A NEW REGULATORY FRAMEWORK FOR PARAMEDIC PRACTICE IN AUSTRALIA

Submitted by

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ABSTRACT

Paramedics provide a fundamental service to the community. While historically paramedics were ‘stretcher-bearers’ and ‘ambulance drivers’ (with very little medical training), they are now highly trained and skilled health practitioners who diagnose, treat and advise on a range of medical conditions and emergency matters. Recently, the roles and responsibilities of paramedics have changed markedly and it is reasonable to assume paramedics will be given more responsibilities in the future. The expanding role of paramedics, and the community’s expectations of paramedics providing skilled service to the community, has increased the risk of harm paramedics pose to the community.

This research considers the regulation of Australian paramedics. In particular, it addresses how paramedics are currently regulated, the effectiveness of those regulatory structures and whether the National Registration and Accreditation Scheme (National Scheme) would be a more suitable regulatory framework to better address the issues facing modern Australian paramedics. In so doing, this research makes three key arguments:

1. The current paramedic regulatory framework is inadequate to protect the public;
2. Paramedicine should be a registered health profession under the Health Practitioner Regulation National Law Act; and
3. The regulatory requirements for paramedic inclusion in the National Scheme are not onerous and can be met.

While there will be challenges to incorporating paramedicine into the National Scheme, the increased risk of harm paramedics pose to patients suggests it is time paramedics are included as a profession within national health practitioner registration. This is a necessary first step to ensure the regulation of paramedics evolves to address the risks posed and increase the standing of paramedics in the community.
DECLARATION OF ORIGINALITY

This is to certify that:

a. the thesis is my own account of research undertaken by me;
b. the thesis has been wholly completed during candidature;
c. the thesis does not contain as its main content any work or material which is embodied in a thesis or dissertation previously submitted by me or any other person for a University degree or other similar qualification at this or other higher education institution; and
d. to the best of my knowledge, the thesis contains no material previously published or written by another person except where due reference is made.

The Australian Guide to Legal Citation (3rd ed) is the referencing style used in this thesis.

Dominique Lee Moritz
13 November 2017

PUBLICATIONS ARISING FROM THIS THESIS


Dominique Moritz, 'Protection of Title - Associated Issues for Paramedics and the Community’ (2014) 41(4) Response 22
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This thesis spanned a very significant period of my life. During the time of research and writing, I got married, adopted a puppy and had a baby. This thesis was a team effort, with many people supporting me to completion! While I can’t thank everyone individually, a few people deserve special attention.

To my husband Ben: thank you for your unwavering support. Despite my bouts of stress, tears and the occasional epiphany, your love and encouragement never ceased to amaze me. For my little girl Adderley: I hope you see this thesis as a way for women to break glass ceilings and know you can do anything.

I had such a supportive team of supervisors who kept me sane and went beyond what was required to assist me. Emeritus Professor Neil Rees: you believed in me even when I doubted myself. Thank you for your encouragement and I forgive you for retiring before I finished this thesis! A big thank you also goes to Associate Professor Bill Lord who has been a supervisor since the beginning. I have enjoyed your practical stories and really appreciated your significant expertise in all things paramedic-related. My current primary supervisor, Associate Professor Jay Sanderson: you only started supervising my project in 2016 but your relaxed approach and guidance taught me so much. I will continue to ask myself “What Would Jay Do” for the rest of my academic career.

I would also like to thank my friends and family. My parents, Tanya and Gunther Moritz taught me to challenge the norm and stand up for what I believe in. Virtues I believe are reflected in my writing. I would also like to thank:

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This thesis is dedicated to those who work in the emergency services – a calling which is often thankless, dangerous and underpaid. Please know your service is appreciated.
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CHAPTER 1 – INTRODUCTION

From the day of its invention the ambulance has attracted a magnetic curiosity from humans … you turn… you wonder… where it might be going, who is inside and what horrific mishap the patient has suffered.1

1.1 Introduction: paramedics and regulation

This thesis is about paramedic regulation. More specifically, this thesis examines the way in which paramedics, and paramedicine more generally, are regulated in Australia. In so doing it evaluates the current regulatory framework governing Australia’s paramedics and argues that paramedics need to be included in the *Health Practitioner Regulation National Law Act 2009* (“the National Law”),2 along with medical practitioners, nurses and physiotherapists, among others. In order to begin this examination of paramedic regulation, this chapter introduces the topic of paramedic regulation by examining the current regulatory framework and proposing options for reform.

This introductory chapter has a number of parts. Part 1.2 introduces the reader to the ‘paramedic’ and their role in the community. This provides context for the thesis and identifies the crucial role paramedics play in the community. Part 1.3 provides an overview of regulatory theory as applied in Australia. The Australian system of health professional regulation, and the current model for regulation of the paramedic profession in Australia, is also considered. In part 1.4, I set out and discuss the research problem and research questions and in so doing justify the purpose and scope of the thesis. Part 1.5 considers the research methods and ethical considerations relevant to the thesis including doctrinal and law reform-oriented material. Part 1.6 provides some additional definitions and terms which will be useful for the reader to consult during their consideration of this thesis. Part 1.7 outlines the scope of the research by identifying which health carer roles are encompassed within the ‘paramedic’ definition. It also justifies the selection of regulatory models which are most relevant to my consideration of Australian paramedic regulation. Finally, part 1.8 is a chapter outline detailing the purpose and content of each chapter of the thesis.

1.2 Who is a paramedic?

Perhaps the best place to begin a study of paramedicine is with a definition or, more accurately, the various definitions of a paramedic. In this way, we are able to see that there is no widely accepted definition of a paramedic. Paramedicine, paramedical science and paramedic practice are broad terms used to define the health care paramedics provide to the community. Paramedics practise paramedicine, much like medical practitioners practise medicine. It is generally accepted that a paramedic provides ‘rapid response, emergency medical assessment, treatment and care in the out-of-hospital

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2 As discussed in 1.3, the *Health Practitioner Regulation National Law Act 2009* was first legislated in Queensland and adopted in the other Australian States and Territories. As such, a jurisdiction is not included in the referencing of this legislation because it is not Commonwealth legislation. Please see 1.3 for further details.
environment’.3 ‘Paramedical’ means ‘relating to healthcare workers other than doctors, dentists, nurses, etc., who have specialist training in the performance of supportive health treatments’. 4 Beebe and Myers further define paramedicine as a ‘special subset of medicine that paramedics provide in the out-of-hospital setting’. 5

Despite various definitions of paramedics and paramedic practice, one of the difficulties of the explanatory term ‘paramedicine’ is the challenge of describing the content of a rapidly changing profession. 6 For this reason, there is no widely accepted definition of paramedic practice. Some state and territory jurisdictions have provided legislative definitions of ‘paramedic’ which will be addressed in Chapter 4 of this research.

While it is a challenge to define paramedics, it is necessary to have a workable definition for this thesis. The United Kingdom has provided a useful explanation of paramedic practice and its role in society which I adopt for the purposes of this thesis. An explanation of the work of British paramedics comes from a 1999 debate in the United Kingdom’s House of Lords with paramedics described as providing:

immediate care to the public and patients with acute clinical emergencies. They assess, treat and monitor patients in a systematic way according to… clinical protocols adapted to the requirements of local communities. The treatments provided include invasive procedures such as intravenous cannulation, intubation and the insertion of chest drains and the administration of a specified range of emergency medications, including analgesics. Paramedics typically will be the first health professionals on hand in an emergency. 7

The House of Lords’ explanation of paramedics identifies the full extent of paramedic expertise and highlights their important role in society. British paramedics are directly comparable to Australian paramedics and the United Kingdom’s paramedic model, which is considered in Chapter 5 of this thesis, provides a useful comparison for Australia.

There is often confusion between paramedics and ambulance officers. Indeed, paramedic practice is evolving which can lead to conflation of paramedics with ambulance officers. The term ‘paramedic’ was, arguably, introduced to Australia from an American television program titled ‘Emergency’ depicting the role of paramedics in the mid-1970s; since that time, the Australian community has tended to use ambulance officer and paramedic interchangeably. 8 However, ambulance officers are historically less skilled and less qualified than today’s paramedics, an argument made in chapter 3. The occupation

6 I use the term ‘profession’ as an occupational category here – and throughout the thesis – but please note, in chapter 3 I discuss how the literature does not definitively conclude whether paramedicine is indeed a ‘profession’. I argue that paramedicine should be a profession.
of paramedicine is rapidly evolving and it may be difficult to define given the continuing change in role and scope between jurisdictions. While ambulance services have origins in first aid, the emergency function paramedics provide to the community is increasing because there are paramedics employed solely for that purpose. Not only are paramedics’ levels of skill and knowledge increasing, but their scope of practice is becoming more autonomous and specialised. Paramedics are trained for emergency environments, and pre-hospital care reduces the economic burden placed on hospital emergency departments highlighting the valuable contribution of paramedics to the wider community.

Paramedicine is also a profession entrusted with significant responsibilities and which enjoys the trust of the community. One of the rationales for this research comes from the community’s ownership of, and trust in, the paramedic profession. The evolution of paramedicine is causing the community’s understanding of, and trust for, paramedics to change. While paramedics were, at one time, considered ‘blue collar’ workers, they have arguably transitioned to the status of a profession. A yearly Reader’s Digest poll highlights the most trusted Australian professions. Paramedics were awarded the most trusted profession in 2014 and for nine consecutive years between 2004 and 2012. In 2013, paramedics and firefighters were equal first in the most trusted profession category. Establishing and maintaining community trust in paramedics is an important factor in their regulation because, as we will see throughout this thesis, trust is one of the purposes of health practitioner regulation.

The community’s trust in the work of paramedics highlights the community’s interest and ownership of the paramedic industry. It also recognises the community’s need to let paramedics do their job safely in order for paramedics to continue serving the community. There has been a recent push for harsher punishments for assaults on paramedics. Many jurisdictions have introduced larger criminal sentences

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10 United Kingdom, Parliamentary Debates, House of Lords, 10 June 1999, vol 601, col 1652 (Baroness Hayman).
11 The concept of a blue collar occupation transitioning to a profession is considered in Leo McCann et al, 'Still Blue-Collar after all these Years? An Ethnography of the Professionalization of Emergency Ambulance Work' (2013) 50 Journal of Management Studies 750, 757 and chapter 3 of this thesis.
12 A poll of 750 to 1500 readers are consulted each year to provide the data to determine the most trusted profession.
14 'Our Most Trusted', Reader's Digest July 2013, 46.
15 Ian Freckelton, 'Regulating Health Practitioner Professionalism' in Law in Context (The Federation Press, 2006) vol 23, 1, 2. Trust is further discussed in chapter 2 of this thesis.
for serious assaults against paramedics\textsuperscript{16} and there has been community outrage when offenders have been released with, what they deem to be, inadequate punishment.\textsuperscript{17} The community, therefore, has an interest in the outcome of regulatory discussions concerning paramedic regulation as the community somewhat takes ownership of the profession already. The community’s desire to protect paramedics from harm and workplace violence suggests an acknowledgment of the altruistic nature of paramedicine.

Paramedics have always had an important role in the community. In the \textit{Parliamentary Select Committee of Inquiry Report into Ambulance Services} in 1991, Jim Elder stated ‘the ambulance service exists to serve the needs of all the people of Queensland. In life and death situations, one has the right to expect the benefit of an efficient service with up-to-date, high tech equipment and the assistance of uniformly skilled officers…’\textsuperscript{18} Elder’s position from 1991 is no less relevant now in 2017.

\textbf{1.3 Regulating Paramedics: An Overview}

To examine the regulation of paramedics, it is necessary to undertake a brief synthesis of regulatory theory. The consideration of regulatory theory provides context and justification for proposing a new regulatory framework for the paramedic industry. It is worth noting here, this thesis evaluating current and alternative frameworks does not provide a complete and thorough overview of regulatory theory.\textsuperscript{19} Instead, this research will draw on relevant regulatory concepts, from various leading authors in the field, evaluate regulatory frameworks applicable to Australian paramedics.

The regulatory themes addressed throughout this thesis will focus on concepts relating to self-regulation, co-regulation, responsive regulation and regulation of risk, all from a health practitioner governance perspective, given that health practitioner regulation has specific and unique regulatory requirements, such as public protection. Chapter 2 discusses the development of objectives for paramedic regulation and forms the basis for criteria to evaluate the current and proposed model for paramedic regulation in Australia.

\textsuperscript{16} See, eg, \textit{Criminal Code} 1899 (Qld) s 340; \textit{Crimes (Sentencing Procedure) Act} 1999 (NSW) s 21A (2)(a); \textit{Crimes Act} 1958 (Vic) s 31(1)(b); \textit{Criminal Code} (NT) s 155A; \textit{Criminal Code Act} 1913 (WA) s 318(1)(h)(i).


\textsuperscript{19} More detailed discussion of regulatory theory can be found in, eg, Arie Freiberg, \textit{The Tools of Regulation} (The Federation Press, 2010); Robert Baldwin, Martin Cave and Martin Lodge, \textit{Understanding Regulation: Theory, Strategy and Practice} (Oxford University Press, 2nd ed, 2012); Christine Parker and John Braithwaite, ‘Regulation’ in Peter Cane and Mark Tushnet (eds), \textit{The Oxford Handbook of Legal Studies} (Oxford University Press, 2005) 119; Julia Black, ‘Critical Reflections on Regulation’ (2002) 27 \textit{Australian Journal of Legal Philosophy} 1; Robert Baldwin, Martin Cave and Martin Lodge (eds), \textit{The Oxford Handbook of Regulation} (Oxford University Press, 2010).
Broadly speaking, according to Freiberg, regulation seeks to influence the behaviour of individuals and groups.\textsuperscript{20} Influencing behaviour through the implementation and use of specific standards can produce ‘mechanisms of standard setting, information gathering and behaviour modification’.\textsuperscript{21} Importantly, different models of regulation exist which Freiberg likens to ‘tools’ in a ‘tool-kit’: a ‘toolkit’ that includes economic, transactional, authorisational, structural, informational and legal regulation.\textsuperscript{22} The regulation of paramedics, like other health professionals, can involve a mixture of self-regulation and government imposed regulation. Self-regulation, a form of private regulation, involves the profession or industry itself governing the conduct and procedures of members.\textsuperscript{23} Government regulation—considered to be public regulation—imposes legislative requirements upon professional bodies and members of the profession. By way of comparison, and highlighting the importance of ‘mixed’ regulation, Black suggests self-regulation is often too limiting, while state-imposed regulation can be inadequate.\textsuperscript{24}

While there can be a (theoretical) distinction between self-regulation and government regulation, most professions are regulated by a hybrid or mixed approach. An approach that combines government regulation and non-government regulation, such as self-regulation, is known as ‘co-regulation’.\textsuperscript{25} In fact, Baldwin, Cave and Lodge suggest ‘the best regulatory outcomes will usually involve mixtures of institutions and instruments’.\textsuperscript{26} John Braithwaite has termed the hybrid mixture of governmental and industry regulation as the ‘new regulatory state’.\textsuperscript{27} Elkin has suggested co-regulation is extremely relevant to the examination of regulatory literature from a health professional perspective due to health professional regulation being necessary for public protection.\textsuperscript{28} These theoretical contributions lead to the conclusion that a co-regulatory model is most suitable for health professions generally. It would appear to follow from this view that paramedicine requires a regulatory framework which incorporates elements of both government and non-government regulation in the form of co-regulation.

\textsuperscript{20} Freiberg, \textit{The Tools of Regulation}, above n 19, 21.
\textsuperscript{22} Freiberg, \textit{The Tools of Regulation}, above n 19; Arie Freiberg, 'Re-stocking the Regulatory Tool-kit' in David Levi-Faur and Avishai Benish (eds), \textit{Jerusalem Papers in Regulation and Governance} (The Hebrew University, 2010).
\textsuperscript{24} Black, \textit{Critical Reflections on Regulation}, above n 19, 34.
\textsuperscript{25} Baldwin, Cave and Lodge, \textit{Understanding Regulation}, above n 19.
\textsuperscript{26} Ibid 157.
\textsuperscript{27} Parker and Braithwaite, Regulation, above n 19, 119; John Braithwaite, 'The New Regulatory State and the Transformation of Criminology' (2000) 40 \textit{British Journal of Criminology} 222.
One of the main ways in which health professionals are regulated in Australia is under a single national system of regulation requiring National Boards to monitor registration of applicants seeking entry to the professions. There are 14 health professions included under the National Health Practitioner Registration and Accreditation Scheme (the “National Scheme”). The *Health Practitioner Regulation National Law Act 2009* (the “National Law”) established the National Scheme and was first legislated in Queensland. The statutory instrument is not Commonwealth law but requires federal co-operation by agreement between states and territories to enact model legislation. All states and territories have since enacted the *National Law*. All future reference to this legislative model land and the state and territory statutes which adopt it, throughout this thesis, will be as the “*National Law*”.

This thesis does not empirically evaluate the effectiveness of the *National Law* and its ability to reduce patient risk, manage health practitioner conduct or fulfil any other objective. There are a number of concerns with the *National Law’s* effectiveness as a health practitioner regulatory framework, with scholarship identifying various problems with the *National Law* including:

- that health practitioners are obligated, under mandatory reporting requirements, to report on the health of other healthcare practitioners whom they are treating, a requirement which provides a barrier for health practitioners accessing health care;
- that mandatory reporting does not deter unprofessional behaviour and is an unnecessary political and social response to inadequate self-regulation; and
- that health practitioners are not complying with mandatory reporting requirements.

Paramedics were not included as a profession governed through the national health registration framework. Instead, ambulance services are regulated through state and territory legislation, with the

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29 Health professions included in the National Scheme are: medical practitioners, chiropractors, dental practitioners (dentists, dental hygienists, dental prosthetists and dental therapists), nurses and midwives, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists, psychologists, Aboriginal and Torres Strait Islander health workers, Chinese medical practitioners, medical radiation practitioners and occupational therapists.

30 *Health Practitioner Regulation National Law Act 2009* (Qld).


32 In this thesis, I use references to the National Scheme and *National Law* somewhat interchangeably.

33 Malcolm Parker, 'Embracing the new professionalism: Self-regulation, mandatory reporting and their discontents' (2011) 18 *Journal of Law and Medicine* 456, 459. An exception exists in Western Australia under the *Health Practitioner Regulation National Law (WA) Act 2010* (WA) s 4 (7) whereby health practitioners do not need to report notifiable conduct of another health practitioner if they are providing healthcare to that health practitioner. See also Nick Goiran et al, ‘Mandatory reporting of health professionals: The case for a Western Australian style exemption for all Australian practitioners’ (2014) 22 *Journal of Law and Medicine* 209, 214, 216.


exception of the Northern Territory and Western Australia. Paramedics themselves are regulated through their employment relationship, although the limited state and territory legislation governing the paramedic industry does contain some provisions relating to paramedics. As there is no national system of paramedic regulation in Australia, there are differing and sometimes inconsistent roles and responsibilities for paramedics among the states and territories. There are also differences between employers who are comprised of public ambulance services and private organisations. The difficulty of prescribing roles and responsibilities of Australian paramedics is further exacerbated by the increasing prevalence of 'private' paramedics. While a majority of paramedics are employed through the public ambulance services, there is an increasing number of paramedics entering private practice than ever before. For example, paramedics are employed for private events and mine sites. Privately employed paramedics are generally not subject to any public regulation. There is also significant disparity in regulation between jurisdictions, which is addressed in Chapter 4, particularly in relation to the minimum training and education for paramedics.

The need for regulatory change within paramedicine has been an issue gaining significant public attention. When I started my research in 2014, possibilities for improving Australian paramedicine regulation had already been proposed. In fact, the Australian Health Ministers’ Advisory Council, established under the National Law, considered the current paramedicine regulatory framework and the possibility of paramedic inclusion under the National Scheme in 2012. It proposed four alternative options for paramedicine regulatory reform:

1. That there be no change to current paramedic regulation;
2. That the existing statutory health complaint mechanisms in each of Australia’s state and territory jurisdictions be strengthened;
3. That the jurisdictional regulation existing in Australia’s states and territories be improved; or
4. That paramedics be registered under the National Scheme in the same way as the other registered health professions.

Since the above options for paramedic regulatory reform were suggested, there have been a number of new developments. A Senate Inquiry into the national registration of Australian paramedics which drew community consultation was conducted in 2015 and concluded that national registration would be the

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36 Chapter 2 explores the function and regulation of Australia’s ambulance services in more detail.
37 Australian Health Ministers’ Advisory Council, ‘Consultation paper: Options for regulation of paramedics’ (Health Workforce Principal Committee, July 2012).
38 See, eg, Commonwealth of Australia, ‘Establishment of a national registration system for Australian paramedics to improve and ensure patient and community safety’ (Senate Legal and Constitutional Affairs Committee, 5 May 2016) <http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Paramedics/Report> and further discussions in chapter 7 of this thesis.
39 Australian Health Ministers’ Advisory Council, ‘Consultation paper: Options for regulation of paramedics’ (Health Workforce Principal Committee, July 2012) 58.
40 Ibid.
best outcome for improving Australian paramedic regulation.\textsuperscript{41} Towards the finalisation of this thesis, on 7 October 2016, the Council of Australian Governments also proposed a draft amendment bill be brought to the Queensland Parliament in 2017 for paramedics to be registered in all jurisdictions under the National Scheme.\textsuperscript{42} Chapter 7 discusses the new developments for regulatory reform of paramedicine.

This thesis argues for paramedic inclusion under the National Scheme as a preferable option than the current regulatory framework governing Australian paramedic practice. There are a number of justifications for regulating paramedics as a health professional group within the ambit of the \textit{National Law}. The objectives of paramedic regulation should be consistent with the governance of Australian health practitioners. Regulation of health professionals promotes integrity and values which ensure behaviour promoting ‘trust and confidence in the standing of the profession’.\textsuperscript{43} It also reduces risk leading to public protection.\textsuperscript{44} Because of the significant degree of trust required between a health professional and patient, inappropriate behaviour contravening the patient’s best interests can cause significant adverse consequences impacting vulnerable patients.\textsuperscript{45} As such, a paramedic regulatory framework must be one which promotes the best interests of the patient. However, a shortfall of the current Australian paramedic regulatory framework is that it promotes organisational self-interest rather than patient interests. Chapters 5 and 6 outline the significant risk to the public which paramedics pose, and show how National Scheme regulation would address these regulatory gaps for the paramedic discipline. In particular, Chapter 6 provides examples of patients who have suffered adverse consequences because of paramedic conduct. For example, a four-year-old patient died following paramedic treatment during helicopter transport; the Coroner concluded the death was wholly attributed to the paramedics’ actions.\textsuperscript{46}

\section*{1.4 Research problem and research questions}

As noted in the preceding paragraphs, the nature and function of paramedicine has evolved. There are at least two important developments within paramedicine’s evolution which call into question the traditional model of Australian paramedic regulation. Firstly, Australian paramedics have evolved from ‘stretcher-bearers’ to ‘ambulance drivers’ and then to ‘ambulance officers’ and ‘paramedics’ who are highly skilled and tertiary trained emergency providers of pre-hospital healthcare. Historically, it was

\textsuperscript{41} Commonwealth of Australia, above n 38. See chapter 7 for a detailed discussion of the community submissions.


\textsuperscript{43} Freckelton, \textit{Regulating Health Practitioner Professionalism}, above n 15, 2.

\textsuperscript{44} Ibid. See also John Braithwaite, ‘Institutionalising Distrust, Enculturating Trust’ in Valerie Braithwaite and Margaret Levi (eds), \textit{Trust and Governance} (Russell Sage Foundation, 1998) 343, 352.

\textsuperscript{45} Freckelton does not specify potential adverse consequences here: Ian Freckelton, ‘Regulating the unregistered’ (2008) 16 \textit{Journal of Law and Medicine} 413, 414.

\textsuperscript{46} Inquest into the death of Ruby Yan Chen (Coroner’s Court of Rockhampton, Coroner O’Connell, 12 December 2014) 16 [82].
common for ambulance officers to be called ‘ambulance drivers’ or ‘stretcher-bearers’ due to their primary function enabling transport for the sick and injured, with only a very minor first aid role being practised; often, there was no first aid component at all.\(^{47}\) Paramedics, and the role of the ambulance services which employ them, have evolved into the civic community considerably since that time, with modern paramedics performing an expanded healthcare role when compared to their historical counterparts. The extent of paramedics’ healthcare role will be explored further in this thesis, particularly in Chapters 2 to 4. Secondly, the emergence of privately employed paramedics working for organisations external to the public service also challenges the traditional model of state-based regulation through the employment relationship.

Despite the significant evolution of paramedics’ discipline, regulatory measures governing paramedic practice have not evolved at the same rate as the discipline itself. For example, the disciplinary system for paramedics remains largely governed by employers which means disciplinary standards, procedures and outcomes are not transparent to the public nor are they consistent between employers. Specifically, Chapters 4 and 6 consider complaints and discipline against paramedics; some specific disciplinary examples which caused patient risk include a paramedic dragging a patient along the floor,\(^{48}\) delaying departure to avoid overtime,\(^{49}\) and treating a patient with saline instead of fentanyl in order for the paramedic to use the drug himself.\(^{50}\) As such, consideration of the current regulatory structures of paramedicine is timely and warranted to determine whether current regulation is adequate to protect the public and whether there is a more suitable model for Australian paramedic regulation. More specifically, the thesis addresses three core questions:

1. **Is the current paramedic regulatory framework adequate to ensure the protection of the public?**

An evaluation of whether the current regulatory framework adequately protects the public from harm will be undertaken in a number of ways. In Chapters 2 to 4 of this thesis, I provide a detailed evaluation of the regulatory framework currently governing paramedic practice in Australia including employer regulation supported by minimal statutory regulation. Regulatory theory pertaining to public protection, as an objective of health professional regulation, is also considered in Chapters 2 and 5. In Chapters 5 and 6, I also look at the meaning of risk and harm in order to evaluate whether paramedics pose a risk of harm, or actually cause harm, to the Australian public. I conclude that the current Australian paramedicine regulatory model does not adequately protect the public.

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\(^{47}\) Evan Willis and Liam McCarthy, 'From First Aid to Paramedical: Ambulance Officers in the Health Division of Labour' (1986) X *Community Health Studies* 57, 61.

\(^{48}\) Ciranoush Aird AND Department of Community Safety, Queensland Ambulance Service (TD/2012/11).


2. Should paramedicine be a registered health profession under the National Law?

This thesis includes a brief discussion of the National Scheme and how it promotes advancing the public interest of Australian patients. I consider how patient risk by paramedics can be avoided, minimised or addressed more effectively if paramedics are included as a health profession registered under the National Scheme in Chapters 5 and 6. I further suggest a precautionary approach to risk would most suitably advance the public interest. That is, paramedics should be regulated under the National Scheme to reduce the potential for risk, even in the absence of evidence to the contrary.

3. Can the regulatory requirements for paramedics’ inclusion in the National Scheme be met?

In Chapter 7, I set out some of the considerations and changes needed to incorporate paramedics in the National Law. In order to do so, I address the specific regulatory requirements which needed to be met for paramedic inclusion under the National Scheme. I specifically make recommendations for the inclusion of paramedics into the National Scheme in the most efficient way. This thesis will provide a limited outline of the relevant provisions of the National Law. A detailed description of all provisions of National Law regulation will not be undertaken in this thesis.

By providing answers to these three questions, this thesis adds to existing scholarship on paramedic regulation and makes an original and significant contribution to legal knowledge in the area. There is little existing research into paramedic regulation. Some sources consider prominent cases or coronial inquests which support the need for a new regulatory structure for paramedics although these publications do not contain the depth of research used in this thesis. 51 Michael Eburn’s and Ruth Townsend’s online blogs address community emergency services queries, utilising primary sources, in their responses. 52 However, the detailed common law and legislative analysis undertaken in this thesis adds to this scholarship.

In 2007, FitzGerald and Bange suggested various options for more appropriate regulation of paramedics. 53 They proposed three models and provided an evaluation of the likely effectiveness of each model. These models included: an independent regulator, outside the profession or employer; an employer regulator; or, a self-regulator where a professional paramedic body represents and regulates Australian paramedics. 54 While instructive, FitzGerald and Bange’s proposal was made before the

54 Ibid.
National Law’s implementation in 2010 and thus did not consider the current regulatory landscape of Australian health practitioners. Further, despite previous publications suggesting a new regulatory framework for Australian paramedics is needed, this thesis will draw on regulatory theory to make recommendations about the content of that regulatory framework for paramedicine.

Before setting out specific the chapter information, it is necessary to say something about the research methods (1.5); relevant definitions (1.6); and scope of the research (1.7).

1.5 Research methods and ethical considerations

This thesis uses a mix of research methods and approaches including doctrinal, reform-oriented analysis, interview and observation. A mix of research methods is necessary for this research in order to answer the research questions as I needed to undertake an analysis of the current law, evaluate its suitability and propose options for reform. Freckelton considered health law to be ‘cross-disciplinary’ and to ‘cross over traditional areas of legal and health practitioner scholarship’. This is certainly true for this thesis which uses a socio-legal discourse to investigate the complexities of paramedic regulation and make recommendations for reform. More specifically, there were a number of stages to the research in this thesis. Hutchinson and Duncan have identified a two-part research process under the doctrinal method of legal research: locating sources of law and analysing the data. In following a doctrinal approach, part of the research in this thesis involved locating primary sources of law. Primary sources of law are the sources which contain the law itself. Legislation and case law were primary sources of law used throughout this thesis to support the regulatory arguments made in the thesis.

The gathering and evaluation of primary research sources reflected the aspects of doctrinal methodology within my thesis. Primary source research comprised of statutory instruments, both Acts and delegated legislation; case law; coronial findings; Royal Commission Reports; and workplace industrial instruments, including awards and agreements. The purposes for collecting the primary data was numerous. Primary sources established the current regulatory structure for Australian paramedics. They

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60 Michelle Sanson and Thalia Anthony, Connecting with law (Oxford University Press, 3rd ed, 2014) 56.
also provided examples of issues which can arise, and challenges posed, in the current paramedic regulatory framework. Primary sources allowed the doctrinal research methodology to function and promoted the reform-oriented approach for evaluating the existing regulatory structure and making recommendations for reform.

After locating primary sources, the second part of the doctrinal research process involved interpreting and analysing the sources.\(^{61}\) This included using ‘reasoning and problem solving skills… to make sense of complex problems’.\(^{62}\) By analysing the primary sources, I was able to evaluate the suitability of the current legal regulation in order to assess its efficiency to regulate paramedicine.

In order to undertake doctrinal legal research incorporating reform-oriented research and policy analysis, I needed to collect a range of ‘data’. The term ‘data’ can be loosely defined as the wide range of primary and secondary sources I have used from cases and legislation to journal articles, textbooks and websites. However, in terms of my classification of law as data, I note McCrudden’s caution that ‘[l]aw is not a datum; it is in constant evolution, developing in ways that are sometimes startling and endlessly inventive’.\(^ {63}\) All references I make to law as ‘data’ reflects my acknowledgement of the fluidity of the law and difficulty with using ‘data’ as an explanatory term for the sources of law and information.

Secondary source research was also used as a data source. Secondary sources are the legal commentary and include textbooks, encyclopaedias, dictionaries, journal articles and websites.\(^ {64}\) While journal articles, textbooks, government reports and websites provided the foundation of existing literature on the thesis topic, media reports provided additional research data. Media reports were used to provide examples of patient harm, and the potential for risk paramedics pose to the community following paramedic treatment. The media sources have been primarily used in Chapter 6 of this thesis.

It is prudent, here, to acknowledge the limitations which arise from the use of media reports as a data source. Using information from media reports can be problematic due to the difficulty in verifying the information. Details from these reports are often not published elsewhere or the author is unavailable to clarify details reported. Further, information provided within the media reports is often vague or ambiguous in nature which can make it difficult to ascertain the validity of the claims made in the report. Media reports, also, do not go through a peer review process so I exercised caution when considering their reliability. As such, media reports have only been used as examples of potential regulatory challenges where a primary source has not been available for citation. Instances where


primary sources were unavailable, necessitating the use of media reports, included paramedics appearing before Magistrates’ Courts which rarely publicise judgments. Notwithstanding these limitations, media reports provide examples of paramedic conduct and application of the current regulatory framework.

Statistical data has also been used, where appropriate, to outline potential areas for risk. Any statistical data used were de-identified. Data was collected from a range of sources including organisations’ Annual Reports and the Health Complaints Commissions in the Australian jurisdictions. When organisations provided complaints data, it was purely statistical in nature and provided no particulars of the complaints, complainants or any other person.

I also interviewed some relevant industry stakeholders during this research project. Interviewees included government officials, union officials and ambulance organisation management. However, the information collected from these individuals was for background purposes only and provided me with context to commence and continue my research. The interview information provided covered general industry information such as explaining organisational processes, and did not contain personal information of any form. No research data for the thesis were collected from interviews or are published here or elsewhere and, as such, did not require ethics approval. Requests for statistical data, from organisations, has been acknowledged within Chapter 5 of the thesis.

This thesis goes further than a traditional doctrinal approach to legal research as the thesis is socio-legal in nature. It has aspects of reform-oriented research and policy research. Reform and policy research have been used to investigate issues beyond the law, particularly question 2 and 3 as outlined in 1.4. Reform-oriented research evaluates the sufficiency of existing regulatory structures and makes recommendations for improvement. Policy analysis involves analysing complex social problems in order to propose solutions to alleviate the problem. Despite the similarity of reform and policy methods seeking to propose recommendations, they can be contrasted through their application of the law. Reform-oriented research focuses on existing regulatory models and problems while policy analysis considers social problems which may or may not have been codified within a regulatory framework. As such, both reform and policy methodologies are suited to my research problems given this thesis examines the existing regulatory structures for Australian paramedics and proposes alternatives for governance in the form of adopting the National Law as the paramedic regulatory framework. Reform and policy analysis can be interdisciplinary in nature as they draw upon public

policy and disciplinary knowledge in an attempt to address a complex social problem, such as the regulation of Australian paramedics. As such, my research has an interdisciplinary direction as it considers issues relating to law, such as vicarious liability, as well as paramedicine.

Early in my doctoral candidacy, I also completed an observer shift with the Queensland Ambulance Service. On Thursday, 16 April 2015 I observed a paramedic crew from the Caloundra Ambulance Station while they attended emergency situations in the community. The co-operation of advanced care paramedic, Gavin Mahon, ensured I was able to maximise the learning experience for the purposes of my research. Figure 1 is a photo taken during the observer shift. While I did not collect any research data to use in my thesis from this observer opportunity, it enabled me to gain a more detailed and current understanding of the role paramedics perform in the community and to undertake a more critical approach to assessing paramedic practice.

![Figure 1 - A photo from my observer shift with Advanced Care Paramedic, Gavin Mahon (16 April 2015)](image)

Ethics approval was not required for this research because all data used was publicly available. I determined information to be ‘publicly available’ when it could be found through an online internet search; an online database through, for example, a library subscription; a hard copy source available through a library subscription; or, an organisation providing documentation voluntarily by request. It was important the data for this research were sourced from publicly available data, particularly as transparency is an important factor for effective healthcare regulation.68

Further, I have attempted to uphold the privacy of all paramedics and patients in this research. Some of the sources, such as case law and media reports, disclosed patient and paramedic names in their publicly available documents. Despite names already being published online, I referred to parties by initials to protect privacy and avoid any ethical ramifications for publishing their identifying information subsequently. Readers of this thesis could access many of the names and identifying details of the cases by going to the primary materials such as the cases; all citations are provided in full.

1.6 Definitions and terms relevant to this research

Chapters 2 to 4 of this thesis provide a detailed analysis of the current regulatory framework for paramedics in Australia. As such, there is a range of important definitional and contextual information for the reader’s familiarisation with the topic. This background information, provided in Chapter 3, includes some important definitional terms including ‘ambulances’, ‘ambulance officers’ and ‘ambulance services’ which will also be briefly explored further below. In the following paragraphs I define, for the purpose of this thesis, the terms ‘paramedics’, ‘ambulance service’ and ‘government’.

As noted above in Part 1.2 of this chapter, paramedics generally work for an ambulance service or, in some cases, are employed by private organisations in an emergency healthcare role. Some paramedics supplement their income by undertaking dual employment in a public ambulance service as well as a private organisation. Paramedics use ambulances which are vehicles ‘specifically created to rapidly transfer a patient from the place of his [or her] injury to a dedicated point of care’ and ‘incorporates in its design haste in dispatch and speed in delivery’.

Also relevant is the term ‘ambulance officer’ which, as we saw in 1.2, is used somewhat synonymously with paramedic within Australian jurisdictions. Further, statutory instruments use ‘ambulance officer’, rather than paramedic, when referring to the paramedic employees of public ambulance services. ‘Ambulance officer’ is considered a comparative term to ‘paramedic’. An ‘ambulance officer’ is a more historic term for a paramedic, stemming from a time in society when paramedics were considered to fulfil an emergency services and transport role rather than their current function in prehospital care.

This research will use the respected and deserved term ‘paramedic’ instead of any other commonly used role descriptors, such as ‘ambulance officer’ or even ‘ambulance driver’. The definitional distinction is important as paramedics have evolved considerably over time which is the topic of Chapter 3.

Furthermore, as I argue in Chapter 7, the consistent use of the designation ‘paramedic’ is an important step in recognising, respecting and regulating the paramedic profession. As we will see in Chapter 7, the consistent use of the term ‘paramedic’ will allow the profession to be well defined. In that chapter, I suggest a definition for paramedicine be created to define the discipline, if needed, and propose the following as a definition for paramedic: ‘a health practitioner who provides pre-hospital emergency care services or community-based alternative models of care including diagnosis, treatment or advice’.

‘Ambulance service’ is another important concept featured in this thesis. An ‘ambulance service’ employs paramedics who provide first aid and emergency medical treatment to patients in a pre-hospital

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71 Willis and McCarthy, above n 47, 57. A more detailed analysis of significant historical aspects of the development of paramedicine is undertaken in chapter 3 of this thesis.
environment as well as providing patient transport to hospital; this is a widely used statutory definition of the term. There are two very distinct limbs to a paramedic’s role as part of an ambulance service: the provision of pre-hospital medical care; and the transportation of sick and injured patients. The nature and significance of these two roles is changing. While paramedics, historically, co-ordinated transport only, modern paramedics provide emergency pre-hospital care which is maintained during transport. Six of Australia’s eight jurisdictions legislate for the public provision of ambulance services and have adapted the above definition of ‘ambulance service’ in one form or another. However, it must be noted the statutory definitions of ambulance service relate to the organisational requirements of ambulance service providers within the jurisdiction. The consequence is there is confusion among the public of the ambulance services’ and paramedics’ roles and responsibilities.

Finally, it is necessary to define and delimit the term government: a term I use quite often and broadly throughout this thesis. ‘Government’ is used to refer to all aspects of government from a regulatory perspective, including the legislature and executive. It can also refer to the different levels of government, whether that is local, state and territory or Commonwealth government. Understanding the scope of the term ‘government’ is necessary to this thesis given the mixed regulation of government and non-government regulation which applies to Australian paramedicine as set out briefly in 1.3 and covered in more detail in Chapter 2.

1.7 Scope of the research

In order to discuss the regulatory issues relating to Australian paramedicine, it is necessary to exclude a number of healthcare groups from the scope of the thesis. The regulatory disparity between jurisdictions can lead to challenges in determining which healthcare workers are ‘paramedics’. The focus of this thesis, therefore, is those health care workers who provide pre-hospital care with appropriate educational and training qualifications as identified in Chapter 4 whether employed in the public or private sector. There are three specific groups excluded from the scope of this thesis:

1. **Patient transport attendants** or officers are not considered paramedics within the scope of this research. Patient transport officers usually have varying levels of first aid training or a vocational certificate only. While they play an important role in pre-hospital care and

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72 Ambulance Service Act 1991 (Qld) sch dictionary (definition of ‘ambulance service’); Health Services Act 1997 (NSW) dictionary (definition of ‘ambulance services’); Ambulance Services Act 1986 (Vic) s 15; Emergencies Act 2004 (ACT) s 60; Ambulance Service Act 1982 (Tas) s 3; Health Care Act 2008 (SA) s 3.
73 Bendall and Eburn, above n 47, 2-3; Ambulance Service of NSW v Worley [2006] NSWCA 102, [29].
74 The Northern Territory and Western Australia have no industry-specific legislation for the regulation of ambulance services or paramedics.
75 Sanson and Anthony, above n 60, 115.
ambulance services, they tend to lack the higher education, training, skill and knowledge of paramedics. As such, they do not fall within a paramedic regulatory framework;

2. Volunteers also provide first aid services or an emergency medical responding service. Hatzolah, in Victoria, is an example. Volunteers of St John Ambulance Service. Many volunteers do not have the higher levels of training and experience expected of qualified paramedics. These volunteers have restricted scopes of practice given their training is limited to first aid level only. Volunteers will not be considered to fall within paramedic regulation for the purposes of this thesis; and

3. Military organisations will also be excluded from the scope of this research. The Australian Defence Force employs paramedics and medical assistants (medics) within their organisation. Defence force personnel will be excluded from the scope of this research as they have different internal education, training and recruitment structures unrelated to civic paramedics.

It should also be noted, here, that one international comparative regulatory model for paramedic regulation has been considered in this research. The United Kingdom’s paramedic regulatory model has been used for a number of reasons. The United Kingdom utilises a paramedic registration model, under the Health and Care Professions Council (HCPC), similar to Australia’s National Law which governs a number of British health professional groups including paramedics. The HCPC regulation is particularly useful for this research because the roles, responsibilities and scopes of practice of British paramedics are similar to Australian paramedics. The United Kingdom’s paramedic regulatory model provides a functional paramedic registration framework currently working in a jurisdiction with a similar legal system to Australia. It further establishes the potential for risk which paramedics pose to the community. Finally, British paramedicine is considered to be a professional discipline, which is an outcome sought by Australian paramedics and considered in Chapter 3. The British model for paramedic regulation will only be used as a comparative analysis, and a descriptive outline of the model will not be provided in this thesis.

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80 Paramedics Australasia, above n 76, 3.
81 Health and Social Work Professions Order 2001 (UK).
83 The Health and Social Work Professions Order 2001 (UK) outlines the United Kingdom’s Health and Care Professions Council regulatory structure. For a discussion of the Health and Social Work Professions Order
No other international jurisdictional comparisons will be used in this thesis. The training, education, skills and knowledge required in jurisdictions such as Canada and New Zealand are similar to Australian paramedics, as are their regulatory structures. New Zealand’s statutory instrument governing registration and regulation of health practitioners does not apply to their paramedics. Despite New Zealand being a single national jurisdiction, there are no nationally recognised qualifications or training programs for paramedics, no specified national standards of practice, nor are there statutory instruments governing paramedic practice or ambulance services in their jurisdiction. Further, notwithstanding New Zealand paramedics’ desire for inclusion in the jurisdiction’s health practitioner registration framework, New Zealand’s model does not provide any additional characteristics which can add to more suitable reform of Australian paramedicine regulation. In relation to Canada’s regulatory structure, each of their provinces and territories have different governing mechanisms. Each of the Canadian jurisdictions can be classified as self-regulating, adhering to governmental regulation or entirely governed through employment. As the Canadian provinces and territories utilise multiple regulatory frameworks across the country, Canada shares the same interjurisdictional regulatory disparity problems as Australia’s paramedics. Because this thesis proposes a regulatory framework significantly different to Canada’s and New Zealand’s paramedic regulation, their regulatory models are not instructive for Australia meaning these jurisdictions are outside the scope of this research.

Another comparative regulatory model which should be mentioned here, but excluded from further consideration, is the regulation of Australia’s other emergency services. Paramedics were, at one time, considered emergency service workers, similar to police and fire and rescue. Now, however, paramedicine is more synonymous with health care and, given paramedics’ potential to harm patients, should be regulated according to the health practitioner regulatory principles rather than as an

85 Health Practitioners Competence Assurance Act 2003 (NZ).
86 Sue Kedgley, 'Inquiry into the provision of ambulance services in New Zealand' (House of Representatives, July 2008) 3, 5, 10.
89 Health Professions Regulatory Advisory Council, A Jurisdictional Review, above n 84.
emergency service.\textsuperscript{91} The other emergency services, police and fire, are regulated through their employment relationship with community service powers granted under relevant statutory instruments.\textsuperscript{92} While this is similar to the current regulation of paramedics, paramedics’ evolving role as highly skilled health practitioners suggests they should no longer be regulated in the same way. Accordingly, consideration of emergency services regulation has not been further undertaken in this thesis.

\subsection*{1.8 Chapter outline}

The following chapter summary outlines how my research will be presented in this thesis. My thesis is presented in two parts. Part 1, consisting of Chapters 2 to 4, analyses the current regulatory framework governing paramedic practice. Part 2 investigates the key challenges to the current paramedic regulatory framework and proposes the extension of the \textit{National Law} to paramedics as the best solution to address those challenges. More specifically, Part 2 discusses the level of risk paramedics pose to the community which current regulation fails to adequately address.

Chapter 2 describes the current regulatory structure of paramedic practice in Australia. In order to provide context to the regulatory discussions and proposals undertaken throughout this thesis, it introduces the reader to relevant aspects of regulatory theory. Chapter 2 further highlights how paramedics are governed primarily through their employment relationship using workplace industrial instruments, clinical policies, codes of conduct and codes of ethics. The chapter also outlines the role of statutory regulation which primarily governs the ambulance industry rather than regulates individual paramedics. Chapter 2 concludes by arguing that current regulation of paramedics is inconsistent as it is employers who are primarily responsible for setting industry standards of education, training and conduct.

Chapter 3 advances the argument for change to the way in which paramedics are regulated by examining the evolution of paramedic practice as a health discipline. Specifically, Chapter 3 argues that paramedics have evolved from ‘stretcher-bearers’, ‘ambulance drivers’ and ‘ambulance officers’ to the highly skilled and specialised emergency health practitioners called ‘paramedics’ whose role it is to diagnose, treat and advise patients, rather than solely transport patients to hospital. Paramedics are now performing more highly invasive treatments than ever before, and have more significant

\textsuperscript{91} Ibid.
responsibilities, leading to the potential for significant risk to the public. Further, paramedics are increasingly being employed in a private capacity which causes additional problems for the current regulatory framework to protect the public. As such, the chapter argues paramedics have transitioned from an occupation to a profession and their regulation also needs to progress from occupational to professional as a result.

Chapter 4 evaluates the notable features of the way in which paramedics are currently regulated in Australia. In particular, it highlights jurisdictional and employer disparity in training and education; title protection; possession, administration and storage of drugs; and, complaints and disciplinary requirements and procedures. A significant criticism with paramedic regulation, identified here, is the fact that there is no positive obligation for community complaints about paramedics to health commissions and ombudsmen to be communicated to the paramedic’s employer. This chapter also explores some of the challenges introduced in Chapter 2 more comprehensively, including issues of jurisdictional disparity in regulation.

Having established the evolution of paramedic practice in Australia and the features of paramedic regulation, the focus shifts to risk and harm. Chapter 5 provides an analysis of ‘risk’ and ‘harm’ in paramedic practice from a regulatory and theoretical context. In so doing, it identifies actuarial, sociocultural and political risks and their effect on risk prediction in Australian paramedicine. Chapter 5 considers risk regulation from two limbs:

(i) that a number of features in current regulation suggest paramedics pose a risk to the community; and

(ii) that the current regulatory framework does not function transparently, which means establishing its suitability to manage risk in paramedicine is problematic.

Chapter 5 also considers data from the United Kingdom, as a comparable jurisdiction, to identify paramedic risk to the community. The United Kingdom is an example of a comparable jurisdiction, in terms of regulation, role and skill, that has instituted a registration system in order to regulate the behaviour of their paramedics. I propose that the United Kingdom’s complaints and disciplinary processes are transparent enough to generate data to demonstrate the potential for risk to the public which, if existing in the United Kingdom, would likely exist here in Australia too.

Chapter 6 then builds upon the ‘risk’ concepts established in Chapter 5. It uses the precautionary principle to argue for paramedic inclusion in the National Scheme. Examples of patient harm are used here to advocate that the current regulatory framework is not sufficient to protect the public from paramedics causing harm. In Chapter 6, areas for paramedic risk are evaluated in two categories: firstly, title, training and education; and, secondly, paramedic misconduct. Further, data from coronial inquests, government reports, health complaints commissions, court judgments and media reports will
be used to consider regulatory efficiency of current paramedic governance. Comparisons with the National Law are also made here to demonstrate how the National Scheme might suitably regulate paramedic practice. The chapter concludes that the current regulatory framework governing paramedic practice is problematic as it fails to adequately protect the public from health and safety risks.

Based on the arguments in Chapters 2 to 6, Chapter 7 considers the application of the National Scheme to Australian paramedics. In particular, the chapter argues that regulation of paramedics through the National Scheme is warranted based on a thorough application of the Council of Australian Government’s Guiding Principles to paramedic practice. Consideration is also given to the changes needed to the National Law, and other statutory instruments, if paramedics are to be included in the National Scheme. Other necessary factors, such as benefits and costs, are addressed in this chapter. I argue that including paramedics in the National Law is not onerous and provides a feasible and workable solution to the regulation of paramedics.

Chapter 8 concludes with a summary of arguments and research findings of this thesis. In particular, Chapter 8 makes the argument that first, the current paramedic regulatory framework is inadequate; second, paramedicine should be a registered health profession under the National Law; and third, the regulatory requirements for paramedic inclusion in the National Scheme can be met.
PART I: BACKGROUND AND EXISTING REGULATORY FRAMEWORK FOR PARAMEDICINE
CHAPTER 2 – AUSTRALIA’S PARAMEDICINE REGULATORY FRAMEWORK

2.1 Introduction

The government plays a substantial and authoritative role in health practitioner regulation. One of the key reasons for the government’s involvement in regulating health professions is the potential significant health and safety risk which health practitioners pose to the public. Within the healthcare sphere, paramedics perform a range of invasive and risky procedures on patients, equivalent to procedures other registered health practitioners perform. While the government acts as an employer for paramedics in the public ambulance sector, it is not involved in regulating the private paramedic industry.

In order to examine the regulatory framework of paramedics, it is necessary to consider the ‘regulatory mix’ of ‘tools’ that exist to govern behaviour. While legal regulation may be warranted in some circumstances, engaging the law is not always the most appropriate method of regulating a discipline. This chapter will consider the differing ‘tools’ of regulation which contribute to a ‘regulatory mix’ of options for governments and policy makers in relation to regulating healthcare providers. It will outline how health practitioners are regulated and the broader theoretical context in which health professionals are governed. The chapter will then evaluate the regulation of Australian paramedics, the extent of government involvement and the effects this regulatory structure has on the public, paramedics, employers and other relevant stakeholders.

The National Scheme, established under the National Law, governs 14 different health professions, yet it does not apply to Australian paramedics. As a result, Australian paramedics are regulated separately to other Australian health practitioners. By examining how paramedics are regulated in Australia, I highlight the piecemeal and disparate roles of the various regulatory mechanisms, such as employment relationships, using workplace industrial instruments and clinical policy documents. Significantly, such industrial instruments and policy documents differ between jurisdictions and employers and, therefore, create significant jurisdictional disparity. This chapter will specifically consider the various frameworks governing paramedic behaviour including workplace industrial instruments, clinical procedures, policies and codes of conduct.

Outlining the ‘regulatory mix’ and situating paramedics within a particular regulatory framework is an important and necessary step in this thesis. Discussing the regulatory options available to govern a discipline, such as paramedicine, enables a more thorough evaluation of the framework’s effectiveness.

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1 The ‘regulatory mix’ refers to the ‘mix’ of regulatory interventions which can be used to achieve regulation. See W A Bogart, Regulating Obesity? Government, Society and Questions of Health (Oxford University Press, 2013). See also Robert Baldwin, Martin Cave and Martin Lodge, Understanding Regulation: Theory, Strategy and Practice (Oxford University Press, 2nd ed, 2012).
3 Baldwin, Cave and Lodge, Understanding Regulation, above n 1, 108.
as it highlights other options for regulation. This chapter sets out deficiencies in current paramedic regulation and suggests why a different regulatory structure addressing the issues of the regulatory framework for paramedic practice would be more beneficial to those community members, paramedics and employers.

2.2 Altering behaviour through regulation

Broadly speaking, regulation is a mechanism used to enforce rules or provide opportunities for governance. It can provide standards for behaviour and a mechanism to alter behaviour. The way in which regulation acts on behaviour has been widely considered, applied and criticised in scholarly literature. Freiberg, for example, has considered differing adaptions to the definition of regulation. He suggests that ‘all behaviour is regulated’ but also that regulation can be ‘an intentional measure or intervention that seeks to change the behaviour of individuals and groups’. Black, as well as Hood, Rothstein and Baldwin, have each suggested that regulation involves the use of specific standards to alter people’s behaviours in order to produce mechanisms of ‘standard setting, information gathering and behaviour modification’. Parker and Braithwaite describe regulation as ‘influencing the flow of events’ through monitoring behaviour using economic incentives, but without necessarily enforcing legal sanctions.

Regulation can, therefore, incorporate mechanisms that influence behaviour on a number of different levels. Firstly, regulation can be a set of binding commands enforced by a body created for that purpose. Secondly, regulation can include a broader, deliberate government influence which covers all governmental action intended to influence business or social behaviour. Thirdly, all forms of social or

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4 Christine Parker and John Braithwaite, 'Regulation' in Peter Cane and Mark Tushnet (eds), The Oxford Handbook of Legal Studies (Oxford University Press, 2005) 1195, 119.
8 Parker and Braithwaite, above n 4, 119.
economic influence are considered regulatory because regulation seeks to affect behaviour. In its broadest sense then, regulation has the potential to seek a specific outcome or function, incorporating general behavioural modification.

Who regulates behaviour in Australia? The government’s role in regulation is significant and is underpinned and informed by regulatory principles. Indeed, the government has significant involvement in the regulation of human behaviour. For example, the Victorian Government’s Guide to Regulation defines regulation as the ‘imposition of rules or principles intended to influence the behaviour of people and/or business, supported by the authority of government’. The state – be that federal, state or territory, or local government – has a particular interest in the regulation of groups which pose a level of harm to the community. Governmental regulation is primarily concerned with promoting the welfare of the community by protecting the public interest, preventing market failure and promoting community trust. However, Freiberg suggests it is difficult to provide a precise definition of the ‘public interest’ because it changes over time, varies between jurisdictions and is often not clearly defined in particular legislative instruments. Regardless, governments will become involved in behaviour regulation where there is an interest for them to be involved.

However, regulation is not confined to the law or the government’s involvement in enforcing behaviour; it can encompass any measures to alter behaviour such as organisational policies or codes of conduct. Freiberg’s statement that ‘while all governments regulate not all regulation is undertaken by government’ highlights the ‘regulatory mix’ of available ‘tools’ available to those who seek to influence the behaviour of others.

Black suggests it is the purpose of regulation which is of primary importance. Freiberg lists some common purposes of regulation as promoting the public interest; redressing market failure; preventing or minimising harm; promoting public policies; managing and distributing risk; and promoting trust within the community. Whether government or non-government, the purpose of regulation is broadly the same: to influence behaviour. That said, different regulatory structures can have different, and sometimes even contradictory, objectives.

The purpose of regulation can also be restrictive (red light) or facilitative (green light). Baldwin, Cave and Lodge consider Harlow and Rawling’s ‘red light’ and ‘green light’ concepts of regulation when

\[9\] Baldwin, Cave and Lodge, Understanding Regulation, above n 1, 3; Black, Critical Reflections on Regulation, above n 5.


\[11\] Freiberg, The Tools of Regulation, above n 2, 49. See also Baldwin, Cave and Lodge, Understanding Regulation, above n 1, 15-24.

\[12\] Freiberg, The Tools of Regulation, above n 2, 5-16.

\[13\] Freiberg, Restocking the Regulatory Tool-Kit, above n 6, 5.

\[14\] Black, Critical Reflections on Regulation, above n 5, 26.

\[15\] Freiberg, The Tools of Regulation, above n 2, 5-16.
evaluating regulations’ objectives. The ‘red light’ purposes of regulation involve restrictive measures to limit undesirable behaviour while ‘green light’ regulation involves enabling or facilitating activities to be undertaken in a controlled way. Regulation is, therefore, often about power and control. In order to fulfil the purposes of regulation, various ‘tools’ of regulation can be used. Freiberg categorised regulatory tools for governmental use in producing behavioural change. The various forms of governmental regulation can be classified into six conceptual categories or ‘tools’: economic, transactional, authorisation, structural, informational and legal regulation. Freiberg suggests the tools of regulation provide a variety of ways in which people and institutions can use their power to influence the behaviour of others. Tools of regulation particularly relevant to Australian paramedic regulation, and health professional regulation, are authorisation and legal regulation.

**Authorisation (eg. registration)**

Authorisation is a significant regulatory tool for governments and allows the state to exercise its authority to monitor behaviour. Given that governments have the ‘ultimate’ authority under this particular tool, even private monopolies are subject to state regulation when authorisation is the regulatory model which applies. The government can control entry to disciplines using their authorisation power, such as requiring applicants to register. Governmental power can be used to set standards to establish community trust. Further, people can be required to demonstrate specific levels of knowledge and skills before they are permitted to use a particular title and reap the financial benefits of a restricted market in the services they offer. An example of authorisation is registration.

Registration, as an authorisational tool, governs Australian health practitioner regulation. Registration requires individuals to add their names to an industry register in order to undertake particular activities. It is a very popular technique for regulators to monitor behaviour. Registration will often require a fee and commonly aims to prevent information asymmetry, that is, where one party to a transaction has more information than another party. Governments often use authorisation, in the form of registration, to set entry standards and establish community trust in the discipline and control markets: only suitably qualified applicants can receive financial benefits from the restricted market. When health practitioners are regulated through a registration scheme, integrity and values are promoted, ensuring behaviour enabling ‘trust and confidence in the standing of the profession’. Nurses and teachers are

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17 Ibid.
20 Freiberg, *The Tools of Regulation*, above n 2, 141.
21 Ibid 9.
22 Ibid 150-1.
both examples of professions requiring registration. The Queensland College of Teachers grants registration for eligible and suitable Queensland teachers upon payment of an annual fee.\textsuperscript{24} The Nursing and Midwifery Board uphold minimum registration standards for applicants seeking admission as a registrant, including payment of an annual fee.\textsuperscript{25} Registration does not prevent unregistered people from undertaking activities requiring registration as it is the practitioner’s responsibility to ensure their registration is maintained;\textsuperscript{26} however, registration with title protection does prevent unregistered persons practising. Title protection is considered further in 4.3.

Legal regulation

Given the government’s interest in governing behaviour, legal regulation is a common ‘tool’ of regulation of health professions. Law is often used as a regulatory tool because of its ability to set standards of behaviour and enforce compliance; this is known as ‘command and control’ regulation.\textsuperscript{27} Legal regulation can include legislation, delegated legislation and quasi-legislation and is often used to manage societal concerns.\textsuperscript{28} When legal rules are backed by criminal sanctions, they arguably create certainty for the public, ensure governmental accountability and result in higher levels of community compliance.\textsuperscript{29} However, ‘command and control’ models are limited as they fail to recognise that State action is not always the most effective means of implementing change. Indeed governmental regulation is often most suitable when used in conjunction with other methods, such as incorporating a self-regulating component into the regulatory structure.\textsuperscript{30}

On its own, legal regulation can be criticised as inefficient. Legal regulation requires enforcement agencies to uphold the standards required and can be inflexible because of the need for parliament to repeal or amend laws which are not operating effectively.\textsuperscript{31} Legal regulation can be unsuccessful as a regulatory mechanism when there are failures in the implementation of laws; legislative instruments are inappropriate; there is inadequate governmental knowledge of the causes of particular issues; or there is a failure of the community to comply.\textsuperscript{32} Parker and Braithwaite raise another concern with legal

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\item \textsuperscript{24} \textit{Education (Queensland College of Teachers) Act 2005} (Qld) ss 8-12A.
\item \textsuperscript{25} \textit{Health Practitioner Regulation National Law Act 2009} (Qld) sch 1, ss 52-6; Nursing and Midwifery Board of Australia, \textit{Fees for Nurses and Midwives} (8 September 2014) <http://www.nursingmidwiferyboard.gov.au/Registration-and-Endorsement/Fees.aspx>.
\item \textsuperscript{26} Freiberg, \textit{The Tools of Regulation}, above n 2, 150-1.
\item \textsuperscript{27} Robert Baldwin, Martin Cave and Martin Lodge (eds), \textit{The Oxford Handbook of Regulation} (Oxford University Press, 2010) 5-6, 8; Australian Law Reform Commission, ‘Principled Regulation Report: Federal Civil & Administrative Penalties in Australia’ (December 2002) 209-10, 216.
\item \textsuperscript{28} Freiberg, \textit{The Tools of Regulation}, above n 2, 52.
\item \textsuperscript{29} Black, \textit{Decentering Regulation}, above n 5, 105; Black, \textit{Critical Reflections on Regulation}, above n 5.
\item \textsuperscript{30} Baldwin, Cave and Lodge, \textit{Understanding Regulation}, above n 1, 108.
\item \textsuperscript{31} Freiberg, \textit{The Tools of Regulation}, above n 2, 178-83.
\item \textsuperscript{32} Black, \textit{Critical Reflections on Regulation}, above n 5, 3.
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regulation: the potential for voluntary responsibility could subside and the very nature of legalistic regulation reduces the people’s ‘will’ to comply.33

Regulation, though, is not exclusively government territory. While a major societal regulator comes from state bodies, regulatory groups can incorporate civil institutions as well, suggesting the scope of governance can be broadened beyond governmental regulators.34 Professional regulation35 can involve rules and regulations made by bodies other than governmental regulators, such as industry organisations.36 Professional bodies are also often given legislative power to make professional rules for the industry, such as National Boards under the National Law.37 The potential for non-government regulators, then, demonstrates the ‘regulatory mix’ which can exist in regulating behaviour. Self-regulation and co-regulation are examples of governance models existing outside the government’s influence.

2.2.1  A ‘regulatory mix’ of tools for paramedic regulation

There is a vast amount of literature discussing a number of models of regulation between government and non-government regulation. There are differing levels of self-regulation to govern behaviour. Self-regulation can involve a profession being given statutory power to make rules governing the activities of its members.38 Individuals can also choose to self-regulate by adopting values or rules and, therefore, self-regulation can occur on an individual, organisational or industry level.39 Parker characterises self-regulation, within a medical practitioner regulatory context, as ‘internal’ regulation because it functions within the profession’s parameters.40 Health practitioners, using a self-regulatory model, have an ‘exclusive right’ to monitor standards and conduct of other health practitioners and to decide on corrective or disciplinary measures for those who do not reach an adequate standard.41 A traditional self-regulatory model has little or no input from government or any other parties external to the

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33 Parker and Braithwaite, above n 4, 128.
35 It is significant to note there is literature detailing the regulatory differences between professions and occupations. A profession undertakes specialised work; medical practitioners, for example, are considered professionals. Paramedics have not been considered a professional group previously; however, a comprehensive discussion of this position is undertaken in chapter 4 of this thesis. For the purposes of chapter 2, health professional regulation is considered from an industry perspective, rather than providing a detailed understanding of the definitive term ‘profession’.
37 See National Law, s 31.
39 Freiberg, The Tools of Regulation, above n 2, 26; Baldwin, Cave and Lodge, Understanding Regulation, above n 1, 137.
profession. For example, medical practitioners formerly exercised self-regulation and their industry had full control over all entry to practise and disciplinary measures until government intervention in the 21st century.\(^{42}\)

Importantly, though, governmental regulation and self-regulation are not mutually exclusive. There are instances when self-regulation and state regulation contribute to the governance of particular activities. This form of regulation, known as co-regulation, can occur when self-regulation is not considered sufficient to protect the public interest and the government decides that it should not accept sole responsibility to regulate a particular activity. Co-regulation can also occur when a self-regulatory model is used to fulfil governmental aims.\(^{43}\) Parker and Braithwaite, specifically, encourage private regulation, in conjunction with governmental regulation, through co-regulation.\(^{44}\) An example of co-regulation comes from the National Scheme and will be discussed below.

Co-regulation has been deemed necessary when legislative provisions are needed to provide legal coverage to the industry or allow for enforceable sanctions.\(^{45}\) Freiberg suggests a co-regulatory model is useful when discipline-specific responsibility should be maintained over complaint handling, disciplinary proceedings and the imposition of some sanctions, but public protection requires overarching governmental authority through a legislative framework. He also supports a co-regulatory model when it is important for professional independence of the discipline and when co-regulation can unite public and private sectors with strong industry oversight.\(^{46}\)

Most Australian health professions are governed through a co-regulatory model. As we have seen, the National Scheme regulates Australian health professions. The National Scheme can be considered co-regulatory as legislative requirements under the National Law provide the governmental authority for the disciplines to operate a self-regulatory model of practitioner governance. The self-regulation component exists through the industries’ National Boards which are made up of both practitioner and community members. The National Boards’ decision-making scope is restricted through National Law provisions to prevent accountability issues.\(^{47}\) Practitioners can be involved in the regulation of their discipline through setting standards of conduct and continuing professional development requirements, for example, to maintain transparency and accountability.\(^{48}\) A more comprehensive critique of self-regulation, used within the healthcare industry, is undertaken in Chapter 7.

