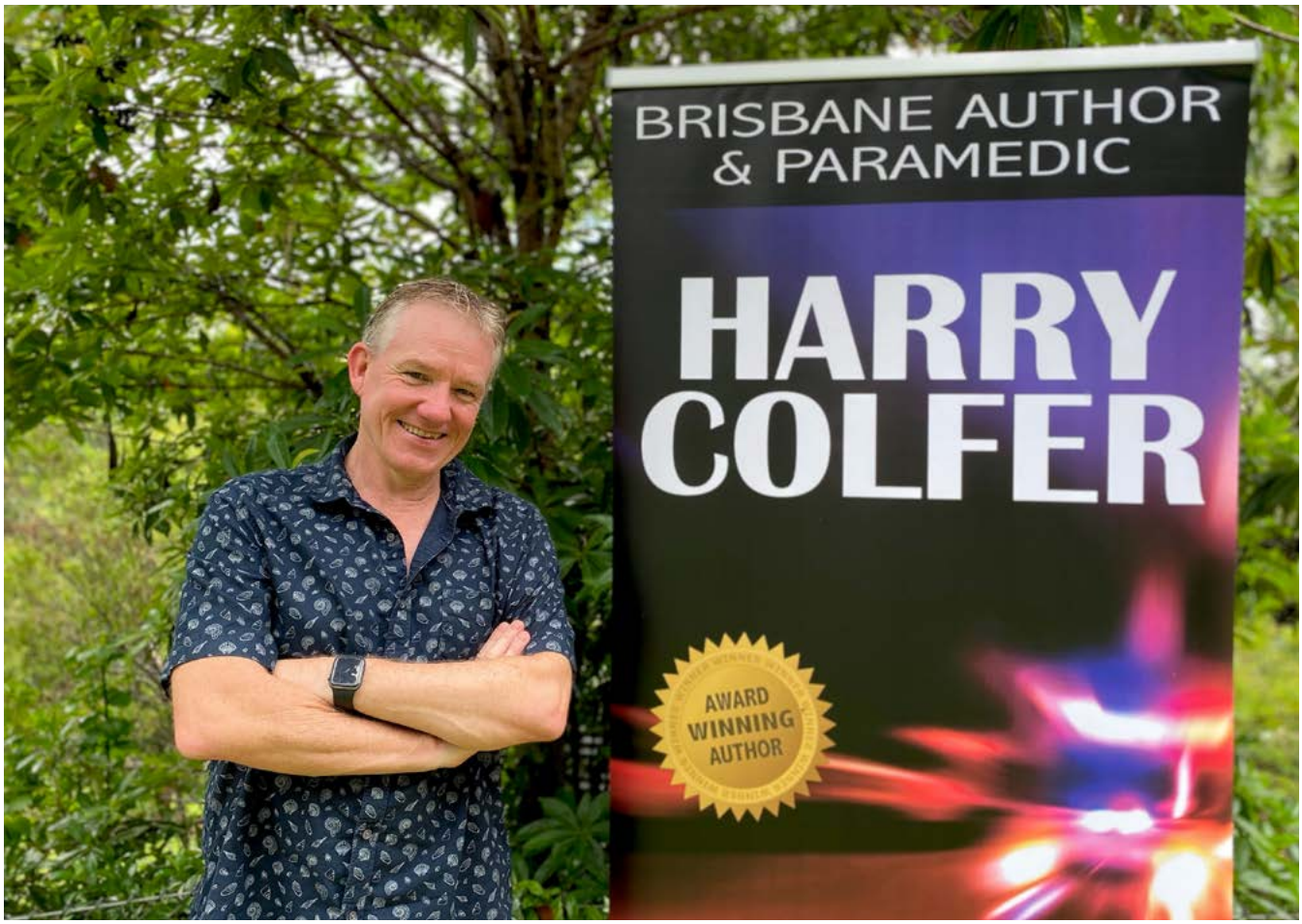
"In the primary healthcare setting, any wound care skill I learn, I get to use that almost immediately. I've got a course in Perth in April for minor surgery and skin excisions and biopsies. Whatever skills I acquire, whatever skills I become confident in, I can then go, 'Hey, this is what I can do now'. So then another subset of patients can be seen to and treated."

He hopes more medical practices will embrace Cygnet's multidisciplinary approach and recognise the important role paramedics can play in delivering improved health services for communities.

"The opportunities to branch out from pre-hospital ambulance in particular are woefully limited for what we can do and for the benefits we can provide."

A STORIED CAREER: AWARD-WINNING AUTHOR AND QAS PARAMEDIC HAS THE WRITE STUFF

Brisbane/Meanjin, Turrbal and Jagera Country



FOR MANY YEARS I'D WANTED TO WRITE A BOOK, TO WRITE CREATIVELY

When Queensland Ambulance Service Critical Care Paramedic Phil Davies' wife told him in 2012 to "just write a bloody book", the story ideas he had been mulling over and jotting down in the years prior began to take shape as he took her advice and put pen to paper.

"For many years I'd wanted to write a book, to write creatively, but everybody has that idea - 'I reckon I've got a book in me'. That was the point where I went, okay."

The former UK paramedic and his wife had relocated to Queensland in 2008, where he had requalified and recredentialed with QAS. While he had already begun what would later become his first full-length thriller, initially he settled on a series of short stories based on the 32 alphabetical Advanced Medical Priority Dispatch System codes (from "abdominal pain" through to "unknown problem") used to categorise emergency call-outs.

Writing under the pen name Harry Colfer, the stories - featuring fictional Brisbane paramedic Jonothan "Jono" Byrne, the central character in his three subsequent novels - are loosely based on his own

professional experiences, albeit set in an equally fictional ambulance service. Initially each was progressively released as an individual e-book, but on completion of the series six years later in 2022, he self-published the book compendium "The Complete Collection".

It was a long and tiring slog. After writing the first six, he realised the mammoth task ahead of him.

"I thought, great, I've got six, I've only got 26 to go. But I didn't do the maths on it because 32 times four or five thousand-word short stories is about 150,000 words, which was two novels worth of writing to get done. That's massive."

In the interim, he took home three successive Kennedy Foundation's SD Harvey Short Crime Story awards, two for the already published short stories ("Number 27: Stabbing" and "Number 30: Traumatic injury") and another he penned specifically for the competition under his own name.

"I heard on the grapevine that they weren't going to let Harry Colfer win the same competition three years in a row, so my submission in the third year had nothing to do with paramedics, it was a science fiction detective story, "Adam Ingram", and I won it under my own name, so that was quite nice."

He was also shortlisted and longlisted for numerous other awards, including being a finalist in America's prestigious Indie Book Awards.

All of the Collected Tales were prequels to the thriller he had begun years earlier in 2012, Dead Regular - the first of a series that was followed by Beneath Contempt and High Acuity.

"The upshot of winning this competition was that it galvanised me into working on the final draft of Dead Regular. I thought, I've got this book almost completed, I'm just going to dust it off and self-publish and see how it goes."

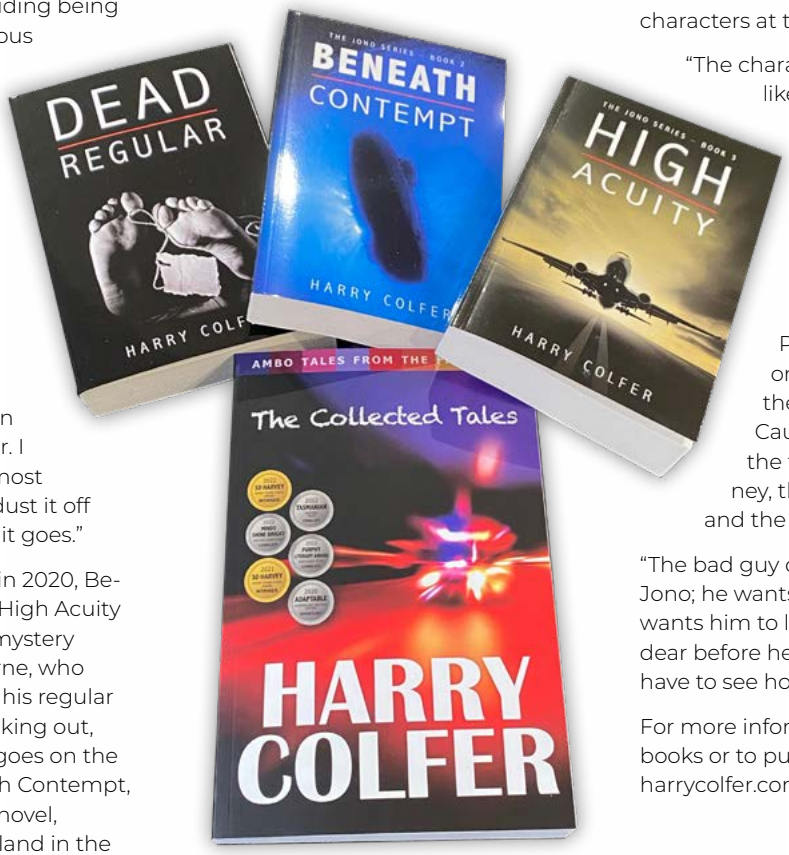
Dead Regular was published in 2020, Beneath Contempt in 2021, and High Acuity in 2023. The first is a murder mystery involving paramedic Jono Byrne, who believes a serial killer is offing his regular patients. When he starts speaking out, he is framed for murder and goes on the run to clear his name. Beneath Contempt, more of an action-adventure novel, follows Jono to Mornington Island in the Gulf of Carpentaria where he has been transferred and becomes embroiled in a people-smuggling operation using the island as a base. High Acuity involves Jono returning to Brisbane and uncovering a terrorist plot to use an ambulance as an excuse to board a plane. It takes place over 13 hours, with each chapter assigned a time stamp, alternating between different characters' points of view.

Despite the fictionalised depictions across his novels, he aims to keep it as realistic as possible, unlike many television and movie portrayals of paramedicine.

THE BEST WAY OF REPRESENTING THE TRUTH IS THROUGH FICTION

"Reality TV shows are very sanitised compared to how we actually talk, how we interact as paramedics. And movie portrayals are always high octane, everyone running around. The reality is most of the jobs we go to aren't like that.

"The best way of representing the truth is through fiction. I do provide some high-acuity jobs, but there's also the lower-acuity work. My focus is more on the way we interact; our banter and our dark humour is a constant thing that flows through when you're working. A lot of paramedics read my books and say that yeah, this is how it is, this is what happens."



Adding gravitas to the realism is the professional experience he gained during a six-month stint as an assistant scenes of crime officer gathering evidence in criminal cases and attending autopsies in the UK prior to becoming a paramedic.

"I would go to crime scenes and take fingerprints and blood samples and collect evidence. Somebody once reported their car had been broken into, so I turned up and found the back window shattered.

"This guy was probably the worst burglar you could possibly imagine. First of all he tried to kick in the glass and left a beautiful boot print on the side window. Then he found a broom and broke the back window. He'd hit it and obviously hit it again, but the first hit embedded glass in the wood and it cut his hand, so there was blood all down the handle. Then he must have put his hand in his mouth to stop the blood, spitting it out on to the car - this big glob of blood and saliva. It was a party bag of DNA and evidence, and he hadn't actually stolen anything."

An early scene he wrote for Dead Regular, based on his real-life post-mortem experiences, is set in a mortuary, where the female being autopsied is found to have a tattoo of three Chinese characters at the base of her back.

"The character says something like, 'I wonder what those mean?', and the rather dry copper says, 'Turn me over'. I was the one who actually asked, 'I wonder what those mean?' and a copper actually said that in reply."

Phil is currently working on the fourth and final in the Jono Byrne series, Show Cause - the culmination of the fictional paramedic's journey, the tying up of storylines, and the return of his nemesis.

"The bad guy doesn't just want to kill Jono; he wants to destroy his life. He wants him to lose everything he holds dear before he's murdered. We'll just have to see how Jono copes."

For more information on Phil and his books or to purchase online, visit: https://harrycolfer.com/

IMPROVING THE PATIENT JOURNEY, ONE PUZZLE PIECE AT A TIME

By **Kate Deppeler**, SA Ambulance Service
Adelaide/Tarntanya, Kaurna Country

Paramedics are problem solvers, and they use their critical life-saving skills in a number of different ways.

At SA Ambulance Service (SAAS), we have increased our paramedic presence in hospitals and in strategic healthcare system roles in a bid to improve the patient experience.

Three pieces of the puzzle are Hospital Ambulance Liaison Officers (HALOs), Hospital Relationship Managers (HRMs) and Clinical Supervisor - Dispatch Network Operations (CS-DNO).

HALOs are now in each major Adelaide metropolitan hospital emergency department, and our HRMs are in each health network's operations centre. The CS-DNO, the 24/7 service in the SAAS Emergency Operations Centre, performs a key role for the State Health Coordination Centre.

SAAS first introduced HALOs into the Flinders Medical Centre in 2018, shortly followed by the Royal Adelaide Hospital. The role then morphed into two, with the HRMs becoming more focused on policy and hospital structure while the HALOs remained focused on specific patient paths and managing daily flow. The CS-DNO also evolved, originating as the State Duty Manager Assist and only open to Intensive Care Paramedics to becoming the role it is now, available to paramedics. The CS-DNO aims to prevent the ramp happening in the first place, minimise the impact when it does, and provide clinical support to the dispatch team.

