Australasian College of Paramedicine

RESPONSE

SUMMER 2023

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MATTERS OF LIFE AND DEATH

Extended Care Paramedics bring their skills to palliative care **P14**

CONTINUITY OF CARE

Community paramedicine comes to Tasmania **P16**

THE CHANGING FACE OF GENERAL PRACTICE

Paramedics to breathe life into ailing health clinic **P18**

BUSH MEDICINE

Rural paramedic students bring a much-needed health workforce to small communities **P20**

INSIDE

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

COVER

Image: Hato Hone St John ECP Jacinta Rangi working in the palliative care space in Aotearoa New Zealand.

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

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

FROM THE CHAIR

50 YEARS OF SERVICE – A MILESTONE YEAR FOR THE COLLEGE

with **Ryan Lovett,** College Chair

UNLIKE ANY TIME BEFORE, WE ARE WELL PLACED TO DELIVER ON THE PROMISE OF WHAT PARAMEDICINE CAN DO AND BE FOR THE HEALTH SYSTEM

Welcome to the Summer edition of *Response* and the first issue for 2023.

2023 marks the 50th anniversary of the formation of the Institute of Ambulance Officers, our predecessor organisation and, as such, this year will be a major milestone for the College. It seems to come at a timely moment in our professional journey. Over the past few years, we have grown and continued to mature as an organisation and, unlike any time before, we are well placed to deliver on the promise of what paramedicine can do and be for the health system.

The College has an Advocacy Team working on our leadership objectives and driving the greater utilisation of paramedics within the health system; we have an Education Team producing insightful and contextualised interactive eLearning content to improve practice; a new international peer-reviewed scientific journal to attract and disseminate the research and evidence base the profession needs; a significant Workforce Research project to inform us of the workforce trends we need to be across; we have a Member Services Team supporting the needs of members and delivering an array of events and conferences; and we have a Communications Team making sure everyone knows what we can and do deliver for the profession. All this is complemented by quality executive leadership, corporate governance, and effective financial and operational oversight.

Registration has ushered in a more collaborative, national approach to paramedicine, with the College the only national and international organisation able to drive paramedicine forward in a holistic manner. The past couple of years have seen the College's capability to lead the profession for paramedics leap forward considerably, and we are working closely with other paramedicine stakeholders to ensure our collective objectives are able to be realised.

So, after 50 years we find the College ideally positioned and resourced to deliver for paramedicine, at a time when the system is ready for paramedics to take a more important role. It is certainly a time to celebrate, as we will do during ACPIC 23 in Melbourne in mid-September. I for one look forward to recognising and celebrating our 50-year milestone and hope not just our members but the whole profession joins us in this moment.

I acknowledge the significant contribution of our founders and the volunteers, Presidents, Chairs, Directors and Officers who have gone before me. Many members have volunteered and undertaken roles to support the College's establishment, development and progression throughout these 50 years. Many members continue to volunteer and support the College's development and progression today, and many more will support our development in the future. We are truly a member-led organisation; by the members for the profession.

In our major milestone year, and with clear opportunities to further embed paramedicine, I'm pleased that the College team is working on a future vision for paramedicine. The College consulted widely during 2022, providing the foundation for further engagement with you, our members, to further refine the positioning of paramedicine, future clinical practice levels, a paramedic career framework, workforce requirements, and professional development opportunities. This work is building to a future vision document, a major piece of work that we hope to deliver later this year, cementing the College as the thought leader and laying the foundation for the next 50 years. It is certainly an exciting time, and one worthy of celebrating.

Stay safe.

FROM THE CEO

THE ROLE OF THE COLLEGE IN THE SUBSCRIPTION AGE

with **John Bruning,** College CEO

Since its inception 50 years ago, the College has always been a member association. Looking back on the original Objects from July 1973, there is a focus on developing, progressing, and supporting ambulance officers and the profession. There is surprisingly, or maybe unsurprisingly considering the more collegial focus of society at that time, little reference to members in the Objects. The Institute of Ambulance Officers, as we were known then, was about moving the whole profession forward; members knew it was not about what they would get but what they were a part of, and that progress they supported by being a member may benefit someone else in the future and not them directly.

WE ARE NOT A SUBSCRIPTION SERVICE; WE ARE AN ASSOCIATION FOR THE PROFESSION THAT REQUIRES EVERYONE IN THE PROFESSION TO SUPPORT AND WORK TOGETHER

Moving forward to 1994, the Objects again do not reference members as the focus but the whole profession, with a mission statement saying: … represent the professional interests of Ambulance Officers throughout Australia … to foster and encourage high standards of Ambulance patient care.

Looking at our current Constitution Objects, there remains the focus on the whole profession, but many aspects talk about services and support for members. It is right that the College delivers for members, but it would seem the original intent for the College was to be driving improvement, education, and services for the whole profession, not just members.

From the 1970s through to 2010, ambulance officers and paramedics joined to be part of and connected with the profession. It was not so much about what the College would do for them individually, but what the College would do for the profession. Over the past 10 years of my involvement with the College, things have changed. We are in the age of subscriptions, where everything is a fee for service; I pay a monthly subscription fee and in return I get access to content. If I don't use the content, I cancel my subscription.

I often hear that this change in societal attitude will be the end of member associations. It has certainly become harder to engage paramedics and students to become members today, so it would seem prudent to reinforce what the College has always been about - moving the whole profession forward and not just a fee for service. That doesn't mean we shouldn't provide great services, just that we need to see the big picture as to what a strong College can do for everyone in the profession.

Over the past six months, we have been reviewing the College Constitution to ensure it meets our needs. Several changes were approved at the AGM in October last year, with further changes to be considered by members this year. A revision of the Objects will be proposed, with a renewed focus on the whole profession and advancing person-centred care that brings the Objects back to that collegial focus and meets the requirements for becoming a charity.

The proposed wording is: The Company is established for the purpose of leading the Paramedic profession in Australasia to deliver excellence in Paramedicine and support person-centred healthcare. The Company works to improve access to, provision of and reduce disparities in healthcare for individuals and communities, including First Nations, Tangata whenua and Indigenous Peoples, through education, research, advocacy, health literacy, and programs that advance the practice and strengthen the contribution of paramedicine to evidence-informed healthcare.

I feel strongly that our purpose should be about working as a collective to cooperatively advance excellence in paramedicine and better patient healthcare. These new Objects do that to an extent. Ultimately, they are only words on a page, so it also requires a change in attitude to the role the College should play in the subscription age, and that is, we are not a subscription service; we are an association for the profession that requires everyone in the profession to support and work together, for the benefit of all paramedics and the communities we serve.

Stay safe and well.

STEP BACK IN HISTORY AS THE COLLEGE CELEBRATES ITS HALF-CENTURY

As our Chair, Ryan Lovett, wrote about in his column, this year marks the 50th anniversary of the College. We have an exciting year ahead celebrating this important milestone, as across our platforms we look back on the evolution of the College and the paramedicine profession, culminating in a Gala Dinner in Melbourne in September as part of our 2023 Australasian College of Paramedicine International Conference (ACPIC 2023).

We've come a long way since our formation in 1973 as the Institute of Ambulance Officers (Australia). The first recorded meeting to discuss the establishment of the Institute was held in Melbourne on 20 June 1971. Laurie Shea, Vice-Chairman of the Ambulance Commission of Tasmania, convened the meeting "as it seemed apparent that there was a need for a body to bring together ambulance officers in Australia with a specific aim of increasing their professional competence and provide a forum for the exchange of technical information between leaders in allied disciplines and between ambulance leaders themselves".

The inaugural meeting of the Institute was held in Canberra at the Academy of Science on 30 July 1973. It was to become the first Annual General Meeting of the Institute of Ambulance Officers (Australia). Over time, branches (or chapters) were established in

WE'VE COME A LONG WAY SINCE OUR FORMATION IN 1973

each state and territory of Australia, and the organisation matured into a vibrant professional body.

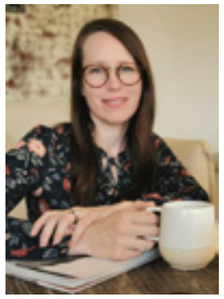
With the passing of the subsequent decades, the Institute evolved into the Australian College of Ambulance Professionals and established a chapter in Aotearoa New Zealand, and with the merger in 2020 of the Australian and New Zealand College of Paramedicine and Paramedics Australasia, the College became the peak professional body it proudly is today, educating, supporting, representing, and advocating for paramedics throughout the region, and increasing diverse practice settings.

Throughout the year we will explore our history and the history of paramedicine in Australasia in the past half-century - the people, the events, the landmark moments, and the achievements.

We look forward to sharing this celebration with you, and to hearing your stories and experiences.

COLLEGE ADVOCACY CONTINUES TO DRIVE CHANGE

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



A milestone anniversary year is reflective by nature, and while we will look back on the evolution and progress achieved in paramedicine in the past 50 years, we continue to stay focused on the future by driving positive change, and recognising and supporting our profession through our advocacy work.

Keeping College members connected, engaged and informed about our advocacy efforts is a high priority for 2023, and we have a range of opportunities in the pipeline as well as increased media coverage. To start with, we've revamped the advocacy webpage to showcase our focus areas, submissions and media activity, and to highlight relevant discussions and announcements happening across the industry. We have also launched our College Polls Your Voice platform, and in February we will release the first episode of our new podcast series Advocacy in Conversation featuring Chair Ryan Lovett, CEO John Bruning, and Advocacy and Government Relations Lead Michelle Murphy ASM.

The calendar is already filling up and 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.

Launching College Polls – Your Voice

To increase our engagement with College members, and the wider profession, we have launched our online College Polls series, and we hope you will take part.

As the name suggests, our polls are designed to gauge the "temperature" of the profession about issues, matters and ideas relevant to paramedicine. You can access College Polls via the QR code above or our advocacy webpage. The polls shouldn't take more than a few moments to complete, so jump on and have your say!

Quarterly highlights: Advocacy in action

23 January: The Australian published an article on healthcare reform and the Strengthening Medicare Taskforce, in which CEO John Bruning was quoted: "The structure of health care needs to completely change. That gap between the GP and the ED is where paramedics could be playing a vital role." Visit our news page for more information.

23 January: In a complementary feature article, The Australian focused on community paramedicine and the successful program at Perth's Dianella Family Medical Centre, in which Alecka Miles, College Community Paramedicine Working Group Chair, was interviewed about this innovative model of team-based care. Visit our news page for more information.

14 December: In a national first and another step forward for the profession, the University of Tasmania Paramedicine Program announced the establishment of a dedicated School of Paramedicine in 2023. Visit our news page for more information.

8 December: The College was represented by CEO John Bruning and Advocacy and Government Relations Lead Michelle Murphy ASM at the NSW Inquiry into ambulance ramping and access block in October 2022. The report, drawing largely from the College's submission, was tabled in the NSW Parliament in December, making recommendations that called for greater paramedic representation, workplace flexibility, career opportunities, and improved workforce wellbeing. Visit our news page for more information.

23 November: The College was represented by Advocacy and Government Relations Lead Michelle Murphy ASM at the Australian Parliamentary Dinner 2022.

15 November: The College presented an engaging seminar at the 14th annual Services for Australian and Rural and Remote Allied Health (SARRAH) conference titled "Community Paramedicine: An untapped resource for rural and remote communities in Australia". Visit our news page for more information.

We also continued to meet with, and submit consultations to, advisors, governments, stakeholders, and collaborators to change policy and legislation aimed at improving health outcomes for individuals and communities across Australasia.

NEW PROJECT, COURSES, WORKSHOPS, WEBINARS AND MORE FROM OUR **EDUCATION TEAM** IN 2023

By **Julie Johnson,** College Education Manager

"The more that you read, the more things you will know. The more that you learn, the more places you'll go." – Dr Seuss

Paramedicine is heading into its fifth year as a registered profession. We have found our feet and are growing, evolving and developing both professionally and personally. We have left behind the technician and embraced the clinician, but with that comes a responsibility.

Registration requires us to engage in 30 hours of continued professional learning. How we plan our CPD is mostly up to us. When identifying opportunities for learning, think about what you do at work, what are you good at, and what could you do better. Think about your career goals - is there anything you need to help you move towards that goal? What are your interests and what are the areas that are evolving professionally - how do you stay informed?

COLLEGE EDUCATION IS AIMED AT PROVIDING A HOLISTIC SUITE OF LEARNING TO ENABLE YOU TO PLAN YOUR DEVELOPMENT

College education is aimed at providing a holistic suite of learning to enable you to plan your development, which is mapped back to professional standards and codes of conduct. Our learning isn't developed on an ad-hoc basis - it is strongly informed by sound educational philosophy and underpinned by evidence-based research and informed by industry.

So, how have we fared in 2022?

- Our new self-paced eLearning platform opened in March last year.
- About 7000 courses have been completed by our members.
- Thousands of course evaluation forms were submitted, for which we pass on a huge thank you. Not only was there overwhelmingly positive feedback, but you provided suggestions and feedback.

What have we done with the feedback? It informs our structure and enables us to plan our course calendar underpinned by your needs. We have adopted a more mobile-friendly platform and included more scenarios and self-check activities based on your feedback.

You have told us that you would like to be able to save your progress, and we completely understand this. We are working with our designers and web platform to integrate a seamless way for this to happen. It may take a bit of time, but it is coming. We also acknowledge that our attempt at gender-inclusive language is sometimes not completely on point. We are also evolving and continue to strive to ensure our learning is fit for purpose for everybody. Bear with us while we too continue to learn and grow.

Thank you for some of the great comments you have sent us, too: "Very well done; informative; introduced new practice; built on current knowledge. Supporting videos were very helpful with clear, easy-to-understand explanations." "Excellent presentation of information. Pictures and descriptions were so beneficial." "I absolutely loved the layout of this course. I find it easy to navigate and gives me time to write notes." "Excellent course, I look forward to seeing more in the future."

Keep that feedback coming. We hear you. This is your learning. If you have a suggestion or request, or you need some help, reach out to our education team education@paramedics.org.

What's on the horizon for 2023?

So much! Each month, new learning will be available to members. As we form more partnerships with industry leaders and collaborate with interdisciplinary professionals, we will bring you innovative ways to extend your knowledge and skills. Included will be opportunities for face-to-face workshops, interactive live online case-based learning, self-paced eLearning, webinars, and a host of opportunities to build your portfolio.

Kicking off the year will be live interactive planning for your learning needs. We have more to come in the stroke series, obstetric continuum and paramedic responsibilities - understanding our code of conduct and a new series on managing mental health emergencies will launch. Cardiology learning is high on the agenda, and if you're practising at the intensive care level you are not forgotten - our partners at Cardiac Physiology in Practice have some amazing topics planned to extend your knowledge and skills. Anyone who attended the session delivered by Mitch Cowan at ACPIC on VT ablation and combating sudden cardiac death will be excited by more offerings in this space. If you didn't see it, we highly recommend having a look.

IN 2023, THE COLLEGE WILL LAUNCH THE PRECEPTORSHIP PROJECT

In 2023, the College will launch a new project: The Preceptorship Project. This will explore the needs of paramedics, students, services, and tertiary education institutes in relation to preceptorship. A collaboration led by Matt Warren-James and a team of paramedic educators, we will explore the experiences, expectations and challenges faced by students and preceptors.

Preceptorship is a major component of a modern paramedic's workstream and requires a multitude of skills, including effective communication, mentorship and coaching aptitudes, to name but a few. The proficiency of the preceptor greatly affects students' successful completion of Work Integrated Learning

(WIL) placements. While there has been a plethora of research about preceptorship from the perspective of the allied health profession, little research has explored the idiosyncrasies of preceptorship in the paramedic profession.

The initial aims of the project include creating a framework document in conjunction with the College Education Team that defines what preceptorship is and outlines a vision of best practice in relation to educating preceptors. The project will also launch a national survey in 2023 to capture the views of the profession about preceptorship and identify areas for future research.

If you're interested in getting involved in this project or would like to undertake research about preceptorship, we would love to hear from you. Please contact ACP Education Manager – Julie Johnson at Julie.Johnson@paramedics.org.

So, to close with another Dr Seuss quote: "Unless someone like you cares a whole awful lot, Nothing is going to get better. It's not."

YOU'RE INVITED TO OUR **INTERNATIONAL WOMEN'S DAY 2023 BRUNCH!**

International Women's Day

"Imagine a gender-equal world. A world free of bias, stereotypes, and discrimination. A world that's diverse, equitable, and inclusive. A world where difference is valued and celebrated. Together we can forge women's equality. Collectively we can all #EmbraceEquity"

To celebrate International Women's Day, we're inviting you to join us for a special College brunch at Sydney's prestigious Doltone House Hyde Park on Wednesday March 8.