\(^{42}\) Ibid 52.
\(^{43}\) Black, Critical Reflections on Regulation, above n 5, 114-5.
\(^{44}\) Parker and Braithwaite, above n 4, 128.
\(^{46}\) Freiberg, The Tools of Regulation, above n 2, 32-3.
\(^{47}\) National Law, s 32.
\(^{48}\) Bernadette Richards, ‘General Principles of Consent to Medical Treatment’ in Ben White, Fiona McDonald and Lindy Willmott (eds), Health Law in Australia (Thomson Reuters, 2010) 93,10; Thomas, above n 41, 53.
2.2.2 Determining the appropriate regulatory response for paramedics

This thesis proposes that paramedics be included as a registered health profession under the National Law. As such, it is suggesting an alternative means of paramedic regulation for Australia to the one currently in place. Having established the need for co-regulation more generally, it is now necessary to consider how this might be achieved. A hierarchy of regulatory responses, in the form of ‘smart regulation’, allows for regulation to be appropriate for the circumstances. ‘Smart regulation’ refers to an ‘emerging form of regulatory pluralism’ designed to move away from direct governmental regulation and incorporate a mix of regulatory methods to increase efficiency of governance. Using a ‘regulatory mix’ of tools acknowledges how informal social controls can contribute to the influence of behaviour as much as a formal control, like legal regulation, might. The use of a selection of appropriate regulatory tools, to suit particular circumstances, encourages an effective regulatory solution.

John Braithwaite has suggested a hierarchy of regulatory responses when considering how to regulate a particular activity. Self-regulation should occur where possible; however, where the industry cannot be given the responsibility to regulate itself, the regulatory response should be escalated to the most suitable regulatory model, exercising punitive and governmentally controlled strategies. After self-regulation, an appropriate escalation response could then increase to enforced self-regulation, command regulation with the discretion to punish, followed by command regulation with nondiscretionary punishment. This hierarchy is known as the ‘Enforcement Pyramid’ and is outlined in Figure 2.

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49 Part 7.4.3 of this thesis further evaluates self-regulation as an unsuitable model of health professional regulation and argues for co-regulation to regulate Australian paramedicine.
52 ‘Enforced self-regulation’ has been categorised as a co-regulatory measure. John Braithwaite has discussed the concept of enforced self-regulation as a regulatory model designed to minimise delay, red tape and costs; and address issues with allowing companies to regulate themselves. Under Braithwaite’s enforced self-regulatory model, the government would direct a company or firm to draft specific enforceable guidelines. The regulator would be responsible for approving or rejecting the rules and a public consultation process would also occur at this stage. Enforcement of the rules would rest with internal structures of the firm and violations to the rules would result in legal liability. See John Braithwaite, ‘Enforced Self-Regulation: A New Strategy for Corporate Crime Control’ (1982) 80 Michigan Law Review 1466, 1470-1.
53 John Braithwaite, To Punish or Persuade: Enforcement of Coal Mine Safety (State University of New York Press, 1985) 120, 142-3.
The ‘enforcement pyramid’ has been proposed as a regulatory measure designed to maximise enforcement opportunities for regulators. Ayers and Braithwaite’s pyramid functions when breaches of regulatory rules are dealt with using sanctions of increased severity. The hierarchy arguably legitimises regulatory enforcement as the industry is more likely to comply with enforcement if a persuasive enforcement style has failed, leading to a punitive penalty used instead. The National Law’s disciplinary measures use a hierarchy of regulatory responses, with minor sanctions, such as a caution, imposed for the less serious infractions, while the disciplinary responses escalate for subsequent, and more serious, disciplinary breaches, including registration suspension or cancellation.

Enforcement responses should be responsive to the industry. A regulatory approach, using a hierarchical model of enforcement, suggests penalties for non-compliance should be no more than necessary to achieve their objective. This was later extended to the ‘strength-based pyramid’ where punitive measures are postponed for as long as possible provided industry workers continue to demonstrate innovation and improvement to their industry. The idea of regulators prescribing rules based on the conduct of those it regulates, and deciding on an interventionist strategy when needed, is known as ‘responsive regulation’. That is, regulation ‘responsive’ to the industry. Responsive regulation is

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55 Ayers and Braithwaite, *Responsive Regulation*, above n 54, 35.
56 Braithwaite, *The Essence of Responsive Regulation*, above n 5, 486. See also Peter Mascini, ‘Why was the enforcement pyramid so influential? And what price was paid?’ (2013) 7 *Regulation & Governance* 48, 49; Braithwaite, *Responsive Regulation and Taxation*, above n 5, 4-5.
57 *National Law*, ss 178(2), 196.
58 Freiberg, *Tools of Regulation*, above n 2, 98.
60 Ayers and Braithwaite, *Responsive Regulation*, above n 54, 4; Braithwaite, *Responsive Regulation and Taxation*, above n 5, 4.
important because it engages with the concerns of the people ensuring regulation is just and effective. Responsive regulation is a concept which has been thoroughly explored.

The basic pyramid, though, may not always reflect the complexity of the enforcement action and multiple regulatory tools can be required at times. Braithwaite, Makkai and Braithwaite suggest this can occur when different causes require different responses; when tools fail, others are needed to be ready for use; different tools can deal with different hazards; interacting interventions can ‘strengthen’ each other; multiple tools can provide accountability; hierarchical and horizontal layering of tools can be effective; and multiple tools can provide more ‘nodes of regulation’. The use of multiple tools to solve a regulatory dilemma can enhance flexibility leading to more effective regulatory outcomes.

Freiberg has evaluated the regulation pyramids and concluded that despite the many strengths existing for these regulatory approaches, there is too much focus on rule enforcement while the ‘day-to-day factors’ influencing behaviour get overlooked. Enforcement is only one part of the regulation process. Further, responsive regulation through a pyramid enforcement scheme is not always appropriate when considerable harm is caused and a sanction is needed immediately. It also fails to capture the complexity of enforcement, with multiple sanctions needed at times. Baldwin and Black add there can be difficulties, on the other end, of de-escalating a response to an action if a lesser regulatory response is needed subsequently.

Understanding regulation, and its purposes, is important when evaluating the suitability of a regulatory framework for paramedics. As regulation involves the influence of behaviour, it is necessary to consider how the behaviour of paramedics, and the ambulance services administering emergency healthcare, is regulated within Australia. The suitability of the framework, in achieving the regulatory goals, can then be determined. It is also important to acknowledge that there is not a one-size-fits-all approach to regulation, and that different disciplines and fields have different objectives, structures and regulatory ‘mixes’. This is true for the regulation of health professionals and paramedics. In the next section of this chapter, I will examine the objectives of health practitioner regulation, and how paramedicine can be compared, in order to evaluate whether differences between the purposes of health practitioner and paramedic regulation exist. This will help determine whether the government’s response to regulation should be comparable for paramedics and other health practitioners.

61 Christine Parker and John Braithwaite, ‘Regulation’ in Peter Cane and Mark Tushnet (eds), The Oxford Handbook of Legal Studies (Oxford University Press, 2005) 1195, 128.
62 See, eg, Parker, Twenty Years of Responsive Regulation, above n 5; Robert Baldwin and Julia Black, ‘Really Responsive Regulation’ (2008) 71 Modern Law Review 595; Braithwaite, Responsive Regulation and Taxation, above n 5; Braithwaite, The Essence of Responsive Regulation, above n 5.
63 Freiberg, Tools of Regulation, above n 2, 99.
64 Freiberg, Makkai and Braithwaite, above n 59.
65 Freiberg, Restocking the Regulatory Tool-kit, above n 6, 11.
66 Baldwin and Black, above n 62, 62-3.
2.2 Objectives of health professional regulation

As mentioned above, government regulation of a professional group usually occurs when there is the potential for an industry to cause harm to the community. Given that health professions are responsible for providing healthcare to patients, health practitioners have the potential to cause significant patient harm. As such, some level of state intervention into healthcare regulation is justified. Other professional industries also involve some element of state regulation. For example, regulation of the legal profession is based on the fair administration of justice, protection of consumers and the facilitation of interjurisdictional regulation and is undertaken through a statutory framework. Likewise, the teaching profession has a statutory registration body with similar regulatory objectives including to uphold standards, maintain public confidence and protect the public. Legal professionals and teachers both have the potential to cause harm to the public, albeit different types of harm; thus, the government has seen the benefits of intervening in the regulation of these professions.

The purpose behind regulating health practitioners is essentially twofold. According to Freckelton, the first objective of health professional regulation is risk reduction and mitigation: in this way health practitioner regulation involves a protective mechanism for patients. Risk is a significant regulatory consideration and one addressed more extensively in Chapter 5 of this thesis. Indeed, the objective of risk mitigation and the associated promotion of public safety have been legislatively acknowledged as an important consideration of health professional regulation. For example, a statutory guiding principle of health practitioner regulation is that the ‘health and safety of the public is paramount’. However, public protection from risk, while significant, is not the sole purpose behind health professional regulation.

The promotion of trust is also a significant factor in health professional regulation. This is particularly the case given the significant level of responsibility afforded to health practitioners such as through the prescription and administration of drugs. The government’s role in the regulation of health practitioners here, then, ensures the health practitioner industry maintains its high regard for the community. Freckelton suggests health practitioners have the trust of vulnerable patients. If a practitioner’s behaviour becomes inappropriate and contravenes the patient’s best interests, significant ‘adverse consequences’ can occur which can adversely affect vulnerable patients. Further, there have been suggestions that more thorough regulation of the medical profession allows for the exclusion of

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67 Legal Profession Act 2007 (Qld) s 3.
68 Education (Queensland College of Teachers) Act 2005 (Qld) s 3.
unsuitable practitioners from practising, leading to an ‘occupational monopoly’ in the division of labour. The ability to exclude particular practitioners from practise is another mechanism to promote trust and standing within a profession as those practitioners who do not reach minimum standards cannot continue to practise.

Importantly, the objectives of risk reduction, public safety and trust are contingent. Society relies on the government to ensure its protection by providing adequate regulators, while the regulation itself allows members of the community to have confidence in the health professions. Because regulation aims to encourage high standards within the profession, which benefit the public, public protection can also be promoted. Parker asserts that sometimes regulation will concurrently serve the public interest while also protecting the profession’s self-interest.

The primary purposes of health professional regulation—risk reduction and increased trust—are relevant and significant to paramedicine’s industry governance. Because paramedics provide emergency healthcare to patients, the general principles and objectives of health professional regulation also apply to paramedicine, particularly if patient risk can be established. As the provision of healthcare to patients is the primary role of Australian paramedics, their regulation should ultimately reduce the potential for public risk and promote integrity, trust, standing and minimum standards within the discipline. This thesis will assess the suitability of paramedicine regulation in reducing public risk and promoting industry values. First though, it is necessary to specifically consider how the government, and the industry itself, articulate the purpose of paramedic regulation.

It is difficult to determine the general purposes of paramedic regulation from the way paramedics are currently regulated. As we will see in Part 2.3 and Chapter 4, there are significant disparities within Australian paramedic regulatory frameworks. This means the purpose of regulation, between each employer body, can be quite diverse. Further, as employers are responsible for the regulation of paramedics, employer motivations differ to that of governmental regulators. For example, employment contract law is generally aimed at ensuring that workers have minimum standards of wages, terms and conditions; there are strict rules governing negotiation between employers and employees; and individual rights, such as freedom from discrimination, are protected. Employer regulation then, does not, to the same extent as government regulation, focus on risk reduction and increased trust objectives.

Elkin, Medical Practitioner Regulation, above n 36, 684.
Christine Parker, Just Lawyers (Oxford University Press, 1999) 119.
While the primary paramedic employers are government organisations, an independent body is needed to prevent conflicts of interest arising in the paramedic organisations’ roles as employer and government. A number of themes arise from the current paramedicine regulatory framework which do not expressly identify the objectives of paramedicine regulation but, I argue in the following paragraphs, may impliedly reflect the regulator’s purposes of governing their part of the industry.

The ability of academics and policy makers to effectively evaluate the purposes of statutory regulation of the paramedic industry is challenging. Legislative instruments governing the ambulance industry often do not apply to the governance of individual paramedic conduct, but instead authorise employers to regulate their employee paramedics. In a limited number of jurisdictions, there are protection of title provisions which eventuated from parliamentary intervention into paramedic regulation.

The purpose behind statutory regulation of paramedic protection of title is consistent with the general principles of health professional regulation. Where health professional regulation aims to protect the public and uphold confidence in the standing of the profession, Australian legislators have made moves to apply consistent principles in the regulation of title protection for paramedics. The key purposes of regulating title include:

1. enhancing the community’s trust in paramedics;
2. public protection; and
3. the need to reflect contemporary practice of Australian paramedics.

Each objective will be explored further below.

**Enhancing trust**

Trust has been acknowledged as an important factor in the regulation of paramedicine. In a speech before the South Australian Legislative Council, the Honourable I K Hunter identified that paramedics create a relationship of trust when treating patients. Because patients tend to trust a paramedic’s competence to practise, decision-making process and referral for care, the additional responsibility means paramedics pose a greater risk of harm to the public. South Australia’s parliament used protection of title as a public protection measure and deemed statutory regulation, in the form of title

76 Australian Health Ministers’ Advisory Council, ‘Consultation paper: Options for regulation of paramedics' (Health Workforce Principal Committee, July 2012) 9.
77 Ambulance Service Act 1991 (Qld) s 3A; Health Services Act 1997 (NSW) s 67B; Ambulance Services Act 1986 (Vic) s 23; Emergencies Act 2004 (ACT) s 40; Ambulance Service Act 1982 (Tas) s 4; Health Care Act 2008 (SA) s 49.
78 Protection of title restricts the use of certain professional titles to those qualified to use them and is a notable feature of Australian paramedic regulation addressed in chapter 3 of this thesis.
79 South Australia, Parliamentary Debates, Legislative Council, 31 October 2013, 5537 (I K Hunter).
80 Ibid.
protection provisions, as necessary to reduce harm to the public. Title protection is further discussed in Chapters 4 and 6.

**Public protection from harm**

Public protection has also been identified as a key purpose of paramedic regulation. The need to regulate commercial ambulance providers and prescribe educational qualifications for paramedics were the justification behind the Tasmanian Government legislating for paramedic protection of title.\(^{81}\) Public safety issues which arise as a result of the current paramedic regulatory framework are considered further in Chapters 5 and 6 of this thesis.

**Reflecting contemporary practice**

Another objective of paramedic regulation is the need to reflect contemporary practice. Contemporary practice refers to the current role of Australian paramedics, as opposed to their historical role as noted in Chapter 1. Paramedics are highly skilled practitioners responsible for patients’ pre-hospital diagnosis, treatment, advice and transport. While Chapter 4 further examines the significant historical evolution of paramedics from the days of “stretcher-bearers” and “ambulance drivers” where only minimum first aid experience was needed, it is necessary to point out here that paramedicine has progressed to a point where contemporary practice involves tertiary qualified practitioners performing invasive medical treatments and administering dangerous drugs. Tasmania, for example, acknowledged the significant progress of the industry in their new protection of title provisions, and acknowledged that regulation should also progress to reflect contemporary paramedicine.\(^{82}\) This resulted in protection of title regulatory mechanisms for Tasmanian paramedics.

Although they have been presented here separately, the objectives of building trust, protection of title and reflecting contemporary practice are not mutually exclusive. For instance, the New South Wales legislative amendments to protect title, introduced in 2015, span all three of the abovementioned themes. The New South Wales protection of title provisions were designed to protect the reputation and professionalism of paramedics and ensure paramedics are appropriately qualified to protect the community. Further, the advances in medical technology mean paramedics can now transfer that medical knowledge to community-based treatment. Interestingly, the Honourable Ernest Wong acknowledged that law was ‘largely symbolic, with limited practical application’.\(^{83}\) The Legislative Council discussions of the Health Services Amendment (Paramedics) Bill 2015 (NSW) also highlighted frustration within parliament with the New South Wales Government’s refusal to agree to a national system of registration for paramedics. Reasons given for this refusal to join the national paramedic

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\(^{81}\) Tasmania, *Parliamentary Debates*, Legislative Council, 26 September 2013.

\(^{82}\) Ibid.

\(^{83}\) New South Wales, *Parliamentary Debates*, Legislative Council, 26 August 2015, 2818 (Ernest Wong).
registration have not been publically acknowledged in parliament. The lack of transparency was highlighted by the Honourable Daniel Mookhey who commented:

This government could do more to aid recognition of the professionalism of the paramedic service. For example, New South Wales could join the national system of registration for paramedics… What is the reason for the Government’s refusal? If the Minister for Health has reasons, she is not sharing them with the Parliament… 84

In should also be noted that the ambulance legislation, apart from provisions restricting the use of paramedic and ambulance-related titles, serve no further purpose in the regulation of paramedics. Currently, all they do is provide for the establishment and governance of the public ambulance services and related matters. As a consequence of this, regulation of paramedic conduct relies heavily on the employment relationship between public ambulance services and the paramedics they employ, with minor assistance from supplementary regulation such as drug legislation.

**Market monopoly**

Given the limited statutory regulation which exists in the paramedic industry, it is difficult to determine whether existing regulation is serving its purpose. As such, we need to speculate on objectives within the existing regulatory structure. As previously mentioned in Chapter 1, employers largely govern paramedic conduct across Australia. Preventing market failure could be one of the existing paramedic regulatory framework objectives, and preventing market failure is a reason for government intervention into a market through regulation. 85 Governments intervene with market monopolies because a market monopoly might ordinarily cause market failure if there are too few suppliers for the market to be competitive. 86 To consider paramedic regulation from an economic perspective, the state and territory governments have something of a market monopoly over ambulance services. There is a single ambulance service in each jurisdiction and private organisations can only encroach on providing ambulance transport with government authority (they can still provide private services without the government authority in many cases). This creates a market monopoly because the public ambulance services produce resources for the entire industry. 87

While a market monopoly might ordinarily cause market failures and, therefore, establish a need for government intervention, the ambulance market works differently. I argue that public ambulance services are a natural monopoly which have different implications under regulatory theory. A natural monopoly occurs when a market can be most efficiently managed through a single firm, rather than

84 Ibid 2819 (Daniel Mookhey).
86 Freiberg, *The Tools of Regulation*, above n 2, 8.
multiple firms, so the market failure problem does not apply.\textsuperscript{88} Given ambulance services are an essential emergency and public service, the monopoly has the opposite effect of allocating emergency resources for ambulance services which may not otherwise be available if multiple firms flood the market. It may be untenable to introduce external organisations to the public ambulance services because ambulance services provide emergency services which may be more difficult to manage if multiple firms are involved. Further, private firms may not receive the monetary returns needed to make the business viable, particularly as the consumers (the patients) may not be able to pay for the service, or it would be fiscally unattractive to the government to support every single service. As such, the existing market monopoly must remain.

However, regulating ambulance services is very different to regulating its paramedics. Monopolies exist for the industries or markets, not for the employees.\textsuperscript{89} As such, paramedic regulation within the industry does not need to be restricted through the existing market monopoly. In order to protect the public and enhance public trust in the profession, the theoretical arguments in favour of ambulance services retaining their natural monopolies should not apply to paramedics. This is significant to this thesis as the regulatory framework I propose, that paramedics should be included as an additional profession under the National Scheme, removes paramedicine from government regulation (and the monopoly which applies) and redirects their governance to a co-regulatory framework which incorporates an element of industry governance, in the form of National Boards. The role of National Boards is further discussed in Chapter 7 of this thesis.

Problems exist with employers acting as the paramedic regulatory body. A conflict of interest between the role of employer and government arises as employers become solely responsible for regulating industry standards. It is reasonable to suggest the employer’s self-interest is a primary consideration in regulation of employees and the ambulance industry is no different. Despite the fact that the primary employers are government organisations, the private paramedic industry still functions to provide ambulance services. Without an external regulator, private employers could choose outcomes which favour organisational self-interest rather than public safety, such as less rigorous disciplinary investigations.

Further, employer regulation could conflict with a paramedic’s right to practise paramedicine. If the employers are responsible for placing restrictions on a paramedic’s right to practise, this can lead to restrictions on the paramedic’s \textit{ability} to practise their profession as paramedics cannot exercise their full knowledge and skills independently of their employer.\textsuperscript{90} If the regulatory body was independent of

\textsuperscript{88} Baldwin, Cave and Lodge, \textit{Understanding Regulation}, above n 1, 443-4.
\textsuperscript{89} Ibid 15-6.
employers, a right to practise may not be an issue as paramedic skills and knowledge would not be limited to use within a single employer organisation. However, Boyle et al.’s\textsuperscript{91} argument of a right to practise may not necessarily be the most persuasive position to be arguing since health professionals should only be practising their discipline with appropriate knowledge, skills, training and education. There is no right to practise as paramedics’ privilege to practise should be based upon their competency.

2.3 An overview of the regulatory frameworks for paramedic practice

Having set out the objectives of paramedic regulation in 2.2, this part of the chapter focuses on different regulatory tools used to regulate paramedics. There are a variety of statutory and non-statutory tools used to regulate paramedic practice in Australia. Legal regulation is one of the tools used in the regulation of Australian paramedicine. The legislation governs ambulance services, as a general industry, rather than the conduct or responsibilities of individual paramedics. There are, however, limited statutory instruments that address the conduct of individual paramedic practitioners, such as:

1. statutory codes of conduct; (discussed in 2.4.3)
2. public complaints procedures; and (discussed in 4.5)
3. drug regulation (discussed in 4.4).

In addition, employer organisations are responsible for setting standards of practitioner behaviour. As such, paramedicine is employer-regulated with an element of government regulation, in the absence of coherent and uniform statutory regulation.

Paramedics are regulated by different bodies. State and territory governments generally administer ambulance services. There is also a growing number of privately employed paramedics who work independently of state and territory governments. As will be discussed in Chapter 4, research indicates that approximately 40 per cent of the paramedic workforce are currently practising privately outside the public ambulance services.\textsuperscript{92} As a consequence of the expanding private sector paramedic workforce, the current regulatory structure imposed on the paramedicine industry is piecemeal and inconsistent because it imposes differing functions, requirements and responsibilities on paramedics, depending on the employer.

State and Territory Regulation

The public ambulance system is legislatively regulated to establish and govern the functions of the public ambulance services. Six of Australia’s eight jurisdictions have ambulance or health specific

\textsuperscript{91} Ibid.
legislation governing paramedic practice. While the legislation generally establishes the public Ambulance Services and describes their functions, it does not regulate the practice of paramedicine in any detail. The state ambulance services in Queensland, New South Wales, Victoria, South Australia and Tasmania are part of each state’s Department of Health portfolio under direct control of the Health Minister. The Australian Capital Territory’s (ACT) Ambulance Service is presided over by the ACT Emergency Services Agency and reports to the ACT Minister for Police and Emergency Services. These government bodies are the primary employers of paramedics in the community.

As mentioned above, public ambulance services function in each state and territory. The organisations employing a majority of Australian paramedics are, in fact, the public ambulance services:

1. Queensland Ambulance Service;
2. Ambulance Service of New South Wales;
3. Ambulance Victoria;
4. Australian Capital Territory Ambulance Service;
5. Ambulance Tasmania; and

The Northern Territory and Western Australian governments do not have a public ambulance service and contract their emergency services to St John Ambulance, an incorporated not-for-profit organisation. While St John Ambulance in Western Australia receives some state government funding, it is primarily funded by patients paying fees for its services. Western Australia and Northern Territory, without a public ambulance service, do not have ambulance specific legislation as do the other states and territories.

93 *Ambulance Service Act 1991* (Qld); *Health Services Act 1997* (NSW); *Ambulance Services Act 1986* (Vic); *Emergencies Act 2004* (ACT); *Ambulance Service Act 1982* (Tas); *Health Care Act 2008* (SA). The Northern Territory and Western Australia contract their public emergency service to St John Ambulance.


97 Senior citizens are excluded from paying ambulance fees. Private health insurance covers this cost for patients who are subscribers: Government of Western Australia, ‘St John Ambulance Inquiry: Report to the Minister for Health’ (Department of Health, October 2009) 15.
Employment Contracts

At present, the principal mechanism for regulating paramedics in Australia is the employment relationship. Employment law operates on a number of levels. Australian workers can be regulated by registered agreements, awards, contractual agreements and legislative obligations. Enterprise or registered agreements are an agreement between an employer and employees which are then registered under the *Fair Work Act 2009* (Cth). Registration under the *Fair Work Act* makes the contracts enforceable. This means that contractual agreements determine conditions of employment between individual paramedics and their employer, the public ambulance service or a private organisation. Finally, legislative obligations regulate the individual employment relationship by providing an avenue for enforcement of employment obligations.98

Paramedics, in every Australian jurisdiction, are regulated through instruments governing the employment relationship, most notably enterprise agreements and awards.99 Awards set out minimum conditions for workers in an industry, such as paramedicine, and breaches of award conditions often lead to the imposition of penalties. These awards, agreements or determinations provide terms and conditions of employment as well as identifying their role in conjunction with clinical governance policy documents. Therefore, the industrial instruments are a regulatory mechanism for paramedics as they enable employers to govern their scope of practice, as well as enforcing minimum training and educational requirements for employees. These documents differ between jurisdictions which makes a comparison between all of the industrial instruments applicable to paramedics difficult.

It is worth noting here, that only the public ambulance services industrial documents will be considered in this thesis. There are too many private employers to compare all industrial documents which exist for Australian paramedics. For example, in 2011, there were an estimated 4,500 paramedics employed with 122 permanent private sector employers, not including those organisations who only employ paramedics on a casual or intermittent basis.100 It is likely the number of private paramedic employers has increased since that time. While the private industry is growing, with more paramedics employed privately than ever before, the majority of paramedics are still employed within the public industry.101

As such, only instruments from the public ambulance services, as the primary employers, will be

100 Paramedics Australasia, above n 92, 5-6.
101 Australian Health Ministers’ Advisory Council, ‘Consultation paper: Options for regulation of paramedics’ (Health Workforce Principal Committee, July 2012)76.
considered in this thesis as they are still the largest employers and can provide a thorough outline of the employment relationship in each of the jurisdictions.

In the following paragraphs, the specific tools of paramedic regulation will be discussed including enterprise agreements, awards and organisational policy providing for workplace regulation of paramedics. Codes of conduct, prescribed legislatively, which are applicable to paramedics in some jurisdictions will also be examined.

2.4.1 Workplace industrial regulation of paramedics

Industrial instruments governing all conduct in the workplace cover most paramedics in Australia. The significance of describing the workplace industrial instruments, to this thesis, is that workplace instruments govern the disciplinary procedures applicable to paramedics who are not fit to practise. As we will see in the following table, the public ambulance services’ industrial instruments, including minimum educational requirements and continuing professional development, primarily govern paramedic conduct. Disciplinary measures applicable to paramedics are considered more fully in Chapter 4.

Table 2.1 outlines the various state and territory industrial instruments. These instruments are only applicable to the paramedics employed under the state and territory ambulance services and do not apply to privately employed paramedics.
<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Industrial Instrument</th>
<th>Educational requirements</th>
<th>Continuing Professional Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Capital Territory</td>
<td><em>ACT Public Service Justice and Community Safety Directorate ACT Ambulance Service Enterprise Agreement 2013-2017</em></td>
<td>The minimum qualification for paramedics is a Diploma of Paramedical Science (Ambulance, or equivalent, with Intensive Care Paramedics requiring an Advanced Diploma.102</td>
<td>Does not stipulate requirements for continuing professional development.</td>
</tr>
<tr>
<td>New South Wales</td>
<td><em>Operational Ambulance Officers (State) Award</em></td>
<td>A paramedic is defined as ‘an employee who has successfully completed the necessary and relevant training and work experience determined by the Service’ and is appointed to a position.103 Minimum training and educational requirements for paramedics are prescribed in delegated legislation.104</td>
<td>A clinical certificate to practise is reissued every three years. This is not further regulated in the Award.</td>
</tr>
<tr>
<td>Northern Territory</td>
<td><em>St John Ambulance (NT) Inc. Ambulance Enterprise Agreement 2010-2013</em></td>
<td>Educational requirements are not specified.</td>
<td>The Agreement contains no continuing professional development requirements, aside from requiring paramedics to hold an “Authority to Practise”, but agrees to support training and development relevant to employment as a paramedic.105</td>
</tr>
<tr>
<td>Queensland</td>
<td><em>Ambulance Service Employees Award 2016</em> and <em>Queensland Ambulance Service</em></td>
<td>A paramedic, according to the Queensland Award, is an employee providing high standards of pre-hospital emergency patient care and provides ambulance transport services to the community. Paramedics must have completed an equivalent qualification of Associate Diploma of Applied Science (Paramedic) or Diploma of Health Science (Pre-hospital Care).108 A Critical Care Paramedic requires the additional completion</td>
<td>Paramedics are required to maintain their skills and currency through a Certificate to Practise, with the potential of reductions in pay when this requirement is not met; there are no guidelines stipulating appropriate continuing professional development</td>
</tr>
</tbody>
</table>

103 *Operational Ambulance Officers (State) Award* (New South Wales, 26 February 2014) [1.5].
104 Qualifications include a Bachelor of Paramedicine; university conferred Graduate Diploma of Paramedicine; or a nationally-recognised, registered training organisation issued Diploma of Paramedicine: *Health Services Regulation 2013* (NSW) s 19A.
105 *St John Ambulance (NT Inc. Ambulance Enterprise Agreement 2010-2013* (10 October 2011) [33.13], [45.1].
106 The Queensland Industrial Relations Commission authorises Queensland awards under the *Industrial Relations Act 1999* (Qld).
108 Further, the instrument does not provide minimum tertiary standards. The rationale for this could be that some paramedics are not tertiary qualified, having commenced practise when on-the-job training was sufficient. Chapter 3 outlines the evolution of the industry, including how the education and training system has progressed.
<table>
<thead>
<tr>
<th>State</th>
<th>Agreement Title</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Australia</td>
<td>SA Ambulance Service Enterprise Agreement 2011</td>
<td>Level 2 paramedics are ‘base line autonomous ambulance clinicians’ holding the equivalent of a Bachelor of Health Science (Paramedic) and have completed a 12-month internship. These paramedics must be able to exhibit time-critical patient intervention, make complex and critical professional judgments and accept accountability for their decisions.</td>
</tr>
<tr>
<td>Tasmania</td>
<td>Tasmania Industrial Agreement 2016</td>
<td>A Paramedic must hold a Bachelor of Paramedic Science and relevant work experience, or other qualification, as approved by Ambulance Tasmania.</td>
</tr>
<tr>
<td>Victoria</td>
<td>Victoria Enterprise Agreement 2015</td>
<td>Basic and Advanced Life Support Ambulance Paramedics have completed a Bachelor of Health Science (Paramedic) or “equivalent accredited qualification”. Mobile Intensive Care Paramedics have attained a Graduate Diploma in Emergency Health (Intensive Care Paramedic) or equivalent qualification.</td>
</tr>
</tbody>
</table>

107 The Queensland Determination applies to all QAS employees. The Determination is a way for the employer to create an industrial enterprise-type agreement which was binding on the employees, in the absence of negotiating an enterprise agreement. It contains the standard workplace information such as pay rates, work hours, and holiday provisions, among other things. It is meant to be read in conjunction with the Queensland State Award in operation at the time and provides entitlements and conditions of employment for Queensland Ambulance Service employees. It does not provide any other definitions or clarification of the skill and educational requirements for paramedics above the information provided in the Queensland Award.

109 Ibid.

110 Ibid.

111 SA Ambulance Service Enterprise Agreement 2011 (3 February 2012) 29. There are also 14 other key indicators which level 2 paramedics must exhibit to be able to progress to higher pay rates.

112 Ibid [36].

113 Ibid specifies the current Authority to Practise for South Australian paramedics includes 160 road hours, completion of online training packages, 13 reflective case reviews and four professional development workshops.
Western Australia

Western Australia St John Ambulance Australia (Western Australia) Inc Ambulance Officers'/Paramedics Enterprise Agreement 2011-2014 Educational requirements are not specified.

The WA Agreement specifies all employees, including ambulance officers/paramedics must undertake a minimum of four days of continuing professional development over a period of two years which will be scheduled during work hours.

| Western Australia | St John Ambulance Australia (Western Australia) Inc Ambulance Officers'/Paramedics Enterprise Agreement 2011-2014 | Educational requirements are not specified. | The WA Agreement specifies all employees, including ambulance officers/paramedics must undertake a minimum of four days of continuing professional development over a period of two years which will be scheduled during work hours. |

A few important observations can be made about the application of industrial instruments to paramedics. The main focus of the instruments are standards of training and education of paramedics, particularly around continuing professional development and minimum educational requirements for entry to the discipline. In relation to the minimum educational standards for entry, some state and territory legislation, to be discussed more thoroughly in Chapter 3, includes minimum educational standards (e.g. Bachelor of Paramedic Science) as part of their protection of title provisions. However, there is no minimum uniform standard of tertiary education which operates across all employers and jurisdictions for Australian paramedics. Standards range from diploma level qualifications to tertiary qualifications in other jurisdictions. As we saw earlier, in Queensland, tertiary education is not a requirement within the instrument. However, in Tasmania and Victoria, for example, tertiary education is specified as a requirement. All jurisdictions with required tertiary qualifications, as a minimum, qualify the requirement with the “equivalent of” a Bachelor’s degree. This allows for paramedics without tertiary qualifications to continue their practice with their current industry experience.

Further, practice and continuing professional development provisions of employer agreements raise similar concerns about the lack of consistency. There is sometimes an absence of these regulatory requirements in some jurisdictions, such as no professional development requirements for a specific number of hours completed on a yearly basis. Given the employer is responsible for issuing an authority to practise, or monitoring continuing professional development, there is no state-wide, or national consistency. Where statutory provisions do not exist, employers are also responsible for prescribing minimum educational requirements, such as a Diploma of Paramedicine. Given the private industry is governed through employer regulation, employers are responsible for prescribing conditions of practice and continuing professional development requirements. One possible consequence is that private employers may not be as rigorous in demanding continuing professional development be undertaken.

115 St John Ambulance Australia (Western Australia) Inc Ambulance Officers’/Paramedics Enterprise Agreement 2011-2014 (18 January 2012) [9.2(b)].
which could result in standards of conduct falling below that reasonably expected by some of the public paramedic employers who require continuing professional development for maintaining competency.

2.4.2 Paramedicine’s clinical policies

In addition to industrial instruments, clinical practice governance documents provide direction on the roles and responsibilities of paramedics while employed within their respective public ambulance service. Each public ambulance provider\textsuperscript{116} has a governance document specifying clinical procedures and guidelines for paramedics working within the organisation.\textsuperscript{117} These clinical policy documents are not part of the employment contract but apply to paramedics employed by the public ambulance services. The policy documents detail contemporary and acceptable standards of clinical care for use by paramedic employees. More specifically the documents outline procedures that can be performed by paramedics of each skill level and they provide the available drugs, and dosages, for the paramedic. Despite the policies being comprehensive in nature, they are also largely discretionary and paramedics can sometimes perform procedures beyond the policy’s specifications following medical consultation. Table 2.2 provides an example of the clinical skills for paramedics in some Australian jurisdictions.

\begin{footnotesize}
\begin{itemize}
\item\textsuperscript{116} Queensland Ambulance Service, Ambulance Service of New South Wales, Ambulance Victoria, Australian Capital Territory Ambulance Service, Ambulance Tasmania, South Australian Ambulance Service, St John Ambulance Australia (Northern Territory) and St John Ambulance Australia (Western Australia).
\end{itemize}
\end{footnotesize}
<table>
<thead>
<tr>
<th>Clinical Skills</th>
<th>ACP1</th>
<th>ACP2</th>
<th>CCP</th>
<th>P</th>
<th>ICP</th>
<th>P</th>
<th>ICP</th>
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<tbody>
<tr>
<td>12 Lead ECG</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>Arterial line insertion</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>Chest decompression</td>
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<td></td>
<td>X</td>
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<tr>
<td>External jugular intravenous cannulation</td>
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<tr>
<td>Fracture reduction</td>
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<td>X</td>
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<tr>
<td>Intravenous drug/fluid administration</td>
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<td>X</td>
<td>X</td>
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<td>Manual defibrillation</td>
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<td>X</td>
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<td>Nasopharyngeal airway insertion</td>
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<tr>
<td>Non-invasive ventilation – CPAP</td>
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<td></td>
<td>E</td>
<td>X</td>
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<td>Oral endotracheal intubation</td>
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<td>Orogastric tube insertion</td>
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<td>Procedural sedation</td>
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<td>Skin stapler</td>
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<td>Subcutaneous drug/fluid administration</td>
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<td>Surgical cricothyrotomy</td>
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<td>Thorocostomy</td>
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<td>E</td>
</tr>
<tr>
<td>Tooth replantation</td>
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<tr>
<td>Transcutaneous cardiac pacing</td>
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<td>Valsalva manoeuvres</td>
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<td>X</td>
</tr>
</tbody>
</table>

Table of abbreviations used

- **ACP1**: Advanced Care Paramedic – level of qualification and experience approved by QAS
- **ACP2**: Advanced Care Paramedic – level of qualification and experience approved by QAS
- **CCP**: Critical Care Paramedic
- **E**: Approved Extended Scope of Practice
- **ICP**: Intensive Care Paramedic
- **P**: Paramedic or Ambulance Paramedic
- **X**: Within Scope of Practice

*Table 2.2 Non-exhaustive jurisdictional skills comparison*

119 Ambulance Tasmania, Clinical Practice Guidelines for Paramedics and Intensive Care Paramedics, above n 117.
120 St John Ambulance Service Northern Territory, Clinical Practice Manual, above n 117.
121 This list is designed to provide examples, only, of some of the clinical skills of Australian paramedics. The Queensland, Tasmanian and the Northern Territory ambulance services provided a list of skills, for their paramedics, within their authority to practise guidelines. The lists provided were not directly comparable to each other so there may be skills missing, from the table, which are within the scope of paramedics’ skills in that jurisdiction. The other states and territories did not include an express list so were not included in this comparison.
The clinical policies are significant as they provide a standard of patient treatment for paramedics within their employer organisation. In so doing, they regulate the way paramedics can treat patients. These documents contribute to the risk mitigation purposes of health professional regulation as they provide treatment guidelines and restrictions on paramedic scopes of practice. While there are publicly and privately employed paramedics, only public ambulance service policies have been considered within the range of this research as private policy is difficult to access as well as provide too broad a scope.

The clinical policies issued by the public ambulance providers are comparable to documents used by other emergency services. For example, the Queensland Police Service Chief Commissioner’s Standing Orders form part of the employment arrangement between police and their employers, in the same way as ambulance policy. As such, the clinical guidelines are a useful employment regulatory tool and are a way for the public ambulance employers to control the conduct of their paramedic employees. Clinical policies authorise the procedures paramedics can perform (such as sedation), outline when paramedics need to consult with a medical practitioner (such as particular drug administration during pregnancy), and also provide guidance on drug dosages and administration. However, even if regulation of the industry changed to incorporate a system of national registration, it is not envisaged the policies would be affected as they are a standard publication of employer organisations.

Queensland’s Clinical Practice Manual (CPM) illustrates the nature of ambulance policy for the purpose of regulation. The CPM is the Queensland ambulance policy which incorporates Clinical Practice Guidelines covering clinical conditions and situations, the Clinical Practice Procedures incorporating clinical procedures for paramedics treating patients and the Drug Therapy Protocols which govern paramedic use of pharmacological agents. It applies to Queensland public paramedic employees only. Another governance document, Queensland Health’s Primary Clinical Care Manual, guides service delivery of clinical care in rural and remote locations for paramedics; however, it also guides nurses and other healthcare practitioners, unlike the CPM. The other Australian states and territories, including the Northern Territory and Western Australia, have similar clinical guidelines as part of the employment arrangement.

The role of a jurisdiction’s publicly employed paramedics is outlined in the organisation’s clinical policies. Queensland and Northern Territory paramedics, for example, employed by their public ambulance service have specified roles set out in their respective policies. Their tasks are identified as:

i. The assessment and prioritisation of the patient’s immediate and definitive needs;

table. As clinical skills are beyond my expertise, I did not investigate the clinical skills in these jurisdictions, or the other jurisdictions, further.

122 Police Service Administration Act 1990 (Qld) s 4.9.
124 State of Queensland (Queensland Health) and the Royal Flying Doctor Service (Queensland Section), Primary Clinical Care Manual (8th ed, 2013)117.
ii. Delivery of the appropriate immediate care; and

iii. The time effective organisation of ‘definitive care’.

The purpose of these clinical policies is internal organisational regulation prescribing procedures for employees to follow in a range of circumstances. Some public ambulance services (e.g. Queensland Ambulance Service) make these documents publicly available, while others (e.g. South Australian Ambulance Service) do not release the contents of their policies to the general public. Employees of the relevant ambulance services are required to follow the guidelines and are responsible for keeping their clinical knowledge consistent with the policy requirements of patient care.

Some clinical policies are enforceable through the workplace industrial instruments in the form of disciplinary action. The Australian Capital Territory, for example, prescribes a range of sanctions for misconduct including demotion and a financial penalty. It is unknown whether a breach of clinical policies constitutes misconduct for the purposes of workplace industrial instruments as the instruments do not define misconduct or provide further guidance on discipline for breaching clinical policy. Misconduct and discipline are considered further in Chapter 3.

2.4.3 Codes of conduct for paramedic compliance

Codes of conduct governing paramedic behaviour provide another regulatory tool for Australian paramedics. Codes of conduct are, in large part, a consumer protection mechanism, designed to promote public safety by focusing on practitioners’ behaviour. A range of disciplines have codes of conduct governing their behaviour, including, for example, medical practitioners and nurses. Unregistered health practitioners, such as paramedics, have different codes of conduct to monitor their behaviour than those health practitioners registered under the National Law. An unregistered health practitioner includes any person providing a health service but not practiseing a regulated profession recognised under the National Law in the relevant state or territory. The codes of conduct applicable to health practitioners can be statutory or non-statutory and are not always binding or enforceable. Further, the applicable codes of conduct differ between jurisdictions and employers.

Some jurisdictions require compliance with a code of conduct for paramedics. When this occurs, a degree of regulatory control exists. One of the notable features of these codes of conduct are their

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128 State Service Act 2000 (Tas).
130 Wardle, above n 127, 352.
enforcement mechanisms, ensuring paramedics are accountable for their actions. When outlining the regulatory framework of Australian paramedics, these codes of conduct play a crucial role because they outline minimum standards of behaviour and provide enforcement tools when those standards are breached. However, as will be discussed in this part, there is significant jurisdictional disparity between the enforceability of paramedic behaviour, through codes of conduct.

When the codes of conduct have enforcement mechanisms, they can be a regulatory tool in the form of negative licensing. Negative licensing is a regulatory concept that does not restrict entry to the profession but provides avenues to take action against a practitioner who fails to comply with the standards of conduct.\textsuperscript{131} If a code of conduct is breached, limitations can be applied to a practitioner’s future conduct in the form of suspension or prohibition orders.\textsuperscript{132} Negative licensing is a tool of paramedic regulation because the codes of conduct, in participating jurisdictions, impose sanctions on paramedics for contravening the codes of conduct. The codes of conduct are set out in Table 2.3 and New South Wales will be considered by way of example.

New South Wales prescribes an enforceable code of conduct applicable to paramedics. Section 100 of the \textit{Public Health Act 2010} (NSW) allows codes of conduct to be prescribed for health practitioners providing health services who are not registered under the \textit{National Law}. The New South Wales code of conduct applies to health practitioners providing a health service, which includes an ambulance service, whether in a public or private setting.\textsuperscript{133} Paramedics, therefore, fall within the scope of this provision. The code sets out a number of requirements for paramedics to comply with including:

1. providing ethical and safe services;
2. adopting standard precautions for infection control;
3. ensuring appropriate conduct when providing treatment advice including not making claims to cure certain serious illnesses, such as cancer;
4. avoiding practising under the influence of alcohol, drugs or other conditions detrimentally affecting their ability to practise;
5. avoiding financial exploitation of clients or engaging in sexual or improper personal relationships with clients;
6. having a clinical basis for treatment; and
7. maintaining insurance, appropriate records and privacy in accordance with the law.\textsuperscript{134}

\begin{itemize}
  \item Ian Freckelton, 'Legal Implications for Complementary Medicine Practitioners of the New South Wales Health Practitioner Code of Conduct' (2013) 20 \textit{Journal of Law and Medicine} 734, 737.
  \item \textit{Public Health Regulation 2012} (NSW) reg 99, sch 3.
  \item Ibid sch 3.
\end{itemize}
New South Wales legislation provides sanctions for breaches of the statutory code of conduct. Paramedics found breaching the code of conduct can be: prohibited from working as a paramedic for a specified time, or permanently; have conditions placed on employment; or, be given a public warning.\(^{135}\) Any paramedic who breaches the imposed sanctions could be subject to a maximum penalty of 12 months imprisonment and/or a $22,000 fine.\(^{136}\)

However, there is an additional code of conduct for public service employees which does not apply a negative licensing framework. Employees of New South Wales Health, which incorporates the Ambulance Service of NSW, must also comply with a further code of conduct. This code of conduct is a policy requirement, rather than a statutory one, and only applies to public sector employees. Pursuant to the code of conduct, paramedics must: promote a positive work environment; demonstrate honesty and integrity; act professionally and ethically; use official resources lawfully, efficiently and only as authorised; maintain security of confidential and/or sensitive official information; and maintain professional relationships with patients or clients.\(^{137}\) Breaches of the policy can result in workplace disciplinary action.

Codes of conduct also exist in other jurisdictions, such as South Australia and Tasmania. The notable features of each code are summarised in Table 2.3.

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Applicability to paramedics</th>
<th>Notable features</th>
<th>Sanctions for breach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Capital Territory</td>
<td>No code of conduct applicable to paramedics.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northern Territory</td>
<td>No code of conduct applicable to paramedics.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Queensland</td>
<td>Queensland legislation allows for the creation or adoption of other jurisdictions’ codes of conduct, although no code currently exists for unregistered health practitioners.(^{138})</td>
<td>Modelled on the NSW code so contains the same features as New South Wales.(^{139})</td>
<td>Enforcement of the codes of conduct in South Australia is also available under a negative licensing framework. After an investigation in South Australia, if there is reasonable belief the code of conduct has been breached, the paramedic can face interim action of a suspension from work for a period of up to 12 weeks, or final action involving suspension</td>
</tr>
</tbody>
</table>

\(^{135}\) Health Care Complaints Act 1993 (NSW) s 41A (1)-(2).

\(^{136}\) Public Health Act 2010 (NSW) s 102(3); Crimes (Sentencing Procedure) Act 1999 (NSW) s 17.


\(^{138}\) Health Ombudsman Act 2013 (Qld) s 288.

\(^{139}\) Health and Community Services Complaints Regulations 2005 (SA) reg 5A, sch 2.
encompasses the private sector as well. for any period of time, including for an indefinite period. The South Australian Ambulance Service must also be notified of the breach and a public statement can be made giving warnings about the paramedic. If the paramedic continues to provide health services after the suspension is effective, they can face up to two years imprisonment and/or a $10,000 fine. However, no express obligations exist for private ambulance employers to be notified of a code of conduct breach, suggesting the negative licensing model in South Australia is limited to publicly employed paramedics only.

| Tasmania | Applies to publicly employed paramedics. | Employees must: behave honestly and with integrity; act with care and diligence; treat everyone with respect and without harassment, victimisation or discrimination; comply with Australian law; maintain confidentiality; disclose and avoid conflicts of interest; use Tasmanian Government resources appropriately; must not knowingly provide false or misleading information; must not make improper use of information or their position to gain advantage, gift or benefit; declare any gifts received; uphold the State Service Principles; behave in a way not adversely affecting the integrity and good reputation of the State Service; and comply with conduct requirements prescribed by the regulations. | A Tasmanian public service employee, who has breached the Code of Conduct, can be liable for workplace sanctions including counselling, reprimand, reassignment in duties, demotion or termination of duties. Fines are not imposed on employees except by way of salary deduction. |
| Victoria | No code of conduct applicable to paramedics. |  |
| Western Australia | No code of conduct applicable to paramedics. |  |

*Table 2.3 Code of conduct features*

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140 *Health and Community Services Complaints Act 2004* (SA) ss 56B (1)-(2), 56C (1)-(2)(b).
141 Ibid ss 56B (3), 56C (2)(c), 56D.
142 Ibid ss 56B, 56C.
143 *State Service Act 2000* (Tas) s 9.
144 Ibid s 10.
In addition to legislative codes which exist in some Australian jurisdiction, a draft National Code of conduct has been proposed for health care workers. This would set minimum standards of professional conduct. The code would apply to registered and unregistered health practitioners, and would be legally enforceable. Paramedics are explicitly listed as an interest group within the National Code. The Australian Health Ministers Advisory Council, in Victoria, has taken responsibility for drafting the provisions of the National Code. Until paramedics are included in a National Code of Conduct, there will be disparity between jurisdictions.

Paramedics Australasia prescribes a voluntary code of conduct for its members. Paramedics Australasia encourages paramedics to maintain high standards of integrity, respect for the client, responsibility/accountability for professional decisions, competence in professional practice, informed consent for patient care, confidentiality, support for research and participation in ethical review. These are voluntary suggestions so there is no requirement for paramedics to maintain the criteria as minimum standards, nor are there penalties for contravention.

The Australian and New Zealand College of Paramedicine (ANZCP) also promotes a voluntary code of conduct. The Australia and New Zealand College of Paramedicine is another professional body whose membership comprises paramedics working in any capacity. The organisation provides professional development, research funding opportunities and promotion of the profession to employers, media, politicians and other bodies. Their code of conduct involves paramedics protecting patient rights, including practising in a non-discriminatory way and accepting patient autonomy; promoting quality patient care; maintaining confidentiality; being accountable for professional

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145 The proposed terms of the National Code of Conduct are health workers: should provide services in a safe and ethical manner; obtain consent; undertake appropriate conduct in relation to treatment advice; report concerns about treatment or care provided by other health care workers; take appropriate action in response to adverse events; adopt standard precautions for infection control; diagnosed with infectious medical conditions practises in a manner that does not put clients at risk; not to make claims to cure certain serious illnesses; not to misinform clients; not to practise under the influence of alcohol or drugs; must not provide treatment to clients while suffering from a physical or mental impairment, disability, condition or disorder that is likely to place clients at risk of harm; must not financially exploit clients; must not engage in sexual misconduct; must comply with relevant privacy laws; must keep appropriate records; must be covered by appropriate insurance; and must display the codes of conduct, their qualifications and details of complaints avenues for clients.


147 Ibid 8-9, 11.

148 Paramedics Australasia, formerly known in older literature as the Australian College of Ambulance Professionals, promotes itself as a “national professional association” whose members comprise of paramedics within the community. It is a company limited by guarantee which operates as a professional association to protect the interests of its members. Paramedics Australasia represents paramedics working in the public or private sector in a range of ways including publication on relevant topics, advocacy on industry issues and providing submissions to government bodies and employers on paramedic-related issues. It also supports healthcare research although not a trade union nor is there any requirement for paramedics to become members. Paramedics Australasia, Who we are (2014) <https://www.paramedics.org/our-organisation/who-we-are/>. Also Paramedics Australasia, ‘Health professionals: prescribing pathway’ (Health Workforce Australia, May 2012 2012) <http://www.paramedics.org.au/content/2012/06/Paramedics-Australasia-HPPP-Submission-040612.pdf> 3.


decisions; acting with courtesy and integrity; and maintaining high standards of professional and personal conduct.\textsuperscript{151} Being voluntary, they are mere suggestions for minimum standards for paramedic behaviour.

It is significant that some professional organisations have codes of conduct which are not enforceable. While Paramedics Australasia and ANZCP, as the professional organisations for paramedics, have created codes of conduct, there are no penalties for paramedics who contravene the codes. They are merely suggested guidelines for good conduct which Paramedics Australasia and ANZCP promotes as good practice for the discipline. As such, their effectiveness is limited because there are no policing or enforcement mechanisms.

There are additional concerns for those jurisdictions without a code of conduct, such as Victoria, or for Tasmania whose code of conduct legislation applies to the public service only. Without a code of conduct, there is potential uncertainty regarding the maintenance and discipline of paramedic behaviour. Where paramedics act in a manner that breaches reasonable standards, there are currently no, or very limited, statutory enforcement mechanisms to manage the issues. As such, it is the duty of the employers to ensure those health practitioners are reprimanded. This raises the additional concern of consistency in the discipline. There is no obligation for employers to ensure their employees are adhering to the minimum standards of behaviour prescribed in the codes of conduct. Further, methods of disciplinary action for codes of conduct contravention are not consistent between employers which could cause unfairness for the paramedic employees.

It is not just the absence of codes of conduct that is problematic. The nature and content of codes of conduct can also be critiqued. Negative licensing has been criticised for being reactive, rather than proactive, meaning paramedic behaviour can only be regulated following a negative outcome.\textsuperscript{152} This is significant to paramedicine as there is no regulatory tool which can restrict entry to the discipline so the industry relies on the negative licensing frameworks, in some jurisdictions, to respond to issues. While it is more preferable, than not, to have some form of sanctions, the negative licensing provisions do not provide protection from harm.

2.4.4 Codes of ethics for paramedic compliance

In addition to the statutory and voluntary codes of conduct, ethical standards apply to all public sector employees including paramedics employed by their jurisdiction’s public ambulance services. Although, paramedics employed outside the public sector are not required to comply with public sector ethical principles. The public sector ethical principles differ between jurisdictions. There are also consequences for breaching public sector ethical principles in all jurisdictions. These are set out in Table 2.4.

\textsuperscript{151} Ibid.
\textsuperscript{152} Freiberg, \textit{The Tools of Regulation}, above n 2, 150.
<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Ethical principles</th>
<th>Consequences for ethical breaches</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Capital Territory</td>
<td>While paramedics are not expressly listed as an employment group, the ethical guidelines apply to paramedics working in the public sector as they are public employees. Public employees must: exercise reasonable care and skill, act impartially and with probity, treat everyone with courtesy and sensitivity, make reasonable efforts to assist the public to understand their legal entitlements, avoid harassing or unlawfully coercing others, comply with all applicable laws, avoid and declare conflicts of interest, avoid improper use of government property and report corruption, fraudulence or maladministration.</td>
<td>Employees can have their employment terminated if they exhibit behaviour which is considered to be misconduct under their industrial instrument. Chapter 3 considers the ACT’s disciplinary and misconduct policies in further detail.</td>
<td></td>
</tr>
<tr>
<td>New South Wales</td>
<td>NSW paramedics employed in the government sector must comply with the 18 government sector principles classified under four core values: integrity, trust, service and accountability.</td>
<td>Contravention of the New South Wales government sector values can constitute misconduct and can result in a number of sanctions against the employee including employment termination, a fine, demotion or a caution/reprimand.</td>
<td></td>
</tr>
<tr>
<td>Northern Territory</td>
<td>Public sector employees must carry out duties to the best of their abilities; in accordance with legislative and code of conduct requirements; and with objectivity, impartiality, professionalism and integrity. They must also treat others fairly and courteously; ensure effective, efficient and appropriate use of public resources; avoid conflicts of interest; and, ensure their conduct does not affect the performance of their duties or bring the public sector into disrepute.</td>
<td>Breaches of the ethical principles can result in remedial action taken against the employee, including reduction in salary, retraining, counselling, transfer to alternative duties or employment termination. As Northern Territory paramedics do not fall within the public sector, any relevant ethical principles would apply.</td>
<td></td>
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153 *Public Sector Management Act 1994 (ACT)* s 9.
155 The principles come under section 7 of the *Government Sector Employment Act 2013 (NSW)*: ‘consider people equally without prejudice or favour; act professionally with honesty, consistency and impartiality; take responsibility for situations, showing leadership and courage; place the public interest over personal interest; appreciate difference and welcome learning from others; build relationships based on mutual respect; uphold the law, institutions of government and democratic principles; communicate intentions clearly and invite teamwork and collaboration; provide apolitical and non-partisan advice; provide services fairly with a focus on customer needs; be flexible, innovative and reliable in service delivery; engage with the not-for-profit and business sectors to develop and implement service solutions; focus on quality while maximising service delivery; recruit and promote employees on merit; take responsibility for decisions and actions; provide transparency to enable public scrutiny; observe standards for safety; be fiscally responsible and focus on efficient, effective and prudent use of resources.’
157 Ibid s 69.
158 *Public Sector Employment and Management Act (NT)* s 5F.
159 Ibid s 46.
<table>
<thead>
<tr>
<th></th>
<th>obligations for public sector employees do not apply to paramedics.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Queensland</strong></td>
<td>The ethical principles require public sector agencies, entities and officials to show high standards of integrity and impartiality, promotion of the public good, commitment to the system of government and accountability and transparency. Paramedics who are employed by the Queensland Ambulance Service are bound by the public sector ethical principles. Breaches of the ethical principles occur in situations where there is a failure to report conflicts of interest, corruption, substance abuse, improper acceptance of gifts or benefits and improper use of public resources. Enforcement of the ethical principles depends upon the employment status of the public official. Disciplinary action may be undertaken under the Public Service Act 2008 (Qld), local government legislation, industry disciplinary processes or regulations. There are different classifications of public sector employees resulting in differing disciplinary measures. Legislation specifies that industry disciplinary measures will apply for Queensland Ambulance Service employees who breach public sector ethics; workplace industrial instruments detail consequences for breaches.</td>
</tr>
<tr>
<td><strong>South Australia</strong></td>
<td>South Australia’s public sector principles include demonstrating public focus, responsiveness, collaboration, excellence, be an employer of choice, show ethical behaviour and professional integrity and adhere to all legal requirements. Contravening South Australia’s ethical governance can result in the same penalty as New South Wales: employment termination, fine, demotion or a caution/reprimand. In addition to South Australia’s ethical principles, there are additional duties for public sector employees to act honestly in the performance of their duties, with a fine and/or imprisonment resulting for breaching honesty requirements. Further, if an employee fails to disclose a conflict of interest in accordance with legislative requirements, their employment can be terminated.</td>
</tr>
<tr>
<td><strong>Tasmania</strong></td>
<td>Tasmania’s Integrity Commission Act 2009 does not list ethical requirements for the public sector. The State Service Act 2000 (Tas), discussed above, outlines the ethical principles for Tasmanian paramedics.</td>
</tr>
<tr>
<td><strong>Victoria</strong></td>
<td>Victoria lists the public sector values as responsiveness, integrity, impartiality, The Victorian Government can terminate an employee for serious misconduct which is</td>
</tr>
</tbody>
</table>

160 Public Sector Ethics Act 1994 (Qld) ss 6-9.
161 Ibid s 10, sch (definition of ‘public sector entity’).
162 Ibid s 24.
163 Ibid s 27.
accountability, respect, leadership and human rights.\textsuperscript{167} breaching any part of legislation, including the public sector values.\textsuperscript{168}

| Western Australia | Public sector employees must comply with legislative provisions, organisational policies and Commissioner’s Instructions; act with integrity in the performance of their duties; be ‘scrupulous in the use of official information, equipment and facilities; and, exercise courtesy, consideration and sensitivity when dealing with the public and other employees.\textsuperscript{169} The Commissioner’s Instructions further require minimum standards of public sector conduct to comply with the principles of personal integrity, positive relationships and accountability.\textsuperscript{170} | Employees who contravene the public sector ethical principles have committed a breach of discipline and can be liable to a range of sanctions including taking ‘improvement action’, suspension or dismissal.\textsuperscript{171} As Western Australian paramedics do not fall within the public sector, any relevant ethical obligations for public sector employees do not apply to paramedics. |

| Table 2.4 Codes of ethics features |

Finally, employees of private organisations are not bound by any public sector ethical principles. As such, paramedics working for organisations outside their public ambulance services do not need to comply with ethical obligations apart from the enforceable regulatory requirements outlined within their respective workplace industrial instrument.

\section*{2.5 Conclusion}

This chapter has shown that the regulatory frameworks for paramedic practice involve a mixture of employer regulation through workplace industrial instruments and clinical policies, with some statutory regulation through protection of title and codes of conduct. The employer regulatory mechanisms often differs on an organisational level, resulting in different requirements for education and continuing professional development between employers. As paramedics are regulated primarily through their employment relationship, and on a jurisdictional basis, the consequence is that paramedic regulation is currently inconsistent throughout Australia.

This chapter further outlined the government’s role in the regulation of Australian paramedics. Using theoretical concepts, such as responsive regulation, it explored how paramedic regulation often serves employer interests, rather than public interests. Co-regulation was introduced as an important concept in health professional regulation and one which would benefit the paramedic industry. The reliance on employment law to regulate paramedicine does not go far enough to protect the public interest and maintain trust in the standing of the paramedic profession.

\textsuperscript{167} Public Administration Act 2004 (Vic) s 7.
\textsuperscript{168} Ibid ss 22, 33.
\textsuperscript{169} Ibid s 9.
\textsuperscript{171} Public Sector Management Act 1994 (WA) ss 80, 82A.
Statutory codes of conduct and ethics are also used as a regulatory mechanism for Australian paramedics. These codes of conduct provide more specific governance of paramedics, with some enforcement options for breaches of codes of conduct. However, the codes are problematic as a regulatory tool. They are not nationally uniform, provide limited avenues for enforcement and do not apply to every paramedic practising in Australia. Some jurisdictions provide enforceable codes of conduct or ethics for public service employees only, while others have no applicable codes of conduct or ethics for any paramedics working in that jurisdiction.

Having set out the general characteristics of paramedic regulation in this chapter, the regulatory frameworks for Australian paramedic practice will be further explored in Chapter 3. More specifically, Chapter 3 will consider the notable features of paramedic regulation including minimum standards for training and education, protection of title and drug regulation, among other things. Chapter 3 will further highlight the disparity in regulatory mechanisms and the issues which arise for Australian paramedics, employers, the public and other stakeholders.
CHAPTER 3 – BLUE COLLAR WORKER TO WHITE COLLAR PROFESSIONAL:
CHARACTERISING THE MODERN PARAMEDIC

3.1 Introduction

As Chapter 2 established, employers – whether in a public or private capacity – are responsible for
upholding minimum standards in the discipline, with limited statutory guidance. This means that
paramedics are regulated primarily through their employment relationship. However, modern
paramedicine is a discipline that has such an important role in the community, and the role and functions
of paramedics are constantly evolving.

More specifically, and as we will see in this chapter, the evolution of Australian paramedics has
occurred in four broad phases. Firstly, paramedics began as stretcher-bearers who removed wounded
patients from danger. The role of paramedics then evolved so that they became transport workers, in
the form of ambulance drivers. Ambulance drivers transported patients to hospital. In the third phase of
evolution, paramedics became ‘ambulance officers’, requiring some medical training in order to fulfil
their role. Most recently, paramedics have become highly skilled practitioners, in emergency healthcare,
for sick and injured patients. Now, a paramedic’s primary purpose is patient diagnosis, treatment and
advice which is far removed from their historical transport-oriented function. Given the significant
evolution of the discipline, it follows that their regulatory framework should also evolve.

In order to make the argument that paramedic practice has evolved beyond the current employer-based
regulatory framework and towards a more professional health practitioner mode of regulation, this
chapter details the changes in paramedic practice in three parts. The first part of the chapter considers
the distinct phases of stretcher-bearer to driver to paramedic and the impact of these phases on the
discipline’s skills and expertise. Part two then considers how the practices and powers of paramedics
have expanded to incorporate more skilled expertise than ever before. Part three of the chapter identifies
the professional and private practice elements which exist within paramedicine. In doing so, I argue
that it is appropriate for paramedics to be regulated in the same way as other health professions such as
medical practitioners and nurses with similar levels of expertise and skills. In the context of this thesis,
this chapter provides much of the justification for including paramedics in the National Scheme. As
such, the National Registration and Accreditation Scheme is the most appropriate regulatory framework
for modern Australian paramedics.