AT SAAS, WE HAVE INCREASED OUR PARAMEDIC PRESENCE IN HOSPITALS AND IN STRATEGIC HEALTHCARE SYSTEM ROLES

Danny Harnas is a HALO at the Northern Adelaide Local Health Network based at Modbury Hospital, while Tracey Hughes is in the HRM role at Flinders Medical Centre at the Southern Adelaide Local Health Network (SALHN). Ruby Genborg works as a CS-DNO in the Emergency Operations Centre.

What ties these three people together is that they relish a challenge, love the strategic overview their roles have given them, and they like solving problems.

"It all comes down to patient outcomes as they navigate their way through the health system. If I can make that experience better for the patient, then that inevitability makes it better for the crew," Danny said.

"It does alleviate a lot of the stress and tension between SAAS and the hospitals," he said.

The pieces of the puzzle for Danny are the incoming patient and crew, the emergency department, and the decision-makers from both organisations.

Danny has had a 20-year career as a paramedic, and the ability to have a greater impact on the patient is what drives him as a HALO.

"I actually think it's one of those positions that everyone should rotate through so they can understand the difficulties that are faced by each individual piece of the healthcare system," he said.

Tracey, who has been with SAAS for 30 years, said the HRM role was about making those pieces of the puzzle fit together and function as a whole.

"I work in the SALHN Operations Centre as part of a team including the bed managers, nurse consultants who also review patients for alternate bed pathways, and the level-four nurse manager here," she said.

"I work with patient flow, assist with interfacility transfers via the RFDS and road, monitor the non-emergency transfers and discharges, and also provide an awareness to the bed managers of incoming patients."

Tracey first started working as a HALO in 2020 and is now a permanent HRM. She is excited by the development of the position and the work involved.

"I do education sessions with the staff in the hospitals and I also work on the policies, procedures and projects that bring about change in the system, helping to link it all together.

"The HRMs are also starting to manage HALOs; they're my team working on patient flow."

Also working at the puzzle table is the CS-DNO, a role Ruby Genborg has been in for the past 12 months.

From left: Tracey Hughes, Danny Harnas and and Ruby Genborg

"I'm that link between the ramp and the hospital - getting the right patient off the ramp, as well as trying to prevent the ramp happening in the first place," she said.

"In the other part of my role, I provide medical and clinical support to the dispatchers. Where there's multiple patients all requiring an emergency response, I help decide which job we need to go to next."

The CS-DNO is a service staffed 24/7, performing the patient advocacy role with hospitals, and decision-makers when HALOs or HRMs aren't available.

"I enjoy solving problems, and I enjoy that the problems I get to solve are more than just the one patient in front of me," Ruby said.

Ruby, Tracey and Danny all reflect on how their role has changed their perspective as an on-road paramedic.

"It's given me a higher order of thinking and a different set of skills," Ruby said.

"It is a very different thing from being on the road. A lot of my work is much longer term, you don't often see the changes every day - some projects take more than a year," Tracey said.

"It's multi-faceted here, it's not focusing on one patient at a time, it's about making sure we're understanding everything that's going on in the background," Danny said.

FEATURE

HEALTH INEQUITY AND INEQUALITY – A CONVERSATION FOR US ALL

By **Aroha (Michelle) Ormsby-Brett**, Māori Health & Equity Lead - Clinical Services, Hato Hone St John
Dan Spearing, National Equity Manager, Hato Hone St John
Tāmaki Makaurau/Auckland, Aotearoa New Zealand

Hato Hone St John Te Kaha ambulance officers

In Aotearoa New Zealand, issues around inequity and inequality in the health sector have evolved over the past 150 years or more to where they are today.

Inequity refers to unfair, avoidable differences arising from poor governance, corruption, or cultural exclusion. Inequality refers to the uneven distribution of health or health resources due to such factors such as geographic isolation and economic limitations.

Research shows that nationally Māori have poorer health outcomes than non-Maori particularly because of their interactions with the healthcare system.

This places an enormous cost on whānau and the wider community in terms of avoidable illness, suffering and financial expense from the loss of income and workdays, and increased health concerns and health expenses.

Overall, lower standards of health lead to poorer outcomes for Māori.

The first step towards closing the gap is understanding what it is and how it has come to exist in our country. We know that we can do better as healthcare professionals, and sometimes it's as simple as talking to the patients we meet and treat and asking the right questions, listening to the answers, being aware and acknowledging our own unconscious biases, engaging in training opportunities, and asking for help.

Historically, the public health system and those within it, including Hato Hone St John, has typically not been good at this. We are finally acknowledging that a tikanga Māori approach is crucial in achieving equity for Māori and improving health outcomes among the population.

Alongside efforts to engage our people, we're taking innovative steps towards addressing inequity, including prioritising empowering our workforce with the cultural competency they need to deliver and adapt to our community's needs.

We know that having the right care in the right place at the right time and by the right person is not always easy for isolated small rural communities where many Māori population reside. Therefore, we are finding new ways to empower whānau and support them to access the care they need.

Acknowledging this inspired Whakaōrite Whiwhinga Mahi, the ambulance service's first region-wide targeted recruitment initiative for Māori and Pasifika living in Tairāwhiti and the Eastern Bay of Plenty areas, with the aim of creating a blueprint for other regions to follow.

As of January 2023, Māori representation in paid ambulance officer and paramedic positions at Hato Hone St John sat at 9.1 per cent.

Having tangata whenua (Māori people of the land) in our Hato Hone workforce who live, know, and love their communities is critical to enabling and advocating for equitable service delivery.

Whakaōrite Whiwhinga Mahi was co-designed alongside tertiary, local iwi, hapū, whānau and hauora Māori providers, with the mission of ensuring our health workforce better represents the communities they serve.

Dedicating resources and time to like-minded initiatives not only enhances equitable health service delivery but also equitable career opportunities.

This is the launch of a long-term commitment to find opportunities to continue this mahi (work) to boost Māori and Pasifika representation in our workforce. In addition to this, we are working with the wider health sector to improve this representation.

While reversing the inequity and inequality challenges accumulated over the past two centuries will take time and funding, Hato Hone St John remains committed to serving many more underserved communities each year and closing the gap on equity and equality.

A TIKANGA MĀORI APPROACH IS CRUCIAL IN ACHIEVING EQUITY FOR MĀORI AND IMPROVING HEALTH OUTCOMES AMONG THE POPULATION

Growing our ability to look through the lens of Indigenous people is critical. If we can't do that then we will never have an impact. In tikanga Māori (customary practices and behaviours), everything in life is connected, including hauora (health). To achieve hauora requires balancing social, emotional, physical, spiritual, cultural and environmental wellbeing.

This philosophy has been the basis of Hato Hone St John five-year strategy Manaaki Ora, which we launched in 2022 with the aim of extending mahi (work) in all communities in Aotearoa New Zealand, focusing on equity to help everyone live healthier, happier and longer.

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THE PATIENT EXPERIENCE: WHAT DO OUR PATIENTS HAVE TO SAY?

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

"A lived experience is not only something that is experienced, its being experienced makes a special impression that gives it lasting importance" (Gadamer, 2004). Paramedics concentrate on mastering our famous bread-and-butter skills - cannulation, advanced airways, CPR. We remember countless protocols, medications, and drug doses. However, at the end of the day, everything we do, every skill we obtain is done in the name of improving our patient care. Despite this, there is relatively little formal research on patient care from the point of view of our patients. In this article, we will delve into three recent journal articles on the topic of "patient experience". So what do patients have to say and why should we listen?

In 2023, the World Health Organization (WHO) chose "Elevate the voice of patients" as their World Patient Safety Day slogan (WHO, 2023). The advocacy for patient engagement can be linked back to 1978 when it was first recognised that patients should have a voice in the planning and implementation of their healthcare. Patient engagement is crucial for improved health outcomes, improved quality of life, a reduction in adverse events, and it has been shown to reduce healthcare costs, positively influence patient experiences, improve patient outcomes, and improve healthcare performance (WHO, 2023). Hearing feedback directly from patients can assist paramedics and ambulance services in their attempts to both improve the patient experience and patient outcomes.

Box 2. Global milestones in patient engagement and empowerment

1978: Declaration Alma-Ata on Primary Health Care supports the right of people to participate individually and collectively in the planning and implementation of their health care.

2005: World Alliance for Patient Safety establishes the WHO Patients for Patient Safety programme.

2016: Sixty-ninth World Health Assembly approves WHO Framework on Integrated People-centred Health Services.

2016–2019: A series of global ministerial summits on patient safety recognize the central role of patient engagement and empowerment in the delivery of safe health care.

2018: Astana Declaration promotes health literacy and the right to information, knowledge, skills and resources needed to maintain health.

2019: Seventy-second World Health Assembly adopts resolution WHA72.6 calling for global action on patient safety.

2019–2022: World Patient Safety Days with consecutive annual themes highlight patient engagement as a key strategy for patient safety.

2021: *The WHO Global Patient Safety Action Plan 2021-2030* identifies patient and family engagement as one of its seven strategic objectives.

2023: Fifth Global Ministerial Summit on Patient Safety sets forth patient engagement for implementation.

2023: World Patient Safety Day is dedicated to the theme of "Engaging patients for patient safety".

World Health Organization, 2023

The first article we will discuss is by Fergusson et al., titled "I was worried if I don't have a broken leg they might not take it seriously": Experiences of men accessing ambulance services for mental health and/or alcohol and other drug problems (2019). This article explores the positive and negative experiences of men in Australia who rang the ambulance due to mental health/drugs or alcohol. The three themes that emerged from the participants included professionalism and compassion, communication, and handover.

FEEDBACK FROM PATIENTS CAN ASSIST PARAMEDICS AND AMBULANCE SERVICES IN THEIR ATTEMPTS TO BOTH IMPROVE THE PATIENT EXPERIENCE AND PATIENT OUTCOMES

Positive experiences were noted in cases in which the paramedic was professional, caring, made the person feel valued, and allowed them to be involved in the process of their ongoing care. Conversely, negative experiences were noted when patients felt they were being judged or ignored by the paramedic, when they felt like a nuisance, or when they felt as though their condition wasn't treated as a priority. The specific quotes taken from patients

were particularly powerful, for example, "One said to me: We could be out saving someone's life rather than transporting you for a check-up; "I heard one paramedic say: You're too old to be doing this". A take home from this article was that further understanding of these patient experiences are needed and increased training could be used to enhance how paramedics communicate with men experiencing mental health and/or alcohol and other drug problems.

The second article by Flannigan et al., is about women's experiences of unplanned out-of-hospital births (2019). This is a powerful qualitative research article that dives into 22 women's experience within Queensland. The women describe both the positive and negatives interactions they had with paramedics in the context of their out-of-hospital births. Experiences that were rated positively described paramedics as showing empathy, good interpersonal skills, and clinical competence. Quotes such as "They were really kind and listened to everything we wanted" and "He was absolutely amazing. He came in and told me what was going to happen, what he was going to do, what stage I was at" highlight these positive interactions. Experiences that were rated as negative described paramedics as disrespectful, lacking empathy or showing poor interpersonal skills.

Quotes such as "They seemed almost annoyed that it [the out-of-hospital birth] looked like it was intentional" and "They took the baby's blood sugar and didn't tell me" demonstrate that in some cases, the way we perform certain actions on scene may have a profound impact on our patients. This research on these women's lived experience found that further education and professional development based on a model of care that is patient-centred, embodies respect, and is focused on developing interpersonal communication skills is needed.

PEOPLE MAY NOT REMEMBER WHAT YOU DO FOR THEM, BUT THEY WILL REMEMBER HOW YOU MADE THEM FEEL

The final article by King et al., discussed patients' experiences of non-conveyance by ambulance (2023). This explored patients' experiences of being attended and left at home after they called an ambulance. Patients described having to call an ambulance as a scary and uncertain situation. While most patients involved in the study were found to have had a positive experience, with many expressing they were made to feel reassured about their situation, there were some who described a more negative experience. These patients felt they were not taken seriously, or that the advice they were given was not correct.

Positive remarks included "I found them very, very, thorough, very, very, professional, very, very, caring and just so well-mannered" and "You can call us, and you don't feel bad about calling if you have to". Negative remarks included "I'm not saying I wasn't completely taken seriously, but I called the ambulance because I thought I really needed to go to hospital and have this tested because I thought it might be something seriously wrong here. But then they said, we don't think you need to go to hospital".

This article explored how our patient's expectations and beliefs about their healthcare journey might be changed by different interactions with the ambulance service. As with the other articles discussed, it highlights the importance of understanding that each of our patients is at a different point in their healthcare journey and have their own lived experiences that further colour their interactions with the health system.

Paramedicine evolving as a profession means we will need further research on how our patients experience our care. Are we inclusive, receptive, and responsive in undertaking a holistic patient approach? And if we're falling short, how can we do better? Reflective practice and keeping up to date on recent, relevant literature can help us all become aware of patient experiences and how we can improve our practice.

Lastly, take note that in all these articles and experiences reported, very few are in relation to the legitimate clinical actions or clinical skills used for the patient. This highlights the importance of the fact that people may not remember what you do for them, but they will remember how you made them feel.