The event acknowledges the remarkable accomplishments, groundbreaking leadership and enormous contribution women have made – and are continuing to make - in paramedicine, in the wider health system, and in our communities.

During the brunch, we will also launch the College's new program, the Global Women in Paramedicine Alliance, which is designed to build a connected, supportive and future-focused international community of women in paramedicine.

The event will feature guest speakers, including registered nurse and paramedic and Olympian Jo Brigden-Jones, goodie bags, activities and giveaways, in what will be a wonderful opportunity to connect with peers in celebration of this important day.

EVENT DETAILS:

Date: Wednesday 8 March

Time: 10am-12.30pm

Venue: Doltone House, Hyde Park, Sydney

Cost: $120 for members
$140 for non-members

Limited spaces are available, so purchase your tickets today at: https://paramedics.org/events/Womens-Day-23

Olympian Jo Brigden-Jones is a registered nurse and NSW Ambulance paramedic, as well as a passionate baker and cake decorator running her own business, Elite Cake Co. Jo is one of Australia's top paddlers and has been for nearly two decades. She has raced for Australia every year since 2004, making it 18 years of national representation. She has won a World Championship medal, multiple World Cup medals, and has been the Australian National Champion 42 times.

NEW COLLEGE CONFERENCE **CALENDAR FOR 2023**

By **Lauren Daws**, College Chief Operating Officer

In 2022, the College was finally able to deliver a full suite of conferences after a challenging few years due to the COVID-19 pandemic interrupting event delivery and occurring right as our merger was finalised and the College began operations as one entity.

At the time of the merger, the College had committed to maintaining the events offered by both Paramedics Australasia and the Australian and New Zealand College of Paramedicine previously, leaving us with five major events on the calendar. While this structure provided opportunity for members to attend varied events at different times of the year, it was logistically challenging to offer conferences at such frequency and without significant cost to the membership. Having reviewed the operations in 2022, we have sought feedback and held discussions on what the structure would look like in future years.

As a result, 2023 will see a new conference calendar with two major events locked in, and some smaller events yet to be finalised to ensure we reach our membership in a more local way.

Critical Care Summit 2023

CRITICAL CARE SUMMIT

A new event on the College calendar, the Critical Care Summit 2023 will be held on 25 and 26 May at Tweed Heads. This event will replace the previously long-standing Trauma on the Border. It will absorb the trauma-focused content while expanding the focus and creating an environment which is inclusive of all clinicians who are involved in complex patient care and who require an understanding of complex patient physiology.

It is designed to be welcoming to all clinicians with an interest in working in the critical care space, even if you are not there yet. The College is seeking the support and involvement of other professional bodies to encourage inter-professional collaboration and multi-disciplinary approaches to complex patient care. You can pre-register your interest online now at https://paramedics.org/events

The Critical Care Summit will run every second year. In the alternate year (running for the first time in 2024), the College will hold a primary-care focused conference, which will absorb the content from our Rural Outback and Remote (ROAR) Conference, but again expanding the focus to include more aspects of primary care, community paramedicine and the rural/remote setting.

ACP International Conference 2023

ACPIC

Last year's ACPIC in Brisbane was a wonderful event, bringing people back together for a fully featured conference for the first time since the pandemic began. Our feedback during and after the event was overwhelmingly positive around the levels of engagement and the difference that being in the same room with colleagues makes. 2023 will see us run ACPIC again in September, this time in Melbourne. We're looking forward to making this event bigger and better than ever, and look forward to some great cele¬brations as it coincides with the year of the College's 50th anniversary. You can pre-register your interest for both ACPIC and the Critical Care Summit on the College website now: https://paramedics.org/events

Research Symposium

The Research Symposium will take a break in 2023, as we build a strong research stream into ACPIC. We acknowledge the collegiate environment and supportive atmosphere that the Research Symposium afforded novice researchers and those immersed in the field. We found last year, though, that our events were effectively competing with each other. This year, we will focus on ACPIC as our flagship platform for delivering the latest in paramedicine research, hearing from seasoned researchers while also creating a welcoming environment for those new to the scientific space and drawing all participants into the importance of paramedicine research and its impact on practice. An enormous thanks must go to the College's Research Committee who delivered a sensational Research Symposium in July of last year.

Other events

We are still planning for some more locally accessible, single-day events in our jurisdictions including New Zealand. Our Education Team, Education Committee and our dedicated Member Committees continue to work hard on delivering local CPD events, webinars and podcasts and we thank them profusely for their wonderful work throughout 2022.

I look forward to an exciting year ahead, with our 50th Anniversary celebrations underpinning our activities and advocacy work. I hope to see you at one of our upcoming events, and as always, please reach out if you have any feedback, suggestions or ideas.

2023 COLLEGE GRANTS

College members meeting the criteria have the opportunity to apply for grants for education or research purposes throughout the year.

Education Grants

We recognise that the costs of continuing professional development can be prohibitive for some paramedics. As the peak professional body, the College is committed to supporting members in their educational pursuits and offers a number of education grants each year that can be used for professional development activities.

Education grants are available for members who wish to expand their knowledge in a non-academic discipline relevant to the field of paramedicine, and include attendance grants for industry conferences such as ACPIC. Education Grants are for a maximum amount of $500 each.

There are two funding rounds per year, usually in February and August.

Research Grants

The College is committed to enabling the development of discipline-specific knowledge through support for members undertaking research.

The development of knowledge that informs clinical practice, health service delivery or paramedic education is critical to the development of the profession. Well-designed and executed research will provide the basis for evidence-based practice, particularly in areas where knowledge is lacking or incomplete.

There are three research grants available to apply for, with one funding round each year usually opening in April:

- Early Career Research Grant
- Higher Degree Research Grant
- Research Dissemination and Translation Grant

How to apply

We will let you know when funding rounds open via email, social media and the College website. Applications and queries can be made via the College website. For more information contact grants@paramedics.org

MATTERS OF LIFE AND DEATH: EXTENDED CARE PARAMEDICS BRING THEIR SKILLS TO PALLIATIVE CARE

Aotearoa New Zealand

For many people, dealing with chronic illness and death can be challenging, confronting, and highly emotional. The end-of-life journey is fraught with grief and inevitable loss, but for Hato Hone St John Extended Care Paramedics working in palliative care, it's also an incredibly intimate experience and a privilege.

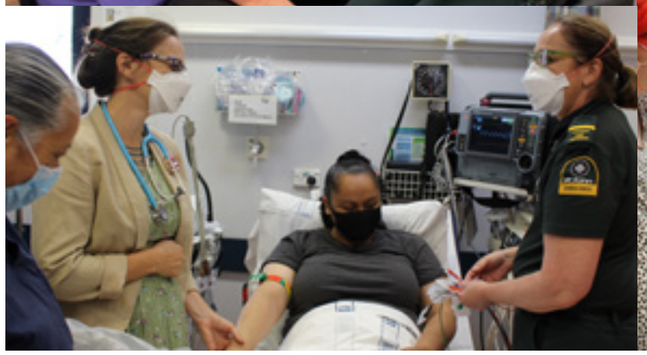
Horowhenua ECPs Craig Barraclough and Jacinta Rangi and Auckland ECP Mechelle Smith are among Hato Hone St John's small team of palliative care specialists filling the out-of-hours gaps for hospices on a call-out basis in patients' homes.

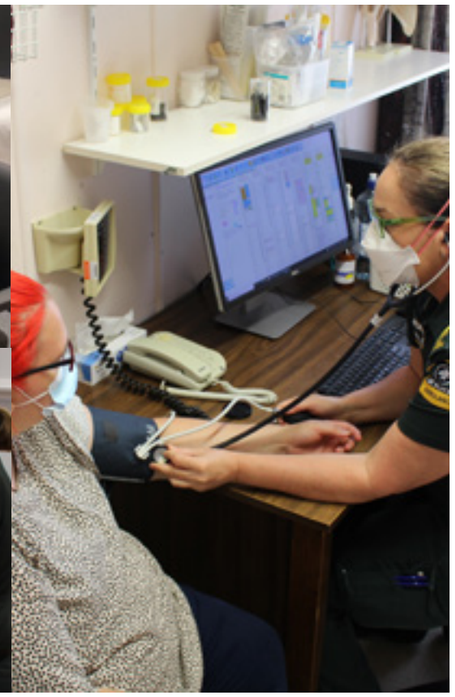
"In many places, hospice out-patient care ends at 5pm, so the ambulance sector supports by picking this up," Jacinta said. "Sometimes we're supporting an established end-of-life care or palliative-care pathway and sometimes we're setting up or coordinating a new pathway."

With an ageing population, the need for palliative care services is on the rise. According to Aotearoa New Zealand's national statistics office, Tatauranga Aotearoa Stats NZ, in 2022, one in six people was aged 65 years or older. And it's paramedics who are increasingly being relied upon to ease the burdens on healthcare providers in this space.

A survey of ambulance services soon to be published in the New Zealand Medical Journal conducted by Hato Hone St John Paramedic and Right Care Advisor Sara Davis and palliative care specialists Andrew Munro and Dr Kate Grundy found that emergency medical technicians were responding to 60% of patients presenting with end-of-life or palliative care issues.

And while paramedics have always attended to palliative care patients, in recent years it has become an area of specialisation for the new ECP role. These paramedics have an extended scope of practice with additional medicines, including some end-of-life-care medications.





EVERY SITUATION IS DIFFERENT AND IT'S PERSONAL TO THAT TIME THAT YOU'RE IN THEIR HOUSE

"Paramedics don't carry those medications - they use what's in the house that the hospice has left there, but as ECPs, we can actually start the pathway with the medications we have," Mechelle said. "If a crew turns up and they have a palliative patient or an end-of-life patient, they can call us, and we come in and look after them if we're available."

With only about 50 ECPs working for Hato Hone St John at this point, the specialisation is still in its early stages, but it is already having an impact on the number of hospital transports and patient care.

A lot of the work involves advance care planning in consultation with hospices and patients and their families as part of a national advanced care planning network. Sara said when a person entered the palliative phase of their life, they wrote a care plan detailing instructions for care if they lost capacity or entered the final stages of dying, as well as instructions for ambulance personnel.

"That's something that we're really good at," she said. "And it definitely reduces the requirement for other ambulances or unnecessary transports."

However, it is an emotionally charged environment to walk into, particularly when the patient is in the final stages of dying - one that requires a calm and reassuring approach and the ability to understand the situation and know to appropriately respond.

I SEE IT AS AN OPPORTUNITY TO ASSIST A PATIENT AND THEIR FAMILY TO STAY AT HOME AND HAVE A REALLY GOOD DEATH, EXACTLY HOW THEY WISHED IT TO OCCUR

"Every situation is different and it's personal to that time that you're in their house," Jacinta said. "You have to be able to read a situation and read what's going on in the house to be able to decide what you're going to say to these people. They may have been pre-warned that their family member may deteriorate over a certain period of time, and they say, 'Yes, we understand', but when that moment comes, they go into a state of shock and panic."

"If you go in there with a really nice quiet approach and just say, 'Hey guys, this is normal, this is what's to be expected', you can just almost hear a collective sigh," Mechelle said. "So it's just about taking charge and keeping calm and quiet. They just need to be warm, comfortable and loved, and it's a privilege for us to be able to do this."

One of the biggest challenges is in ensuring a clear chain of communication among the ECPs, hospices and paramedics about instructions for a patient's care and their wishes in relation to issues such as resuscitation. Despite the ECPs leaving notes for paramedics, that information isn't always relayed - a system they're currently working to streamline.

"There's not always the information coming down on the notes to say that patient's palliative and that patient was expected to die," Jacinta said. "So occasionally, we see crews going in and doing CPR and resuscitating patients, because the patient's wishes are not immediately obvious."

Craig said the ability to determine if a call-out was palliative in nature was vital in ensuring patients passed away at home with their families rather than in a hospital. In reviewing the notes for one call-out for shortness of breath, he suspected the presentation was palliative in nature. It transpired that there was a large mass in her lung pressing on her pulmonary artery.

As the paramedics began doing baselines and putting her on oxygen, he found her hospital discharge notes that said she had poor oxygen saturation and hypotension that should not be measured, with the focus to be placed on comfort care.

"We managed to slow the job down a lot and tried not to do any emergency ambulance service intervention and, in conjunction with the hospice team and her family, we worked on a plan. We got her oral morphine and gave her some medication and then left her at home, where she died overnight at home with her family.

"If I hadn't been there, she may have been bundled into an ambulance and most likely died in hospital, and that's what we try and prevent. Complying with what they want and their wishes and doing our best to keep them in a really nice environment to pass away is what our goal is."

Working in palliative care requires compassion, respect and sensitivity, particularly in relation to the cultural traditions and protocols of Māori and Pacifica communities.

"I let the family lead me," Mechelle said. "I always ask, 'Is this appropriate? What would you like from me? How can I help?' It's their time and we are secondary to them, and it's always their wishes. We're not in there to take charge of the situation. We're there to support them and do what they want us to do."

And while working in palliative care has its challenges, both personally and professionally, for Hato Hone St John's ECPs it's an enriching and rewarding experience that helps people live and die with dignity.

"I see it as an opportunity to assist a patient and their family to stay at home and have a really good death, exactly how they wished it to occur," Sara said. "It's incredibly fulfilling."

CONTINUITY OF CARE: COMMUNITY PARAMEDICINE COMES TO TASMANIA

Hobart, Muwinina Country

With increasing demand being placed on the state's health system, in August last year Ambulance Tasmania (AT) became the latest Australian ambulance service to adopt a community paramedicine model of practice to better address public health needs and bridge the gaps in primary care.

Six months later and still in its initial trial phase, there are now 12 Community Paramedics operating statewide, four in each of the three jurisdictional regions: Northwest, North and South. By early December, they had attended close to 1,000 cases, an average of 58% of which were provided with support to remain in the community.

THE FLOW-ON EFFECTS ARE NUMEROUS BUT ALL VERY SIGNIFICANT

AT Integrated Care Manager Charles Wendell-Smith, who oversees the initiative, said the results highlighted that there were safe and efficient alternative healthcare pathways available if people were appropriately trained and supported, with the added benefit of easing pressure on hospitals.

"We've been able to look after a lot of people who traditionally would have been transported to hospitals," he said. "The flow-on effects are numerous but all very significant in their own right."

The model, while still evolving, is similar to an Extended Care Paramedic scope of practice in that the emphasis is on primary and preventative care, albeit at a lower level to an ECP. Community paramedic training is primarily focused on enhanced clinical assessment and diagnostics, decision-making, risk stratification and referral, and the team has iSTATs and otoscopes to assist with diagnostics. The professional definition is within the skill set of an AT Intensive Care Paramedic, with synergies and crossovers in terms of their assessment and diagnostic skills in interventions such as suturing and catheterisation.

At present, they still largely operate within the parameters of the traditional emergency response system, with 000 calls being received, assessed, and dispatched when required. However, a key difference is that Community Paramedics are provided with live access to jobs as they come in, enabling them to screen calls to evaluate their attendance.

And unlike other AT paramedics, they are "reserved" to enable them to focus entirely on low-acuity cases. Each is assigned a car equipped with standard emergency response kits in the event of immediate threats to life, and while they will respond to emergency callouts in extenuating circumstances, the bulk of their work is one-to-one patient care.

"The model is quite proactive in that manner. Cases are identified through our communication centre as appropriate or flagged through pre-approved determinants as appropriate for Community Paramedic attendance. They're going out there, they're attending those scenes and assessing, treating and planning what the patient's needs are from there."

For Community Paramedic Andrew Norman, the difference between normal on-road response and his current role is the mindset involved.

"I'm going into that job without the mindset that this person is going to hospital," he said. "I'm going into the scene with an idea of how I'm best able to get this patient through our health system and what's the most appropriate type of care for their situation.

"I'm here to deal with complex medical needs as opposed to intermediate, higher-acuity emergency-type jobs. We attend to a lot of musculoskeletal, back pain, and chronic-pain type of presentations. Sometimes we deal with palliative care presentations, and we see a lot with older patients in nursing homes."

Previously, AT would see many low-acuity patients who presented to emergency services as a result of not being able to access appropriate primary-care pathways or lacking the health literacy needed to make the most suitable choice of care for their healthcare needs. That meant patients were often unnecessarily transported to emergency departments.

"The introduction of a Community Paramedic program has addressed a void and allowed us to better provide the right care at the right time in the right place for our clients," Charles said.

Engagement with multiple stakeholders across the health sector was needed to lay the foundations for the initiative, and initially there was a broad lack of awareness about the role paramedics can play in the primary care space.