3.2 A historical context for paramedicine’s evolution

Paramedics can be traced to antiquity. The first reported paramedics were in the form of stretcher-
bearers, who were sometimes known as ‘medical corpsmen’ because of their key military role. Medical
corpsmen were the less-skilled soldiers who followed the battalions into battle in order to ‘pick up and
give aid to anyone seriously wounded in the battle, or who has fallen off his horse, or is otherwise out
of action, so they may not be trampled by the second line or die through neglect of their wounds.\(^1\) Stretcher-bearers also carried water to reduce the risk of men ‘fainting’ from wounds inflicted during battle.\(^2\)

Stretcher-bearers performed a common military role and an important medical response to the hand-to-hand combat of war. Ambulance services, in the form of ‘stretcher-bearers’ or ‘medical corpsmen’, were used as early as 382BC by Alexander the Great’s father, Phillip II (382BC – 336BC). Stretcher-bearers were attached to the fighting battalion and entrusted to recover wounded soldiers in battle using stretchers.\(^3\) Stretcher-bearers were also used in military fighting for the sixth century Byzantine Empire. Roman Emperor Maurice outlined his requirement for ‘Medical Corpsmen’ in his Handbook of Byzantine Military Strategy. Medical corpsmen transported injured soldiers on stretchers to the surgeon’s tent directly from the battle-lines, and the Knights of St John, the chivalrous order caring for wounded crusaders and sick pilgrims, evolved from eleventh century crusaders who would carry wounded soldiers to hospital in Jerusalem.\(^4\) Spaniards in 1476 transported wounded soldiers in wagons at the behest of Queen Isabella of Spain. Chair carriers were also used in eighteenth century Leipzig and Edinburgh for patients to travel to hospital.\(^5\)

In Australia, possibly the most well-known stretcher-bearer comes from the legendary tale of Simpson and his donkey in Gallipoli during World War I. Private John Simpson (Kirkpatrick), of the Third Australian Field Ambulance, used his donkey to collect injured soldiers from the battlefield and transport them to medical assistance.\(^6\) His fame grew from the public’s acknowledgement and respect of his selflessness in the face of constant and substantial danger. Simpson’s altruism exists with modern paramedics and will be discussed throughout this chapter.

However, stretcher-bearers were not only utilised in times of war. The ‘Brothers of Mercy’ (the Compagnia della Misericordia) established the world’s first civilian ambulance service in thirteenth century Florence.\(^7\) Porters transported the sick and injured to a charity hospital or the deceased to a chapel, or pauper’s graveyard, depending on the family’s level of impoverishment. Generally, ambulance services were provided gratis and porters maintained individual anonymity while

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\(^{2}\) Ibid 30.


\(^{5}\) Pollock, above n 3, 218.


\(^{7}\) Bell, above n 4, 5-10.
performing their charitable work. The porters became iconic for Florence, dressed in black, with monk’s cowls hiding their identities from the community. Monetary bequests and property donations provided funding during this early ambulance endeavour.8

Australia’s first civilian paramedics also originated from stretcher-bearer backgrounds. The original Australian stretcher-bearers were members of the St John Ambulance Brigade which, itself, had its origins in the Knights of St John in the time of the crusades, as discussed above.9 Many of Australia’s ambulance services commenced operations in the late nineteenth century as colonial populations grew and the major cities rapidly expanded. Each state and territory created its own ambulance service which evolved into the modern ambulance services operating today in the Australian states and territories.

For example, an organised ambulance service began to emerge in the late 1800s in Queensland. An accident at the Brisbane Showgrounds in 1892 kick-started Queensland’s ambulance movement. A man fell off his horse and sustained a leg fracture and, as a consequence, he was transported in the back of a ‘Molly Brown Cab’ (a horse drawn vehicle) to the nearest hospital. Unfortunately, due at least in part to the lack of skilled medical assistance and the bumpy ride, the patient’s simple fracture became a compound fracture on the way to hospital. As a consequence, a member of the Ambulance Corps of the Queensland Defence Force, who witnessed the accident, decided patients should be treated with greater care and began the first Queensland ambulance movement training medical responders in first aid.10

Following the showground accident in 1892, Queensland established an ambulance service, the City Ambulance Transport Brigade, that used stretcher-bearers with straps over their shoulders to carry patients. The stretcher-bearers were also armed with a home-made bandage winder and unbleached calico and the night shift bearers used newspaper to pad the floor while they slept between call-outs.11

In approximately 1902, the City Ambulance Transport Brigade expanded to regional areas in Queensland, with self-governing centres, eventually changing its name to the Queensland Ambulance

8 Ibid.
10 Ernest Bradley, History of the Queensland Ambulance (Queensland Ambulance Service, 1991) 38; Wayne Sachs, Gympie Ambulance 1902-2002: The First Hundred Years (Gympie Graphics, 2002) 9. Surprisingly, an 1860 edition of the British Medical Journal chronicles an almost identical case to Queensland’s abovementioned accident. The Journal detailed the inadequacies of early emergency responders and the lack of skilled transport for patients in the United Kingdom. A building worker, who had fallen off scaffolding, had fractured his femur. A cab transported the patient to the doctor’s house and then to the hospital. During transport, his fracture was exacerbated to a compound one and lead to amputation which could have been avoided through responders possessing basic medical skills. In another similar, British case, a famous surgeon who sustained a broken leg from falling out of his carriage, understood the dangers of being transported by people without medical knowledge or training. He resisted offers for assistance, brandishing a stick, until he could be helped onto a door and carried appropriately to minimise further damage to his leg: Pollock, above n 3, 218.
11 Bradley, above n 10, 38; Sachs, above n 10, 9-10.
Transport Brigade. The Brigade operated with independent centres and committees throughout Queensland and eventually evolved to the modern ambulance service in Queensland today.12

‘Stretcher-bearers’ were also used in other Australian states and territories. They also had similar features and characteristics including ‘primitive’ methods of patient transport and basic first aid skills only. Victoria’s ambulance service evolved from 1883 with Melbourne hosting the first St John Ambulance Association in Australia: wheeled ‘Ashford Litters’ (stretchers attached to wheels) were used to transport patients.13 A transition was made to horse drawn ambulance transport, and motor vehicle transport followed soon after.14 Victoria’s ambulance service became the Victorian Civil Ambulance Service before progressing to the current public ambulance service in Victoria.15

New South Wales’ inaugural ambulance service was formed by the New South Wales Government Board of Health in 1881. The original purpose for the ambulance service was for the transport of infectious disease patients from Little Bay to the hospital. A state-wide, organised service was not formed immediately and ambulance transport in New South Wales grew, with a number of independent organisations providing ambulance services including the Army Medical Corp, Sydney No. 1 City Ambulance Corps and the Redfern Bicycle Club of Sydney. In 1895, the Civil Ambulance and Transport Brigade of New South Wales was established and then in 1904 amalgamated with the St John Ambulance Brigade to form the Civil Ambulance and Transport Corps.16 The modern Ambulance Service of New South Wales was eventually established by the Ambulance Service Act 1972 (NSW).17

Privately operated groups established a largely unco-ordinated South Australian ambulance service throughout the state. Some of the groups responsible for early South Australian ambulance transport included the St John Ambulance Brigade and the South Australian Police Force.18 The St John Ambulance Brigade was set up in Adelaide in 1884 by its English counterparts and expanded to other outposts.19 In 1952, St John Ambulance Brigade took responsibility for state-wide ambulance coordination.20 Then, in 1989, the South Australian Ambulance Service took over from the St John

14 Willis and McCarthy, above n 9, 58.
15 Bird, above n 13, 5.
17 This legislation has since been repealed.
19 Howie-Willis, above n 9, 14.
Ambulance Brigade and transitioned to a paid, career workforce rather than relying on a mixture of volunteers and paid staff.21

Ambulance provision in the other states and territories of Australia also began independently of each other. Tasmanian pre-hospital care originated from local councils in conjunction with support from local hospitals. St John Council was involved in Hobart’s ambulance provision but there was no state-wide co-ordination until 1965 when the Ambulance Commission of Tasmania took responsibility for Tasmanian ambulance services.22 Northern Territory ambulance transport also had its origins in the St John Council. Early ambulance services in Western Australia and the Australian Capital Territory were originally provided by the jurisdictions’ fire brigades. St John Ambulance took responsibility for Western Australian ambulance services in 1922, while the Canberra Hospital Board eventually assembled the ACT’s ambulance services.24

3.2.1 From stretcher bearer to paramedic

As identified above, paramedics commenced as stretcher-bearers being utilised in Australia’s military and civilian history. From stretcher-bearers, paramedic practice evolved and, while there were not necessarily discrete periods, in the following paragraphs I will trace the evolution and categorise into three phases:

1. Stretcher-bearers to ambulance drivers;
2. Ambulance drivers to ambulance officers; and
3. Ambulance officers to paramedics.

As we will see, a central feature of the evolution of paramedics was the need for training and the development and expansion of highly-skilled emergency professionals.

Stretcher-bearers to ambulance drivers

Following the introduction of the primary ambulance services throughout Australia, and the availability of motor vehicles as a mode of transport, ‘stretcher-bearers’ became ‘ambulance drivers’. As the name suggests, ambulance ‘drivers’ drove ambulances to collect sick and injured patients to transport them to hospital. Ambulance drivers were ‘transport workers’ only and did not usually possess medical or health-related qualifications or skills.25 In this way, there was no real substantive change in the role of

21 Woods, above n 18, 8.
22 Wilde, above n 20, 9-10.
23 Ibid 10.
24 Ibid.
25 Bradley reports Queensland introduced some training of Brisbane ambulance staff in the Brisbane General Hospital’s outpatient section in 1893 as a skill development exercise. However, this was not a standard training regime for the ambulance drivers and there is no other scholarship detailing ambulance drivers receiving any medical-type training. Ernest Bradley, History of the Queensland Ambulance (Queensland Ambulance Service, 1991)10, 41.
stretcher-bearers; it was the mode of transport that changed. Indeed, recruitment for ambulance drivers in the early days of Australian ambulance services required only that applicants possessed a driver’s licence and arrived wearing a collar and tie. The driver’s licence and dress prerequisites remained the primary method of recruitment until the 1960s. There was no requirement for prior medical training despite ambulance service establishment occurring to provide better patient care during transport to hospital.

The ambulance services were originally established to enable a safer method of patient transportation to hospital. Despite ambulance vehicles designed to transport patients safely, the ambulance drivers were not always trained to minimise damage to patients during transport. As such, despite an ambulance service which existed to provide patient care, in reality, ambulance drivers were no more than that: a faster and more efficient method of transporting patients. There was no medical assistance available to patients until they reached hospital.

**Ambulance drivers to ambulance officers**

The transition from ambulance ‘driver’ to ‘officer’ began on two fronts. In order to improve pre-hospital medical assistance, and provide the best outcomes for patient health, ambulance drivers began receiving medical-type training as part of their employment. The standard for ambulance officer training became post-employment medical training while on road.

There was, however, an absence of common or consistent training requirements for ambulance officers throughout Australia. Instead, the nature and scope of emergency medical training for ambulance officers evolved on a jurisdictional basis, with different Australian jurisdictions trialling various ambulance officer training regimes over the years. Most often the training was conducted while the ambulance officers were working in the industry. For example, New South Wales and Victoria both recognised the need to improve training and education for their first responders and established training programs in 1961. In 1969, the Queensland Government approved an official training school for Queensland ambulance staff. The training courses, in the various Australian jurisdictions, acknowledged emergency driving was a skill to be taught as a separate course, in addition to the rescue and emergency medical skills the ambulance officers required to serve the community.

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26 Willis and McCarthy, above n 9, 61.
27 Bradley, above n 10, 4; Ibid 58.
29 Ibid.
30 Deeth, above n 16, 13. A number of different training programs were developed in New South Wales over the years and a 14-week course, in 1976, was introduced utilising principles from the Los Angeles Paramedic Training Course. See Dennis Rogan, For love of life: the story of the first decade of the NSW Ambulance Paramedics (NSW Ambulance Publishing, 1986) 3.
31 Bradley, above n 10, 3.
32 Wilde, above n 20, 51, 54.
The second aspect of the transition of ambulance ‘driver’ to ‘officer’ was industrial. Ambulance officers began to challenge the ‘occupational ideology’ of the low status working class group of drivers, who were little more than poorly paid chauffeurs, through trade union activity. In Victoria, for example, a greater desire for acknowledgement of their discipline, beyond a mere ‘driver’, culminated in the 1976 creation of the Ambulance Employees Association, a professional association working to de-emphasise the driving work and promote healthcare as a primary function of ambulance officers. As such, the official transition between driver and officer occurred during the 1960s and 1970s as a result of industry medical-type training and an industrialised workforce.

A national progression to vocational education, such as a Diploma of Paramedicine, also occurred to evolve paramedic training requirements. Vocational training was either undertaken prior to employment with an ambulance service and/or during a term of employment. A person completing vocational training, while working for an ambulance service, was a student paramedic until the qualification was complete; they then became a fully qualified paramedic upon completion of the course. This model was still being utilised in many jurisdictions of Australia until very recently with New South Wales still using a vocational model to train paramedics employed in the public ambulance service. Many paramedics currently employed by public ambulance services have vocational qualifications only, as they were employed prior to the availability and requirement for tertiary qualifications. This will be discussed in more detail in Chapter 4, which will highlight the prevalence of vocationally versus tertiary qualified paramedics currently practising.

The shift from driver to officer was complete by the end of the 1980s. It was also recognised that the role of paramedics was still evolving at a fairly rapid rate. These sentiments were expressed in Queensland, when the Ambulance Service Bill 1991 (Qld) was being considered in the Legislative Assembly. The evolution from ambulance ‘driver’ to ‘officer’ was legislatively acknowledged at this time:

> The role of an ambulance officer is becoming more and more complicated, with society demanding greater skills of those involved in emergency and pre-hospital care… Frequent reference to “first aid qualifications” and “bearers” indicated to me that people making those remarks had been caught in some form of time warp. Today’s ambulance officer is a true professional and, as such, recruitment procedures should reflect that commitment to excellence.

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33 Willis and McCarthy, above n 9, 62.
**Ambulance officers to paramedics**

Paramedics did not stay ‘officers’ for long. A key to this was tertiary study. Specifically, the progression beyond ‘ambulance officer’ occurred with the more comprehensive training and education paramedics receive in emergency medicine through tertiary training pathways. A tertiary qualified workforce is now the norm for Australian paramedics. Tertiary qualifications are the minimum educational requirement for graduate paramedics in all jurisdictions except New South Wales. Some tertiary institutions are now promoting a conversion course to encourage vocationally qualified paramedics to achieve tertiary qualifications. The newer requirements for tertiary qualified paramedic graduates is an indication of the extent of progression of the paramedic industry.

Another factor which contributed to the transition from ambulance officer to paramedic occurred because of a television show. An American television show titled ‘Emergency’ was aired in Australia in the mid-1970s. The program depicted America’s emergency responders as ‘paramedics’ and Rogan has argued that the term was introduced to Australia and subsequently adopted following the ‘Emergency’ television program.

Despite an officer to paramedic transition having occurred, the legislative distinction between ‘paramedic’ and ‘ambulance officer’ is still unclear. Some jurisdictions continue to legislatively describe paramedics as ‘ambulance officers’. Other jurisdictions’ statutory instruments refer to ‘paramedics’ in their provisions. The jurisdical differences suggests there is either a misunderstanding of the paramedic role, the respective parliaments have failed to acknowledge the discipline’s transition from ‘officer’ to ‘paramedic’, or the difference is in name only.

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37 A more detailed discussion of tertiary requirements for paramedics is undertaken in chapter 4.

38 Rogan, above n 30, 7.

39 See, eg, Ambulance Service Act 1991 (Qld) s 13; Mental Health Act 2000 (Qld) s 33; Health (Drugs and Poisons) Regulation 1996 (Qld) ss 66, 174; Poisons and Therapeutic Goods Regulation 2008 (NSW) reg 101(1)(g); Mental Health Act 2007 (NSW) ss 4, 18, 20; Medicines, Poisons and Therapeutic Goods Regulation 2008 (ACT) s 350, sch 1; Mental Health Act 2009 (SA) ss 3 (definition of ‘authorised officer’), s 56; Medicines, Poisons and Therapeutic Goods Act (NT) s 28A; Mental Health and Related Services Act (NT) s 31.

40 See, eg, New South Wales, Parliamentary Debates, Legislative Council, 26 August 2015, 2819 (Daniel Mookhey); Health Services Act 1997 (NSW) s 67ZDA(1); Ambulance Service Act 1982 (Tas) s 3AB; Health Practitioner Regulation National Law (South Australia) Act 2010 (SA) s 120A.
There seems to be confusion about a paramedic’s role within the community as well. Paramedics are regularly called ‘ambulance drivers’ and ‘ambos’ in the media which appropriates the misunderstanding of their significant role as emergency healthcare providers. An Australian paramedic once commented, ‘[p]erhaps the greatest insult one can give a genuine paramedic is to call him or her an ambulance driver…’

Many of the ambulance legislative instruments, and other governance legislation, still refers to ‘ambulance officers’. They do not uniformly acknowledge paramedics using the appropriate and correct term of ‘paramedic’. This title discrepancy is problematic as it demonstrates both a misunderstanding of the evolution of the discipline, as well as confusion in the service paramedics provide to the community. Further, when the government is not appropriately acknowledging the expertise of paramedics, it is unlikely the community will appreciate the skill and knowledge paramedics possess. Parliaments, Australia-wide, need to remove references to ‘ambulance officers’ from legislation and adopt ‘paramedic’, as a title instead. Protection of title provisions being implemented in all jurisdictions may resolve these issues. ‘Ambulance officer’ could then remain as a term used by volunteer ambulance officers without the training and experience of paramedics.

As we have seen from the preceding paragraphs, there have been various stages in the evolution of paramedicine. However, the final transition, from ‘ambulance officer’ to ‘paramedic’ is still progressing. In order to move towards a universal term of ‘paramedic’ (and uniform regulation), it is necessary to further clarify the paramedic role. It will be clear, following this chapter, that paramedics have significant duties and responsibility which can produce substantial public good, as well as harm. Their community contributions are reflected by the Honourable Daniel Mookhey in the New South Wales Legislative Council:

Today’s paramedics are no mere ambulance drivers… We now require paramedics to have this high level qualification because the emergency health system in this State has evolved in response to evolving needs. Once, the mission of a paramedic was to take distressed people to hospital as quickly as possible… That era, the era of the ambulance driver, is over and has been for a long time. The imperative now is to provide as much high-quality care at the point of need as is medically possible. That means that those


43 See, eg, Ambulance Service Act 1991 (Qld) s 13; Mental Health Act 2000 (Qld) s 33; Health (Drugs and Poisons) Regulation 1996 (Qld) ss 66, 174; Poisons and Therapeutic Goods Regulation 2008 (NSW) reg 101(1)(g); Mental Health Act 2007 (NSW) ss 4, 18; Medicines, Poisons and Therapeutic Goods Regulation 2008 (ACT) s 350, sch 1; Mental Health Act 2009 (SA) ss 3 (definition of ‘authorised officer’), s 56; Medicines, Poisons and Therapeutic Goods Act (NT) s 28A; Mental Health and Related Services Act (NT) s 31.
providing the care are entitled to ask for, and should receive, the social recognition and respect they have earned – the respect attached to the term ‘paramedic’.44

Because paramedics have not completely progressed beyond being viewed as ‘ambulance officers’, this limits the community’s understanding of the role these health professionals play in delivering high quality care to the community. In many ways, it also undermines their skills, training and professionalism. As the quote from Daniel Mookhey, above, suggests, paramedic practice has evolved beyond the title of ‘ambulance officer’. This position can be compared to paramedic practice from a decade earlier where Coroner Cavanagh stated ‘ambulance officers must accept that they are not diagnostic physicians. That is not their role. Their role is to stabilise patients and transport them to hospital for assessment… they are not and should not be the decision making gateway to [sic] access to emergency assessment’.45 Paramedics are no longer transport-focused, with an additional diagnosis role that requires them to treat patients and provide advice. Within a ten year period, paramedics have progressed from transport and stabilisation to care that reflects contemporary evidence based practice.

Today’s ‘ambulance services’ employ paramedics who provide first aid and emergency medical treatment to patients in the community as well as providing patient transport to hospital.46 There are two very distinct limbs to this role: the provision of pre-hospital medical care and the transportation of sick and injured patients.47 Most jurisdictions have ambulance legislation establishing a public ambulance service as a separate statutory authority and setting out ambulance service’s role and functions.48 According to section 3D of the *Ambulance Service Act 1991* (Qld), for example, ambulance services:

1. Protect the community from injury and death, whether or not the patient is sick or injured;
2. Provide transport to medical or health care facilities;
3. Provide casualty room services;
4. Provide referral to other health services;
5. Provide community and workplace education in first aid, cardiopulmonary resuscitation (CPR) and other matters; and
6. Perform other functions.

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47 Bendall and Eburn, above n 29, 2-3.
The above statutory functions of the Queensland Ambulance Service are similar to other public ambulance services throughout Australia.\textsuperscript{49} It can be noted that these functions do not limit clinical care to emergency or urgent treatment; rather, they address patient care holistically and are very broad in their scope. Not all Australian jurisdictions have ambulance legislation. The St John Ambulance Services of Western Australia and the Northern Territory operate under contract to their respective governments so there is no legislation establishing these organisations.\textsuperscript{50} These functions are limited to the public ambulance services and do not apply to services in a private capacity. However, the legislative functions are prescribed for the public ambulance services generally, rather than to determine the role of the paramedics it employs.

While legislation governs some aspects of the ambulance industry, the industry is largely employer driven. Therefore, the employers prescribe paramedic roles and responsibilities which can differ according to jurisdiction and employer. For example, Queensland public paramedics must assess and prioritise a patient’s needs, deliver appropriate care and deliver definitive care efficiently.\textsuperscript{51} For the Northern Territory, paramedics must determine immediate treatment to their appropriate training level; provide transport to a health facility; determine whether a medical practitioner or higher trained paramedic is needed at the scene or enroute to hospital; and decide whether aeromedical services should be utilised to get the best possible clinical outcome for the patient.\textsuperscript{52}

All of the public ambulance service clinical governance documents set out specific treatment policies for the different types of cases attended with guidelines for adults and children, as well as drug treatment policies.\textsuperscript{53} The clinical policy documents, as discussed in Chapter 2, apply at an employer level so privately employed paramedics, working outside the public ambulance services, have different roles and responsibilities to public employees.

Another feature of paramedics’ roles is that publicly employed paramedics also respond to incidents classified at different levels of urgency. Emergency incidents require an immediate response with the use of ‘lights and sirens’, that is, the warning devices on their vehicle; urgent incidents also require

\textsuperscript{49} See also \emph{Health Services Act 1997} (NSW) s 67B(1); \emph{Ambulance Services Act 1986} (Vic) s 15; \emph{Emergencies Act 2004} (ACT) s 41; \emph{Health Care Act 2008} (SA) s 51.
\textsuperscript{50} Australian Health Ministers’ Advisory Council, ‘Consultation paper: Options for regulation of paramedics’ (Health Workforce Principal Committee, July 2012).
\textsuperscript{52} St John Ambulance Service Northern Territory, ‘Clinical Practice Manual’ (March 2013), Introduction, 7.
immediate attendance but without lights and sirens; while non-emergency incidents warrant a non-urgent response. The timely response required for emergency and urgent incidents reflects the need for a high level of knowledge and expertise by paramedics as there is limited time for consultation with other health professionals in emergency and urgent cases. Paramedics, working for public ambulance services, have also been given road rule exemptions.

Yet another feature of paramedics’ roles is that drivers of emergency vehicles have certain exemptions from adhering to the road rules. Road rules under the relevant jurisdictional traffic regulations do not apply to publicly employed paramedics if they are driving an emergency vehicle in the course of their employment duties and the vehicle is displaying a red flashing light or sounding an alarm. However, the paramedic must be taking reasonable care and it should also be reasonable that the specific road rule provision should not apply. Paramedics who are employed privately outside the public ambulance services cannot rely on the road rule exemptions. These exemptions demonstrate the high level of trust the community has in paramedics as it prevents sanctions being imposed upon paramedics who are acting reasonably in emergency situations. Other significant legislative powers of paramedics are discussed further below.

While the road rule exemptions highlight paramedics’ transport roles, this is one of the least significant aspects of the discipline. In addition to the community need growing, the role of paramedics in Australia is also expanding beyond an emergency response and transport focus to more involvement in primary health care. As such, there is an expanded role paramedics are providing to the community which goes beyond the traditional ‘ambulance officer’ role which existed in the past.

The clinical policy documents allow for discretion of paramedic decision-making for patient treatment. Paramedics are exhibiting more autonomous decision-making than ever before, demonstrating the evolution in patient care within the industry. The policies then provide a broad decision-making matrix with multiple options for paramedics to consider. For example, paramedics often need to diagnose the condition of the patient. The final decision for diagnosis and treatment of patients lies with the paramedic. Paramedics, therefore, have a significant responsibility to the community to provide timely diagnosis, treatment and advice. Given the significant amount of autonomy and discretion afforded to paramedics, as well as time demands and the stressful environment, there is significant potential for

patient harm.\textsuperscript{57} The increased risk and harm has necessary consequences for the way in which paramedics are regulated. As we will see in Chapters 5 and 6, the increased paramedic risk and harm are a central justification for paramedic inclusion in the National Scheme. Risk and harm are considered more thoroughly in Chapters 5 and 6.

\subsection*{3.2.2 Expanding societal role for paramedics}

So far we have seen that Australian paramedics have undergone a significant evolution since their origins as stretcher-bearers. Paramedics have moved beyond the traditional skills and expertise of emergency response to incorporating a diagnosis and treatment role in their practice. In this section, I will explore that evolution even further to demonstrate how paramedic roles and responsibilities have changed so much that current regulation fails to adequately govern the industry and does not sufficiently protect the public. Specifically, the advancements in paramedic regulation have occurred in health promotion and paramedics’ powers to treat patients without consent.

\textit{Expanded scopes of paramedicine – health promotion}

Expanded scopes of practice refer to practitioners using additional skills beyond the originally training.\textsuperscript{58} An expanded scope of practice is particularly significant to this research for a number of reasons. Expanded practice demonstrates the evolution of the discipline because expanded practice highlights the additional skills and knowledge paramedics possess, particularly when compared to ambulance drivers or ambulance officers. It further contributes to an evaluation of risk to the community as the additional skills and knowledge paramedics perform as part of an expanded scope of practice have the potential to harm patients. Risk is addressed further in Chapter 5 of this thesis. Expanded scopes of practice are particularly prevalent in rural and remote communities of Australia. Blacker, Pearson and Walker identified three models of expanded paramedic practice functioning in rural and remote locations of Australia: the primary health care model, substitution model and community coordination model.\textsuperscript{59}

Primary health care, as a broad concept, involves health promotion, with emphasis on preventative health, in addition to service provision.\textsuperscript{60} The primary health care model of expanded practice involves working in an expanded scope of practice role in partnership with other health professionals.\textsuperscript{61} Rather than addressing the immediate need, some paramedics, particularly in more rural and remote locations,
are taking on additional responsibilities to provide ongoing care to the community. Mulholland et al. consider the expanded scope of practice, for rural and remote paramedics, to be ‘multidisciplinary practice’. Rural and remote paramedics’ roles have expanded in response to the difficulties which arise from geographically sparse rural and remote locations which still need access to high quality pre-hospital care. These paramedics have been called upon to make home visits to elderly patients to check medication compliance and assist with ongoing maintenance of their general health. Paramedics have also attended prearranged home visits to perform blood pressure testing, monitoring blood sugar levels, undertaking 12 lead electrocardiographs and providing general health advice.

In areas with limited health resources, paramedics may perform home assessment and patient management, fulfilling a role which medical practitioners performed in the past. Stirling et al. suggests community members often consult directly with paramedics to determine whether their ailment requires hospital or medical centre attendance, or to obtain general medical advice. Paramedics are providing ‘general-practice’ type medical assistance and patients rely solely on their advice to determine whether to seek further medical assistance or remain at home. Further, using a Tasmanian example, when rural and remote paramedics transport their patients to hospital, they often continue patient care at the hospital. While at the hospital, they might perform nursing and radiology duties to assist staff at the local hospitals. In this way, Tasmanian paramedics have a similar level of responsibility and risk to the public as nurses, yet nurses are regulated under the National Scheme and paramedics are not.

Paramedics are also fulfilling a community education role as well which corresponds with Blacker, Pearson and Walker’s community coordination model. Some rural and remote area paramedics provide health education to community groups, including volunteer ambulance officers. Mulholland et al. identify that paramedics also run education sessions for health professionals, including medical practitioners and nurses, using a Tasmanian community as an example. These sessions, held in Tasmania, cover emergency skills such as cardiopulmonary resuscitation and intubation. The fact that health professionals are attending education sessions run by paramedics suggests other health professionals acknowledge the useful and important emergency skills paramedics possess and find their knowledge beneficial for the improvement of their own medical practice.

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63 Peter O'Meara, 'Professional and community expectations of rural ambulance services in Australia' (2001) 5(1) Pre-Hospital Immediate Care 27.
64 Steve Raven et al, 'An exploration of expanded paramedic healthcare roles for Queensland' (Australian Centre for Prehospital Research, September 2006) 19.
65 Stirling, above n 58, 6.
66 Mulholland et al, above n 62, 3.
67 Peter O'Meara et al, 'Extending the paramedic role in rural Australia: a story of flexibility and innovation' (2012) 12 Rural and Remote Health 1, 5.
68 Mulholland et al, above n 62, 6.
Finally, the substitution model refers to paramedics working as substitutes for nurses and medical practitioners. To use an example from Queensland, the additional clinical skills required of an extended care paramedic\footnote{Known, for legislative purposes, as an Isolated Practice Area Paramedic in Queensland.} include:

1. venepuncture;
2. insertion of naso/orogastric tube;
3. urethral catheterisation;
4. suture of a simple laceration or skin glue application, as well as wound assessment;
5. using an Oxylog 2000 emergency ventilator;
6. community immunisation;
7. home visits to provide medical checks and advice;
8. assistance with hospital x-rays; and
9. transcutaneous pacing.\footnote{Council of Ambulance Authorities, \textit{Expanding roles}, above n 56, 7; Raven, above n 64 19.}

Importantly, not all roles and responsibilities appear to come from legislation. Raven has suggested that some Queensland extended care paramedic activities are not officially endorsed under Queensland’s clinical policies but are being carried out by paramedics under supervision of other health care providers.\footnote{Raven, above n 64, 19.} This implies that publicly employed paramedics are performing tasks beyond their organisation’s policies.

Another example of paramedics performing a role synonymous with other registered health practitioners comes from the Northern Territory. In previous years, paramedics employed by Northern Territory St John Ambulance Service worked in the emergency department in the Alice Springs Hospital. Paramedics had been working alongside nurses as a result of a nursing shortage and were completing shifts while off duty from the St John Ambulance Service.\footnote{Ged Williams, Jeanette Berthelsen and David Baker, 'Employment of ambulance officers in the emergency department: A short-term strategy for a nursing shortage' (2004) \textit{7 Australian Emergency Nursing Journal} 5, 6.} This could be considered an extended care role although no additional qualifications or experience were required from the paramedics who were employed in the emergency department in this instance. Paramedics do not, normally, work in the hospital emergency departments but their use here highlights the importance of their skills and the clinical similarity to other registered health practitioners.

Yet another example of paramedic extended practice is the use of paramedics to fulfil a health practitioner role. Blacker, Pearson and Walker also describe an extended care example of paramedics working in South Australian country hospitals, in response to a general practitioner shortage.\footnote{Blacker, Pearson and Walker, above n 59, 7.} No further particulars were provided in the research to explain the effectiveness and outcome of this use of...
paramedics. However, it may reflect severe shortages of medical practitioners in remote areas.

However, if paramedics are performing, or have performed in the past, the professional roles of medical practitioners, it illustrates how the boundaries of the paramedic discipline have progressed and the level of respect their skills and expertise receive in the community.

The examples of paramedics practising in an expanded scope of practise role, in the preceding paragraphs, highlights the diversity of the paramedic discipline. Despite these differences, paramedics are now considered as substitutes for registered health practitioners, in some circumstances, and capable of performing a similar role. Their ability to undertake primary health care demonstrates their capabilities as an evolving professional group. The progression of the discipline can also be demonstrated through the powers paramedics have been prescribed, particularly around the need for obtaining consent.

**Paramedics practicing without patient consent**

Another indicator of the paramedic evolution comes from parliament granting paramedics the powers to practise without patient consent in many circumstances. Given that paramedics respond to emergency situations in the same way as the police service and/or the fire and rescue service, paramedics have been given additional statutory powers when compared to patient transport workers. In some jurisdictions, paramedics have been given legislative powers to enable them to treat patients without fear of liability for contravening patients’ legal rights, or exempting them from prosecution, such as treating patients without consent in particular circumstances. These powers demonstrate the significant degree of responsibility placed on paramedics in their role as first responders, the progression of the discipline when compared to their historical counterparts and suggests why thorough regulation of the discipline is essential.

While there are a range of powers which prescribe the extent of paramedic responsibilities, in the following paragraphs I focus on three of the key powers: providing medical treatment without consent; the power to detain patients without consent; and entry to property without consent. Generally speaking, this allows paramedics to contravene patients’ legislative and common law rights in particular circumstances.

Every competent, adult patient has the right to determine what is done to their own body, including the right to refuse medical treatment, regardless of the potential outcome.74 Where a patient’s self-determination conflicts with the sanctity of life, health practitioners must usually yield to patient autonomy despite their underlying desire to treat patients in their best interests.75 In order for a patient

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74 See, eg, Schloendorf v Society of New York Hospital 195 NE 92 (1914) 93; Secretary, Department of Health and Community Services (NT) v JWB and SMB (Marion’s Case) (1992) 175 CLR 218; Re T (Adult: Refusal of Treatment) [1993] Fam 95, 102.

to consent to treatment, or refuse treatment, they must have the capacity to make treatment decisions; make a free and voluntary decision; and consent to the particular medical act.\textsuperscript{76}

There are some circumstances, however, where paramedics and other health practitioners can treat patients without consent. This must be in the patient’s best interests. Exceptions to requiring consent exist in the form of common law necessity and emergency and statutory guardianship exceptions. Common law principles of necessity and emergency allow reasonable and necessary medical intervention when a person is unable to consent, such as through some form of incapacity.\textsuperscript{77} Incapacity can include permanent or sudden incapacity.\textsuperscript{78} The common law exceptions have been legislatively adopted at a state and territory level.\textsuperscript{79}

To use Queensland as an example, there are multiple instances where paramedics have the legislative authority to treat patients without seeking consent. These circumstances range from urgent to minor medical situations. Consent to patient treatment is not required, when an adult has impaired capacity, if:

1. The patient needs urgent healthcare to prevent ‘imminent risk to the adult’s life or health’;\textsuperscript{80}
2. urgent healthcare is needed to prevent significant pain or distress, provided the health provider does not know the adult objects to the healthcare;\textsuperscript{81} and
3. minor and uncontroversial healthcare is necessary to promote the adult’s health and wellbeing and the health provider does not know the adult objects to the healthcare.\textsuperscript{82}

These consent provisions are applicable to Queensland paramedics. The legislative definition of healthcare is: care, treatment, service or procedure to diagnose, maintain or treat the adult’s physical or mental condition and is carried out by, or under the direction of, a health provider.\textsuperscript{83} Further, a health provider is defined as a person who provides healthcare in the practice of a profession or in the ordinary


\textsuperscript{77} Rogers v Whitaker (1992) 175 CLR 479, 489.


\textsuperscript{79} See, eg, \textit{Criminal Code} (Qld) ss 25, 282; \textit{Civil Liability Act 2003} (Qld) s 26; \textit{Criminal Code} (WA) ss 25, 259; \textit{Criminal Code (Tas)} ss 51, 149.

\textsuperscript{80} \textit{Guardianship and Administration Act 2000} (Qld) s 63 (1)(b)(i).

\textsuperscript{81} Ibid ss 63 (1)(b)(ii), (2).

\textsuperscript{82} Ibid s 64. It is significant that minor and uncontroversial healthcare can still be provided, in the absence of an emergency, as it demonstrates the importance of health providers acting in the best interests of their patients.

\textsuperscript{83} Ibid sch 2, s 5.
course of business. While professionalism scholarship does not support a paramedic as a professional, as per the later discussions in this chapter, nor are paramedics considered as registered health professionals under the National Law; paramedics do provide healthcare within the ordinary course of business as their role is treatment, diagnosis and advice in a pre-hospital setting. Even private paramedics could fall within this health provider definition as they still perform a healthcare role in a prehospital setting.

In addition to consent, paramedics have the power to detain patients. The involuntary assessment of patients refers to the detention of patients, against their will, for medical practitioner assessment to determine whether the patient needs treatment. Involuntary assessment applies to mentally ill patients who will not consent to treatment and may pose a danger to themselves or others. Some jurisdictions allow paramedics to detain and transport mentally ill patients based on their own clinical assessment, while other jurisdictions require paramedics to gain medical practitioner authority for involuntary assessment. Police officers and medical practitioners have similar assessment powers to paramedics in some jurisdictions.

The mental health powers of paramedics differ between jurisdictions. Table 3.1 provides a comparison of the statutory mental health powers available to paramedics. The determination by a paramedic of whether a person has a mental illness, in any jurisdiction, is based upon the paramedic’s clinical judgment and evaluation of the patient at the scene.

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84 Ibid sch 4 (definition of ‘health provider’).
85 Mental Health Act 2000 (Qld) ss 33, 37 (specifies a psychiatrist); Mental Health Act 2007 (NSW) s 18(1)(c)-(d).
<table>
<thead>
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<th>Jurisdiction</th>
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| **Australian Capital Territory** | Paramedics can detain a person with a mental disorder or illness if they have, or are likely to attempt, suicide or the infliction of serious harm on themselves or someone else.  

87 Mental Health Act 2015 (ACT) s 80. |
| **New South Wales** | Paramedics are authorised to transport a mentally ill or mentally disturbed person to a declared mental health facility if they believe it would be beneficial to the person’s welfare. 

88 Mental Health Act 2007 (NSW) s 20. |
| **Northern Territory** | Detention of a patient for up to six hours is allowed if the paramedic reasonably believes the person is likely to cause serious harm to themselves or someone else, or suffer serious mental or physical deterioration, because of their mental illness. 

89 Mental Health and Related Services Act (NT) ss 14, 31. |
| **Queensland** | Paramedics can detain a patient in a health service facility for up to 6 hours if the person’s behaviour indicates they are at ‘immediate risk of serious harm’, the risk is a result of a major disturbance in their mental capacity and they require urgent examination. 

90 Public Health Act 2005 (Qld) ss 157B, 157E(1). |
| **South Australia** | Paramedics can take a person into their care and control, and transport them, if it appears they have a mental illness and the person has caused, or there is significant risk of causing, harm. 

91 Mental Health Act 2009 (SA) ss 3 (definition of ‘authorised officer’), 56. |
| **Tasmania** | A paramedic may apply to a medical practitioner for an assessment order for a mentally ill person but cannot transport the person without the medical practitioner’s consent. 

92 Mental Health Act 2009 (Tas) s 23. |
| **Victoria** | Victorian paramedics can only transport mental health patients on authorisation of a medical practitioner, psychiatrist or Mental Health Tribunal; they have no authority to detain for involuntary assessment based on their own clinical assessment. 

93 Mental Health Act 2014 (Vic) ss 28, 45, 52. |
| **Western Australia** | Paramedics do not have any powers of involuntary detention in Western Australia; apprehension of a mentally ill person for transport and treatment, in an emergency, can be undertaken by a police officer only. 

94 Mental Health Act 2014 (WA) s 156. |

Table 3.1 Summary of paramedics’ mental health powers

The involuntary detention powers demonstrate the community’s trust in paramedics. Paramedics are required to use their professional judgment, and medical knowledge, in order to assess the mental health status of patients.  

95 This statutory power of involuntary detention is one reserved purely for paramedics, police and medical practitioners. In addition to detaining patients, paramedics, in some circumstances, have the power to restrain patients. On occasion, mental health patients will forcefully object to their transportation despite the statutory authority of paramedics for involuntary assessment of a patient’s condition, discussed above. In these instances, some paramedics are authorised to use restraint to enable the safe transport and treatment of

87 Mental Health Act 2015 (ACT) s 80.  
88 Mental Health Act 2007 (NSW) s 20.  
89 Mental Health and Related Services Act (NT) ss 14, 31.  
90 Public Health Act 2005 (Qld) ss 157B, 157E(1).  
91 Mental Health Act 2009 (SA) ss 3 (definition of ‘authorised officer’), 56.  
92 Mental Health Act 2013 (Tas) s 23.  
93 Mental Health Act 2014 (Vic) ss 28, 45, 52.  
94 Mental Health Act 2014 (WA) s 156.  
those patients and also to protect themselves from patient violence. Restraint can refer to the physical, mechanical or chemical restraint of a patient to manage their behaviour. Physical restraint is the use of physical force while mechanical restraint uses a device for physical restraint, such as hand cuffs or tie down straps. Chemical restraint refers to pharmacological sedation. It is useful to undertake a jurisdictional comparison to highlight the level of autonomy and decision-making discretion afforded to some Australian paramedics employed within the public sector. Table 3.2 explains the jurisdictional differences of patient restraint use.

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Restraint provisions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Australian Capital Territory</strong></td>
<td>ACT legislation does not expressly authorise chemical sedation. However, it is impliedly authorised. Paramedics must report any medication administered to a patient forcibly to the mental health facility. Any medication administered forcibly would include chemical sedation according to the ACT ambulance service’s clinical drug policies.</td>
</tr>
</tbody>
</table>
| **New South Wales**     | Paramedics can use reasonable force when exercising powers to transport mental health patients and to restrain the patient in ‘any way that is reasonably necessary in the circumstances’. Legislation does not authorise restraint although stipulates the prescription of medicine to a mentally ill person should be done to meet their health needs. Their clinical policies suggest physical restraint should only:  
  - be exercised with police assistance;  
  - be used with mechanical restraint, by appropriately trained paramedics; and  
  - use pharmacological sedation in the best interests of patient care and to reduce the risk of harm to the patient. |
| **Northern Territory**   | Use of restraints on mentally ill patients is allowed to prevent harm, prevent further health deterioration or to relieve symptomatology. ‘Restraint’ is not further defined in the legislation, although the Northern Territory clinical policy allows, sedation of patients in the form of restraint. |
| **Queensland**          | Paramedics can use necessary and reasonable force to detain and transport mentally ill patients being involuntarily assessed. However, the clinical policy authorises paramedics to pharmacologically sedate severely agitated patients to ‘ensure the safety of both the patient and officers and ensure a safe transfer to medical care’. Physical restraint is permitted provided it is utilised as a last resort, in the least restrictive way and a critical care paramedic, if available, must be consulted. |

97 Mental Health Act 2015 (ACT) s 266.  
98 Mental Health Act 2007 (NSW) s 81 (2).  
99 Ibid s 68.  
101 Mental Health and Related Services Act (NT) s 31 (2).  
102 St John Ambulance Service Northern Territory, 'Clinical Practice Manual' (March 2013) 52.  
103 Public Health Act 2005 (Qld) s 157L.  
105 Ibid, the physically restrained patient.
South Australia | Paramedics can physically or chemically restrain a patient when it is reasonable in the circumstances.\(^{106}\) South Australia’s clinical policies specifically authorise the use of ‘limb restraints’ in conjunction with pharmacological restraint.\(^{107}\)

Tasmania | Restraint not legislatively authorised.\(^{108}\)

Victoria | Paramedics can transport a patient using bodily restraint if other options of negotiation have proved unsuitable and it is necessary to prevent “serious and imminent harm to the person” or another.\(^{109}\) Restraint includes physical and mechanical restraint.\(^{110}\) Paramedics are also authorised to sedate patients on a registered medical practitioner’s direction, or as part of normal clinical care, if it is necessary to prevent serious and imminent harm to the person, or another, and there is no suitable alternative.\(^{111}\)

Western Australia | Restraint not legislatively considered.\(^{112}\)

| **Table 3.2 Use of patient restraint according to jurisdiction** |

Restraining mentally ill or behaviourally disturbed patients is a significant power and one which has the potential for adverse consequences. Physical restraint has been documented to cause outcomes such as sudden death, severe acidosis, excited delirium and a combination of these factors.\(^{113}\) Weiss et al. reported the adverse effects of using chemical restraint on agitated patients was difficult to assess, but in a small percentage of cases had caused minor abrasions, contusions and small lacerations.\(^{114}\) The power to restrain patients, physically or chemically, demonstrates the high level of training, education and responsibility expected from Australian paramedics given the volatile and potentially dangerous circumstances under which paramedics would use these techniques. For more details of paramedics’ use of midazolam, ketamine or other sedatives to restrain patients, see Chapter 4, Table 4.5.

Powers authorising treatment of impaired patients without consent, or restraining patients, are a state and territory responsibility. They are not a regulatory measure which could be standardised under the National Law. As such, they do not contribute to the consideration of paramedicine’s regulatory efficiency. However, powers to treat patients without consent do demonstrate significant community trust which paramedics possess and the potential to contravene patient rights. They are also a further example of the industry’s progression from first aid and transport to skilled prehospital healthcare.

Paramedics can not only treat and restrain patients without consent, but can also sometimes enter premises without consent. Generally, to enter and remain on another’s property without consent is

\(^{106}\) *Mental Health Act 2009 (SA)* s 56 (3).


\(^{108}\) *Mental Health Act 2013* (Tas).

\(^{109}\) *Mental Health Act 2014 (Vic)* ss 3 (definition of ‘authorised person’), 350 (1)(a).

\(^{110}\) Ibid s 3 (definition of ‘bodily restraint”).

\(^{111}\) Ibid s 350 (1)(b).

\(^{112}\) *Mental Health Act 2014 (WA)*.

\(^{113}\) Weiss et al, above n 96, 824.

\(^{114}\) Ibid. See also McSherry, Bernadette and Juan Jose Tellez, ‘Current Challenges for the Regulation of Chemical Restraint in Health Care Settings’ (2016) 24 *Journal of Law and Medicine* 15, 16 who suggest other possible issues with chemical sedation include cardio-toxicity.
trespass to land.\textsuperscript{115} Similarly, interfering with an individual’s personal property without consent can constitute a trespass to goods.\textsuperscript{116} Paramedics in some jurisdictions, however, are not liable for a trespass to land or goods, following their interference with such, in an emergency. These powers are applicable to public ambulance service employees who are acting within the scope of their employment. Table 3.3 describes the powers of entry for Australian paramedics, per jurisdiction. Some jurisdictions only have powers of entry under mental health legislation.

To provide a specific example, Queensland law authorises paramedics to enter property, without consent, in an emergency. Queensland Ambulance Service paramedics’ statutory powers extend to: entering, destroying or damaging premises, a vehicle or a vessel; using reasonably necessary force to open any receptacle; bringing any equipment onto the premises; removing or dealing with articles or materials in the area; causing gas, electricity or other forms of energy to be shut off or disconnected to the source; requesting assistance from any person; and administering basic life support and advanced life support procedures consistent with their training and qualifications.\textsuperscript{117} If Queensland paramedics are required to forcibly enter a premises in order to locate a patient, they are permitted to cause damage to a person’s property although their policy suggests informing their communications centre, as well as the Queensland Police Service of the forcible entry, and every effort should be made to cause the least damage possible.\textsuperscript{118}

\textsuperscript{115} See, generally, Dumont v Miller (1873) 4 AJR 152; Halliday v Nevill (1984) 155 CLR 1; Brophy v Western Australia [2007] FCA 519.
\textsuperscript{116} See, generally, Kirk v Gregory (1876) 1 Ex D 55; Slaveski (by his litigation guardian Slaveska) v Victoria [2010] VSC 441.
\textsuperscript{117} Ambulance Service Act 1991 (Qld) s 38(2).
<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Powers of entry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Capital Territory</td>
<td>Paramedics may enter any premises to take a person to a mental health facility, subject to mental health apprehension provisions, discussed above. The minimum amount of force necessary may be used to apprehend the patient.119</td>
</tr>
<tr>
<td>New South Wales</td>
<td>New South Wales mental health legislation does not give paramedics the power of entry, although they have authority to perform searches of a person, as well as seize and detain anything which could present a danger to a person or could lead to their escape from custody.120 Only police officers are authorised to enter property to apprehend a patient.121</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>Northern Territory paramedics are only expressly authorised to enter private property upon a psychiatrist’s recommendation; police officers are given express authorisation of entry to property.122 However, paramedics are authorised to use ‘reasonable measures’ to prevent the person causing themselves or someone else harm and to prevent further deterioration.123 Entry to a patient’s house, without consent, could be a reasonable measure here.</td>
</tr>
<tr>
<td>Queensland</td>
<td>Queensland paramedics may enter, destroy or damage premises, a vehicle or a vessel; use reasonably necessary force to open any receptacle; bring any equipment onto the premises; remove or deal with articles or materials in the area; cause gas, electricity or energy to be shut off or disconnected to the source; request assistance from anyone; and administer life support procedures consistent with their training and qualifications.124</td>
</tr>
<tr>
<td>South Australia</td>
<td>A South Australian paramedic employed by the South Australian Ambulance Service may enter a place to determine if a person is in need of medical assistance and to provide any person with medical assistance. Reasonable force can be used to break in, if needed.125 Their mental health legislation also authorises entry to take a person to a mental health service for treatment and powers of search and seizure of dangerous property.126</td>
</tr>
<tr>
<td>Tasmania</td>
<td>Paramedics may enter a patient’s property if they believe a person on that land requires urgent ambulance services. They must be either wearing the organisation’s uniform or produce identification.127</td>
</tr>
<tr>
<td>Victoria</td>
<td>The power of entry to premises exists under mental health legislation, with paramedics authorised to enter property, without consent, to take a person to a designated mental health service for treatment.128 They have also been granted legislative power to physically search a person and seize and detain anything which could present a danger to the person or help them to escape.129 Victorian paramedics can use reasonable force to gain entry if they have been denied access under mental health provisions.130</td>
</tr>
<tr>
<td>Western Australia</td>
<td>Entry to premises not legislatively considered.131</td>
</tr>
</tbody>
</table>

Table 3.3 Paramedic powers of entry

119 *Mental Health Act 2015 (ACT)* s 263.
120 *Mental Health Act 2007 (NSW)* s 81 (4), (5).
121 Ibid s 21.
122 *Mental Health and Related Services Act* (NT) ss 32A, 34 (8)
123 Ibid s 31.
124 *Ambulance Service Act 1991 (Qld)* s 38(2).
125 *Health Care Act 2008 (SA)* s 61.
126 *Mental Health Act 2009 (SA)* s 56 (3)(e)-(f).
127 *Ambulance Service Act 1982 (Tas)* s 14A.
128 *Mental Health Act 2014 (Vic)* s 353.
129 Ibid ss 354, 356.
130 Ibid s 353 (4).
131 *Mental Health Act 2014 (WA).*
In summary, paramedics’ powers to treat, detain and restrain patients, as well as enter property without consent are significant. In order to treat impaired patients, health providers are required to make an assessment of the patient’s impairment and incapacity. As such, a paramedic treating a patient must have sufficient knowledge of the legal and ethical issues relating to capacity, patient decision-making and their statutory powers. This power demonstrates the evolution of the discipline as the early stretcher-bearers, ambulance drivers and even ambulance officers had a first aid and transport focus, without the legal and ethical understanding required of paramedics. Today’s paramedics perform functions which include skilled healthcare. Therefore, paramedics have more responsibility and trust than ever before.

The powers of treating patients without consent, including involuntary assessment and restraint, and the powers of entry show the level of trust bestowed on paramedics who interact with the sick, injured and vulnerable patients on a frequent basis. Granting paramedics the same authority bestowed upon medical practitioners and police officers demonstrates the community’s high regard for paramedics and the necessity of their skills and service.

3.3 Filling a niche: growing private practice

Another indicator of paramedicine’s evolution is the growing private practice which services Australia. An increasing community reliance on private paramedicine is significant because it demonstrates that regulation solely through public ambulance services does not reach all practicing paramedics. A regulatory framework which governs public and privately employed paramedics is needed in Australia. This part outlines the extent of the private paramedicine industry in Australia.

Paramedics’ roles are not only evolving but there is a greater reliance for their services amongst the community. Paramedics are attending more emergency incidents currently than in previous years. While population numbers are increasing, so too is the reliance on ambulance services Australia-wide. Between 2014 and 2015, paramedics attended 3.70 million incidents nationally, with 37 percent of those being emergency responses.132 The 2011-12 period saw paramedics attend 3.19 million incidents nationally, with 44 percent being emergency incidents.133 The 2008-09 period logged 2.9 million incidents while a comparison to 2002-03 data shows paramedics attended 2.2 million incidents nationally over that period.134 These figures show the utilisation of ambulance services increasing on a yearly basis although population growth may also be occurring. With the level of skill and expertise

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required of paramedics also rising, the potential harm to the community from those who may not be performing the paramedic role adequately, is also increasing. Chapter 5 further considers how the growing number of paramedics also creates additional risk to the public.

While publicly employed paramedics are responding to more emergency incidents than ever before, there is also a growing rate of paramedics employed privately. The precise number of paramedics employed outside the public ambulance service organisations is unknown, although the Australian Health Ministers’ Advisory Council has suggested there is a ‘substantial and growing’ number of privately employed paramedics in Australia. Four categories of privately employed paramedics have been identified: private providers of ambulance or aero-medical services; first-aid and medical event providers; the Australian Defence Forces; and industrial providers.

Paramedics Australasia have estimated the number of privately practising paramedics in Australia. They have suggested there were approximately 2,500 paramedics, comprising of 28 percent of all Australian paramedics, who were employed outside the public ambulance service primary employers in 2006. The number of privately employed paramedics in Australia further rose in 2011 with approximately 4,500 paramedics working outside the primary government ambulance providers, comprising a total of 36 percent of all Australian paramedics. Given the trajectory of an increasing private paramedic workforce, it is likely the numbers of paramedics employed outside public ambulance services have further increased beyond 40 percent since 2011.

However, it is not only the number of privately practising paramedics which is significant. Private paramedic providers are also treating large numbers of patients. A Queensland private paramedic employer, Immediate Assistants Pty Ltd, estimated that each of their Queensland sites would treat approximately 10-12 patients per day. As such, private paramedics are being utilised and there is frequent exposure to patients.

The increasing prevalence of emergency paramedic responses, and the growing private industry, is significant to the progression of the discipline for a number of reasons. It demonstrates the community’s need for emergency healthcare, and related services, which paramedics provide. The statistical data presented above documenting the community’s use of paramedic services shows how the industry has evolved so as to fulfil an important community healthcare need. Paramedics’ professionalised workforce, and increasing presence within the private practice sphere, also demonstrate the discipline’s extensive growth. Further, as there are more opportunities for privately practising paramedics, the

135 Australian Health Ministers; Advisory Council, Consultation Paper, above n 50, 11.
136 Ibid.
138 Ibid.
139 Immediate Assistants Pty Ltd v Chief Executive, Queensland Health [2012] QCAT 245 (21 June 2012) [31].
public employer regulatory structure which once controlled the industry, can no longer govern all paramedics as the private industry has grown too large. The public ambulance regulatory structure failing to appropriately regulate private practice is a further reason to support a move towards paramedic registration under the National Scheme. Chapter 4 will consider the notable features of paramedic regulation, including private practice, in more detail.

3.4 Occupation or profession?

Paramedicine has always been considered an occupation; however, evolution from vocationally trained ambulance officers to tertiary qualified paramedics fulfils the characteristics of a profession. Professionalism is significant to paramedicine because it supports a changing regulatory structure from occupational to professional regulation. Professionalism, and related theoretical discussions, will be considered where it is relevant to paramedicine, but this section does not purport to identify all relevant literature considering professionalism. 140

Particular characteristics distinguish professions from occupational groups. A profession entails ‘specialised work’ identified by ‘relatively high standing in classifications of the labour force’. 141 Its membership requires more advanced and complex knowledge and skills than occupations. 142 There is

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141 Kay Kittrell Chitty, 'Nursing's Pathway to Professionalism' in Kay Kittrell Chitty and Beth Perry Black (eds), Professional Nursing: Concepts and Challenges (Saunders Elsevier, 2011) 60, 62.

also the autonomy to control work rather than the work allocations indicative of occupations. Freidson characterises a profession as an ‘occupational monopoly’ rather than an employee’s work allocations indicative of occupations. Further, professionalism encompasses professional parameters of law and ethics; professional behaviours using industry knowledge, skills and collaboration; and professional responsibilities to all relevant stakeholders in the profession. Freidson argues professionalism can only exist when particular tasks performed by professionals are different from the tasks performed by other workers.

Occupations have different characteristics and regulatory requirements to professions. An occupation, according to Freidson, relies on managerial control through an employer. When the employer ‘organises and controls work’, there is less responsibility for the worker to act autonomously than the professional who exercises more independent control of their tasks. Further, occupational control of a market prevents consumers from employing specific people for a task; rather, the employers and managers allocate personnel to fulfil occupational requirements. Finally, occupations often participate in training and educational activities within the labour market itself. In that regard, it is often vocational training, rather than tertiary training, which is indicative of occupational status.

Significantly then, paramedics satisfy the characteristics for professional classification, particularly given the evolution in practice we have seen 3.2.1 - 3.2.2. As such, they should no longer be considered an occupation, rather a profession and in so doing be regulated under the National Scheme. Commentators are reluctant to definitively declare paramedics to be a professionalised discipline, only suggesting they can fulfil particular characteristics indicative of professional groups.

There are three themes appearing consistently throughout the professionalism literature: a sense of service or altruism; theoretical and technical knowledge gained from specialised education; and autonomy of practice with a code of professional ethics. These themes will be considered, for the purpose of this thesis, to be an amalgamation of the significant characteristics of professionalism, from the large body of research already published.

146 Eliot Freidson, Professionalism, the third logic (Cambridge, 2004).
147 Freidson, Theory of Professionalism, above n 143, 118.
148 Ibid 120.
149 Ibid 121.
Sense of service or altruism

A sense of service or altruism is significant to professionalism. Service incorporates a devotion to serving the community above the desire for monetary compensation. Altruism can be exhibited in a number of ways. When health professionals respond to patient needs in their service to the community, rather than the wants of a consumer, their functions are altruistic in nature. Because of the beneficial and respected functions professionals play in society, they are granted certain rights to enable them to serve the community. For example, medical professionals are obliged to keep certain patient information confidential, they are granted special powers to prescribe and administer dangerous pharmaceuticals and they can refuse to perform procedures not in the best interests of their patient.

Paramedicine is a discipline which functions as a community service. Paramedics must comply with confidentiality, they are granted statutory drug administration powers and they can refuse to administer treatment not in the best interests of patients. These powers enable them to serve the community. Legislative and parliamentary consideration has also affirmed the notion that paramedic and ambulance services exist as a community service. As such, a definitive conclusion can be drawn that paramedics are altruistic and exist to serve the community.

Theoretical and technical knowledge from specialised education

Paramedics also exhibit theoretical and technical knowledge. For example, Mahony argues paramedics are ‘recognised’ experts on resuscitation and emergency obstetrics, and goes so far as to suggest they have more experience than the average general practitioner when performing these tasks. Paramedics are authorised to administer certain restricted drugs without medical practitioner authority, and are also authorised to make medical decisions in emergency situations. As such, their considerable scope of practice demonstrates a professional authority, according to Mahony. Sheather suggests that paramedics now perform more invasive procedures than they did in the past because of a range of external influences including growing demand for health services, an aging population, usage of health

154 Bernadette Richards and Jennie Louise, Medical Law and Ethics: A Problem-Based Approach (LexisNexis, 2014) 5.
155 See, eg, New South Wales, Parliamentary Debates, Legislative Council, 26 August 2015, 2817 (Ernest Wong); Ambulance Service Act 1991 (Qld) s 3D(b); Health Services Act 1997 (NSW) s 67B; Ambulance Services Act 1986 (Vic) s 15; Emergencies Act 2004 (ACT) s 41(1); Health Care Act 2008 (SA) s 5(a).
157 Ibid 3. See chapter 4 for paramedics’ drug administration powers.
technologies and shrinking rural communities.\textsuperscript{158} The complexities in their practice suggest a greater degree of professionalism.

The theoretical and technical knowledge paramedics possess comes from specialised education. Tertiary education is, therefore, crucial for paramedics to demonstrate specialised education for professionalism. Redirecting education, from vocational to tertiary, has been considered a move towards professionalism for paramedics.\textsuperscript{159} Tertiary educational pathways also promote good communication skills which is a professional skill as well.\textsuperscript{160} Williams, Brown and Onsman suggest it is the tertiary education curriculum, promoted through a national accreditation process, which is most important to establishing paramedic professionalism.\textsuperscript{161} Paramedics, through their progression to tertiary education, are in a stronger position for professionalism given the prevalence of a tertiary educated industry which now exists.

**Professional autonomy with a code of ethics**

Autonomy of practice, with a code of professional ethics, is the final theme prevalent for professions. Autonomy of a discipline can exist when there is state legitimisation in the form of legislation establishing a statutory authority which then permits a profession to regulate itself.\textsuperscript{162} In this way, autonomy is linked to self-regulation. According to Freidson, ‘legitimated autonomy’, an occupational self-regulation over the manner employment activities are performed, is crucial for professionalism.\textsuperscript{163} From a historical context, provided a professional group could demonstrate professional traits, it was trusted to self-regulate in the best interests of the community, that is, the profession itself being responsible for the regulation of its members.\textsuperscript{164} Specifically, autonomy is significant to professionals in three ways: non-professionals are not equipped to evaluate professionals sufficiently; professionals should be trusted to work independently; and professions should be allowed to control their own disciplinary measures.\textsuperscript{165} Autonomy is an important factor in a health professional and patient

\textsuperscript{158} Rod Sheather, 'Professionalisation' in Peter O'Meara and Carol Grbich (eds), *Paramedics in Australia: contemporary challenges of practice* (Pearson, 2009) 62, 67.
\textsuperscript{159} Louise Reynolds, 'Is Prehospital Care Really a Profession?' (2004) 2(1) *Journal of Emergency Primary Health Care* 1, 1.
\textsuperscript{160} Franziska Trede, 'Becoming professional in the 21st century' (2012) 7(4) *Journal of Emergency Primary Health Care* 1, 3.
\textsuperscript{162} Mike Horsley and David Thomas, 'Professional regulation & professional autonomy: Benchmarks from across the professions, the New South Wales experience' (2003) 6(1) *Change: Transformations in Education* 34, 37.
\textsuperscript{164} Linda Haller, 'Regulating the Professions' in Peter Cane and Herbert Kritzer (eds), *The Oxford Handbook of Empirical Legal Research* (Oxford University Press, 2010) 216, 217.
\textsuperscript{165} Ibid 137.
relationship, and the professionalism of nurses has been acknowledged because of their autonomy in treating and responding to patients.\footnote{Karen Willis and Shandell Elmer, \textit{Society, Culture and Health: An Introduction to Sociology for Nurses} (Oxford University Press, 2nd ed, 2011) 336.}

It is difficult to determine how paramedic autonomy contributes to their professionalism. Wyatt has previously argued that professional autonomy does not yet exist for paramedics because employers have control over the discipline.\footnote{Andrea Wyatt, 'Toward Professionalism - An Analysis of Ambulance Practice' (1998) \textit{5 Australasian Journal of Emergency Care} 16, 18; Mahony, above n 156, 6.} Despite the article being published in 1998, and the significant progression of the discipline since that time, employers still regulate the industry. There are no self-regulatory elements, nor does a professional body regulate the discipline using a co-regulatory structure. Wyatt further argued for appropriate processes of peer review and clinical audit to warrant complete autonomy of the discipline, as well as paramedic contributions to their own professional standards.\footnote{Wyatt, above n 167, 18.}

Paramedics do not have the organisational autonomy to control or contribute to the regulation of their own profession. However, they are autonomous practitioners.

Paramedics do function autonomously. They attend pre-hospital incidents, requiring patient treatment and transport, without supervision. They have also been granted a range of statutory powers to perform activities, without seeking approval from a registered health practitioner, such as the administration of dangerous drugs. While their clinical policies provide some guidance on the treatment options available, paramedics still require the expertise to diagnose and treat patient conditions, with the discretion to treat according to the patient’s requests and symptoms. Paramedics are being given more responsibility to make clinical decisions about treatment options for patients and are practising autonomously with very little supervision. In addition to the transition away from vocational education to a tertiary model, these factors indicate professionalism is occurring and should be acknowledged.\footnote{Joyce et al, above n 34, 533-5; Ruth Townsend and Morgan Luck, \textit{Applied Paramedic Law and Ethics: Australia and New Zealand} (Elsevier Australia, 2013) 83.}

Regulatory codes of ethics are another professional characteristic, as well as a way of maintaining standards within a profession. Greenwood identifies codes of ethics as the profession’s ‘commitment to social welfare’. \footnote{Greenwood, above n 152, 20-2.} When a profession has monopolised the market, ethical codes ensure community confidence through standardisation of industry behaviours. Ethical codes can be a formal requirement through a written code, as well as an informal one, serving as an unbinding professional commitment to the social welfare of clients. In this regard, codes of ethics are linked to the concept of self-regulation. When a profession is self-regulatory and governs members through a code of practice, ethical behaviour is often compelled as a result as the profession seeks to maintain community confidence. \footnote{Ibid.} As Chapter 2 highlighted, some jurisdictions enforce paramedic codes of ethics while others make no such
requirements. There is a significant gap in ethical requirements with none existing within the private industry. As such, paramedicine, while being autonomous, does not have a code of ethics in conformity with professionalism.