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AN ED VISIT LIKE NO OTHER

By **Mark Garner**

Mark worked as an Offshore Critical Care and Extended Care Paramedic in both Australia and Aotearoa New Zealand, and was an undergraduate lecturer teaching paramedicine. He now works as a consultant to the industry

As a retired Critical Care and Extended Care/Remote Paramedic, I was recently invited to be an observer on a NetworkZ trauma simulation training scenario, held in a major hospital emergency department in Aotearoa New Zealand.

The simulation package run by NetworkZ, a division of the University of Auckland's Uniservices department, was developed more than eight years ago by a team of clinicians and academics using a high-fidelity manikin and realistic special effects overlays to allow interdisciplinary teams to practise their skills with convincingly authentic scenarios. It is backed by robust academic research and rolled out throughout the country in multiple care settings.

The manikin talks, blinks, bleeds, breathes, has pulses, can be intubated and cannulated, and have chest drains inserted, as well as features realistic wounds, amputations, or various other injuries. It is as realistic as one can get without using a real patient. It is remotely controlled by a technician who can alter any parameter, including heart rate, cardiac rhythm, SpO2, etCO2, respirations, pupils, eyes, and pretty much everything else except movement and colour.

Facilitators of the program brief the teams beforehand, demonstrating how the manikin works and the rules of engagement for the event. Once briefed, the action begins. Of note, all the participants are actual healthcare workers in the roles they would normally perform; doctors, nurses, laboratory involvement, HCAs, and pre-hospital care staff. And all the scenarios are performed in the actual clinical space - in situ.

Just like a realistic event, the scenario begins with an R-40 (radio call to hospital) from the incoming ambulance, informing them of the patient, their injuries, treatment given, status and ETA. The team uses this information, alongside their protocols, to prepare for the imminent arrival and request the attendance of any other team members they think they might need.

ONE OF THE SENIOR DOCTORS SAID SHE WOULD LOVE IT IF THE PARAMEDICS STAYED AND HELPED IF THEY COULD

After roughly five minutes, the "patient" is wheeled in the door and the paramedic gives their typical handover, introducing the patient, highlighting their injuries, treatment, and any other relevant information. After assisting with transferring the patient on to the ED stretcher, they exit the room or can stay and assist if requested. In my case, I stood back and observed.

This is what I learnt from the experience:

The R-40 information is critically important

While it is routine for paramedics to call in an R-40 for status one or two patients, I underestimated the importance of the information we give. The mechanism of injury and baselines of the patient can be used to determine what experts are called into the resuscitation room. I also realised one of the things we don't mention in R-40s that would be helpful to the ED is an estimated weight of the patient. We use this information in the field to guide the drug doses we give, and passing this vital piece of information in an R-40 can also help them to prepare and draw up drug dosages before the ambulance arrival. Timing of the R-40 is also important. Giving it around 15-20 minutes seems to be the optimal time so the right resources can be summoned without them waiting around too long for the ambulance arrival.

Our contribution doesn't have to stop after handover

Traditionally, ambulance staff deliver and hand over the patient to the hospital ED staff and then walk away to do a clean-up and complete the paperwork. There is, however, an appetite from some hospital staff that they actually stay and continue clinical involvement in the patients' treatment in the resuscitation room. In the debrief I witnessed, it was discussed what happens if the unit is short-staffed, critically busy, or there is simply not the staff available to carry out the many tasks that need doing. One of the senior doctors said she would love it if the paramedics stayed and helped if they could. She recognised the diverse skill set paramedics have and said their skills could often be well utilised during resuscitation efforts. It also became evident that sticking around meant that paramedics were able to answer further questions about the patient that the hospital staff may have as the resuscitation efforts progressed.

Bleeding control

Paramedics often do their best to pack and bandage up severe wounds to mitigate bleeding, but if the dressings are soaked in blood then they will likely be quickly torn off by the surgeon in an effort to stop bleeding. The surgeon in this scenario said if it appeared that bleeding had not been stopped, even with a tourniquet in situ, that he would often attempt to physically identify the offending blood vessel(s) and clamp them directly, even if it meant simply squeezing it with his fingers. He said it was far more effective than just tightening a torniquet.

A picture is worth a thousand words

A photo or photos taken from the scene (with the patients' permission where possible, of course), can provide additional valuable information that may otherwise be overlooked. As a paramedic, I made it a routine habit to take quick scene shots with the ePRF tablet to show ED staff what the incident looked like, what the environment looked like, how the patient was encased/trapped, or what their injuries or wounds looked like at the scene prior to splinting/dressing. ED staff always appreciated the extra information the photos presented. In the scenario I watched, I realised that if a photo of the scene had been included, it may have enhanced the handover information given. I think we often underestimate the value such pictures can bring, and this would also be an area worthy of some academic research.

The information in the ePRF follows the patient through their hospital journey

The information entered into the ambulance ePRF, including your description of the event, treatment and baselines, ECGs and photos, is often used by specialists throughout the hospital during the patients' journey through the hospital system. It may be used as a basis for important clinical decisions or, in the event the patient dies, by the coroner, so it is vital to make sure it is as accurate and descriptive as it can be! Use the timelines provided in the monitor summary to ensure times of actions are entered as accurately as possible.

While paramedics carry out multiple roles to treat the patient, this is done by specialist teams in hospital

Hospitals work in specialist teams. This includes an airway team (anaesthetists, anaesthetic technicians, and airway nurses) who take care of the airway and breathing, a surgical team (typically a surgical registrar who looks at the fractures, circulation, organ damage and blood loss), pharmacy (medication nurses and pharmacists who draw up the drugs), ED doctors (registrars, senior medical officers, and house officers who generally run the resuscitation), a scribe (to take down notes and/or write them up on the whiteboard), orderlies and healthcare assistants (who often fetch equipment or may do CPR) and an IV nurse (cannulating and setting up fluids). Depending on the hospital, you may also have someone from plastics, neurology, obstetrics, orthopaedics, radiology, blood bank and intensive care. This is why the resus room can suddenly become so crowded.

Interdisciplinary interaction can be complex and practice helps perfect it

The huge advantage of this inter-disciplinary training is that it helps to ensure that these expert teams work effectively, efficiently, and that ultimately the patient benefits from the treatments being given - and in a timely fashion. It also can identify latent threats that will only show up when such simulations are carried out and when training is done in the actual clinical workspace. Is the equipment fit for purpose and in the right place? Are there sufficient quantities of the right medications? Are there barriers (physical or otherwise) to effective communication? Is the layout of the room effective?

Don't forget the whānau (family)

As paramedics, we use the pneumonic IMISTAMBO when giving a handover to ensure we pass on the most important and relevant information. One thing that could be added to the end of this is W (for whānau) or F (for family). Letting the ED staff know what family members, if any, have accompanied the patient or are in the waiting room is important information both for those family members and the patient so they can be kept informed of the patient's care.

As the role of paramedics continues to diversify, it is important that they become more integrated into the emergency management teams, and the NetworkZ simulation training is an excellent way to do this in a non-threatening, safe, equitable environment. If you are offered the chance to participate in a NetworkZ training, I would highly recommend it. Not only will it count towards your CPD hours, but it will help to improve communication, relationships, and appreciation of the paramedic's role in the overall healthcare system.

AS THE ROLE OF PARAMEDICS CONTINUES TO DIVERSIFY, IT IS IMPORTANT THAT THEY BECOME MORE INTEGRATED INTO THE EMERGENCY MANAGEMENT TEAMS

PARAMEDIC STUDENTS AND THE PATIENT'S PATH TO RECOVERY

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Paramedics play a critical role in the delivery of healthcare and in emergency service sectors around the world as primary healthcare providers. The demand for ambulance services in Australia has soared in recent decades and the paramedic workforce has grown significantly. At the same time, the nature of our work has been recast to encompass a broader range of clinical interventions and treatment options besides transporting the patient to hospital[1,2]. As the profession continues to evolve, so too must pedagogy to ensure the changing demands of graduate paramedic practice are met, and the delivery of optimal healthcare by paramedics in our communities is maintained.

In the dynamic realm of healthcare, innovation often emerges from smaller, collaborative projects between academic institutions and allied healthcare providers. An example of this is the partnership between Charles Sturt University (CSU) and NSW's Mid North Coast Local Health District (MNCLHD), which has given rise to a transformative initiative - facilitated paramedicine allied health placements.

While facilitated placements may not be an entirely new concept, this project allows students to follow the patient's journey through the health system while assessing a variety of patient presentations in diverse clinical environments. It is hoped that this approach will develop their knowledge of their allied health partners and the wider health system. This approach has been developed to address the dual challenges of sector-wide shortages of paramedicine ambulance placements and increasing scope of paramedicine practice beyond patient transport and emergency presentations.

THE PARTNERSHIP BETWEEN CSU AND THE MID NORTH COAST LOCAL HEALTH DISTRICT HAS GIVEN RISE TO A TRANSFORMATIVE INITIATIVE - FACILITATED PARAMEDICINE ALLIED HEALTH PLACEMENTS

The National Priorities and Industry Linkage Fund (NPILF) is a component of the federal government's job-ready graduates package offering financial support to universities to foster increased collaboration between academic institutions and industry. This project has been funded and supported to increase the number of internships, practicums, and other innovative approaches to work-integrated learning. Further, it is designed to improve student employment outcomes and support universities to develop and strengthen partnerships with industry.

In this work-integrated learning (WIL) model, paramedicine students undertake a four-week placement block in a hospital and follow the patient journey in its entirety, from the initial presentation through to discharge. Students are allocated in pairs to promote peer-assisted learning and debrief throughout their WIL placement and to provide opportunistic support in an unfamiliar environment. This immersive learning experience is guided and supervised by registered professionals who specialise in specific areas of healthcare, ensuring that students gain practical insights and skills aligned with the diverse challenges they may encounter in their future roles as paramedics.

Supervisors include registered nurses, mental health specialists, occupational therapists, medical doctors, psychologists, radiographers, anaesthetists, and midwives, allowing exposure to a broader scope of practice. Areas of rotation includes, but is not limited to, the paediatric ward, intensive care unit, cardiac catheter lab, the emergency department, community health, radiology, physiotherapy, and surgical theatres. Given current placement shortages and the expansion of the paramedicine scope of practice, this interprofessional allied

health placement is highly valuable and needs to be efficiently coordinated and effectively utilised.

In these health service settings, preceptors can foster the growth of students' understanding of a range of clinical practice areas and support their initiative and development of critical thinking skills. Importantly, the interprofessional allied health placement does not come from a deficit placement model; rather, it is a deliberate and innovative strategy to place paramedicine students in meaningful workplace contexts that will foster the development of a broad range of practice knowledge and skills. The interprofessional model is critical in preparing students to enter the health workforce, where teamwork and collaboration are vital in facilitating strategic goals to produce job-ready graduates and achieve positive patient outcomes.

THE INTERPROFESSIONAL MODEL IS CRITICAL IN PREPARING STUDENTS TO ENTER THE HEALTH WORKFORCE, WHERE TEAMWORK AND COLLABORATION ARE VITAL

Interprofessional learning is an essential aspect of education for healthcare professionals and is defined by the World Health Organisation (WHO) Framework for Action on Interprofessional Education and Collaborative Practice (2010)[3] as "when two or more professionals learn about, from and with each other to enable effective collaboration and improve health outcomes. Interprofessional learning enhances communication skills, fosters collaboration and teamwork, and promotes a better understanding of the unique roles, responsibilities, and contributions of each profession. It is a critical requirement in addressing complex healthcare issues, enabling professionals to provide patient-centred care. Work-integrated interprofessional learning should therefore be an integral part of paramedic education. Interprofessional health placements provide purposeful, authentic learning in environments where students learn from professionals in their area of expertise and specialists within their field. Real-world experiences provide many developmental learning opportunities and are shown to be productive and beneficial for students. An extensive qualitative review of experiences of learning, development, and preparedness for clinical practice among both student and graduate/intern paramedics identified these themes regarding facilitated models[4].

Along with the many benefits of the facilitated model, both participants and Paramedic Educators identified that learning from a clinical educator in allied health settings, where established systems of education and mentorship exist, significantly improved the quality of teaching and learning[4].

To extend the facilitated model, the placement is supported by planned debriefing and discussion time, in which the clinical facilitator provides real-time feedback in a small group setting (four to six students). Learning circles harmonise the power of peer and expert-led learning, allowing deliberate focus on the hidden curriculum, including social interaction, deeper reflections, ethical perspectives, and further development of critical thinking[5,6].

These rostered debriefing sessions are emphasised to give students an authentic opportunity to practice the skills of reflection and debriefing that are not often afforded during busy ambulance placements. Students are also supported by a Placement Champion (registered paramedic) who monitors their progress and provides discipline-specific feedback and application to paramedic professional capabilities.

The benefits of assigning students to facilitated placements in groups is widely documented across other health disciplines and has been suggested for exploration as a model in paramedicine[4-6]. Peer learning, underpinned by social constructivist learning theorists Vygotsky and Piaget, leverages our understanding that learning is best constructed in collaboration with significant others, and that social interaction is integral to developing understanding, knowledge, and cognition[7,8].

Peer learning is not a new concept; however, in medical education literature its contribution to positive student experiences by decreasing stress and anxiety, mitigating challenges, enhancing clinical knowledge, and prompting deeper clinical reasoning by mutually solving problems has been acknowledged[5,6]. Working in pairs or groups stimulates the development of new schemas to navigate similar situations or new challenges in the future, enhancing the safety of their patient care[9].