"Once we started to explain the things that we do on a day-to-day basis and how we already deal with a large percentage of primary healthcare complaints and how we're now branching into that space with Community Paramedics, they jumped on to it. They loved it, they loved the idea. They want to integrate with us and they want us involved. It's raising that level of awareness about what paramedics can do."

Andrew said this model of practice provided a more holistic healthcare framework and improved continuity of care, which is being shaped by a new, collaborative approach to patient assessment and in-situ treatment. Being able to focus on the longer-term patient journey allowed him to develop individual care plans that could span weeks and months as required.

"It's mainly just finding the right avenue for a patient to stay at home or giving them the right advice they need to manage their condition themselves, which has been really satisfying.

The Community Paramedicine trial ends in June, but with the results generated to date, AT is optimistic about the ongoing role of Community Paramedics and are hopeful that the initiative can be continued and expanded.

"I 100% think this is one of the exciting future directions of paramedicine," Charles said. "Ambulance services will evolve to have a greater role in proactive primary and preventative care. It's a very exciting time for the industry, and also for us."

AMBULANCE SERVICES WILL EVOLVE TO HAVE A GREATER ROLE IN PROACTIVE PRIMARY AND PREVENTATIVE CARE

FEATURE

THE CHANGING FACE OF GENERAL PRACTICE: PARAMEDICS TO BREATHE LIFE INTO AILING HEALTH CLINIC

Taranaki, Aotearoa New Zealand

In the early months of 2022, Avon Medical in Stratford in the Taranaki region of Aotearoa New Zealand's North Island was struggling to meet the healthcare demands of the local community. The departure of its long-serving doctors and other key staff left just one part-time GP to serve the practice's 7,500 patient population.

The backlog meant three to four-month delays for routine appointments and the lack of almost all acute care. A dedicated team of nurses was shouldering the burden and were largely responsible for enabling the clinic to remain operational, but as new Avon Specialist General Practitioner Dr Shaun Butler said, they were "drowning".

Coastal Medical Ltd, with whom Dr Butler is a Director, was approached to provide assistance for the ailing clinic and initially deployed locum GPs on a part-time basis. Recognising that the company had better staffing and resources, then owner Primary Health Care Ltd offered to sell the practice and in July it officially changed hands, with doctors Shaun Butler and Nick Loveridge-Easther at the helm.

However, addressing the clinic's longer-term staffing shortfalls required thinking outside of the box and adopting a new model of multidisciplinary healthcare.

THE DAYS OF A GP HAVING TO SEE EVERY SINGLE PATIENT ARE GONE. IT'S GOING TO BE TEAM-BASED CARE FROM NOW ON

"We needed to find a balance between keeping continuity of care but also allowing our GPs to enjoy the work and not burn out, so we're shifting to more team-based care where we have different specialists within primary care. We'll have paramedics seeing a lot of the acute presentations alongside Physicians Associates and the nursing staff doing more long-term routine care," Dr Butler said.

"The General Practitioner is probably going to move to more of a consultant-type role, where they'll be available for case discussions with the non-GP clinicians, such as Extended Care Paramedics, as well as seeing more of the complex health presentations, palliative care, and difficult kinds of medication issues. This is the changing face of general practice."

And in a country facing chronic GP shortages, particularly in rural areas, it's a practice model that offers hope for improved health services for traditionally underserved communities. For the Stratford community, it will also mean improved acute care health service delivery. The half-dozen to a dozen acute care appointments available each day are typically filled within half-an-hour, requiring patients who miss this window and are unwell or have been injured to travel up to 45 minutes to another clinic or to a hospital emergency department to receive treatment.

"First and foremost, we will have capacity to be able to better serve the local population and their acute care needs. That in turn also takes a lot of the load off GPs, enabling them to have more time to see other cases and their routine care consults as opposed to having the bulk of their day tied up with acute care presentations.

"And the reality is that paramedics are the ideal people for this space. If I have a health issue, I want to see the best person to treat that issue, and nine times out of 10 that's going to be the paramedic who has worked extensively in acute care and has done way more acute care than most GPs. It's providing better care as a whole."

It also helps curb unnecessary emergency department transports and presentations, reducing pressure on ambulance services and hospitals, and the clinic's impact on ED attendance rates has been included in its new Key Performance Indicators.

The idea of bringing paramedics into the clinic was born out of a casual conversation with a Hato Hone St John Intensive Care Paramedic and Extended Care Paramedic. As word of the initiative spread, a group of paramedics assisted the clinic in the planning stages, and in early 2023 Avon will employ its first two full-time paramedics.

"Due to the shortage of GPs, a lot of the ECPs have been providing community primary care for quite some time now, so for them it's a bit of a shift from being out in the community to actually having a fixed location in the clinic.

"A lot of it is about developing ways in which we can make the clinic function more efficiently without the paramedics always having to come and knock on the GP's door to get scripts done and that sort of thing. So a lot of our work has been setting up things like standing orders for certain conditions that the paramedics can work within. That way they can manage patients in the clinic and provide medicine in the clinic without us as the GPs having to be involved in a supervisor-type role."

That process involved reviewing Hato Hone St John's existing standing orders and selecting those that were applicable for paramedics in the clinic, as well as identifying areas that were not currently covered.

"That might be certain ways we would like things like migraines or ear infections to be managed, so for a lot of those things we've basically created our own standing orders, and that involves everything from how to assess a patient to what medications can be used in the clinic for that purpose and when to discuss with the GP.

"The days of a GP having to see every single patient are gone. It's going to be team-based care from now on, and that's what we're working towards. By bringing in different specialties, different clinicians, to manage different patient needs, we think we can improve healthcare as a whole."

Dr Butler said such team-based models of practice demonstrated to patients and other clinicians that opportunities existed to reshape the way healthcare was delivered to the betterment of the community and the health system as a whole.

"It's going to take a bit of a shift in mentality here as patients throughout the years have become accustomed to seeing their GP every time, and it's strange for them to come in and see a paramedic or a nurse, but this is very much the evolution of medical care."

PARAMEDICS ARE THE IDEAL PEOPLE FOR THIS SPACE

Dr Shaun Butler

WE KNOW THAT'S WHAT OUR RURAL AND REGIONAL COMMUNITIES NEED

RURAL PARAMEDIC STUDENTS BRING UNDERSTANDING, CONNECTION, AND A MUCH-NEEDED HEALTH WORKFORCE TO SMALL COMMUNITIES

Bendigo, Dja Dja Wurrung and Taungurung Country

Long beset by health workforce shortages and challenges in accessing health services, rural and regional areas of Australia are often left without a full complement of medical staff and the ability to receive comprehensive, high-quality healthcare.

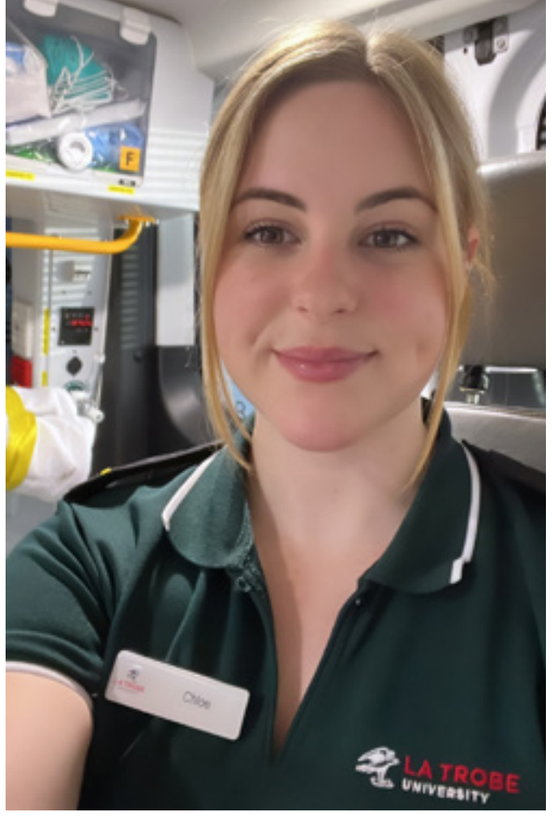
The challenges are compounded by an ageing population - at present more than 30% of people aged over 65 live in rural and regional Australia - and a tendency for lower levels of health literacy, resulting in poorer overall community health outcomes.

At La Trobe Rural Health School in Bendigo, educators and paramedic students are working to bridge those gaps through clinical placements focused on traditionally underserved rural communities - a move that is designed to attract and retain more paramedics in those areas of need and address existing healthcare shortfalls. However, unlike other paramedicine degree courses, the emphasis is on attracting students who themselves hail from rural areas.

“We've actually made a conscious decision to have recruitment thresholds,” said Associate Professor Melanie Bish. “Our aim across our 14 disciplines is to have a minimum of 70% of students of rural origin, and in doing that, we've actually created a recruitment pathway.”

The findings of the 2022 “Does undertaking rural placements add to place of origin as a predictor of where health graduates work?” study highlight the importance of this approach in retaining a regional/rural workforce, with student origin a strong predictor of working rural or regionally, together with undertaking placements in rural areas. The study recommends that priority for rural/regional student placements should be given to students in end-to-end regional/rural programs and students from those geographical backgrounds.

“As a university, we’re prioritising this because we know that's what our rural and regional communities need. Our school is very much ahead of the game in this regard, particularly in our focus on interdisciplinarity. Whereas at a lot of other universities paramedicine will traditionally sit with nursing/midwifery or public health and maybe allied health, our students and academics are collaborating and working across 14 disciplines. There's great work-ready benefits for students having that understanding of interdisciplinarity.”



THEY'RE PROVIDING A SKILL SET, BUT IT'S BIGGER THAN THAT; THEY'RE ACTUALLY CONTRIBUTING TO THE HEALTH AND WELLBEING OF THAT COMMUNITY

That interdisciplinarity is integral in the models of community paramedicine being undertaken in rural areas. The further a community is from access to health services, the greater the disparities in available healthcare - and greater the willingness to adopt new models of medical practice.

“There's a real maturity and sophistication of paramedics that's probably undervalued in rural communities in their willingness to collaborate with other health disciplines in new models of care that are in the best interests of their community. They know better than anyone what they need to maximise the use of their skills and knowledge. You can see paramedicine increasing in terms of people's understanding of its potential and its capacity to contribute to community-level resilience.”

Paramedicine student Chloe Pyne, who grew up in a small town in Victoria and is embarking on her final year of study at the school, said the emphasis on the admission of rural students - who had a better understanding of the inherent community health challenges and opportunities for professional development - and curricula that included dedicated rural-health subjects provided “a much-needed education pathway” and an important option for those who struggled with relocating to larger cities to study.

Chloe, who, like many of her peers, aims to work in smaller communities after graduating, said building rapport and spending more time with patients in her rural placement was advantageous as a budding practitioner and enabled her to develop her communication and clinical assessment skills to a degree not possible in an on-road-ambulance urban setting. And with lower levels of health literacy, she was able to help educate people about their health issues, particularly untreated or undiagnosed conditions stemming from a lack of awareness and the difficulties involved in accessing health services.

She said that in addition to emergency response, the scope of work was significantly more focused on longer-term preventive care and providing continuity of care within the community, working directly with patients in their homes, liaising with other healthcare workers when required, and offering a level of support that was often missing in rural areas.

“I think that sometimes people don't understand the importance of our role in these communities until they get to do a rural health placement, or unless they do a rural health subject. It would be immensely helpful if everyone did a stint in rural health. There's so much to be gained from that experience and being able to have that perspective of what we’re dealing with within our health system.”

Associate Professor Bish said the School of Rural Health’s place-based learning in small communities exposed students to a more holistic model of community paramedicine that was well suited for towns in rural and regional areas of the country.

“It's about preventive care and being able to keep people out of hospitals. It's being able to work with people in their own homes. It's being able to address health issues before they become emergencies. And there's much more scope for that approach to care to happen in smaller communities.

“The opportunity to work to our full scope of practice is also arguably enhanced in rural and regional locations. The situations and scenarios that a paramedic working in a rural or regional community may encounter will be very different to the work in urban locations in terms of impact and satisfaction, patient connection and the development of rapport. They're providing a skill set, but it's bigger than that; they're actually contributing to the health and wellbeing of that community.”

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BURNOUT AND PSYCHOLOGICAL HEALTH AND SAFETY

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

"When the well's dry, we know the worth of the water" - Benjamin Franklin

The 21st century has seen literature place a greater focus on the prevalence of paramedic burnout and the impact on individuals, as well as on psychological health and safety and overall wellbeing.

Burnout is "a prolonged response to chronic emotional and interpersonal stressors on the job, and is defined by the three dimensions of exhaustion, cynicism, and inefficacy" (Maslach et al., 2001, p. 397), and unfortunately the paramedic profession is at high risk.

Recent literature is reflective of ambulance employees around the world having a high level of burnout, anywhere from 16-56% (Reardon et al., 2020). A recent survey of Australian paramedics found some predictors of burnout were female, a metropolitan workplace, and 15-19 years of service (Thyer et al., 2018). The impacts of burnout are numerous, including absenteeism, declining mental health, fatigue, sleeping problems, and decreased quality of life (Miller, 2021; Rankin, 2019). This is a huge problem.

RECENT LITERATURE IS REFLECTIVE OF AMBULANCE EMPLOYEES AROUND THE WORLD HAVING A HIGH LEVEL OF BURNOUT

Burnout is not a new concept. It was first introduced by Herbert J Freudenberger, who published a paper in 1974 called "Staff Burn-out" (Freudenberger, 1974). In his paper he discusses the physical signs of burnout, consisting of fatigue, exhaustion, headaches, sleeplessness, gastrointestinal issues, and feeling short of breath. He also speaks about the behavioural signs that are characterised by difficulty holding in feelings, withdrawing, overconfidence, risk-taking on the job, the use of recreational drugs, blocking progress or change, and being inflexible.

He acknowledges that those who are most prone to burnout are the caring professions, including occupations such as healthcare and teaching. "We work too much, too long and too intently" (Freudenberger, 1974, p 3). Unfortunately, when the opposite occurs, we are struck by the same phenomenon. When our work becomes less challenging, routine and meaningless, it can lead to the same symptoms of burnout.

One of the suggestions lies around the obligations employers have in their role in preventing burnout in their organisations. Within this, he describes the need for entry-level training programs, ongoing staff education, rotating job roles, limiting working hours, allowing time off when needed, teams feeling together, sharing experiences and learning from one another, allowing staff to have training days, increased staffing, and encouraging physical activity.

In addition to from preventing burnout, he also provides suggestions to assist staff members experiencing burnout. Two of the most prominent suggestions are allowing the person as much time away as needed and offering ongoing support. Two powerful quotes from his paper are "Time off means time off" (Freudenberger, 1974, p. 5) and "Letting someone take some time off when he feels he needs or wants it makes more sense than pushing a human being further than he wants to go" (Freudenberger, 1974, p 5). These could not be truer now in the 21st century with the increased demands on workers in general, and the expectation of constant connectivity with the workplace.

At the turn of the century, burnout was described as a "syndrome of emotional exhaustion, depersonalization and reduced accomplishment that can occur among individuals who do 'people work' of some kind" (Shelley et al., 1989). The signs and symptoms included fatigue, exhaustion, feelings of hopelessness, depression, and negative attitudes (Murphy et al., 1994). Further studies by Felton describe the ongoing effect of burnout (Felton, 1998). Burnout affects organisations by lowering productivity, increasing absenteeism, increasing healthcare costs, and increasing staff turnover (Felton, 1998).

Felton describes preventative measures as giving the individual more control, having improved communication, facilitating job flexibility, appropriately training staff, and having assistance programs for staff (Felton, 1998). "The absence of fatigue, sickness, and other psychological markers of stress might mislead supervisors into believing paramedics are not stressed" (Felton, 1998, p 244). This shines a unique light on the complexity of burnout in the paramedic profession. During this period, Shelton and Kelly suggest there are four stages of burnout (honeymoon, disillusionment, brownout, and total burnout) and indicate that burnout is part of the career pathway for paramedics and their only choice is to survive it or move on to a different profession (1995). This shouldn't be the norm; burnout should not be a normal part of any occupation.

Photo by Meghan Holmes on Unsplash

How can we prevent or mitigate our own chance of burnout?

Reach out for support early. A good support network can include friends, family or colleagues. Socially interacting with colleagues and becoming friends can make work a more engaging and enticing place. Find a work-life balance that works for you. This will be different for everyone, and it may take some experimenting to find your balance. Take time off if you need it. We have holidays and sick days for a reason, and using them when you need them important. When you have time off, switch off completely from work. Exercising, eating well, sleeping well and relaxing are all important for us as we recharge between shifts. Set clear boundaries. This might be that you don't respond to work emails outside of work hours or you don't do more than a certain amount of overtime in a month. Find what you need to stay feeling you (Smith et al., 2022).