**Determining a professionalised status for paramedics**

Commentators consider how professionalism of the paramedic discipline can occur. Williams, Brown and Onsman suggest professional status of the discipline can be achieved through higher education being the sole entry pathway, registration of paramedics thorough regulatory structures and an alliance with medicine. Mahony argues the professional status of the paramedic discipline requires a shift from employer and university regulation of education and professional recognition to a form of self-regulation within the profession. Paramedic regulation through the National Scheme would be a positive outcome for the professionalism of paramedics as it would ensure minimum standards of training and education, an external accreditation body and a self-regulatory aspect allowing the industry to be involved in their own regulation.

There is no final decision-making body which determines the professional status of a discipline. As such, despite the achievement of many professional characteristics, it is difficult to ascertain whether paramedics are professionals, what remains to be achieved for professionalised status or if professionalism is even important for them to join other professional disciplines under the National Scheme.

The concept of professionalism provides significant debate when considering the evolution of paramedicine in Australia. While stretcher-bearers and ambulance officers were very much an occupation, there is growing support for paramedicine becoming a profession. However, the arguments for this transition from occupational worker to professional are somewhat circulatory. If paramedics are included as registered health practitioners within the National Scheme, it is likely they will be considered as health professionals. Yet paramedics may not be accepted into the National Scheme until there is evidence of the professional status of their discipline.

Paramedics should be considered professional. Their work is altruistic in nature; their practice requires a theoretical and technical knowledge, graduates are now tertiary educated, and they exhibit

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172 Williams, Brown and Onsman, *From stretcher bearer to paramedic*, above n 161, 6.
173 Mahony, above n 157, 3-4.
174 Anne-Louise Carlton, 'Occupational regulation of health practitioners in Australia' in Rosemary Kennedy (ed), *Allied Health Professionals and the Law* (The Federation Press, 2008) 56, 74; Cf Malcolm Woollard, 'Professionalism in UK paramedic practice' (2009) 7(4) *Journal of Emergency Primary Health Care* 1, 5 who would not definitively conclude whether British paramedics were professionalised following their inclusion in a registration system. Woollard’s discontent suggests registration does not guarantee professional status for an occupation.
175 With the exception of New South Wales which prescribes vocational training for paramedics as discussed in chapter 2.
professional autonomy. Given paramedics have been compared to medical practitioners and nurses, paramedics should be given the same acknowledgement as a profession. However, their regulation as an occupation is problematic.

Given paramedics have fulfilled the requirements for professionalism, they should no longer be regulated as an occupation. This part of the chapter will begin to argue that paramedics should be regulated as professionals rather than in conformity with occupational regulation. Paramedics are currently regulated using an occupational model, whereas other health practitioners registered under the National Scheme are regulated in a way consistent with professional groups. This is an argument taken up further in Chapters 4 and 6. It will further consider the implications of this change, highlight the industry’s desire for acknowledgement of professionalism and consider why professionalism is important to paramedics.

The difficulty with paramedicine being considered an occupation is that they are regulated as an occupation, through employer regulation, rather than as a profession, utilising a self-regulatory component to their regulation. Chapter 2 argued that Australian paramedicine relies primarily on employer regulation with some legislative oversight. This is consistent with occupational regulation rather than professional regulation. However, Chapter 3 has argued paramedics fulfil the characteristics of attaining a professionalised status. In order to bridge the competing dichotomies between occupational and professional regulation, paramedicine should be professionalised through the National Law’s professional regulation. Further support for professional regulation comes from a theoretical consideration of blue collar professionalism and paramedics’ views on their industry’s professionalism.

3.4.1 The effect of medical dominance and blue collar professionalism on paramedics

Some comparisons can be made between paramedics and the responsibilities of similar health professionals in relation to their professional status. Reynolds and O'Donnell\(^{176}\) highlight an ‘institutional mix’ between paramedics and medical practitioners. They suggest a correlation exists between medical practitioners and paramedics as their primary focus is the ‘preservation of human life’ and they each rely on other health practitioners to assist in patient treatment.\(^{177}\) Nurses have similar healthcare motivations to paramedics and have been considered by literature as a comparable discipline.\(^{178}\) Some researchers argue that medical practitioners and nurses are ‘dominant professions’ when making comparisons to paramedics, suggesting medical practitioners and nurses have more

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\(^{176}\) Louise Reynolds and Madeleine O'Donnell, 'The Professionalisation of Paramedics: The Development of Pre-hospital Care' in Eileen Willis, Louise Reynolds and Helen Keleher (eds), *Understanding the Australian Health Care System* (Elsevier, 2nd ed, 2012) 241, 244.

\(^{177}\) Ibid 245.

\(^{178}\) Brett Williams, Ted Brown and Andrys Onsman, 'Is the Australian Paramedic Discipline a Full Profession?' (2010) 8(1) *Journal of Emergency Primary Health Care* 1, 2.
authority and are in a more dominant medical position.\textsuperscript{179} Significantly, medical practitioners and nurses are considered professions, yet paramedics are not.\textsuperscript{180} This medical dominance requires further consideration.

The professional status of a new health discipline, which has not been previously considered professionalised, can occur through a process of creating ‘medical dominance’. This relates to paramedics, because paramedics would be seeking professionalised status. Willis and Elmer suggest that governmental legitimisation of the discipline occurs when health professionals are given statutory authorisation to perform particular functions to the exclusion of all other disciplines, thereby creating ‘medical dominance’.\textsuperscript{181} The origins of medical dominance can be traced to the state’s role in granting a monopoly of practice to the institution of medicine.\textsuperscript{182} Some examples given for medical practitioners include issuing medical certificates, death certificates and workers’ compensation evidence, as these roles are exclusively allocated to medicine.\textsuperscript{183} When an occupational monopoly exists in the division of labour, this can be indicative of a profession. Professions monopolise their industry leading to an autonomy in the industry as discussed above.

Health-related occupations are not generally considered to occupy a position of medical dominance. Because key professions, such as medical practitioners, are responsible for the supervision of the industry, there is an occupational subordinate position which results for the new occupation, with all decisions deferred to the dominant profession. The dominant profession still has the ultimate decision-making authority. Further, when the government regulates, the new occupation is regulated in a ‘managerial dominance’ situation, the role performed is a required function, with the worker having little control and power over their work skills. When this occurs, the new occupation is not considered to have attained professional status as they are regulated through their employment relationship, as paramedics are. Freidson suggests an avenue for a new occupation to bypass the existing medical dominance is to occupy a new ‘niche’ in the industry that is unsubordinated yet runs parallel to the medical monopoly.\textsuperscript{184}

\begin{itemize}
\item \textsuperscript{179} Louise Reynolds, 'Contextualising Paramedic Culture' in Peter O'Meara and Carol Grbich (eds), \textit{Paramedics in Australia: Contemporary Challenges in Practice} (Pearson, 2009) 28, 36.
\item \textsuperscript{181} Willis and Elmer, above n 166, 295.
\item \textsuperscript{182} Dennis McIntyre, 'Technological determinism: A social process with some implications for Ambulance Paramedics' (2003) 1(3) \textit{Journal of Emergency Primary Health Care} 1, 3; Freidson, \textit{Professional Dominance}, above n 140, 83-4.
\item \textsuperscript{183} Willis and Elmer, above n 166, 295.
\item \textsuperscript{184} Freidson, \textit{Profession of Medicine}, above n 163, 69.
\end{itemize}
As paramedicine is a new health discipline, and one which is evolving quickly, medical dominance, and its role in determining professionalism, is particularly relevant. Paramedicine, as a discipline encroaching on medical dominance, has been authoritatively considered. Freidson suggested that with paramedicine being a medical-related discipline in nature, it is subject to medicine’s own autonomy and professional responsibility. As such, he argued paramedicine will remain subordinate to medicine and unable to exist as an independent professional discipline until leaders of the paramedic field can establish a discrete area of work which can be practised without dependence on the medical discipline. Freidson suggested this was unlikely.185

However, there are limitations to Freidson’s professional dominance model. Freidson considered paramedicine incorporated nursing as well as paramedical responders, and his research was based on the 1970s position of American paramedicine. With the significant progression of nursing and paramedicine since the 1970s, this assertion no longer has the credibility it did in the past. Mahony, as previously discussed, argued that Australian paramedics can be considered as experts in their discipline so the professional autonomy, lacking in 1970, may be present now.186 Given paramedics practise their discipline autonomously and unsupervised, they have a discrete area of work. While some patient conditions require medical practitioner consultation, treatment is largely left to paramedic discretion.

The term ‘paramedicine’ is problematic to instituting medical dominance of the paramedic industry. The fact that it contains the word ‘medicine’ does not help to establish paramedics as separate and autonomous from medicine or any other health profession. However, given the significant progression of the discipline, paramedicine has evolved beyond the 1970s reliance on medicine.

Comparisons with nursing could also be made to paramedicine here. Nursing is dependent on the medical discipline and arguably subject to medicine’s autonomy and professional responsibility. However, nursing has been acknowledged as a health profession warranting national regulation. If the nursing discipline can bypass medical dominance to become a profession, it follows paramedicine can too.

‘Blue collar professionalism’, a significant contribution of Metz, can be considered as a by-product of medical dominance. Metz considered blue collar professionalism to be a form of professionalism stemming from the blue collar roots of paramedicine.187 He argued blue-collar professionalism can be established through paramedic knowledge and on-road experience which cannot always be documented in the same way as professionalism for other health practitioners.188 Metz listed stressful and exhausting working conditions, poor pay and limited prospects of upward mobility to be indicative of ‘blue collar’

185 Ibid.
186 Mahony, above n 157, 3.
188 Ibid.
ambulance work. These blue collar roots can also be seen in Australia and stem from Australian paramedics being drivers, without a tertiary background. The stress, danger and dynamic working environment of Australian paramedics differs to other health practitioners who are not treating patients in the community. So ambulance work, inherently, has a ‘blue-collar’ nature. However, the significance of Metz’s contribution is that the blue collar nature of ambulance work does not preclude paramedics from acknowledgement as professionals. Instead of blue collar workers, they could be blue collar professionals.

Blue collar professionalism has been considered very sparingly in literature since Metz’s publication. McCann et al. suggest blue-collar professionalism exists for British paramedics. It is a concept crucial to the paramedic identity, in the form of the nature of their work being pre-hospital and ‘street-level’, despite the arguable prevalence of professionalism within the United Kingdom ambulance institutions. The authors have acknowledged paramedic work is evolving from a ‘blue collar occupation into a profession’.

Blue collar professionals are an apt label for Australian paramedics. Given paramedics are now tertiary qualified and practising largely autonomously, they have arguably transitioned from vocational ambulance drivers to professionals synonymous to nurses and medical practitioners. Given the nature of their work being emergency and pre-hospital, it may be difficult to reclassify the industry as ‘white-collar’, so blue collar remains a suitable explanatory term. However, given paramedics’ progression, and their fulfilment of professionalism characteristics, ‘blue collar professionals’ certainly encompasses their role and reflects their professionalised status.

### 3.4.2 The importance of professionalism on the regulation of paramedics

While much has been written about professions and professionalism, these concepts could be considered old-fashioned and elitist. Marshall’s 1939 publication outlines 19th and 20th century research surrounding professionalism debates in social policy. Traditionally, there were three recognised professions: divinity, incorporating a religious calling and university teaching; the law; and, medicine. These expanded, during the 1800s, to incorporate the additional professions of dentists, civil engineers, pharmacists, teachers, architects, veterinarians, social workers, librarians, accountants, nurses and opticians. The number of disciplines claiming professional status has increased since that

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189 Leo McCann et al, ‘Still Blue-Collar after all these Years? An Ethnography of the Professionalization of Emergency Ambulance Work’ (2013) 50 *Journal of Management Studies* 750, 754.
193 Wilensky, above n 140, 141.
time. However, despite whether the concept is dated and old-fashioned, disciplines who have not
attained a professionalised status continue to petition for inclusion in the elite group. Because of the
respect afforded to professional groups in society, professionalism grants legitimacy to occupations.\textsuperscript{194}

Paramedics want their discipline to be professionalised. In 2008, 63 paramedics employed within the
education and training sector of their employment organisation, or through a university or polytechnic
organisation, participated in a study of paramedic professionalism. The results from Williams, Brown
and Onsman’s study found that most participants believed the paramedic discipline was not a
profession, they should be considered a profession, they would benefit from becoming recognised as a
profession and they already exhibited traits of a professional group.\textsuperscript{195} The authors published a further
study in 2012 based on 872 practising paramedics. The results, from the larger study, came to the same
above conclusions.\textsuperscript{196}

\section*{3.5 Conclusion}

In this chapter I have argued that paramedics have evolved into a profession. This means that regulating
paramedics as an occupation (as opposed to a profession) is no longer the most appropriate regulatory
method for the discipline. As we have seen, while paramedics began as stretcher-bearers and ambulance
drivers, it is their progression to ambulance officers and then paramedics which is most notable.
Ambulance officers required vocational and on-road training only; now, however, paramedics function
as highly skilled and autonomous healthcare practitioners with tertiary qualifications. Paramedics are
being given more responsibility than ever before and the expanded scope of practice, afforded to some
paramedics, highlight the significant healthcare functions paramedics fulfil. With the private sector also
growing, current regulation is failing to provide regulatory structures applicable to all Australian
paramedics.

There are several measures needed to finalise the transition from ambulance worker to healthcare
professional. Firstly, paramedics need to be legislatively acknowledged as such and references to
‘ambulance officers’ in statutory instruments such as in the \textit{Ambulance Service Act 1991} (Qld) are no
longer appropriate. As paramedics diagnose, treat and provide advice on a range of patient illnesses and
injuries, they have been bestowed with wide-ranging statutory powers to assist with patient treatment
in emergencies which, without this legislative authority, would find other healthcare workers
contravening patients’ legal rights. Paramedics’ legislative authority to provide medical treatment
without consent; detain and restrain patients without consent; and enter property without consent,

\textsuperscript{194} Richards and Louise, above n 154, 5; Friedson, \textit{The Profession of Medicine}, above n 163, 131.
\textsuperscript{195} Williams, Brown and Onsman, \textit{Is the Australian Paramedic Discipline a Full Profession?}, above n 178, 4-5.
See also Brett Williams et al, ‘Are paramedic students ready to be professional? An international comparison
\textsuperscript{196} Brett Williams, Andrys Onsman and Ted Brown, ‘Is the Australian paramedic discipline a profession? A
national perspective’ (2012) \textit{2 International Paramedic Practice} 77.
demonstrates the community’s trust in paramedics and highlights the industry’s progression from a first aid and transport function to skilled prehospital healthcare.

Paramedics must be regulated as a health profession under the *National Law*. They fulfil the characteristics of a profession as their work is altruistic in nature; their practice requires a theoretical and technical knowledge; graduates are now tertiary educated; and they exhibit professional autonomy. While ‘blue collar professional’ might be a more apt term for paramedics, given the stressful, prehospital environment of their workplace, their advanced medical skills and knowledge should be recognised in the form of national registration.

Having made the argument that paramedic practice has evolved, and regulation needs to do the same, Chapter 4 adds to this argument. Before looking at how paramedics might be included under the National Scheme, it is necessary to thoroughly examine current regulation of paramedics. As we will see, despite evolution of paramedic practice, the regulation of paramedics is still largely piecemeal and inconsistent. In the context of this thesis, Chapters 3 and 4 should be read closely together, with Chapter 3 showing the evolution of paramedics and Chapter 4 showing the elements of employer and occupational regulation. This is significant as the Chapter 4 discussions further highlight the extent of employer regulation in the industry and why this is not the most appropriate regulation for Australia’s paramedics.
CHAPTER 4: NOTABLE FEATURES OF AUSTRALIAN PARAMEDIC REGULATION

4.1 Introduction

As we have seen in Chapter 2, paramedics in Australia are governed largely through the employment relationship. More specifically, paramedics are regulated through workplace industrial instruments, clinical policy documents and statutory codes of conduct which were outlined in Chapter 2. Chapter 3, then, considered how paramedicine has evolved into a profession where occupational regulation, which currently applies to paramedicine, is no longer the best regulatory model. This chapter will develop the argument that paramedics should be included under the National Scheme by more thoroughly examining the current regulation of paramedics. This chapter will expand upon those regulatory tools to provide an overarching framework for the governance of paramedicine.

More specifically, this chapter evaluates the effects of paramedicine and discusses the issues which arise from the current regulatory framework. Currently, paramedics are regulated in four main ways:

1. prescribing rules for tertiary education and accreditation;
2. protection of title;
3. the possession, administration and storage of drugs; and,
4. complaints and discipline.

Many of these features derive from legal regulation, although the disparate jurisdictional regulation of Australian paramedicine means this is not absolute and there are a range of different statutory instruments which apply to paramedics and their practice in each jurisdiction. For example, protection of title and drug regulation are a legislative intervention into paramedic regulation. However, other notable features reflect occupational regulation, through employers, such as disciplinary action.

Part 4.2 considers the training and educational requirements for the paramedic industry. Part 4.3 evaluates the use of title protection, as a regulatory tool, in some jurisdictions of Australia. Drug regulation, through the possession, administration and storage of scheduled drugs is addressed in part 4.4. The complaints and disciplinary processes are then considered in part 4.5. Utilising a legal doctrinal approach, this chapter will ‘identify, analyse and synthesise the content of the law’1 for paramedic practice in Australia. Applying this research method, Chapter 4 will explain how the current paramedic regulatory framework has deficiencies and inconsistencies, and in so doing, introduces National Law provisions which govern health practitioners as a comparison.

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1 Terry Hutchinson, 'Doctrinal research: researching the jury' in Dawn Watkins and Mandy Burton (eds), Research Methods in Law (Routledge, 2013) 9.
4.2 Training and educational requirements for the paramedic industry

The types of paramedics, and their scope of practice, differ between jurisdictions. The most widely used job titles or ‘types’ of paramedics are:

1. are advanced care paramedics (ACPs);
2. intensive care paramedics (ICPs); and
3. extended care paramedics (ECPs).

The training and educational requirements for paramedics depend on their role classification and Table 4.1 outlines the paramedic role classifications. Once paramedics are qualified, through the vocational or tertiary education qualifications identified in Table 4.2, further training is often required to progress to roles requiring higher skills and expertise. For example, ACPs may undertake further training to transition to an ICP or ECP role. The requirements for additional qualifications mitigate risk as it ensures paramedics receive a level of training in order to be proficient in more invasive procedures.

It is worth noting here that currently the ‘types’ of paramedics are often referred to in conflicting ways. For example, Queensland’s ICPs are considered critical care paramedics instead, while their ECPs are ‘isolated practice area paramedics’. The inconsistent use of titles is problematic for the regulation of paramedics as it is another area for jurisdictional disparity in the requirements for, and treatment of, paramedics. While paramedic employers may have the resources to make inquiries into the skill and expertise of prospective paramedic applicants, there may be confusion within the community surrounding the different types of paramedics and their roles. Without consistency in roles, it is difficult for the public to determine the level of skill and expertise of paramedics, particularly if their role titles differ between jurisdictions. A similar problem was addressed by nurses who were referred to as ‘nurses’ and ‘nurse practitioners’. Nurse practitioners require a registration endorsement which can only be achieved following three years advanced practice in their specific area of expertise. Regulation of nurse practitioners is undertaken through their National Board, rather than under the National Law.² Combining paramedic role classifications into a unified term of ‘paramedic practitioner’ could achieve a similar result in standardising paramedic role classification and reducing public confusion.

Classification | Role
---|---
Advanced care paramedic | These are entry-level paramedics who ‘provide emergency health care and transport for injured, sick, infirm and aged persons to medical facilities’.\(^4\)
Also called ‘ambulance paramedic’.\(^3\)
Intensive care paramedic | Intensive care paramedics (ICPs) have a higher calibre of skills and expertise than an advanced care paramedic and often require more advanced qualifications and training. An intensive care paramedic has been described as an ‘advanced clinical practitioner in Paramedicine who provides medical assessment, treatment and care in the out-of-hospital environment for acutely unwell patients with significant illness or injury’.\(^5\) The Australian and New Zealand Standard Classification of Occupations further defines an ICP as someone providing ‘intensive pre-hospital health care to injured, sick, infirm and aged persons and emergency transport to medical facilities’.\(^6\)
Also called ‘critical care paramedic’.
Extended care paramedic | An extended care paramedic (ECP) is another job title used for paramedics who have an expanded scope of practice, although the use of this title differs between jurisdictions. They are primarily used in more rural or remote locations when access to emergency and primary health practitioners is limited.
Also called ‘general care paramedic’ or ‘isolated practice area paramedic’.

South Australian ECPs have also supported general practitioner work, in the past, when there was a shortage of general practitioners to treat patients. The use of paramedics to supplement general practitioners demonstrates a significant level of responsibility and trust which has been afforded to South Australian paramedics.\(^7\) The extended care role, and its contribution to the evolution of the paramedic discipline, is given more thorough consideration in Chapter 4 of this thesis.
Table 4.1 Explanation of the types of Australian paramedics

Another problem for the current regulatory scheme for paramedics is that the training and educational requirements derive from a variety of sources. In jurisdictions with relevant legislation, employers and statutory instruments prescribe minimum levels of training and education for Australian paramedics.\(^8\) New graduates, in all Australian jurisdictions except New South Wales, must possess tertiary qualifications in order to become a public sector paramedic.\(^9\) The tertiary requirement does not apply

\(^5\) Paramedics Australasia, *Paramedicine Role Descriptions*, above n 3, 5. ‘Critical Care Paramedic’ and ‘Mobile Intensive Care Ambulance paramedic’ (Victoria) has been used as a title as well.
\(^7\) Ibid 10.
\(^8\) See table 4.2.
to paramedics already employed in the public ambulance services. Table 4.2 outlines minimum qualifications for paramedics in the public ambulance services.

One of the problems of the current approach to training and education is that minimum levels of training and education for paramedics have evolved.\textsuperscript{10} While paramedics were originally trained vocationally and learnt skills “on the job”, Australia has now transitioned to predominantly university-based education for paramedics. In fact, the Council of Ambulance Authorities (CAA) has suggested a Bachelor’s Degree in Paramedicine, or equivalent, should be the minimum requirement for all paramedics, allowing for a realistic transition for those with vocational education qualifications only.\textsuperscript{11}

\textsuperscript{10} Chapter 3 considered the full extent of the paramedic industry’s progression from “stretcher-bearer” days to the current practicing paramedics.

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Advanced Care Paramedic</th>
<th>Intensive Care Paramedic</th>
<th>Extended Care Paramedic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Australian Capital Territory</strong>&lt;sup&gt;12&lt;/sup&gt;</td>
<td>Diploma of Paramedical Science (Ambulance), or equivalent, and a period of supervised clinical practice.</td>
<td>Advanced Diploma of Paramedical Science (Ambulance) or equivalent, plus supervised clinical practice.</td>
<td>Not addressed in the industrial instrument or any legislation.</td>
</tr>
<tr>
<td>New South Wales</td>
<td>Bachelor of Paramedicine; university conferred Graduate Diploma of Paramedicine; or a nationally recognised, registered training organisation issued Diploma of Paramedicine.&lt;sup&gt;13&lt;/sup&gt;</td>
<td>Not addressed in the industrial instrument or any legislation.</td>
<td>Not addressed in the industrial instrument or any legislation.</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>Not addressed in the industrial instrument or any legislation.</td>
<td>Not addressed in the industrial instrument or any legislation.</td>
<td>Not addressed in the industrial instrument or any legislation.</td>
</tr>
<tr>
<td>Queensland</td>
<td>Certificate IV in Basic Emergency Care or Associate Diploma of Paramedical Science (Ambulance) for a “Paramedic” or equivalent; or Diploma of Paramedical Science (Ambulance) or Associate Diploma of Applied Science (Ambulance), or equivalent, for a “Critical Care Paramedic”.</td>
<td>Graduate Diploma in Intensive Care Paramedical Practice, Advanced Diploma of Health Science (Pre-Hospital Care) or equivalent plus five years’ paramedical experience.</td>
<td>An Isolated Practice Area Paramedic&lt;sup&gt;15&lt;/sup&gt; has completed a James Cook University Graduate Certificate of Rural and Remote Paramedic Practice which includes an Isolated Practice Area Paramedic course.&lt;sup&gt;16&lt;/sup&gt; However, an IPAP can still be qualified as either an advanced or intensive care paramedic, although their qualifications and experience mean they have more advanced clinical skills than a standard advanced care paramedic.</td>
</tr>
<tr>
<td>South Australia&lt;sup&gt;17&lt;/sup&gt;</td>
<td>Bachelor of Health Science plus a 12-month internship. Sponsored students are</td>
<td>Advanced care paramedic qualifications plus successful completion of</td>
<td>Intensive Care level training but no additional skills are</td>
</tr>
</tbody>
</table>

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<sup>13</sup> *Health Services Regulation 2013 (NSW)* s 19A.

<sup>14</sup> *Ambulance Service Employees Award - State 2012* (Queensland, 14 June 2012) 3.4(g).

<sup>15</sup> Isolated Practice Area Paramedics (IPAP) are “appropriately qualified paramedics operating under an extended role of practice in an isolated designated station” according to the *Queensland Ambulance Service – Determination 2013* (2 December 2013) 4. The *Health (Drugs and Poisons) Regulations 1996* (Qld) apps 5, 9 (definition of ‘isolated practice area (paramedics)’) expressly identify areas in the State that are classified as an isolated designated station within this definition and are considered to be geographically rural or remote areas of Queensland.

<sup>16</sup> *Health (Drugs and Poisons) Regulations 1996* (Qld) app 9 (definition of ‘isolated practice area paramedic’).

<sup>17</sup> *SA Ambulance Service Enterprise Agreement 2011* (3 February 2012) 29.
eligible for entry to the program with a “Certificate IV BEC” or equivalent and complete tertiary study while working as students under direct paramedic supervision. ‘the relevant clinical education required for advancement to this level’. No further details are provided in the industrial instrument. needed above Intensive Care qualifications.18

<table>
<thead>
<tr>
<th>Country</th>
<th>Requirement</th>
<th>2014 Bachelor of Paramedic Science or relevant work experience.19</th>
<th>Not addressed in the industrial instrument or any legislation.20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>Western Australia allows Ambulance Paramedics to commence working on-road after the completion of a pre-employment course; a Paramedical Science degree is then completed throughout the paramedic’s employment in order to transition to higher rates of pay.</td>
<td>Advanced Diploma, with three years on-road ambulance experience.24</td>
<td></td>
</tr>
</tbody>
</table>

Table 4.2 Minimum educational requirements for public sector paramedics

The way in which education and training are regulated is different between public and privately employed paramedics. As previously discussed in Chapter 3, paramedics are being employed in a public and private capacity throughout all jurisdictions of Australia. Although, the public ambulance services are the primary paramedic employers. One of the consequences of an employer-regulated discipline is that the minimum educational requirements which exist in the public sector may not be applied for privately employed paramedics. Given that employers are generally responsible for prescribing minimum educational standards, there is no requirement for private employers to uphold minimum standards of training and education for paramedics they employ. One way in which paramedics are

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18 Council of Ambulance Authorities, Expanding roles, above n 22.
19 Ambulance Service (Paramedic) Regulations 2014 (Tas) reg 3.
23 St John Ambulance Australia (Western Australia) Inc Ambulance Officers'/Paramedics Enterprise Agreement 2011-2014 (18 January 2012) 9.1(a).
employed privately is by organisations that employ paramedics for special events or remote locations including music festivals or mines. For example, Medic One is a registered training organisation which trains and employs first aid and emergency medical responders for event management and patient transfers. Medic One requests that paramedics hold a Diploma, Advanced Diploma or Degree in Paramedic Science, but also employ Medics holding a Certificate IV in Health Care (Ambulance). Without minimum educational standards being prescribed and enforced uniformly across all jurisdictions, there will continue to be disparity in the education and training of paramedics within the industry as there will potentially be different standards of skills and expertise between publicly and privately employed paramedics.

Despite the Bachelor’s degree generally being a minimum employment requirement for Australian graduate paramedics, public and private paramedic practice is occurring without tertiary qualifications. Of the total numbers of paramedics currently employed in Australia in any capacity, 55.9 per cent had an Advanced Diploma or Diploma as their highest level of educational attainment in 2013. Only 23.7 per cent of Australian paramedics had achieved a Bachelor’s degree qualification in the same year. These figures demonstrate how paramedicine is evolving as a discipline, with more emphasis being given to tertiary requirements presently than in the past. New South Wales also continues to promote vocational training, over tertiary education, which allows a national minimum standard of training to be delayed. Paramedics without tertiary qualifications can be employed in a private capacity or many have considerable on-road experience within the public system and their prior experience overrides their lack of tertiary qualifications. The evolution of paramedic skills and expertise will be further explored in Chapter 4.

The transition from vocational to tertiary education has been justified on a number of grounds. Bill Lord suggested, in 2003, that tertiary qualification were a necessary requirement for the paramedic industry. Specifically, Lord argued that movement away from vocational training leads to a reduction in cost for the employer organisations and increased professional status for the discipline. It also assists in developing skills which have been traditionally absent from the vocational program, such as health

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services management, law and ethics, research methods and other professional issues. The Council of Ambulance Authorities’ recommendation for all paramedics to attain tertiary qualifications is a positive step to promote minimum training and educational standards for paramedics across Australia.

In summary, while most new paramedic graduates require a Bachelor’s degree for entry to the discipline, many existing paramedics completed on-the-job training and have vocational qualifications. New South Wales is still accepting student paramedic applicants without tertiary training because vocational entry pathways ‘provide for flexibility in workforce planning and management’. The inconsistent standards of training and education raise some significant issues surrounding minimum standards of paramedic competence and employability.

One of the consequences of different standards is that paramedics may have difficulties transferring their employment between jurisdictions, particularly if they do not possess tertiary qualifications. Where a tertiary qualification is required, some jurisdictions, such as Victoria, accept an ‘equivalent’ training option which means they might waive the Bachelor’s degree specification for paramedics with sufficient on-road experience. Individual employers, however, are responsible for evaluating the suitability of paramedic applicants to perform the role in the new jurisdiction. The recruitment processes, then, lack consistency as there is no standardisation between employers in accepting jurisdictional staff transfers. For example, New South Wales paramedics, without tertiary qualifications, may not be eligible for employment in another jurisdiction where there are minimum tertiary standards of education; however, the final decision about a New South Wales paramedic’s employability rests with the new employer.

Another consequence of conflicting standards is that there are also paramedic competency issues between jurisdictions. Without a national and uniform approach to minimum standards of education and training, there is no guarantee that paramedics will possess comparable skills and expertise across jurisdictions. A National Board would ensure the training and educational standards across jurisdictions were as consistent as possible. One of the ways to ensure consistency in the quality of training is through industry accreditation, an approach used under the National Scheme.

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32 Skinner, above n 28, 8.
4.2.1 Tertiary qualifications and accreditation

Accreditation of university qualifications to ensure uniformity has become an important element of the paramedicine industry’s regulation. Accreditation standards are used to ensure educational providers deliver minimum levels of competence within an industry. According to regulatory theory, accreditation is an authorisation regulatory tool in which official confirmation of standards come from an authorised body, helping to ensure the competence of applicants. Accreditation schemes consider qualifications, skills, knowledge, experience, codes of conduct and professional development, among other things, to ensure minimum standards of practitioner competence in the industry. Significantly, the credibility of the authorising body to ensure that competence can determine the value of accreditation as a regulatory tool. Accreditation can sometimes be conferred by express legislative authority but it can also be a voluntary process. Further, there can be a single accreditation authority with exclusive rights to facilitate the accreditation process or multiple accreditors may exist.

The current accreditation process within the paramedicine industry ensures tertiary courses are delivering requisite competencies for graduates. Specifically, paramedic accreditation comes from the Australian and New Zealand Paramedic Professional Competency Standards (PPCS), administered through the CAA and Paramedics Australasia. The PPCS set out the professional expectations of a paramedic and the knowledge, understanding and skills required for practice. The CAA accredits paramedic courses through the Paramedic Education Programs Accreditation Scheme and organises the accreditation panels for higher education, although final authority to practise still rests with the various employers.

The PPCS works as an accreditation guideline for tertiary institutions to prescribe learning outcomes for paramedic students and provide competencies for fully qualified paramedics. The CAA requires universities to apply for accreditation and then undertake annual reporting of compliance with the

35 Ibid.
37 According to this competency standard, a paramedic acts in accordance with accepted standards of conduct and performance; makes informed and reasonable decisions; demonstrates professional autonomy and accountability; and develops and maintains professional relationships.
38 Adherence to the second standard means a paramedic demonstrates the knowledge and understanding required for practice as a paramedic; operates within a safe environment; identifies and assesses health and social care needs in the context of the environment; formulates and delivers clinical practice to meet health and social care needs within the context of the environment; and critically evaluates the impact of, or response to, the paramedic’s actions.
39 O’Brien et al, above n 36, 3.
PPCS. The application process includes site visits to assess compliance with the PPCS. The universities must also show evidence their courses promote the PPCS.\textsuperscript{41}

Apart from the accreditation requirements for paramedic education, there is no enforcement of the PPCS; all competency monitoring is done through workplace agreements. It is interesting to note that despite accreditation being previously considered ‘synonymous with control and standardisation’,\textsuperscript{42} the CAA have suggested ‘[a]ccreditation is not about standardisation of paramedic education programs’.\textsuperscript{43} Instead, the CAA promotes paramedic accreditation as responsive to industry needs, meeting professional competency standards and preparing graduates for the role of paramedic.\textsuperscript{44} Unfortunately though, without standardising paramedic accreditation, there is no guarantee paramedics are achieving comparable graduate outcomes between tertiary institutions. The accreditation body prescribing minimum educational standards is a form of indirect regulatory control over paramedic standards within the industry.\textsuperscript{45} However, as there is no means to currently enforce accreditation standards of paramedics, employers can choose graduates with qualifications that are noncompliant with accreditation requirements. This means the regulatory value of the current accreditation model is minimal as employers can circumvent the minimum standards without any accountability.

There are a number of issues with employers assuming responsibility for industry accreditation. Despite the promotion of the public interest being the primary purpose of health practitioner regulation, employer organisations might instead focus on the best interests of their organisation. Organisational self-interest is then promoted above the public interest. It is problematic that the CAA is the accreditation body for the paramedicine industry. They are the organisation whose members make up the public ambulance employer providers in each state and territory of Australia, as well as New Zealand.\textsuperscript{46} As a result, there is a conflict of interest because the employers are also, then, directly responsible for industry educational accreditation. Further, with more employment opportunities available for paramedics within the private sector, it is no longer appropriate for public ambulance employers to solely regulate paramedic accreditation because they are not representative of the industry. Public ambulance employers cannot comprehend the full ambit of applicable issues within the private sector, such as scopes of practice and the types of emergencies which arise. Finally, without a regulatory


\textsuperscript{43} Council of Ambulance Authorities, ‘Guidelines for the Assessment and Accreditation of Entry-level Paramedic Education Programs’ (January 2014) 5-6.

\textsuperscript{44} Ibid 6, 8.


framework which can enforce accreditation for all employers, the accreditation processes determined by the CAA do not apply to the private sector anyway. This means there could be paramedics without tertiary paramedic qualifications, or the requisite experience, treating patients and performing a paramedic role. As such, employers should not be responsible for industry accreditation and an external accreditation body, such as the National Scheme’s approach to accreditation, should be adopted for paramedicine. If paramedics are included in the National Law, many of the issues around accreditation and training would be reduced.

Perhaps most importantly, under the National Law accreditation is undertaken externally to employers. The National Boards can establish an accreditation committee or an external entity can develop accreditation standards. If accreditation standards are developed externally, the National Board must approve them. In this way, employer interests remain external to industry regulation for registered health practitioners and the employer role is separated from the accreditation regulatory role.

4.3 Title protection

Under the current paramedic regulatory framework, there is a problem with tertiary paramedic students being employed as casual paramedics. In addition to the tertiary educational requirements, a period of on-the-job training applies for prospective paramedic graduates: this is often called an internship. The period of internship, with supervised clinical practice, is undertaken after graduation. Every public ambulance service in Australia, with the exception of New South Wales, enforces an internship period for graduate paramedics. New South Wales does not require an internship period given their diploma-qualified paramedics are concurrently performing ‘on-the-job’ training while attaining their vocational qualification. Currently, once students have satisfied the minimum educational requirements, they are eligible to apply for employment as a paramedic within the public or private sector. A majority of paramedic graduates seek employment with an Australian public ambulance service. However, paramedic employment can commence prior to students receiving their formal qualifications.

Paramedic students, enrolled in a tertiary program, can also obtain paramedic work before they are accepted into a graduate paramedic program. In Queensland, there are opportunities for currently...
enrolled tertiary students to work as casual student paramedics and they perform a paramedic role under the supervision of a qualified paramedic. They are then undertaking paramedic duties prior to receiving their tertiary qualification or undertaking the period of supervised clinical practice internship.

There are significant public safety issues with tertiary students being employed as casual paramedics. Rather than having two qualified paramedics attending an emergency situation, public ambulance services are utilising students in place of fully trained, experienced and qualified paramedic staff. While the decision might benefit the employer organisations fiscally, members of the public would not receive the standard of care they might expect from two qualified paramedics. As student paramedics do not have the scopes of practice to administer drugs or perform more invasive procedures, employer organisations, in these situations, are putting the public at risk by allowing unqualified casuals to perform the role of a qualified paramedic. A more rigorous and enforceable regulatory structure, incorporating title protection, might provide a solution to reduce public risk associated with unqualified practitioners.

As will be argued in this part, there are problems with the way in which paramedic title is currently protected. When proposing legislative amendments in New South Wales, Mrs Jillian Skinner, the Minister for Health, stated:

There is one gap in the regulation of paramedics. Currently any person can call themselves a paramedic in New South Wales regardless of their level of qualifications and training… By protecting the use of the title “paramedic”, members of the public can be sure that those who call themselves a paramedic have the necessary qualifications, training or experience.51

Protection of title, also called reservation of title, refers to the regulatory mechanism restricting the use of various professional titles.52 Specifically, title protection makes it unlawful for unqualified people to use a protected title and, as such, protection of title is an important way to maintain minimum standards within a profession.53 By ensuring that there are penalties applicable to unqualified people using protected titles, community confidence is instilled in those professionals as it promotes a minimum standard of skill and expertise which can be monitored.54 It also serves as a proxy for carrying qualifications; the public assumes the practitioner is qualified if they use the title.

50 Hou, Rego and Service, above n 33, 116.
51 New South Wales, Parliamentary Debates, Legislative Assembly, 3 June 2015, 1393 (Jillian Skinner).
54 Lin and Gillick, above n 53, 460.
Protection of title provisions apply to a range of disciplines. Lawyers are an example of a protected title. Protection of title also applies to health professionals registered under the *National Law*. Under the *National Law*, a person who is not appropriately qualified must not knowingly or recklessly:

a. take or use the title of “registered health practitioner”;

b. take or use any title, name, initial, word or symbol or description indicating they are a health practitioner, or they are authorised or qualified to practise a health profession;

c. claim to be registered; or

d. claim to be qualified to practise as a health practitioner.56

Specific health specialties within the broad ‘health practitioner’ classification are also further protected. For example, ‘medical practitioner’, ‘medical specialist’, ‘nurse’ and ‘midwife’ are all examples of protected titles with restrictions on use of the titles without registration.57 ‘There are significant fines of up to $30,000 for an individual or $60,000 for a body corporate for the unauthorised use of the title ‘registered health practitioner’ or the more specific specialty titles of ‘medical practitioner’ and ‘medical specialist’, for example.58

Not everyone agrees with the effectiveness of title protection as a regulatory tool. Literature discussing protection of title highlights criticisms with it being used as a regulatory tool. Protection of title, on its own, does not necessarily ensure high standards of conduct for health practitioners, with Stone arguing public respect must be earned through practitioner competence, ethics, commitment to research and responsive complaints procedures.59 Elkin proposes regulation through title protection is ‘ineffective’ in its goal of protecting the public as the public do not have the means to interpret and use information about title reservation.60 Another criticism highlighted is protection of title does not prevent harmful practices, as it does not directly regulate harmful practices, and there is no protection from unsuitable practitioners using the title.61

Title protection exists in the paramedic industry on two levels. Firstly, some jurisdictions offer protection against the misuse of ambulance-related titles, such as ‘ambulance service’. Secondly, there are also ‘paramedic’ title protection provisions. Table 4.3 describes provisions relating to the protection of ambulance-related titles and Table 4.4 outlines protection of the ‘paramedic’ title in Australia.

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55 *Legal Profession Act 2007* (Qld) ss 6, 24-5.
56 *National Law*, s 116.
57 *National Law* ss 113, 115. ‘Doctor’ is not protected as it is a title used by those who have completed a PhD in any discipline.
58 *National Law* ss 113, 115-6.
60 Elkin, above n 53, 688.
61 Tran, above n 52, 362; Lin and Gillick, above n 53, 460.
<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Ambulance title protection provisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Capital Territory</td>
<td>It is an offence to provide emergency or ambulance services that are not approved.62</td>
</tr>
<tr>
<td>New South Wales</td>
<td>No title protection for ambulance-related titles.</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>No title protection for ambulance-related titles.</td>
</tr>
<tr>
<td>Queensland</td>
<td>It is an offence to suggest an affiliation with an ambulance service or use ‘ambulance’ unless an association with such exists.63</td>
</tr>
<tr>
<td>South Australia</td>
<td>It is unlawful to provide ambulance services, without approval of the Minister; using 'Emergency Ambulance' on a motor vehicle without authorisation is also prohibited.64 If a person or organisation outside the South Australian Ambulance Service wants to provide a non-emergency ambulance service, they must apply for a 'restricted ambulance service licence’ or risk a substantial penalty.65</td>
</tr>
<tr>
<td>Tasmania</td>
<td>Tasmania prohibits the unauthorised provision of ambulance services, outside the public Ambulance Service, without written consent, as well as prescribing an offence for falsely representing a vehicle as an “ambulance”.66 Private organisations can only participate in non-emergency patient transport with the provision of a licence.67 Businesses are prohibited from encouraging a mistaken belief that their business is staffed by paramedics.68</td>
</tr>
<tr>
<td>Victoria</td>
<td>It is an offence to suggest an affiliation with an ambulance service or use ‘ambulance’ unless an association with such exists.69</td>
</tr>
<tr>
<td>Western Australia</td>
<td>No title protection for ambulance-related titles.</td>
</tr>
</tbody>
</table>

Table 4.3 Protecting ambulance-related titles in Australia

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62 Emergencies Act 2004 (ACT) s 63. This section does not apply to medical practitioners or persons providing first aid only.
63 Ambulance Service Act 1991 (Qld) s 48.
64 Health Care Act 2008 (SA) s 57.
65 Ibid s 58.
66 Ambulance Service Act 1982 (Tas) ss 37, 39.
67 Ibid s 35A.
68 Ibid s 39A.
69 Ambulance Services Act 1986 (Vic) s 39.
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<tr>
<th>Jurisdiction</th>
<th>Protection of title provision</th>
<th>Definition of paramedic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian</td>
<td>No protection for the ‘paramedic’ title.</td>
<td>‘Paramedic’ is then further defined as a person who is qualified, trained or has the expertise prescribed by regulations; authorised as a paramedic under another Australian jurisdiction; or an Ambulance New South Wales staff member, or other person, who has been authorised to hold the title of paramedic from the Health Secretary. Qualifications include a Bachelor of Paramedicine, university conferred Graduate Diploma of Paramedicine; or a nationally-recognised, registered training organisation issued Diploma of Paramedicine.</td>
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<tr>
<td>Capital</td>
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<tr>
<td>Territory</td>
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<tr>
<td>New South</td>
<td>‘A person who is not a paramedic must not, in any way, hold himself or herself out to be a paramedic’ with a maximum penalty prescribed as $11,000.</td>
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<tr>
<td>Wales</td>
<td></td>
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</tr>
<tr>
<td>Northern</td>
<td>No protection for the ‘paramedic’ title.</td>
<td></td>
</tr>
<tr>
<td>Territory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Queensland</td>
<td>No protection for the ‘paramedic’ title.</td>
<td></td>
</tr>
<tr>
<td>South</td>
<td>South Australia protects the title of ‘paramedic’ from unauthorised use, making it unlawful for a person to knowingly or recklessly take or use the title ‘paramedic’ or allow someone to falsely believe the person to be a paramedic, unless the person holds the appropriate qualifications expressed by parliament; the maximum prescribed penalty is $30,000.</td>
<td></td>
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<tr>
<td>Australia</td>
<td></td>
<td>A paramedic is a ‘health practitioner who provides pre-hospital emergency care services or community-based alternative models of care as a result of a request for emergency medical assistance’. The prescribed paramedic qualifications include a paramedicine degree, diploma or advanced diploma in paramedicine.</td>
</tr>
<tr>
<td>Tasmania</td>
<td>Protection of title exists in the form of potential imprisonment or fines for people who impersonate or present themselves as a paramedic without the required qualifications.</td>
<td>A paramedic is ‘an officer of the Ambulance Service [or ambulance service in another jurisdiction] who holds a prescribed paramedic qualification or a qualification and experience… to a satisfactory level of understanding and competence…’ A paramedic qualification is a Bachelor of Paramedic Science. However, a paramedic can also be a person who meets any ‘requirements, conditions or approvals prescribed relating to that class of persons’. No further clarification is provided in the Act or</td>
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70 *Health Services Act 1997 (NSW) s 67ZDA(1); Crimes (Sentencing Procedure) Act 1999 (NSW) s 17.*  
71 *Health Services Act 1997 (NSW) s 67ZDA(2).*  
72 *Health Services Regulation 2013 (NSW) s 19A. This provision commenced on 1 February 2016.*  
73 *Health Practitioner Regulation National Law (South Australia) Act 2010 (SA) s 120A (1).*  
74 *Ibid s 120A(2) as amended by the Health Practitioner Regulation National Law (South Australia)(Protection of Title – Paramedics) Amendment Act 2013 (SA).*  
75 *Health Practitioner Regulation National Law (South Australia) Regulations 2010 (SA) reg 11A.*  
76 Ambulance Service Act 1982 (Tas) ss 39A, 39B (5).  
77 *Ibid s 3AB as amended by the Ambulance Service Amendment Act 2013 (Tas).*  
78 *Ambulance Service (Paramedic) Regulations 2014 (Tas) reg 3.*
Regulations. It is possible this provision will allow the paramedic title to be expanded to paramedics outside the public ambulance service, such as employees of private organisations, the defence force, international visitors and/or similar parties.  

| Victoria | No protection for the ‘paramedic’ title. |
| Western Australia | No protection for the ‘paramedic’ title. |

Table 4.4 Protecting paramedic-related titles in Australia

Despite some regulation of titles, there are problems with the existing ways in which paramedic titles are regulated. Protection of ambulance-related titles do not impact upon regulating paramedicine as a discipline. Protecting ambulance-related titles relates to the public ambulance services’ exclusive use of the term ‘ambulance service’ to prevent private encroachment on their industry from private companies. They exist to operate as a monopoly on public ambulance services. As such, changing the regulation of individual paramedics to a registration scheme will not impact on the public ambulance services’ ability to exclude private ambulance providers from performing patient transport-type roles.

While protection of paramedic-related titles is a crucial issue relating to the suitability of the current paramedicine regulatory framework, the policy justifications behind protection of paramedic title provisions are unclear. On the one hand, the provisions might act as a public safety measure to protect patients by imposing minimum standards on those wishing to treat and transport patients. For example, the Honourable I K Hunter, a South Australian Minister of Parliament, suggested protection of the paramedic title should play a role in minimising risk of harm to the public.  

As paramedics are often involved in highly invasive care which has the potential to cause significant harm to members of the public, protection of title is a mechanism which reduces the chances of unqualified people performing a paramedic role.

Another problem with the way in which title is regulated is an increase in the provision of private ambulance services which means paramedics are being employed outside of public ambulance services more frequently. The absence of nationally consistent and uniform protection of title provisions has the potential to cause problems for community members who are unable to distinguish between suitably qualified paramedics and those with first aid skills only. Legislative protection of title for paramedics will reduce the confusion surrounding who can legitimately call themselves a paramedic by enforcing sanctions for contraventions to the legislative provisions.

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There is another, more sceptical, view about the existing protection of title provisions. It is possible the provisions, on paramedic title, exist to maintain the monopoly for public ambulance services in relation to treating and transporting patients. Because statutory restrictions on the use of the title of ‘paramedic’ only apply to public sector paramedics, private employers cannot compete. In other words, privately employed paramedics’ qualifications would not be recognised if they are not considered a ‘paramedic’ under the statutory definition. This is true even if they have completed tertiary qualifications. Further, the current provisions on protection of title limit private companies external to the public ambulance services from offering patient transport unless they have been authorised by the Commissioner or Minister of Ambulance Services. As such, statutory title protection only protects the public sphere because of the way the legislation was drafted. Theoretically, title protection could extend to the private sector if parliament intends for title protection to apply to the industry as a whole.

There are problems with the way in which paramedic and ambulance titles are currently protected. Firstly, there is no national protection of title, with differing provisions applying between the state and territory jurisdictions. Without the uniform protection of the paramedic title, there is potential risk to public safety as the public has no guarantee that treating paramedics have the requisite qualifications. Theoretically, a person without qualifications or experience could represent themselves as a paramedic without any fear of reprisals; there would be no guarantee for the employer or patient that the person is suitably qualified. This applies to public and privately employed paramedics. With protection of title operating, members of the public in applicable jurisdictions understand that people who attend to their healthcare, and identify as ‘paramedics’, are facing a substantially penalty for dishonesty. As such, there is more trust that all paramedics will have a minimum standard of training, education and skills.

The benefits of having uniform protection of title for paramedics are significant. Requiring the paramedic title to be held by a class of people with specific education and training ensures the public have confidence in the skills of the paramedic treating them.82 Because the public ambulance services are the primary providers, and employers, of ambulance services in most jurisdictions, they can use their employment powers to require appropriate standards for their employees. This is a positive regulatory tool to protect the public. Although, as the public ambulance services’ monopoly over paramedic employment in the community diminishes, the protections provided within employment contracts, such as minimum qualifications, no longer apply. With more paramedic employers, it becomes more difficult to regulate title protection without statutory governance. There is evidence that more paramedics are being employed in the public sector than ever before, which suggests protection of title provisions is required in all states and territories of Australia.83 Most importantly, perhaps, is the need for uniform protection of title: it is currently not available in all jurisdictions. Furthermore,

82 Elkin, Medical Practitioner Regulation, above n 53, 688.
83 Australian Health Ministers’ Advisory Council, ‘Consultation paper: Options for regulation of paramedics’ (Health Workforce Principal Committee, July 2012)49.
even in those jurisdictions with existing protection of title, they are not sufficient to adequately protect the public. National protection of title, or at least protection of title operating in every Australian jurisdiction, will reduce the negative implications of the lack of title protection existing currently.

4.4 Regulatory issues relating to the possession, administration and storage of drugs

Yet another way paramedics are regulated in Australia is through the use of drugs. The authorisation for paramedics to possess, administer and store controlled and restricted drugs is an indirect means of regulating the work of paramedics. As we saw in Chapter 2, an increasingly important role performed by paramedics is the administration of dangerous drugs and medications which would often normally require a doctor’s prescription. Some of the drugs administered by paramedics are highly addictive and/or have the potential to cause death or serious injury to patients if not administered correctly. For example, paramedics in all states and territories of Australia can administer morphine, high doses of which can, due to the potential for creating respiratory depression, cause patient fatality. Further, drug addicts may also seek morphine when they cannot access heroin.84 As such, the power for paramedics to administer morphine, and other similar drugs, is significant given the potential for patient harm.

In order to deal with emergency situations where dangerous drugs are needed, paramedics have been granted legislative powers to administer certain restricted drugs. Such provisions grant a positive power for paramedics to possess and administer particular dangerous drugs, such as ketamine, which would otherwise amount to criminal conduct.85 Given the potential for these drugs to be highly addictive, there is also additional governance relating to storage requirements.

Significantly, then, paramedics are (indirectly) regulated through their ability to administer drugs. Specifically, drugs are classified at a Commonwealth level which is then further regulated within each state and territory. The Poisons Standard 2011 (Cth) (“the Standard”) contains the Standard for Uniform Scheduling of Medicines and Poisons established under section 52D of the Therapeutic Goods Act 1989 (Cth). The states and territories use the schedule of drugs set out in the Standard to maintain jurisdictional uniformity of drug classification. Table 4.5 provides a summary of the provisions regulating paramedic drug possession and administration in other jurisdictions. Table 4.6 provides a summary of the drugs available for administration. Drugs are classified into schedules according to their level of seriousness. The most commonly used drugs administered by paramedics which have restrictions imposed are:

1. Prescription only medicine (schedule 4 drugs);86 and

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85 See, eg, Drugs Misuse Act 1986 (Qld) s 9.
86 Schedule 4 drugs are also known as ‘restricted drugs’.
2. Controlled drugs (schedule 8 drugs).\textsuperscript{87}

Drug administration can be exclusively restricted to intensive care paramedics,\textsuperscript{88} while there are other medications which can be administered by advanced care paramedics. The regulation of drugs is not uniform throughout Australia.

\textsuperscript{87} Schedule 8 drugs are also called ‘narcotic substances’, ‘drugs of addiction’ or ‘drugs of dependence’ in some jurisdictions.

\textsuperscript{88} Intensive Care Paramedics have postgraduate training and the authority to perform more invasive procedures than other types of paramedics. Intensive Care Paramedics, and their scopes of practice, were discussed in chapter 2.
<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Authorisation</th>
</tr>
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<tbody>
<tr>
<td><strong>Australian Capital Territory</strong></td>
<td>The Australian Capital Territory allows publicly employed paramedics to obtain, possess or administer medicines within the scope of their employment. Dealing with the medicines, without statutory authorisation, could result in an offence punishable by up to $30,000, imprisonment for two years or both. Medicines, within this scope, include sch 4 and sch 8 drugs from the Standard.</td>
</tr>
<tr>
<td><strong>New South Wales</strong></td>
<td>Ambulance Service of New South Wales paramedics may supply sch 8 drugs in the ‘lawful practice’ of their ‘occupation’. There is no express legislative authority for paramedics to administer sch 4 drugs. However, the Ambulance Service of New South Wales authorises its paramedics to administer sch 4 drugs as per their Protocols and Pharmacology policy.</td>
</tr>
<tr>
<td><strong>Northern Territory</strong></td>
<td>Express authorisation is given to paramedics under the Northern Territory legislation which specifies paramedics may administer and possess schs 4 and 8 substances in accordance with their ‘substance treatment protocol’.</td>
</tr>
<tr>
<td><strong>Queensland</strong></td>
<td>Regulations 66 and 174 of the Health (Drugs and Poisons) Regulation 1996 (Qld) gives Queensland paramedics the authority to ‘obtain, possess or administer’ schs 4 and 8 drugs. The level of training and qualification of the paramedic dictates the drugs they can possess and administer. Schedule 8 drugs, being those classified as the most dangerous, are regulated differently to other drugs in Queensland. For example, there are two sch 8 drugs, for paramedic administration, listed in the Regulations: ketamine and morphine. Ketamine is a controlled drug which can only be obtained, possessed or administered by a critical care paramedic while performing duties for the Queensland Ambulance Service. Advanced care paramedics are not authorised to deal with ketamine. Further, authorisation for schedule 8 drug administration only exists for Queensland Ambulance Service paramedics, rather than paramedics employed in any other private capacity. In comparison, advanced, extended or critical care paramedics are authorised to administer morphine, the other sch 8 drug paramedics can administer in Queensland. Morphine and ketamine are both controlled drugs under sch 8 of the Standard yet the restrictions on their administration to patients differ. Paramedics must deal with sch 8 drugs according to the Queensland Ambulance Service’s clinical practice protocols. In some circumstances, the QAS Drug Therapy Protocols recommend paramedics consult with the QAS on-call medical officer. For example, paramedics must obtain QAS medical officer approval for morphine administration where more than 20mg is required and intravenous access is not able to be obtained. The power to administer morphine and ketamine is significant as they are listed as dangerous drugs in Queensland and a</td>
</tr>
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89 *Medicines, Poisons and Therapeutic Goods Regulation 2008 (ACT)* regs 350, 370, sch 1 pt 1.1.
90 *Medicines, Poisons and Therapeutic Goods Act 2008 (ACT)* s 35. A penalty unit is $150 according to section 133 of the *Legislation Act 2001 (ACT)* and the maximum penalty is 200 penalty units.
91 *Medicines, Poisons and Therapeutic Goods Act 2008 (ACT)* s 11.
92 *Poisons and Therapeutic Goods Regulation 2008 (NSW)* reg 101(1)(g).
94 *Medicines, Poisons and Therapeutic Goods Act (NT)* ss 28A, 64, 250; St John Ambulance Australia (Northern Territory), 'Drug Handling' (1 July 2011).
95 Formerly classified as an Intensive Care Paramedic.
96 *Health (Drugs and Poisons) Regulation 1996 (Qld)* reg 66. This is an example highlighting the use of the employment relationship as a means of regulation.
98 Ibid.
substantial criminal penalty results for unauthorised or unlawful possession of these drugs.\textsuperscript{99}

Schedule 4 drugs also have strict guidelines on possession and administration by paramedics while performing ambulance work. Advanced care paramedics cannot use some schedule 4 drugs, but they fall within an extended and intensive care paramedic scope of practice under the Queensland Regulations. Some examples, included in the Regulations, are benzotropine, frusemide, haloperidol, hydrocortisone, metoclopramide and promethazine.\textsuperscript{100} Comparatively, there are a range of other sch 4 drugs whose administration is regulated in Queensland for advanced care paramedics to administer while performing shifts including atropine, amiodarone, benzotropine, box jellyfish antivenom, ceftriaxone, clopidogrel, enoxaparin, frusemide, haloperidol, heparin, hydrocortisone, lignocaine, methoxyflurane, metoclopramide, midazolam, naloxone, nitrous oxide, promethazine, reteplase, salbutamol and tenecteplase.\textsuperscript{101} The statutory regulations also allow paramedics to administer a vaccine for an infectious medical condition in a declared public health emergency including oseltamivir and zanamivir.\textsuperscript{102}

| South Australia | The South Australian Ambulance Service operates under a drug licence provided by the South Australian Department of Health and Ageing which authorises purchase, possession and use of specific drugs contained in the Standard.\textsuperscript{103} South Australia also has a licensing framework where private paramedical organisations can apply to the South Australian Department of Health and Ageing for authority to administer scheduled medicines outside the state ambulance service.\textsuperscript{104} In determining an organisation’s eligibility, the department considers the level of risk to the community, as well as the employee’s qualifications. The approval for the administration of medications depends upon the level of risk and the highest employee’s qualification.\textsuperscript{105} Intensive care paramedics and registered nurses are authorised to provide vaccines. There are low, high and very high levels of risk, with five categories of qualifications; a degree qualified paramedic is Category D while Category E is comprised of intensive care paramedics and registered nurses.\textsuperscript{106} |
| Tasmanina | Paramedics employed by the Tasmanian Ambulance Service are authorised to possess sch 8 drugs,\textsuperscript{107} or sch 4 drugs,\textsuperscript{108} and use them in the course of their employment.\textsuperscript{109} The administration of these drugs must be done at the direction of a medical practitioner or in accordance with the Ambulance Commissioner’s Drug Field Protocols.\textsuperscript{110} |

\textsuperscript{99} Drugs Misuse Act 1986 (Qld) s 9; Drugs Misuse Regulation 1987 (Qld) sch 2.
\textsuperscript{100} Health (Drugs and Poisons) Regulation 1996 (Qld) app 2A.
\textsuperscript{101} Ibid app 2A.
\textsuperscript{102} Ibid reg 174(4).
\textsuperscript{103} Controlled Substances Act 1984 (SA) s 55; Australian Health Ministers’ Advisory Council, \textit{Options for regulation of paramedics}, above n 83, 21.
\textsuperscript{104} Controlled Substances Act 1984 (SA) s 55.
\textsuperscript{105} The drugs listed for administration include adenosine, adrenaline, amiodarone, aspirin, atropine, benzylpenicillin, diazepam, glucagon, glucose, glyceryl trinitrate, methoxyflurane, oxygen, salbutamol, hydrocortisone, ipatropium bromide, lignocaine, metoclopramide, midazolam, morphine and naloxone.
\textsuperscript{106} Government of South Australia, ‘Controlled Substances Licensing of First Aid Providers’ (Department for Health and Ageing, June 2012)48, 6-7.
\textsuperscript{107} Narcotic substances are schedule 8 drugs according to the \textit{Poisons Act 1971} (Tas) s 3 (definition of ‘narcotic substance’).
\textsuperscript{108} Restricted substances are schedule 4 drugs according to the \textit{Poisons Act 1971} (Tas) s 3 (definition of ‘restricted substance’).
\textsuperscript{109} Poisons Regulations 2008 (Tas) regs 3 (definition of ‘Ambulance Service’), 9(d).
\textsuperscript{110} Poisons Act 1971 (Tas) ss 38(h), 47(1)(dd).
| Victoria            | Paramedics in Victoria are authorised to possess any of the Schs 4 or 8 drugs listed in their health services permit; a health services permit is a licence the government issued to the ambulance service.  

<p>| Western Australia   | The <em>Poisons Regulations 1965</em> (WA) do not expressly list paramedics as having authority to possess scheduled drugs. However, a ‘person authorised in writing by the CEO’ is authorised to possess scheduled drugs. As such, Western Australian paramedics can only administer the scheduled drugs under a poisons’ permit which has been issued to St John Ambulance Service (Western Australia). |</p>
<table>
<thead>
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<th>Drug administration</th>
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<th>New South Wales</th>
<th>Victoria</th>
<th>Australian Capital Territory</th>
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<th>South Australia</th>
<th>Western Australia</th>
<th>Northern Territory</th>
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<td></td>
<td>ACP1</td>
<td>ACP2</td>
<td>CCP</td>
<td>ALS</td>
<td>ICP</td>
<td>A</td>
<td>P</td>
<td>P</td>
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<td>X</td>
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<td>X</td>
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<td>Amoxycillin</td>
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<td></td>
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<td></td>
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<td>Aspirin</td>
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<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
<td>X</td>
<td>X</td>
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<td></td>
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<td>X</td>
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<td></td>
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<td>X</td>
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<td>X</td>
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<td></td>
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<tr>
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<td>X</td>
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<td>X</td>
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<td>X</td>
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<td>X</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Metoprolol</td>
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<td></td>
<td></td>
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<td>X</td>
<td>X</td>
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<td>X</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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</tr>
<tr>
<td>Propofol</td>
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<tr>
<td>Rocuronium</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Tetanus immunisation</td>
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<td>E</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Tranexamic acid</td>
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</table>

<table>
<thead>
<tr>
<th>Table of abbreviations used</th>
<th>ACP P</th>
<th>Advanced Care Paramedic – level of qualification and experience approved by QAS</th>
<th>A</th>
<th>P</th>
<th>ICP</th>
<th>A</th>
<th>P</th>
<th>ICP</th>
<th>A</th>
<th>P</th>
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<th>ICP</th>
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<tbody>
<tr>
<td></td>
<td>ACP2</td>
<td>Advanced Care Paramedic – level of qualification and experience approved by QAS</td>
<td>ALS</td>
<td>Advanced Life Support</td>
<td>C</td>
<td>Prior consultation and approval</td>
<td>CCP</td>
<td>Critical Care Paramedic</td>
<td>E</td>
<td>Approved Extended Scope of Practice</td>
<td>ICP</td>
<td>Intensive Care Paramedic</td>
<td>MICA</td>
<td>Mobile Intensive Care Ambulance Paramedics</td>
</tr>
</tbody>
</table>

114 Ambulance Victoria, ‘Clinical Practice Guidelines for Ambulance and MICA Paramedics’ (July 2014).
117 St John Ambulance Australia (Western Australia), ‘Clinical Guidelines for Ambulance Care in Western Australia’ (22 July 2011).
118 St John Ambulance Australia (Northern Territory), *Drug Handling*, above n 94.
One of the problems with regulating paramedics through drug legislation is that publicly and privately employed paramedics are subject to different drug regulations. As such, there are different rules for administering drugs for commercial organisations not covered under the statutory drug regulation for paramedics. The statutory drugs provisions, discussed above, apply to paramedics employed for the public ambulance services. Despite the limited scope of drug regulation, private paramedics across Australia still often possess and administer ‘prescription only medicine’ and ‘controlled drugs’ in order to treat their patients effectively. Yet private paramedics’ use of drugs is not regulated in the same way.

A privately employed paramedic must be granted a statutory exemption or drug licence by their state or territory government to be able to legally possess or administer dangerous drugs in Australian jurisdictions. A person who is not endorsed to possess controlled drugs (sch 8) drugs, under the relevant legislation, can risk a substantial fine or criminal charges. So, even if the person was previously qualified to administer sch 8 drugs as a result of their employment with an ambulance service, once their employment ends or they are operating independently of the ambulance service- they cannot automatically administer the drug, despite any qualifications they may have. They must then rely on an employer organisation’s licence, or a statutory exemption, to continue possessing and administering sch 4 and 8 drugs to patients.