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A DRIVE TO RESHAPE PAEDIATRIC EDUCATION IN PARAMEDICINE CURRICULUM

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My path to paramedicine

At age 15, a life-changing medical crisis propelled my journey into paramedicine. It's a story marked by medical oversight, misjudgements and, thankfully, a mother's unwavering persistence that saved me from an impending health crisis. That harrowing experience, peppered with instances of exemplary and concerning paramedic care, fuelled my passion for reshaping paediatric education in paramedicine.

While at school camp, I awoke immobilised, signalling the onset of recurrent sepsis-like episodes that persisted for nearly 10 months. In my many encounters across the entire health system, diagnostic assessments were infrequent, leading to a reliance on pain management rather than a comprehensive investigative approach. Ambulance rides exposed me to varying paramedic approaches: Compassionate and thorough care versus misunderstandings resulting in complications. These encounters galvanised my academic pursuit in paramedicine, drawing from lived experiences.

THE SCARCITY OF PAEDIATRIC CONTENT IN UNIVERSITY CURRICULA UNDERSCORES THE URGENT NEED FOR CURRICULUM REFORM

Until a leap of faith fostered by maternal instinct, coupled with the threat of legal recourse, resulted in my mother deciding to refuse pain relief and persistently advocate for a specialist's opinion. Finally, on my 30th odd hospital trip, days away from a ruptured gallbladder that had been poisoning my body for nearly a year, the specialist finally identified the issue. While my case was somewhat uncommon, it echoes the experiences of many children and women in the modern world. The historical predominance of male subjects in clinical research has resulted in substantial gaps in evidence-based approaches tailored to female and child-specific care, often resulting in a lack of communication, assessment, pain relief and understanding.[1,2]

At a young age I could recognise the impact the first point of care would have on my outcome. Having been on both ends of the spectrum, I applied for a Bachelor in Paramedicine degree. While my experiences, both positive and negative, extended beyond paramedics and encompassed the broader health system, I saw an opportunity to start the process right, at the first encounter for the next paediatric patient. My aim was to use my experiences to alleviate the potential trauma another paediatric patient might experience in the future.

I was surprised to discover that, throughout my semesters, there was minimal emphasis on paediatric patients, with only fleeting references and assurances of revisiting the subject later. This content eventually surfaced in the final semester, bundled within a broader unit. Here, we learned the necessity of adapting our knowledge for diverse groups, including children, older individuals, pregnant individuals, those with disabilities, and from culturally or linguistically diverse backgrounds.

I, like most of my peers, tried my best to take in all this information but quickly understood why so many of my treating paramedics didn't understand how to adapt their communication, assess my pain, or recognise the need for established support networks to be involved in the care of a paediatric patient. I only encountered a few kids across all placements, and when I did, I was relegated to observer.

This personal revelation propelled me to pursue further education, now nearing the completion of my PhD. The aim of my research is to identify and evaluate how we can improve paramedic education in Australia. While my research findings remain unpublished, they illuminate a pressing reality: Paramedic students graduate feeling unequipped to manage paediatric cases. Early exposure and heightened emphasis on paediatrics are imperative, with students feeling significantly underprepared. The scarcity of paediatric content in university curricula, averaging below 2.5%, underscores the urgent need for curriculum reform. Clinical placements also fall short in providing exposure to paediatric cases, detrimentally impacting students' preparedness. Limited exposure - averaging 0.32 paediatric patients per shift - reveals a critical educational deficiency. Students might experience fewer than 10 paediatric cases during their degree, averaging roughly one patient per placement cycle. This limited exposure greatly impacts students' readiness, highlighting the necessity for a more comprehensive educational approach.

The unique challenges of paediatric care

Despite constituting a minority of pre-hospital emergencies (4.5–13%),[3] paediatric cases pose significant challenges due to their low-frequency yet high-acuity nature. They exhibit faster deterioration, smaller bodies with higher physiological instability, and challenges in communication, which can all complicate treatment. Studies show provider stress and anxiety increase safety incidents with paediatric patients, often linked to a lack of exposure.[4] Pain undertreatment in paediatric pre-hospital care,[5] and lower survival rates in paediatric out-of-hospital cardiac arrests[6] further underscore disparities in paediatric management.

Addressing these gaps in the literature and revisiting current training is critical for enhancing paramedic readiness and improving paediatric patient outcomes.

Paramedicine's evolution

Paramedicine stands as a frontline force, a critical bridge between emergency care and ongoing health services. This profession is indispensable, often serving as the initial point of contact for individuals in distress, requiring not only immediate medical attention but also empathetic care and effective communication. The historical trajectory of paramedicine, rooted in war-time practices and subsequently moulded by a male-dominated culture,[7] has led to the adherence of a standardised medical teaching model. This model centres around a systems-based approach integrating various organ systems and medical disciplines, generally within the context of a traditional archetype, which may not fully represent the diverse needs of today's patient population.[8]

Yet, the landscape of healthcare recipients is far from homogenous. The demographics of patients encountered by paramedics encompass a diverse tapestry of cultures, genders, ages, and socioeconomic backgrounds.[9] The evolving societal fabric demands a paradigm shift in paramedic education - one that transitions from the conventional, narrowly-focused teachings to a scaffolded approach encompassing diverse groups across all facets of paramedicine.

Shaping paramedicine's future

This transition isn't merely about inclusivity for the sake of diversity; it's a necessity born from the recognition that healthcare doesn't conform to a one-size-fits-all model.[9] Paramedics encounter individuals with distinct needs. Each demographic necessitates a nuanced understanding, tailored communication, and specialised care.[8]

PAEDIATRIC PATIENTS REPRESENT AN UNDERSERVED AGE DEMOGRAPHIC EXPERIENCING UNIQUE DISPARITIES COMPARED TO THE ADULT POPULATION

The evolution of paramedicine acknowledges this imperative for change. It's steering away from a rigid, homogeneous teaching model toward an inclusive, comprehensive framework that prepares future paramedics to engage with and cater to the multifaceted needs of the communities they serve. This evolution doesn't discard the fundamental principles of systematic care, but rather enhances them by integrating a deeper understanding of diverse perspectives and needs.

A scaffolded approach in paramedic education ensures that every facet of training - be it medical protocols, communication strategies, or cultural competency - is finely attuned to encompass and address the diverse spectrum of patients encountered. It's not a departure from the traditional but a necessary augmentation that fortifies the profession's capacity to provide effective, empathetic, and responsive care to all individuals, irrespective of their background, age or circumstance.

In embracing a social justice framework, we must question if the current curriculum upholds equity. Are paramedics graduating equipped to confidently serve diverse demographics? Perhaps a solution lies in a curriculum focused on health equity, strategically redistributing educational resources to address health disparities influenced by health determinants. Typically, underserved populations are perceived through the lens of socioeconomic, cultural, and racial disparities. However, it's pivotal to acknowledge that age serves as a significant determinant in health inequities.[10] Therefore, an effective health equity-centred curriculum must acknowledge the profound impact of age on health outcomes and strive to cater to the distinct needs of diverse age groups.

Arguably, within the realm of paramedicine, paediatric patients represent an underserved age demographic experiencing unique disparities compared to the adult population.[4-6] Addressing these specific paediatric disparities becomes imperative within the framework of a health equity-focused curriculum. I acknowledge that paediatrics are a minority patient group; however, equating the curriculum's content percentage to that of actual cases or population assumes uniform needs at the onset, which isn't the reality. This understanding drives the imperative for change from an equal to an equitable approach.

Paramedicine stands at a crossroads. It's not merely emergency care; it's a fusion of disciplines with a societal responsibility. It's time to ensure our education equips future paramedics to address the diverse needs of the communities they serve.

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NEONATE IN VR: USING IMMERSIVE VIRTUAL REALITY TRAINING FOR PARAMEDICINE

By **Michella Hill, Belinda Flanagan, Sara Hansen, Alecka Miles, Luke Hopper, Brennen Mills**
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Contemporary pre-hospital education faces several challenges in the current environment. One significant limitation is exposure to rare or unusual conditions, leading to what is called the theory-practice gap. Paramedic students have traditionally spent time on clinical placements learning relevant clinical and non-clinical skills. While students will often be exposed to the more common medical and trauma conditions, the rarer conditions such as cardiac arrest or childbirth may never be experienced as a trainee (O'Meara et al., 2014).

Paramedicine is a very "hands on" discipline and exposure is vitally important to translating what is taught in the classroom and applying this information into real-world practice (O'Meara et al., 2015). With rare or unusual conditions like childbirth, the lack of exposure is not only a limitation for the experienced and student paramedic, emergency medical technician volunteers have fewer training opportunities and intermittent exposure to clinical practice.

SPECIALISED SKILLS AND KNOWLEDGE DECAY OCCURS OVER TIME WITHOUT ONGOING PRACTICE EXPOSURE

Unfortunately, specialised skills and knowledge decay occurs over time (often times returning to baseline levels within 12 months) without ongoing practice exposure (Woodman et al., 2021). Perinatal obstetric care comprises less than 1% of ambulance workload, and while most births are uncomplicated, approximately 10% of neonates will require respiratory resuscitation and 1% will require cardiopulmonary resuscitation (Flanagan et al., 2017). Given interventions in these circumstances may be lifesaving, it is vital these skills and specialised knowledge are retained above the minimum competency level for easy and accurate recall in an emergency.

A novel way to combat lack of exposure to rare situations is to provide experiential learning via digital technology. Immersive virtual reality (iVR) is a completely immersive digitally created environment where the user can participate in a virtual space and manipulate/interact with virtual stimuli. iVR usually utilises a headset (similar to goggles) and hand controllers, immersing the user in a fabricated reality, and is particularly effective in capturing users' conscious attention due to multisensory input and the interactive nature of the technology. While technology cannot replace real-world experience, it can help bridge the theory-practice gap, minimise skills and knowledge decay, and is particularly useful for low-frequency, high-risk situations such as childbirth.

The NEONATE in VR simulation program (Novel Educational Overview of the Neonatal Apgar and Treatment Experience in Virtual Reality) was specifically designed to provide virtual exposure to a neonate born out of hospital. The simulation refreshes previously taught initial assessment and management of a neonate, including the one-minute Apgar score which should be undertaken in the first minutes of life. Targeting fundamental knowledge and skills, the aim of the educational application is to promote a solid understanding of normal and non-normal parameters for neonates (e.g., heart rate above 100 beats per minute, above or below 60 beats per minute) and the clinical management necessary to optimise patient outcomes.

The NEONATE in VR program exposes users to two scenarios. Scenario one doubles as a tutorial, where a healthy neonate is adjusting normally to extrauterine life. Through audio input, a clinical expert guides the user through every step of the process; drying and wrapping the baby to reduce the risk of hypothermia, checking the heart rate, respiratory effort, and movement. After 30 seconds of being born, the user must decide what intervention (if any) is needed for this neonate. After one minute, the user reassesses the neonate and again decides what management is required, and the one-minute Apgar assessment is undertaken (Australian Resuscitation Council, 2021).

Virtual panels provide key written information and instruction in case the user missed important audio information. The Australian Resuscitation Council's neonate resuscitation flowchart is also provided for

Figures 1 (a) and (b) depict screenshots from the NEONATE in VR program: (a) Assessing the neonate's heartrate; and (b) providing chest compressions with the aid of a virtual assistant conducting ventilations

reference. As this is an instructional program, the user will be redirected to "try again" should they select an improper pathway.

Scenario Two is more "DIY" with less audio instruction; however, visual prompts are still available via a hint button on the reference panel. This scenario divides, with two possible outcomes. In the first, the neonate requires respiratory assistance only, but in the second requires full cardiopulmonary resuscitation. An important learning outcome is the timing required for bag-valve-mask ventilations and chest compression, as research indicates pre-hospital providers tend to provide these interventions too slowly.

THE PROGRAM WAS SPECIFICALLY DESIGNED TO PROVIDE VIRTUAL EXPOSURE TO A NEONATE BORN OUT OF HOSPITAL

At the end of both scenarios, feedback is provided to the user on how many incorrect options were taken and how often the hint button was utilised. The project team is seeking additional funding to expand the program to include more advanced clinical skills such as cannulation, medication administration, and endotracheal intubation, as well as allowing for the possibility of incorrect management choices leading to a worsening of the neonate's condition.

By providing virtual exposure to neonates born out of hospital, skills and knowledge decay can be avoided. Research suggests many pre-hospital clinicians suffer anxiety and reduced confidence in attending out-of-hospital births (Hill et al., 2023). This program can help address these issues.

iVR programs such as NEONATE in VR are of particular benefit to rural and remote clinicians who have limited opportunity for in-person continuing professional development and specialist clinical placements. No educator is required to deliver the training and the program will always provide consistent feedback and repeatable experiences. NEONATE in VR can be used as a standalone training tool or alternatively be integrated into a more comprehensive education program. This method of training is highly flexible, can be undertaken at a time suitable for the user and in a limited space, and is well suited to situations which are dangerous in real life. Given that the medical profession has been utilising iVR to learn surgical techniques and procedures for many years, it seems timely that paramedicine also adopts similar innovative practices in clinical education.