What are my employer's responsibilities?

In Australia, an employer is responsible for eliminating or minimising psychological risks as far as reasonably practical. Psychological risks are psychosocial hazards which can cause stress over extended periods and lead to an increased risk of burnout. There are numerous psychosocial hazards, including high or low job demand, low job control, lack of support, no role clarity, poor workplace change management, lack of reward and recognition, poor organisational justice, witnessing traumatic events, remote or isolated work, bullying, harassment and poor physical environment. Each workplace will be unique and have individual challenges and hazards, and employers need to work with employees to ensure they are reducing the chance of psychological risks within their organisation.

As we reflect on decades past and continue into the 21st century, we can understand just how far we still must go to ensure individuals are provided a psychologically safe workplace in which to thrive, and how far we still need to climb to reduce burnout in the paramedic profession.

A recent study from the United States found that burnout was a significant concern and that more research needs to be done to prevent, identify and address the issue (Sporer, 2021). There is still plenty of room for further in-depth studies on burnout. Of note is the role an organisational psychologist could play in assisting organisations to meet their obligations for psychosocial safety in the workplace. Organisational psychologists are employee advocates who identify workplace hazards and work with employees and employers to reduce those hazards and create a psychosocially safe workplace for everyone.

At the end of the day, as per Benjamin's Franklin's quote at the beginning of this piece, it is only when the ambulance is empty that we know the worth of our paramedics.

BURNOUT SHOULD NOT BE A NORMAL PART OF ANY OCCUPATION

References

Felton, J. (1998). Burnout as a clinical entity—its importance in health care workers. Occupational Medicine, 237–250. https://doi.org/10.1093/occmed/48.4.237

Freudenberger, H. J. (1974). Staff Burn-Out. Journal of Social Issues, 30(1), 159–165. https://doi.org/10.1111/j.1540-4560.1974.tb00706.x

Maslach, C., Schaufeli, W., Leiter, M. (2001). Job burnout. Annual Review of Psychology, 52(1), 397–422. https://doi.org/10.1146/annurev.psych.52.1.397

Miller, E. (2021). The prevalence of stress and burnout in UK emergency ambulance service workers and its impact on their mental health and well-being. British Paramedic Journal, 5(4). https://doi.org/10.29045/14784726.2021.3.5.4.62

Murphy, S., Beaton, R., Pike, K., & Cain, K. (1994). Firefighters and paramedics: years of service, job aspiration, and burnout. American Association of Occupational Health Nurses Journal. https://doi.org/10.1177/216507999404201102

Rankin, T. (2019). Factors associated with anxiety, depression, burnout, and PTSD in Australian paramedics. https://ro.ecu.edu.au/theses/2249

Reardon, M., Abrahams, R., Thyer, L. and Simpson, P. (2020), "Review article: prevalence of burnout in paramedics: a systematic review of prevalence studies", Emergency Medicine Australasia, Vol. 32, https://doi.org/10.1111/1742-6723.13478.

Safe work Australia. (2022). Managing psychosocial hazards at work. https://www.safeworkaustralia.gov.au/doc/model-code-practice-managing-psychosocial-hazards-work

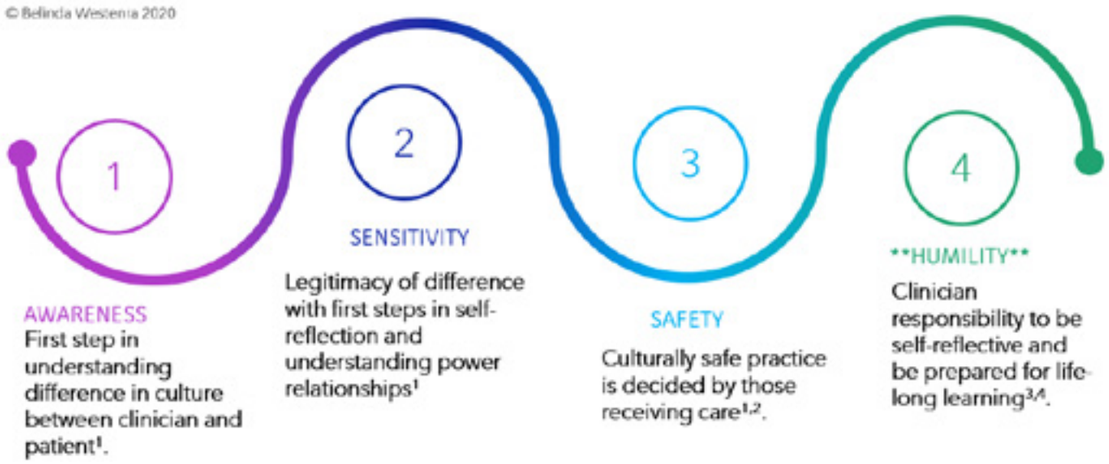
Shelly, J., Wong, M., & Rackcliffe, J. (1989). Are Texas dentists burned out? Texas Dental Journal, 106(12):9-14, 53, https://pubmed.ncbi.nlm.nih.gov/2638047/.

Shelton, R. and Kelly, J. (1995), EMS Stress: An Emergency Responders Handbook for Living Well, JEMS Communication, Carlsbad, California, CA.

Smith, M., Segal, J., & Robinson, L. (2022). HelpGuide. Retrieved 23rd December 2022 from https://www.helpguide.org/articles/stress/burnout-prevention-and-recovery.htm

Sporer, C. (2021), "Burnout in emergency medical technicians and paramedics in the USA", International Journal of Emergency Services, Vol. 10 No. 3, pp. 366-389, https://doi.org/10.1108/IJES-03-2020-0012

Thyer, L., Simpson, P., & Nugteren, B. (2018). Burnout in Australian paramedics. International Paramedic Practice 8(30, 48-55. https://doi.org/10.12968/ippr.2018.8.3.48



CULTURAL SAFETY IS A JOURNEY NOT A DESTINATION

By **Belinda Westenra** (she/her)
Registered Paramedic, MProfPrac (Ed), BSc (Comp Sci)
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Te Pūkenga t/a Whitireia

Introduction

This article introduces the concept of the journey towards cultural safety. I developed this analogy while writing a lecture on gender diversity and cultural safety that I teach to health students at Te Pūkenga t/a Whitireia (Whitireia). I think and problem-solve in images, and the visual tool accompanying this piece represents what cultural safety might look like in practice. Like all journeys, there are ups and downs and differences in each person's starting point and journey depending on their background and culture. When working in healthcare, it is important to understand there is no end point to this journey.

Cultural safety is a concept that was developed by Dr Irihapeti Ramsden, a Māori nurse and educator. Cultural safety education was added to the nursing curriculum and requirements for registration in Aotearoa New Zealand in the early 1990s (NCNZ, 2011). Why is cultural safety education important for paramedics? Māori and other ethnic minorities continue to experience inequities in health outcomes, racism, and increased exposure to social determinants of health (Curtis et al, 2019; Heke et al, 2021).

THE PRIVILEGE OF BEING INVITED INTO PEOPLE'S HOMES MAKES IT MORE IMPORTANT TO WORK IN A CULTURALLY RESPONSIVE MANNER

As registered health professionals, paramedics working in Aotearoa New Zealand under the Health Practitioners Competence Assurance Act 2003 (HPCA Act) are now required to work in a way that is both culturally safe and applies Te Tiriti o Waitangi (Treaty of Waitangi) principles to their paramedic practice (Te Kaunihera, n.d.). Until registration, some paramedics may have used the excuse of the "emergency" response to side-step this requirement. However, regardless of the acuity of patient presentation, the privilege of being invited into people's homes makes it more important to work in a culturally responsive manner.

When discussing cultural safety, it is important to declare my position. I am tauiwi (foreigner, European, non-Māori, colonist) whose ancestors migrated from Ireland, landing in Lyttleton in 1851. Although I was born in Ōtautahi (Christchurch), I grew up in England, only returning to Aotearoa New Zealand as a teenager. I am a vocationally trained, neurodiverse, queer, registered paramedic who manages the Bachelor of Health Science (Paramedic) programme at Whitireia.

The journey

The first step on this journey is awareness, and this requires learning about ourselves. Consider what impact your upbringing, ethnicity, education, social class, sexual orientation, gender identity, and religion have had on your cultural identity. What messages did you receive while growing up that have impacted on the biases, stereotypes, attitudes, and prejudices that you take to work with you every day. Now create a list of "cultures" that are different to your own, not just ethnicity. The awareness part of the journey is understanding that cultural differences exist between all patient and clinician interactions.

The next step in the journey is working in a way that is culturally sensitive. The paramedic will understand that every patient/clinician interaction is bicultural (there will be differences in culture between us) and that there is a power imbalance when we walk into someone's house wearing a uniform (Westenra, 2019).

SIMPLY LEARNING ABOUT ANOTHER'S CULTURE DOES NOT RESULT IN POSITIVE CHANGE OR IMPROVED HEALTH OUTCOMES

A paramedic who is culturally sensitive will be reflective and understand the move away from acquiring knowledge about the "other", towards a focus on how patients receive their care. Simply learning about another's culture does not result in positive change or improved health outcomes (Curtis et al, 2019). Instead of treating everyone the same, as some homogeneous representation of any group, (age or generation, migrant, socioeconomic, sexual orientation, gender, weight, disability, neurodiverse or Indigenous), we recognise and treat everyone as individuals.

Cultural safety involves critically analysing and moving the "power" in the interaction from the paramedic to the patient and their whānau (extended family). Only those receiving the care get to decide if the interaction met their cultural needs. However, because cultural safety is decided by those receiving the care, it is not the end point or destination of this journey. There is no finite checklist of cultural competencies that can be ticked off that means you are now a culturally safe paramedic. It does not exist because there will always be more to learn. This then leads the healthcare professional into the cultural humility part of the journey.

The last element of the journey is cultural humility, a "process of inquisitiveness, self-reflection, critiquing and lifelong learning" (Fahlberg et al, 2016) that was developed in 1998 in medical education in the United States. Cultural humility suggests it is the responsibility of the clinician/paramedic to remain humble and recognise there will always be more to learn. What does this mean in practice? We can attend someone and become aware of a "culture" that is new to us. This might result in us returning to the "awareness" part of the journey and reflecting on what we would do differently next time. We might need to be vulnerable and ask the patient about their cultural needs.

The journey to cultural safety is not only in one direction or always moving forward. I will give you a personal example of my own journey. As a queer paramedic, I had become complacent about providing culturally safe care to queer and gender diverse patients. I thought I was providing safe care when I asked a gender diverse patient what their preferred pronoun was when completing a patient report form. One gender diverse patient had the strength to tell me that their gender identity and pronoun was not a preference. I had good intentions going into the interaction but still had not provided culturally safe care as decided by the patient. When I reflected on the situation later, I was upset that I had been disrespectful and ignorant of their needs. I sourced reference material and research from transgender organisations (Gender Minorities Aotearoa, 2020) and authors (Veale et al, 2019) to better educate myself for future healthcare provision. I also developed the gender diverse and cultural safety session to better inform other healthcare professionals about what I had learned.

Conclusion

The journey towards cultural safety is an ongoing process for health professionals and there is no finite list of cultural competencies to tick off that indicates that you are now culturally safe. It doesn't exist. Remember, paramedics get invited into homes and how do you think you would feel if you were made to feel culturally unsafe in your own home?

Paramedic education has previously focused on clinical skills, but if the clinician is making a judgment on who is "worthy" to receive those skills, then inequitable health outcomes will continue. As registered health professionals, we will always need to reflect on how our biases, assumptions, and prejudices impact on the care we provide. Like any journey, there will be ups and downs. It is normal for us to make mistakes, but what is key is to learn from them and do better next time.

Graphic References:

1. Nursing Council of New Zealand Council (2011). Guidelines for Cultural Safety, the Treaty of Waitangi and Māori health in nursing education and practice, retrieved from https://online.flippingbook.com/view/960779225/
2. Ramsden, I (2002). Cultural Safety and nursing education in Aotearoa and Te Waipounamu [Doctoral dissertation]. Victoria University of Wellington.
3. Fahlberg, B, Baptiste, D, & Foronda, C. L. (2016). Transitions: Cultural humility: The key to patient/family partnerships for making difficult decisions. Nursing, 46(9), 14-16. https://doi.org/10.1097/01.NURSE.0000490221.61685.e1
4. Khalsa, S, Barnes, L, Audet, R, et al. (2020). The Impact of Cultural Humility in Prehospital Healthcare Delivery and Education a Position Paper from the National Association of EMS Educators (NAEMSE). Prehospital emergency care, 24(6), 839–843. https://doi.org/10.1080/10903127.2019.1709001

References:

Curtis, E, Jones, R, Tipene-Leach, D. et al. (2019) Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. Int J Equity Health 18, 174. https://doi.org/10.1186/s12939-019-1082-3

Fahlberg, B, Foronda, C, & Baptiste, D. (2016). Cultural humility: The key to patient/family partnerships for making difficult decisions. Nursing, 46(9), 14–16. https://doi.org/10.1097/01.NURSE.0000490221.61685.e1

Gender Minorities Aotearoa (2020), Trans 101: Glossary of trans words and how to use them. Wellington New Zealand.

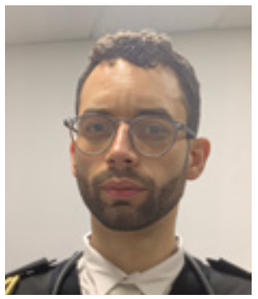
Heke, D, Wilson, D, & Came, H. (2019). Shades of competence? A critical analysis of the cultural competencies of the regulated-health workforce in Aotearoa New Zealand. International journal for quality in health care: journal of the International Society for Quality in Health Care, 31(8), 606–612. https://doi.org/10.1093/intqhc/mzy227

Te Kaunihera Manapou Paramedic Council (n.d.). Standards of Cultural Safety and Clinical Competence for Paramedics. Wellington New Zealand.

Veale J, Byrne J, Tan K, Guy S, Yee A, Nopera T & Bentham R. (2019). Counting Ourselves: The health and wellbeing of trans and non-binary people in Aotearoa New Zealand. Transgender Health Research Lab, University of Waikato: Hamilton, New Zealand. https://researchcommons.waikato.ac.nz/handle/10289/12942

Westenra, B. (2019). A Framework for Cultural Safety in Paramedic Practice. Whitireias Journal of Nursing, Health & Social Services (26): p11-17.

RESPOND, RESUSCITATE, RELAPSE: COULD COMMUNITY PARAMEDICS BREAK THE OVERDOSE CYCLE?



By **Joshua Ferdinand**
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Introduction

No one starts taking drugs with the intention of becoming an addict. Unfortunately, however, these addictions are on the rise again and there is little new public policy or planning on approaches to assist these patients other than an early warning system.

The peak of drug-induced deaths for Australia was in 1999, succeeded by an immediate sharp decline mostly due to the implementation of the National Illicit Drugs Strategy (1997). The "Tough on Drugs" approach had exceptional results in Australia and offers an interesting alternative to Portugal's post-millennium strategy; the Portuguese Drug Policy Model (PDPM).

DRUG-INDUCED DEATHS ARE PREVENTABLE WITH SPECIFIC POLICY CHANGES, SOCIAL EDUCATION PROGRAMS, AND MEDICAL HELP

Simply, in Portugal, drug use stopped being a crime but remained a misdemeanour under the jurisdiction of the Commissions for the Dissuasion of Drug Addiction. A civil penalty administered similar to traffic violations would be equivalent to the PDPM strategy in Australia, producing revenue that could be used to advance healthcare. However, it should be noted that while initially ambitious, the Portuguese approach has been beset with anachronisms and ambiguity.

Worldwide, we are in search of a solution to drug use, abuse, and overdose. While writing this article, I was inundated with a plethora of inconclusive studies and reports surrounding drug use, not to mention hundreds of pages of legislation from different Australian and American States, the United Kingdom, the European Union and the United Nations.

There appears to be two dominant philosophies:

1. United Nations conventions (1961, 1971 and 1988): Member countries should do everything in their power to combat the spread of the illicit use of drugs.
2. Decriminalisation and a healthcare approach to drug use.
    a. In 1999, Dr Erik van Ree proposed amending the Universal Declaration of Human Rights to include Article 31: "Everyone has the right to use psychotropic substances of one's own choice."[1]
    b. In 2003, the European Union proposed a repeal of the 1988 UN convention citing wide failures in implementation of the conventions throughout the past 30 years.[2]

One key takeaway is that drug-induced deaths are preventable with specific policy changes, social education programs, and medical help.