Queensland provides an example of the different drug licensing for private organisations. Queensland’s statutory drug regulation allows paramedics to obtain endorsements to administer scheduled medicines when employed by an organisation other than the Queensland Ambulance Service. When assessing a paramedic’s suitability for endorsement, Queensland Health may consider a range of criteria including qualifications and experience; character and standing; knowledge and understanding of obligations to adhere to Regulations; and previous convictions or likelihood of risks when dealing with the medicines. Endorsed paramedics are limited to administering certain scheduled medicines under an organisation’s clinical practice protocol. Approved schs 2 and 3 poisons include adrenaline, aspirin, glucagon, glyceryl trinitrate, paracetamol and salbutamol. Other schs 4 and 8 pharmaceuticals can be provided in consultation with, and instruction by, a medical practitioner. Schedule 4 drugs include amiodarone, atropine, benztrapine, ceftriaxone, frusemide, hydrocortisone, ipatropium bromide, metoclopramide, midazolam, promethazine; while morphine has been approved as the sch 8 drug. Significantly though, Queensland Health policy suggests private paramedics may administer the specified schedule drugs without consultation with a medical practitioner in circumstances of an

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119 St John Ambulance Australia (Western Australia), 'Clinical Guidelines for Ambulance Care in Western Australia' (22 July 2011).
120 St John Ambulance Australia (Northern Territory), Drug Handling, above n 94.
121 Health (Drugs and Poisons) Regulation 1996 (Qld) s 51; Penalties and Sentences Act 1992 (Qld) s 5; Drugs Misuse Act 1986 (Qld) s 9; Controlled Substances Act 1984 (SA) s 22; Poisons Act 1964 (WA) s 44.
122 Queensland Health, 'Approvals for organisations providing commercial paramedic services in Queensland' (Environmental Health Branch, February 2012) 4.
123 Health (Drugs and Poisons) Regulation 1996 (Qld) reg 15.
immediately life-threatening clinical emergency provided consultation occurs afterwards.\textsuperscript{124} Importantly, it is an offence to contravene an endorsement.\textsuperscript{125} So, paramedics who administer drugs without an endorsement could face criminal charges.

In addition to use of certain drugs being regulated, the way in which drugs are stored provides (indirect) regulation of paramedics. Currently, the requirements vary throughout Australia. Table 4.7 provides a brief description of the legislative requirements for drug storage for paramedics. Generally speaking, paramedics must maintain drug registers and undertake record keeping following patient drug administration in most jurisdictions. A drug register, or a record book, is a catalogue allowing entries to be made in relation to the administration of scheduled drugs.\textsuperscript{126} The Northern Territory, Victoria, Queensland and the Australian Capital Territory require a register to be kept for administration of prescription-only (sch 4) drugs.\textsuperscript{127} In relation to controlled (sch 8) drugs, most ambulance services are required to keep drug registers to record various details, including the quantity of the drug; particulars of the paramedic administering the drug; and the circumstances relating to the drug’s administration.\textsuperscript{128} By contrast, South Australia does not currently legislate for registers being kept by paramedics administering schedules 4 or 8 drugs; record keeping must adhere to the South Australian Ambulance Service’s individual licence permit. Tasmania does not prescribe record keeping of the administration of scheduled drugs for paramedics; only certain registered health practitioners and veterinary surgeons are required to keep drug registers.\textsuperscript{129} The control of schedule 8 substances, in the form of record keeping and storage, comes from directives issued by the Commissioner of Ambulance Tasmania.\textsuperscript{130}

Penalties for contravening drug register requirements in the Australian jurisdictions range from fines of $2,600\textsuperscript{131} to $15,000,\textsuperscript{132} or an imprisonment period of up to three years.\textsuperscript{133}

\begin{footnotesize}
\begin{itemize}
  \item[124] Queensland Health, above n 122, 8.
  \item[125] Health (Drugs and Poisons) Regulation 1996 (Qld) reg 21.
  \item[126] See, eg, Health (Drugs and Poisons) Regulation 1996 (Qld) reg 112; Poisons and Therapeutic Goods Regulation 2008 (NSW) regs 111.
  \item[127] Medicines, Poisons and Therapeutic Goods Regulations (NT) reg 46; Drugs, Poisons and Controlled Substances Regulations 2006 (Vic) ss 39-40; Health (Drugs and Poisons) Regulation 1996 (Qld) regs 207 (1B), 208; Medicines, Poisons and Therapeutic Goods Act 2008 (ACT) s 48.
  \item[128] Health (Drugs and Poisons) Regulation 1996 (Qld) reg 112; Poisons and Therapeutic Goods Regulation 2008 (NSW) regs 111-2; Drugs, Poisons and Controlled Substances Regulations 2006 (Vic) regs 39-40; Medicines, Poisons and Therapeutic Goods Act 2008 (ACT) s 48; Medicines, Poisons and Therapeutic Goods Regulation 2008 (ACT) regs 540, 542-3; Poisons Regulations 1965 (WA) reg 44; Medicines, Poisons and Therapeutic Goods Regulations (NT) regs 52-4.
  \item[129] Poisons Regulations 2008 (Tas) regs 13, 25(3), 44.
  \item[130] Ibid reg 38.
  \item[131] Northern Territory has the smallest penalty of the jurisdictions with sanctions for breaching drug register requirements.
  \item[132] The Australian Capital Territory and Western Australia both have the largest fines for breaches of drug register requirements.
  \item[133] Medicines, Poisons and Therapeutic Goods Act 2008 (ACT) ss 48-57; Legislation Act 2001 (ACT) s 133; Poisons and Therapeutic Goods Regulation 2008 (NSW) reg 111; Crimes (Sentencing Procedure) Act 1999 (NSW) s 17; Medicines, Poisons and Therapeutic Goods Regulations (NT) regs 62-72, 77; Penalty Units Act (NT) ss 3-4; Health (Drugs and Poisons) Regulation 1996 (Qld) reg 112; Drugs, Poisons and Controlled Substances Regulations 2006 (Vic) regs 39-44.
\end{itemize}
\end{footnotesize}
Adequate drug storage is also required with jurisdictions expressing different standards of storage required. Some jurisdictions, though, only regulate storage for controlled (sch 8) drugs. Depending on the facility and the health occupation involved, there are different regulatory mechanisms which restrict use of the drugs. Penalties also exist for contravening the legislative requirements for drug storage including fines and imprisonment.134

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Schedule 8 drugs</th>
<th>Schedule 4 drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Capital</td>
<td>Schedule 8 drugs must be kept in a locked room or vehicle when not in use.135</td>
<td>Public access must be restricted to a schedule 4 storage space.136</td>
</tr>
<tr>
<td>Territory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New South Wales</td>
<td>Schedule 8 drugs must be kept in a locked room or vehicle when not in use.137</td>
<td>Schedule 4 drugs must be kept in a place the public cannot access and separately to food intended for human consumption.138</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>Schedule 8 storage of drugs must comply with the Code of Practice policy document.139</td>
<td>Schedule 4 drugs must be stored in a way to prevent unauthorised access to them.140</td>
</tr>
<tr>
<td>Queensland</td>
<td>Queensland requires paramedics to keep schedule 8 drugs in a lockable cabinet with hinge, door and mounting requirements, but also allows paramedics to keep them in a secure place under their personal control.141</td>
<td>Schedule 4 drugs can be kept in a place to which the public does not have access.142</td>
</tr>
<tr>
<td>South Australia</td>
<td>Schedule 8 drugs must be kept in a place that prevents the unauthorised removal of, or interference with, the drug.143</td>
<td>Schedule 4 drugs must be kept in a place that is not used for food or beverage storage.144</td>
</tr>
<tr>
<td>Tasmania</td>
<td>Only those authorised under the legislation must comply with the drug storage requirements. As Tasmanian paramedics are not, there is no obligation for them to store scheduled drugs in any particular way under the statutory provisions.</td>
<td></td>
</tr>
<tr>
<td>Victoria</td>
<td>Schedule 8 drugs must comply with six security measures specified in the</td>
<td>Schedule 4 drugs are to be kept in a lockable storage facility.146</td>
</tr>
</tbody>
</table>

134 See, eg, the Drugs, Poisons and Controlled Substances Regulations 2006 (Vic) regs 34-5 specifies a penalty of 100 penalty units. The Poisons and Therapeutic Goods Regulation 2008 (NSW) reg 73 imposes a penalty of 20 penalty units. The Health (Drugs and Poisons) Regulation 1996 (Qld) reg 119 dictates 60 penalty units as the maximum penalty. The penalty is 100 penalty units or imprisonment for 1 year (or both) under the Medicines, Poisons and Therapeutic Goods Act 2008 (ACT) s 61. The Controlled Substances Act 1984 (SA) s 25 specifies a penalty of $10,000.

135 Medicines, Poisons and Therapeutic Goods Regulation 2008 (ACT) reg 532(2).
136 Ibid reg 521.
137 Poisons and Therapeutic Goods Regulation 2008 (NSW) reg 73.
138 Ibid reg 29.
140 Medicines, Poisons and Therapeutic Goods Regulations (NT) reg 25.
142 Health (Drugs and Poisons) Regulation 1996 (Qld) reg 211.
143 Controlled Substances (Poisons) Regulations 2011 (SA) reg 27(d); Government of South Australia, 'Code of Practice for the Storage and Transport of Drugs of Dependence' (Department of Health and Ageing, November 2012) 7.
144 Controlled Substances (Poisons) Regulations 2011 (SA) reg 27(a).
145 Drugs, Poisons and Controlled Substances Regulations 2006 (Vic) regs 34.
So far, part 4.4 of this chapter has highlighted the various requirements for drug administration, storage and record keeping for Australian paramedics. There are issues which arise from paramedic drug regulation which the current regulatory framework fails to address. From this, a number of observations can be made about public paramedicine’s drug regulation. Firstly, drug administration, storage and record keeping differs between jurisdictions. For instance, Tasmania does not prescribe storage requirements for paramedics possessing scheduled drugs, while Queensland’s storage requirements are comprehensive. While the disputes between jurisdictions raise some concerns about a lack of consistency in patient treatment and paramedic powers relating to scheduled drugs, it is not a significant shortfall of paramedic regulation. Indeed, the other registered health practitioners specified in the jurisdictions’ legislation have similar regulatory issues, such as nurses and medical practitioners. Apart from the Commonwealth’s *Poisons Standard 2011* applicable across all jurisdictions of Australia providing jurisdictional uniformity of drug classification, state and territory law governs scheduled drug regulation. Adapting a new regulatory framework for paramedic practice using a national system of registration would not change paramedic drug regulation being state-based.

Paramedic administration of scheduled drugs has the potential to cause patient injury and death. As Tables 3.6 and 3.7 highlight, paramedics are involved in administering a wide range of scheduled drugs to patients. For example, drugs can be administered to patients through intravenous, intramuscular or intraosseous avenues which are invasive to the patient. Despite dosage guidance being provided in the clinical policy documents, paramedics are still required to understand the effects of drugs and circumstances surrounding their administration. Paramedics must diagnose the condition requiring pharmaceutical intervention, understand when additional medication might be needed and monitor the

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**Table 4.7 Statutory requirements for storage of scheduled drugs**

| Western Australia | Schedule 8 drug storage must be contained in a lockable safe with certain thickness requirements; if the drugs stored within the safe exceed the amounts specified in the regulations, an intruder’s alarm must also be fitted. Requirements can change with written permission of the Chief Executive Officer. |
| Schedule 4 drug storage requirements only apply to particular registered health practitioners and veterinary surgeons; paramedics are not included in the legislative storage requirements. |

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145 *Drugs, Poisons and Controlled Substances Regulations 2006 (Vic)* regs 35. The security measures specified include the storage facility must be: constructed of a 10mm steel thickness; constructed with continuous welding of all edges; fitted with a 10mm steel door, swung on hinges and welded to the door and body of the cabinet, with the door being ‘flush fitting’; fitted with a welded, fixed locking bar which engages a rebate when closing; fitted with a 6 lever lock; and securely attached to the wall or floor which will resist attack by hand tools for 30 minutes or power tools for 5 minutes.

146 *Poisons Regulations 1965 (WA)* app M.

147 Ibid reg 56 (3)(b).

148 Ibid reg 36A.

patient following drug administration. Further, the expertise needed to understand the effect of these drugs demonstrates the high level of skill paramedics possess and the risk they pose to the Australian community.

As such, the potential of paramedics to cause patient harm is significant. Harm could occur if paramedics administer the incorrect drug or dosage, or if patients provide the wrong information about their condition leading to paramedics treating them incorrectly. There is also a possibility that patients might have an adverse reaction to a drug they are administered during treatment, requiring paramedics to respond to the consequences accordingly. The potential for risk paramedics pose to patients is further explored in Chapter 5; however, here it is important to point out that there is a significant risk of harm to patients from paramedics administering controlled and prescription-only drugs.

Apart from the risks scheduled drugs pose to the health of patients, the above scheduled drugs regulation highlights gaps in the government’s ability to hold paramedics accountable for their actions. It is concerning that Tasmania and South Australia do not prescribe record keeping for the scheduled drugs being administered. There are examples, throughout Australia, of paramedics stealing and abusing drugs obtained during their employment.151 While Chapter 6 examines the potential for harm arising from paramedics stealing drugs and exhibiting other concerning behaviour, without greater statutory regulation in this area, the responsibility for investigating incidents and administering paramedic discipline lies with the individual employers. This means that any sanctions available to deal with storage or record keeping concerns are those stipulated within the workplace industrial agreement or employer policies. The statutory offences prescribed within the drugs regulations, applicable to other registered health practitioners, do not apply to Australian paramedics. Having already considered the current regulation of paramedics through training and education (4.2), title protection (4.3) and drug use and storage (4.4), the remainder of this chapter completes its overview of the current regulation of paramedics by examining the complaints and disciplinary procedures for Australian paramedics.

4.5 Complaints and discipline of Australian paramedics

Yet another way that Australian paramedics are regulated is through complaint and disciplinary mechanisms. The complaints and disciplinary processes are particularly significant because they are the mode of investigating wrongdoing and unreasonable standards of conduct, particularly around conduct that could impact patient safety and reduce public trust. It is also often the sanctions imposed during complaints and disciplinary procedures that prevent similar conduct from occurring. For example, if a patient accuses a paramedic of improper or indecent conduct, there needs to be an investigations process

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culminating in disciplinary action, if applicable.\textsuperscript{152} Table 4.8 provides a comparative description of mechanisms which can adjudicate complaints against paramedics in the different jurisdictions of Australia. New South Wales, South Australia and Queensland have the most rigorous complaints mechanisms when compared to the other states and territories.

Because paramedics are not regulated under the National Scheme, the complaints process is different to that of other health professionals. On the one hand, complaints about registered health professionals are usually dealt with by the relevant National Board under the \textit{National Law}.\textsuperscript{153} On the other hand, complaints about the conduct of paramedics can be made to the applicable Health Complaints Commission or Ombudsman in the relevant jurisdiction. Alternatively, complaints about paramedics can be made to the appropriate employer. There are some notable factors, as well as problems, in the complaints and disciplinary regulation of paramedics that warrant elaboration.

The various jurisdictional commissions and ombudsmen follow a similar complaints process. When the complaint is assessed, it can be investigated, dismissed or referred to a conciliator.\textsuperscript{154} The conciliation encourages a resolution between the complainant and the practitioner and is a confidential process.\textsuperscript{155} If an investigation is undertaken and the complaint is substantiated, the results can be provided to the practitioner’s employer.\textsuperscript{156} Legislation also requires the complaint to be referred to the relevant board of the registered health practitioner. Given paramedics are not registered, this is not a power relevant to their complaints and there is not a positive obligation on the commissions and ombudsmen to communicate the outcome to the paramedic’s employer in most jurisdictions.\textsuperscript{157}

\textsuperscript{152} \textit{R v Jones} [2011] QCA 19.
\textsuperscript{153} \textit{National Law} s 35(1)(h).
\textsuperscript{155} \textit{Health and Community Services Complaints Act} (NT) ss 38, 47; \textit{Health Complaints Act 1995} (Tas) ss 31, 37; \textit{Health Services (Conciliation and Review) Act 1987} (Vic) s 20; \textit{Health and Disability Services (Complaints) Act 1995} (WA) s 38, 71; \textit{Human Rights Commission Act 2005} (ACT) s 55.
\textsuperscript{156} \textit{Health and Community Services Complaints Act} (NT) s 66; \textit{Health Complaints Act 1995} (Tas) ss 55-6; \textit{Health and Disability Services (Complaints) Act 1995} (WA) s 32.
\textsuperscript{157} \textit{Health and Community Services Complaints Act} (NT) s 68; \textit{Health Complaints Act 1995} (Tas) ss 24A, 55; \textit{Health Services (Conciliation and Review) Act 1987} (Vic) s 24; \textit{Human Rights Commission Act 2005} (ACT) s 92.
<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Notable features of complaints system</th>
<th>Employer reporting</th>
</tr>
</thead>
</table>
| Australian Capital Territory | The Australian Capital Territory legislation allows complaints to the Human Rights Commission about a health service if the service is not provided appropriately; it contravenes the health code, health provision principles or the generally accepted standard of health service delivery; or a service is not being provided.  
While the legislation does not expressly include ambulance services as health services, there could be an implied inclusion as a health service ‘diagnoses or treats an illness… or condition’ which is arguably the role of an ambulance service. However, a health service also includes a service provided by a health professional or health practitioner in their professional capacity; paramedics are not considered health professionals so it is unclear whether the Australian Capital Territory health complaints legislation applies to paramedics. | The Human Rights Commission is not required to share complaint details with the paramedic’s employer although has the discretion to do so. Mandatory disclosure of the complaint applies to health practitioners registered under their National Board only. |
| New South Wales      | Complaints can be made to the NSW Health Care Complaints Commission about the professional conduct of a ‘health practitioner’, which is a person who provides a health service, including ambulance services, whether provided in a public or private capacity. This legislation does not specify that the health practitioner needs to be registered, so complaints can be made about paramedics under this law.  
If a New South Wales paramedic is found to have breached a code of conduct after investigation of the complaint, and there is a risk of health or safety to members of the public, the paramedic can be prohibited from providing health services, or work under imposed conditions, for a specified period or permanently. It is also within the scope of the legislation for the Commission to issue a public statement warning the community about the health practitioner or health service. | Mandatory referral of the complaint’s outcome to the relevant employer is not available for complaints against paramedics. While only registered health practitioners can be referred for performance assessment, the Commission has discretion to provide notification of the decision to a ‘relevant person or body’ which could include an employer. |

159 Ibid s 7.  
162 Health Care Complaints Act 1993 (NSW) ss 4, 7.  
163 Ibid s 41A.  
164 Ibid s 41A (2)(b).  
165 Ibid ss 39(1)(c), 41.
| **Northern Territory** | A complaint about a health service can be made to the Health and Community Services Complaints Commission. Health service includes ambulance services so paramedics fall within the Commission’s jurisdiction for investigation. Complaints can be made about paramedics who: fail to reasonably provide a health service, the health service provided was unnecessary, fail to exercise due care and skill, fail to treat a patient professionally, fail to provide adequate information about treatment and fail to protect a patient’s privacy or dignity, among other things. Complaints which have been justified can be reported to the paramedic’s employer. | 

Queensland complaints regulation can restrain paramedics from practising in certain circumstances. Queensland allows for interim prohibition orders upon a complaint received about a health practitioner which includes a paramedic. A paramedic can be prohibited from working or required to adhere to restrictions until the matter is considered by the Queensland Civil and Administrative Tribunal (QCAT). If QCAT concludes the paramedic could cause a serious risk to a person, they can be prohibited from working or restrictions could be placed on their practice. A number of circumstances have been listed as a ‘serious risk’ including drug or alcohol intoxication, financial exploitation, a sexual or improper relationship with the complainant, discouraging the complainant from seeking clinically accepted treatment or making false and misleading statements about their experience or qualifications. The Queensland Health Ombudsman must give the paramedic and their employer notice of the decision made about a complaint. However, an exemption exists if the ombudsman has not previously communicated with the employer about the matter. While this provision appears ambiguous, it is interpreted to mean the ombudsman is only obligated to contact the employer about a decision if they were contacted about the complaint. The ombudsman must also publicly publish details about any prohibition orders imposed on the health practitioner. |

| **South Australia** | If a patient has a complaint about the provider, such as failing to exercise due skill, failing to treat in a professional manner, failing to respect privacy or dignity or unreasonably failing to provide health care, among other things, the Health and Community Services Complaints Commissioner must investigate. After investigation, if the Commissioner is satisfied there has been a breach of the code of conduct or a prescribed offence has been committed, and there is an unacceptable risk to the public, A public statement can be published identifying the paramedic and/or the prescriber of health services, although the legislation does not authorise reporting of a... | 

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166 *Health and Community Services Complaints Regulations (NT)* sch 2, part 1.7.
167 *Health and Community Services Complaints Act (NT)* s 23.
168 Ibid s 66.
169 *Health Ombudsman Act 2013 (Qld)* ss 7-8. Because paramedics arguably provide a service of dealing with public health such as the prevention and control of disease or sickness; prevention of injury; or protection and promotion of health, they are considered a health practitioner under this legislation and subject to its provisions.
170 Ibid s 67.
171 Ibid s 278.
173 Ibid s 113 (2).
174 Ibid ss 278.
175 *Health and Community Services Complaints Act 2004 (SA)* ss 24-5.
176 A prescribed offence is specified in regulation 5C of the *Health and Community Services Complaints Regulations 2005 (SA)* as an offence against the *Australian Consumer Law (SA)*, Part 3 of the *Criminal Law Consolidation Act 1935 (SA)* (offences against the person etc) or *South Australian Public Health Act 2011 (SA)*.
<table>
<thead>
<tr>
<th>State</th>
<th>Description</th>
<th>Notes</th>
</tr>
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<tbody>
<tr>
<td>Tasmania</td>
<td>Complaints can be made about a health service which includes an ambulance service. Complainants can be made about paramedics who: fail to reasonably provide a health service, the health service provided was unnecessary, fail to exercise due care and skill, fail to treat a patient professionally, fail to provide adequate information about treatment and fail to protect a patient’s privacy or dignity, among other things.</td>
<td>Breaches of conditions or restrictions imposed on the paramedic can result in a maximum penalty of $10,000, two years imprisonment or both. Reports on a complaint are provided to the employer.</td>
</tr>
<tr>
<td>Victoria</td>
<td>Complaints can be made about health services to the Health Services Commissioner. A health service includes an ambulance service, so complaints can be made about paramedics. A complaint can be based upon a health provider acting unreasonably by either providing or not providing a health service, or an unreasonable manner of providing the health service.</td>
<td>The Commissioner must give notice of complaint to an employer and also has discretion to refer the complaint for ‘investigation by another person, organisation or agency’ such as an employer.</td>
</tr>
<tr>
<td>Western Australia</td>
<td>Paramedics are subject to Western Australian complaints legislation as ambulance services are included within the definition of a health service. Complaints can be made to the Health and Disability Services Complaints Office when a person alleges a paramedic acted unreasonably by either providing or not providing a health service, or the manner of providing the health service was unreasonable.</td>
<td>A register of complaints against health services practitioners is kept in Western Australia, however, it is not publicly available.</td>
</tr>
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Table 4.8 Jurisdictional comparison of paramedic complaints regulation

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177 Health and Community Services Complaints Act 2004 (SA) s 56C.
178 Ibid s 56C.
179 Ibid s 56C.
180 Ibid s 56C.
181 Health Complaints Act 1995 (Tas) sch 1 pt 1.7.
182 Ibid s 23.
183 Ibid s 55.
184 Health Services (Conciliation and Review) Act 1987 (Vic) s 3.
185 Ibid s 16.
186 The legislation defines a ‘provider’ as a body providing a health service. A ‘health service’ includes ambulance services. Therefore, a provider could be an ambulance service employer according to the Health Services (Conciliation and Review) Act 1987 (Vic) s 3 (definition of ‘provider’ and ‘health service’).
187 Health Services (Conciliation and Review) Act 1987 (Vic) ss 19 (7), 22(3).
188 Health and Disability Services (Complaints) Act 1995 (WA) s 3 (definition of ‘health service’).
189 Ibid s 25.
189 Ibid s 68.
A further problem with the current complaint and disciplinary process is that private organisations may not be included. Complaints can generally be made about ‘health services’; however, most of the legislation defines a health service to include ‘ambulance services’. Private ambulance providers are businesses who do not provide ambulance services but provide on-site medical assistance. As such, private providers could be classified as ‘ambulance services’ and therefore, it is likely the complaints legislation applies to publicly employed paramedics only.

Currently, New South Wales, South Australia and Queensland have positive enforcement powers in relation to their complaints system. These enforcement powers refer to the commissions’ ability to impose conditions or orders on unregistered health practitioners. The other states and territories, while providing legislative power to investigate and assess complaints, do not have the same powers of being able to exclude practitioners from providing a health service or publishing their details if the complaint is substantiated and valid. Once misconduct has been substantiated, employers are responsible for disciplining the paramedic. Disciplinary action is not legislatively considered, with each employer responsible for prescribing appropriate sanctions in response to the incident. Disciplinary action for paramedic conduct is, therefore, a workplace regulation and varies considerably from employer to employer and industry to industry. Table 4.9 describes the disciplinary action available for paramedic employees under the workplace industrial instruments.

Given the investigations and disciplinary processes are the responsibility of the employers, there is no consistency between employers, accountability for paramedics or transparency of the process. This is problematic. Sanctions are potentially arbitrary as they are decided on an organisational basis. There is nothing to ensure paramedics are being adequately managed as there is no external body monitoring the results.

190 Health Care Complaints Act 1993 (NSW); Health and Community Services Complaints Regulations (NT); Health Complaints Act 1995 (Tas); Health Services (Conciliation and Review) Act 1987 (Vic); Health and Disability Services (Complaints) Act 1995 (WA).

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Definition of misconduct</th>
<th>Penalties for misconduct</th>
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<tbody>
<tr>
<td><strong>Australian Capital Territory</strong>&lt;sup&gt;192&lt;/sup&gt;</td>
<td>Misconduct is a failure to fulfil public sector obligations under the <em>Public Sector Management Act 1994</em> (ACT), conduct bringing the organisation into disrepute, taking unauthorised absence without satisfactory reason, conviction with a criminal offence and failure to notify the organisation of criminal charges.</td>
<td>Disciplinary measures for misconduct can result in a range of sanctions including counselling, a warning, a written admonishment, financial penalty, and transferral to another position, demotion or termination of employment.</td>
</tr>
<tr>
<td>New South Wales&lt;sup&gt;193&lt;/sup&gt;</td>
<td>Misconduct undefined and no procedures included to deal with misconduct.</td>
<td></td>
</tr>
<tr>
<td>Northern Territory&lt;sup&gt;194&lt;/sup&gt;</td>
<td>Misconduct undefined.</td>
<td>Dismissal allowed for ‘serious neglect of duty or misconduct’. Other avenues of discipline also exist including a reprimand or suspension.</td>
</tr>
<tr>
<td>Queensland&lt;sup&gt;195&lt;/sup&gt;</td>
<td>Misconduct undefined and no procedures included to deal with misconduct.</td>
<td></td>
</tr>
<tr>
<td>South Australia&lt;sup&gt;196&lt;/sup&gt;</td>
<td>Misconduct undefined and no procedures included to deal with misconduct.</td>
<td></td>
</tr>
<tr>
<td>Tasmania&lt;sup&gt;197&lt;/sup&gt;</td>
<td>Misconduct undefined and no procedures included to deal with misconduct.</td>
<td></td>
</tr>
<tr>
<td>Victoria&lt;sup&gt;198&lt;/sup&gt;</td>
<td>Misconduct undefined.</td>
<td>Ambulance Victoria allows dismissal of paramedics to occur for acts of ‘serious and wilful misconduct’.</td>
</tr>
<tr>
<td>Western Australia&lt;sup&gt;199&lt;/sup&gt;</td>
<td>Misconduct undefined.</td>
<td>Dismissal allowed for ‘serious misconduct’.</td>
</tr>
</tbody>
</table>

**Table 4.9 Disciplinary action against paramedics**

Whether private or public, there is very limited information available concerning paramedic disciplinary procedures. Apart from the Australian Capital Territory Ambulance Service’s comprehensive description of misconduct and applicable sanctions,<sup>200</sup> the other jurisdictions provide inadequate guidance on disciplinary action which can be taken against paramedics.

Further, the lack of external disciplinary body, managed on a national level, suggests fitness-to-practice issues are transferred between employers. There is usually very little employers could do to access work history of paramedics without a system of registration in operation. However, paramedic applicants

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<sup>193</sup> *Operational Ambulance Officers (State) Award* (New South Wales, 26 February 2014).
<sup>194</sup> *St John Ambulance (NT Inc. Ambulance Enterprise Agreement 2010-2013* (10 October 2011) 11.
<sup>196</sup> *SA Ambulance Service Enterprise Agreement 2011* (3 February 2012).
<sup>197</sup> *Ambulance Tasmania Agreement 2013* (13 February 2014).
<sup>199</sup> *St John Ambulance Australia (Western Australia) Inc Ambulance Officers’/Paramedics Enterprise Agreement 2011-2014* (18 January 2012) 47.
seeking employment with the Queensland Ambulance Service may be required to disclose particulars of any ‘serious disciplinary action’ taken against them in the past. This is a discretionary provision only and it is unknown when a requirement might be made under this section. If a requirement for disclosure is made, without compliance, the person becomes ineligible for a position in Queensland’s ambulance service.\(^{201}\) No further guidance was provided to define serious misconduct or suggest circumstances surrounding the request.\(^{202}\) However, the provision was inserted as an integrity measure for the government to use a person’s previous public service history to uphold ethical standards and public confidence.\(^{203}\) There is no equivalent safeguard for private ambulance employers, nor is it a standard requirement for the public service in all Australian jurisdictions.

Finally, transparency does not currently exist in paramedic regulation. It is difficult to evaluate the suitability of the current disciplinary process as there is very little publicly available information on the processes used to investigate and make decisions on paramedic conduct. Unlike registered health practitioners, paramedics are not held accountable for their actions. While New South Wales, South Australia and Queensland ensure sanctions can be imposed on paramedics whose behaviour falls short of a reasonable standard, privately practising paramedics may not be included in the enforcement powers of the Commissions. Other jurisdictions, which do not have enforcement powers, can refer disciplinary action back to the employers who do not publicise details of the sanctions available or the discipline imposed. As such, it is difficult to assess whether paramedics can be adequately disciplined for misconduct under the current regulatory structure as the information is just not available. Transparency, as a risk factor to the public, is considered further in Chapter 5 of this thesis.

One of the solutions to the problems with current complaints and disciplinary procedures is for paramedics to be included in the National Scheme. The National Scheme has a comprehensive disciplinary process for dealing with health practitioner misconduct. If a health practitioner’s conduct, performance or health poses a serious risk to patients, their National Board may take action to protect public health or safety.\(^{204}\) An assessment or investigation into a registered practitioner by the National Board, or a tribunal, may warrant a range of sanctions including caution or reprimand, having conditions imposed on registration, paying a fine of up to $30,000 to the National Board, suspending registration for a period or cancelling the practitioner’s registration.\(^{205}\) The National Board or tribunal’s sanctions are not punitive in nature and orders are made to protect the public and prevent further loss of practitioner privilege.\(^{206}\) Any conditions of registration or undertaking by the practitioner are recorded

\(^{201}\) *Ambulance Service Act 1991* (Qld) s 13A.

\(^{202}\) *Integrity Reform (Miscellaneous Amendments) Act 2010* (Qld) s 5.

\(^{203}\) *New South Wales, Parliamentary Debates*, Legislative Council, 26 August 2015, 2817 (Ernest Wong) 6.

\(^{204}\) *National Law* sch 1, s 156 (1)(a).

\(^{205}\) *National Law* sch 1, s 196 (2).

on the register which is publicly available for access.\textsuperscript{207} In this regard, members of the public can ascertain the outcome of any health complaints made which allows them to make informed decisions about receiving treatment and have confidence that an appropriate disciplinary process has been undertaken. As transparency is important for health practitioner regulation, the National Law’s governance ensures health practitioners are accountable for their actions.\textsuperscript{208}

\textbf{4.6 Conclusion}

This chapter considered the notable features of paramedicine’s current regulatory framework, namely training and education; protection of title; drug use and storage; and complaints and disciplinary processes. In so doing, the chapter demonstrated the shortcomings of Australian paramedic regulation. There are a number of problems with the current approach. Most broadly, the current approach is inconsistent and piecemeal. There are significant differences in the way paramedics are regulated in private and public practice and between jurisdictions. A number of more specific problems with current regulation were also identified. One of the problems of the existing paramedic regulatory framework relates to the disparity in minimum educational and training qualifications for paramedics. The jurisdictions with protection of title safeguards have legislated for minimum educational standards for paramedics; however, the remaining jurisdictions are governed through employer specification of qualifications. Of the public ambulance services, the Ambulance Service of New South Wales does not require new paramedic graduates to possess tertiary qualifications. Further, employers are solely responsible for approving educational qualifications for prospective paramedic applicants. Without national standards, private employers may not require tertiary qualifications either, which means there is no standardisation in industry training. As such, there is significant disparity in minimum competency standards of Australian paramedic employers.

Another problem with the current paramedicine regulatory framework is that employers are responsible for industry accreditation. This means there is a difference between the training and education expected of publicly and privately employed paramedics. Employer control over qualification standards means they are subjectively governed and disciplined, but they are not promoting the public interest. The Council of Ambulance Authorities, as the accreditor of paramedic qualifications, promotes organisational interest in the accreditation of paramedic courses which then outweighs the public’s best interests.

This chapter further identifies issues with title protection as a regulatory mechanism applicable to paramedic practice. While title protection is a suitable regulatory method to restrict practice to qualified practitioners only, it is not being used on a national basis, for paramedicine, and only applies to a select

\textsuperscript{207} National Law sch 1, ss 124, 225, 228.

few Australian jurisdictions. Where it does apply, privately employed paramedics are not always included within the title protection framework leading to disconnectedness between publicly and privately employed paramedics. This causes disparity within the regulatory framework. It also means employers are responsible for assessing paramedic competency before paramedics transfer to employment in other jurisdictions.

Another problem with Australian paramedic regulation lies in the way drug use and storage are regulated. The drug regulatory requirements are not as stringent for paramedics as they are for other registered health practitioners. Further, given paramedics have not been included within the legal regulation in some jurisdictions, it is difficult for the government to hold paramedics accountable for their actions. This means there is significant potential for paramedics to abuse their drug administration powers.

Finally, we saw how the complaints and discipline framework, as a notable feature of Australian paramedic regulation, also has issues. Because imposing disciplinary sanctions on paramedics is generally the employer’s responsibility, there is inconsistency in the disciplinary process as there is no standardisation of disciplinary practices. Further, the disciplinary outcomes of misbehaviour are not made publicly available which means the complaints and discipline system lacks transparency.

One of the key themes through Chapters 2 to 4 was the increased responsibility of paramedics, for example, administering drugs, invasive procedures, pre-hospital treatment and urgency of treatment. As a consequence of these responsibilities, there is increased risk of harm to patients. This is important because the risk poses the potential for harm to the community which is something the National Scheme aims to reduce. Due to the increased risk posed by paramedics, Chapter 5 explores the conceptual foundations of risk, further supporting the argument that paramedics be included under the National Scheme.
PART II: NATIONAL REGISTRATION AND ACCREDITATION OF PARAMEDICS
CHAPTER 5: PARAMEDICS, RISK AND HARM: A LESSON IN TRANSPARENCY

5.1 Introduction

This chapter will explore the conceptual foundations of risk and harm in relation to paramedic practice. Evaluating risk and harm is necessary for this research – and the argument that paramedics should be included in the National Scheme – because health professional regulation involves managing risk and preventing harm to patients. More specifically, the Council of Australian Governments considers whether the activities of a discipline pose a significant risk of harm to the health and safety of the public when determining new additions to the health professional groups regulated under the National Scheme.¹

This chapter will begin by defining risk in the healthcare context and detailing how conceptual theories of risk can apply to paramedic practice. In so doing it distinguishes risk from harm by highlighting that risk involves the potential for an event while harm relates to a specific action. The chapter then considers how a lack of transparency, in the current paramedic regulatory framework, can increase risk and harm to patients in paramedicine. In order to consider a transparent regulatory model, which currently functions to reduce paramedic risk and harm to the community, I use the United Kingdom’s paramedic registration, specifically their complaints and discipline data, to highlight the level of risk, and potential for harm, which exists for paramedics who perform a healthcare role in the community. This chapter will further explain how the United Kingdom’s regulatory framework can inform Australian paramedic practice and help establish the importance of transparency in Australian paramedic regulation. Chapter 6 will then develop the general argument of this thesis by providing examples of actual harm to justify why the current regulatory framework fails to address the risk Australian paramedics pose to the public and, therefore, the argument that paramedics should be included in the National Scheme.

5.2 Defining ‘risk’ and ‘harm’ in a healthcare context

In order to examine the regulation of paramedics in Australia, it is necessary to understand the related concepts of risk and harm. According to much of regulatory theory, regulation involves reducing or controlling unacceptable risks.² Risk can be defined as the likelihood of a specified event occurring and the ‘consequent severity of the impact of that event’.³ Risk is something ‘undesirable’⁴ or ‘threatening’.⁵

¹ Council of Australian Governments, Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions (at 26 March 2008) attachment B, r 1.3, 22-4.
whether that be a natural event or caused by human interactions. It is the extent of an undesirable event occurring, and the potential effect on parties, which regulation seeks to address.

The concept of ‘risk’ can be distinguished from the concept of ‘harm’. While risk involves the likelihood of an event occurring, harm relates to a definable action. On the one hand, risks can be largely theoretical and make predictions for possible harm, such as potential side effects following the use of medication. On the other hand, harm is a measured concept, which results from the risks, such as experiencing those side effects following the use of medication. Giddens likens the concept of harm discussed here to ‘hazard’ or ‘danger’; however, he suggests hazards are a ‘given’ while governing risk involves the avoidance of an unwanted outcome.

There are three conceptual categories which relate to risk regulation and the concept of harm. Haines suggests actuarial risk, sociocultural risk and political risk provide a framework for establishing risk in public policy regulation and affect regulation to produce positive regulatory outcomes. Haines cautions these risk types overlap and should not be considered as distinct categories.

5.2.1 Actuarial risk

Actuarial risk refers to the ‘reality of harm’. When harm can be quantifiably measured and predicted, based upon empirical knowledge, actuarial risk is the outcome. Actuarial risks might be obvious risks or they might carry some uncertainty as to the potential harm. The consequences of uncertainty in actuarial risk can, thus, produce a number of outcomes relevant to regulation. Gratt suggests risk is measured by the potential harm and the probability of harm occurring. Firstly, the extent of harm might be high but the probability of risk is low, such as risks from nuclear power. Secondly, the probability of risk and potential for harm is high but the public and regulator are unconcerned by the outcome, such as with climate change. Finally, there is a low probability of risk or harm which still causes significant public concern, such as the potential for terrorism. As such, assessing risk and harm can be a challenging exercise when advocating for regulatory reform.

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7 Ibid 3.
9 Ibid, above n 8, 35.
10 Ibid 36.
12 Haines, above n 8, 39.
14 Murphy, above n 8, 203.
In order to determine the level of regulation which is needed to address risk, there are a number of challenges which must be overcome. Firstly, risk identification must occur, as well as an appraisal of stakeholders’ participation in regulatory decision-making. Identifying risk involves a determination of the probability of a risk occurring and the probable outcome. When the public has an interest in the regulatory response, the perceptions of the public can inhibit the regulator’s ability to manage societal risk as the public may expect particular responses to the risk which the regulator may not consider appropriate.15 This chapter seeks to identify risks and probable outcomes in relation to paramedic regulation and discuss the appropriate level of government intervention.

5.2.2 Sociocultural risk

Sociocultural risk is the second regulatory typology for risk classification. Sociocultural risk considers the wider societal risks which threaten social order and the community.16 The societal aspect of this risk typology means the impact of the risk on the community is the most significant consideration, rather than considering the quantifiable harm of actuarial risk.17 The potential for harm which paramedics pose to the public can also be used as an example of sociocultural risk due to the threat to the community’s wellbeing.

The sociocultural risk which paramedics impose on the community is a significant consideration of this thesis. This chapter will argue that paramedics pose a significant risk to the community at large through the interactions they have with the public, the clinical skills they can perform and the drugs they can administer.18 The classification of relevant societal risk is, therefore, particularly relevant to determining the appropriateness of paramedic regulation. Potential for risk causes community concern;19 therefore, the distinction between voluntarily accepted risks and ‘societally imposed’ risks is significant to determining the level of risk to a society.20 Voluntarily accepted risks are those which citizens choose to risk in the form of informed consent, such as an understanding that taking certain medication could have dangerous side-effects for particular people. However, ‘societally imposed’ risks are those which citizens cannot choose to control, such as the identity and competence of the paramedics who arrive when ambulance assistance is requested.

Calculating societal risk can be problematic when the public becomes involved in the regulatory process. When the public is driving regulation because of a significant public issue, regulation may result which is not necessarily based upon a ‘rational appraisal’ of risk. Further, when an industry is

15 Baldwin, Cave and Lodge, above n 3, 93.
17 Haines, above n 8, 43-4.
18 See chapters 2 to 4 of this thesis for a detailed discussion.
19 Beck, above n 5, 332.
20 Baldwin, Cave and Lodge, above n 3, 87.
over-regulated, for whatever reason, regulation can cause more harm than intended.\textsuperscript{21} The result is diminished trust in regulators and regulation guided by irrational motives.\textsuperscript{22} As such, a balance is needed between a rational appraisal of genuine societal risk and governments providing a suitable response to public concern. Given the public’s significant role in hypothesising the potential for risk, it follows that the government has an interest, and mandate, in risk regulation.

\subsection*{5.2.3 Political risk}

Haines’ final regulatory typology lies in political risk.\textsuperscript{23} When faced with actuarial or sociocultural risk, individuals and communities seek protection from their elected government. If the government fails to address the security threat, political risk results as the government’s legitimacy to govern is questioned. As such, the government intervenes, when faced with risk and uncertainty, in order to maintain societal order, reassure the public and limit risk exposure.\textsuperscript{24}

Julia Black further expands on the role of risk in governmental action, suggesting there are four roles of risk in regulation. Risk provides an object for regulation as governments can regulate in the name of risk prevention. Risk justifies regulation and prescribes the limits of the government’s power in reducing risk. Risk further provides a context for regulatory procedures because it is used as a basis for developing organisational routine and procedures. Finally, risk structures the requirements for accountability of regulators because regulators can be evaluated based on the effectiveness of their management of risk.\textsuperscript{25}

Government regulators deal with risk on two levels. Societal risk involves ‘threats’ to the public and society, in general, while institutional risk threatens the regulatory organisation itself.\textsuperscript{26} Examples of institutional risk include financial liability and insurance. When institutional risk is being managed, Freiberg suggests organisations can fail to manage the societal risks which were the desired regulatory outcome.\textsuperscript{27} As a result, managing societal risk becomes subsequent to the organisation’s interests. It is this very concern which applies to the public ambulance services in Australia. When the public employer ambulance services are responsible for governing the industry, including regulating the employees and their scopes of practice, the employers’ organisational self-interest is managed at the expense of public safety. In order to fulfil institutional obligations, the public interest is not always the

\begin{footnotes}
\footnotetext[21]{Stephen Breyer, \textit{Breaking the Vicious Circle: Toward Effective Risk Regulation} (Cambridge, 1993) 80. Breyer suggests deregulation can solve many of the problems associated with governmental regulation.}
\footnotetext[22]{Baldwin, Cave and Lodge, above n 3, 98.}
\footnotetext[23]{Haines, above n 8, 48-52.}
\footnotetext[24]{Ibid.}
\footnotetext[25]{Ibid.}
\footnotetext[27]{Freiberg, above n 2, 58.}
\end{footnotes}
paramount consideration which causes further risk to patients relying on the paramedic industry for service.

Risk is used as a mandate in governmental regulation. The government’s role in regulation is considered to be the management of risk, and the boundaries of their involvement in society is justified according to the level of risk a particular activity poses.28 The level of risk determines the level of governmental involvement. A more substantial risk requires a heavier government response. For example, while self-regulation may be suitable for a low risk industry, and one which does not pose a significant risk of harm to the public, it would not be suitable for an industry where some form of societal risk can be established.29 The greater the risk to the public, the more justification for the government’s involvement, which is why co-regulation is so readily utilised for health professional regulation. The risk to the public is the justification for the National Scheme using a co-regulatory structure.30 As the competence and effectiveness of paramedics is a societal imposed risk, and one the public cannot opt out, the level of risk, therefore, determines the extent of the government’s involvement.

5.2.4 Risk prediction

The regulation of risk, therefore, has dual purposes. First, it involves an ‘objective’ appraisal of the potential for things to go wrong: a risk prediction. Secondly, regulation addresses individual and social concerns of risk, regardless of the likelihood or practicality that the perceived event will come to pass.31 The most effective regulation of risk is responsive to the regulatory environment and adapts to the changing regulatory purposes.32

Risk is concerning to regulators, and the community, because of the level of harm it imposes on the public.33 While the purpose of governmental regulation, in general, does not always involve risk mitigation or prevention,34 the object of health practitioner regulation does aim to reduce risk because of the potential for patient harm.35 Part of the risk reduction exercise involves ‘risk prediction’.

31 Baldwin, Cave and Lodge, above n 3, 102.
33 Giddens, above n 6, 3-4.
Risk prediction is a useful mechanism to support paramedic regulation. Risk prediction involves ‘forecasting from patterns of conduct what practitioners may do in the future’. 36 This chapter, as well as Chapter 6 of this thesis, uses risk prediction to set out patterns of previous paramedic conduct in order to predict the potential for future risk to the public.

This thesis is an exercise in risk prediction because there is very little evidence of paramedic wrongdoing available on the official public record. Researchers face difficulties in obtaining data which analyses the level of risk paramedics pose to the community for a number of reasons. Employers are reluctant to release information which could lead to liability if their employees’ practises have not reached appropriate standards of care. Further, government departments guard information about paramedic complaints closely for fear of contravening patient confidentiality. As a result, establishing the potential for paramedics to cause patient harm is challenging. Many of the examples used in this thesis to demonstrate a level of community risk fall short of providing a thorough foundation to establish patient harm as the employer organisations seek to keep evidence of paramedics causing community risk hidden from the public view. However, parts 5.3 - 5.5 seek to establish some evidence of risk which demonstrates the potential for patient harm through paramedic admissions of high risk behaviour, the extent of community reliance on the paramedic industry, and how public liability may affect paramedic risk. Specifically, this chapter will predict paramedic risk of harm to the community in the following way:

1. Admission of risky behaviour (5.3);
2. Numbers of paramedics practicing in the community (5.4);
3. Public liability immunity (5.5); and
4. Limited or no transparency (5.6).

### 5.3 Paramedic admissions of high risk behaviour

Paramedics pose a potential risk of harm to the community. Paramedics Australasia identify a number of risks which arise as a result of the role paramedics perform within the community and ones which have the potential to cause patient harm.37 These include paramedics:

1. performing invasive procedures;38
2. administering scheduled drugs;39
3. practising autonomously and without supervision;

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38 Table 2.2 (Chapter 2) outlined a selection of the invasive procedures Australian paramedics can perform on patients.
39 Table 3.6 (Chapter 3) prescribed a selection of dangerous drugs Australian paramedics can administer.
4. ‘providing complex and critical clinical assessments and care’; and
5. a dangerous and uncontrolled work environment.40

Paramedics, themselves, have also acknowledged the potential for risk of harm they pose to the community. In a 2011 study of paramedic risk, 3,081 paramedics were questioned about their understanding and observations of patient risk.41 The results are quite unexpected because they signify the occurrence of substantial patient harm caused by paramedics. There were 277 respondents (9 per cent) who indicated they had personal knowledge of paramedics causing patient deaths. A further 250 respondents (8 per cent) indicated they were aware of significant harm or injury a paramedic had personally caused to a patient. A further 337 respondents (11 per cent) agreed they had knowledge of paramedics causing moderate harm or injury to patients they had treated. Also significant was the fact that 35 per cent of paramedic respondents admitted to remembering incidents involving unqualified people who had been employed as a paramedic or performed a paramedic role in some capacity.

A number of important observations can be made from the findings of the study. Firstly, paramedics consider that their own skills, autonomy and practices have the potential to harm patients in certain situations and have acknowledged this through the findings of the study. Secondly, patient harm is occurring and paramedics are observing the effects of this risk from the outcomes of their patient interactions. In some instances, paramedics have alleged patients have died and had damage caused, or exacerbated, following paramedic treatment. Finally, the evidence of patient harm which is occurring is not being communicated to the public or being made available, in any form, for public consideration. As such, a level of risk involved for the public can be predicted when paramedics practise, although the precise level of risk cannot be specifically measured.

5.4 How the regulatory dichotomy between public and private paramedicine in Australia may suggest risk

Given an appropriate regulatory response can be determined from the level of risk applicable to the public, another risk factor of Australian paramedic practice is the number or practising paramedics in Australia. The significant number of paramedics practising in Australia indicates how many patients paramedics can be treating which, as a result, suggests the level of patient risk of harm which paramedics pose. Paramedic numbers are comparable to other registered health professionals. For example, as at March 2016, there were 4,626 registered podiatrists;44 5,148 registered chiropractors;45

40 Paramedics Australasia, Public risk and Paramedic Regulation, above n 37, 6.
41 Ibid 9.
42 Term undefined in study.
43 Term undefined in study.
and, 18,159 registered occupational therapists.\textsuperscript{46} Paramedics have similar numbers which suggests there is a comparable demand for paramedical services as some of the other health professions. Risk prediction, for the paramedic industry, can further benefit from a consideration of the numbers of practising paramedics. Given there are more practising paramedics than some of the other registered health professions, paramedicine is clearly a service being utilised Australia-wide.

The paramedic workforce, Australia-wide, is larger than registered podiatrists and chiropractors. During the 2014-2015 period, the Productivity Commission recorded 10,045 ‘qualified ambulance officers’ within the public service.\textsuperscript{47} A monthly aggregate of Australian Bureau of Statistics data, with variable sampling, reported approximately 11,300 people employed as ‘ambulance officers’ or ‘paramedics’ in 2014, incorporating public and private sector employment Australia-wide.\textsuperscript{48} The Australian Workforce and Productivity Agency’s data conflicted with the Australian Bureau of Statistics’ averaging, suggesting 13,900 employed as public or private ambulance officers and paramedics in Australia in 2014.\textsuperscript{49} It is difficult to determine exact numbers of practising paramedics without a registration system. Chapter 3 established the extent of the private paramedic workforce in Australia and estimated it is likely private paramedics comprise of approximately 40 percent of the total paramedic workforce.\textsuperscript{50}

As identified in Chapter 3, paramedics are also attending a large number of emergency incidents suggesting a heavy public reliance on the ambulance industry. Between 2014 and 2015, paramedics attended 3.70 million incidents nationally, with 37 percent of those being emergency responses.\textsuperscript{51} With the level of skill and expertise required of paramedics also rising, the potential risk to the community from those who may not be performing the paramedic role adequately is also increasing.

The increasing prevalence of emergency paramedic responses and the growing private industry is significant to predicting risk within the discipline. It demonstrates the community’s need for emergency healthcare, and related services, which paramedics provide. As there are more opportunities for privately practising paramedics, the public employer regulatory structure, which once controlled the industry, can no longer govern all paramedics as the private industry has grown too large. As such, an employer regulated discipline is not appropriate to meet the potential risk to the public which paramedics impose.

\textsuperscript{46} Occupational Therapy Board of Australia, \textit{Statistics} (March 2016)
\textsuperscript{50} Paramedics Australasia, \textit{Public risk and Paramedic Regulation}, above n 37, 5.
A significant regulatory challenge to paramedics and public safety comes from the disparity between public and private ambulance provision, a concept I have called the “regulatory dichotomy” between public and private paramedicine in this chapter. This is an important consideration because, as we saw in Chapter 3, many paramedics are employed by private companies and therefore treat many patients. For example, an administrative review matter in the Queensland Civil and Administrative Tribunal (QCAT) in 2012 provides a detailed consideration into the regulatory framework of a private ambulance organisation. Immediate Assistants Pty Ltd applied for a review of a Queensland Health decision following a drug endorsement granted to their organisation. Queensland Health could grant drug endorsements, and impose conditions, on organisations for their employees to administer controlled and restricted drugs. One of Queensland Health’s conditions required Immediate Assistants to consult with a ‘doctor’ prior to the administration of metoclopramide, midazolam or morphine. In the event of a life-threatening situation, and doctor consultation not being possible immediately, contemporaneous consultation may occur. Immediate Assistants appealed Queensland Health’s conditions on the basis they were unnecessary for the safe administration of the drugs and were not imposed on Immediate Assistants in a previous endorsement.

QCAT’s findings highlight issues with private employers, particularly around regulatory practices. This is especially relevant to this research as it is one of a limited number of cases involving private paramedic regulation. When considering a potential paramedic employee, Immediate Assistants considered their vocational or tertiary qualifications, any training or recertification within their ambulance service and undertook clinical assessment if there were concerns relating to the paramedic’s competence. However, there was no induction course and new employees were ‘talked through’ the organisation’s policies. There was also an annual recertification of paramedic employees during their employment with Immediate Assistants. Comparatively, the Queensland Ambulance Service gave evidence their own induction and training requirements ensured paramedics transferring from another ambulance service undertook a three-week induction course, three months working with a QAS paramedic, a one month intensive program and examinations with multiple scenarios.

Immediate Assistants made a number of additional submissions about their ability to effectively regulate employee paramedic administration of drugs. When discussing the paramedics’ drug administration skills, Immediate Assistants identified their organisation had strict protocols with graded dosage, removing the need for practitioner discretion. Immediate Assistants further gave evidence that ‘it was possible for an experienced paramedic to have more expertise than a general practitioner or a specialist in another field’ and a doctor responding to a remote consultation request was in ‘no better

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52 Immediate Assistants Pty Ltd v Chief Executive, Queensland Health [2012] QCAT 245 (21 June 2012).
53 Health (Drugs and Poisons) Regulation 1996 (Qld) s 18.
54 Ibid [17], [19], [21], [48].
position’ to make a clinical judgment about the most suitable patient care.55 These submissions were made in support of Immediate Assistants’ objections to the conditions imposed on their paramedics.

QCAT found in favour of Queensland Health. They deemed the contingency for the applicant’s paramedics to consult a medical practitioner after the drug administration was a sufficient discretion to allow for the best patient care. The administrative review highlighted:

- the discrepancy between policies and procedures of paramedic employers demonstrated how paramedic regulation, in the private industry, is almost entirely at the employer’s discretion; and

- As the industry lacks an external body to monitor employer practices, or ensure consistency between employers, any instances of patient harm are not known to the public unless they cause death or the patient reports concerns to a health complaints commission.

A number of significant issues can be highlighted from this administrative review. While the Queensland Ambulance Service may have more rigid employment transfer procedures for prospective paramedics than private organisations, the absence of an external regulatory body means these transfer procedures do not apply to private paramedic employers. Despite Queensland Health’s requirement to consult with a medical practitioner at some point during patient care when drugs are administered, there is still the potential for patient harm if the private employer has not appropriately screened their employees for past misconduct or fitness-to-practice issues. By comparison, the Queensland Government only grants drug endorsements when they are satisfied the applicants’ employees have suitable training and education to administer drugs, so there are minimum safeguards in place in an attempt to maintain minimum standards. Without a national system of paramedic regulation, there will continue to be significant disparity between the public and private system’s requirements for paramedic training, education, knowledge and skills.

Another challenge with Australia’s private paramedicine industry is that private paramedics are exercising expanded scopes of practice, sometimes beyond what a publicly employed paramedic might administer, such as vaccination. Immediate Assistants’ role includes ‘training, accreditation and specialised products’. No further clarification was provided to determine the extent of these services although the applicant has been involved in administering commercial rescue competencies, drug and alcohol testing, vaccination programs and nationally accredited training and wellness programs. These are all skills which fall within an expanded scope of practice model and go beyond training competencies of public paramedics.56

55 Ibid [23], [24].
56 Ibid [16].
There are significant responsibilities attached to private paramedic practice. As evidenced in QCAT’s decision outlined above, some private paramedics are performing skills, with requisite knowledge, equivalent to an expanded scope of practice in the public system. While some organisations may require frequent certification of skills and knowledge, there is no external body in place which ensures all Australian practising paramedics are maintaining minimum standards of skills, knowledge, training and conduct. All of these contribute to the risk of harm paramedics pose to patients.

5.5 Public liability immunity and the impact on paramedic risk

Public liability immunity exists for some Australian paramedics practising in the public sector. Some jurisdictions legislatively exempt paramedics employed with the public ambulances services from civil liability for injury, or damage for actions performed during their practise. This exemption usually applies when paramedics are providing emergency assistance and are acting in ‘good faith’ or without recklessness in assisting the patient. However, the jurisdictions prescribing civil liability exemptions only legislate for paramedics employed with the public ambulance service providers.

The civil liability exemptions have a number of implications for risk prediction. The various legislators, in exempting liability in particular jurisdictions, have acknowledged the inherent risk which exists for paramedics when providing emergency assistance to patients. Given the potential to cause patient damage and injury, legislators have removed the possibility of public liability by prohibiting the public from taking civil action, provided paramedics act in good faith or without reckless disregard for patient safety. In the jurisdictions providing civil liability exemptions, only publicly employed paramedics can exercise them, meaning private practitioners could be held personally liable unless vicarious liability laws apply to them.

Despite the examples detailing the potential for paramedic risk provided above, a significant barrier to the successful establishment of patient risk is transparency. Transparency is a significant and crucial aspect of professional health regulation, and one which does not exist in current Australian paramedic regulation. Without transparency, risk prediction is especially difficult, which makes establishing paramedic risk to patients especially problematic.

5.6 Lack of transparency in paramedicine and the impact on risk prediction

Transparency is needed for paramedic complaints and disciplinary processes throughout Australia. As we saw in Chapter 4, however, the complaints and disciplinary processes for Australian paramedics are

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57 Civil Liability Act 2003 (Qld) s 26; Civil Liability Regulation 2014 (Qld) sch 1; Ambulance Service Act 1991 (Qld) s 39; Health Services Act 1997 (NSW) s 67I; Ambulance Service Act 1982 (Tas) s 41.

58 Ibid.

59 The civil liability exemptions for individual paramedics do not limit vicarious liability of employer organisations.

inconsistent and disciplinary processes which enable employers to communicate fitness-to-practice concerns are decided on at an employer level and are arbitrary in nature. One of the significant issues for Australian paramedic regulation is the lack of transparency of complaints data and disciplinary outcomes.

Transparency is a necessary element of health practitioner regulation generally. Freckelton and Flynn identify the importance of transparency in health practitioner disciplinary processes.  

They suggest the accessibility of data relating to the National Boards’ decisions enhances the ‘transparency and accountability’ of health complaints processes. The availability of data is a ‘constructive’ outcome because it allows for communication of health practitioner ethical and unethical conduct occurring in society. When employers and regulators of an industry have an element of state-based governance, transparency becomes even more crucial because of the presumption governments operate in a transparent way.

As complaints and discipline are addressed at an employer level, transparency is necessary to identify the level of paramedic risk to the public and to ensure employers are following proper procedures to ensure the safety of the community. This part of the chapter will address the gaps in transparency which exist within Australian paramedic practice and the implications those gaps have for patient risk and harm. Further, this chapter will argue that transparency in paramedicine needs improvement to reduce the health and safety risk paramedics pose to the public. In order to make this argument, I have investigated the public’s access to the data from the paramedic complaints and disciplinary processes in each Australian jurisdiction as complaints and discipline provide further evidence to establish the level of patient risk to the community.

Transparency is imperative to the ‘development and enforcement’ of government regulation. Transparency builds public trust in the regulatory model and the integrity of its processes, as it provides information to the public which they can use to make informed decisions about their government and choices as citizens. Further, government decision-making, recording and reporting procedures should all be transparent in order to introduce suitable reforms. If the community is not given sufficient information to determine the effectiveness of health practitioner regulation, which has such significant potential for public harm and has an element of governmental regulation, there is no government accountability.

62 Ibid 97.
The level of transparency in the paramedicine complaints and disciplinary processes is relevant to establishing risk. Both employer governance and legal regulation govern paramedic complaints and disciplinary processes as discussed in Chapters 2 and 4 of this thesis. The statutory instruments governing existing paramedic complaints procedures are a government intervention to reduce risk to the public and ensure there are adequate measures to deal with paramedic misbehaviour and incompetence. As such, details of complaints made under these legislative instruments, and the related disciplinary action imposed on the paramedic, is relevant to this research as it helps establish the level of patient risk paramedics pose to the community.66

In 2009, an administrative governmental review of transparency in the paramedic complaints system was conducted.67 The St John Ambulance Inquiry assessed a number of significant issues in the Western Australian ambulance industry, the most relevant of which to this discussion was the effectiveness of the paramedic complaints system. Indeed, the Western Australian Parliament initiated the St John Ambulance Inquiry (“the Inquiry”) following an Australian Broadcasting Corporation’s Four Corners televised investigation into ambulance services in Western Australia, which focussed on four patient deaths resulting from inadequate ambulance service responses.68 There were 13 recommendations proposed to the Western Australian Health Minister following the inquiry, three of which are directly relevant to the regulation of Australian paramedics. The Inquiry recommended the existing continuing education program be expanded, national registration of paramedics be pursued and the complaints system be strengthened.69 The existing complaints system for the Western Australian ambulance service was problematic given the lack of transparency which existed when members of the public made complaints. While strengthening the complaints system will be addressed here, the other recommendations will be discussed in Chapter 6 of this thesis.

Significantly, the Inquiry found that the existing system allowed for employers undertaking internal investigations of complaints, and, as there was little publication on the processes for making a complaint, the complaints framework was closed and unaccountable. These issues caused a number of significant concerns. It was difficult for the public to obtain information on the complaints process, and the outcomes of investigations were not publicised. Additionally, where the complaint was unresolved or the complainant was dissatisfied with the outcome, there was no avenue for an internal review of the complaint. Further, there was no mechanism to allow for improving the organisation’s functions, as a result of the complaint, nor did the complaints process allow the prevention of similar incidents

66 Health and Community Services Complaints Act (NT); Health Complaints Act 1995 (Tas); Health Services (Conciliation and Review) Act 1987 (Vic); Health and Disability Services (Complaints) Act 1995 (WA); Human Rights Commission Act 2005 (ACT).
67 Government of Western Australia, 'St John Ambulance Inquiry: Report to the Minister for Health' (Department of Health, October 2009) 49.
68 Australian Broadcasting Corporation, 'Out of Time', Four Corners, 6 July 2009 (Matthew Carney).
69 Government of Western Australia, above n 67.
recurring. Finally, the Inquiry found complaints management for paramedicine was inconsistent throughout all Australian jurisdictions. The Inquiry concluded that strengthening the complaints’ system could improve the complaints process for patients and their families.

The Western Australian St John Ambulance Service initiated a number of changes to their processes following the Inquiry’s publication. The St John’s Ambulance Service developed their complaints system to allow regular communication with the complainant throughout their internal complaints process.\textsuperscript{70} Further, the organisation’s website included a link to the complaints system to enable easier access to the complaints processes for complainants.\textsuperscript{71} The St John Ambulance Service concluded the Inquiry’s recommendation had been addressed and achieved through the amendments to their internal complaints processes.\textsuperscript{72}

Despite the Western Australian St John Ambulance Service making positive changes to their internal complaints processes, significant concerns of the Inquiry are still outstanding. As a result of the changes, while the public may be able to access information about the process of making a complaint, there is no avenue for those external to the complaint to gain access to the data to ensure full transparency in operations. Further, paramedic complaints management remains inconsistent throughout Australia. In this way, the community is still unable to evaluate the effectiveness of the complaints processes of paramedic regulation in dealing with risk to the public. The lack of transparency in paramedic complaints systems prevents the public from accessing data relating to complaints against paramedics. This, in itself, contributes to increasing the risk of harm paramedics pose to the public.

Having used the lack of transparency to help predict and argue for risk to the public, in the remainder of this part I set out details of public complaints about paramedics. Data was requested and obtained from various organisations.\textsuperscript{73} Some data was publicly available, such as Annual Reports, while other data was requested specifically, such as data of complaints against paramedics not otherwise published. Importantly, however, was the limited data available. I determined that the level of data provision, and access to the data itself, would indicate the transparency of the system as it would show the public’s ability to access data dealing with paramedic complaints.