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HATO HONE ST JOHN STREAMLINES GRADUATE PATHWAY IN NEW RECRUITMENT PROGRAMME

Tāmaki Makaurau/Auckland, Aotearoa New Zealand

The coming months will see the introduction of a new Hato Hone St John graduate paramedic programme aimed at consolidating the pathway to recruitment and employment within the service from application through to independent practice in one streamlined process.

Te waharoa o Waka Manaaki | Graduate Paramedic Programme - meaning to stand with excitement at the gates of the ambulance service - is similar to the Australia's recruitment system in employing graduates directly into graduate paramedic roles.

Hato Hone St John Tertiary Relationship Manager Jono Cash said in the past the service would employ graduates as EMTs, after which they could apply for paramedic internships, which varied by district, area and availability, then be upskilled.

"We're encompassing everything into one process. In the new programme, we bring them on a two-week foundation course in the classroom going through our foundation courses and our clinical procedures. They then spend a few weeks mentoring in our ambulances, three up, to become operationally competent, before spending at least three months working two up as a graduate paramedic with another clinician putting their knowledge into practice, and understand Hato Hone St John and the delivery of clinical care within Aotearoa.

WE'RE ENCOMPASSING EVERYTHING INTO ONE PROCESS

"Then they will be assigned a paramedic preceptor. Our paramedic preceptors are trained, which is very unique. We have been training our preceptors for years and something that is always reviewed and refined to ensure the best experiences for our graduates and mentors. They'll spend a minimum of three months with that graduate paramedic supporting their transition from graduate to independent practice. At the end of it, they'll do an assessment, and hopefully they will become independent paramedics."

Jono said the preceptors were there to provide support for the final stage of transition to autonomous clinicians, ensuring they are able to work by independently in an ambulance. They weren't there to assess the graduates; their role was to answer their questions, support them on jobs, encourage them to start practicing more independently and make their own decisions."

"They're a bit of a safety net, making sure that the graduate paramedic's safe and the patient's safe and that everyone's transitioning."

To support the long-term continuity of the programme, Hato Hone St John is planning to more widely integrate preceptor training into its workforce and for Te waharoa o Waka Manaaki graduates. Self-directed training modules are available online, providing flexibility for optimal individual learning.

Jono said that while becoming a preceptor wasn't mandatory for staff, it was hoped that eventually they will at least have undertaken preceptor training to better mentor and support colleagues.

"We're also introducing the expectation that graduates train up as preceptors a year or so following the completion of the programme so we can continue to develop our workforce.

"The preceptor training covers how to be a good mentor, how to give constructive feedback, how to support, develop and encourage fellow students, fellow paramedics, fellow clinicians and fellow colleagues. We see that training as beneficial in developing our whole profession within Hato Hone St John, not just our graduates.

"Hopefully by introducing this one nationally consistent, streamlined graduate programme, we'll be able to listen to what graduates say, listen to what our preceptors say, listen to what our managers say, and continue to evolve the programme to make sure it's reflective of what graduates and our service needs."

For more information on Te waharoa o Waka Manaaki, visit https://paramedics.org/storage/news/Tertiary-and-graduate-full-time-employment.pdf

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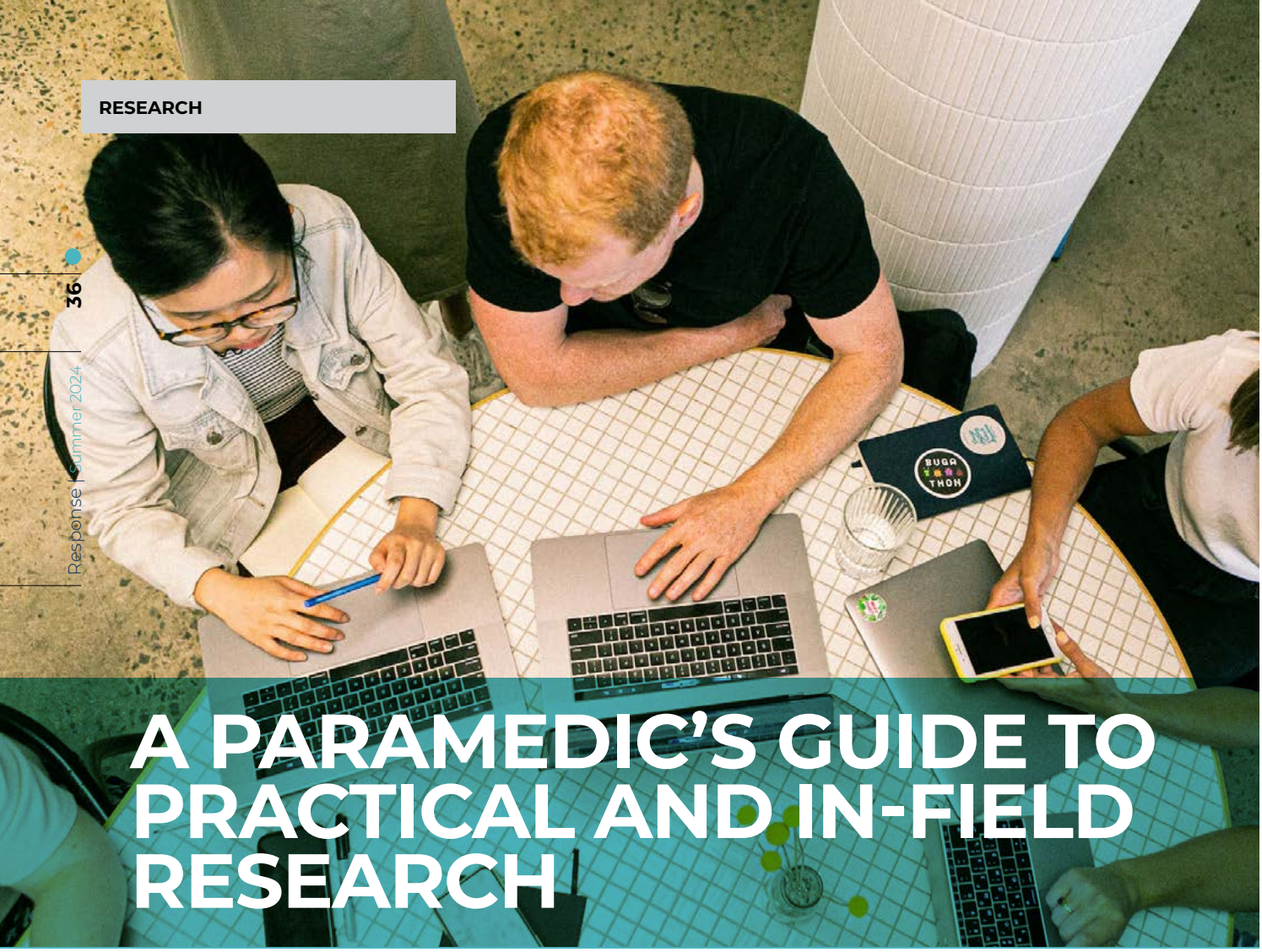

A PARAMEDIC'S GUIDE TO PRACTICAL AND IN-FIELD RESEARCH

By **Dr Ben Meadley**, Adjunct Associate Professor, Department of Paramedicine, Monash University

Melbourne/Naarm, Wurundjeri Country

For many paramedics, getting involved in research can be daunting. People hear tales of spreadsheets, qualitative research theorem, hours of data analysis, statistics, complex software, and lengthy database searches. While all of these are in some way essential to conducting robust research projects, practical and in-field research can add a new dimension to your research journey, complementing the very important and necessary desktop work.

What is practical and in-field research?

While "field study" refers to a specific area of observational research, for the purposes of this article practical and in-field research can be defined as "hands-on" work, often involving the recruitment of participants, the assessment of an intervention, some kind of equipment, or a novel method. Studies of this nature can be designed in many ways, but commonly such work may involve:

- Randomised Controlled Trials: A controlled clinical trial that randomly (by chance) assigns participants to two or more groups.
- Cross sectional studies: The observation of a defined population at a single point in time or time interval. Exposure and outcome are determined simultaneously.
- Longitudinal studies: A clinical research study in which people who presently have a certain condition or receive a particular treatment are followed over time (but may or may not be compared with another group).
- Cohort studies (prospective observational): A clinical research study in which people who presently have a certain condition or receive a particular treatment are followed over time and compared with another group of people who are not affected by the condition.

Large studies using these designs can often require a significant amount of work and funding to complete. However, for paramedics new to research, small, practical pilot studies are achievable, and can also be cost-neutral. Consideration of these types of studies is important as access to large clinical datasets from health services (including jurisdictional ambulance services) can be time consuming, and the timelines of the data provider often do not match those set by a tertiary institution. Additionally, analyses of large datasets may require specialist skillsets in biostatistics. Acquisition of such skills in short timeframes can

PRACTICAL AND IN-FIELD RESEARCH CAN ADD A NEW DIMENSION TO YOUR RESEARCH JOURNEY

be challenging, and dependent on expert instruction.

What is the process to undertake a small practical research project?

Start by getting good advice. There are many experienced researchers in paramedicine, and the College Research Committee can help guide you to a mentor. You can then discuss your area of interest and start working on a plan. Conversely, don't confine your advice-seeking to paramedicine researchers. If your area of interest is broader, then seek advice from subject matter experts. You'll be pleasantly surprised how enthusiastic researchers from other specialities are to help you start on your journey.

The next step is to find out what is already known in your area of interest. Practical research should be informed by the wider body of evidence. Most Honours and Masters research programs start with a literature review of some kind (e.g., narrative, scoping or systematic literature review). So, the desktop work is essential in order to generate the research question. This doesn't have to be completed within a formal tertiary program, but doing so allows for access to a range of great resources to help you along the way.

The literature review will allow you to focus on what's missing in your area of enquiry. Once the research question is defined, a research proposal should be written in collaboration with the experienced research mentors or supervisors. It's not too onerous, but it's essential. This will allow for progression to gaining ethics approval, which is a necessary step in any project, and ethics committees are easily accessible through a university.

Depending on who your participants are, you may need organisational research governance approvals (e.g., if you are studying paramedics working in an ambulance service, that service's research committee will need to approve the project in addition to the ethics approval). Fortunately, if you develop a structured research proposal with your mentors, ethics and research governance applications are mostly a "cut and paste" exercise. The other benefit of writing a detailed research proposal is that it will allow you to develop your analysis plan and identify what resources you will need.

So, I have all the approvals, what's next?

It's time to start gathering the resources you'll need, recruiting participants, and getting started with the first study session. Recruitment can take several forms, but it's essential to ensure you abide by the processes detailed in your ethics approval. Often, small pilot studies rely on convenience sampling, whereby the researchers will advertise the project locally, often to university students. This is usually the cheapest and most efficient recruitment method. Adding to convenience sampling is snowball sampling, where existing participants recruit acquaintances into the study.

FOR PARAMEDICS NEW TO RESEARCH, SMALL, PRACTICAL PILOT STUDIES ARE ACHIEVABLE, AND CAN ALSO BE COST-NEUTRAL

The acquisition of resources can be tricky, especially if you are trying to keep costs down. Don't be afraid to ask for "in-kind" support from ambulance services, device manufacturers, and universities. For example, a small pilot study we recently completed required a very expensive and complex piece of physiological monitoring equipment. If we were unable to acquire the equipment, we'd have to reconsider the project. One well-mannered phone call to the device manufacturer resulted in a six-month loan of the equipment at no cost, and we designed and ran a second study just so we could make good use of that device. We then acknowledged the manufacturer in the journal papers. So, when you're next at an ACP conference, take the time to have a chat with the device manufacturers in the sponsors' area, as those relationships can be very handy down the track. You'll never know if you don't ask.

Planning your project is key. There's a lot of preparation required for practical studies, so make sure you generate some checklists for the sessions. Asking fellow researchers or students to assist is essential - many hands make light work. Make sure your assistants and team members are briefed on what's needed. Ensure all equipment is present and functional. Have some spares just in case, and make sure you know how to use all your technical tools. Sometimes this means making sure you have an expert present on the day, or at least on call. Make sure you have the explanatory statement, consent forms and data collection tools at the ready. Digital records are great but consider that paper-based data collection sheets can be just as good, and maybe even better if you're working outdoors. Duplicate the data as you go, and get it into a digital cloud-based medium as soon as possible after your session.

Critically, look after your participants. Make sure they know where to be and when, and any preparation they may need to undertake (e.g., being fasted, adequately rested). Participants are usually partaking in small pilot studies at no benefit to them. Make sure they feel valued. Also, remember that your participants are humans. They will get sick or have other situations that need to be prioritised. They will inevitably cancel their session at the last minute, which might leave you at lab or location with all the gear set up and no one to study. Practical studies are dynamic, so have a plan B for what might happen if you have a cancellation or no-show.

Wrapping up the project

Once your data collection is complete, it's time for analysis and publication. When it comes to analysis, you will have worked with the senior researchers to develop an analysis plan when writing your research proposal. Simple descriptive and inferential statistics are usually suited to these small

studies. Modern statistical software is straightforward to use and will do most of the heavy lifting, including the generation of figures. Your mentors will guide you through this, and most universities have a range of great resources to assist.

For the write-up of your study, look to other similar projects and see how they have structured their papers. Additionally, following journal guidelines will set you on the path to publication. It all takes times, but it's incredibly satisfying to see these project through to journal publication.