We must remember that there is a plethora of reasons people use drugs that go beyond the recreational abuse we commonly see in EMS. There are functional[3], non-dependant[4], religious[5], healthy[6], socially integrated[7], and non-problematic reasons[8] for people to consume drugs. We also acknowledge that psychoactive substances have been used since ancient times.[9]

Unfortunately, this case study offers no silver bullet for drug policy as policies are often rooted in cultural beliefs, existing international relationships and agreements, as well as in the availability of national resources. From an ambulance perspective, irrespective of current legislation, social or societal stigma, we must treat drug users with empathy and compassion or risk that they no longer seek our services or support. We will explore two cases of drug-induced toxicity over the holiday period to understand how diametrically opposed each patients experience is, as well as the underlying aetiology.

Case 1: Cocaine toxicity causing SVT

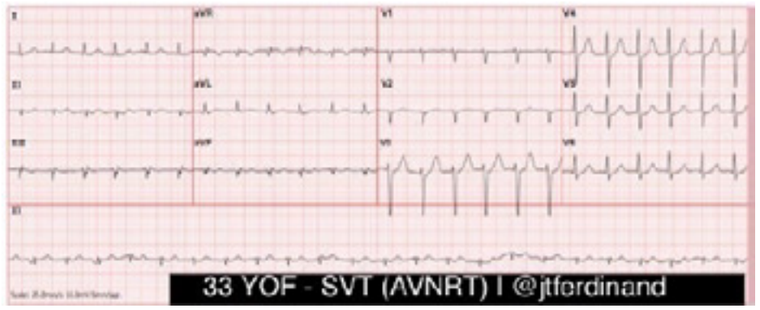
A 33-year-old female was heading into the city for a Christmas party when she experienced palpitations and chest pain. Her friend alerted staff at the train station, who called an on-site paramedic.

Hx: States she has consumed alcohol and cocaine at a pre-drinks event. **PMx:** Nil. **SHx:** Nil

Vitals: HR: 140BPM! | RR: 24 | BP: 100/60mmHg | SpO2: 96% Air | GCS: 15/15 | ECG: SVT (AVNRT) | BMoL: 7.2

Action: Reassurance*, vagal manoeuvres (Valsalva), 12 lead ECG with continuous monitoring, transport to ED.

Response: No reversion on scene; urgently transported to ED. Cardioversion considered but not indicated.



** Often overlooked it can be one of the best things paramedics can offer and allows us to show empathy for the patient rather than frustration and judgment over their personal choices*

Case 2: Heroin toxicity

A 42-year-old male with pinpoint pupils was found unresponsive in a toilet. It was evident that he was sleeping rough by his appearance and his backpack containing a sleeping bag, camping mat and methadone prescription. No sharps could be found, but in a peripheral examination track marks were noted on his arms.

Hx: Previous OD. **PMx:** Opiate Addiction. Leukaemia. MH issues. **SHx:** Rough Sleeping (homeless)

Vitals: HR: 86BPM | RR: 5 | BP: 126/78 | SpO2: 78% Air | GCS: 3/15 | ECG: NSR | BMoL: 4.1

Action: Recovery position, OPA, IPPV, IV Naloxone 100mcg diluted q.2.min

Response: GCS improved O/S, transported to ED.

Discussion

The first case is a stereotypical example of a person who believes they can improve their night by taking a psychoactive stimulant. As an intelligent professional, she was aware of some of the risks but not that it could have caused such changes as to have led to a cardiac arrest; a fatal outcome if medical support isn't quickly forthcoming.

The second case is another typical example of someone trying to escape a void they feel at Christmas. While we may attempt to empathise with this patient, it would be impossible for many people to imagine the despair of loneliness, isolation and despair that comes with having cancer and being homeless over Christmas.

Both cases occurred with the existing drugs policy in place, suggesting that neither will be prevented by increased punitive measures, except perhaps the young professional. And while both were aware of the potential physical and financial consequences of their actions, they decided to continue for very different reasons.

At present we are tasked with responding to these patients when they are at crisis point, and potentially already in a life-threatening situation. From here, we are unable to offer solutions to break the cycle of respond, resuscitate and relapse we see in EMS. Nevertheless, education and outreach could prevent such occurrences. Community paramedics are ideally placed to explore such prevention possibilities with the right support from government and public policy.

COMMUNITY PARAMEDICS ARE IDEALLY PLACED TO EXPLORE SUCH PREVENTION POSSIBILITIES

References

1. van Ree E. Drugs as a human right. International Journal of Drug Policy. 1999;10(2):89–98. https://doi.org/10.1016/S0955-3959(99)00008-0.

2. Proposal for a recommendation on the reform of the conventions on drugs - B5-0541/2002. European Parliament. December 23, 2002. https://www.europarl.europa.eu/doceo/document/A-5-2003-0085_EN.html#_section4, retrieved November 28, 2022.

3. Smith M, Smith P (2005), The problem of drug prohibition for drug users: A Mertonian analysis of everyday experience. Electronic Journal of Sociology, p. 7.

4. Keene J. An international social work perspective on drug misuse problems and solutions: reviewing implications for practice. J Soc Work. 2001;1(2):187– 99, https://doi.org/10.1177/146801730100100205.

5. Feeney K, Labate B. The expansion of Brazilian Ayahuasca religions: law, culture and locality prohibition. In: Labate B, Cavnar C, editors. Religious freedom and human rights: regulating traditional use. Berlin: Springer; 2014. https://doi.org/10.1007/978-3-642-40957-8_6.

6. Whiteacre K, Pepinsky H. Controlling drug use. Crim Justice Policy Rev. 2002; 13(1):21–31. https://doi.org/10.1177/088740340201300100 2.

7. Pavarin R. First consumers, then socially integrated: results of a study on 100 Italian drug users who had never turned to public or private addiction services. Subst Use Misuse. 2016;51(7):892–901. https://doi.org/10.3109/10826084.2016.1155620.

8. Nicholson T, Duncan D, White J, Watkins C. Focusing on abuse, not use: a proposed new direction for US drug policy. Drugs Educ Prev Policy. 2012;19: 303–8. https://doi.org/10.3109/09687637.2012.682231.

9. Blackman, Shane J.. Chilling Out: The Cultural Politics of Substance Consumption, Youth and Drug Policy. United Kingdom: Open University Press, 2004.

THE PALLIATIVE PATIENT

By **Craig Barraclough**
Extended Care Paramedic – Central South Hato Hone St John

Case introduction

You have just started the evening shift and have been dispatched to a case of shortness of breath, 58-year-old female; there is mention of hospice with no additional context or notes. An emergency ambulance is dispatched with a paramedic intern (practising as an EMT) and an EMT crew partner, and an Extended Care Paramedic requests dispatch to this case to support the crew and, in particular, the intern. On arrival, you are met by her family and presented with a severely short-of-breath female with rattly breathing in a warm, dry home supported by her husband and greater family.

Initial baselines: **SpO2 <50 RR 40+ HR 120+ BP 70/50 GCS 14 E4 V4 M 6**

Discussion

What are your concerns?

You find a hospital discharge note with significant history; key aspects include:

- Inoperable cancer of the lung pressing on the pulmonary artery.
- Discharge advice of "do not use BP or SpO2 to guide management as these have been consistently low; management should focus on comfort and managing symptoms".
- She is enrolled with the local hospice; however, there are no hospice medications except the patient's oral morphine.

Pharmacology

The following are common medications that can be used as PRN or mixed and delivered via a syringe driver:

Morphine and Oxycodone 10mg/1ml

Both are used to manage pain and have the benefit of more prolonged effects; doses can appear large if used for a longer duration as patients develop tolerance to morphine and require increasingly higher doses.

Midazolam 15mg/3ml

Midazolam is used as an anxiolytic and can be used for reducing agitation.

Levomepromazine 25mg/1ml

Levomepromazine is an older mental-health medication used primarily to manage nausea; doses are usually 5-10 mg. In larger doses, it can be used to control agitation.

Hyoscine butybromide (Trade name Buscopan™) 20mg/1ml

Hyoscine is an anticholinergic medication that can provide some drying or reduction of respiratory secretions. Its use is somewhat controversial as patients generally do not complain about the secretions. Side effects include drying of mucosal membranes and constipation.

New Zealand Ambulance CPGs authorise the use of opiates (fentanyl or morphine), midazolam for anxiety and droperidol to reduce agitation. Link to NZ CPGs: Apple Android.

Agitation can be caused by pain and analgesia, and management of reversible causes should be an early consideration; distended bladders are common causes of discomfort, and many patients will have catheters inserted by hospice or ECPs.

Palliative vs end-of-life care: Defining the difference

Palliative care

Palliative care provides caring and dignified support and services for people of all ages facing a life-limiting condition. This care can be long-term and includes the management of cancers, chronic kidney disease, lung diseases and dementia, for example.

End-of-life care occurs in the final stage of palliative care and focuses on patient comfort.

End of life choice Act 2019 (NZ)

Legislation allowed assisted dying, as a health service, from 7 November 2021. Eligibility is strictly limited, and the applicant must be:

- Aged 18 years or over.
- A citizen or permanent resident of New Zealand.
- Suffering from a terminal illness that is likely to end their life within six months.
- In an advanced state of irreversible decline in physical capability.
- Experiencing unbearable suffering that cannot be relieved in a manner that the person considers tolerable.
- Competent to make an informed decision about assisted dying.

The procedure is performed by a Medical Practitioner or Nurse Practitioner under the instruction of a Medical Practitioner.

Key learning point

Assisted dying must not be initiated by health practitioner: End of Life Choice Act 2019 S. 10. The person requesting assisted dying must raise this with someone in their health care team; this will often be their primary health doctor. Paramedics asked about assisted dying should refer these queries to the patient's primary doctor.

Conclusion

The ECP asked the crew to gain vital signs while reviewing the hospital discharge note; this contained essential information, including the primary issue of a pulmonary mass pressing on the pulmonary artery, and specifically recommended the blood pressure ad SpO2 not be used to guide management, instead focusing on treating symptoms to make her comfortable.

The ECP contacted the hospice, who advised there were no beds available and stated the patient would need to go to ED if transported. The nurse managing the patient's outpatient care was surprised by the sudden deterioration and agreed with the ECP and crew's plan to try managing her symptoms in the community. The ECP placed a subcutaneous line, and midazolam, hyoscine and levomepromazine were administered to treat her symptoms. The ambulance crew departed for another emergency case while the ECP completed documentation and movement of the patient to another room. On follow-up the following day, the GP clinic confirmed she died comfortably at home with her family that morning.

If you'd like more information on palliative care, the Australasian College of Paramedicine offers a range of educational offerings and courses.

DEATH ANXIETY: THE CONDITION AT THE CENTRE OF MENTAL HEALTH

By **Dr David Dawson PhD**
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Paramedic Mental Health Researcher
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Introduction

"I've seen terrible things as a paramedic. The worst isn't what you'd expect," was a headline of a 2018 article in The Guardian newspaper by Liz Harris.[1] The paramedic concerned was not named. The paramedic describes a "callout to an elderly man who is struggling to breathe". At the scene are Bert and his wife, Mavis; both are quite frail. Bert is slouched in the front room and it is soon apparent that he needs to go to hospital.

HUMAN BEINGS' ABILITY TO RECOGNIZE THEIR OWN MORTALITY CAN LEAD TO DEATH ANXIETY

Mavis begins to pack a few things for the hospital; pyjamas, toothbrush and razor. It quickly becomes evident that the situation is serious and deteriorating. A looming possibility develops that this might be the last time they see each other. Bert is stoic, he tells his wife he will be okay. "He is kind, too, reminding Mavis of how much he loves her". Mavis shows pride in Bert and the fact that they have been married for 60 years. Around the room are many faded photos showing the generations of family members. "Bert tells me they are all dead now, even their son who died young." Between tiring breaths, Bert says Mavis is the love of his life. "I remember his soft slow words perfectly and the telling look in his eyes - he knows he is not coming home again."

Mavis also grasps the gravity of the situation and her eyes well up. She limps over to Bert, who is still telling her he will be fine. "Her hands cup his cheeks as her small, stooped frame leans forward to give him a kiss. I pause momentarily, trying to be invisible, and then ask quietly if we can go. Mavis delicately flattens Bert's hair to one side of his head, smiles at me and nods her head. I ask Bert if that is okay, and he smiles and nods too." Bert died later that day.

The paramedic relating this experience goes on to say, "It is the job that stayed with me for the longest time after it was over. You might think it can't be the worst thing I've ever seen, but it is definitely the worst thing I've ever felt."[1]

Human beings' ability to recognize their own mortality can lead to death anxiety. Brady (2015) stated: "Emergency healthcare workers and paramedics are constantly reminded of death, dying, human fragility and their own mortality, however. As a result, these workers are more susceptible to anxiety about death than their colleagues in, for example, community care services."[2]

Dealing with a case like that of Mavis and Bert could trigger a person to ponder many aspects of this case, as happened with the paramedic who was involved. These thoughts could reasonably be expected to include thoughts about one's own mortality and circumstances of their own death, and lead to a degree of death anxiety, as indicated by Brady. This raises the question of what is meant by death anxiety?

Death anxiety and who is at risk

Dealing with death is part of life, and no one would claim it is easy; sometimes it is horrific and traumatic. People who deal with trauma and traumatic death can have higher levels of death anxiety[3] which can be compounded with PTSD, as could arise from the experiences of, for example, paramedics and emergency room nurses.[4] There is no standard definition of death anxiety. However, Cai, et al., (2017)[5] presents a description with four dimensions:

1. Physiological nervous reactivity (similar to a stress response).
2. Recurrent thoughts about death and dying or death-related events.
3. Feeling worry and fear when thinking about one's own death or dying.
4. Avoidance of thoughts and events associated with death and dying.

The fear of death is common in the general population, but most show only low to moderate levels of death anxiety.[6] People who have contact with death generally have lower levels of death anxiety. For example, a study of medical students (all of whom encountered ageing and death) found lower levels of death anxiety compared with other students of equivalent age and compared with adults from the general population.[7] An investigation of funeral directors found that death anxiety decreased as the number of funerals with which they were involved increased.[8]

Payne, et al. (1998)[3] found lower levels of death anxiety in palliative care nurses compared with nurses working in the emergency department. These researchers remarked that emergency nurses experienced sudden and traumatic death and were required to deal with distraught relatives, and felt unprepared for this role. The comment was also made that people with low death anxiety may feel comfortable working with dying patients in palliative care, but emergency nurses deal "with death as an unfortunate consequence of the job". It can be postulated that dealing with death in the "normal conditions of life" reduces death anxiety, but dealing with death in traumatic circumstances increases death anxiety; these situations are plainly stressful. In similar circumstances, similar consequences could apply to paramedics.

MOST PEOPLE EXPERIENCE TOLERABLE LEVELS OF DEATH ANXIETY; AT HIGHER LEVELS IT IS A CONCERN IN ITS OWN RIGHT

The level of death anxiety in paramedics is not known and research is needed. In the interim, consideration could be given to addressing death anxiety as a part of paramedic education.

Why death anxiety matters

Most people experience tolerable levels of death anxiety; at higher levels it is a concern in its own right. However, death anxiety is a transdiagnostic idea meaning that it is associated with, and underlies, a range of mental health conditions. Menzies, et al., (2019)[9] found that death anxiety was associated with 12 mental health conditions, including depression and anxiety; an earlier review found an association with PTSD.[10] Raised levels of death anxiety were linked to the (higher) number of different mental health diagnoses the study participants reported over time. People with elevated death anxiety reported more frequent hospital use and a higher recurrent use of medications. It appears that people may be successfully treated for one condition but subsequently present with another if the underlying death anxiety is not addressed.

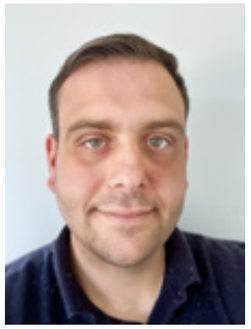
A number of paramedic studies have shown raised levels of mental health conditions (e. g. Wagner et. al. (2020)[11] such as anxiety and depression, and a higher risk for PTSD.[12] All people, including paramedics, presenting with mental health conditions should be assessed for death anxiety. Otherwise, the presenting problem might be healed but another is more likely to pop up if any underlying death anxiety is not also managed.

Successfully dealing with death anxiety is associated with ongoing good mental health.