On 5 August 2015, I contacted the Health Complaints Commissions in each jurisdiction of Australia. In doing so, I requested details about the frequency of complaints against paramedics and ambulance providers and the disciplinary action which resulted. Only de-identified statistical data was requested in order to void the need to obtain research ethics approval. Following the request, only Queensland

\textsuperscript{70} Government of Western Australia, ‘St John Ambulance Inquiry: Implementation of Recommendations’ (Department of Health, December 2010) 17.
\textsuperscript{71} Ibid.
\textsuperscript{72} Ibid.
\textsuperscript{73} Please see the discussion of the use of the term ‘data’ in chapter 1.
and South Australia provided complaints information which was very limited in substance. Other jurisdictions either did not respond to follow-up requests for information or required ethics approval for the information to be released. The data received was not sufficient to determine whether complaints data could help to substantiate the level of risk Australian paramedics pose to the public. Further, the data provided was not enough to make any determinations about the quality of disciplinary processes applicable to misbehaving or incompetent Australian paramedics. The primary employers of state and territory ambulance services were also contacted to provide data relating to complaints against their paramedic employees. None of the available data detailed the outcome of the complaint or any investigation. The ambulance services also required ethics approval to disclose complaints data in many cases. The limited complaints data obtained is outlined, below, per jurisdiction.

5.6.1 Australian Capital Territory

The Health Services Commissioner from the ACT Human Rights Commission agreed to provide complaints information on the ‘caveat that other State and Territory Commissions were doing the same’. The ACT Human Rights Commission were concerned their complaints were ‘easily identifiable’ given their ‘small jurisdiction with one ambulance service’. Complaints data was never provided. Their Annual Reports published broad data concerning the number of health complaints received, categorised according to veterinary science, registered practitioners under the National Law and other complaints, but there was nothing which distinguished the percentage of complaints, if any, received about ACT paramedics. The ACT Ambulance Service responded to the request for complaints data although declined to participate on the basis of lack of resources to extract and supply the information.

5.6.2 New South Wales

The latest data available dealing with health complaints, in New South Wales, comes from the 2013/2014 financial year. During that time, the New South Wales Health Care Complaints Commission only recorded one relevant complaint and that related to ‘ambulance personnel’. It is unknown whether this complaint related to a qualified ‘paramedic’ or other ambulance staff without paramedic qualifications and experience. The nature of the complaint and the outcome of any

74 Email from Office of the Health Ombudsman to Dominique Moritz, 10 August 2015.; Telephone conversation with Lucy (surname not provided), South Australian Complaints Office (5 August 2015).
75 Email from Stefanie Schweiger, Intake and Review Officer, to Dominique Moritz, 7 August 2015.
76 Ibid.
78 Letter from Dr Carol Brook, General Manager - Quality, Safety and Risk Management, to Dominique Moritz, 14 December 2015.
investigation is also unknown. The New South Wales Health Complaints Commission did not respond to a request for information on complaints against paramedics while the Ambulance Service of New South Wales required human research ethics committee approval for the provision of information.

### 5.6.3 Northern Territory

Data relating to Northern Territory paramedic complaints was not forthcoming from related organisations. The Northern Territory Deputy Commissioner for the Health and Community Services Complaints Commission agreed to provide information about paramedic complaints; however, this information was never forwarded. Further, the St John Ambulance Service (NT) also indicated their intention to provide assistance in locating de-identified data, but no further details were provided. No other publicly available documents disclosed complaints against Northern Territory ambulance services or paramedics.

### 5.6.4 Queensland

The Office of the Health Ombudsman, Queensland, provided data over a 12 month period between 1 July 2014 and 7 August 2015. The Health Ombudsman reported 16 complaints against the Queensland Ambulance Service, as a provider of ambulance services in Queensland in that time. They also indicated only one complaint was made against a named 'Ambulance Officer' between those dates although they did not specify the nature of that complaint. No further particulars were provided nor were the outcome of the complaints investigations. The Annual Report did not publish any relevant details of complaints against paramedics or ambulance services during the 2014 – 2015 year. The Queensland Ambulance Service required ethics approval to release data relating to complaints against their employees.

### 5.6.5 South Australia

The South Australian Health and Community Services Complaints Commissioner indicated there were very few complaints against paramedics (only 5 or 6 complaints per year). Most complaints surrounded the fee involved for engaging ambulance assistance. However, the South Australian Commission indicated their unwillingness to provide further details given complaints searches on their database requires manual searching and they did not have the resources to investigate the request for

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80 Email from Michael McKay, Director of Ambulance - Operations, to Dominique Moritz, 21 October 2015.
82 Email from Office of the Health Ombudsman to Dominique Moritz, 10 August 2015.
84 Telephone conversation with Lucy (surname not provided), South Australian Complaints Office (5 August 2015).
85 Ibid.
information further. No further details could be ascertained from online publications of the department. The South Australian Ambulance Service required ethics approval from a South Australian ethics committee for release of requested data.

5.6.6 Tasmania

The only data available for complaints against Tasmanian ambulance services came from the Health Complaints Commission’s Annual Report. One complaint against the Health Organisation ‘Ambulance’ was received during the 2013 – 2014 financial year. The particulars of that complaint, and relevance to paramedics, is unknown. Ambulance Tasmania did not refuse assistance in providing complaints data, although completion of an extensive data access protocol was required including potential costs to the applicant; this was not further pursued as it required resources beyond those a member of the public could access. The Tasmanian Health Complaints Commission did not respond to requests for de-identified data.

5.6.7 Victoria

There is very limited data available about Victorian paramedics and the nature of complaints made about their practice. The Victorian Health Services Commissioner reported 23 complaints were made about ambulance services during the 2014-2015 financial year but no further details were included to establish the particulars of these complaints, nor whether the complaints related to individual paramedics or the ambulance service as an organisation. Ambulance Victoria acknowledged the request for information but did not provide further assistance.

5.6.8 Western Australia

The Western Australian Health and Disability Services Complaints Office did not respond to the request for ambulance data. The St John Ambulance Service of Western Australia declined to provide the data requested. Western Australian health complaints data published in the organisation’s Annual Report was very broad and did not provide any detail relating to ambulance services or paramedics. The Western Australian Health and Disability Services Complaints Office reported 1,754 health complaints received for the state during 2014-2015 but only particulars for the top three health providers were

88 Ibid 16.
89 Email from Alex Wilson, Operational Performance Analyst, to Dominique Moritz, 29 October 2015.
91 Email from Michael McKay, Director of Ambulance - Operations, to Dominique Moritz, 21 October 2015.
outlined: general practices and practitioners, prison health services and dental practices and practitioners. Unregistered practitioners, ambulance services or paramedics were not expressly considered.\(^{92}\)

The only definitive data, relating to complaints against paramedics, was outlined in the St John’s Ambulance Service Inquiry. In the 2008-2009 financial year, the ambulance service received, on average, five complaints for every 10,000 cases.\(^{93}\) No further details regarding the outcome, or nature, of these complaints was provided. If this is accurate, given there were 193,166 attended cases during the 2009 period, this suggests there could have been up to 100 complaints received during that time.\(^{94}\) More recent data was not available. However, if the 100 complaints received per year is close to the actual number of complaints made against paramedics, this is a significant finding because it highlights the full range of public dissatisfaction with paramedics.

### 5.6.9 Limitation of data collection

After reading 5.6.1 - 5.6.8, it is evident that there were a number of limitations around the collection of complaints data. There was organisational reluctance to provide requested data, even when the information was de-identified. The data that was provided was often incomplete as it did not identify the type of complaint or seriousness of the alleged paramedic conduct. Despite these limitations, the data collection exercise helps support the argument that there is a lack of transparency in paramedicine regulation. It showed how challenging it is for the public to gain access to paramedic complaints and disciplinary data.

A number of observations can be made about the data collection. The data obtained from the Health Complaints Commissions did not directly establish risk within the paramedic industry. The Health Complaints Commissions were reluctant to provide assistance to establish complaints against paramedics or even ambulance services. Complaints information was only occasionally published in the Annual Reports and when it was, it was generally vague in nature and lacked the substance needed to ascertain potential public risk specific to paramedics.

Complaints and discipline data was also not available from the ambulance services. Ambulance services either did not provide data or required ethics approval for data provision. Both of these eventualities result in the public being unable to access this information. Making complaints data inaccessible could be part of the ambulance services’ attempt to reduce organisational liability arising from admitting potential wrongdoing, a lack of resources in sourcing the information from their internal databases, or

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\(^{93}\) Government of Western Australia, above n 69, 52.

the desire to avoid a precedent where the public has access to this data. It is understandable that employer organisations elect not to provide information about the actions of their employees; however, in the absence of any other data documenting complaints and discipline, it is another example of the difficulty in obtaining complaints data for paramedics.

A further difficulty arises because there are multiple avenues for complaints and discipline for paramedics. As health complaints can be made to the Health Complaints Commissions, or to the ambulance providers themselves, it is difficult to determine whether the limited data obtained accurately reflects the complaints made against the paramedics or providers. The numbers of complaints, or whether the disciplinary outcome was sufficient to address the complaint concern, could not be established.

The difficulty in accessing complaints is problematic. If data is not released detailing complaints made to the Health Complaints Commissions or paramedic employers, it is difficult to determine whether jurisdictions are sufficiently addressing inadequate paramedic conduct and patient treatment. As such, there is a lack of transparency because the risk to the public cannot be completely established, limiting the ability to evaluate the effectiveness of the regulatory framework and predict risk in the discipline. The transparency issues contribute to risk prediction as there is a huge potential for paramedics to harm patients and there is no evidence to establish the contrary. That said, the contextual nature of complaints data should also be remembered. As complaints originating from members of the public account for only a very small percentage of all paramedic misconduct cases,95 there could be widespread risk to the community where evidence originates from other sources, such as peers and employers. Peer reporting, in the form of mandatory reporting, is a required aspect of professional health practitioner regulation under the National Scheme and is further explored in Chapter 6 of this thesis. The difficulty accessing health complaints data is substantially different to the Australian registered health professions where health complaints and disciplinary data is publicised online and is another justification supporting National Law regulation for paramedics.96

5.7 Paramedic Regulation in the United Kingdom

Having predicted the risks of paramedicine in Australia in 5.2 - 5.6, it is instructive to consider how paramedics are registered outside Australia. While there are a range of approaches to the regulation of paramedics worldwide,97 in the remainder of this chapter I focus on the United Kingdom. The United

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95 Four per cent of all complaints originate from members of the public. See 5.8.4 for further details.
97 Chapter 1 provides a summary of the regulatory approaches for governing paramedic practice in international jurisdictions and explained why the other approaches will not be evaluated further in this research.
Kingdom provides an appropriate and useful comparison of Australian paramedic regulation because the role of British paramedics is very similar to that of Australian paramedics. Furthermore, British paramedics are subject to a national registration system,\(^98\) similar to the one I am proposing. In comparison to the current regulatory scheme in Australia, the United Kingdom’s approach is a very strong regulatory framework to promote trust and standing in the profession, as well as protecting the public. Given there is an established regulatory system which can document paramedic behaviour, risk to the community can be more easily established in the United Kingdom. As such, the risk paramedics pose to the community in the United Kingdom can inform the potential for paramedic risk in Australia and the transparency of their system highlights those risks. A brief overview of the United Kingdom’s paramedic regulatory framework, as well as some observations about the role and risk of paramedics in the United Kingdom, are highlighted below.

Before examining the notable features of United Kingdom’s paramedic regulatory scheme, it is instructive to say something about its evolution. The evolution of health professional regulation in the United Kingdom demonstrates the risk health practitioners pose to the public and provides further evidence for paramedicine risk prediction in Australia. The regulatory landscape of health professionals in the United Kingdom was shaped by a number of significant and high profile medical cases.\(^99\) These cases, which caused significant harm to members of the public, resulted in Parliament commissioning inquiries and making recommendations for the better regulation of the health professions.

The fifth report of the Shipman Inquiry, released in 2004, is worthy of further exploration. The Shipman Inquiry is significant for a number of reasons. In 2000, Harold Shipman was found to have murdered over 200 of his patients while practising as a general practitioner in the United Kingdom.\(^100\) The Inquiry was designed to investigate avenues for better healthcare regulation to safeguard patients in the future. The Shipman Inquiry is especially relevant to health professional regulation because it considers the processes of the health practitioner regulatory body and the stages of the healthcare regulatory process.\(^101\) It also commenced an overhaul of health professional regulation in the United Kingdom and the effects of the regulatory changes influenced British paramedicine regulation.

The role of the regulator has particular importance to ensuring public safety of patients. According to Dame Janet Smith, Chairperson of the Shipman Inquiry, the primary purpose of regulators should be to protect the public.\(^102\) Medical practitioners exhibiting paternalism and self-protection of each other have

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\(^{98}\) *Health and Social Work Professions Order 2001* (UK).

\(^{99}\) The Ledward Inquiry, Bristol Inquiry, Ayling Inquiry, Neale Inquiry and the Kerr/Haslan Inquiry are examples.


no place in modern medical regulation. Instead, medicine should be ‘patient-centred’. It was suggested that the regulator should be directly accountable to parliament and publish an annual report of activities.\(^{103}\) Despite the recommendations’ reference to medical practitioners, their application to a wider group of health practitioners can be undertaken, including paramedics, as paramedics perform a medical role requiring complete decision-making autonomy. While Australian public ambulance services are accountable to parliament and publish annual reports, private ambulance providers do not, which demonstrates less transparency than needed.

The Shipman Inquiry also produced recommendations following scrutiny of the medical regulator’s procedures. When dealing with fitness-to-practice issues, the regulator’s procedures should have transparent and consistent decisions and be capable of scrutiny. Patients should be able to access a central database of information containing details of fitness-to-practise history of the medical practitioner and ‘all professional people must accept [the need for the investigation of complaints] as the right of the patient, as a learning experience and as an important means of uncovering substandard care and protecting patients.’\(^ {104}\) While the National Law allows scrutiny and transparency of health practitioners’ backgrounds, the Australian paramedic regulatory framework does not.

The Trust, Assurance and Safety Paper, a further review following the Shipman Inquiry, detailed policy and principles to be applied for health professional regulation in the United Kingdom.\(^ {105}\) It reinforced the view that health professionals should be acting in the best interests of their patients, rather than protecting the interests of their profession. Conflicts of interest between patient safety and health practitioner interest have the potential to undermine trust and confidence in the standing of the profession, and should be avoided.

Among the detailed recommendations of the Trust, Assurance and Safety Paper, it was held that independence of the individual regulators is particularly important.\(^ {106}\) Regulators need to be independent to external pressures which might arise. Independence, in this context, requires regulators to be:

1. Separate from government and insulated from political pressures;
2. Independent from employers; and
3. Independent from health professionals themselves.\(^ {107}\)

The recommendation for regulator independence from employers is particularly noteworthy to Australian paramedic regulation. When employers are involved in the regulation of the industry,

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\(^{103}\) Ibid 42, 46, 49.
\(^{104}\) Ibid 71, 1023.
\(^{105}\) United Kingdom, Trust, Assurance and Safety - The Regulation of Health Professionals in the 21st Century, Cm 7013 (2007).
\(^{106}\) Ibid 24.
\(^{107}\) Ibid.
employer interests could be ‘perceived to weaken safeguards for the public or undermine the fair conduct of regulation’.\textsuperscript{108} Regulators need to exist outside the employer realm in order to perform the impartial function bestowed upon them from the legislature. Current paramedic regulation in Australia fails to achieve the employer-regulator independence suggested above, which is needed to reduce patient risk in the industry.

Revalidation was another significant theme arising from the review of health professional regulation in the United Kingdom. Revalidation, in the form of continuing professional development, refers to a practitioner demonstrating their skills and knowledge have sufficient currency. Trusting an individual practitioner to maintain their fitness to practise would no longer be considered acceptable. Instead, revalidation should occur in proportion to the level of risk the practitioner’s discipline poses to the community, rather than having a standard revalidation structure applicable to all health professional groups unanimously. The independent regulatory body should be responsible for approving revalidation practices.\textsuperscript{109} There is no uniform requirement for paramedic professional revalidation in Australia, with employers accepting responsibility for prescribing revalidation. As such, revalidation is not occurring for all practising paramedics suggesting a higher level of risk from paramedic skills and knowledge becoming outdated.

It is useful to undertake a jurisdictional regulatory comparison with the United Kingdom for a number of reasons. The United Kingdom, who have a comprehensive registration system for their paramedics, underwent a health practitioner regulatory transformation in order to protect the public and prevent harm to patients, as discussed above, following instances like Harold Shipman’s treatment of patients under his care. Australia’s health practitioners also followed a similar regulatory progression, with a national registration system created to reduce patient risk; Chapters 6 and 7 of this thesis will investigate Australian health practitioner regulation further. Part 5.7, though, identifies why British paramedics were included in health practitioner regulation. Given British paramedics are so closely aligned with Australian paramedics, in terms of skills and scopes of practice, a need for paramedic registration in the United Kingdom should be mirrored in Australia.

British paramedics were not always included within the United Kingdom’s health professional regulatory framework. The United Kingdom created a registration system for British paramedics. The House of Lords extended paramedic registration, under a statutory regulation system, in 1999 for paramedics to fall within the framework of the former \textit{Professions Supplementary to Medicine Act 1960} (UK). Paramedic inclusion under state regulation was considered, at the time, to modernise the

\textsuperscript{108} Ibid.
\textsuperscript{109} Ibid 37.
profession and benefit the public.\textsuperscript{110} Paramedics have remained within the state’s jurisdiction of regulating health professionals since that time.

The benefit to the public appears to be the primary reason for acknowledging British paramedics as a professional group worthy of statutory regulation. Because British paramedics were working autonomously and performing invasive and risky procedures on patients, it was deemed to be in the public’s best interests for paramedics to be regulated under the jurisdiction’s existing registration scheme in order to reduce the risk paramedics pose to the community. Because paramedics were working in an unsupervised capacity, and exercising their own judgment and discretion to make patient care decisions, even prior to 1999, the parliament acknowledged the professionalism, potential risk and autonomy British paramedics possess. The British paramedic industry is considered a professionalised industry because of their education and training structures as well as their national registration scheme.\textsuperscript{111} When adding paramedics to the regulatory body which became the Health and Care Professions Council, Baroness Hayman stated:

Statutory regulation is a privilege and should not be granted just because the profession concerned aspires to it. It should be justified because it provides safeguards for the public which would not otherwise be available. We are satisfied that unlicensed practice in any of these fields [including paramedics] has the potential for harm to patients and that state registration provides better protection for patients and the general public.\textsuperscript{112}

For the United Kingdom, paramedic registration managed the risk of patient harm which, in turn, better protected the public. The House of Lords suggested implementing paramedic registration leads to the following benefits:

1. an objective assurance, for the public, in high standards of training, conduct and practice;
2. a benchmark standard for employers;
3. workforce planning through the continuous record of staff;
4. opportunity for collaboration between health professionals; and
5. coherency in dealing with overseas qualified practitioners.\textsuperscript{113}

Health professional regulation in the United Kingdom uses a variety of regulatory tools to govern their regulatory landscape. Glynn and Gomez discuss how the paramedic profession is regulated in three ways.\textsuperscript{114} ‘Student fitness to practise’ ensures prospective practitioners gain essential knowledge, skills and professional values prior to their application for registration. This is undertaken through the tertiary

\textsuperscript{110} United Kingdom, \textit{Parliamentary Debates}, House of Lords, 10 June 1999, vol 601, col 1652 (Baroness Hayman).


\textsuperscript{112} United Kingdom, \textit{Parliamentary Debates}, House of Lords, 10 June 1999, col 1654.

\textsuperscript{113} Ibid.

\textsuperscript{114} Glynn and Gomez, above n 101, 12-3.
education and accreditation process. Secondly, the regulators’ publications of standards, codes of practice and guidelines require uniform minimum standards. Finally, the continuing professional development requirements allow for ‘continuous appraisal’ of industry standards. In this way, Glynn and Gomez argue British health professional regulation is a ‘proactive mechanism’, to respond to potential risk, rather than ‘reactive’ to established harm, to ensure public protection.

The British paramedic regulatory framework effectively reduces patient risk and provides an acceptable benchmark for Australian paramedic regulation. The paramedic complaints and disciplinary systems in the United Kingdom are transparent, which means the public can make a very clear assessment of the system’s effectiveness and the actuarial, sociocultural and political risk which arise within their system. Australian paramedic practice would benefit from a similar system and incorporating paramedics with the National Scheme would be an appropriate Australian response to implementing a comparable paramedic regulatory system to the United Kingdom.

Part of the reason United Kingdom paramedics are included in a national scheme is the acknowledgement of the significant role of paramedics. Paramedics, according to the United Kingdom’s Council, provide ‘specialist care and treatment to patients who are either acutely ill or injured. They can administer a range of drugs and carry out certain surgical techniques’. The College of Paramedics defines paramedics as ‘autonomous first contact practitioners who undertake a range of diagnostic and treatment activities as well as directing and signposting care’. Further, paramedics treat health problems, attained from injury, illness or exacerbation of a chronic illness.

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115 For the Council to grant registration to an applicant, an applicant must hold an approved qualification and be capable of safe and effective practice. The minimum qualification approved for a registered paramedic is listed as an equivalent to a Certificate of Higher Education. However, new graduate paramedics must complete a Foundation Degree in Paramedic Science to be eligible for registration. This suggests the Council is acknowledging the value of tertiary education while allowing paramedics, qualified prior to statutory registration requirements, to continue to practise with their existing skills set. See Health Act 1999 (UK) s 60; Health and Social Work Professions Order 2001 (UK) art 9 (2); Health and Care Professions Council, ‘Fitness to Practise Annual Report 2014’ (2014) <http://www.hpc-uk.org/publications/reports/index.asp?id=967>. The Council also performs an accreditation role for paramedic courses. Educational providers must ensure there are appropriate admissions procedures including English communication requirements, criminal history checks and compliance with industry health requirements. Practice placements are a requirement for paramedic courses, with the Council closely monitoring assessment procedures and curriculum design. Health and Care Professions Council, ‘Fitness to Practise Annual Report 2014’ (2014) <http://www.hpc-uk.org/publications/reports/index.asp?id=967>.

116 The Council’s requires all paramedics, and their employers, to follow their standards of practice. See Health and Care Professions Council, ‘Standards of Proficiency: Paramedics’ (August 2014) 7-16.

117 The Health and Social Work Professions Order 2001 (UK) arts 10, 14, 19 allows the Council to specify continuing professional development requirements for registrants to maintain registration. The Council requires registered health professionals to maintain CPD that is relevant to current and future practice, ensure it benefits patients and contributes to the quality of their practice and to provide a written profile with evidentiary documentation, if requested according to Health and Care Professions Council, ‘Continuing Professional Development and Your Registration’ (March 2014) <http://www.hcpe-uk.org/assets/documents/10001314CPD_and_your_registration.pdf> 6.

118 Ibid.

119 Glynn and Gomez, above n 101, 10-1.

120 College of Paramedics, 'Paramedic - Scope of Practice Policy' (May 2015) <https://www.collegeofparamedics.co.uk/>.
and undertake health promotion and admission avoidance, which supports the ambulance service as not only an ‘illness’ service but also a ‘health’ service. A more detailed list of paramedic scopes of practice are listed in Table 5.1 below. As at 1 March 2016, there were 22,250 paramedics registered under the Health and Care Professions Council (“HCPC”).

121 Ibid.
<table>
<thead>
<tr>
<th>Clinical Skills**</th>
<th>ACP1</th>
<th>ACP2</th>
<th>CCP</th>
<th>Registered Paramedic</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 Lead ECG</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Arterial line insertion</td>
<td></td>
<td></td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>Arterial tourniquet</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Breech delivery – obstetrics</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Chest decompression</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>External jugular intravenous cannulation</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Fracture reduction</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Intramuscular drug/fluid administration</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Intravenous drug/fluid administration</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manual defibrillation</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Nasopharyngeal airway insertion</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-invasive ventilation – CPAP</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral endotracheal intubation</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orogastric tube insertion</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Procedural sedation</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Skin stapler</td>
<td></td>
<td></td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>Subcutaneous drug/fluid administration</td>
<td></td>
<td></td>
<td>E</td>
<td>X</td>
</tr>
<tr>
<td>Surgical cricothyrotomy</td>
<td></td>
<td></td>
<td>E</td>
<td>X</td>
</tr>
<tr>
<td>Thoracostomy</td>
<td></td>
<td></td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>Tooth re plantation</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transcutaneous cardiac pacing</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Valsalva manoeuvres</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Table of abbreviations used*
- ACP1: Advanced Care Paramedic – level of qualification and experience approved by QAS
- ACP2: Advanced Care Paramedic – level of qualification and experience approved by QAS
- C: Prior consultation and approval required
- CCP: Critical Care Paramedic
- E: Approved Extended Scope of Practice
- X: Within Scope of Practice

Table 5.1 Non-exhaustive jurisdictional skills comparison

125 This list is designed to provide examples, only, of some of the clinical skills of British paramedics. The Queensland and UK ambulance services provided a list of skills, for their paramedics, within their authority to practise guidelines. The lists provided were not directly comparable to each other so there may be skills missing, from the table, which are within the scope of paramedics’ skills in that jurisdiction. Only Queensland was provided, by way of short comparison. As clinical skills are beyond my expertise, I did not investigate the clinical skills in these jurisdictions further. Please also note, if the skills are listed under another name in the UK clinical protocols, my lack of expertise means I have not been able to recognise the skills, under a different name, to acknowledge them above.
Table 5.1 compares a selection of clinical skills for United Kingdom paramedics to Queensland paramedics. Queensland was chosen as an exemplar of Australian paramedic skills to provide context to British paramedics’ clinical skills. The comparison shows Queensland and British paramedics exercise similar clinical skills so are comparable to each other. This means that British paramedical regulation is directly comparable to Australian paramedical regulation as paramedics have similar scopes of practice and purposes in both jurisdictions.

Healthcare, in the United Kingdom, is a co-regulatory system established through statute. The Health and Social Work Professions Order 2001 (UK) (the “Health Order”), made under section 60 of the Health Act 1999 (UK), created the Health and Care Professions Council (“the Council”), while the Constitution Order 2009 (UK) sets out the composition of the Council. The Health Order is comparable to Australia’s National Law as it formalises a range of regulatory tools including:

1. registration;
2. education and training;
3. fitness to practise;
4. appeals;
5. offences; and other miscellaneous-type provisions.

The more specific provisions for paramedic practice requirements are administered in the form of clinical practice guidelines, similarly to Australian paramedics. In the United Kingdom, the Joint Royal Colleges Ambulance Liaison Committee is responsible for creating and reviewing national clinical practice guidelines for the National Health Service. There are a further nine healthcare regulators in the United Kingdom governing 31 healthcare professions. The HCPC is responsible for regulating 16 health professions in the United Kingdom, including paramedics. The HCPC’s functions include setting standards for education and training, professional skills, conduct, performance, ethics and health; keeping a professional register; approval of registration programs; accreditation of training and education; and, co-ordination of disciplinary processes for registrants failing to meet

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126 Table 2.2 (Chapter 2) provides the comparison of clinical skills from all Australian jurisdictions.
127 This order was made under the Health Act 1999 (UK) s 60.
129 These guidelines govern paramedics working within the National Health Service and do not apply to private organisations.
130 The HCPC is responsible for regulating 16 health professions in the United Kingdom, including paramedics. The HCPC’s functions include setting standards for education and training, professional skills, conduct, performance, ethics and health; keeping a professional register; approval of registration programs; accreditation of training and education; and, co-ordination of disciplinary processes for registrants failing to meet.
131 Formerly called the Health Professions Council.
132 The Council’s other regulated groups include arts therapists, biomedical scientists, chiropodists/podiatrists, clinical scientists, dieticians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists/orthotists, radiographers, social workers in England only, and speech and language therapists.
133 Paramedics, and all other health professionals regulated under the Health and Care Professions Council, are listed on a public register which is maintained by the Council. The register allows patients, or any interested parties, to search for the health practitioners registered under the Council. See Health and Care Professions Council, Check the Register (2015 <http://www.hcpc-uk.org/check/>).
standards. Nurses and medical practitioners have other regulators and are not included under the Council’s jurisdiction.

There is also a statutory body which governs the nine healthcare regulators in the United Kingdom, including the HCPC. The Professional Standards Authority for Health and Social Care was established under section 222 of the Health and Social Care Act 2012 (UK). The Professional Standards Authority can review the performance of the healthcare regulators and appeal against fitness-to-practice decisions.

There is also an additional regulator of paramedic services in the United Kingdom. The Care Quality Commission (“the Commission”) independently regulates health services and places additional requirements on providers of ambulance services. Any provider intending to deliver a regulated activity must be registered with the Commission. A regulated activity includes the treatment of disease, disorder and injury; or transport services, triage and medical advice provided remotely, which categorises ambulance services.

There is a significant difference between the Care Quality Commission and the HCPC. Given the Commission regulates the employers, paramedics do not have to individually register with them. The provider becoming the legal entity responsible for the regulated activity, with paramedics only required to register with the Council. If a paramedic provides ‘off duty’ medical assistance using their higher skills acquired by virtue of being a qualified paramedic, the individual paramedic is still not classified as providing a service involving a regulated activity, so responsibility for the regulated activity will still rest with their employer. In this way, there are obligations on both healthcare professionals and employers to comply with regulatory standards.

In addition to industry clinical guidelines, there are also external legislative frameworks governing particular conduct. Drug administration is a useful example of legislative regulation of paramedic

134 Health and Social Work Professions Order 2001 (UK) art 3.
135 Nurses in the United Kingdom are regulated by the Nursing and Midwifery Council under the Nursing and Midwifery Order 2001 (UK).
136 The General Medical Council regulates medical practitioners in the United Kingdom under the Medical Act 1983 (UK).
137 Glynn and Gomez, above n 101, 8.
140 The Care Quality Commission and the Health Care and Professions Council work together in the regulation of the healthcare industry in the United Kingdom. A memorandum of understanding exists between the two bodies. The cross referral of concerns and exchange of information between the regulatory bodies promotes public safety, public confidence in the organisations and transparency. See Care Quality Commission, Memorandum of understanding between the Care Quality Commission and the Health Care Professions Council (22 September 2014) <http://www.cqc.org.uk/sites/default/files/documents/memorandum_of_understanding_between_hpcc_and_cqc.pdf>.
practitioners which exists outside the state registration framework. The *Medicines Act 1968* (UK), *Misuse of Drugs Act 1971* (UK) and *Human Medicines Regulations 2012* (UK) permit paramedics to possess and administer particular drugs. Table 5.2 provides a comparison of drugs British paramedics can administer, when compared to Queensland paramedics, for context.
<table>
<thead>
<tr>
<th>Drug administration**</th>
<th>Queensland 141</th>
<th>United Kingdom 142</th>
<th>Registered Parame dic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adrenaline</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Amiodarone</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Aspirin</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Atropine</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Benztrapine</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Calcium Gluconate 10%</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Ceftriaxone</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Clopidogrel</td>
<td>E</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Enoxoparin</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Frusemide</td>
<td></td>
<td>E</td>
<td>X</td>
</tr>
<tr>
<td>Glucose 5%</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Glucose 10%</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Heparin</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Hydrocortisone</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Ipratropium bromide</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Ketamine</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Lignocaine 2%</td>
<td></td>
<td>E</td>
<td>X</td>
</tr>
<tr>
<td>Magnesium sulphate</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Metaclopramid</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Midazolam</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Morphine</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Naloxone</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Ondansetron</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Salbutamol</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Sodium bicarbonate 8.4%</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Sodium chloride 0.9%</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Tenecteplase</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Tetanus immunisation</td>
<td>E</td>
<td>E</td>
<td>E</td>
</tr>
<tr>
<td>Tranexamic acid</td>
<td>E</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

Table of abbreviations used

ACP1: Advanced Care Paramedic – level of qualification and experience approved by QAS
ACP2: Advanced Care Paramedic – level of qualification and experience approved by QAS
C: Prior consultation and approval required
CCP: Critical Care Paramedic
E: Approved Extended Scope of Practice
X: Within Scope of Practice

Table 5.2 Non-exhaustive list of drugs approved for paramedic administration

142 Association of Ambulance Chief Executives, above n 124.
5.7.1 Specific regulatory requirements for British registered paramedics

There are a number of notable features of the United Kingdom’s regulatory framework for paramedic practice. While every feature of British paramedic regulation cannot be discussed in this thesis, a number of features which effectively minimise paramedic risk to the public are addressed below. Significantly, the notable features of UK paramedic regulation – professional indemnity insurance, protection of title requirements and fitness-to-practise investigations – highlight the similarity of the United Kingdom’s regulatory framework to Australia’s National Scheme and therefore add to the argument for the inclusion of paramedics in the National Scheme.

Professional indemnity insurance

Indemnity insurance is a requirement of paramedic registration in the United Kingdom. Paramedics must have appropriate cover to indemnify against potential risk and this can come from their employer, trade union, professional organisation, directly from an insurer or a combination of any. A declaration that confirms the registrants’ possession of indemnity insurance is required for health professional registration.143

Protection of title

Protection of the paramedic title is used as a regulatory tool in the United Kingdom. It is an offence for a person to falsely represent themselves to have registration under the HCPC, use the title ‘paramedic’ without entitlement and falsely profess to possess qualifications as a paramedic.144 The offence of false representation as a paramedic can still apply if the misrepresentation occurs by implication. For example, if a person does falsely represent themselves to be a paramedic, sanctions can also be imposed on any person who fraudulently deals with an entry on the HCPC’s register or fails to comply with any requirements imposed by the HCPC or Practice Committee. A person contravening the UK’s regulatory requirements on paramedic title and qualifications can be liable on summary conviction to a fine of up to £5,000.145

Fitness-to-practise issues within paramedicine

The HCPC monitors fitness-to-practise issues which can result in disciplinary matters against paramedics. Allegations against health professionals, including paramedics, can be made if they are in writing, include the practitioner’s name and give enough detail about the concerns to allow for an investigation.146 Where it is alleged that a paramedic’s fitness to practise is impaired because of

144 Health and Social Work Professions Order 2001 (UK) art 39.
145 Ibid art 39(6); Criminal Justice Act 1982 (UK) s 37.
146 Health and Care Professions Council, Fitness to Practise Annual Report 2014, above n 115, 9.
misconduct; lack of competence; a conviction or caution for a criminal offence; physical or mental health issues; a licensing body declares the person is unfit to practise; or fraudulent or incorrect entries into the register have been made, the HCPC will investigate the allegation and decide on appropriate disciplinary measures.147

The reporting of health practitioner conduct falling below reasonable standards of conduct can be undertaken in a number of different ways. The United Kingdom’s co-regulatory system imposes mandatory notifications on health professionals to report unsatisfactory conduct of their peers. There is also a statutory obligation for employers to report unsatisfactory conduct to the HCPC for investigation. Reporting unsatisfactory conduct can also come from self-reporting and police reporting. The self-reporting rules require registrants to report criminal convictions or cautions, disciplinary action by another health or social care regulatory agency, and any employer suspension because of conduct or competence concerns.148

That sanctions imposed for contraventions of fitness to practise vary. If a complaint is ‘well founded’, and it is appropriate to take further action, the paramedic can be ‘struck-off’ the register; face suspension of up to one year; be subject to practising conditions for a period of up to three years; or cautioned. The details of the registrant’s disciplinary sanction is then recorded on the register and becomes publicly available information.149

5.7.2 Paramedic risk arising from public complaints and paramedic discipline

Examining the complaints data relating to British paramedics is a useful exercise to establish paramedic risk and regulatory transparency. The British complaints data provides evidence of the types of misconduct British paramedics commit while practising. Complaints made against paramedics, and the outcome of investigations, are publicly available information in the United Kingdom. Publishing complaints information promotes transparency in health regulation as the public is then able to evaluate health practitioner conduct and assess the effectiveness of the health system to protect the public. The instances of paramedic misconduct in the United Kingdom serve as examples of the potential for risk which all paramedics pose to the public, Australia included. They also illustrate how a ‘registration’ scheme for paramedics results in greater transparency and better protection for the public.

Complaints against British paramedics originated from a number of different sources. During the 2013/2014 year, there were 265 complaints made against paramedics. Self-reporting of issues affecting an individual paramedic’s fitness to practise accounted for 34 per cent of all investigations which was

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149 Health and Social Work Professions Order 2001 (UK) art 29.
the highest complainant method. Fitness-to-practice issues were also investigated as a result of employer (11 per cent), peer (17 per cent), professional body (7 per cent) and police reporting (16 per cent) of conduct issues. Surprisingly, complaints from members of the public only comprised four per cent of the total complaints against paramedics in that year. The small number of complaints originating from the public is particularly significant as public complaints are the only types of complaints which can be measured in an Australian context. This adds to my argument in this thesis as Australian paramedic regulation, without a national registration system requiring mandatory reporting, cannot measure employer, peer, professional or police reporting of conduct issues in order to determine the level of risk Australian paramedics pose to the public.

Paramedics registered in the United Kingdom have been disciplined for a number of inappropriate behaviours. A range of penalties apply to paramedics who have demonstrated conduct which falls short of a reasonable standard, including dismissal, suspension, conditions imposed on practice and a caution. Where the Council investigated a complaint further, there were 62 paramedics, during the reporting period, with fitness-to-practice issues deemed sufficiently serious to warrant a disciplinary hearing to determine a suitable outcome. The outcome of the hearings was varied. During the 2013/2014, there were a number of hearings which determined disciplinary sanctions for paramedic misbehaviour. Dismissal from the register, the most serious sanction, occurred in 15 cases, where the paramedic:

1. engaged in sexual activity with a patient;
2. communicated inappropriately with a vulnerable female patient;
3. failed to provide adequate care and accurately assess a vulnerable adult patient who was having a seizure;
4. failed to respond to an emergency call, gave false information and attempted to influence a witness to provide false evidence;
5. struck a patient in the face;
6. failed to provide appropriate care for a patient and identify seriousness of patient’s condition;
7. failed to conduct a full assessment on a patient and provide adequate patient care;
8. self-administered morphine, forged manager’s signature and falsified records;
9. self-administered entonox whilst on duty;
10. colluded with colleagues to complete an inaccurate patient assessment record;
11. failed to assess and examine a patient effectively, failed to respond to a patient in a critical condition and colluded with colleagues to complete an inaccurate patient assessment record;
12. misused alcohol, worked while driver’s licence was suspended, self-administered entonox while on duty and made oral/written threats towards a colleague;

151 Ibid 60-81.
152 Two different paramedics were dismissed for this reason.
13. Failed to undertake full assessment and examination of a patient, provided inadequate patient care and provided false information; and
14. Failed to effectively supervise a trainee paramedic and dishonestly colluded with another person to provide a false report.¹⁵³

Nine paramedics were suspended on the grounds that they:

1. Removed and retained patient records without authorisation;
2. Failed to provide adequate clinical care and support to patients;
3. Failed to maintain satisfactory timekeeping and attending work smelling of alcohol;
4. Failed to act in an emergency, conduct accurate assessment and provide adequate care;
5. Failed to provide adequate clinical care and support to patients;
6. Failed to conduct full assessment on a patient and did not transport patient to hospital;
7. Did not provide appropriate care to a patient;
8. Demonstrated poor judgment at the scene of an emergency call; and
9. Failed to assess a patient and identify serious injuries.¹⁵⁴

Four paramedics had conditions imposed on their practice because they:

1. Were in possession of an entonox cylinder at an ambulance station whilst signed off sick and abused Entonox, or had intended to do so;
2. Failed to maintain a controlled drugs register and conduct regular audits;
3. Failed to provide full assessment and appropriate care for a patient; and
4. Failure to identify injuries to a patient.¹⁵⁵

Nine paramedics were cautioned because they:

1. Failed to conduct suitable and sufficient patient assessments;
2. Failed to provide adequate care and support to patients;
3. Forged a colleague’s signature when signing morphine back into the ambulance station;
4. Posted offensive remarks on Facebook in relation to former colleagues;
5. Falsified signatures on patient reporting forms;
6. Bullied and harassed several colleagues;
7. Submitted a fitness to work certificate with the date altered;
8. Failed to carry out adequate assessment on a patient; and

¹⁵⁴ Ibid.
¹⁵⁵ Ibid.
9. Consented to a caution order for poor standards of driving whilst at work.\textsuperscript{156}

In addition, two paramedics voluntarily removed themselves from the register as they were found to have provided inadequate patient care and assessment.\textsuperscript{157} There were also many fitness-to-practice complaints which did not incur any sanctions following a disciplinary hearing. There were 22 complaints deemed ‘not well founded’\textsuperscript{158} and one complaint required no further action.\textsuperscript{159} The few cases which avoided a formal sanction, following a disciplinary hearing, suggest that the investigations process, undertaken prior to the disciplinary hearing, is usually sufficient to establish those complaints or issues which are trivial enough to avoid disciplinary action. The United Kingdom’s fitness-to-practice data also leads to some other interesting conclusions.

The source of the complaint generally indicates the reliability of the complaint.\textsuperscript{160} For example, employer complaints to the Council resulted in the more restrictive sanctions imposed upon paramedics, such as striking off the role, suspension or having conditions imposed on practice. Employers’ success in predicting paramedic misconduct suggests employers can identify conduct which is significant enough to warrant further investigation by the professional regulator and, therefore, employer reporting of paramedic conduct is an important regulatory mechanism to ensure paramedic conduct is scrutinised. Conversely, complaints originating from members of the public were most likely to be considered not well founded.\textsuperscript{161} The public’s inability to discern unsatisfactory professional conduct of health professionals suggests the public does not have the expertise to determine whether conduct amounts to misconduct. As such, other methods of reporting, apart from public complaints, should be used to evaluate paramedic misconduct in order to determine the efficiency of paramedic regulation.

Without the mandatory reporting to an external regulator which occurs in the United Kingdom, there are several adverse outcomes to the public which could eventuate. Most of the complaints about British paramedics (96 per cent) would not have been submitted to the regulatory body if there was no mandatory reporting requirements. The consequences, as a result, could include misconduct which is not brought to the regulator’s attention; paramedics continuing to practise despite exhibiting inappropriate behaviour; and a regulatory framework which lacks transparency and cannot establish risk to members of the public. These three factors are all present in Australian paramedic regulation.

The United Kingdom paramedic registration system raises many implications for Australian paramedic regulation. In Australia, there is no mandatory reporting of peers or employer reporting to an external

\begin{footnotesize}
\begin{enumerate}
\item\textsuperscript{156} Ibid.
\item\textsuperscript{157} Ibid.
\item\textsuperscript{158} ‘Not well founded’ referred to complaints made with insufficient evidence presented to the Council to establish the complaint.
\item\textsuperscript{159} Health and Care Professions Council, \textit{Fitness to Practise Annual Report 2014}, above n 115, 35.
\item\textsuperscript{160} Ibid.
\item\textsuperscript{161} Ibid 39.
\end{enumerate}
\end{footnotesize}
body for paramedics, which means that the only way to measure complaints against paramedics comes from the public. By comparison, if the public is only responsible for reporting 4 per cent of all fitness-to-practice issues in the United Kingdom, it is likely there is a much higher occurrence of unsatisfactory paramedic conduct occurring in Australia which cannot be identified from the available Australian complaints data without a registration system. Further, employers in the United Kingdom are responsible for reporting the more serious misconduct issues. As such, there is a conflict of interest when Australian employers are responsible for the discipline of paramedics as the lack of transparency means the public cannot know whether the regulatory framework is functioning effectively, achieving its purposes of promoting trust and reducing patient risk.

In summary, the United Kingdom paramedic regulation framework functions in a similar way to Australia’s National Scheme. Significantly, the United Kingdom’s regulatory model is aimed at protecting the public. Specifically, public protection is promoted through a transparent regulatory system and consistent disciplinary decisions. These measures are made easier by the centralised registration of paramedics in the United Kingdom.

5.8 Conclusion

This chapter argued that paramedics pose a significant and increasing risk to the community. Establishing the risk of harm to the community is necessary to make the argument for paramedic inclusion under the National Scheme given the Council of Australian Governments considers risk as a factor when adding new health professional groups to the National Law’s jurisdiction, an argument further developed in chapter 7 of this thesis.162 This chapter, however, highlighted a number of important issues including the risk that paramedics pose to the community. Currently, Australian paramedic regulation lacks transparency and consistency in the Australian paramedic complaints and disciplinary processes. Further support for risk regulation, and the argument for paramedic inclusion in the National Scheme, came from an analysis of United Kingdom paramedic regulation.

A key problem of the current Australian approach is a lack of transparency. The current complaints and disciplinary regulatory tools governing paramedic practice lack transparency as important information to evaluate regulatory effectiveness is not being made available to the public. As such, it is impossible to determine the full potential of paramedicine’s risk to the Australian public because the data which could establish it does not exist. The difficulties in accessing current information, which is publicly available in the United Kingdom, shows a significant deficiency in the regulatory model in Australia.

The United Kingdom’s paramedic registration model provides a useful jurisdictional comparison. Given the United Kingdom’s complaints and disciplinary system provides transparent complaints and discipline data, it shows the potential risk paramedics pose to the United Kingdom. Given the

162 Council of Australian Governments, above n 1. 
similarities in skills and knowledge to Australian paramedics, the United Kingdom paramedic risk is comparable to Australia. The published data also highlights the need for peer, employer and self-reporting of unsatisfactory professional conduct to an external regulator as the British mandatory reporting requirements outlined how 96 per cent of complaints stemmed from mandatory reporting, rather than public complaints.

This chapter established difficulties determining the risk that paramedics pose to the Australian community. Chapter 6 will take this risk analysis further, using specific examples of harm to justify why changes to the current regulatory framework is needed.
CHAPTER 6: A PRECAUTIONARY APPROACH TO PARAMEDIC REGULATION

6.1 Introduction

The previous chapter, Chapter 5, made two main assertions. First, it presented paramedicine as a ‘risky’ activity that needs to be suitably regulated. Secondly, it showed how the United Kingdom’s approach to paramedic regulation promoted a more transparent regulatory framework which reduced risk to the public amongst British paramedics. Importantly, paramedic regulation alleviates some of the problems of risk by facilitating a transparent and consistent paramedic profession. This chapter will build upon the analysis in Chapter 5 by considering specific examples of patient harm. These examples are sourced from jurisdictional and administrative legal decisions such as coronial inquests and Magistrates Court decisions. In doing so, the chapter argues that paramedic regulation should be informed and sustained by the ‘precautionary principle’ of regulation. That is, the idea that regulation to paramedicine should aim to reduce risk even without evidence establishing the existence of risk in the paramedic industry.

Significantly, as we have seen throughout this thesis, paramedicine is an industry which poses the potential for risk to the public. Every paramedic interaction contains the potential for patients to suffer harm from the treating paramedic. Evidence of paramedics causing patient harm, highlighting the risk of harm, is significant for a number of reasons. Paramedics treat patients who are in a vulnerable position and trust paramedics to have adequate expertise in diagnosis, treatment and the provision of advice. Further, if paramedic practice does not reach a minimum standard of care, there could be severe adverse outcomes for patients including injury and death. This chapter will argue that the National Scheme is the most appropriate regulatory framework which will reduce the potential of paramedic risk to patients.

In order to make the argument that paramedics pose a significant risk to the public, and the National Scheme should be adopted as a precautionary approach to regulating Australian paramedicine, this chapter has a number of parts. This chapter will begin with an evaluation of the precautionary principle; arguing that a precautionary approach to regulation requires governmental regulation to prevent risk to the public regardless of any documented evidence to the contrary. The chapter will then use judicial and administrative examples of harmful practices in the title, training and education of paramedicine as well as paramedic misconduct. These examples add further to the argument that paramedics pose a significant risk to the public, particularly because of the vulnerability of their patients. All of these arguments lead to the conclusion that paramedics should be regulated under the National Scheme. Importantly, Chapter 7 will then evaluate how the incorporation of paramedics, under the National Law, would work most appropriately.
6.2 Precautionary principle

This chapter builds upon the conceptual and practical considerations of risk regulation in paramedicine. More specifically, in this Chapter 6, I argue that the precautionary principle applies to Australian paramedic regulation which creates a justification for the inclusion of paramedics under the National Law.

This chapter will present some evidence of harmful practices occurring within paramedic practice which is important because the prevention of patient risk is a primary purpose of health practitioner regulation; however, risk is also an element the Council of Australian Governments consider to justify a further health profession’s inclusion under the National Scheme which will be addressed in Chapter 7. In this chapter, I will argue for the inclusion of paramedics in the National Scheme as a precautionary approach to address paramedic risk to the Australian community.

A precautionary approach to regulation requires positive actions aimed at the minimisation of risk. Anticipating risk is widely known as the ‘precautionary principle’. The precautionary principle is a political response to reduce risk without, necessarily, the scientific evidence to warrant regulation. There are two limbs to the precautionary approach to regulation. Precautionary regulation will occur when there is the potential for ‘irreversible’ harm; and, the risk cannot be empirically assessed but there is a need to reduce risk before there is proof of harm. When regulation is precautionary, it reduces risk.

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1 Ian Freckelton, 'Trends in Regulation of Mental Health Practitioners' (2008) 15 Psychiatry, Psychology and Law 415, 415.
3 Cf with a resilient approach to regulation which works in response to an adverse event. Resilient approaches allow for the mitigation of hazards which risks impose, such as informing the public of a risk and allowing them to make an informed choice about their continuance of an activity. Resilient regulation in risk management allows regulators to ensure system resilience to unknown factors and can be a ‘trial and error’ approach to regulation. However, it is often not ‘politically acceptable’ given resilient regulation can be curative in nature and does not allow for management of irreversible risks. See Robert Baldwin, Martin Cave and Martin Lodge, Understanding Regulation: Theory, Strategy and Practice (Oxford University Press, 2nd ed, 2012) 94; Aaron Wildavsky, Searching for Safety (Transaction Books, 1998); Julia Black, 'The Role of Risk in Regulatory Processes' in Robert Baldwin, Martin Cave and Martin Lodge (eds), The Oxford Handbook of Regulation (Oxford University Press, 2010) 321. Paramedic regulation could not adopt a resilient approach. Even if paramedics became registered under the National Scheme, patients would not get to choose the paramedics that attend to them, nor could they exercise an informed choice to exclude a particular paramedic from treating them. As such, paramedics are particularly risk adverse as patients have no choice in their treating practitioner. In this way, paramedic regulation would be similar to nurse registration as patients, in most circumstances, are not able to exclude a nurse from their treatment following consultation of the register. The regulatory dichotomy between public and private paramedic practitioners provides an example of the importance of the precautionary principle and highlights why resilient regulation is not appropriate in Australian paramedic regulation.
when there are harmful but uncertain outcomes and immediate benefits are needed; there is no requirement of the risk having caused harm.6

While the scholarship overwhelmingly applies the precautionary approach to concepts of environmental damage,7 it can be particularly relevant to paramedicine. As argued in Chapter 5, paramedics have the potential to do irreversible harm to their patients in the form of injury and death. Further, it is difficult to empirically assess paramedic risk due to the lack of existing evidence and the transparency issues in paramedic regulation which Chapter 5 also considered. Therefore, paramedic regulation should apply a precautionary approach in regulating the discipline through the National Scheme given the potential for risk and lack of evidence of harm.

Further, paramedic regulation could not adopt a resilient approach either. Even if paramedics became registered under the National Scheme, patients would not get to choose the paramedics that attend to them, nor could they exercise an informed choice to exclude a particular paramedic from treating them. In this way, paramedic regulation under the National Scheme would be similar to the National Scheme’s nurse regulation as patients, in most circumstances, are not able to exclude a nurse from their treatment following consultation of the register. Despite nurses being listed on the National Scheme’s register for the public to view, patients (in most cases) cannot choose their nurse and so consulting the register for nurses may not have value for patients. Paramedic registration under the National Scheme would have the same result for patients. The regulatory dichotomy between public and private paramedic practitioners provides an example of the importance of the precautionary principle and highlights why resilient regulation is not appropriate in Australian paramedic regulation.

Chapter 5 established that paramedics pose some patient risk and Chapter 6 will further this argument. Given the consequences of risk which paramedics pose to patients, that patients could be injured or die from paramedic actions, a regulatory response through the ‘precautionary principle’ is more appropriate to regulate paramedics than the current approach to paramedic regulation discussed in Chapters 2 – 4 of this thesis.

6.3 Title, training and education

Part 6.3 outlines specific examples of paramedic risk in the community and concludes that regardless of the extent of risk which title, training and education poses, a precautionary approach to paramedic regulation would reduce the risk of these challenges to the public. Specifically, part 6.3 examines how

7 See, eg, Ronnie Harding and Elizabeth Fisher, ‘Introducing the precautionary principle’ in Ronnie Harding and Elizabeth Fisher (eds), Perspectives on the Precautionary Principle (The Federation Press, 1999) ; Timothy O’Riordan and James Cameron, Interpreting the Precautionary Principle (Routledge, 2002).
examples of paramedic conduct – within the broad categories of paramedic title and education, student paramedic registration and continuing professional development – have contributed to patient risk. These examples are significant to this thesis as they demonstrate a potential for patient harm which cannot be established without a more transparent regulatory system, such as the National Scheme.

6.3.1 Paramedic title and education

Protection of title, as a statutory regulatory tool of paramedicine, is only available in some Australian jurisdictions. Specifically, as outlined in Chapter 4, protection of title provisions have been introduced in New South Wales, Tasmania and South Australia in order to restrict the use of the title ‘paramedic’ to those appropriately skilled or qualified. Other Australian States and territories, however, do not have protection of title provisions for paramedics. This raises a number of potential problems related to minimum paramedic educational requirements. These problems can be addressed if a precautionary approach to regulating paramedicine is used as protection of title would be implemented for paramedicine.

A potential challenge with current paramedic regulation not having nationally recognised protection of title mechanisms arises from injurious falsehood: a civil wrong in which a false assertion injures a person’s property, products or business. An application for relief, as a result of alleged injurious falsehoods breaching section 42 of the *Fair Trading Act 1987* (NSW), was sought in *Paramedical Services Pty Ltd v Ambulance Service of New South Wales*. Paramedical Services Pty Ltd, an incorporated organisation, employed two paramedics on a casual basis, who were also employed by the Ambulance Service of NSW. The paramedics later resigned from their employment with the Ambulance Service of NSW to work solely for Paramedical Services. Paramedical Services’ business involved ‘training in first aid and advanced pre-hospital care’, as well as providing ‘paramedical and ambulance services at sporting and recreational events’. Paramedical Services was a private ambulance provider and claimed the Ambulance Service of NSW made remarks which constituted injurious falsehood. While Paramedical Services was unsuccessful in the Federal Court, the circumstances surrounding the claim, has significant application for protection of title.

The injurious falsehood action in *Paramedical Services Pty Ltd* involved allegations about the Ambulance Service of NSW’s representation that ‘to be a paramedic, one had to be working for the them, and that when a paramedic ceased to work for them, he ceased to be a paramedic’. The Federal Court accepted this representation to mean the Ambulance Service of NSW did not recognise the paramedical qualifications of the paramedics as they had ceased their employment with the Ambulance

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8 *Ratcliffe v Evans* [1892] 2 QB 524.
11 Hely J held that the claim for injurious falsehood was not substantiated by the applicant.
12 Ibid 511 [49].
Service of NSW. There was also an alleged representation that Paramedical Services’ business lacked the quality assurance systems of the respondent including recertification requirements. One example of this is that Paramedical Services’ paramedics had difficulty getting accepted into the Charles Sturt University’s Bachelor of Health Science (Pre-Hospital Care) Conversion bridging program because they were not current employees of the Ambulance Service of NSW as required for program admission.\(^\text{13}\)

That paramedics obtained their title through employment with a state or territory ambulance service raises a very significant issue in the Federal Court’s decision. The term ‘paramedic’ had not been defined in NSW at the time of this judgment, although ‘paramedic’ became a protected title in NSW in 2016.\(^\text{14}\) No protection of title existed to restrict the use of the title to a certain class of persons either. While the Ambulance Service of NSW, here, may not have recognised Paramedical Services’ employees to be paramedics, there was nothing restricting those paramedics from using that title while employed with Paramedical Services or any other employer. ‘Paramedic’ was not protected at the time so a person without a particular level of skill and knowledge could market themselves as a paramedic without facing any adverse consequences. While protection of title has since been implemented in New South Wales, as discussed in Chapter 4, other states and territories do not have protection of title provisions. This means that there are not necessarily minimum standards of education and training required for a person to call themselves a ‘paramedic’ in the jurisdictions without title protection, such as Queensland and the Australian Capital Territory.

Protection of title was also judicially considered in the Perth Coroner’s Court. A death occurring at the Western Australian Big Day Out music festival in 2009 led to Coroner D H Mulligan proposing recommendations for paramedic registration.\(^\text{15}\) The 17 year old subject of the inquest (“GGT”)\(^\text{16}\) attended the Big Day Out with a friend. Prior to the festival, GGT consumed one ecstasy tablet and then a further two ecstasy tablets upon entry into the festival.\(^\text{17}\) She became ill after the drug consumption and attended the first aid tent where a St John’s Ambulance Service volunteer first aider attended to her. GGT did not admit to taking ecstasy but dishonestly acknowledged the consumption of a single ‘Dexie’, a prescription drug.\(^\text{18}\) She was released back into the festival, but when she collapsed a second

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\(^\text{13}\) Ibid 520-2.

\(^\text{14}\) Health Services Act 1997 (NSW) s 67ZDA; Health Services Regulation 2013 (NSW) s 19A. Also discussed in chapter 4.

\(^\text{15}\) Inquest into the death of Gemma Geraldine Thoms (Coroner’s Court of Western Australia, Coroner Mulligan, 8 March 2013).

\(^\text{16}\) I am using the deceased person’s initials in the text, rather than her full name, for a number of reasons. Firstly, despite the coronial inquest findings being publicly available, I am trying to protect the deceased person’s privacy as much as possible. Further, referring to initials, rather than “the deceased” will reduce confusion throughout the chapter as I discuss a number of inquests.

\(^\text{17}\) Inquest into the death of Gemma Geraldine Thoms (Coroner’s Court of Western Australia, Coroner Mulligan, 8 March 2013) 2 [4]-[5], 10 [64].

\(^\text{18}\) Ibid 18 [102].
time, was taken back to the first aid post. An ambulance was called and she was transported to hospital where she died of acute Methyleneoxyethylamphetamine (MDMA) toxicity.19

When discussing the first aid treatment the St John’s Ambulance first aider administered, the Coroner expressed concerns about the standard of care GGT received. Coroner Mulligan specifically compared paramedic expertise to a mere first aider, stating:

> without intending to diminish [the]… volunteers, it is obvious that his [the first aider’s] degree of training and expertise was far removed from that of medical professionals, such as doctors, nurses and paramedics who have studied and trained for years before obtaining their qualifications.20

More specifically, Coroner Mulligan acknowledged a number of concerns regarding the first aider’s care of GGT. The first aider did not take GGT’s temperature despite training documentation indicating a need to record a patient’s temperature. A full set of observations were only recorded once despite training documentation suggesting twice is required. Medical practitioner evidence at the inquest also identified that a person with ‘greater medical expertise and experience’ would have considered the deceased’s abnormal pulse, respiratory rate and consumption of a ‘Dexie’ as indicative of a requirement for urgent treatment and transport to hospital, which the first aider did not consider.21 Coroner Mulligan found early intervention for an ecstasy overdose can increase the chance of a patient’s survival although may not have prevented GGT’s death in these particular circumstances.22 Since GGT’s death at the Big Day Out in 2009, organisers now employ a ‘tertiary qualified medical practitioner’23 which the Coroner reported to include a paramedic, nurse or doctor.24

Following the inquest, the Coroner made a number of recommendations.25 Significant to this research was the proposal for a definition of ‘paramedic’ under Western Australian law so the ‘general public can have confidence in the abilities of those who are protecting their medical interests at large scale events’26. It was also recommended that a form of registration be implemented to ensure only qualified practitioners can use the title of paramedic. 27 These proposals reflect the arguments made throughout this thesis, namely that a definition of paramedic, in the form of protection of title, would be a useful regulatory tool to promote public safety as discussed in Chapter 4. Given paramedic regulation would be a response to improve public safety at events such as music festivals, Coroner Mulligan’s

19 Ibid 25 [145].
20 Ibid 16 [99].
21 Ibid 20 [106], 21 [110], 22[114].
22 Ibid 25 [143], 41 [253].
23 As ‘medical practitioner’ is a protected title, I believe Coroner Mulligan may have intended to refer to ‘tertiary qualified health professionals’ instead.
24 Inquest into the death of Gemma Geraldine Thoms (Coroner’s Court of Western Australia, Coroner Mulligan, 8 March 2013) 38 [229].
26 Ibid 43.
27 Ibid.
recommendations are precautionary in nature as they respond to political concerns of irreversible harm which could occur without qualified persons in attendance.

Finally, it is also worth repeating here that there is evidence of people practising as ‘paramedics’ without the necessary training and education. As noted in Chapter 5 of this thesis, a 2011 study of paramedic risk identified the prevalence of people practising as ‘paramedics’ without requisite training or education. According to the study, 35 per cent of paramedic respondents admitted to personally recalling cases involving unqualified people who had been employed as, or had operated as, a paramedic.\(^{28}\) Without national statutory protection of title provisions, which also contain a regulatory enforcement tool, such as a disciplinary sanction, the public could be at risk of harm from underqualified, or unqualified, people performing a paramedic role without the requisite expertise.

### 6.3.2 Student paramedic registration is needed for precautionary regulation

One of the significant gaps in the current regulation of Australian paramedics is the absence of student regulation. There is no regulatory body to monitor or enforce fitness-to-practice standards for Australian students studying to be paramedics. However, student regulation has been deemed important within health professional regulation. There is very limited empirical evidence which suggests student registration is needed for paramedicine so my suggestion that student paramedics be registered under the National Scheme is precautionary in nature.

Student health practitioner registration is required under the National Scheme and would be required for paramedic students if paramedics are included as a health profession under the *National Law*. Students undertaking an approved program of study towards a registered health profession must be registered under their National Board. Notable features of student registration include:

1. there is no fee payable and students are registered for their full enrolment as a student, rather than for the 12 month period applicable to other registration types;\(^{29}\) and
2. if a student’s conduct, performance or health poses a serious risk to patients, their National Board may take action to protect public health or safety with the same disciplinary action and sanctions available as health practitioners.\(^{30}\)

The importance of implementing student registration for paramedics, a regulatory response according to the precautionary principle, reflects the circumstances arising in Queensland. While the media


\(^{29}\) *National Law* ss 89-90.

\(^{30}\) This includes cautions, accepting undertakings, imposing conditions on practise, suspensions or registration cancellation, for example. See *National Law* ss 156 (1)(a), 178, 191 for further information.
reported\textsuperscript{31} that the Queensland Ambulance Service rejected “JLS” as a student paramedic, \textsuperscript{32} it is unclear whether she was removed from the diploma program after commencement, whether she was a tertiary student undertaking practical paramedical training or whether some other circumstances applied to her. Because of the reported ‘rejection’ from her chosen employer, JLS stole an ambulance and set it on fire on 26 October 2010. She also caused a fire which burnt down the Cleveland Ambulance Station; a suburb of Brisbane, Queensland. The Brisbane District Court released JLS on probation as she had already served her three years imprisonment period. She also spent 20 months in a mental health facility during that imprisonment period.\textsuperscript{33}

Under the current regulatory model, there are no additional safeguards to prevent someone with a criminal history similar to JLS from practising as a paramedic in another jurisdiction\textsuperscript{34} or privately. If paramedics were regulated under the National Scheme, prospective employers could access details of a person’s conduct as a student. A registration system could also prevent students from practising as paramedics in the future and would be a precautionary measure to protect the public from harm.

\textbf{6.3.3 Continuing professional development needed as a precautionary approach to regulating paramedicine}

Continuing professional development (CPD) in the current paramedic regulatory framework is another challenge which can be overcome using a precautionary approach to regulation. CPD refers to the ongoing training and education professionals undertake throughout their careers to ‘maintain, improve and broaden their knowledge, expertise and competence to develop personal and professional qualities’.\textsuperscript{35} Generally, employers have the responsibility for prescribing CPD requirements, which means that there is no consistency of CPD compliance between jurisdictions. Further, there are no measures to ensure CPD is completed.

By contrast, if paramedics are included in the National Scheme, they are required to undertake CPD.\textsuperscript{36} Under the National Scheme for annual registration to be renewed, applicants must declare that they have completed the required CPD for their discipline.\textsuperscript{37} Failure to comply with CPD standards can result in disciplinary action such as a caution or suspension.\textsuperscript{38}

\textsuperscript{33} Ibid.
\textsuperscript{34} Public ambulance services generally require criminal history checks prior to employment. See part 6.4.1.
\textsuperscript{36} \textit{National Law} s 128. These provisions do not apply to those with non-practising registration. National Boards also have discipline-specific registration standards which impose additional CPD requirements.
\textsuperscript{37} \textit{National Law} s 109 (1)(a)(iii).
\textsuperscript{38} Ibid s 128 (2).
The lack of paramedic CPD has been administratively considered by the Western Australian government in an independent inquiry. The St John Ambulance Inquiry, mentioned previously in Chapter 5, identified a number of problems with continuing professional development for paramedics in Western Australia. Paramedics reported there was very limited access to annual refresher training courses and there was no system in place to ensure continuing professional development be a mandatory requirement for ongoing employment. Further, the Inquiry considered that there was no way to monitor paramedic clinical performance.