In summary, small practical research projects are achievable, satisfying, and provide the foundations and guidance for future work. With some planning, patience and good advice, you can start your journey with some fulfilling hands-on research.

CASE STUDY

An undergraduate paramedicine student was curious about the effectiveness of mechanical CPR (mCPR). She approached two experienced researchers and asked, "What are the major concerns regarding this intervention?" She was told that the time taken to apply the device may be contributing to variable outcomes in cardiac arrest patients.

To assess application time, the student designed a randomised crossover protocol, gained ethics committee approval, and recruited 18 paramedic students through convenience sampling. However, the student did not have access to an mCPR device. Leveraging existing relationships, one of the experienced researchers contacted the manufacturer, who offered to provide a loan device and free training on mCPR application to the 18 study participants. The small pilot study showed that after initial training, device application time decreased with repeated exposure to the use of mCPR, but then this application time increased if the participant was not using mCPR frequently. These results provide a solid foundation for further exploration in larger studies.

Dr Meadley has more than 25 years' experience in paramedicine, and is an Adjunct Associate Professor at Monash University in the Department of Paramedicine. He also works as an Intensive Care Flight Paramedic at Ambulance Victoria. He has research interests in critical care, human performance optimisation, and working in mission-critical teams. You can check out his research at www.benmeadley.com.

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EXPANDING THE SCOPE OF PARAMEDIC PRACTICE

By **Michael Eburn,** Australian Emergency Law
https://australianemergencylaw.com/

Paramedics are an underutilised resource in the health sector. There are calls both from within and outside the profession to make better use of paramedics in health settings, e.g., in medical practices, health clinics or hospitals. As paramedics push, or are asked to contribute to this broader health setting, what are the limits on their scope of practice?

Paramedicine is traditionally associated with ambulance work, and in particular the jurisdictional ambulance services that respond to triple zero emergency calls. Although there has been a growth in private ambulance companies providing event health services and non-emergency patient transport, these services continue to link paramedicine to traditional ambulance work. There is, however, no legal reason for paramedic practice to be so restricted.

The Health Practitioner Regulation National Law

The Health Practitioner Regulation National Law (see the note, below) does not define scope of practice, it works by the regulation of title[1]. The law establishes a scheme for the registration of health professionals so a consumer can be confident that anyone using a protected title - including "paramedic" - has had background checks to ensure that they are a fit and proper person for registration, they have demonstrated that they have obtained prescribed qualifications and have maintained a currency of practice. It does not, except with some limitations relating to dentistry, optometry and spinal manipulation[2], define or limit a professional's scope of practice.

The Act provides for the establishment of National Boards that determine a code of conduct for each profession[3] and to determine what qualifications are necessary for registration into that profession. In that way, National Boards go a long way to determining what is the appropriate practice for a profession. The Paramedicine Board has approved a number of degree courses as being qualifications that can lead to registration[4]. By doing so the Board can influence or direct what must be in the curriculum of a paramedic degree and the level of study required. Paramedicine would look very different if the Board decided to accept a Certificate III in Health Care as a qualification leading to registration, or if it required paramedic students to pass units of study in homeopathy or flower arranging.

The Act also provides for a system of professional discipline where professionals who are alleged to have engaged in inappropriate practice will be judged against the standard of what could and should be "reasonably expected of a health practitioner of an equivalent level of training or experience" or that "which might reasonably be expected of the health practitioner by the public or the practitioner's professional peers"[5]. Again, it is the profession that largely determines the scope of practice of the profession. For example, a profession may determine that some practices, e.g., prescribing homeopathic remedies, is not something any paramedic would do[6].

But where the standard is a person of "equivalent level of training or experience", a person's scope of practice can be defined by their particular skills and training. The Code of Conduct says this about scope of practice:

"Scopes of practice vary according to different role … Practitioners have a responsibility to recognise and work within the limits of their skills and competence."[7]

[Practitioners must] "ensure that, when moving into a new area of practice, you have sufficient training and/or qualifications to achieve competency in that new area",[8] and

"Good practice involves you keeping knowledge and skills up to date to ensure that you continue to work within your competence and scope of practice."[9]

A professional can expand their scope of practice by making an honest and reflective assessment of their capabilities and ensuring that they are sufficiently qualified and competent to engage in that practice, bearing in mind their overriding obligation to put patient safety ahead of their own ego or financial gain. If they are to be assessed against the standard of "a health practitioner of an equivalent level of training or experience" then that will include a paramedic who has done the same extra study and practice rather than the general population of paramedics for whom a particular procedure may be outside their scope.

The role of employers

In the current environment, it is largely employers who determine a particular paramedic's scope of practice. Employers do (or should) have in place protocols or clinical practice guidelines that set out what is expected of their employees. These should aim to ensure that every paramedic delivers, and every patient receives, consistent evidenced-based best care. Even so, paramedics are recognised health professionals who can be expected to apply their clinical judgment and to even deviate from such directions where that can be justified in the patient's best interest. [10]

Future employers, whether they are doctors, hospitals or entrepreneurs setting up new health clinics, can work with health professionals that they chose to employ, including paramedics, to define their scope of practice within that employment. There is no law to stop an employer engaging a paramedic to do anything that the paramedic has "sufficient training and/or qualifications to achieve competency in". Accordingly, a doctor or hospital could employ paramedics to "start IVs, intubate, defibrillate, cardiovert, etc". [11]

Paramedics themselves can also take the initiative and set up their own forms of practice and sell their services to other practitioners and to the community. The limit on what services they can offer is set by their own imagination and some of the limitations discussed below.

Limitations

Drugs

A significant limitation in expanding the role of paramedic practice is restrictions on the use of scheduled drugs. A medical practitioner can buy, possess, and supply any schedule 4 or 8 drugs that are necessary in the practice of their profession.[12] Paramedics do not, simply by virtue of their registration, have the same authority. For paramedics, the drugs authority is vested in the employer who is authorised to delegate to the employees the right to carry, supply and administer scheduled drugs.[13] A practice or health institution that wanted to employ paramedics and wanted them to make decisions about the administration of drugs would need to have an appropriate authority from the state or territory health department.

That limitation does not apply where an authorised practitioner has prescribed drugs. Where a person has been prescribed medication and that medication has been delivered to them - typically they have had a script from their doctor and a pharmacist has filled that prescription so the drugs are now packaged and labelled for the particular patient - then anyone can assist that person to take or receive the drugs as prescribed.[14] Accordingly a practice could employ a paramedic to do patient house calls and administer prescribed medication to the patient.

Medicare

Funding is also an issue. Until paramedics can obtain Medicare provider numbers, they can only bill their consumer/client. That will limit who could and would be willing to pay for paramedic care. Further patients need referrals for specialist and other tertiary care from doctors for everyone to get the support from the government Medicare pool. It is beyond the scope of this paper to look into the Medicare arrangements in detail, but this would prove to be a limit on private paramedic practice. It may also have an effect for medical practitioners and hospitals that may choose to employ paramedics in new clinical roles if it limits the services that can be paid for.

Insurance

A health professional cannot practice without adequate professional indemnity insurance.[15] How insurers assess the risk of new and novel ways to practice may impose a limitation on private paramedic practice or the ability of others to employ paramedics.

Conclusion

The law does not define a paramedic's scope of practice or what is the appropriate scope of paramedicine as a profession. The Health Practitioner National Law establishes a system, led by the Paramedicine Board, to allow paramedics themselves to define what is and what is not

within their individual scope of practice and what is appropriate professional practice.

It follows that with demands for a more flexible and adaptive health workforce, paramedics can and should fill many new roles. The limitation on what paramedics can do is set by the imagination of those in the profession subject to some external influences, most notably the restrictions on the use of scheduled drugs, lack of access to Medicare funding and, possibly, the attitude of professional indemnity insurers. None of those are insurmountable with the right imagination and advocacy.

Note

The Health Practitioner Regulation National Law is not really a national law, it is a model law that has been adopted in each state and territory, but like all attempts at cooperative law-making, there are minor differences in each state and territory. In this paper, references are to the model Act set out in the schedule to the Health Practitioner Regulation National Law Act 2009 (QLD).

References

1. Health Practitioner Regulation National Law s 113.
2. Ibid ss 121, 122 and 123 respectively.
3. Though 12 of the 16 registered health professions, including paramedicine, have a adopted a common Code of Conduct rather than a code unique to their profession.
4. https://www.paramedicineboard.gov.au/Qualifications.aspx
5. Health Practitioner Regulation National Law s 5 definitions of "unsatisfactory professional performance", "professional misconduct" and "unprofessional conduct".
6. See for example Health Care Complaints Commission v Baxter [2023] NSWCATOD 185 where the defendant was disciplined for amongst other things, providing "care and treatment … which exceeded the scope of practice of a Chinese Medicine Practitioner", although what was the scope of a Chinese Medicine Practitioner was not defined nor did the tribunal explain how this allegation fell within the definitions of unsatisfactory professional conduct or professional misconduct.
7. Paramedicine Board of Australia, Code of Conduct (June 22), p. 5.
8. Ibid [1.2(b)].
9. Ibid [7.4].
10. See Queensland v Masson [2020] HCA 28.
11. https://australianemergencylaw.com/2023/12/05/can-paramedics-work-in-hospitals/#comment-55046.
12. See for example Medicines and Poisons (Medicines) Regulation 2021 (Qld) sch 6.
13. See for example Medicines and Poisons (Medicines) Regulation 2021 (Qld) sch 5 with respect to employees of Queensland Ambulance Service.
14. See for example Poisons and Therapeutic Goods Act 1966 (NSW) s 16(d1) and the Poisons and Therapeutic Goods Regulation 2008 (NSW) r 59 (with respect to sch 4 drugs), and Poisons and Therapeutic Goods Act 1966 (NSW) s 23 (with respect to sch 8 drugs).
15. Health Practitioner Regulation National Law s 129.

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SHIFTING GEARS AFTER A BUSY SUMMER SEASON

By **Fortem Australia**

There is no doubt the summer season in Australia is one of the busiest for paramedics; often characterised by extreme weather events, a higher number of emergency incidents during Christmas and New Years celebrations, and a greater number of people in the water and on the roads leading to an increase in overall risk of misadventure. These challenges are further compounded by prolonged and more unpredictable weather events impacted by climate change[1].

Summer brings a consistently higher workload for paramedics, and with it a possibly higher stress load, which is compounded by a greater likelihood of involvement with critical events which can have detrimental mental health impacts for paramedics and their families[2]. Moreover, family dynamics can also be impacted over the festive season by the pressure of family and work commitments impossibly competing for priority.

It would not be uncommon for paramedics to feel stretched at the end of the summer season, and to find it difficult to wind down. It is important for them to have a chance to shift gears and reflect on what has occurred during the season, how it has affected them - emotionally, physically, mentally and socially - and to have an opportunity to address any new or ongoing tensions and stress before the year gets away from them. Consciously navigating a way out of a busy period is just as important as preparing to head into one.

Impact of a stressful season

Involvement in - or preparation for - challenging and unpredictable situations can trigger an automatic stress reaction in the body. These reactions can be physical, emotional or mental, and are completely normal and largely automatic. Generally, stress reactions occur when demands feel greater than the resources a person feels they have access to, which is particularly relevant for paramedics who may feel their resources are stretched and focused on others during the summer season.

Stress reactions prime the body to be able to quickly respond in the face of perceived danger or threat - commonly known as the fight-flight-freeze response. There are evolutionary survival advantages to being able to immediately respond to dangers; however, there is a toll on the body anytime the flight-fight-freeze response occurs; stress hormones flood the body and can trigger a multitude of acute stress responses including:

- Physical reactions: For example increased heart rate, shaking, sweating and nausea.
- Emotion reactions: For example anxiety, feeling overwhelmed, irritability and impatience.
- Mental reactions: For example poor concentration, racing thoughts, worrying and brain fog.

Implications of a prolonged or severe season

Stress hormones generally circulate in the body until a threat is withdrawn, usually subsiding within the weeks following the danger. This is often followed by a stress-hormone dump, leaving people feeling tired, listless and lacking momentum. Long-term activation of the stress response can also leave people feeling a sense of compassion fatigue and burnout, as well as causing disruption to many of the body's natural processes. A prolonged and more severe summer season for paramedics is a prime example of a context that may lead to long-term activation of the stress response.

Exposure to critical events can also compound already present role-related challenges. Exposure to cumulative stressors can interfere with an individual's functioning returning to a manageable level. If stress symptoms persist, it can be a sign of an acute stress disorder which may benefit from specialist psychological support. Examples of warning signs that stress may be impacting you in a negative way include:

SUMMER BRINGS A CONSISTENTLY HIGHER WORKLOAD FOR PARAMEDICS, AND WITH IT A POSSIBLY HIGHER STRESS LOAD

TAKING SPACE TO FOCUS ON YOUR OWN WELLBEING AS A PROTECTIVE STEP IN PREPARING FOR THE YEAR AHEAD

- Not being able to switch off
- Withdrawing
- Low mood/motivation
- Poor sleep
- Irritability

There is also the potential for stressful periods of time to have a ripple effect on the family of first responders, as they are often the primary support and bear the weight of any changes in moods, behaviours and emotions of their loved one, in addition to potentially supporting children[3]. The added stress, tension and weight of expectations that can come with juggling family time and increased work commitments over the Christmas and New Year period can be particularly challenging for the whole family. Acknowledging that this season may be a pressure point each year, and communicating feelings that come up around this time, can be helpful in identifying strategies as a family that may assist.