References:

1. Harris, L. in The Guardian Australia (Guardian News & Media Limited, 2018), https://www.theguardian.com/healthcare-network/2018/apr/05/terrible-things-paramedic-worst.
2. Brady, M. Death anxiety among emergency care workers. Emergency nurse: The journal of the RCN Accident and Emergency Nursing Association 23, 32-37, https://doi.org/10.7748/en.23.4.32.e1448 (2015).
3. Payne, S., Dean, S. & Kalus, C. A comparative study of death anxiety in hospice and emergency nurses. Journal of advanced nursing 28, 700-706 (1998).
4. Adriaenssens, J., de Gucht, V. & Maes, S. The impact of traumatic events on emergency room nurses: Findings from a questionnaire survey. International Journal of Nursing Studies 49, 1411-1422, https://doi.org/10.1016/j.ijnurstu.2012.07.003 (2012)..
5. Cai, W., Tang, Y.-l., Wu, S. & Li, H. Scale of Death Anxiety (SDA): Development and Validation. Frontiers in Psychology 8, https://doi.org/10.3389/fpsyg.2017.00858 (2017).
6. Furer, P. & Walker, J. R. Death anxiety: a cognitive-behavioral approach. Journal of Cognitive Psychotherapy 22, 167-182 (2008).
7. Thorson, J. A. & Powell, F. C. Medical students' attitudes towards ageing and death: a cross-sequential study. Medical Education 25, 32-37, https://doi.org/10.1111/j.1365-2923.1991.tb00023.x (1991).
8. Harrawood, L. K., White, L. J. & Benshoff, J. J. Death anxiety in a national sample of United States funeral directors and its relationship with death exposure, age, and sex. OMEGA-Journal of Death and Dying 58, 129-146, https://doi.org/10.2190/OM.58.2.c (2009).
9. Menzies, R. E., Sharpe, L. & Dar-Nim¬rod, I. The relationship between death anxiety and severity of mental illnesses. British Journal of Clinical Psycholo¬gy 58, 452-467, https://doi.org/10.1111/bjc.12229 (2019).
10. Iverach, L., Menzies, R. G. & Menzies, R. E. Death anxiety and its role in psy¬chopathology: Reviewing the status of a transdiagnostic construct. Clinical Psychology Review 34, 580-593, https://doi.org/10.1016/j.cpr.2014.09.002 (2014).
11. Wagner, S. L. et al. Ambulance person¬nel: Systematic review of mental health symptoms. Traumatology Advance online publication, https://psycnet.apa.org/doi/10.1037/trm0000251 (2020).
12. Berger, W. et al. Rescuers at risk: a systematic review and meta-regres¬-sion analysis of the worldwide current prevalence and correlates of PTSD in rescue workers. Soc Psychiatry and Psychiatric Epidemiology 47, https://pubmed.ncbi.nlm.nih.gov/21681455/ (2012).

TIME TO REASSESS PARAMEDICINE STUDENT ASSESSMENT



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Undertaking assessments at university is part and parcel of obtaining a degree, and different strategies allow for the assessment of different learning outcomes. However, as academics and educators, we need to ensure that our assessment strategies are fit for practice, are current, and are focused on the core goals and expected outcomes for learners in completing their degrees.

We don't want to end up falling into the trap of "this is how it has always been done" or "this is how I had to do it". While I appreciate that this is a very complex topic with many moving parts and differing awarding bodies and facts to consider, let's look at one of the most common assessment strategies.

The Objective Structured Clinical Exam (OSCE)

The OSCE has been utilised in the healthcare training section for many decades to practically assess healthcare students. Looking at this in the paramedicine education space, it is traditionally set up as a final examination at the end of a clinical unit. The exam typically has a pass-fail grade attached to it. Discussions about the advantages and disadvantages of the OSCE has been very limited and mainly focused on nursing degree students. We, as a profession, need to consistently review our assessment practices and the evidence that supports them. Some of the student experiences of OSCE that have been researched show that students have increased anxiety and stress levels when undertaking OSCE's.

So, we need to ask whether the OSCEs still fit in our assessment toolbox. How does it prepare the learners, what learning outcomes does it demonstrate, what benefit does it have for student learning, and how does it prepare them for practice in real life?

Currently, from my experience, the OSCE has been structured with the idea that the student is required to demonstrate competence in a clinical scenario by acting as a clinical lead for a job. This generally leads to a hyperacute stress state for the students. While there was some evidence for stress inoculation, a growing body of evidence shows that exposing humans to these hyperacute stressful situations decreases mental performance and can increase anxiety and depression rates. This can see students with sound clinical knowledge and good skill application fail due to moving into a high-stress zone while undertaking the OSCE. A good proportion of these students have studied and demonstrated good practice in clinical labs.

The second question to ask about this form of assessment is whether are all created equally? Generally, there are multiple scenarios that the student could be faced with. Do all these scenarios require students to demonstrate the same knowledge and skill levels, and finally, are the markers assessing each student of the same land standard? Does an Intensive Care Paramedic mark in the same way as an ambulance paramedic? These additional factors can be reduced with good moderation, but still, it leaves a significant possibility for variance in each OSCE marking.

WE NEED TO ENSURE THAT OUR ASSESSMENT STRATEGIES ARE FIT FOR PRACTICE

Alongside these factors, OSCEs are conducted in a non-realistic setting, even if you use high-fidelity simulation or real actors. There is a lack of visual cues that we have in real life, and these are very difficult to replicate in a simulation. The shortness of breath of an end-stage COPD presentation. The pale, sweaty look of a hypovolemic patient. Paired with forcing the student to act as the primary paramedic and decision-maker either by themself or with another student. This is a setting in which the student is extremely unlikely to find themself in for at least a couple of years on the road as most will enter a graduate program and be paired with experienced paramedics.

With all this in mind, we need to consider how we utilise OSCE and change practice to better assess healthcare students' clinical skills and abilities. In my opinion, we can utilise a more structured scaffolding approach. Focus on micro-skills and building towards more extensive assessments, but with acknowledgment of what has already been demonstrated by the learner.

While I believe that complete skills and assessment pieces can be utilised to ensure learning outcomes are met, these assessment methods should not place the students under hyperacute stressful situations with no support but should be built to lead towards the actual practice and real expectations of learners. We can start to build new assessment models and methods that focus on building up the learner and preparing them to be job ready at the completion of their degree.

PARAMEDICINE STUDENTS AND REFLECTIVE PARTNERSHIPS

By **Howra Al Timimy**
Paramedic student
Sydney, Wangal Country

There has been an unexpected growth in professional opportunities for Australian paramedicine students upon graduation. The anticipation of employment competitiveness and uncertainty has eased as many state-based ambulance services are now offering an abundance of guaranteed jobs. It is, of course, an exciting prospect for students who are keen to enter the profession in Australia and in the public health system where they are needed.

It's an investment that is no doubt aimed at tackling chronic short staffing, inadequate resourcing, and burnout. It's also an adjustment that is desperately needed to keep up with our communities' growing health needs and the shortage of health services that has snowballed in the past several decades. The effects that will be seen on patient-centred care will result in significantly more positive health outcomes.

What is not often observed is a conversation on what will be done to support a workforce that already has some of the highest rates of burnout, and who will be required to train and mentor the next generation of paramedics. There is pressure on paramedics who may not feel prepared or feel they have the level of support needed to facilitate the best learning environment for their students. This is not a sustainable option for anyone, for both the mentors and mentees, who all deserve the opportunity to be adequately prepared for this profession.

When there is an overarching sense of rigidity in just accepting the situation as it is, doing anything more can feel uninspiring. Work demands can be so all-consuming that there isn't time to focus on much more beyond the job. However, being reflective and improving our approach to patient-centred care is also part of the job. It's a standard echoed by every healthcare profession, and all ambulance services must be mindful of how they will accommodate this.

While there is no denying there are major systemic issues that need to be addressed, opportunities exist that promote the sustainability of growth in how we reflect and improve on patient-centred care. For anyone entering the profession, the responsibilities of taking on the work required to sustain our growing industry must always reflect safe practice and the evolving nature of evidence-based practice.

The employment of such practice can often be limited by protocols and resources, regardless of the information available at the time. Spinal immobilisation practices are one such example; the removal of rigid cervical collars will ultimately provide impetus for the use of the soft C-collar. However, the practice of "soft skills" has too many nuances for the same line of logic to be mirrored. This gives paramedics the opportunity to employ their own communication strategies to ensure the right care is provided for the patient. The uniqueness of individualising every approach is the crux of patient-centred care. With such nuances and changing social norms, mistakes can be made.

OPPORTUNITIES EXIST THAT PROMOTE THE SUSTAINABILITY OF GROWTH IN HOW WE REFLECT AND IMPROVE ON PATIENT-CENTRED CARE

In a healthcare setting, it is vital to foster an environment that welcomes reflective discussion and debriefing to avoid the risk of exacerbating recurrence and risking patient safety. While this is a given and a common exercise, the power and knowledge imbalance may feel daunting for students who wish to contribute. This is important if students come to pick up on indicators of unsafe practice or approaches that feel ethically questionable. Placing value on a students' input fosters a partnership between incoming and experienced paramedics, while invalidating feedback can render stagnant the opportunities for learning.

Students want to learn and put into practice clinical reasoning, and understanding the grey areas surrounding the conflicts of ethical frameworks is an important part of the process. It provides accountability for both registered paramedics and students to be mindful in their practice.

PRE-HOSPITAL MANAGEMENT OF PAEDIATRIC PALLIATIVE CARE: BREAKTHROUGH CANCER PAIN

A HYPOTHETICAL CASE STUDY

By **Madison Steer**
Bachelor of Paramedic Science, Flinders University
Adelaide, Kaurna Meyunna Yerta

This hypothetical case study is unique as it explores the complexity of paediatric palliative care, particularly in the pre-hospital environment. Paramedics were dispatched Priority 2 to a residential address to a 7-year-old female patient for breakthrough cancer pain. Additional clinical support from an Intensive Care Paramedic (ICP) and the patient's Palliative Care Team (PCT) was received throughout.

Primary take-away messages: Paediatric palliative care, paediatric pain relief, understanding the pathophysiology of acute myeloid leukaemia (AML) and chemotherapy, breakthrough cancer pain and communication between allied health professionals.

The patient was a 7-year-old (22kg) presenting as distressed, agitated, inconsolable, tachypnoeic, flushed, tachycardic and hypertensive. Her primary complaint was severe global pain accompanied by nausea and vomiting. The patient was diagnosed with AML four years earlier, for which she received six months of intensive chemotherapy and was remissive in 2019. In 2021, the patient was diagnosed with aggressive AML - terminal. The patient was given a Palliative Care Plan (PCP) late 2021. Her PCT visits days per week. Additionally, she has been diagnosed with mild anxiety disorder. Their current medications include methotrexate, folic acid and codeine. The patient has very supportive family and friends.

Table 1: RDR Chart of vital signs and treatment

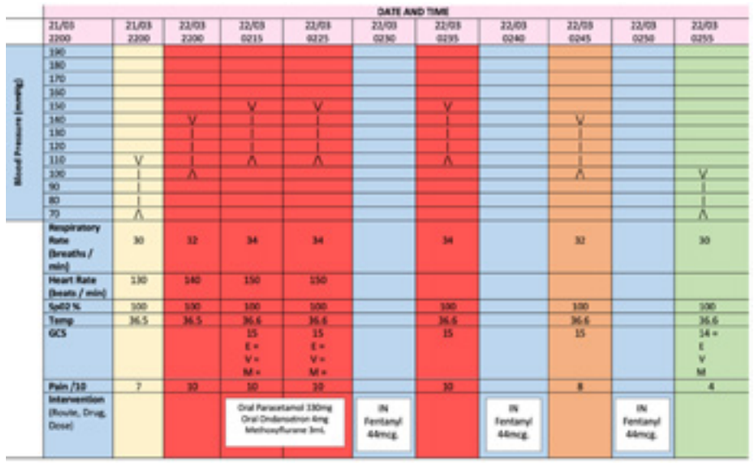


Table 1 displays the patient's vital signs and medical interventions. These are concurrent with date and time stamps which correlate with the Figure 1 Timeline opposite.

Upon paramedic arrival, the patient was suffering with severe pain; 10/10. ECG displayed sinus tachycardia. Her body was compensating for the pain with an increased heart rate, increased blood pressure, and increased respiratory rate. A combination of analgesics was administered to treat the global pain, as well as anti-emetics to target the nausea and vomiting, which would in turn stabilise the compensatory responses.

Therapeutic intervention:

Paracetamol: Analgesic.[1] Dose: 15mg/kg. 330 mg. Route: Oral.[1], [2]

Methoxyflurane: Analgesic.[3] Dose: 3mL/vial. Route: Oral Inhalation.[3]

Fentanyl: Opioid Analgesic.[5] Dose: 2mcg/kg. 44mcg.[2] Route: IN

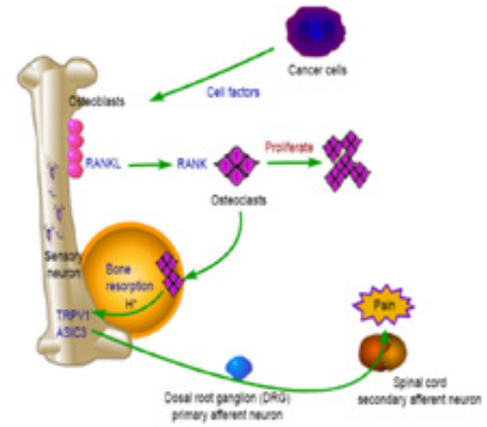
Ondansetron: Anti-emetic.[6] Dose: 4mg.[6] Route: Oral

Paediatric palliative care heavily involves symptomatic management.[5] Due to this, diagnosis and differentials will vary between patients, depending on their history and circumstances. Differential diagnoses to consider for this patient were sepsis, febrile neutropenia, asthma, upper respiratory tract infection, and lower respiratory tract infection. Based on the negative clinical findings of the patient, these were not the top provisional diagnoses.

NIL diagnostic challenges were observed in this patient. However, the challenge of hospital versus TNT was evident in this case. As the PCT was constantly consulted throughout this event alongside the family, as well as having an active care plan, the paramedics completed a TNT.

Figure 1: Reconstructed timeline of the events

Figure 2: Pathogenesis of cancer cells creating bone pain (Zu et al., 2015)



Discussion:

AML is complex cancer that occurs due a cascade of genetic changes that occur in the hematopoietic precursor cells.[7] The growth and differentiation of the normal hematopoietic cells are altered, which in turn leads to an increase of immature and abnormal myeloid cells present in both the peripheral blood and bone marrow.[7] These myeloid cells are capable of being able to divide and proliferate; however, they aren't able to differentiate themselves into the required mature hematopoietic cells (e.g. neutrophils).[7]

This increase of myeloblasts present in the patient's bone marrow causes negative effects of haematopoiesis, which can eventually result in bone marrow failure.[8] *Figure 2* demonstrates how AML can progress to breakthrough cancer pain in the bones, illustrating the ability of the osteoclasts to be reabsorbed through the bone and the excretion of protons, which leads to degradation of bone minerals causing an acidosis. The acidosis leads to excitation of the sensory neurons, which progresses to activating the acid-sensing nociceptors (TRPV1 and ASIC3).[9] As a result, the DRG passes the painful stimuli to the spinal cord, which in turn evokes the stimulation of "pain" in the brain.[9]

Paediatric palliative care is unique as it explores both ethical and legal barriers in which children who are terminally ill can make informed decisions and consent to treatment with the same authority as an adult.[10] Additionally, palliative care for children is complex; due to the nature of daily constant risks, distressing symptoms, unpredictable deterioration, reliance on emergency care, hospital admissions, and death.[11] Trust between the medical professionals, the patient, and their family is essential to achieve high-quality palliative care and treatment in their home environment.[11]

Conclusion:

This case report demonstrates effective pre-hospital palliative care treatment provided by the paramedics and ICP, alongside the PCT. The patient received appropriate symptomatic management of analgesics and anti-emetics. The treatment provided was in-line with the evidence of effective paediatric palliative care that has been outlined throughout this report. The primary takeaway lessons from this case include effective symptomatic management of breakthrough cancer pain, communication between allied health professionals/the family, as well as a prompt review and restructure of the patient's current PCP.