The current CPD situation for Australian paramedics raises public safety issues. Individual employers mandate CPD and skills refreshers required for continued practice. There are no industry guidelines and no binding legislative requirements for paramedics to maintain skills and knowledge. As such, discrepancies between employer requirements and individual paramedic skills can exist. The lack of CPD is a public safety issue as there is no legislative obligation for paramedics to maintain their industry knowledge or upgrade their skills. The industry, therefore, relies solely on employers to maintain minimum standards of skill and expertise with no external oversight.

In summary, title, training and education are all areas of paramedicine regulation which pose a risk to the public. Despite the examples of harm I have provided in 6.3, it is challenging to determine the full extent of the risk to the public from paramedic practice. Informed by the precautionary principle, it is only through the inclusion of paramedics in the National Scheme that the risk which paramedics currently pose to the public can be reduced.

6.4 Misconduct and fitness to practise

There have been a wide range of public safety incidents, in Australia, which give rise to fitness-to-practise concerns for Australian paramedics. There is little to ensure standards of practice are consistent throughout Australian states and territories without national registration. Further, disciplinary matters are not communicated between employers so paramedics can move to another employer following disciplinary action without any fear of reprisals for their previous conduct. The following discussion of data provides examples of instances where public safety risks have been identified and the current disciplinary process has not adequately addressed the risk in order to reduce the potential for harm to the public.

This chapter will analyse the National Scheme’s fitness-to-practice obligations to illustrate differences between disciplinary outcomes for paramedics (who currently do not have national registration) versus registered health practitioners. Evaluating fitness-to-practice requirements, as well as the standard of being a ‘fit and proper person’, highlights the challenges of Australian paramedic regulation as these

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39 Government of Western Australia, 'St John Ambulance Inquiry: Report to the Minister for Health' (Department of Health, October 2009).
standards do not apply to current paramedics. Fitness-to-practise concerns can be classified in three ways under the National Scheme:

1. ‘unsatisfactory professional performance’;
2. ‘unprofessional conduct’; and
3. ‘professional misconduct’.40

These categories are defined in the National Law and are summarised in Table 6.1.

<table>
<thead>
<tr>
<th>Concept</th>
<th>Explanation</th>
</tr>
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<tbody>
<tr>
<td>Unsatisfactory professional</td>
<td>The health practitioner’s knowledge, skill or judgment is below the standard reasonably expected of an equivalent health practitioner.41 A health practitioner’s conduct will be below the standard reasonably expected of an equivalent practitioner if ‘the registrant’s conduct is… to a high degree, below the standards expected of a registrant with equivalent training and experience’.42</td>
</tr>
<tr>
<td>performance</td>
<td></td>
</tr>
<tr>
<td>Unprofessional conduct</td>
<td>Conduct of a lesser standard reasonably expected of a health practitioner including contravening the National Law; contravening a condition or undertaking; a conviction of an offence; providing unnecessary health services; influencing practitioner conduct which compromises patient care; accepting inducement, consideration or reward for services; offering inducement, consideration or reward for referral; or referral to another health service provider which results in a pecuniary interest for the referral.43</td>
</tr>
<tr>
<td>Professional misconduct</td>
<td>Serious infractions including unprofessional conduct substantially below the standard reasonably expected of an equivalent registered health practitioner; multiple instances of unprofessional conduct; or conduct inconsistent with the practitioner being a ‘fit and proper person’ to hold registration.44 Criminal conduct occurring during practice is an example. However, these examples are not exhaustive.45 Practitioners’ conduct can be held as professional misconduct if it adversely affects their ability to exercise ‘sound judgment’ in any sphere of the practitioners’ lives or causes the public to consider the ‘reputation and standing of the profession’ unfavourably.46</td>
</tr>
</tbody>
</table>

Table 6.1 Fitness-to-practice classifications

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41 National Law s 5 (definition of “unsatisfactory professional performance”).
42 Pharmacy Board of Australia v The Registrant [2012] QCAT 515, [49].
43 National Law s 5 (definition of “unprofessional conduct”).
44 Ibid s 5 (definition of “professional misconduct”).
45 Nursing and Midwifery Board of Australia v Jackson [2013] WASAT 140 (3 September 2013) [20].
The ‘fit and proper person’ test required for determination of professional misconduct is not further defined in the National Law. However, the test has been extensively considered in case law and it has been determined that the ‘fit and proper person’ test should not be construed too narrowly. Generally speaking, a fit and proper person is one who possesses ‘sufficient moral integrity and rectitude of character’ who should be entrusted with registration. This means that integrity and honesty are essential components of a ‘fit and proper person’. Finally, a person’s behaviour may indicate they are not a fit and proper person even if a person’s conduct does not fall within the express statutory definition of professional misconduct.

This remainder of this chapter outlines examples of Australian paramedics who are exhibiting behaviour which falls short of the conduct reasonably expected of a fit and proper person. The lack of regulatory safeguards in current paramedic governance imposes a significant risk of harm to the public. A precautionary approach to paramedic regulation, under the National Law, is a suitable response to safeguard the public given the limited evidence of paramedic risk of harm. Specifically, the current paramedical regulation framework examined in Chapters 2 and 4 does not address misconduct as suitably as the National Law.

Currently, misconduct is not defined in paramedicine. Employers are responsible for discerning unacceptable behaviour and there is no external body to ensure consistency of disciplinary sanctions or assist in the determination of potential misconduct. In order to reduce risk to the public, ‘misconduct’ needs explicit and consistent definition across the industry. Without an express definition of misconduct, employers cannot follow proper disciplinary processes as it is unclear what behaviour constitutes misconduct. If the definition of misconduct differs between paramedic employers, there is also potential uncertainty with role requirements. This causes equity issues as paramedics are potentially disciplined differently and held to different standards of conduct depending on the jurisdiction and employer. At least some of the problems of this would be reduced if paramedics are included in the National Scheme and adopt similar categories to those set out in Table 6.1: unsatisfactory professional performance, unprofessional conduct and professional misconduct.

In addition to the definitions of misconduct, an external investigative body that deals with paramedic disciplinary matters, and potential misconduct, is also needed to improve current paramedic regulation. An external body, dealing with disciplinary matters, would have more expertise and impartiality than

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47 Hughes and Vale Pty Ltd v New South Wales (No 2) (1955) 93 CLR 27, 156-7.
49 Wilks v The Medical Board of South Australia [2010] SASC 287; Drury v Medical Board of Australia (Occupational and Business Regulation) [2011] VCAT 858 (10 May 2011) [21]; Hughes & Vale Pty Ltd v New South Wales (No 2) (1955) 93 CLR 127, 156-7.
an employer when dealing with fitness-to-practice issues such as potential misconduct. They would be appointed for the purposes of independently investigating a matter so that employers are removed from the disciplinary processes which prevents conflicts of interest. Any sanctions externally imposed on a paramedic are also likely to be fairer than those the employer imposes as the disciplinary body would be able to dictate disciplinary action consistent with all other health professionals under its regulatory umbrella, rather than outcomes being, arguably, arbitrary in nature.

Misconduct, and the challenges faced without a uniform definition and disciplinary approach, has been judicially considered in the context of paramedicine. For example, in Mathiew v Higgins & Anor, the Queensland Supreme Court considered a judicial review application concerning a finding of paramedic misconduct. The applicant, an acute care paramedic (“JRM”), was disciplined on the basis he had failed to demonstrate an appropriate standard of care when treating a patient and failed to properly supervise a student paramedic he was mentoring. The first respondent, the Queensland Ambulance Service (QAS) Commissioner, redeployed JRM to patient transport for a 12-month period with the option of reapplying as a paramedic subsequently. JRM appealed to the second respondent, the Public Service Commissioner under the Public Service Act 1996 (Qld), who upheld the QAS Commissioner’s decision. JRM subsequently appealed to the Supreme Court of Queensland on three grounds:

1. That there was no evidence, or other material, to justify making the decision that the applicant’s conduct constituted misconduct as defined in the Queensland Ambulance Service Discipline Policy;
2. That the Public Service Commissioner failed to consider that even if substantiated, JRM’s conduct could not amount to misconduct; and
3. That the decision was ‘so unreasonable that no reasonable decision maker could have made it’.

The grounds of appeal in Mathiew were primarily concerned with the definition of ‘misconduct’. The employer’s policy considered ‘unacceptable workplace behaviour’ to include misconduct. Misconduct was then defined as ‘disgraceful or improper conduct in an official capacity’. Misconduct was considered grounds for disciplinary action against JRM. Daubney J concluded that misconduct:

contemplates something more than mere incompetence, or a failure to attain the established standards of conduct… ‘misconduct’… requires a deliberate departure from accepted standards, serious negligence to the point of indifference, or an abuse of the privilege and confidence enjoyed by ambulance officers.

In relation to the grounds for review, the Court held JRM may have exhibited ‘carelessness or even incompetence’ but there was no ‘deliberate departure from accepted standards, serious negligence or abuse of privilege’ required to constitute misconduct. Further, there was a failure to expressly define

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52 Mathiew v Higgins & Anor [2008] QSC 209, [26].
53 Ibid [36].
the term ‘misconduct’ which resulted in an error of law.\textsuperscript{54} JRM succeeded in his order for review and the Supreme Court set aside the Public Service Commissioner’s decision.

\textit{Mathiew v Higgins & Anor}\textsuperscript{55} emphasises some of the challenges within the paramedic regulatory framework. Key disciplinary terms within the policy, such as ‘misconduct’, lack clear and consistent definition and an external disciplinary investigative body is needed for standardisation of the discipline across employers. Within the broad category of ‘paramedic misconduct’, there are a number of fitness-to-practice issues which highlight the risk paramedics pose to patients and the need for a precautionary regulatory approach. Paramedic misconduct can come in the form of criminal conduct; drug theft and substance abuse; and, a failure to fulfil the requirements of paramedicine. These fitness-to-practice concerns, and how paramedic inclusion in the National Scheme will help them, will be discussed in parts 6.5.1 – 6.5.3 below.

\textbf{6.4.1 Criminal paramedic misconduct}

The National Scheme prescribes a framework for dealing with health practitioner criminal conduct. A number of reporting obligations exist within the \textit{National Law} to monitor criminal behaviour of registered health practitioners. More specifically, registered health practitioners are required to report criminal conduct when making their application for initial registration as well as reporting subsequent criminal conduct which occurs during their practice as a registered health practitioner.\textsuperscript{56} Mandatory reporting obligations also exist for health practitioners to report conduct, both their own and that of their peers, which falls below the standard reasonably expected of a health practitioner.\textsuperscript{57}

\textit{Reporting criminal conduct}

If paramedics are included in the National Scheme, they will be subject to the same reporting requirements as the other registered health practitioners. That is, paramedics would be required to report criminal conduct and conduct which suggests they, or their peers, are not fit and proper to practise paramedicine. Requiring paramedics to report criminal conduct at all stages of the recruitment and employment stages is important because paramedics have constant interactions with vulnerable groups such as children and elderly people.

\textsuperscript{54} Ibid [44]-[45].

\textsuperscript{55} [2008] QSC 209.

\textsuperscript{56} The \textit{National Law} prescribes registration standards for an applicant’s criminal history. A health practitioner may be deemed unsuitable to practise their profession if their criminal history is relevant to their practice, and suggests it would be inappropriate to practise, or it is not in the public interest for them to practise. The National Board is also authorised to obtain a health practitioner’s criminal history at any time during their registration. See \textit{National Law} ss 5 (definition of ‘criminal history’), 55 (1)(b), 77, 79, 130, 135.

\textsuperscript{57} \textit{National Law} s 140. See also Malcolm Parker, ‘Embracing the new professionalism: Self-regulation, mandatory reporting and their discontents’ (2011) 18 \textit{Journal of Law and Medicine} 456.
Current paramedic regulation does not have standard and uniform procedures to deal with practitioners who have committed misconduct of a criminal nature. There are two aspects to reporting criminal conduct:

1. **Reporting prior criminal histories when applying for paramedic employment**: paramedics are required to undergo criminal history checks when applying for employment with the public ambulance services. This stipulation is an organisational requirement rather than a legislative one; as such, it does not necessarily exist for private employers. Therefore, paramedics may obtain employment in the private sector without needing to disclose their criminal history.

2. **Ongoing reporting of criminal misconduct while employed as a paramedic**: there are no uniform requirements for paramedics to report criminal conduct which has occurred after their employment has commenced. The Australian Capital Territory and New South Wales public ambulance services are the only jurisdictions requiring ongoing reporting of criminal conduct committed during the employment period. Whether private employers conduct criminal checks is unknown. It is also unknown whether private paramedic providers require criminal conduct reporting during employment. Private organisations may require disclosure as part of their employment agreement. As there is no central governing structure, there is no general requirement for paramedics employed in the private sector to undergo any criminal history checking prior to employment. There is the possibility these requirements have been stipulated within other public or private ambulance services at an organisational policy level. However, if this has occurred, these details are not easily accessible to the public and have not been found in this research.

Table 6.2 prescribes the criminal conduct reporting requirements for Australian publicly employed paramedics.

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<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Particulars</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Capital Territory</td>
<td>Paramedics must report any criminal conduct subsequent to employment. Employees must advise the ACT Ambulance Service of any criminal charges laid against them, as well as any criminal convictions. Where the ACT Ambulance Service could be adversely affected by the criminal conduct, the paramedic can be disciplined under their industrial disciplinary procedures. 59</td>
</tr>
<tr>
<td>New South Wales</td>
<td>Paramedics must report criminal offence convictions, with a penalty of at least 12 months, to the Ambulance Service of NSW throughout their employment. 60 However, the regulations do not specify a penalty for failure to report criminal offences. Supervisors are also required to report suspicions that paramedics may have failed to disclose criminal or traffic offences although no consequences for concealing this information have been prescribed. 61</td>
</tr>
</tbody>
</table>

Table 6.2 Reporting criminal conduct

Paramedic inclusion in the *National Law* would have a number of significant implications to protect patients from paramedic criminal conduct. If the criminal conviction involves an offence which has the potential to harm patients in the future, such as a drug offence or sexual offence, there are no measures in place to ensure the employers can take steps to protect patients. In fact, there are no obligations for paramedics to inform their employers at all. While New South Wales and the Australian Capital Territory have taken positive measures to require reporting of criminal convictions by publicly employed paramedics or their supervisors, they do not go far enough to protect the public as there is no penalty for non-compliance. 62 Without a penalty which encourages paramedic compliance, the likelihood of non-compliance with the criminal reporting regulatory requirements is higher.

Examples of paramedics committing criminal conduct will be provided below. If paramedics were registered under the *National Law*, these actions would be reportable to their National Board; 63 however, no requirement to report criminal conduct currently exists for Australian paramedics as explained above. The outcome, here, is that employers are unlikely to be aware of criminal conduct being committed. If employers do become aware of criminal conduct, there is no process for this outcome to be addressed in current employment or communicated to future employers. Table 6.3

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60 Health Services Regulation 2013 (NSW) reg 15. See also Health Services Act 1997 (NSW) s 117 for the duty of all public service employees to report serious sex or violent offences to their employer within 7 days of the charges being laid or a conviction.
61 Health Services Regulation 2013 (NSW) reg 17.
provides examples, and particulars, of paramedics committing criminal conduct, which, under the current model, do not need to be reported.

<table>
<thead>
<tr>
<th>Case</th>
<th>Summary</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>R v Jones</em> [2011] QCA 19</td>
<td>The appellant (&quot;GFJ&quot;) was a 45-year-old paramedic employed by the Queensland Ambulance Service. He first met the complainant when he treated and transported her, as a patient, to hospital. Two days after the attendance, he presented at the complainant’s house, in uniform and with an ambulance, and informed the complainant he had been asked to check on her to perform another electrocardiogram. The complainant agreed based on that representation but a medical practitioner had not authorised GFJ to attend the complainant’s house. While performing an electrocardiogram, GFJ placed the pads partly on the complainant’s breast tissue and GFJ’s wrist also came into contact with the complainant’s breast.</td>
<td>GFJ was convicted of indecent assault in the District Court. On appeal, GFJ’s conviction was set aside and a re-trial was ordered. The particulars, or outcome, of a re-trial were unable to be located.</td>
</tr>
<tr>
<td><strong>Child exploitation material</strong></td>
<td>A paramedic (&quot;JPH&quot;) was convicted of possessing child exploitation material and using a carriage service to access child pornography on 4 February 2012. 65</td>
<td>The Hervey Bay District Court sentenced JPH to 15 months’ imprisonment with immediate parole eligibility and a 12 month suspended sentence. It is unclear whether JPH continued to work as a paramedic although other media reports suggest he resigned from his position as a paramedic with the Queensland Ambulance Service. Whether JPH commenced further employment with another public ambulance service or a private provider, after his resignation, while possible, is unknown.</td>
</tr>
<tr>
<td><strong>Child pornography</strong></td>
<td>A paramedic (&quot;BM&quot;), who was the officer-in-charge of Stanthorpe Ambulance Station and named in the media, was convicted of using the internet to access child pornography material and possessing child pornography material.</td>
<td>The Toowoomba District Court sentenced BM to 18 months’ imprisonment, with a minimum of three months served, and a two-year good behaviour bond on release. It was reported that the Queensland Ambulance Service stood down BM on full pay after his arrest, and, following the sentence, will ‘consider’ his future employment status. The result of QAS’</td>
</tr>
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</table>

64 The appellant appealed on the basis that ‘there was a miscarriage of justice because the learned trial judge erred in directing the jury that the appellant’s intention was irrelevant in determining whether the assault was indecent’. The Queensland Court of Appeal held the motive of the alleged offender is relevant when determining ‘indecency’ and, as such, the appellant lost a chance of acquittal. See *R v Jones* [2011] QCA 19, [4], [32].
decision, regarding BM’s future employment, is unknown.68

| Child pornography 2 | The County Court, in Victoria, convicted an Ambulance Victoria paramedic (“ZD”) and former head of Ambulance Victoria, of transmitting and receiving child pornography on 11 April 2013.69 | Judge Mullaly released ZD from custody at sentencing as he had already served 106 days of imprisonment and imposed an 18-month good behaviour bond. ZD was also convicted and fined $1000 for firearm and ammunition possession without a licence. The media article referred to ZD as a “former” paramedic although it is not clear whether he continued employment in any capacity as a paramedic following the pornography and weapons convictions.70 |
| Attempted murder | A New South Wales paramedic (“DCH”) was sentenced to 14.5 years’ imprisonment on 16 September 2009 for the attempted murder of his former partner. | DCH will be eligible for parole in 2017 after serving 10 years’ imprisonment. DCH used character evidence, from his work as a paramedic, as mitigating in his sentencing submissions.71 |

Table 6.3 Paramedic criminal conduct examples

Criminal behaviour can indicate a person is not fit and proper to be registered as a health practitioner.72 Even if no criminal conviction has been recorded, criminal conduct often shows ‘systematic non-compliance with legal and civic obligations’ which demonstrates unfitness to practise.73 The current regulatory framework does not provide a suitable disciplinary response when paramedics commit criminal actions.

Paramedics frequently treat vulnerable patients with fluctuating capacity and in various stages of undress. Paramedics work unsupervised, are in a position of trust, and the treatment they provide may require intimate physical contact with the patient. Instances of misconduct can adversely affect patients. For example, in HCCC v Litchfield,74 a medical practitioner engaged in sexual conduct with three female patients. The Supreme Court of New South Wales held:

Female patients entrust themselves to doctors, male and female, for medical examinations and treatment which may require intimate physical contact which they would not otherwise accept from the doctor. The standards of the profession oblige doctors to use the opportunities afforded to them for such contact for proper therapeutic purposes and not otherwise.75

70 Ibid.
72 Health Care Complaints Commission v Hutchinson [2014] NSWCATOD 151 (18 December 2014) [27].
74 (1997) 41 NSWLR 630.
75 Ibid 638.
Despite *Litchfield* addressing medical practitioner discipline, the judicial propositions are no less relevant to paramedics. Paramedics also treat vulnerable patients and should only use their contact with patients for therapeutic purposes. Therefore, paramedics have the same potential to harm vulnerable patients as medical practitioners.

The serious nature of the paramedics’ misbehaviour, from the case examples, indicates that paramedics do not always act in ethical or professional ways. Paramedics may also have mental health issues which are no less serious in terms of the risk to the community. Significantly, paramedic registration administered under a National Board, could ensure that criminal conduct is declared and recorded as professional misconduct, and as a consequence, offending paramedics might be removed from the register for a period of time. They would then be unable to seek work as a registered paramedic in any form in Australia until they are granted registration again. Criminal conduct is generally declared to be professional misconduct under the *National Law* and practitioners are disciplined appropriately with the disciplinary findings generally publicly available.

The case examples also highlight the need for an external investigative and disciplinary body for paramedics outside their employer. When paramedics are criminally convicted, it is currently not known whether the paramedic’s employer investigated the matter appropriately as the outcomes are not publicised. As argued in Chapter 5, the current paramedicine complaints and disciplinary processes lack transparency and accountability. A Paramedical National Board would ensure appropriate investigation and disciplinary action would take place.

**Mandatory reporting of misconduct**

Another issue with current paramedic regulation is an absence of mandatory reporting of misconduct. Currently, there is no legislative obligation for paramedics, or employers, to report to an external


77 For example, the Medical Practitioners Board of Victoria in *Re: Dr Abraham Stephanopoulos* [2006] MPBV 12 (16 August 2006) imposed a number of conditions on the practice of a medical practitioner convicted of three child pornography offences, holding the medical practitioner had engaged in ‘criminal and unethical conduct of a kind that has brought serious discredit upon the profession of medicine’. The medical practitioner was prohibited from treating patients under the age of 18 for a 10-year period and after that period, a treating psychiatrist would need to declare his practice as safe. He was also to undergo ongoing medical treatment. In a similar case, *Nursing and Midwifery Board of Australia v Omant (Review and Regulation)* [2013] VCAT 1679 (13 September 2013), the Nursing and Midwifery Board imposed a 12-month suspension, reprimand, counselling and employment conditions on a registered nurse convicted of child pornography offences. Another enrolled nurse was removed from the roll and prohibited from reapplying for at least two years for child pornography offences in *Health Care Complaints Commission v Gillett* [2007] NSWNMT 7 (1 August 2007). The judicial decisions described show that the National Boards take child pornography seriously and ensure community safety in the disciplinary decisions imposed.
regulatory entity any acts which might constitute paramedic misconduct.\textsuperscript{78} By contrast, mandatory reporting is necessary for registered health practitioners under the National Scheme.

A brief overview of the requirements for mandatory reporting under the National Scheme will be discussed here to provide context to the information presented, and to show how paramedic inclusion in the National Scheme will improve public safety and paramedics’ standing in the community. Mandatory reporting involves a statutory requirement for certain people, and certain classes of people, to report health practitioners’ questionable or dangerous conduct, called ‘\textit{notifiable conduct}'.\textsuperscript{79} Statutory mandatory reporting arose following a concern that failure to report health practitioner conduct, in the past, may have prevented state and territory health boards from taking necessary action to protect the public from health practitioner harm.\textsuperscript{80}

Specifically, registered health practitioners are required to report another health practitioner’s ‘\textit{notifiable conduct}', or student impairment which could harm patients, to the Australian Health Practitioner Regulation Agency.\textsuperscript{81} Failure to report ‘\textit{notifiable conduct}' can result in disciplinary action.\textsuperscript{82} Employers must also notify Australian Health Practitioner Regulation Agency if they believe a health practitioner has committed ‘\textit{notifiable conduct}' and failure to report can get reported to the Health Minister, health complaints entity or employer’s licensing authority.\textsuperscript{83} Finally, education providers must report students who have an impairment which could place the public at a substantial risk of harm. Education providers who fail to comply with reporting requirements can be publicly identified.\textsuperscript{84}

Voluntary reporting of practitioner conduct is also an option for registered health professionals. If a practitioner’s professional conduct is of a lesser standard than what is required of their profession; their knowledge, skill or expertise is below the reasonably expected standard; they have an impairment; they may have contravened the \textit{National Law}; they may have contravened the National Board’s conditions;
or their registration was improperly obtained because of false or misleading material, their conduct may be reported to the National Agency. The conduct is then referred to the relevant national board.

Significantly, there are currently no obligations to report misbehaviour or competence issues of paramedics to any regulatory body for investigation. Reporting obligations could include paramedics reporting their own conduct, paramedics reporting problematic peer behaviour, or employers reporting inappropriate paramedic behaviour. Furthermore, if paramedics were included in the National Scheme, and there was a requirement for mandatory reporting of paramedic conduct, the existing complaints data would not be the only method of assessing paramedic complaints and discipline. If paramedics were subject to the National Scheme’s mandatory reporting system requiring ‘notifiable conduct’ to be reported, paramedic wrongdoing may trigger an external investigation by the discipline’s National Board. The benefits of mandatory reporting for paramedics could reduce the risk of harm to the public as all notifiable conduct would be suitably investigated.

Part of the challenge for the current regulatory scheme is it relies too heavily on employers. Indeed, coronial inquest findings from a New South Wales Coroner’s Court in 2010 highlight a breakdown in employer policies and procedures which, in the absence of statutory mandatory notification requirements, contributed to the deaths of two people. “TS”, a paramedic, commenced employment with the Ambulance Service of New South Wales in 1996. His colleagues filed complaints about him due to his poor temper, and also alleged he displayed bullying behaviour. Following the peer complaints, TS’ response was to counter-claim that the complainants were bullying him. TS also claimed he was suffering ‘stress anxiety’ and lodged worker’s compensation claims which were found not to be work related. As a result of aggressive and offensive behaviour to colleagues, TS was stood down on full pay pending an investigation. He was eventually given a ‘show cause’ letter to signify potential dismissal. The ambulance service also requested the police service suspend TS’ gun licence but, according to police, there was ‘insufficient evidence to justify licence suspension’.

During the ambulance service investigation, TS posted numerous letters to colleagues, and the media, disclosing an intention to kill himself and his mother. Upon receipt of the letter, a newspaper employee contacted police. Police attended TS’ home and, finding the home unoccupied, attended his mother’s (“MS”) house. Tragically, TS and MS were both found dead, both with a gunshot wound to the head.

85 Ibid s 144. The voluntary reporting provisions do not apply to Queensland as per section 7A of the Health Practitioner Regulation National Law Act 2009 (Qld).
86 National Law s 148.
87 Inquest into the deaths of Monica and Trent Speering (Coroner’s Court of New South Wales, Magistrate Jerram, 3 September 2010).
88 Ibid [6].
89 Ibid [8].
90 Ibid [10].
A suicide note, and the gun, were also found with TS. The Coroner found TS to be responsible for both deaths.\footnote{Ibid [47], [62].}

A number of matters arose during the inquest into TS’ death. TS was psychiatically assessed during his request for worker’s compensation and had been diagnosed with a severe paranoid personality disorder and depression, neither of which were likely reported to his employer.\footnote{Ibid [32].} Colleagues had also filed concerns, to their employer, relating to TS’ fitness to practise, but no action was taken to address those concerns.\footnote{Ibid [6], [33], [48].} Furthermore, the Coroner indicated TS may have accepted treatment had it been made a condition of his ongoing employment.\footnote{Ibid [35].}

While the Coroner did not suggest the New South Wales ambulance service directly caused the deaths of TS and MS, she did suggest the ambulance service’s policies and procedures dealing with health and disciplinary matters were inadequate.\footnote{Ibid [53], [56], [62].} When disciplinary matters overlap with misconduct, criminal and mental health matters, the employer needs to be able to sensitively address fitness-to-practice concerns. When there are concerns for the mental health of paramedics, the ambulance service needs to document, and act upon, those concerns. Under the current scheme, this is not required or facilitated.

Including paramedics with the National Scheme would help address some of the issues associated with reporting. Had a similar situation to TS’ arisen with a registered health practitioner under the National Scheme, there would have been a legal obligation for colleagues to report the paramedic’s conduct to their National Board.\footnote{National Law s 141.} Further, the employer would have been able to report the conduct to the National Board as well, absolving them of the responsibility of deciding how to address the issues. The National Boards under the National Scheme can recommend conditions for ongoing practice which means it is likely that TS may have been able to receive treatment and then continue to practise without harming himself or his mother.

Other instances of misconduct have been judicially and administratively considered and publicised. These include behaviours relating to drug theft and abuse, and, failing to provide appropriate care, transport or advice to a patient. These examples of misconduct will be discussed in turn.

\textbf{6.4.2 Drug theft and abuse}

Drug theft, and abuse, appears to be a fitness-to-practice issue which is prevalent amongst Australian paramedics. It is also an obvious risk associated with paramedic practice as paramedics have access to, and frequently administer, dangerous drugs as a normal part of their scope of practice. Given the
discipline deals with life-threatening conditions in emergency situations, and often without necessary resources, there is the potential for paramedicine to be a highly stressful profession. Other characteristics of the profession can exacerbate stress including shift work, being sleep-deprived and dealing with trauma, which leads to the increased potential for paramedics to abuse substances like alcohol and drugs.\textsuperscript{97} Finally, substance abuse is a public safety risk as paramedic use of drugs and alcohol could prevent patients from receiving the best care possible.\textsuperscript{98} The examples of patient harm, highlighted in this chapter, provide a snapshot only of the risk paramedics pose because of alcohol and drug use. As such, a precautionary approach to regulation, under the National Law, would reduce the potential for harm highlighted in part 6.4.

Table 6.4 provides examples of fitness-to-practice issues, amongst Australian paramedics, arising from drug use and theft. The examples indicate the drug theft and substance abuse problems are potentially widespread amongst the paramedic discipline and across multiple jurisdictions.

\textsuperscript{97} Elizabeth Donnelly and Darcy Siebert, 'Occupational risk factors in the emergency medical services' (2009) 24 \textit{Prehospital and Disaster Medicine} 422.

\textsuperscript{98} Ibid.
<table>
<thead>
<tr>
<th>Issue</th>
<th>Particulars</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Drug theft (fentanyl and morphine) 2013 &amp; 2014</strong></td>
<td>A number of burglaries at a Victorian ambulance depot occurred between December 2013 and March 2014 where fentanyl and morphine were stolen upon forced entry into the building. A ‘former’ paramedic was charged with the offences.</td>
<td>Any investigative or disciplinary outcomes imposed on the paramedic are unknown and no further details have been found.</td>
</tr>
<tr>
<td><strong>Drug theft (fentanyl) 2010</strong></td>
<td>An 80-year-old patient died from a heart attack on 25 December 2010 after emergency medical assistance was sought from Ambulance Victoria. It is alleged the paramedic involved treated the patient with saline, instead of fentanyl, as the paramedic had already siphoned off the painkiller for his own personal use before the patient’s treatment.</td>
<td>It is not known whether the incident affected the paramedic’s ongoing employment as a paramedic or the extent the Coroner deemed the paramedic responsible for the patient’s death. The paramedic involved avoided a criminal conviction and was drug diverted instead.</td>
</tr>
<tr>
<td><strong>Drug theft (fentanyl) 2008 – 2012</strong></td>
<td><em>The Age</em> reported five cases of Victorian paramedics stealing fentanyl from ambulance supplies. The article indicates paramedics were found to be siphoning Fentanyl from Ambulance Victoria drug supplies and replacing it with water.</td>
<td>Three paramedics were dismissed while two paramedics resigned as a result. The article reports “hundreds” of patients were potentially affected after being administered tap water instead of the painkiller.</td>
</tr>
<tr>
<td><strong>Drug theft (methoxyflurane) 2010</strong></td>
<td>A Queensland paramedic, unnamed in the media, was convicted in the Magistrates Court after stealing methoxyflurane from the Queensland Ambulance Service.</td>
<td>The 40-year-old paramedic received a $500 fine and five days’ imprisonment. The <em>Courier Mail</em> reported the paramedic received a ‘formal reprimand’ and demotion from the Queensland Ambulance Service following the incident.</td>
</tr>
</tbody>
</table>

99 It is unknown whether the term ‘former’ refers to a former paramedic or former employee of Ambulance Victoria.


102 This case was considered in Victoria’s Coroner’s Court; however, the findings were not made publicly available and the Coroner would only release the findings with ethics approval so obtaining this data went outside the scope of this research.


104 Ibid.


106 Another paramedic was also dismissed from employment after stealing drugs, although no further details were provided in Alison Sandy’s article (Ibid).
<table>
<thead>
<tr>
<th>Drug theft (fentanyl) 2011</th>
<th>A Western Australian paramedic pleaded guilty to stealing as a servant and possessing a prohibited drug. The paramedic, “BSVH”, was a South African paramedic who had moved to Australia with his family. He stole fentanyl from the St John Ambulance Service supplies on multiple occasions and replaced it with saline solution.</th>
<th>The journalist reported BSVH’s defence lawyer told the court he was unlikely to return to work as a paramedic as he submitted his resignation, although no further details were given about his future employment. Sentencing in this case was adjourned and not further reported in the media.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug theft (morphine &amp; midazolam) 2013</td>
<td>A Tasmanian paramedic, “TJM”, appeared in the Launceston Magistrates Court and pleaded guilty to 13 counts of stealing morphine, one count of using morphine, one count of stealing midazolam and one count of possessing midazolam. TJM resigned as a result of the criminal charges. There have been no further publications on the sentence imposed on TJM in this matter.</td>
<td></td>
</tr>
<tr>
<td>Possessing dangerous drugs (morphine, ketamine &amp; methoxyflurane) 2011</td>
<td>A Queensland Magistrates’ Court fined a Queensland Ambulance Service paramedic, “JPH”, $1000 after he pleaded guilty to possessing dangerous drugs. Police found morphine, ketamine and methoxyflurane after raiding his house. JPH told the court he had forgotten to return the drugs following an ambulance shift. No conviction was recorded and despite JPH being stood down without pay from the Queensland Ambulance Service, the length of his suspension or any other disciplinary or restorative sanctions imposed are unknown.</td>
<td></td>
</tr>
<tr>
<td>Drug use (ecstasy and amphetamines)</td>
<td>A Tasmanian paramedic, “CC”, admitted to journalists she was working as a paramedic while under the influence of ecstasy and methamphetamines. She self-confessed to treating patients, despite not having the capacity to do so as a result of her drug use, while colleagues never questioned her sobriety. She was taken to hospital numerous times because of drug-induced psychosis and treated patients while under the influence of illicit substances. CC told journalists: I don’t know if they were trying to protect me because I was in the ambulance service, but either way they shouldn’t have been protecting me because firstly, I was dealing with...</td>
<td>The outcome of CC’s career, or ongoing employment as a paramedic, is unknown.</td>
</tr>
</tbody>
</table>

108 Ibid.  
110 Ibid.  
111 The source does not specify which Queensland Magistrates’ Court heard the matter.  
113 The same paramedic was convicted, the following year, of possessing child exploitative material and using a carriage service to access child pornography, and was described in table 6.3 above: Brightman, above n 65.  
people and patients and secondly, like anyone else I deserve the best treatment.\textsuperscript{115}

Table 6.4 Drug theft and abuse examples

The examples provided in Table 6.4 highlight a number of shortcomings of current Australian paramedic regulation. A number of issues arise from the prevalence of drug thefts and abuse within Australian ambulance services.\textsuperscript{116} Some of the examples identify that paramedics have caused patients harm, or negatively affected their treatment, in some way. According to the examples, patients received saline, instead of the required medication, due to the paramedic’s actions in stealing the drugs. Paramedics also practised while under the influence of drugs which may have impaired the paramedics’ decision-making capacity and adversely affected patient treatment. As such, these examples demonstrate that some paramedic conduct significantly falls short of the standard reasonably expected of an equivalent health practitioner under the \textit{National Law}, some paramedics are not ‘fit and proper’ to practise as paramedics and/or some paramedics require support for substance abuse problems.

The National Scheme prescribes a framework for dealing with drug theft and substance abuse. This framework would apply to paramedics if they are included as a registered health profession under the \textit{National Law}. Drug theft and substance abuse can be considered professional misconduct as professional misconduct can include conduct arising in a practitioner’s personal life that is connected to the practitioner’s profession in some way.\textsuperscript{117} Specifically, if a health practitioner’s or student’s conduct, performance or health poses a serious risk to patients, their National Board may take action to protect public health or safety.\textsuperscript{118} If the National Board reasonably believes the practitioner or student has an impairment,\textsuperscript{119} such as a substance abuse problem, they may be required to undergo a health assessment from a medical practitioner or psychologist unaffiliated with the National Board.\textsuperscript{120} Likewise, if the National Board reasonably believes the health practitioner’s practise is unsatisfactory,

\begin{itemize}
  \item \textsuperscript{115} Ibid.
  \item \textsuperscript{116} This thesis does not purport to consider whether organisational policies are adequate to prevent drug theft and substance abuse as that is beyond the scope of this research and is not relevant to evaluating paramedic regulation.
  \item \textsuperscript{117} \textit{Hoile v The Medical Board of South Australia} (1960) 104 CLR 157, 163. For example, a pharmacist was convicted of dangerous driving causing death after driving her vehicle intoxicated. The pharmacist had an alcohol addiction and as a result, the National Board imposed conditions on her practice, including abstinence from alcohol, frequent drug and alcohol testing, frequent attendances at a specialist psychiatrist and practice must only occur under the supervision of another registered pharmacist: \textit{HCCC v Hinde} [2013] NSWPHT 5 (11 September 2013).
  \item \textsuperscript{118} \textit{National Law} s 156 (1)(a).
  \item \textsuperscript{119} An impairment includes a disorder, such as substance abuse or dependence, which could detrimentally affect a person’s capacity to practise their profession: \textit{National Law} s 5 (definition of ‘impairment’).
  \item \textsuperscript{120} \textit{National Law} ss 169, 171(2)(a).
\end{itemize}
another registered health practitioner must carry out a performance assessment.\textsuperscript{121} Only regulation under the National Scheme could appropriately safeguard patients from harm in these circumstances.\textsuperscript{122}

6.4.3 Failure to fulfil the requirements of paramedicine

Another area of paramedic misconduct is where paramedics fail to fulfil the requirements of paramedicine. This incorporates a failure of paramedics to provide appropriate care, transport and/or advice to patients. Table 6.5 provides some examples of paramedics failing to fulfil the requirements of paramedicine. A failure to fulfil the requirements of paramedicine is particularly concerning, as a risk factor contributing to patient harm, because it means some paramedics are not reaching a standard reasonably expected of a competent paramedic. National Scheme regulation for paramedics would ensure paramedics were upholding minimum requirements and/or provide avenues for discipline as a precautionary response to the regulatory challenges.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Particulars</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to provide appropriate care to a patient 2014</td>
<td>The Rockhampton Coroner’s Court considered a four-year-old girl’s cause of death (“RYC”) following treatment by flight paramedics.\textsuperscript{123} RYC was transferred between Blackwater Hospital and Rockhampton Base Hospital, by helicopter, for further care in a routine aeromedical transfer. The aero-medical team, made up of Queensland Ambulance Service intensive care paramedics,\textsuperscript{124} collected RYC from Blackwater Hospital and requested a nurse remove her intravenous (IV) saline bag which was hydrating RYC at the time. One of the paramedics then ‘primed’ the same IV bag and ‘re-spiked’ it ready for reuse on RYC. This process allowed paramedics to reuse the IV bag on RYC.\textsuperscript{125} During the flight, RYC’s condition deteriorated leading to seizure and cardiac arrest. The flight</td>
<td>The Coroner found the paramedics to have caused RYC’s death. The Coroner held the air embolism came from the reuse of the partially depleted IV bag which could have been prevented by utilising a new saline bag, readily available in the paramedics’ supplies. During the inquest, paramedics gave evidence the reuse of the IV bag was to ‘remain in a full state of preparedness’; however, the Coroner held this was inappropriate and IV bags should be single use only. The Coroner preferred the registered nurse’s evidence, over the critical care paramedic, as the nurse’s evidence was deemed more reliable due to inaccuracies in the paramedics’ statements. The Coroner concluded RYC’s death was attributed wholly to the re-spiking of the IV bag.\textsuperscript{127} The Coroner did not comment on whether the</td>
</tr>
</tbody>
</table>

\textsuperscript{121} Ibid ss 170, 171 (2)(b).
\textsuperscript{122} Under the \textit{National Law}, equivalent cases to the examples in Table 6.4 could render a practitioner guilty of professional misconduct. A registered nurse was found to have stolen pethidine, damaged the Drugs Register to hide the theft and forged a staff member’s signature to hide it. The health practitioner was removed from the Register of Nursing, and Register of Midwifery, and prohibited from reapplying for registration for at least 18 months: \textit{HCCC v Pierce} [2010] NSWNMT 23 (26 July 2010). See also \textit{Health Care Complaints Commission v Holland} [2007] NSWNMT 14 (20 December 2007); \textit{Nursing and Midwifery Board of Australia v Pethic} [2011] SAHPT 15 (31 May 2011).
\textsuperscript{123} \textit{Inquest into the death of Ruby Yan Chen} (Coroner’s Court of Rockhampton, Coroner O’Connell, 12 December 2014).
\textsuperscript{124} Now called critical care paramedics.
\textsuperscript{125} \textit{Inquest into the death of Ruby Yan Chen} (Coroner’s Court of Rockhampton, Coroner O’Connell, 12 December 2014) 13 [60].
\textsuperscript{127} Ibid 16 [82].
paramedic commenced cardiopulmonary resuscitation but RYC was unable to be resuscitated. She was declared deceased upon arrival at the Rockhampton Hospital. An autopsy found an air embolism in RYC’s heart and jugular vein which, the Coroner commented, was very unusual.\(^{126}\)

paramedics’ actions constituted misconduct or were unprofessional, only that they were inappropriate. It is unknown whether paramedics were subject to any disciplinary sanction including cautioning or retraining, or whether they were even considered for disciplinary action at all.

<table>
<thead>
<tr>
<th>Failure to provide appropriate care to a patient 2013</th>
<th>“KW” applied for an unfair dismissal remedy after his employment as a flight paramedic(^{128}) was terminated.(^{126}) KW was dispatched to a head-on motor vehicle collision where the patient was unconscious and in need of immediate assistance. Despite the urgency required, KW delayed the aircraft’s departure significantly, causing risk to the patient to avoid working overtime. Specifically, KW, being towards the end of his shift, delayed waking the flight crew, unnecessarily changed the aircraft’s blood bricks and delayed readying the aircraft until the oncoming shift arrived. As a result, preparation took three times longer than normal.(^{130})</th>
<th>Commissioner Cribb dismissed the unfair dismissal application, stating that the dismissal was not harsh, unjust or unreasonable and the applicant’s conduct constituted serious misconduct.(^{131})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to provide appropriate care to a patient 2012</td>
<td>“CA” had her employment, as an advanced care paramedic, terminated with the Queensland Ambulance Service following an incident with a patient. CA was dismissed for dragging a patient along the floor; grabbing the patient’s wrist and throwing her arm towards the ground; kicking the patient in the right buttock; and taking the patient’s handbag outside the hospital and pointing the patient in a direction away from the hospital.(^{132})</td>
<td>Deputy President Bloomfield, in the Queensland Industrial Relations Commission, held CA’s conduct constituted misconduct and employment termination was warranted. Further, a lesser penalty than termination would have been inappropriate given the severity of her conduct.(^{133})</td>
</tr>
<tr>
<td>Failure to provide appropriate care to patients 2009 – 2013</td>
<td>The Courier Mail reported their investigation into 76 Queensland Ambulance Service patient deaths occurring in Queensland between 2009 and 2013. One particular case included alleged negligence after a patient was treated for reflux instead of a heart attack. Other patient deaths were attributed to training and educational issues amongst paramedics.(^{134})</td>
<td>The Queensland Ambulance Service refused to disclose disciplinary outcomes of the paramedics involved in the cases to the investigating journalists.(^{135})</td>
</tr>
</tbody>
</table>

\(^{126}\) Ibid 8 [33].
\(^{128}\) Flight paramedics attend to patients via helicopter.
\(^{130}\) Ibid [289], [295].
\(^{131}\) Ibid [330]-[332].
\(^{132}\) Ciranoush Aird AND Department of Community Safety, Queensland Ambulance Service (TD/2012/11).
\(^{133}\) Ibid.
\(^{135}\) Ibid.
<table>
<thead>
<tr>
<th>Failure to provide advice</th>
<th>2005</th>
<th>“NJW” was involved in a motor vehicle crash when she failed to give way in accordance with a traffic sign. She had been drinking heavily the night before. Those on scene reported NJW appeared uninjured although the Queensland Ambulance Service was called. Three paramedics attended and conducted health assessments on NJW. They indicated their preference to transport NJW to hospital but she refused. The paramedics were satisfied NJW had capacity to make a valid refusal of treatment. Upon Queensland Police Service arrival, the paramedics communicated NJW was ‘fine’ and not being transported to hospital. The police performed a road side breath test which revealed a blood alcohol concentration of 0.198%. She was taken to the police station for further testing where she appeared to be falling in and out of sleep. Police believed her to be very intoxicated. They left NJW to complete paperwork and upon return, could not find her pulse. Upon ambulance arrival, NJW could not be resuscitated and died. The court addressed NJW’s injuries and considered the paramedics’ response to NJW. The Coroner found NJW had internal bleeding and injuries as a result of the traffic crash which caused her death. Medical experts considered the intoxication and medication NJW was taking could have masked the pain she felt from her injuries during the crash. However, the Coroner found the paramedics’ response to NJW was adequate and they had no authority to compel her to undertake transport. The Court did recommend, though, that an exchange of information should have taken place between the police and paramedics. If paramedics had warned police to closely observe her, and call for ambulance assistance if she became drowsy, she may have had access to the early medical treatment needed to save her life.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to transport</td>
<td>2004</td>
<td>St John Ambulance Service paramedics were called to examine “MY” complaining of chest pain and fever but were unable to substantiate the cause of the patient’s pain. MY had a midline thoracic scar which should have informed the ambulance crew of MY’s history of heart disease. There was some confusion about MY’s wishes regarding transport. The ambulance crew suggested MY refused treatment and transport; however, the Coroner, Mr Greg Cavanagh, concluded MY’s communication was ‘at best, an acquiescence by the deceased not to be transported’. The ambulance crew did not transport MY but also did not comply with their employer’s “Ambulance Not Required” policy necessitating patients sign a refusal of transport. After leaving the scene, the ambulance crew were later recalled but MY had died. The Coroner found MY should have been transported to hospital for assessment. Following the death, but prior to the inquest, the St John’s Ambulance Service amended their “Ambulance Not Required” policy and had disseminated it to staff. They had also implemented an auditing process for refusal cases as well as instituting cultural awareness training for all trainee paramedics. The Coroner acknowledged the policy changes.</td>
</tr>
</tbody>
</table>

136 *Inquest into the death of Nola Jean Walker* (Coroner’s Court of Cairns, Coroner Barnes, 23 November 2007).
137 Ibid 8.
138 The ambulance crew comprised of a qualified paramedic, a student ‘ambulance officer’ and a St John volunteer who was also an enrolled nurse.
140 Ibid 10 [15].
142 Ibid 11 [18].
143 Ibid 11 [17].
| Failure to provide advice | 2001 | Police found “MSN” with a head laceration on the side of the road and believed him to be severely intoxicated. They called paramedics who attempted to examine MSN; however, MSN refused treatment and transport. Police detained MSN in the watchhouse overnight where his condition deteriorated. The next morning, he was taken to hospital and underwent surgery for an extradural haematoma. MSN suffered ongoing disabilities, some of which were caused by the delay in medical treatment. |
|--------------------------|------|The District Court found the paramedics were correct in their failure to transport MSN against his express refusal. However, the paramedics still had a duty to communicate to the police they had not been able to examine MSN, that there were potential adverse consequences for failing to seek medical treatment and that MSN should be medically assessed.|
| Failure to transport | 1994 | “DK” needed medical assistance after he attacked a taxi driver and was then assaulted in self-defence. The paramedics spent only four minutes examining DK, despite him being unconscious earlier, and formed the correct view that he was intoxicated. DK’s blood pressure was not taken, his Glasgow Coma Score was 13 out of 15 and some his answers to questions were not indicative of someone completely conscious or competent. There were also inconsistencies in the paramedics’ medical reporting and evidence given during the trial. The paramedics informed the police officers they could ‘take the patient into custody, that he did not require any further medical treatment and was fit to remain in custody’. Police transported DK to the watchhouse and closely observed him. When DK’s behaviours became concerning, the police requested a medical practitioner consultation, who recommended ambulance transport immediately. |
|--------------------------|------|Mandie J was very critical of the paramedics’ conduct towards DK. His Honour suggested the paramedics approached DK with ‘undue haste and with the presumption… that the handcuffed offender should remain in police custody’. Further, the paramedic failed to make adequate or sufficient inquiries about DK’s consciousness and the blows to the head he had sustained. DK’s presentation indicated a transfer to hospital would have been the most appropriate decision. The failure to receive timely treatment resulted in aggravation of DK’s injury leading to permanent and ongoing disabilities and substantiated his claim in negligence. This finding indicates the paramedics’ treatment fell below a reasonable standard of practice than what might have been expected and resulted in patient harm.|

Table 6.5 Examples of paramedics failing to fulfil the requirements of paramedicine

A number of significant observations, related to patient risk and the need for a precautionary regulatory approach to paramedic regulation, can be made from the examples of paramedics failing to fulfil the requirements of paramedicine. Firstly, paramedic regulation needs an external investigations and disciplinary process, outside the employer’s jurisdiction. Secondly, an external register for paramedics

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145 Ibid [39]-[40]. Please note, MSN appealed the lack of police liability and the amount of damages received from the Ambulance Service. The Ambulance Service cross-appealed their liability in negligence. The Court of Appeal upheld the District Court’s decision that the police officers were not negligent in their dealings with the applicant. However, Basten JA also held that had MSN been taken to hospital, there was no evidence he would have consented to treatment anyway. As such, had a duty and breach of duty been established, it did not cause MSN’s damage so negligence could not be established. There was no further discussion, on appeal, concerning whether paramedics should have advised police MSN needed assistance.
147 The paramedic crew consisted of a paramedic and a trainee mobile intensive care ambulance paramedic, who had previously worked as a paramedic.
148 Ibid [37]-[38].
149 Ibid [53]-[55].
is needed. Thirdly, the examples from Table 6.5 highlight further transparency issues in paramedic regulation.

Significantly, if paramedics are included in the National Scheme, an external investigations and disciplinary process would act independently to the employer. Currently, there are no measures in place to communicate this conduct falling below a standard reasonably expected of a competent paramedic to future employers. If paramedics change employers (between public or private employers), there is nothing to prevent the paramedic exhibiting similar negligent or substandard behaviour towards a patient. Further, the paramedic could seek employment with another public ambulance service, or in a private capacity, without any obligation to disclose prior conduct which failed to reach an appropriate standard. Prospective paramedic employers, currently, can only gain access to information which is generally publicly available for registered health practitioners, if the information is disclosed by the paramedic, or has been publicised through a media outlet or case law judgment. The lack of an external register to record misconduct is problematic as paramedics terminated for behaviour constituting misconduct could continue to practise paramedicine and pose a serious risk to other patients.

In summary, the examples from Table 6.5 reinforce the transparency issues identified in Chapter 5, particularly that employers are hesitant to provide details of paramedic wrongdoing which could expose them to civil liability. Some of the investigating journalists above reported that the public ambulance services refused to disclose disciplinary outcomes of the paramedics involved in the cases\textsuperscript{150} which highlights, once again, the lack of transparency with the current disciplinary model. As argued in Chapter 5, when the regulatory model lacks transparency, there is less trust and integrity in the discipline’s regulation, which makes it difficult to determine the level of risk which applies to the community.\textsuperscript{151} As such, a precautionary approach to regulation is needed in which paramedic regulation is administered under the National Scheme and would address the challenges faced by the current paramedic regulatory framework.

6.5 Conclusion

This chapter argued that the current regulatory approach for Australian paramedics does not adequately address the significant risk paramedics pose to the community. Using examples of patient harm, it highlighted some evidence of harm paramedics have caused to patients and the risk of harm under the current regulatory framework for Australian paramedics. This chapter also identified the evidence that paramedics have caused problems in the community that current regulation has either failed to prevent or failed to adequately address. The data presented, while not exhaustive, provides evidence of potential for patient harm. It is, however, difficult to anticipate the full extent of potential paramedic misconduct

\textsuperscript{150} Sandy and Thompson, above n 134.

\textsuperscript{151} State of Victoria, 'Victorian Guide to Regulation' (Edition 2.1, Department of Treasury and Finance, August 2011) 19.
due to the jurisdictional disparity of paramedic regulation; lack of transparency in the complaints and
disciplinary process highlighted in Chapter 5; the regulatory dichotomy between public and private
regulation; and, current regulation having no external register or governing body. As such, a
precautionary approach to regulation must apply for Australian paramedics. Importantly then,
incorporating paramedics into the National Scheme is a form of risk prevention.

The issues identified in this chapter around title, training and education; student registration; continued
professional development; misconduct; and fitness to practise, could all be improved if paramedics were
included in the National Scheme. Chapter 7, then, will discuss the practicalities of absorbing paramedics
into the National Scheme as an additional registered health profession.
CHAPTER 7: OPERATIONAL REQUIREMENTS FOR PARAMEDIC REGISTRATION UNDER THE NATIONAL SCHEME

7.1 Introduction

This thesis, so far, has explored how paramedics have been regulated primarily through their employment relationship. Yet as paramedics’ skills and knowledge have increased, they have been performing more invasive procedures than ever before. Further, given the significant evolution of the profession, and the fact that more paramedics are being employed in a private capacity, in Chapter 3 I argued that current regulation has not evolved with the discipline. Chapters 5 and 6 then evaluated the level of risk paramedics pose to the public, and the potential to harm patients which eventuates from paramedics’ societal role. The chapter will undertake an evaluation of the National Scheme’s evolution from jurisdictional regulation to a nationally consistent framework. This assists the thesis as it compares the evolution of health practitioner regulation to paramedic regulation and, in so doing, establishes why paramedics also need to progress from employer and jurisdictional regulation to the National Law’s governance. This chapter will argue paramedics be included as an additional health profession under the National Registration and Accreditation Scheme and will consider how paramedics can best be absorbed into the existing health professional regulatory structure.

Since I commenced this thesis in 2014, there has been significant community and industry support for promoting a new regulatory framework for Australian paramedic practice. In fact, on 7 October 2016 the Council of Australian Governments (COAG) proposed a draft amendment bill be brought to the Queensland Parliament in 2017 for paramedics to be registered in all jurisdictions under the National Scheme. Importantly, paramedics already fulfil COAG’s criteria for inclusion into the National Scheme. In arguing for the inclusion of paramedics in the National Scheme, this chapter has 8 parts. In 7.2 I outline the different perspectives of paramedic regulatory reform from crucial industry stakeholders. In 7.3 I highlight the evolution of the National Scheme in Australia which provides context to the policy changes I suggest are needed for paramedic inclusion in the National Law. Part 7.4 considers the Guiding Principles which paramedicine must fulfil for the Council of Australian Governments to accept paramedics as an additional health profession under the National Law. In part 7.5 I specify the regulatory requirements for reform which will be needed for paramedicine to be included in National Scheme regulation. Part 7.6 recommends professional indemnity insurance for

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1 See Chapters 2 and 4 of this thesis for a discussion of the role employers play in regulating the paramedic discipline.
paramedics and considers how professional indemnity insurance might work. Part 7.7 discusses how paramedics without tertiary qualifications might use a grandparenting clause to continue practising once National Scheme regulation applies to Australian paramedics. Finally, part 7.8 concludes that the requirements of National Scheme regulation can be met.

This chapter ties together the material from the earlier chapters. While Chapters 5 and 6 argued that National Scheme regulation is the most suitable regulatory framework for Australian paramedics, this chapter argues that the regulatory requirements for National Scheme regulation of paramedics are not onerous and can be met.

### 7.2 Industry acknowledgment of national paramedic registration

Prior to considering the practical and operational requirements to incorporating paramedic practice into the National Scheme, it is useful to consider different perspectives on the most suitable regulation for paramedics from relevant industry stakeholders. The different regulatory options for paramedic governance have been considered by government, industry and academics and will be discussed below. The Australian Health Ministers’ Advisory Council which was established under the National Law in 2009 and considered the possibility of paramedic inclusion under the National Scheme in 2012. The four options for regulatory reform, suitable for paramedics in Australia, introduced in Chapter 1 of this thesis, are outlined in table 7.1.

<table>
<thead>
<tr>
<th>Options</th>
<th>Recommendation</th>
<th>Mechanisms</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No change to regulation</td>
<td>Rely on existing regulatory and non-regulatory mechanisms, and a voluntary code of practice</td>
</tr>
<tr>
<td>2</td>
<td>Strengthen statutory health complaints mechanisms</td>
<td>Strengthen statutory code of conduct and powers to prohibit those who breach the code from continuing to provide health services</td>
</tr>
<tr>
<td>3</td>
<td>Jurisdictional regulation</td>
<td>Strengthen state and territory regulation of paramedics</td>
</tr>
<tr>
<td>4</td>
<td>Registration</td>
<td>Include paramedics in health practitioner regulation under the National Law</td>
</tr>
</tbody>
</table>

**Table 7.1 Options for paramedic regulation**

There has been a mixed response from the community regarding a changing regulatory framework for Australian paramedics. During a Senate Inquiry, held in 2015, into national registration of Australian paramedics, a number of submissions were made in support of, and in opposition to, paramedic registration to improve and ensure patient and community safety. Some stakeholders support the additional regulatory tools for paramedicine, including registration, while others advocated no change.

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4 Australian Health Ministers’ Advisory Council, ‘Consultation paper: Options for regulation of paramedics’ (Health Workforce Principal Committee, July 2012) 58.

5 Commonwealth of Australia, above n 2.
being needed due to the current framework being sufficient. It is important to document community
responses to these issues as it not only shows significant community interest in paramedic regulation,
but also the overwhelming support for paramedic registration under the National Scheme.

Some counter-arguments against National Law regulation for Australian paramedics includes:

1. **the employer bodies losing control over the industry**: employers would no longer be
   responsible for setting industry standards so employers would then defer to the National
   Boards.

2. **paramedics undergoing more stringent scrutiny of their practice**: paramedics would be
   accountable to their National Board rather than a single employer.

3. **a cost outlay for the state and territory governments**: it would be a governmental
   responsibility to create a National Board for paramedics.

Despite the differing options and opinions on regulating Australian paramedicine, overall there is
consistent industry and community support of national paramedic registration. Private paramedic
employers, such as Private Paramedicine Australia and the Royal Flying Doctor Service, believe
registration is advantageous. The National Council of Ambulance Unions (NCAU) and Paramedics
Australasia support national registration for paramedics. Indeed, NCAU has suggested that paramedic
registration is the only option which will address the most important issues for members: flexibility in
employment; portability of qualifications; protection of title; consistent and transparent handling of
complaints and/or fitness-to-practise issues; protection of the public and the safety of patients. Other
stakeholders – including the Australian Medical Association, Australian Paramedics Association

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Queensland, Ambulance Employees Australia (Victoria) and the Australian and New Zealand College of Paramedicine – also support paramedic registration.9

The CAA had been hesitant to support paramedic registration previously, suggesting it is:

imperative to avoid overly rigid prescriptions of the scope of practice of paramedics, in light of the different configurations of health systems and ambulance services in each jurisdiction… and to avoid any new regulatory measures that inhibit the recruitment or deployment of volunteers by public ambulance services.10

Now, however, the CAA has come out in support of national registration. In 2016, the CAA, representing the primary paramedic employers, agreed that national registration is the most suitable option for Australian paramedic regulation.11 They argue the National Scheme is in the best interests of the public because it provides a regulatory framework which is transparent and accountable, among other things.12

There is other commentary which discusses the evolution of the industry and calls for changes to the current regulatory structure. Eburn and Bendall discussed the growing private ambulance sector and suggested private paramedicine reduces the burden of non-emergency services on public ambulance

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9 See Australian and New Zealand College of Paramedicine, Submission No 1 to Senate Standing Committee on Legal and Constitutional Affairs, The establishment of a national registration system for Australian paramedics to improve and ensure patient and community safety, January 2016; Australian Medical Association, Submission No 2 to Senate Standing Committee on Legal and Constitutional Affairs, The establishment of a national registration system for Australian paramedics to improve and ensure patient and community safety, January 2016; Ambulance Employees Australia - Victoria, Submission No 4 to Senate Standing Committee on Legal and Constitutional Affairs, The establishment of a national registration system for Australian paramedics to improve and ensure patient and community safety, 2016; Michael Eburn and Ruth Townsend, Submission in response to the Australia Health Ministers Advisory Council's Consultation Paper: Options for regulation of paramedics (5 September 2012) <https://law.anu.edu.au/sites/all/files/users/u4810180/2012_submission_to_the_australian_health_ministers_advisory_council.pdf>; Royal Flying Doctor Service, Submission No 11 to Senate Standing Committee on Legal and Constitutional Affairs, The establishment of a national registration system for Australian paramedics to improve and ensure patient and community safety, 29 January 2016; Australian and New Zealand College of Paramedicine, Submission No 1 to Senate Standing Committee on Legal and Constitutional Affairs, The establishment of a national registration system for Australian paramedics to improve and ensure patient and community safety, January 2016; Jill Hennessy, Submission No 15 to Senate Standing Committee on Legal and Constitutional Affairs, The establishment of a national registration system for Australian paramedics to improve and ensure patient and community safety, 2016; Jillian Skinner, Submission No 13 to Senate Standing Committee on Legal and Constitutional Affairs, The establishment of a national registration system for Australian paramedics to improve and ensure patient and community safety, January 2016; Ruth Townsend, Submission No 12 to Senate Standing Committee on Legal and Constitutional Affairs, The establishment of a national registration system for Australian paramedics to improve and ensure patient and community safety, 2016.


12 Ibid.
services. To ensure all ambulance services are delivering quality services to the community, they argue registration of paramedics is needed. The authors recommend the use of various titles used by pre-hospital care providers should also be restricted. The paper identified a number of registration benefits including better access to equipment and medications, protection of title and patient confidence in paramedic expertise.

Other publications also recommend registration and protection of title for paramedics in Australia. O’Meara argued the professional identity of paramedics is growing because of the paramedic regulation debate. He has suggested recognition and acknowledgement of paramedics, as an emerging profession, is crucial for inclusion in a national regulatory framework, but it will come down to the various community stakeholders, such as other health professionals, government and community members, as to whether paramedics are suitable for inclusion. O’Meara, though, does not suggest a suitable model for regulation or how it should be implemented.

Williams, Onsman and Brown considered how research participants of their study felt about impending national registration. A majority of the participants believed the paramedic discipline would benefit from professional recognition of their discipline in the form of national registration. However, the study found participants did not believe national registration would occur in the two years following the study’s 2010 publication, but did not explain why.

Boyle et al. considered the paramedic regulation debate and its regulatory state in 2003. They argued self-regulation is not an appropriate regulatory model for paramedic practice. Specifically, they highlighted how membership to their professional organisation, which could act as a regulatory body, was voluntary, while patients also had no right to choose their treating practitioner: categories indicative of self-regulation. Non-compliance of regulatory provisions by members could also have catastrophic consequences for patient safety. Finally, the authors argued paramedics were not comparable to a number of other health ‘professions’ using self-regulatory models because the other health

14 Ibid.
16 Ibid.
19 The other professions listed are: Aboriginal health workers, childbirth educators, counselors and psychotherapists, ‘Doula’ birth helpers, herbalists, hypnotherapists, lactation consultants, massage therapists, music therapists, naturopaths, occupational therapists, optical dispensers, orthoptists, personal care attendants and speech therapists.
practitioners mentioned do not have the same potential to cause serious damage in one clinical encounter. As such, self-regulation would be an inappropriate regulatory option for paramedicine.

FitzGerald and Bange’s discussion paper titled ‘Defining a Regulatory Framework for Paramedics’ considered the possibilities for paramedic regulation. Most specifically, the authors argued that a suitable regulatory structure for paramedics should permit differences in the scopes of practice between employment environments and should apply to all paramedics, regardless of their employment status. FitzGerald and Bange proposed three types of regulatory models for paramedics which might be suitable. Their first suggestion involved instituting a regulator independent of the professional paramedic association or the employer bodies. The second option proposed having a regulator affiliated with the employer organisations but separate from the professional association. The final proposal involved a self-regulatory model whereby the professional association takes responsibility for both regulation and representation of paramedics. While unique in its coverage of proposed regulatory reform, this article was published three years prior to the National Scheme’s implementation and, as such, bears no further relevance in determining a suitable regulatory framework for Australian paramedics. Despite consideration of regulatory theories being notably absent from the existing literature on paramedic regulation, the general consensus appears to support adopting a co-regulatory model of registration within the National Scheme’s jurisdiction.