Strategies for managing stress

The way in which an individual copes with a stressful period can have a bearing on their overall wellbeing in the weeks to follow. Coping responses can generally be categorised into those which are likely to be unhelpful (e.g. isolation, withdrawal and alcohol use), and those which are likely to be helpful. Examples of helpful coping responses include:

- Looking after your body; hydrating, eating, resting
- Breathe: Breathing is a "body hack" to regulate the stress system
- Grounding: Cold water on the face, moving the body, focusing on natural objects/sounds
- Allow yourself and colleagues to be human; shaking, crying, shock just means you're human
- Get help: Seek support from an understanding colleague, friend, family member or a professional

Recovering from a busy season

It is not only those who have experienced acute stress reactions that may benefit from an intentional change of pace after a busy season. Regardless of how a busy season has impacted an individual, carrying out months' worth of consecutive intense service is worthy of a pause and intentional reset and reconnect; taking space to focus on your own wellbeing as a protective step in preparing for the year ahead. This may look like slowing down, or for some who are already feeling washed out and low, a reset may function as a way to get the cogs moving and to start feeling more yourself.

Some ideas to help the body and mind reconnect include:

- Physical activity: Exercise, stretch, yoga, move
- Creative expression: Music, art, gardening
- Quality time and connection with your tribe; release a feel-good hormone
- Laughter and fun: A quick and effective way to reset the stress system
- Crying: The body's way of soothing the nervous system
- Reconnect with identity: Reignite a hobby and a sense of "normal me"

In addition, Fortem Australia, a national not-for-profit organisation that supports the mental health and wellbeing of first responders, has a suite of wellbeing resources that can be accessed for free on their website www.fortemaustralia.org.au. Fortem places high importance on connecting the first responder community with accessible, quality, and relevant information that can promote insight, reflection and help-seeking, and normalise the experiences of first responder life and its challenges.

Conclusion

There are additional complexities and demands that the summer season can bring for paramedics - above and beyond routine role-related challenges. Dealing with increased workload, heightened stress reactions and family pressures can take a real toll. Finding a way to carve out time to acknowledge and address any lingering impacts of the season - and reaching out for support in this process if needed - is crucial to establishing a solid foundation of wellbeing.

Content warning: If reading this article triggers thoughts of suicide or vulnerability and you need professional support, please reach out to Lifeline (13 11 14) or Beyond Blue (1300 22 4636).

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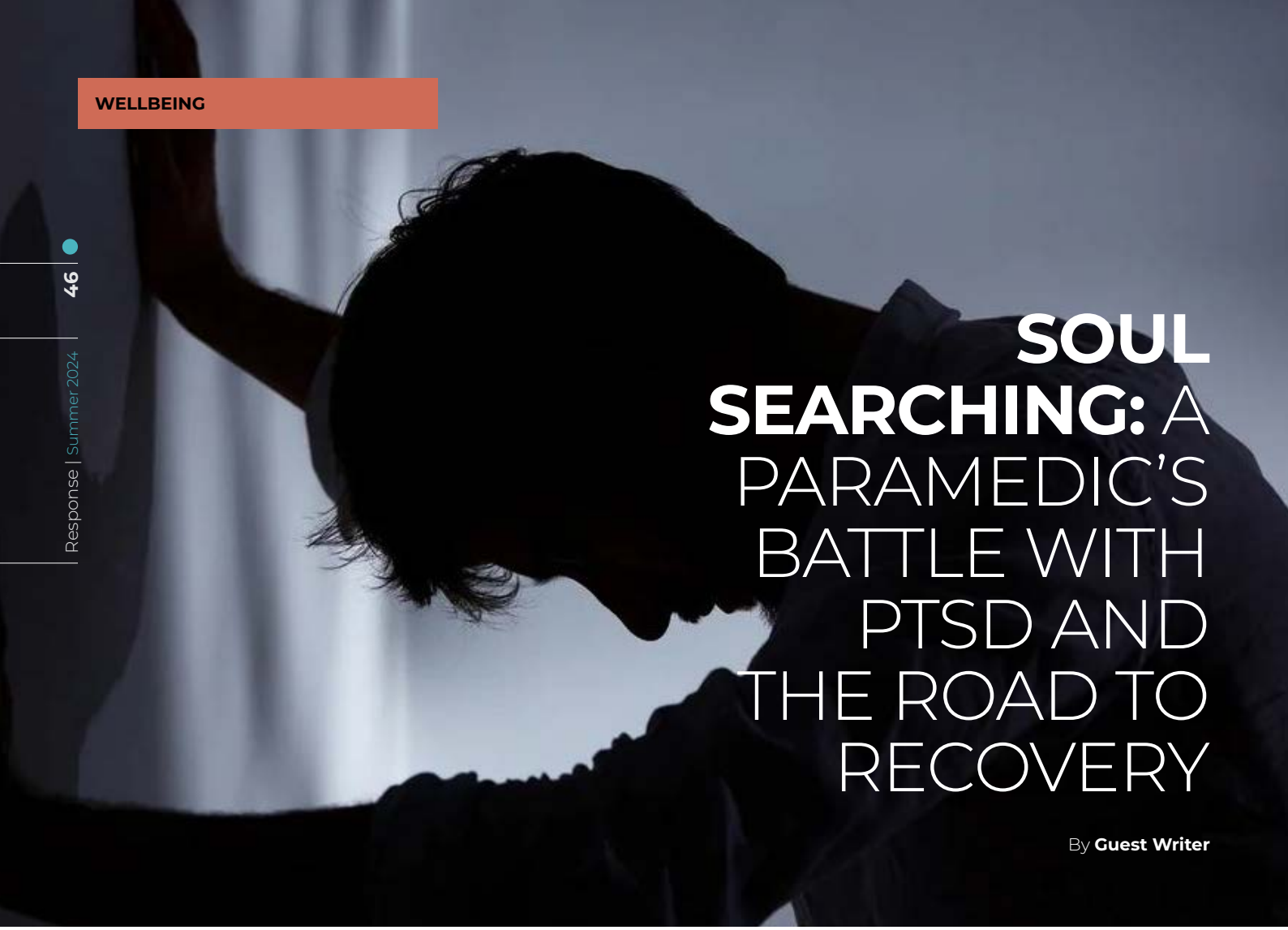

SOUL SEARCHING: A PARAMEDIC'S BATTLE WITH PTSD AND THE ROAD TO RECOVERY

By **Guest Writer**

The injury

"What are you doing to my daddy, are you hurting him?" The memory will stay with me forever, seemingly burnt in my hippocampus (although I know that this isn't possible). A small boy stands in the open bedroom doorway staring at me with tears in his eyes, clutching his teddy bear in one hand, transfixed on me performing CPR on his father.

Thirty minutes earlier, just starting early shift, equipment checks just about completed, and a Priority One call starts the day. It's a local call and it's my turn to attend. I have just enough time to start writing the PCR, it's all autopilot as I prepare myself for an early morning non-responsive patient.

Although I'm not working with my regular partner, we get on well and we have a good rapport. While I'm writing the details of the unresponsive male patient on the PCR, I read the name aloud out of habit, and from the astonished reaction of my partner I realised we are heading to treat one of our own.

Suicide or misadventure, I never took the time to find out, but the end result was the same. In attempting to resuscitate a colleague who had just returned from his night shift, still in uniform, we dragged him out of the bathroom to allow for better access, but of course this also made my clinical response visible to anyone who walked past the bedroom door. And what child would not want to know what was going on in his father's room?

"What are you doing to my daddy, are you hurting him?"

The post-event response was minimal. A quick chat with the Chaplin then back on shift; "get over it" was the mantra of the organisation that promotes that they are "For the service of humanity".

To be honest, I knew I was changing, I just didn't want to admit it. As if looking down on a scene from a TV show, I could see the person I was becoming but was powerless to act.

The condition

15 years later: I was getting worse. I could see danger in the most innocent of situations and was always thinking the worse. Was it my wife not locking the door - "Of course anyone can come in and rob us, are you stupid!" Or the kids, just being kids - "I've told you not to do that; do you know how many children I've treated that thought it was ok?"

I was always shouting. I would explode like a hand grenade at the slightest thing. My kids were afraid of me, my wife was threatening to leave me, and I was a mess. I was an angry man, fuelled by the dark spiral of self-medicating with alcohol in an attempt to blur the image of that poor little boy all those years ago. "What are you doing to my daddy, are you hurting him?"

I KNEW I WAS CHANGING, I JUST DIDN'T WANT TO ADMIT IT

It was mid-COVID. An old army mate, one of my old students and now best friend, was working in ICU. He felt powerless watching so many people be admitted but never discharged. He had the same symptoms as me, but he was better than me. He went for a diagnosis. He had Post-Traumatic Stress Disorder. Nobody pointed the finger, nobody blamed him, nobody told him he was weak.

The recovery

I had treated people with PTSD, it would never happen to me. PTSD was a curse. It was a weakness. It was a career-ending statement.

But times have changed. Attitudes have changed. This is not a condition of the weak, it is a curse of the brave. This plague attacks first responders everywhere; not weak people; strong people. The very people who put themselves on the line in order to help people in their worst moments. I had been listening to podcasts of people who had come out and spoke of their injury and, more potently, of the loved ones of those first responders who had kept the demon in the lamp, all bottled up. They had taken their own lives and left a lifetime of hurt for those loved ones left behind.

I knew deep down that I had it, but was it just me being an angry man? I needed a professional opinion.

Being in the clinical environment sometimes has its advantages. Over a coffee and a long chat with an old friend (and more importantly a clinical psychologist specialising in PTSD) it took 20 minutes for him to break the worst-kept secret of my life: "Of course you have PTSD, mate. Not surprising really after all you've seen."

The treatment

As my friend and clinical consort explained to me, there are two main different schools of thought when it comes to the treatment of PTSD.

Pharmaceutical-based treatment, relying on a broad range of drug combinations from selective serotonin reuptake inhibitors (SSRI's), antidepressants and beta blockers that have proven effective for some people. To some degree, this strategy tries to mitigate the symptoms of PTSD.

Solution-focused strategies, mainly social/ behavioural lifestyle changes that attempt to heal the body and mind, a holistic approach that requires time and a great deal of support.

Being opposed to any type of pharmaceutical approach to what may be long-term treatment, and knowing that I had a wonderful family that would support me, I opted for the social/ behavioural route.

It was explained to me that this comprised several foundation pillars:

Diet/rest/exercise: This would be the foundation of me moving forward. Alcohol consumption is a vital component of the diet-based philosophy; it's a common self-medication drug for many PTSD sufferers often has a detrimental lifestyle effects. The consumption of alcohol, over and above that of social drinking, can often result in poor sleep patterns, binge eating, and unpredictable mood swings. The diet will improve with reduced consumption of alcohol, and must reflect a healthier choice. When we're on the road, it's easy to lapse into a pattern of fast food and nutritionally poor food choices. As healthcare professionals, we're all aware that "you are what you eat", eh?

A good sleep pattern, with me getting at least 7-8 hours of quality sleep every day, was the best reset for me when I was feeling a little fragile, and it would remain my staple lifestyle choice. This is difficult with night shifts, but every effort was made to achieve this.

Recent medical research has all but proven the inseparable link between our gut health and depression and mood swings; this must also be true for PTSD. This approach requires just a little more planning for the on-road shift; packing healthy food choices and snacks formed the basis of this approach for me.

THIS IS NOT A CONDITION OF THE WEAK, IT IS A CURSE OF THE BRAVE

Exercise already played a vital role in my self-treatment strategy. I feel that it's a vital component of any healthy choice plan - endorphins and serotonin levels are all enhanced with exercise.

Arousal reduction: This was a big one for me. After my initial consultation, I sat down with my family and explained what was going on, what my "triggers" were, and how to avoid them as much as possible. Of course, in the world we live in, it's not possible to eliminate all the triggers, so reduction is the next best thing.

The message

My life is better. My wife is my soulmate again, and my family is my rock. I'm so glad that I took that final step of asking for help, it was the gateway to accepting that I had been damaged in way not visible to the naked eye and needed treatment to heal.

As it was explained to me, "PTSD eats away at your resilience to absorb stress, meaning the body goes into 'fight or flight' mode quicker than it normally would before".

Getting good sleep, better nutrition, and emotional support from my family has given me some of that buffer back again, to be a nicer person to the ones I loved.

I advise any of my colleagues reading this to seek help if they think they may be affected. Call one of the many organizations available and ask for help. Speak to the ones that you love, and most of all do not consider this a weakness.