References

1. Pacifici, GM, Allegart, K. Clinical Pharmacology of Paracetamol in Neonates: A Review. Current Therapeutic Research. 2015;77:24-30. https://doi.org/10.1016/j.curtheres.2014.12.001
2. Ambulance Victoria. Clinical Practice Guidelines Ambulance and MICA Paramedics. Victoria: Ambulance Victoria. 2018. 179 - 180p. https://www.ambulance.vic.gov.au/paramedics/clinical-practice-guidelines/
3. MIMS Australia. Penthrox Inhalation. VIC, Australia: MIMS, 2020. https://www.mimsonline.com.au
4. MIMS Australia. Aspen Fentanyl. Vic, Australia: MIMS, 2020. https://www.mimsonline.com.au
5. Verberne LM, Kars MC, Schepers SA, Antoinette Y N Schouten-van M, Grootenhuis MA, Johannes J M van D. Barriers and facilitators to the implementation of a paediatric palliative care team. BMC Palliative Care. 2018;17:1-8. http://dx.doi.org/10.1186/s12904-018-0274-8
6. Falvey, S, Shipman, L, Illowite, N, Beukelman, T. Methotrexate-induced nausea in the treatment of juvenile idiopathic arthritis. Pediatric Rheumatology. 2017;15. https://doi.org/10.1186/s12969-017-0180-2
7. UpToDate. Pathogenesis of acute myeloid leukemia. Netherlands: Wulters Kluwer; 2022. https://www.uptodate.com/contents/pathogenesis-of-acute-myeloid-leukemia?search=%E2%80%98Pathogenesis%20of%20acute%20myeloid%20leukemia%E2%80%99.&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1
8. Skayneh, H, Jishi, B, Hleihel, R, Hamieh, M, Darwiche, N, Bazarbachi, A, Marwan, ES, Hiba, EH. A Critical Review of Animal Models Used in Acute Myeloid Leukemia Pathophysiology. Genes. 2019;8(10):614. https://doi.org/10.3390/genes10080614
9. Zhu, X., Zhang, J., Ge, C., Yu, Y., Wang, P., Yuan, T., & Fu, C. (2015). Advances in cancer pain from bone metastasis, UK: Taylor & Francis Ltd. 2015. https://doi.org/10.2147/DDDT.S87568
10. Haines, ER, Frost, AC, Kane, HL, Rokoske, FS. Barriers to accessing palliative care for pediatric patients with cancer: A review of the literature. Cancer. 2018; 124(11):2278-2288. https://doi.org/10.1002/cncr.31265
11. Mitchell, S, Spry, JL, Hill, E, Coad, J, Dale, J, Plunkett, A. Parental experiences of end of life care decision-making for children with life-limiting conditions in the paediatric intensive care unit: a qualitative interview study. BMJ Open. 2019;9(5). https://doi.org/10.1136/bmjopen-2018-028548

FLINDERS UNIVERSITY PARAMEDICINE STUDENT AWARDS CEREMONY 2022

By **James Pearce FACPara**
Senior Lecturer, Flinders University

The Flinders University Paramedicine Student Awards Ceremony was held on 15 December 2022. Two awards, the Russell Liston Award for Paramedic Clinical Excellence and the Australasian College of Paramedicine Award for Research Excellence are generously sponsored with a $500 cash prize from ACP.

This year's ceremony was particularly poignant for students and staff at Flinders University and SA Ambulance Service as it is the 10-year anniversary of the tragic death of the highly respected SA Ambulance Service Intensive Care Paramedic and former Flinders University student Russell Liston in 2012, the first time the Stafford Wulff Paramedic Graduate of the Year Award has been awarded since the death of the much-loved SAAS Paramedic and Flinders University graduate and tutor, Stafford Wulff earlier in 2022, and the awarding of the Tom Sutherland Engagement Prize in the year when outstanding student Tom Sutherland would have been graduating had he not sadly passed during his first year of paramedicine studies at Flinders in 2020.

We warmly and wholeheartedly congratulation the 2022 award recipients:

- Russell Liston Award for Paramedic Clinical Excellence: Joel Gregurev
- Australasian College of Paramedicine Award for Research Excellence: Tori Psichogiopoulous
- Stafford Wulff Paramedic Graduate of the Year Award: Jemma Highett
- Tom Sutherland Engagement Prize: Chris Clayson

Russell Liston Award for Paramedic Clinical Excellence:

2022 Recipient:
Joel Gregurev

Brian Liston (Russell Liston's Father), Joel Gregurev and Bryan Ward (SA Ambulance Service A/Operations Manager, Metro South)

Australasian College of Paramedicine Award for Research Excellence:

2022 Recipient:
Tori Psichogiopoulous

Stafford Wulff Paramedic Graduate of the Year Award:

2022 Recipient Jemma Highett

Jemma Highett and Dr. Tim Rayner (Flinders University Discipline Lead, Paramedicine)

Tom Sutherland Engagement Prize:

2022 Recipient:
Chris Clayson

Chris Clayson, Riki Sutherland (Tom Sutherland's brother), and Dylan Reed (inaugural recipient of the Tom Sutherland Engagement Prize)

CONGRATULATIONS TO OUR **STUDENT AWARD WINNERS!**

The College sponsors a number of awards for paramedicine students throughout Australia. We'd like the congratulate the following students who received awards in December:

At the **University of Southern Queensland, the ACP Prize in Applied Paramedicine** went to Ipswich paramedic student **Cassandra Whip**.

At the **Australian Catholic University**, **Sherlyn Hii** was awarded the **ACP Les Hotchin Award 2022** and **Breanna Liddicoat** received the **ACP Academic Achievement Award 2022**.

Congratulations to all recipients!

UNDERSTANDING THE BASICS OF PEER REVIEW IN SCIENTIFIC JOURNALS

By **By Robin Pap, Kelly-Ann Bowles, and Paul Simpson**

Dr Robin Pap is Lecturer and Academic Program Advisor for Paramedicine in the School of Health Sciences at Western Sydney University and an Associate Editor of Paramedicine

Dr Kelly-Ann Bowles is Associate Professor and Director of Research for Paramedicine in the School of Primary and Allied Health Care at Monash University and an Associate Editor of Paramedicine

Dr Paul Simpson is Associate Professor in Paramedicine at in the School of Health Sciences Western Sydney University and the Editor-in-Chief of Paramedicine

Introduction

Peer review may be defined as the process of experts in the same field reading and providing feedback on manuscripts submitted to scientific journals.[1] Scientific journals strive to publish high-quality articles by assessing the validity, significance, and originality of the studies they describe.

Thus, the principal purpose of peer review is to improve the quality of manuscripts which are deemed suitable for publication and ultimately ensure that published articles adhere to acceptable standards. Despite its prevalent use by journals, peer review is frequently criticised, mostly due to the lack of quality in the feedback that authors might receive and the time the process can consume to reach publication. This article aims to provide a brief overview of the peer-review process, describe the different types of peer review, and summarise the key responsibilities of reviewers. The list of further readings and resources at the end of the article will help interested readers to find out more.

Overview of the peer review process

The peer-review process begins with authors submitting a manuscript that describes and discusses the background, aim, methods, findings, and significance of their study to a suitable scientific journal that specialises in a corresponding area of research.

One of the journal's editors will initially assess the manuscript to ensure the topic is in line with the journal's scope and that the manuscript meets minimum standards to be considered at all. If this is the case, the handling editor will send the manuscript to appropriate and accomplished researchers to start the peer review. The manuscript is usually sent to at least two peer reviewers, but more may be involved.

After the reviewers agree to review the manuscript, they read it meticulously and scrutinise it to assess its quality. Reviewers pay particular attention to the methods that the researchers used, the results of their study, and how they have interpreted their findings. The manuscript should how the study is original and how it makes significant contributions to the field of research.

Once they have completed their appraisal, the reviewers give feedback to the handling editor and make a recommendation on whether the manuscript should be accepted, needs revisions, or should be rejected. The handling editor will make the final decision and, using the feedback from the peer reviewers, will respond to the authors. The most common decisions are explained in *Table 1*. If the manuscript was rejected, the process ends.

Some journals offer a transfer service, whereby the manuscript can be automatically submitted to another journal. If the recommendation was to make revisions, the authors are given an opportunity to improve their manuscript and submit a revised version. Once a manuscript is accepted, it goes into the production phase where final edits are made by a copy editor before it is finally published in the scientific journal. A flow chart of the process is presented in *Figure 1*.

Peer review can be a lengthy process. While the actual review of the manuscript takes only a few hours to a day, the entire process can take several weeks or often months.[2] Thus, unsurprisingly one of the most common criticisms of peer review is that it is too slow.[3]

Figure 1.

Table 1. Editors have several options when it comes to deciding on a manuscript. Here are the most common ones.

Accept	The manuscript will be published in its originally submitted form.
Accept with minor revisions	The manuscript will be published once the authors have made some small amendments/corrections.
Accept after major revisions	The manuscript will be published if the authors make significant amendments/corrections.
Revise and resubmit	A resubmission of the manuscript will be reconsidered if the authors make major changes.
Reject	The manuscript will not be considered for publication

Types of peer review

There are various types of peer review, each with its own advantages and disadvantages. The most common types are single-blind, double-blind, and open peer reviews.

In a single-blind (or single-anonymous) peer review, the reviewers know the identity of the authors, but the authors do not know the identity of the reviewers. The purpose of blinding the authors to the identity of the reviewers is to make reviewers more comfortable with giving complete and honest feedback on a manuscript. The anonymity and the fact that reviewers can be completely honest in their feedback, without fear that the authors might hold it against them, is the main advantage of a single-blind peer review. Some disadvantages are risk of bias (conscious or unconscious) by knowing who the authors are, or providing unhelpful, non-constructive, or even unprofessional comments.

In a double-blind (or double-anonymous) peer review, the reviewers don't know the identity of the authors, and the authors don't know the identity of the reviewers. Many researchers prefer double-blind peer review because it removes the risk of bias inherent to single-blind reviews. The risk of reviewers providing unhelpful, non-constructive, or even unprofessional comments remains.

In an open peer review, the identity of the authors and reviewers are known to both parties, although several variations of this type of review exist with the identities being disclosed at different points in the peer review process. In some open peer reviews, the names of the reviewers and possibly even their peer review comments are published with the final article. The idea is to provide readers of the journal with a high level of transparency of the process that led to publication. Some of the disadvantages of an open peer review are that peer reviewers provide approbative feedback or decline to review because they don't want their identity to be disclosed to authors and/or readers.

The science of peer review is constantly evolving, evidenced by several emerging models that challenge traditional peer-review paradigms. In transparent peer review, not only are the reviewers' reports published with the final paper, but also the authors' responses to the review and editors' decision letters. Collaborative peer review involves a team of reviewers working together to review a paper, working with the authors as the review progresses to produce the final paper. In a post-publication peer-review model, there is little or no peer review before a paper is published (there is some editorial review to ensure methodological rigour). Once published, a forum is established by the journal in which all readers can engage in analysis and critique.

While these many models exist, there remains contention about which model is optimal; objectively, there is no empirical evidence indicating one model to be superior to another. Prospective reviewers should ensure they understand the model of peer review operating at a journal from which an invitation to review has been received before agreeing to perform the review.

Photo by Bernd Klutsch on Unsplash

Key responsibilities of reviewers

Considering the purpose and process of peer review, it becomes clear that reviewers have several significant responsibilities. Assessing possible or perceived conflicts of interest is extremely important; the reviewer declares these to the journal editor and, if significant, may result in the reviewer declining or being removed from the process.

Maintaining confidentiality throughout the process, which may span several rounds of feedback, is critical. A reviewer is not permitted to discuss a paper they are reviewing with colleagues; the confidentiality continues after publication unless the review model permits identification.

Reviewers need to ensure they are current in the literature of the specific subject matter and should only agree to review a manuscript within their area of expertise. Furthermore, reviewers should have a thorough understanding of the methods deployed by the authors, although they can advise the handling editor that additional review by another reviewer, for example a biostatistician, should be sought. Feedback must be unbiased and remain obstructive. Since peer review is not only a quality assurance mechanism but also a means for quality improvement, reviewers should be constructive in the comments they provide to the handling editor and, ultimately, the authors.

How to get involved in peer review

A recommended pathway into peer review is to engage a mentor, someone experienced in peer review with whom you can collaborate to develop the skill set required to be seen as suitable by a journal.

Reviewers generally have research methodology expertise, but one does not have to be an expert in all research approaches. Reviewers should have content expertise where possible, too. Ideally, a journal editor seeks to allocate reviewers who have research or content expertise relevant to the article undergoing review.

Completing formal training by way of online courses in peer review is strongly recommended and viewed well by journal editors. Many of these involve engagement with a mentor, who supports the new reviewer through the review process, providing feedback to help shape a professional and congenial review. Finally, engage with a journal editor to express your interest. Most journal editors will be receptive and keen to engage with and develop aspiring reviewers with appropriate content and/or research expertise.

Paramedicine, the official journal of the Australasian College of Paramedicine, has a peer-review mentor and development scheme arising from its commitment to contribute to the enhancement of peer-review quality in paramedicine. Contact the Editor in Chief at editor.paramedicine@paramedics.org to learn more about the scheme.

Further readings and resources

This short article provides a brief overview of the peer review process. Readers who are interested in finding out more or would like to get involved in peer review can consult the following readings and resources:

- Web of Science Academy: https://webofscienceacademy.clarivate.com/learn/public/catalog/view/23 - A suite of free peer-review short online training courses for those wanting to start or those wishing to further develop their review capacity
- Committee on Publication Ethics: https://publicationethics.org - An extensive array of forums and resources aimed at promoting integrity, honesty and ethical conduct in peer review and broader journal publishing
- Sage Reviewer Gateway: https://us.sagepub.com/en-us/nam/journal-reviewer-gateway - A broad collection of resources, including guidelines and videos discussing peer review
- "How to conduct a peer review": https://youtu.be/qLONnz4AzsY - A Sage video providing a step-by-step description of the how to conduct a peer review
- Sage Peer Reviewer Guide: https://us.sagepub.com/sites/default/files/how_to_become_a_reviewer_new.pdf - A comprehensive guidebook to undertaking peer review

References

1. Samens, J. ed., 2017. The SAGE Encyclopedia of Communication Research Methods. Vol. 4. Thousand Oaks, CA: SAGE Publications, Inc, https://dx.doi.org/10.4135/9781483381411
2. Huisman J, Smits J. Duration and quality of the peer review process: the author's perspective. Scientometrics. 2017;113(1):633-650, https://doi.org/10.1007%2Fs11192-017-2310-5
3. Cornelius JL. Reviewing the review process: Identifying sources of delay. Australas Med J. 2012;5(1):26-29, https://doi.org/10.4066%2FAMJ.2012.1165

TRAFFIC LAW FOR PARAMEDICS

By **Michael Eburn**

A discussion of the law's impacts on paramedicine is, usually and rightly, focused on paramedics' role in the delivery of healthcare. However, there is more to paramedicine (as there is more to medicine and nursing) than clinical decision-making.

One aspect of paramedic work (particularly those in the jurisdictional ambulance services but also for some in the private sector) is driving - or "responding" - to the scene of an emergency. That part of their work probably carries a much greater personal legal risk than the work they do delivering patient care. In this article, I review the relevant law and provide some suggestions on the approach the reasonable paramedic may take when driving an emergency ambulance.

The risk

Driving an ambulance under emergency conditions - red/blue flashing lights and siren activated - and relying on the exemption proved by law and the goodwill of other motorists, carries significant risk. Travelling at a faster speed than normal means it may be harder to stop or react to events on the road, the vehicle may be less stable, other drivers may react badly to the approaching ambulance, the driver may be thinking about the job they are going to do rather than the job at hand (i.e. driving). Ambulances may be driven into intersections where other drivers would usually have "right of way" (for example, an emergency ambulance may proceed through a red traffic light). Paramedics who attend motor vehicle accidents do not need to be told that things can go very wrong very quickly, and the risk will be compounded by urgent duty driving.

The duty of care

It is axiomatic that every driver owes a duty of care to every other road user - that is, all other drivers, pedestrians and cyclists. It is a duty to take reasonable care to avoids acts or omissions that might cause an accident or injury.

When assessing what is "reasonable care", a person is judged against the standard of the "reasonable person". The legal "reasonable person" is not the same as an ordinary person.

> The reasonable person refers to a hypothetical person who demonstrates average judgment or skill. The reasonable person has various generalised attributes, including risk aversion, sound judgment, and a sense of self-preservation which prevents them from walking blindly into danger.
>
> The reasonable person is pure legal fiction. It was crafted by judges to represent the concept of the Common Law and used as a tool to standardise the application of the law.
>
> The reasonable person is not an average person or a typical person, and the average person is not necessarily guaranteed to always be reasonable.[1]

Ultimately the only judge of whether one's conduct meets the test of "the reasonable person" is a judge or jury.

The reasonable response to risk

When deciding what a reasonable person would do in response to a risk, Justice Mason said:

> The perception of the reasonable man's response calls for a consideration of the magnitude of the risk and the degree of the probability of its occurrence, along with the expense, difficulty and inconvenience of taking alleviating action and any other conflicting responsibilities which the defendant may have. It is only when these matters are balanced out that the tribunal of fact can confidently assert what is the standard of response to be ascribed to the reasonable man placed in the defendant's position.[2]

The issue is the risk of a vehicle collision. The magnitude of the risk could be quite high. An ambulance moving very fast that collides with another vehicle or a pedestrian is likely to cause significant injuries to others and the occupants of the ambulance.

There is always a chance that there will be motor vehicle accidents. Governments impose speed limits, down to 40km/h in urban areas, in the belief that slower traffic means a reduced risk of collision and a reduced risk of serious injury if there is a collision. An ambulance that is being driven in excess of the speed limit or contrary to the road rules being followed by other drivers means that there is an increased probability of a collision. The faster the vehicle is being driven, the higher the risk.

What can be done to reduce the risk? One way to reduce the risk is police motorcycle escorts riding ahead and closing off intersections. One can see immediately that the cost and inconvenience of that response is impracticable, so it is not "reasonable" to try and implement those responses.

Light/sirens will go some way to reduce the risk, as will the obligation on other drivers to make way for the emergency vehicle. But equally, they can increase risk as other drivers try to react and the driver of the emergency vehicle may become too focused on the task. The pressure of "goal seduction", that is focusing on the goal of getting to and responding to the emergency, can lead to bad decisions by the driver of the emergency vehicle.[3]

Another simple way to reduce the risk is to slow down. There is an inconvenience in that response as it delays response time, but then one has to ask by how much. How much time is it really saving?

Finally, there is the issue of "conflicting responsibilities". There is a duty to respond to the emergency call,[4] but that, too, is a duty to act reasonably in all the circumstances.[5] Driving without due care so that there is a collision will not meet the duty to the patient. And no matter how desperate the patient's condition is, a desire to treat them cannot justify killing someone else.

Traffic law

The driver of any emergency vehicle should be familiar with the exemption from the road rules. The exemption is part of the national road rules scheme, so there is an equivalent provision in every state and territory but, for ease of reference, I shall refer to the rules in New South Wales. Rule 306 of the Road Rules 2014 (NSW) says:

A provision of these Rules does not apply to the driver of an emergency vehicle if:

(a) In the circumstances

(i) The driver is taking reasonable care, and

(ii) It is reasonable that the rule should not apply, and

(b) If the vehicle is a motor vehicle

> that is moving - the vehicle is displaying a blue or red flashing light or sounding an alarm.

Rule 306 is not an exemption from all the rules that apply to drivers and driving. It is an exemption from the rules set out in the Road Rules 2014 (NSW). However, there are many rules of the road that are not in the Road Rules. The Crimes Act 1900 (NSW) deals with offences such as manslaughter, dangerous driving occasioning death or grievous bodily harm, and causing injury by "wanton or furious riding, or driving, or racing, or other misconduct, or by wilful neglect". The Road Transport Act 2013 (NSW) provides for the offence of driving "at a speed or in a manner dangerous to the public". There is no exemption from these offences, so if the driving, objectively judged, meets the standard of criminal negligence or an unreasonable danger to the public, then the use of lights and sirens provides no exception.

The Crimes Act 1900 (NSW) s 52A(1) says:

> A person is guilty of the offence of dangerous driving occasioning death if the vehicle driven by the person is involved in an impact occasioning the death of another person and the driver was, at the time of the impact, driving the vehicle ... (b) at a speed dangerous to another person or persons ...

There is a similar offence of dangerous driving causing grievous bodily harm.[6]

In both cases, the offences are made worse if there are "circumstances of aggravation".[7] The circumstances of aggravation include "driving the vehicle concerned on a road at a speed that exceeded, by more than 45 kilometres per hour, the speed limit (if any) applicable to that length of road".[8] The maximum penalty for causing death in circumstances of aggravation is 14 years' imprisonment; for causing GBH it is seven years' imprisonment. We can infer that the legislature thinks exceeding the speed limit by more than 45km/h is not only dangerous, it is extremely dangerous.

Paramedics as employees will be aware of the concept of vicarious liability. That doctrine says that an employer is liable for the negligence of their employee. It means that if a paramedic provides substandard care to a patient, that patient may sue the paramedic's employer. With respect to car accidents, every state has a comprehensive compensation system that includes compulsory third-party insurance. All cars, including government-operated ambulances, carry "CTP" insurance. Anyone injured in a motor vehicle accident will look to the insurer (which may be the government as self-insurer) to pay the compensation benefits to which they are entitled. That means that the driver of the ambulance will not be personally liable for the cost of compensating anyone injured in an accident. But here we are talking about criminal, not civil, law, and vicarious liability does not apply in the criminal law. The negligent driver of an ambulance will personally pay any fine and only the driver - not their employer - can go to jail.

In R v Jurisic, the NSW Supreme Court said: "A non-custodial sentence for an offence against s52A [dangerous driving occasioning death] should be exceptional and almost invariably confined to cases involving momentary inattention or misjudgement."[9] In sentencing, a court would no doubt take into account the fact that the driver was the driver of an emergency vehicle and they were not "racing" or abandoning their responsibility as a driver, but the prospect of a custodial sentence is real.

The driver's personal risk assessment

Let us take just the question of speed. The obligation to travel at the speed limit is contained in the Road Rules.[10] It is therefore one of the rules that Rule 306 applies to - that is, the driver of an emergency vehicle is exempt from the need to comply with the speed limit if those conditions set out in Rule 306, above, apply.

But deciding whether a driver has taken "reasonable care" and whether it is "reasonable" that the rule against speeding should not apply in the particular circumstances is not a matter for the driver to decide. Rather, that decision will be made in the first instance by a police officer and, ultimately, by a court if the matter goes that far. The driver of an ambulance may believe that he or she should get the benefit of Rule 306, but they may be wrong.

If they are wrong, then the law that applies to everyone else also applies to them. Travelling in excess of the speed limit is an offence. The maximum court penalties for exceeding the speed limit are:

- By less than 30km/h - 20 penalty units.
- By 30km/h or more - 20 penalty units and automatic disqualification from driving for three months.
- By 45km/h or more - 30 penalty units and automatic disqualification from driving for six months.

The periods of disqualification mentioned apply if the court makes no specific order. A court can increase or, in some circumstances, decrease that period of disqualification.[11] A penalty unit is $110,12 so the maximum fines range from $2200 to $3300.

If the matter is dealt with by way of a penalty notice, i.e. without going to court, the penalties are:[13]

- Exceed speed limit by less than 10km/h, $128 and 1 demerit point.
- Exceed speed limit by more than 10 but less than 20km/h, $295 and 3 demerit points.
- Exceed speed limit by more than 20 but less than 30km/h, $507 and 4 demerit points.
- Exceed speed limit by more than 30 but less than 45km/h, $970 and 5 demerit points.
- Exceed speed limit by more than 45km/h, $2616 and 6 demerit points.

Where the driver has exceeded the speed limit by more than 30km/h, Transport for NSW may elect to suspend or cancel their licence.[14] Further, if the driver is exceeding the speed limit by more than 45km/h and is stopped by police (rather than detected by a speed camera), the police officer can immediately suspend the driver's licence for a period of six months or, if a person is killed or injured, until the matter is finalised in a court.[15]

The driver can do a personal risk assessment.

> I'm exceeding the speed limit by less than 10km/h. At this speed, the risk of crashing is not materially increased so it will be easier to argue that, notwithstanding the fact that I'm speeding, I'm taking "reasonable care". I think I meet the conditions for Rule 306, but if I'm wrong, I face a fine of $128 and one demerit point.

Versus:

> I'm exceeding the speed limit by more than 45km/h. The risk of crashing is materially increased, so it will be hard to argue that I am taking reasonable care. I think I meet the conditions for Rule 306, but if I'm wrong, I face a fine of $2616 and six demerit points; if I'm stopped by police, I may lose my licence for six months, and if I'm fined after detection by a speed camera, Transport for NSW may cancel my licence. If I crash at this speed, and someone is killed or seriously injured, I can expect to go to prison or be subject to an intensive correction order.

Speed is not the only issue. Drivers must do a risk assessment before proceeding into an intersection. It may be lawful to proceed through a red light or past a stop sign, but it can only be reasonable to do so once the driver has taken reasonable steps to determine that other road users are aware of their presence and are giving way to allow the ambulance to proceed.[16]

Drivers also need to be aware of their vehicle's capacities. In Victoria, a firefighter was convicted of dangerous driving causing death. He was not exceeding the speed limit but was aware that when fully loaded, his tanker was top heavy so that his speed, although below the speed limit, was too fast in the circumstances.[17]

Conclusion

Paramedics rightly concern themselves with the law as it apply to their clinical practice - understanding what reasonable paramedic practice is, the need for consent, the rights of patients to refuse treatment, etc., are all important.

But if paramedics are concerned with legal risk - that is, the risk that there will be adverse legal consequences for them - then they should also stop and consider their duty when driving an emergency ambulance. The law does allow the driver of an emergency vehicle, including an emergency ambulance, some leeway to drive in a way that other drivers may not. They are not required to wait for a green light but may proceed against a red light if all other drivers will give way. They may travel in excess of the posted speed limit. They may turn against No Left and No Right turn signs, etc. With those liberties come the extra burden of responsibility. They may only do those things when they are taking reasonable care when judged against the standard of the hypothetical "reasonable person".

Failure to take reasonable care means the exemptions do not apply and the normal law applies. Further, the exemption does not apply to serious offences such as dangerous driving. The greater the departure from the "norm", the harder it will be to argue that the driver was taking reasonable care, and the more severe the penalty for any breach. Drivers should consider these factors and ask: "How much time will I really save?" when considering how they will respond to their next emergency call.

References:

1. Prosper Law, 'What is the Reasonable Person Test?' https://prosperlaw.com.au/post/what-is-the-reasonable-person-test/, June 5, 2022.
2. Wyong Shire v Shirt [1980] HCA 12, [14].
3. Christopher Bearman and Peter A Bremner, 'A day in the life of a volunteer incident commander: Errors, pressures and mitigating strategies' (2013) 44 Applied Ergonomics 488-495.
4. Kent v Griffiths [2001] QB 36; Queensland v Masson [2020] HCA 28.
5. Logar v Ambulance Service of New South Wales Sydney Region [2017] NSWCA 274.
6. Crimes Act 1900 (NSW) s 52A(3).
7. Ibid ss 52A(2) and (4).
8. Ibid s 52A(7).
9. [1988] NSWSC 597.
10. Road Rules 2014 (NSW) r 20.
11. Road Rules 2014 (NSW) r 10-2.
12. Crimes (Sentencing Procedure) Act 1999 (NSW) s 17.
13. Road Transport (General) Regulation 2021 (NSW) Sch 5 (fines) and Road Transport (Driver Licensing) Regulation 2017 (NSW) Sch 1 (demerit points).
14. Road Transport Act 2013 (NSW) s 59 and Road Transport (Driver Licensing) Regulation 2017 (NSW) cl 67.
15. Road Transport Act 2013 (NSW) s 224.
16. Logar v Ambulance Service of New South Wales Sydney Region [2017] NSWCA 274.
17. Steve Butcher, 'Suspended sentence for Black Saturday firefighter who killed teen in smash' The Age (Online) https://www.smh.com.au/national/suspended-sentence-for-black-saturday-firefighter-who-killed-teen-in-smash-20091023-hcdn.html, 23 October 2009

AMBULANCE TASMANIA PARAMEDIC RETIRES AFTER NEARLY 50 YEARS

In 1974, Simon Butterley's friend suggested that he volunteer for Ambulance Tasmania. At the age of 19, Simon joined up, and a year later trained as a fully qualified paramedic following a recruitment drive for paramedics after the Tasman Bridge collapse. Little did he know, he'd stay with Ambulance Tasmania for 48 years.

"It's almost like yesterday since I started, the time has disappeared."

Simon has seen it all attending countless incidents and trauma events, with the most memorable including the Port Arthur massacre and a seaplane crashing in the Franklin River in 2006.

"It's been my career; it's been very fulfilling and extremely rewarding."

In his near five decades, Simon has undertaken many roles, including Intensive Care Paramedic, Wilderness Paramedic and Flight Paramedic, as well as working in various stations across Tasmania - his last position as a Branch Station Officer on the state's East Coast.

Simon celebrated his retirement in November with family and colleagues who shared funny stories and kind words.

"I will certainly miss the comradery," he said.

He says he has enjoyed his time with Ambulance Tasmania and has loved working with volunteers.

"I couldn't have worked without them ... they have been invaluable."

Simon would like to spend his retirement with his family, and travel around Tasmania in his caravan with his wife.

MORE LEADING WOMEN IN AMBULANCE TASMANIA'S COMMUNICATION CENTRE

Ambulance Tasmania is proud of the outstanding leaders we have recruited to the Communications Centre, and in November we were excited to share that 75% of these leaders were women.

50% of staff who share the Operations Manager position are women and 100% of the Communications Centre support roles are performed by women.

Our service supports all of our people to achieve their leadership goals to strengthen and add value to our already brilliant team!

MOTHER GUIDED BY AMBULANCE TASMANIA CALL-TAKER TO HELP SAVE SON'S LIFE

Ten-year-old Nathaniel Choo was at home with a cold when he suddenly experienced a serious asthma attack. His mum Jolene Choo called triple-0 and as two ambulances and a helicopter rushed to the scene, Nathaniel lost consciousness and she had to perform CPR. A moment, she will never forget.

"So many thoughts were running through my head, and I don't think anyone is ready to let their child go, so I was not stopping," Jolene said.

She had guidance and reassurance from Kay Dove, who took the call and remained on the phone the whole time.

"She saved his life, she did everything that I asked her to do on the call," Kay said.

Ambulance Tasmania Paramedic Emma Hill was one of the crew members who arrived by ambulance to provide immediate assistance.

"You never want to get a 10-year-old male not breathing across your pager, but it's something that you train for and you have to be ready for," Emma said.

Dr Nick Scott arrived shortly after on the helicopter to the rural property to provide further care.

"We can do those time-critical interventions as quickly as possible and things that traditionally would have been done in a hospital," Dr Nick said.

In November, Nathaniel and his family were able to reunite with Kay, Emma and Dr Nick.

"Very, very thankful," Jolene said.

This incredible case is a great example of different Ambulance Tasmania units coordinating and working closely together to achieve a positive patient outcome.

Paramedicine Board – Ahpra

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

Public consultation on review of National Scheme accreditation arrangements

The National Boards and Ahpra are reviewing the current accreditation arrangements for the national health practitioner regulatory scheme to prepare for the next period to mid-2029.

The current accreditation arrangements end on 30 June 2024 for all professions except paramedicine, which end on 30 November 2023.

This consultation is a key stage of the review and aims to confirm performance and progress on current accreditation priorities and will inform the priorities for the next period, including how progress in priority areas could be measured. Consultation closes 14 February 2023.

Find out more: https://www.ahpra.gov.au/News/Consultations.aspx

Annual Report 2021/2022

The Ahpra 2021/2022 annual report observed continued growth in the registered health workforce.

Paramedics again comprised the largest growth in Ahpra registrants in 2021/2022, with a total of 23,053, an increase of 7.3% on 2020/2021.

The number of registered paramedics continues to grow, and now represent 2.7% of all registered health practitioners, of whom 47.6% identified as female and 52.3% as male.

Find out more: https://www.ahpra.gov.au/Publications/Annual-reports/Annual-Report-2022.aspx

National Scheme newsletter released

Ahpra recently released National Scheme News, an update that replaces their previous newsletter Ahpra Report. National Scheme News will provide the latest news from the National Scheme, covering topics to support safe and professional practice.

Find out more: https://www.ahpra.gov.au/Publications/National-Scheme-news/Summer-2022.aspx

Kaunihera Manapou Paramedic Council

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

Newsletter updates include:

- How do I prove to my employer, or anyone else, that I am registered as a paramedic?
- Te Kaunihera Annual Report
- Financial update
- Accreditation of Aotearoa New Zealand qualifications
- Extension of approval of current Aotearoa New Zealand qualifications
- Continuing professional development (CPD) opportunities
- Children and Young People's Commission - Board Positions
- 2023 Hui dates

The National Clinical Evidence Taskforce

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

Funding Update December 2022

In December 2022, the National Clinical Evidence Taskforce was informed that the Commonwealth Department of Health and Aged Care will not be continuing their contract to develop clinical guidelines for COVID-19 beyond 31 December 2022.

As a collaboration of 35 member organisations, among them the Australasian College of Paramedicine, the National Clinical Evidence Taskforce has provided up-to-date, independent, evidence-based guidance for clinicians on how to best care for people with and after COVID-19, and are currently seeking alternative sources of funding to continue their work in 2023.

Find out more: https://clinicalevidence.net.au/news/national-clinical-evidence-taskforce-funding-update/

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