Round-the-clock crisis support is available at:

Australia

- Lifeline provides access to 24-hour crisis support, counselling, and suicide prevention services: 13 11 14
- Beyond Blue provides information and resources (including on PTSD), helpline - chat, email, or phone 1300 224 636
- SANE Australia is a national mental health charity working to support four million Australians affected by complex mental illness: 1800 18 72 63
- Suicide Call Back Service is a free service for people who are suicidal, caring for someone who is suicidal, bereaved by suicide or are health professionals supporting people effected by suicide: 1300 659 467

Aotearoa New Zealand

- The Samaritans offer confidential, non-religious and non-judgemental support to anyone who may be feeling depressed, lonely, or may be contemplating suicide: 0800 726 666
- Need to Talk 1737 is staffed by government-funded counsellors 24/7. Phone or SMS 1737
- Lifeline Aotearoa provides access to 24-hour crisis support, counselling and suicide prevention services: 0800 543 354
- The Depression Helpline provides resources, self-tests: Helpline - email, SMS 4202, or phone: 0800 111 757

THE 1969 VIOLET TOWN TRAIN CRASH

By **Peter Dent**, Former Paramedic, Ambulance Victoria
Editor of The Beacon, Ambulance Historical Society of Victoria
Melbourne/Naarm, Wurundjeri Country

As the clock neared 7am on February 7, 1969, the luxury Sydney to Melbourne sleeper passenger train, the Southern Aurora, carrying 192 passengers and 22 crew, was travelling comfortably at its 110km/h cruising speed toward the Victorian capital.

The passengers aboard had woken and many were eating breakfast in the buffet car, while others were still in bed enjoying the sun rising over the northeast Victoria country landscape passing through Violet Town. None of them were aware that their train driver, John Bowden, was either dead or comatose at the controls and had been for some 10km or more, and that his backup, the train's fireman, was not in his assigned position with the driver to be able to stop the train.

After failing to reduce speed and come to a stop at the Violet Town crossing loop 174km north of Melbourne, the Southern Aurora collided head-on with an Albury-bound goods train. With a combined locomotive weight of close to 1,500 tonnes and an estimated collision speed of 172km/h, the impact was so powerful that it was heard kilometres away.

Goods train assistant driver Arnfried Brendecke, who had managed to jump clear, said: "On impact, the Aurora locomotive seemed to rise about 30ft (10m) in the air and climb up on the goods locomotive causing an instant explosion and the train caught fire." He watched as a carriage rose in the air and fell within 60cm of where he lay on the ground.

A motorist who witnessed the collision said: "There was a tremendous noise shock wave. A goods wagon rose high in the air with other parts of the trains. There was dust and smoke."

Worse was to follow when the wrecked goods train, which was then on fire, set alight the residue of spilled diesoline beneath both locomotives and burnt through the wreckage, sending a column of black smoke more than 30m in the air. Trapped and injured passengers screamed for help; others who were free of the wreckage wandered around dazed.

A Violet Town police officer received a call at 7.08am, and on arrival at the scene found the heat from the two mangled trains too intense to approach any closer than 60m from the wreckage. He was soon joined by a fire truck from Euroa, and along with locals they rallied to rescue and treat the survivors. Many of those involved in the rescue sustained injuries and many suffered PTSD in the aftermath.

An ambulance manned by Euroa's Senior Station Officer and an attendant from Euroa was dispatched at 7.09am carrying already prepared disaster kits. The Superintendent took the lead as the overall coordinator and all staff were recalled to duty. The Shepparton Division

of St John Brigade was advised that its Rescue Squad could be required.

When the first car to reach the area reported the extent of the accident and the likely number of casualties involved, additional ambulances were immediately dispatched from Seymour and Shepparton. Seven northeastern ambulances were also on their way.

IN ALL, NINE PEOPLE DIED AND 117 WERE INJURED

At the scene, the crew of the first car and the doctor from Euroa extricated people trapped in the train, administered any urgent treatment required, and began sorting patients into priorities for movement from the area.

The wreckage was strewn over a vast area, and the fires that were burning in parts of the wreckage hindered their efforts. Several casualties were taken from the scene by passing motorists and were admitted to Euroa or Benalla hospitals. However, because authorities at the scene were not told of this, they assumed these people were still in the wreckage and wasted valuable time trying to locate them.

Eventually a casualty clearing centre was set up at the local Shire Hall and a radio link was established between the two sites. This enabled a more accurate estimate of the number of casualties requiring ambulance transport to be determined.

When the most urgent of the casualties were dealt with, the doctor then went to the clearing centre and, together with two more local doctors, nursing sisters and other helpers, were able to treat those arriving from the crash site. Ambulances operated as a shuttle service, while others transferred patients from the Shire Hall to hospitals.

An ambulance was placed at Mooroopna Base Hospital with a radio operator and a runner to assist with the passing of messages between headquarters and the hospital and to organise the unloading of vehicles. Other cars were moved around the region and normal service was provided throughout the period.

With the exception of two trapped people, all surviving casualties had been taken from the scene by 8.53am. The two who were trapped were eventually freed and taken to hospital at 10.45am. The Shire Hall was cleared of patients and ceased operations at 10am and all casualties were admitted to the various hospitals by 11.15am.

Eight bodies were taken from the scene during the morning by the local undertaker and moved to Melbourne. The remaining body was released from the wreckage at 5.30pm and taken to Melbourne by ambulance.

In all, nine people died and 117 were injured.

At the peak of the operations, 15 ambulances were involved, three of which were used as communications vehicles, travelling a total of 4,303km.

In June 1969, Melbourne Coroner H.W. Pascoe handed down his finding: No mechanical defects contributed to the accident, and the driver Mr Bowden, who was aged 54 and had a pre-existing cardiovascular disease, was either dead or comatose prior to the crash and had been for an appreciable time. In conclusion, he recommended a finding of misadventure.

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EMPOWERING WOMEN IN AMBULANCE HEALTH SERVICES

At the Council of Ambulance Authorities (CAA), we believe that the ambulance sector has a large pool of hidden talent - women currently in leadership roles or who aspire to leadership but are unsure about how to take that next step in their careers.

Have you heard the oft-quoted statistic that men apply for a job when they meet only 60% of the qualifications, but women apply only if they meet 100% of them? (Tara Sophie Mohr, Harvard Business Review, 25 August 2014.)

Among all CAA members, women make up more than half of the workforce, but these numbers are not reflected in management and executive roles, with only around one-third of these roles occupied by women.

The CAA is proud to be able to support an effort towards gender parity at a sector-wide level with three key initiatives: The Women in Ambulance Awards, the Women in Leadership Scholarship, and the Women in Leadership Symposium.

Women in Ambulance Awards

In 2020, the CAA was proud to launch the inaugural Women in Ambulance campaign designed to highlight successful and hardworking women in ambulance services across Australia, Aotearoa New Zealand and Papua New Guinea.

This year, the CAA Women in Ambulance campaign recognised 55 women who were awarded the CAA Women in Ambulance Honour for their work and career progression, and are being championed as role models to the rest of the workforce.

Women in Leadership Scholarship

Now in its second year, the CAA Women in Leadership Scholarship provides leadership development and mentoring, encouraging more women to take on leadership roles and supporting the ongoing growth of existing women leaders in ambulance health services.

This year, the scholarship was awarded to Fiona Windsor from Ambulance Victoria, who will receive dedicated coaching and mentoring via a fully funded 12-month virtual leadership course. The two runners-up, Belinda Callaghan and Heidi McGuire from NSW Ambulance, received a fully funded one-on-one six-month leadership course. All the scholarship finalists were also given two group online leadership sessions.

Women in Leadership Symposium

With a target audience of women currently in leadership roles or who aspire to leadership, the program covered topics from women's health and wellbeing, personal career journeys and insights, into management styles of the future as well as a Q&A panel session featuring several CAA Board members.

Speakers included presentations by Ambulance Tasmania's CEO Jordan Emery and Executive Medical Director Ercia Kreismann; St John WA's Senior Operations Manager Karen Stewart; Jennie S. Helmer from the British Columbia Emergency Health Services' Mindy Thomas, the 2022 Women in Leadership Scholarship winner; and regular FIRST Magazine contributor, paramedic, and health and wellbeing instructor Mitch Mullooly.

Judging from feedback so far, many of the people who joined us at the Forum are feeling more certain about their next steps.

We warmly invite you to join us on November 21 in Sydney, Australia, to share in this year's symposium. Learn more at caa.net.au/symposium.

VICTORIAN-FIRST AMBULANCE SIMULATOR HELPS SAVE GIPPSLAND MAN'S LIFE

By **Ambulance Victoria**
Melbourne/Naarm, Wurundjeri Country

A Victorian-first mobile simulation ambulance which helps Ambulance Victoria (AV) paramedics practice high-risk life support skills has helped save a Gippsland man's life.

The mobile simulation vehicle, known as "GippSim", services Gippsland paramedics by offering them mock scenario sessions while they are in between patients at hospital. The innovative truck is the only one of its kind in Victoria offering simulated training for cardiac arrest, seizure, chocking, overdose or asthma attack incidents in a controlled environment, and journeys across regional hospitals three days a week.

In August last year, AV Advanced Life Support (ALS) paramedics Nathan Looby and Kerry Senior undertook airway training in the GippSim at Latrobe Regional Hospital but couldn't predict that the life-saving skills they'd practiced would be needed for an emergency incident just minutes later.

After their GippSim session, Nathan and Kerry went back on-duty, only to be dispatched 20 minutes later to a 70-year-old man who had collapsed in a Churchill bakery. Gippsland local, John Sewell, had gone into cardiac arrest and was being treated by quick-thinking bystanders with early cardiopulmonary resuscitation (CPR) and the use of a nearby Automated External Defibrillator (AED).

Kerry said John's case showed that undertaking scenario-based training in an almost identical environment has real, positive impacts on patient outcomes.

"When Nathan was managing the airway of the patient, he was using the equipment we'd just used in the GippSim 20 minutes ago and I thought to myself, 'What are the chances?'," Kerry said. "Nathan was comfortable and confident in the skills he was performing because he had just trained in using them.

"It highlighted the importance of ensuring paramedics undertake regular skills maintenance training, especially within a life-like environment like the GippSim."

Nathan said he felt better equipped when responding to John's case after having just completed a "high stress" training scenario in the GippSim.

"The training actually required advanced airway management and problem-solving to resolve life-threating complications, which is what we saw in John's case," Nathan said. "This, combined with rapid bystander intervention, meant John's case ran as smoothly as possible."

John was flown by air ambulance to the Victorian Heart Hospital in a critical condition. Incredibly, he was discharged five days after his admission and with the insertion of a pacemaker, rehabilitation and medication, he is recovering well.

WHEN NATHAN WAS MANAGING THE AIRWAY OF THE PATIENT, HE WAS USING THE EQUIPMENT WE'D JUST USED IN THE GIPPSIM 20 MINUTES AGO

"All I remember from that day is jumping out of my car and I didn't feel good," John said. "To now learn about what happened is amazing. I'd like to thank everyone for helping me that day."

The GippSim features equipment typically found in an operational ambulance, as well as a simulation patient mannequin, which responds to CPR with its chest able to rise and fall if successfully administered.

The intuitive mannequin can also replicate a trauma patient, be intubated, or have an intravenous cannula (IV) inserted.

AV Clinical Support Officer Mick Azzopardi trained Nathan and Kerry in the GippSim before John's case and said he was over the moon to hear the training he'd facilitated had been put to the test.

"We provide this opportunity so that paramedics can maintain their skills in a training environment so when they do go out into emergencies, the skills are front of their mind," Mick said.

Nathan said his experience proved that the GippSim was a great asset to AV's fleet, and he would utilise the training again in future.

"Training in the GippSim is like training at your own football ground. The environment is familiar, and you are using equipment that is set up like you expect it to be. This allows you to just focus on the skills and the training," he said.

AV Gippsland Regional Director Ross Salathiel introduced GippSim to the community after it was donated by the Helimed 1 Auxiliary. GippSim can be used for a wide range of training scenarios including both ALS and MICA paramedics as well as Ambulance Community Officers (ACOs), Non-Emergency Patient Transport (NEPT) training and broader training situations such as mass causality or major incidents.

SECTOR NEWS

Paramedicine Board Ahpra

Paramedicine Board releases latest registrant data

The Board has released its quarterly data report. To 30 September 2023, there were 24,271 registered paramedics nationally; 23,686 of these had general registration and 585 had non-practicing registration. By gender, the national percentages are 49.2% (11,937) female, 50.8% (12,324) male and <0.1%)10) not stated or intersex or indeterminate.

For further data breakdowns by age, gender, registration type and principal place of practice, visit https://www.paramedicineboard.gov.au/News/Statistics.aspx

Annual Report 2022/2023

This year's Annual Report shows the registration of paramedics is up by 4.8% compared with last year. Further highlights regarding paramedicine in the Annual Report can be found at https://www.paramedicineboard.gov.au/News/Annual-report.aspx. A full version can be downloaded at https://www.ahpra.gov.au/Publications/Annual-reports.aspx

The Paramedicine Board of Australia supports safe practice by publishing regulatory standards, codes, guidelines, updates and other resources for practitioners, employers, students and the public.

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

Kaunihera Manapou Paramedic Council

Kaunihera Manapou Paramedic Council

Kaunihera meets several times throughout the year. The 2024 Kaunihera hui dates will be:

- Friday 23 Pēpuere | February 2024
- Friday 3 Mei | May 2024
- Thursday 25 and Friday 26 Hūrae | July 2024
- Friday 20 Hepetema | September 2024
- Friday 29 Noema | November 2024

In addition to set hui dates, teleconferences for urgent mahi may be held throughout the year.

For all the latest news from Kaunihera Manapou Paramedic Council, visit https://www.paramediccouncil.org.nz/

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