In summary, the scholarship I have outlined shows support for change to the current regulatory framework for paramedic practice in Australia. The research details a range of options available for regulation of paramedics including implementing a paramedic registration system. In the remainder of this chapter, I argue that including paramedics in the National Scheme is the most appropriate framework for regulating Australian paramedics and is one which will best promote public safety. In so doing, the precautionary approach to paramedic regulation, which I considered in Chapter 6, can be exercised to reduce the risk paramedics pose to the public and regulating paramedics under the National Scheme.

7.3 Australia’s national health practitioner regulation evolution

Prior to the National Law’s implementation in Australia in 2010, each state and territory was responsible for regulating its own health practitioners. The Australian Health Ministers’ Council reported during 2009 that there were 65 separate legislative instruments establishing 83 statutory bodies for state-based
health practitioner regulation. Some health practitioners had full registration, while others followed a model of partial registration. This made the health professions’ regulatory frameworks complicated and disparate. In particular, the state-based regulatory structure created mobility issues for practitioners wanting to work across jurisdictional borders. There were also jurisdictional inconsistencies in legislation and administration of registration which caused issues with industry accreditation in the absence of a national accreditation authority.

In the mid-2000s, and following a research study into the quality of the healthcare workforce in Australia, the Productivity Commission recommended a single national registration scheme for health professionals. A national regulatory system was recommended to protect the public, to ensure accountability and transparency in partnerships between professionals and the community and to support a flexible and responsive health workforce. National regulation of health professions was considered the only viable alternative to combat these issues. The Council of Australian Governments, in an Intergovernmental Agreement, created the National Health Practitioner Registration and Accreditation Scheme (the “National Scheme”). The National Scheme was created to ‘simplify and improve the consistency’ of regulation, for health professionals, on a national level. Specifically, the Health Practitioner Regulation National Law Act (the “National Law”), responsible for establishing the National Scheme, was first legislated in Queensland, with the Queensland Minister for Health, Honourable Paul Lucas, in his second reading speech before the Queensland Parliament, discussing justifications for implementing the National Scheme. He stated:

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24 Chiropractors, dental care providers (dentists, dental specialists, dental therapists, dental hygienists and dental prosthetists were included but dental technicians and dental assistants were not), nurses (registered and enrolled nurses (Victorian division 1 and 2 enrolled nurses only), nurse practitioners and midwives), medical practitioners, optometrists, osteopaths, pharmacists, physiotherapists and psychologists.
25 Northern Territory Aboriginal health workers, Victorian Chinese medicine practitioners (acupuncturists, Chinese herbal medicine practitioners and Chinese herbal dispensers), dental technicians (Australian Capital Territory, New South Wales, Queensland and South Australia only), medical imaging professionals (radiation therapists, radiographers and nuclear medicine technologists in Queensland, Australian Capital Territory, Tasmania, Victoria and Western Australia only), occupational therapists (Northern Territory, Queensland, South Australia and Western Australia only), New South Wales optical dispensers, podiatrists (all states and territories except for Northern Territory) and Queensland speech pathologists.
26 Australian Health Ministers Advisory Council, above n 23, 9-10.
27 Ibid 11.
30 Explanatory Memorandum, Health Practitioner Regulation National Law Bill 2009 (Qld) 7.
31 Council of Australian Governments, above n 28.
32 Ibid r 2.4.
33 Australian Health Ministers’ Advisory Council, 'Consultation paper: Options for regulation of paramedics' (Health Workforce Principal Committee, July 2012) 5-6.
This bill represents a quantum leap forward in improving Australia’s healthcare system for the better. The most significant amendments seek to boost public safety protection by ensuring health practitioners are suitably trained and qualified to practise in a competent and ethical manner; cut red tape to allow health professionals to work anywhere in Australia without requiring additional registration; establish a single national register for each profession that will be publicly available; simplify registration processes which currently require a person to be registered in each jurisdiction in which they wish to practise; establish nationally consistent standards for registration applying to each profession; require all registrants to have suitable professional indemnity insurance during the period of their registration...; require mandatory reporting of professional misconduct across all professions; and require criminal history checking of all new applicants for registration in all professions and auditing of criminal histories of existing registrants.34

The statutory instrument requires federal co-operation by agreement between states and territories, but as it is not Commonwealth legislation, there was no need for Commonwealth referral of powers.35 All states and territories have since enacted the National Law.36

As of 1 July 2010, ten professions were registered nationally under the National Scheme; these were medical practitioners, chiropractors, dental practitioners (dentists, dental hygienists, dental prosthetists and dental therapists), nurses and midwives, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists37 and psychologists.38 Aboriginal and Torres Strait Islander health workers, Chinese medical practitioners, medical radiation practitioners and occupational therapists were added to the National Scheme from 1 July 2012.39 Paramedics have not been included under the National Law.

While the National Law was created for various reasons, such as to foster transparency and accountability of health regulation and to encourage a professional workforce, public protection is the primary consideration. Indeed, the main guiding principle of the National Law is that ‘the health and safety of the public is paramount’.40 This is a relatively new provision and one inserted after the National Law’s implementation. The principle was added to instil public confidence and respond to concerns that the National Law did not go far enough to promote public safety.41 In this way, the

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35 Explanatory Memorandum, Health Practitioner Regulation National Law Bill 2009 (Qld) 7.
37 Podiatrists were originally excluded from registration in the Northern Territory only, during the first rollout of the National Scheme, due to a shortage of registrants; they have since been included for registration in the Northern Territory as well. See Explanatory Memorandum, Health Practitioner Regulation National Law Bill 2009 (Qld) 3.
39 Ibid.
40 National Law s 3A.
41 Queensland, *Parliamentary Debates*, House of Representatives, 4 June 2013, 1899 (Lawrence Springborg, Minister for Health).
National Law is a measure to protect the public from health practitioners causing risk and harm to patients.

As I have argued throughout this thesis, it is now time paramedics joined the National Scheme. As a profession, paramedics are facing similar challenges to other ‘health professionals’ who are now part of the National Scheme. As Chapter 3 established, the paramedic industry is in need of a professional, flexible and responsive workforce and one without the significant jurisdictional disparity of regulatory structures. Further, Chapter 5 established the risk paramedics pose to the community, the need for public protection from that risk and how the paramedic system lacks transparency, all factors which the National Scheme was created to address; these concepts go directly to public protection, which is at the heart of the National Scheme.

7.4 Guiding principles for inclusion under the National Scheme

How can paramedics be included in the National Scheme? In order for paramedics to qualify for inclusion under the National Scheme, the discipline must satisfy the Council of Australian Governments’ (COAG) specific criteria. Additional health professions are only considered for inclusion in the National Scheme if a majority of jurisdictions support the change and if regulation under the National Scheme would minimise a serious public safety risk. 42 In making its decision, COAG takes into account a range of factors including:

1. The appropriateness of health ministers to be responsible for regulating the occupation or whether the occupation falls within the domain of another ministry;
2. Whether the activities of the occupation pose a significant risk of harm to the health and safety of the public;
3. Whether the existing regulatory mechanisms fail to address health and safety issues;
4. Whether regulation can be implemented for the profession;
5. The practicality of regulating the occupation; and
6. Whether the benefits to the public outweigh the potential negative impact of regulation. 43

These principles will be addressed below in 7.4.1 to 7.4.6.

43 Ibid. The Council of Australian Governments, in their Intergovernmental Agreement, provides further clarification to interpret the Guiding Principles and this will be considered further below as well. Boyle et al (above n 20) specifically apply the Guiding Principles to paramedicine, in their publication; however, the article was published in 2003 so currency is an issue here. The article will be referenced below where it still has relevance to the industry.
7.4.1 It is most appropriate for the state and territory governments’ health ministries to regulate paramedicine

The state and territory health ministers are the most appropriate people to govern paramedic practice; indeed paramedicine falls within the health department domain in Australia. Health ministers are already primarily responsible for regulating the paramedic disciplines with Queensland, New South Wales, Victoria, South Australia and Tasmania, falling within their jurisdiction’s Department of Health portfolio under direct control of a health minister.\(^44\) Despite paramedicine’s emergency role, it is health care provision which is the primary purpose of paramedics’ roles and responsibilities.\(^45\)

A useful example of an Australian jurisdiction acknowledging the health ministry as most appropriate to govern paramedic practice comes from Queensland. The portfolio for the Queensland Ambulance Service (QAS) moved from the Department of Community Safety to Queensland Health on 1 October 2013 as a result of the Keelty Report.\(^46\) The Keelty Report recommended the change for QAS to be more aligned with Queensland Health as a majority, 83.3 per cent, of ambulance responses were already interfaced between the two bodies. Further, moving QAS was considered more beneficial as its core function is emergency health services rather than community safety. The Queensland Government’s decision to move paramedicine from the emergency services portfolio to health accurately reflects the position which should apply across all jurisdictions of Australia, because the health department can more efficiently manage ambulance services’ resources in line with other health care in Australia. Therefore, it is most appropriate for the Health Ministers to be responsible for industry regulation.

Other Australian jurisdictions do not currently recognise paramedicine within a health portfolio. The Australian Capital Territory Emergency Services Agency presides over the ACT’s Ambulance Service and reports to the ACT Minister for Police and Emergency Services.\(^47\) Western Australia and the Northern Territory outsource ambulance services to St John Ambulance in a private capacity. Consequently, their ambulance services do not fall within the domain of any ministry executive portfolio.


\(^{45}\) Bendall and Eburn, above n 13.


7.4.2 Paramedicine poses a significant risk of harm to the public’s health and safety

Another consideration for COAG in including paramedics in the National Scheme is the degree of risk to the public’s health and safety. When assessing the likelihood of significant risk of harm to the health and safety of the public, the Council of Australian Governments suggests the nature and severity of the risk, to all stakeholders, is highly relevant. Particularly relevant is the occupation’s use of equipment, material or processes; whether a failure to follow procedures could cause harm; whether intrusive techniques are practised which could cause serious or life threatening danger; whether pharmacological or dangerous substances are used; and whether there is significant potential to cause environmental damage. The risk assessment will consider available epidemiological or other data, such as coroners’ cases, trend analysis or complaints to determine harm.\(^{48}\)

As we have seen throughout this thesis, paramedics pose a significant risk of harm to the public’s health and safety. More specifically, the extent of risk paramedics pose to the community was established in Chapters 5 and 6 of this thesis. These chapters used examples of harm suffered by community members to show the potential for risk paramedics pose to the community and evidence of patient harm having already occurred. Coronial inquest findings, court reports, complaints data and media reports were all used as evidence to determine harm.

When applying paramedics to COAG’s risk factors, there are four considerations to be addressed. Firstly, paramedics use intrusive equipment, materials and processes which could cause a serious threat to public health and safety including, but not limited to, intubation, chest decompression, surgical cricothyrotomy and cannulation.\(^{49}\) Further, Boyle et al. identifies how paramedics use the same clinical process of ‘sedation, paralysis, endotracheal intubation and artificial ventilation of seriously ill patients’ on road as anaesthetists do when they prepare a patient for surgery in a hospital; however, paramedics do not have the advantage of prior planning to minimise patient harm.\(^{50}\) This means that patients of paramedics are often at a greater risk of harm from those paramedics than anaesthetists due to the urgency in which they are required to respond. Further, much of the prehospital emergency care is performed in difficult locations in the community; with limited equipment; without access to advice from professional colleagues; and when dealing with patients who are often unconscious or deeply distressed. Thus emergency work causes public safety risks due to its urgent nature.

Secondly, a failure to practise in a particular way could also result in a serious threat to public health and safety. Examples of exacerbated injury or deaths caused from a failure to follow certain procedures

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\(^{48}\) Council of Australian Governments, above n 43, 23.

\(^{49}\) Please see table 2.2 for a broader range of examples of paramedics’ clinical skills.

or observe standards include the *Inquest into the death of Ruby Yan Chen*,\(^{51}\) *Inquest into the Death of Marshall Yantarrnga*\(^{52}\) and *Neal v Ambulance Service of New South Wales*,\(^{53}\) among others. These cases of patient harm given detailed consideration in Chapter 6 of this thesis, in summary, highlight a range of significant responsibilities which paramedics possess and the subsequent harm they could cause to their patients.

A third factor in establishing risk is the use of substances including pharmacological compounds, dangerous chemicals or radioactive substances. Chapter 4 of this thesis considered the administration of substances and the powers of paramedics when using pharmacological substances on patients.\(^{54}\) While paramedics do not administer or use radioactive substances, their practice does involve the use of schedule 4 and schedule 8 drugs which the Commonwealth government has regulated under the *Therapeutic Goods Act 1989* (Cth). The administration and use of these drugs, without authorisation, could result in a significant criminal penalty.\(^{55}\)

Finally, a profession’s potential for risk of harm can be derived from a set of risk categories. As the key objective of national health practitioner regulation is public protection, inclusion of the partially regulated professions\(^{56}\) under the National Scheme was based on the level of risk the profession posed to the public. Thirteen risk categories were established and the Australian Health Ministers’ Advisory Council considered whether the scope of practice for health professions gave rise to public safety risks.\(^{57}\) The extent of a discipline’s risk to public safety can be inferred from a range of considerations:

1. putting an instrument, hand or finger into a body cavity;
2. manipulation of the spine;
3. application of a hazardous form of energy or radiation;
4. procedures below dermis, mucous membrane, in or below the surface of cornea or teeth;
5. prescribing a scheduled drug, supervising that part of a pharmacy that dispenses scheduled drugs;
6. administering a scheduled drug or substance by injection;
7. supplying substances for ingestion;
8. managing labour or delivering a baby;
9. undertaking psychological interventions to treat serious disorders or with potential for harm;

51 (Coroner’s Court of Rockhampton, Coroner O’Connell, 12 December 2014).
54 See table 4.6 for a detailed outline of drugs available for paramedic administration.
55 See, eg, *Drugs Misuse Act 1986* (Qld) s 9.
56 Those professions which had a state or territory based registration system.
10. setting or casting a fracture of a bone or reducing dislocation of a joint;
11. primary care practitioners who see patients with or without referral from a registered practitioner;
12. treatment commonly occurring without others present; and
13. patients commonly being required to disrobe.58

Health professions, registered under the National Scheme, have different levels of risk according to the above risk categories. Medical practitioners were considered to involve risk in every category. The nursing and midwifery discipline involved 11 categories of risk out of 13.59 Optometry, psychology and pharmacy only involved three risk areas each.60 Comparatively, when the activities of paramedics were documented, the Australian Health Ministers’ Advisory Council identified 9 risk categories for paramedics. Paramedics were considered a risk to the community for all categories except for manipulation of the spine; application of a hazardous form of energy or radiation; prescribing a scheduled drug; or the setting or casting of a bone fracture or reducing joint dislocation.61

Significantly, however, paramedics now fulfil 10 categories of risk out of 13. They are a risk to the community in ‘setting or casting a fracture or reducing dislocation of a joint’. While paramedics are not involved in setting or casting a fracture, paramedics, in some jurisdictions, reduce joint dislocations. Extended Care Paramedics in New South Wales, for example, can perform a dislocation reduction.62 Therefore, under these parameters, paramedics are arguably at a higher risk to the community than 10 of the other health professions – such as chiropractors, podiatrists and occupational therapists – currently registered under the National Scheme. It can therefore be concluded that paramedicine does pose a significant risk of harm to the health and safety of the public, satisfying this criteria for inclusion in the National Scheme.

7.4.3 Current paramedic regulation fails to address health and safety issues

Another risk factor which COAG considers for regulation under the National Scheme is that current paramedic regulation fails to address health and safety issues. As we saw in Chapters 2 to 6, the existing regulation of paramedicine is inadequate. It fails to address health and safety issues to the community. To satisfy the COAG’s criterion that paramedic regulation fails to address health and safety issues, there are a number of additional considerations that need to be satisfied. Specifically, COAG requires other regulatory options to be considered, such as supervision by registered practitioners of a related

58 Ibid.
59 Ibid 116. Nursing and midwifery were considered a risk for all categories except for numbers 2 and 10.
61 Australian Health Ministers’ Advisory Council, Options for regulation of paramedics, above n 39, 35.
occupation or self-regulation by the occupation, as a means to provide alternatives to regulation apart from regulation under the National Scheme. These factors will be considered below.

Firstly, there are problems with the way in which paramedicine is currently regulated. Chapters 2 and 4 of this thesis highlight that the current regulation of Australian paramedics is inadequate. More accurately, because paramedics are primarily regulated through their employment relationship with limited statutory governance, this means that employers are responsible for setting industry standards of competence and can also cause regulatory disparity between employers. 63 While there is some regulation in place to address health and safety issues, such as drug legislation, workplace industrial agreements, industrial awards and employer policies, the disparity between jurisdictions causes public safety issues as privately employed paramedics are not subject to the same regulatory framework as paramedics employed in the public ambulance services. Further, given employers are primarily responsible for regulating the discipline, there are no minimum standards applicable across the industry which means some employers’ priorities may align with organisational self-interest rather than public interest. As such, the discipline faces many challenges perpetuated by the current regulatory framework.

Secondly, it is not feasible for another registered professional discipline to supervise paramedics. Paramedics are pre-hospital first-responders and attend patient emergencies without the support or supervision of other registered health practitioners. There are some circumstances where paramedics must consult with a medical practitioner; 64 however, it would not be practicable for medical practitioners to supervise paramedics. Paramedics attend emergencies alone or as part of a team. The paramedic employers would not have the resources to send registered health practitioners, such as nurses or medical practitioners, to emergencies to accompany paramedics. Further, paramedics do not need the supervision of other registered health practitioners. Paramedics are autonomous practitioners and possess the skills and knowledge to diagnose and treat patients without relying on other registered health practitioners for guidance.

Finally, self-regulation of the paramedic discipline is problematic. Self-regulation is recommended when there is no strong public interest or public safety issues in the discipline’s practice; the ‘regulatory problem’ which the self-regulation seeks to solve is low risk; cost of compliance regulatory is small and the problem can be fixed within the industry itself. 65 Most notably, perhaps, for a self-regulatory model to be effective, the industry needs to be committed to implementing self-regulation 66 and have

63 See Chapter 2 of this thesis.
64 Such as, for example, administration of drugs at more than the dosage prescribed in the drug therapy protocols. See Queensland Government, 'Drug Therapy Protocols' (Queensland Ambulance Service, August 2016).
the expertise and capacity to maintain and enforce professional requirements. 67 There are fiscal advantages for the government from having an independent industry regulator. Depending on the level of self-regulation imposed on an industry, the government is given a monetary reprieve as their responsibility for co-ordinating the regulatory mechanisms lessens. 68 Further, self-regulation has been argued to be responsive to industry needs, flexible, informed, targeted and encouraging of industry compliance. 69 However, self-regulation is not appropriate for regulating health professions. One example of self-regulation failing as a regulatory tool is medical professional regulation. Using a self-regulatory model for health professions has been widely criticised for an apparent pattern of unacceptable tolerance for unprofessional conduct. 70 In fact, Parker attributes the shortcomings of medical practitioner self-regulation as a contributing factor to the implementation of the National Law. 71

Thomas highlighted the issues with self-regulatory models, referring specifically to a healthcare context. 72 Using the medical profession to outline a history of failures, he cited examples of accountability failures of various Australian Medical Boards over the years, culminating in the widely publicised 2005 case of Dr Jayant Patel from Bundaberg, Queensland. Dr Patel, a medical practitioner, was responsible for 48 adverse patient outcomes resulting in at least 13 patient deaths. 73 Other medical practitioners did not report his alleged incompetence. 74 Medical practitioners being required to report each other’s misconduct is a self-regulatory concept as medical practitioners are responsible for regulating their own profession. 75 As such, self-regulation can be troublesome, particularly with reporting practitioner incompetence, because medical practitioners, with a strict self-regulatory

71 Parker, Embracing the new professionalism, above n 70.
72 David Thomas, 'Peer Review as an Outdated Model for Health Practitioner Regulation' in Law in Context (The Federation Press, 2006) vol 23, 52, 53.
74 Thomas, above n 72, 53. See also Lindy Willmott and Ben White, 'Mandatory Reporting of Health Professionals' (2010) 30 Queensland Lawyer 172.
75 Thomas, above n 72.
approach to regulation, do not always conform with industry requirements.76 Black also highlighted additional issues with self-regulation including its propensity for being self-serving, having inadequate sanctions and harbouring ‘free-rider’ problems.77

More broadly, perhaps, the use of self-regulation has declined within Australian health professional regulation. Freckelton gave significant consideration to self-regulation losing popularity as a regulatory tool.78 It is becoming common for members of regulatory bodies to be comprised of both practitioner and non-practitioner members. Standards of conduct are thus judged in line with contemporary community standards rather than by professionals in the discipline themselves.79 Specifically, serious misconduct investigations for mental health practitioners have been removed from the Registration Board’s jurisdiction to an external tribunal, suggesting mistrust of the old self-regulation model.80 Mandatory reporting, the requirement for registered health practitioners to report concerning conduct of their peers, is also a co-regulatory requirement to combat the problems of self-regulation.81

Co-regulation replaced self-regulation in the medical profession. Thomas argued as a result of the autonomy afforded to the medical practitioner regulatory body causing widespread unprofessional conduct to go unpunished, the disciplinary self-regulation system was abolished before the National Law’s implementation.82 Instead, medical practitioners became accountable to a co-regulatory system between the state-run complaints body and the Medical Board.83 The co-regulation model, arguably, became a more effective way to cover the deficiencies of the previous self-regulatory model. As such, self-regulation was no longer the regulatory model being exercised for medical professional discipline, rather a model of co-regulation is the preferred health practitioner regulatory regime.84

Similarly to other health professions, it is not appropriate to impose a solely self-regulatory model of governance on Australian paramedics. Given the risk of harm to the public which paramedics pose, self-regulation would introduce the same challenges for targeting and disciplining unprofessional conduct which existed for medical practitioners. Further, the industry’s transparency issues would not

77 Black, Decentring Regulation, above n 69, 115.
78 Freckelton, Regulation of Health Practitioners, above n 70, 500-1.
79 Ibid.
83 Ibid.
be resolved through self-regulation. Establishing an external body for regulation outside the employer’s jurisdictions, or industry self-regulation, addresses the challenges which arise.\footnote{Mal Boyle et al, ‘Monash University Centre for Ambulance and Paramedic Studies (MUCAPS) Submission to the Department of Human Services (DHS), in response to the DHS Discussion Paper examining the regulation of the Health Professions in Victoria’ (2003) 1(3) Journal of Emergency Primary Health Care 120, 7.}

The National Law offers a co-regulatory framework which incorporates the most useful aspect of self-regulation: that members of the profession are involved in the regulation of their own discipline through their National Boards. Co-regulation also incorporates the government’s contribution to protect the public from the more problematic aspects of self-regulation like condoning unprofessional conduct. Through co-regulation, a self-regulating component to paramedic regulation and the benefits of such, could still exist. Self-regulation would allow the discipline to be involved in its own governance. Freckelton highlights the concept that colleagues in the same discipline are in the best position to evaluate a practitioner’s professional conduct.\footnote{Freckelton, Regulation of Health Practitioners, above n 70, 500. See also Black, Decentring Regulation; above n 69; Eliot Freidson, The Profession of Medicine: A Study of the Sociology of Applied Knowledge (University of Chicago Press, 1998 ed, 1970) 137.} Self-regulation promotes integrity in the health professions because only the practitioners themselves can assess the levels of competence needed in their own profession.\footnote{Paula De Prez, ‘Self-regulation and Paragons of Virtue: The Case of “Fitness to Practise”’ (2002) 10 Medical Law Review 28, 30.} Further, self-regulatory bodies have higher levels of expertise which leads to a more effective regulatory structure.\footnote{Baldwin, Cave and Lodge, above n 69, 139.} As such, it would be useful to allow paramedics to be involved in their own regulatory structure without adopting self-regulation as a sole-regulatory model.

### 7.4.4 National Scheme regulation can be implemented for paramedicine

A further risk factor COAG considers for regulating health professions under the National Scheme is whether National Scheme regulation can be implemented. To determine whether regulation can be implemented for the paramedic discipline, COAG has considered a number of factors. These include whether the occupation is well-defined, has a body of knowledge and requires core and government accredited qualifications.

**Is paramedicine well defined?**

The meaning of an occupation being “well-defined” causes some confusion. COAG could be seeking an explicit definition of the occupation or simply the need for the occupation to have well-defined parameters which other disciplines do not encroach.

Defining paramedicine has been problematic given the discipline has been expanding so rapidly. Paramedicine, as an occupation, has also been difficult to define because of the existing legislative disparity between jurisdictions. Some jurisdictions have attempted to draft a definition in order to
implement protection of title regulation for those employed in the public sector ambulance services. Having an explicit definition is a tool for clarity in determining the scope of employees to be regulated.

A definition of ‘paramedic’ may be beneficial to provide clarity surrounding paramedics’ roles and responsibilities. South Australia currently defines a paramedic as a ‘health practitioner who provides pre-hospital emergency care services or community-based alternative models of care as a result of a request for emergency medical assistance’.89 Due to their extended care role, paramedics no longer attend to patients purely ‘as a result of a request for emergency assistance’, so the South Australian definition is too limited. As such, a national definition for ‘paramedic’ should, instead, be a ‘health practitioner who provides pre-hospital emergency care services or community-based alternative models of care including diagnosis, treatment or advice’. The discipline would then be categorised as well defined. However, there are no statutory definitions of other registered health practitioners so a definition may not be necessary for the discipline to be “well-defined” according to the COAG’s criteria.

If COAG was referring to the parameters of the discipline being well-defined, instead, the parameters are more challenging to establish. Given the significant evolution of the discipline, outlined in Chapter 3, occurring over a relatively short period, there is community misunderstanding of the role of paramedics. People without requisite training and education can still practise as paramedics in jurisdictions without protection-of-title provisions; it is the individual employer’s responsibility to uphold minimum standards of paramedic expertise. Further, privately practising paramedics have no universal requirements to maintain professional competency. As such, it is difficult to determine the role because of the diversity of regulatory standards across the private and public systems. Paramedicine could be well-defined if it had a regulatory system, like the National Law, upholding minimum standards of competency.

**Paramedics have a body of knowledge**

Consideration must also be given to whether the occupation has a body of knowledge, forming the basis of its standards of practice, and whether that body of knowledge can be taught. The paramedic discipline arguably has a body of knowledge which forms the basis of its standards of practice. Chapter 3 argues for the professionalism of Australian paramedics which incorporates specialised knowledge, autonomy and complexities of practice. While Reynolds highlights how medical professional research had dominated prehospital care practices in the past, there is now specialist paramedicine research establishing prehospital paramedic care as a distinct body of knowledge.90 The Council of Australian

89 Health Practitioner Regulation National Law (South Australia) Act 2010 (SA) s 120A (2).
Governments does not determine whether the body of knowledge needs to exist outside medical professional dominance.

**Paramedics require core and government accredited qualifications**

Finally, members of the paramedicine discipline should have core and government accredited qualifications. In order to reduce national disparity in paramedicine education and training, government regulation should be implemented which allows for an accreditation body, external to the employer bodies, to monitor tertiary education for paramedics. Further, a minimum requirement for tertiary qualifications should exist across all jurisdictions.

Regulation is able to be implemented for the discipline and it would be relatively straightforward to initiate. There is an existing regulatory system which can envelop paramedicine. Paramedicine can be easily defined, has core knowledge and very specific qualifications. As such, this criterion can be satisfied.

### 7.4.5 It is practical to regulate paramedics under the National Scheme

Yet another consideration for COAG to regulate paramedics under the National Scheme is the practicability of doing so. Before including paramedics in the National Scheme, COAG considers a number of factors including:

1. whether self-regulation and other alternatives are practical to implement;
2. whether occupational leadership favours public interest over occupational self-interest;
3. whether members of the occupation will seek compliance with regulation from members;
4. whether there are sufficient numbers who are willing to contribute to regulatory costs;
5. whether there are cost recovery issues; and
6. whether all governments agree with the proposal for regulation.

There are no regulatory suitable alternatives for paramedics other than the National Scheme. A national system is needed to address the industry’s significant jurisdictional disparity so continuing with jurisdictional regulation, even in the form of registration, would not be sufficient. Further, there is also a need for a national accreditation system for qualifications, external complaints, disciplinary processes and mandatory continuing professional development as was established in Chapters 2, 4 and 6.

Perhaps most importantly, regulating paramedics under the *National Law* is the most practical option for improving the discipline’s regulatory system. The *National Law* already provides a useful framework for registered health practitioner governance. While a new, national regulatory system could be established, which caters only to paramedics, it would be a costly and unnecessary endeavour and one which could be avoided through their inclusion in the National Scheme. Adding paramedics to the
parameters of the National Scheme would avoid the difficulty and cost of creating a separate and new regulatory framework purely for paramedics.

Favouring the public interest over occupational self-interest is also an important factor for occupational leadership and one relevant to regulation under the National Scheme. Currently, occupational leadership falls within the employer bodies. While the primary paramedic employers are statutory authorities accountable to the state and territory governments, other employers are private organisations. As such, it is difficult to conclude that the current occupational leadership favours the public interest over occupational self-interest. It is more likely leadership favours organisational self-interest, which was argued in Chapter 3.

Paramedic registration, under the National Scheme, favours the public interest. The *National Law* was originally recommended to protect the public, among other things, and the health and safety of the public is considered ‘paramount’. It is reasonable to suggest the proposed regulation for the paramedic discipline, under the National Scheme, favours public interest over occupational self-interest as this is consistent with the *National Law’s* objectives. It is also the context of paramedic work to favour the public interest and be *altruistic* in nature which was also addressed in Chapter 3.

Scholarship discussing professional altruism highlights the altruistic nature of medical practitioner work in the community. Richards and Louise suggest that because of the beneficial and respected functions health professionals play in society, they are granted certain rights to enable them to serve the community. Medical professionals, for example, are obliged to keep certain patient information confidential. They are also granted special powers to prescribe and administer dangerous pharmaceuticals and can refuse to perform procedures not in the best interests of their patient. The same principles apply to paramedics. Paramedics are granted certain statutory powers to allow them to serve the community, as outlined in Chapter 2. Their access to patient information, the ability to administer dangerous drugs and to perform invasive procedures highlights their role in serving the community, an altruism which affirms the nature of paramedicine as favouring the public interest.

Yet another consideration of the practicalities of national registration for paramedics is the sufficiency of numbers in the occupation. While Chapter 5 identified the difficulty determining paramedic numbers with the prevalence of privately practising paramedics, the Australian Workforce and Productivity Agency suggest 13,900 people were employed as ambulance officers and paramedics in Australia in

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91 Explanatory Memorandum, Health Practitioner Regulation National Law Bill 2009 (Qld) 7; Health Practitioner Regulation National Law Act 2009 (Qld) s 3A.
93 Ibid.
While the numbers of practising paramedics in 2014 was significantly less than nurses and medical practitioners, there were around three times as many paramedics as podiatrists who are also registered under the National Scheme. If there are sufficient podiatrists to warrant national registration, it follows there are sufficient paramedics.

Another factor which COAG considers is the discipline’s role is contributing to regulatory costs of national regulation. For this matter, there are two options involved in the payment of registration fees. One option is for the paramedic employers to accept registration fee payments as their responsibility. However, it is envisaged there would be some opposition from the primary paramedic employers as this would increase their organisation’s functioning costs and, by association, the government’s regulatory costs for the industry. The other option is for the discipline’s members to pay for their registration fees. It is often standard practice, in other health professions, for the practitioners to self-fund their registration fees. Either way, the employer or the paramedic could easily contribute to regulatory costs of including paramedics in the National Scheme.

The final factor influencing COAG’s assessment of regulatory practicality is for all state and territory governments to agree on the proposal for regulation. This presents the greatest obstacle to including paramedics in the National Scheme, and a concern for paramedic regulation is the failure of governments to agree to a national, uniform regulation. That said, over time it has been only New South Wales that has maintained its refusal to acknowledge the benefits of a national paramedicine regulatory system. New South Wales’ refusal, however, should not prevent national paramedic registration from going ahead. If New South Wales paramedics are expressly excluded from the National Law, the other states and territories can still implement national registration without co-operation from the New South Wales government. COAG has suggested an ‘opt out’ system would be suitable and allow New South Wales the option to remain separate from national registration.

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96 There were 323,297 nurses registered (General Registration) under the National Scheme as at June 2014: Nursing and Midwifery Board of Australia, ‘Nurse and Midwife Registrant Data’ (Australian Health Practitioner Regulation Agency, June 2014) 2.
97 There were 32,389 medical practitioners registered (General Registration) under the National Scheme as at June 2014: Medical Board of Australia, ‘Medical Practitioner Registrant Data’ (Australian Health Practitioner Regulation Agency, June 2014 2014) 2.
98 There were 4,017 podiatrists registered (General Registration) under the National Scheme as at June 2014: Podiatry Board of Australia, ‘Podiatry Registrant Data’ (Australian Health Practitioner Regulation Agency, June 2014) 2.
99 For medical practitioners, for example, see Medical Board of Australia, *Fees* (2015 2015) <http://www.medicalboard.gov.au/Registration/Fees.aspx>.
100 Jillian Skinner, Submission No 13 to Senate Standing Committee on Legal and Constitutional Affairs, *The establishment of a national registration system for Australian paramedics to improve and ensure patient and community safety*, January 2016.
though, have expressed concern that an ‘opt out’ system would ‘undermine the foundations of patient and community safety’ and the ‘integrity and purpose of national registration’. While that may be the case, an ‘opt out’ system, without New South Wales, would still be more advantageous to paramedics, employers and the community than the current jurisdictional regulatory systems in place. New South Wales could then adopt the National Law for paramedics at a later stage, if desired. Therefore, it can still be practical to regulate paramedicine under the National Scheme.

7.4.6 The benefits of National Scheme regulation for paramedicine outweigh the potential negative impact of regulation

A final consideration for COAG to register paramedics is whether potential benefits outweigh the negative impacts. The National Law would be a suitable alternative to the current paramedicine regulatory framework to rectify the public safety problems, identified in Chapters 5 and 6 of this thesis, which current paramedic regulation fails to address in Australia. More specifically, the registration of paramedics as health practitioners under the National Scheme has a number of direct benefits:

1. public assurance and confidence of paramedic education and expertise;
2. reduction of risk to the public from practitioners;
3. establishing an external body, the National Board, to deal with health, conduct or performance issues;
4. establishing professional standards;
5. establishing national minimum educational standards;
6. establishing a national accreditation body to assess educational qualifications;
7. legislated national protection of ‘paramedic’ title;
8. the portability of health professional qualifications and the ability to move between jurisdictions;
9. greater degree of transparency and accountability in all areas of emergency community care;
10. improved capacity for paramedics to respond to public health threats because of national uniformity; and
11. better data on registrants.

102 See, eg, Australian Health Practitioner Regulation Agency, Submission No 3 to Senate Standing Committee on Legal and Constitutional Affairs, The establishment of a national registration system for Australian paramedics to improve and ensure patient and community safety, 27 January 2016, 3; Ambulance Employees Australia - Victoria, Submission No 4 to Senate Standing Committee on Legal and Constitutional Affairs, The establishment of a national registration system for Australian paramedics to improve and ensure patient and community safety, 2016, 4.

103 Australian Health Ministers’ Advisory Council, Regulatory Impact Statement for the Decision to Implement the Health Practitioner Regulation National Law, above n 58, 5, 17; Government of Western Australia, ‘St John Ambulance Inquiry: Report to the Minister for Health’ (Department of Health, October 2009) 49; Australian Health Ministers’ Advisory Council, Options for Regulation of Paramedics, above n 39, 74.
There are few negative consequences of paramedic regulation under the National Scheme. Opposition to the National Law was addressed above in 7.2, however includes the employer bodies losing control over the industry, paramedics undergoing more stringent scrutiny of their practice and a cost outlay for the state and territory governments.

However, the public benefit of national registration outweighs the potential negative impact of employer loss of control, paramedic accountability and cost.

**Costs to include paramedicine in the National Scheme**

Given a new regulatory framework for paramedics will involve a significant overhaul of the current system, the cost of implementing regulatory change is a significant factor to regulators. Baldwin, Cave and Lodge warn that caution is necessary when evaluating potential regulatory reform from a purely economic perspective because of other non-economic factors, such as the government’s mandate and due process.\(^\text{104}\) They suggest economic evaluations should supplement policy-making rather than impede the process.\(^\text{105}\) From the perspective of this research, there are two potential costs arising from paramedic registration under the National Scheme: costs to paramedics and costs to the government.

There are a number of government costs which would apply to paramedic registration under the National Scheme. State, territory and Commonwealth governments would need to meet costs associated with inclusion of paramedics in the National Scheme. Specifically, the Health Workforce Principal Committee (HWPC) identified costs to the government would include parliamentary sitting time, legislative drafting and the establishment of a national board for paramedicine. Governmental costs would include creating infrastructure to support the registration functions.\(^\text{106}\) A further cost would arise if employers were responsible for funding registration fees, as mentioned above, as the public ambulance services are statutory authorities with government funding.

There would also be costs applicable to paramedics intending to be registered under the National Scheme. Costs to paramedics would include annual registration fees as well as compliance costs. Annual paramedic registration fees would be applicable and fees would maintain the ongoing administrative costs of the National Board and the Australian Health Practitioner Regulation Agency.

The Paramedical Board of Australia would be responsible for prescribing fees for registration. The National Law currently requires fees to be ‘reasonable having regard to the efficient and effective operation of the scheme’.\(^\text{107}\) There would be an application fee, for new applicants to the discipline, as well as a registration fee for ongoing registrants. Currently, the Medical Board of Australia prescribes application fees and registration fees for medical practitioner general registration to be $724 as at 22

\(^\text{104}\) Baldwin, Cave and Lodge, above n 69, 334.

\(^\text{105}\) Ibid.

\(^\text{106}\) Australian Health Ministers’ Advisory Council, *Options for Regulation of Paramedics*, above n 39, 73.

\(^\text{107}\) National Law s 3(3)(b).
July 2015. Medical practitioner fees are the highest registration fees of the registered health professions. The Nursing and Midwifery Board of Australia’s fees comprise of an annual payment of $150, with a $150 application fee, effective from 9 September 2014. The lowest prescribed fees come from the Aboriginal and Torres Strait Islander Health Practice Board of Australia with an $80 application fee and $100 annual registration fee per year. Given there will be fewer registered paramedics than medical practitioners, and paramedics are less of a health and safety risk to the community, it is envisaged registration fees would not be as high as medical practitioner registration and would probably be comparable to nursing fees.

In addition to annual registration fees, compliance costs could include costs associated with achieving the qualifications for initial registration; costs associated with regulatory compliance, such as undertaking continuing professional developing or maintaining professional competence; and maintaining professional indemnity insurance. However, achieving initial qualifications may not be the only educational cost payable upon the discipline’s entry into the National Scheme.

There may also be an extra cost for those paramedics not tertiary trained. There are currently practising paramedics without tertiary qualifications. Paramedics may not have attained tertiary qualifications if they possess vocational qualifications or have no recognised qualifications at all. Vocationally qualified paramedics may either be practising in New South Wales or they commenced paramedic work prior to the current tertiary requirements for entry to the discipline. As such, if the National Board deems tertiary qualifications to be the minimum requirement, those paramedics without higher educational qualifications may need to undergo bridging courses to upskill sufficiently for the minimum standards of registration. A ‘grandparenting’ clause may be necessary to allow current practitioners, without tertiary qualifications, to qualify for registration and allow them time to obtain their additional qualification. This is discussed further in 7.7 below.

The National Boards are primarily self-sustaining so the maintenance costs are minimal. Using the Nursing and Midwifery Board of Australia, as an example, there is a projected budget, for the 2015/2016 year incorporating a total income of $55,571,000 per year sourced from registration fees, application fees, interest, late fees, fast track fees and other income. The income mostly covers the $63,905,000 expenses. These costs comprise of a number of functions. Table 7.1 prescribes the costs of the Nursing and Midwifery Board during the 2015/2016 period.

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108 Medical Board of Australia, above n 99.
110 Ibid 73-4.
111 Nursing and Midwifery Board of Australia, 'Health Profession Agreement: Nursing and Midwifery Board of Australia and The Australian Health Practitioner Regulation Agency 2015/16' (5 November 2015) 31-3.
### Table 7.2 Costs incurred by the Nursing and Midwifery Board

<table>
<thead>
<tr>
<th>Costs</th>
<th>Particulars</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Board and committee costs</strong></td>
<td>Sitting fees, travel and accommodation for Board members to attend meetings.</td>
</tr>
<tr>
<td><strong>Legal and tribunal costs, including expert advice</strong></td>
<td>Assessing and managing notifications received about registrants.</td>
</tr>
<tr>
<td><strong>Accreditation expenses</strong></td>
<td>Costs of the Australian Nursing and Midwifery Accreditation Council funding for accreditation functions.</td>
</tr>
<tr>
<td><strong>Direct expenditure</strong></td>
<td>Board’s work on registration standards including community and professional consultation as well as publications.</td>
</tr>
<tr>
<td><strong>Indirect expenditure</strong></td>
<td>Includes costs associated with the Office of the Health Ombudsman (Queensland).</td>
</tr>
</tbody>
</table>

The National Boards mostly fund their own activities from registration fees although there is an overall deficit where the income derived from fees does not quite cover expenses. The income and expenditure for the Nursing and Midwifery Boards are particularly high given the significant number of nurses and midwives registered in Australia. Perhaps a more comparable discipline, in terms of income and expenses, is the Occupational Therapy Board of Australia. The projected income for the 2015/2016 financial year was $2,719,500, with expenses totalling $3,459,600.114

A Paramedical Board of Australia, once created, would also be able to pay its expenses through the registration fee income received. However, there would be initial establishment costs which would need to be funded in advance of the registration fees received. This would need to be government funded. Once the National Board is established, any deficit would also be the government’s responsibility in the same way it funds the deficits for the other health practitioner National Boards.

In summary, the paramedic discipline satisfies all of the criteria for inclusion as an additional health professional group in the National Scheme. As such, I will now consider some of the more practical considerations to implementing National Scheme regulation for Australia’s paramedics.

#### 7.5 Regulatory requirements to enable National Scheme inclusion for paramedics

One of the key arguments made in this thesis is that paramedicine can be included in the National Scheme. In order to make this argument, part 7.4 will briefly outline some of the legislative and policy changes needed for paramedicine to transition to a registered health profession under the National Law. This part is not intended to be a comprehensive framework for legislative change as the responsibility

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113 Ibid.
for legislative change lies with the state and territory parliaments. However, I will propose some areas for reform of the current legislative structure to allow for paramedic inclusion.

The Health Workforce Principal Committee identified some regulatory requirements for paramedics to be included in the National Scheme. These include:

1. Amendment to the *National Law*;
2. Establishment of a National Board for Paramedicine;
3. Amendments to state and territory legislation; and
4. Endorsement of a national course accreditation process.\(^{115}\)

The HWPC did not further explore the implications of the abovementioned regulatory requirements. In the remainder of this chapter, I will explore the proposed changes, along with some other recommendations for incorporating paramedics into National Scheme regulation.

**7.5.1 The changes needed to amend the National Law to include paramedics**

The National Scheme was first implemented using an ‘adoption of laws’ model whereby Queensland hosts the substantive legislation giving effect to the Scheme. Once Queensland enacted the *National Law*, the other states and territories adopted the *National Law* in a uniform piece of legislation. The *National Law* was amended in 2012 to allow for four additional health professions to the National Scheme, so adding paramedics in a subsequent amendment would not be a new process.\(^{116}\) Amendments made to the Queensland version of the *National Law* are automatically adopted in the other states and territories of Australia.\(^{117}\) So, if the *National Law* is amended to include paramedicine as a health profession, it applies automatically to all states and territories except for Western Australia. Western Australia’s Parliamentary Legislative Committee requires amendments to be passed through them rather than the automatic adoption of laws which occurs in the other Australian states and territories.\(^{118}\)

If paramedics are included in the *National Law*, Western Australia’s parliament would then also need to adopt the proposed *National Law* changes through a legislative amendment.

In order to include paramedicine as an additional health profession in the *National Law*, a number of changes would be required. Table 7.2 outlines some examples of changes which would be needed to the *National Law* for paramedic inclusion as a health profession.

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\(^{115}\) Australian Health Ministers’ Advisory Council, *Options for Regulation of Paramedics*, above n 39, 73.

\(^{116}\) Aboriginal and Torres Strait Islander health practitioners, Chinese medicine practitioners, medical radiation practitioners and occupational therapists.


\(^{118}\) Ibid 8.
Section 5 Definitions (definition of ‘health profession’)

*health profession* means the following professions, and includes a recognised specialty in any of the following professions—
(a) Aboriginal and Torres Strait Islander health practice;
(b) Chinese medicine;
(c) chiropractic;
(d) dental (including the profession of a dentist, dental therapist, dental hygienist, dental prosthetist and oral health therapist);
(e) medical;
(f) medical radiation practice;
(g) nursing and midwifery;
(h) occupational therapy;
(i) optometry;
(j) osteopathy;
(k) pharmacy;
(l) physiotherapy;
(m) podiatry;
(n) psychology.

Insert –

(provision)

Section 31 (1) Establishment of National Boards

Each of the following National Health Practitioner Boards is established for the health profession listed beside that Board in the following Table—

<table>
<thead>
<tr>
<th>Name of Board</th>
<th>Health profession</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal and Torres Strait Islander Health Practice Board of Australia</td>
<td>Aboriginal and Torres Strait Islander health practice</td>
</tr>
<tr>
<td>Chinese Medicine Board of Australia</td>
<td>Chinese medicine</td>
</tr>
<tr>
<td>Chiropractic Board of Australia</td>
<td>chiropractic</td>
</tr>
<tr>
<td>Dental Board of Australia</td>
<td>dental (including the profession of a dentist, dental therapist, dental hygienist, dental prosthetist or oral health therapist)</td>
</tr>
<tr>
<td>Medical Board of Australia</td>
<td>medical</td>
</tr>
<tr>
<td>Medical Radiation Practice Board of Australia</td>
<td>medical radiation practice</td>
</tr>
<tr>
<td>Nursing and Midwifery Board of Australia</td>
<td>nursing and midwifery</td>
</tr>
<tr>
<td>Occupational Therapy Board of Australia</td>
<td>occupational therapy</td>
</tr>
<tr>
<td>Optometry Board of Australia</td>
<td>optometry</td>
</tr>
<tr>
<td>Osteopathy Board of Australia</td>
<td>osteopathy</td>
</tr>
<tr>
<td>Pharmacy Board of Australia</td>
<td>pharmacy</td>
</tr>
<tr>
<td>Physiotherapy Board of Australia</td>
<td>physiotherapy</td>
</tr>
<tr>
<td>Podiatry Board of Australia</td>
<td>podiatry</td>
</tr>
<tr>
<td>Psychology Board of Australia</td>
<td>psychology</td>
</tr>
</tbody>
</table>

Insert –

Name of Board | Health Profession
---|---
Paramedical Board of Australia | Paramedicine
### Section 113
Restriction on use of protected titles

<table>
<thead>
<tr>
<th>Profession</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal and Torres Strait Islander Health Practice</td>
<td>Aboriginal and Torres Strait Islander health practitioner, Torres Strait Islander health practitioner</td>
</tr>
<tr>
<td>Chinese Medicine</td>
<td>Chinese medicine practitioner, Chinese herbal dispenser, Chinese herbal medicine practitioner, Oriental medicine practitioner, acupuncturist</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>chiropractor</td>
</tr>
<tr>
<td>Dental</td>
<td>dentist, dental therapist, dental hygienist, dental prosthodontist, oral health therapist</td>
</tr>
<tr>
<td>Medical</td>
<td>medical practitioner</td>
</tr>
</tbody>
</table>

### Section 222 (2)
National Registers

<table>
<thead>
<tr>
<th>Name of Board</th>
<th>Name of public national register</th>
<th>Divisions of public national register</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal and Torres Strait Islander Health Practice Board of Australia</td>
<td>Register of Aboriginal and Torres Strait Islander Health Practitioners</td>
<td>Dentists, Dental therapists, Dental hygienists, Dental prosthodontists, Oral health therapists</td>
</tr>
<tr>
<td>Chinese Medicine Board of Australia</td>
<td>Register of Chinese Medicine Practitioners</td>
<td>Acupuncturists, Chinese herbal medicine practitioners, Chinese herbal dispensers</td>
</tr>
<tr>
<td>Chiropractic Board of Australia</td>
<td>Register of Chiropractors</td>
<td></td>
</tr>
<tr>
<td>Dental Board of Australia</td>
<td>Register of Dental Practitioners</td>
<td>Dentists, Dental therapists, Dental hygienists, Dental prosthodontists, Oral health therapists</td>
</tr>
<tr>
<td>Medical Board of Australia</td>
<td>Register of Medical Practitioners</td>
<td></td>
</tr>
<tr>
<td>Medical Radiation Practice Board of Australia</td>
<td>Register of Medical Practitioners</td>
<td>Diagnostic radiographers, Nuclear medicine technologists, Radiation therapists</td>
</tr>
<tr>
<td>Nursing and Midwifery Board of Australia</td>
<td>Register of Nurses</td>
<td>Registered nurses (Division 1), Enrolled nurses (Division 2)</td>
</tr>
<tr>
<td></td>
<td>Register of Midwives</td>
<td></td>
</tr>
</tbody>
</table>
Part 12 of the National Law outlines transitional provisions which enabled the new health professions to join the National Law from 1 July 2012 (Aboriginal and Torres Strait Islander health practice, Chinese medicine, medical radiation practice and occupational therapy).

Legislators would need to include transitional provisions for paramedics to be regulated within the National Scheme. If a ‘grandparenting’ clause is needed, as discussed in part 7.7 of this thesis, it may appear in this part of the legislation.

Table 7.3 Changes needed to the National Law for paramedic inclusion as a health profession

| Part 12 Transitional Provisions | Legislators would need to include transitional provisions for paramedics to be regulated within the National Scheme. If a ‘grandparenting’ clause is needed, as discussed in part 7.7 of this thesis, it may appear in this part of the legislation. |

7.5.2 Establishing a Paramedical Board of Australia

In order to include paramedics under the National Scheme, a national paramedic board is required. One of purposes of the National Law is to establish National Boards which regulate and monitor the registered health professionals within the Australian Health Practitioner Regulatory Agency guidelines. The Boards are policy makers for particular professions setting guidelines to complement the National Law. They are also decision-makers in relation to the performance of individual practitioners.

Each registered health practitioner has a National Board, and the National Law allows for the establishment of state and territory boards. For example, the Medical Board of Australia governs medical practitioner regulation and is supported by state and territory boards. The Nursing and Midwifery Board of Australia was established for registered nurses and midwives and has state and territory boards for every jurisdiction.

119 National Law s 31.
120 See National Law ss 35(1)(a) and 38(1) for the National Boards’ statutory functions.
121 These Boards include the Aboriginal and Torres Strait Islander Health Practice Board of Australia, Chinese Medicine Board of Australia, Chiropractic Board of Australia, Dental Board of Australia, Medical Board of Australia, Medical Radiation Practice Board of Australia, Nursing and Midwifery Board of Australia, Occupational Therapy Board of Australia, Optometry Board of Australia, Osteopathy Board of Australia, Pharmacy Board of Australia, Physiotherapy Board of Australia, Podiatry Board of Australia, Psychology Board of Australia: National Law s 31.
122 National Law s 36. The state and territory boards provide a local response to matters relevant to the National Boards.
There are two key options available for the creation of a National Board for paramedics. A new board could be established to regulate the single profession of paramedics. Or alternatively, paramedics could join an existing board.

1. **A new board:** the ‘Paramedical Board of Australia’, or the ‘Paramedic Board of Australia’ could be formed which operates independently of the other health professions. This would fulfil the profession’s requirements of a National Board under the *National Law* and become the 15th National Board under the *National Law*. State and territory paramedic boards would also require creation to deal with jurisdictional matters.

2. **Join an existing board:** Alternatively, paramedics could join the Nursing and Midwifery Board of Australia to create the *Nursing, Midwifery and Paramedical Board of Australia*. Nurses and midwives already have differing educational requirements to each other leading to different registration standards. Further, within nursing, there are registered nurses and enrolled nurses: two types of registration arising from different training, qualifications and scopes of practice. Concurrent registration is available for registrants to practise as both enrolled and registered nurses. Registered nurses can also register concurrently as midwives under the National Scheme allowing them to practise as a registered nurse and a midwife. There would then be scope for paramedics possessing nursing qualifications to apply for concurrent registration as a registered paramedic and a registered nurse. Given some tertiary institutions offer a Bachelor of Nursing/Bachelor of Paramedic Science qualification, these disciplines are complementary so could be regulated together.

There are some advantages to merging numerous professions into a single existing board such as Nursing and Midwifery. Paramedics joining an existing National Board may reduce government establishment costs as the registration standards have already been drafted. Paramedicine and nursing are often taught in the same schools at university so are comparable disciplines. While the existing Nursing and Midwifery Board may need some funding to assist in the development of standards to support an additional profession’s inclusion, the overall cost of establishment may be less than the creation of a new National Board solely for paramedics.

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125 Ibid.
There are disadvantages to paramedicine being absorbed into the existing Nursing and Midwifery Board. Merging paramedicine with nursing and midwifery may not be the most preferable option despite being economically advantageous. The underpinning philosophical model of practice differs between nursing and paramedicine. To address the philosophical model on a very basic level, nurses and midwives use a nursing process which considers problems specific to nursing and their clients/patients. Nursing is adapted to suit those clients’ needs, which may reach an individual, family or community level. As such, nursing deals holistically with a problem which goes beyond addressing medical needs and can incorporate social, cultural, spiritual and environmental data.\textsuperscript{127} The paramedic philosophical model of practice differs markedly to nursing. While some parts of the extended scope of practice for rural and remote area paramedics may reflect the nursing model of healthcare, paramedics generally utilise a medical model of healthcare which is more closely aligned with medicine.\textsuperscript{128} The bio-medical model of healthcare, also defined here at a very basic level, centres on diagnosing and treating abnormalities within the body and considers the view that health is a ‘reflection of science’s understanding of the body’.\textsuperscript{129} Following this line of reasoning, it may be no more appropriate to align paramedics with nurses than to align them with another health professional group, such as podiatry, which would be an unsuitable comparison.

Establishing a National Board distinct to the other disciplines raises other considerations. If a separate \textit{Paramedical Board of Australia} is created, registration standards would need to allow for health professionals to be registered under two Boards if those health professionals are seeking co-registration (such as registration under the Paramedical Board of Australia as well as the Nursing and Midwifery Board). It is likely concurrent paramedic and nursing registration may be sought given the propensity for tertiary training of those two disciplines to occur together. There would also be challenges with continuing professional development. The registration standards would need to reflect whether continuing professional development hours completed towards registration under one board would be recognised under another. Given paramedicine and nursing are comparable disciplines, and share similar skills and knowledge, continuing professional development hours could be shared between them as nursing and midwifery disciplines share professional development hours.\textsuperscript{130}

\textsuperscript{130} Nursing and Midwifery Board of Australia, ‘Continuing professional development registration standard’ (1 July 2010) <http://www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx> 1.
7.5.3 Amendments to state and territory legislation

The inclusion of paramedicine inclusion under the *National Law* would also require changes to state and territory legislation. In particular, amendments to the state and territory ambulance legislation would be necessary. As discussed in Chapter 2, ambulance legislation\(^{131}\) regulates the public ambulance services as entities with very few legislative provisions applicable to individual paramedic regulation. As such, only limited changes will be needed in some jurisdictions. However, in amending the public ambulance service legislation, legislators should remember that these statutes govern other ambulance service employees, in addition to paramedics, so some changes would need to apply to paramedics only and not other employees, such as patient transport officers. Table 7.4 provides examples of the amendments needed to state and territory legislation to accommodate paramedic inclusion under the *National Law*.\(^{132}\)

Amendments to reclassify the title of paramedic would also be needed. Currently, some jurisdictions refer to ‘ambulance officers’ within their statutory instruments. Amendments would be needed to change these terms to ‘paramedic’ or ‘registered paramedic’ instead, to comply with the *National Law*, to avoid confusion and to reflect the discipline’s new status in the community as a registered health practitioner.

Some provisions of state and territory legislation also require repeal. Provisions specifically relating to the regulation of individual paramedics will no longer be necessary as the National Scheme will regulate paramedics. Table 7.4 provides further suggestions for legislative repeal. Repealing the state and territory ambulance legislation as a whole, though, would not be warranted. State and territory legislation which regulated the other health professions, prior to the National Scheme, was repealed once the *National Law* took effect, as it was no longer needed.\(^{133}\)

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\(^{131}\) *Ambulance Service Act 1991* (Qld); *Health Services Act 1997* (NSW); *Ambulance Services Act 1986* (Vic); *Emergencies Act 2004* (ACT); *Ambulance Service Act 1982* (Tas); *Health Care Act 2008* (SA). The Northern Territory and Western Australia contract their public emergency service to St John Ambulance.

\(^{132}\) There are also additional amendments which would be needed to state and territory regulations, for example, *Health (Drugs and Poisons) Regulation 1996* (Qld) ss 66, 174; *Poisons and Therapeutic Goods Regulation 2008* (NSW) reg 101(1)(g); *Medicines, Poisons and Therapeutic Goods Regulation 2008* (ACT) s 350, sch 1. Given regulations do not require the same legislative procedures for amendment, they have not been further considered in Table 7.3.

\(^{133}\) For Queensland examples, see *Health Practitioners (Professional Standards) Act 1999* (Qld); *Health Practitioner Registration Boards (Administration) Act 1999* (Qld); *Chiropractors Registration Act 2001* (Qld); *Dental Practitioners Registration Act 2001* (Qld); *Dental Technicians and Dental Prosthetists Registration Act 2001* (Qld); *Medical Practitioners Registration Act 2001* (Qld); *Medical Radiation Technologists Registration Act 2001* (Qld); *Nursing Act 1992* (Qld); *Occupational Therapists Registration Act 2001* (Qld); *Optometrists Registration Act 2001* (Qld); *Osteopaths Registration Act 2001* (Qld); *Pharmacists Registration Act 2001* (Qld); *Physiotherapists Registration Act 2001* (Qld); *Podiatrists Registration Act 2001* (Qld); *Psychologists Registration Act 2001* (Qld); *Speech Pathologists Registration Act 2001* (Qld). For a list of repealed health practitioner legislation in other states and territories of Australia, see Australian Health Ministers’ Advisory Council, ‘Regulatory Impact Statement for the Decision to Implement the Health Practitioner Regulation National Law’ (3 September 2009) 90-6.
<table>
<thead>
<tr>
<th>Legislation</th>
<th>Section</th>
<th>Current provision</th>
<th>Discussion of amendments needed</th>
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</table>
| Ambulance Service Act 1991 (Qld) | Section 13 Employees | (1) The chief executive may appoint and employ on salary or wages or engage and employ under contracts such persons—  
(a) as ambulance officers; and  
(b) as medical officers; and  
(c) as other staff members; as are necessary for the effectual administration of this Act. | Omit ‘ambulance officers’, insert ‘paramedics’                                                            |
| Section 18A Grounds for discipline | This section comprehensively prescribes grounds for discipline of paramedics.                                                                                                                                                                                                 | An amendment to the provision would need to reflect paramedic inclusion in the National Law such as requiring disciplinary action for contravention of the National Law. |
| Section 18B Disciplinary action that may be taken against a service officer generally | (1) In disciplining a service officer, the chief executive may take the action, or order the action be taken, (disciplinary action) that the chief executive considers reasonable in the circumstances. | A provision should be inserted which affirms the National Law’s mandatory employer notifications to the Paramedical Board of Australia as part of the disciplinary action available. |
| Ambulance Service Act 1982 (Tas) | Section 39A Representation of person as paramedic | (1) A person, other than a paramedic, must not present himself or herself in such a manner as to imply, or lead to the belief, that the person is a paramedic capable of providing ambulance services… | Repeal – protection of title is prescribed in section 113 of the National Law so paramedic inclusion within the National Scheme would negate the need for this provision to be included in the Tasmanian legislation. |
| Health Practitioner Regulation National Law (South Australia) Act 2010 (SA) | Schedule 2, section 120A Use of title “paramedic” | (1) Subject to this section, a person must not knowingly or recklessly—  
(a) take or use the title of "paramedic", whether with or without any other words; or  
(b) take or use a title, name, word or description that, having regard to the circumstances in which it is taken or used, indicates or could be reasonably understood to indicate the person is a paramedic, unless the person holds qualifications prescribed by regulations made by the Governor under the Act for the purposes of this section.  
(2) For the purposes of subsection (1)(b), a paramedic is a health professional who provides emergency medical assessment, treatment and care in the pre-hospital, or out-of-hospital, environment.  
(3) Subsection (1) applies to a person | Repeal – protection of title is prescribed in section 113 of the National Law so paramedic inclusion within the National Scheme would negate the need for this provision to be included in the South Australian legislation. |
| **Health Services Act 1997 (NSW)** | Section 67J Obstruction of and violence against ambulance officers | (1) A person must not intentionally obstruct or hinder an ambulance officer when the ambulance officer is providing or attempting to provide ambulance services to another person or persons.  
(2) A person must not, by an act of violence against an ambulance officer, intentionally obstruct or hinder the ambulance officer when the ambulance officer is providing or attempting to provide ambulance services to another person or persons…  
(4) In this section: "ambulance officer" means a member of staff of the Ambulance Service of NSW…. | Omit ‘ambulance officer’, insert ‘paramedic’  
However, legislators may need to clarify that for the purposes of this provision, ‘paramedic’ relates to a member of staff of the Ambulance Service of NSW. It may not be appropriate for this provision to extend to privately practising NSW paramedics. |
| **Medicines, Poisons and Therapeutic Goods Act (NT)** | Section 28A Meaning of approved ambulance officer | An approved ambulance officer is an ambulance officer declared under section 250(1)(c) to be an approved ambulance officer. | Omit ‘ambulance officers’, insert ‘paramedics’ |
| **Mental Health Act 2000 (Qld)** | Section 25 Taking person to authorised mental health service | (2) For subsection (1), the health practitioner or ambulance officer—…  
(3) If asked by a health practitioner or ambulance officer, … | Omit ‘ambulance officer’, insert ‘paramedic’ |
<table>
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<tr>
<th><strong>Mental Health Act 2007 (NSW)</strong></th>
<th><strong>Mental Health Act 2009 (SA)</strong></th>
<th><strong>Mental Health and</strong></th>
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<tr>
<td>Section 33 Application of sdiv 1</td>
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<td>Section 4 Definitions</td>
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<tr>
<td>This subdivision applies if a police officer or an ambulance officer reasonably believes—…</td>
<td> </td>
<td>&quot;ambulance officer&quot; means a person: (a) employed as an ambulance officer,</td>
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<tr>
<td><strong>Section 34 Taking person to authorised mental health service</strong></td>
<td> </td>
<td>This section may require amendment to reflect</td>
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<tr>
<td>The police officer or ambulance officer must take the person to an authorised mental health service for examination to decide whether assessment documents for the person should be made.</td>
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<tr>
<td><strong>Mental Health Act 2007 (NSW)</strong></td>
<td><strong>Mental Health Act 2009 (SA)</strong></td>
<td><strong>Mental Health and</strong></td>
</tr>
<tr>
<td><strong>Section 4 Definitions</strong></td>
<td><strong>Section 3 Interpretation (definition of ‘ambulance officer’)</strong></td>
<td><strong>Section 4 Definitions</strong></td>
</tr>
<tr>
<td>&quot;ambulance officer&quot; means a member of staff of the NSW Health Service who is authorised by the Secretary to exercise functions of an ambulance officer under this Act.</td>
<td>&quot;ambulance officer&quot; means a person who is— (a) employed as an ambulance officer, or engaged as a volunteer ambulance officer, with an organisation that provides ambulance services; and (b) authorised by the chief executive officer of SA Ambulance Service Inc to exercise the powers conferred by this Act on authorised officers;</td>
<td>&quot;ambulance officer&quot; means a person: (a) employed as an ambulance officer,</td>
</tr>
<tr>
<td><strong>Section 18 When a person may be detained in mental health facility</strong></td>
<td><strong>Section 3 Interpretation (definition of ‘authorised officer’)</strong></td>
<td><strong>This section may require amendment to reflect</strong></td>
</tr>
<tr>
<td>(1) A person may be detained in a declared mental health facility in the following circumstances:…’ (b) after being brought to the facility by an ambulance officer (see section 20),…”</td>
<td>&quot;authorised officer&quot; means— … (b) an ambulance officer; or</td>
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<td><strong>Section 20 Detention on information of ambulance officer</strong></td>
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<td>(1) An ambulance officer who provides ambulance services in relation to a person may take the person to a declared mental health facility if the officer believes on reasonable grounds that the person appears to be mentally ill or mentally disturbed and that it would be beneficial to the person’s welfare to be dealt with in accordance with this Act. (2) An ambulance officer may request police assistance if of the opinion that there are serious concerns relating to the safety of the person or other persons if the person is taken to a mental health facility without the assistance of a police officer.</td>
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134 Mental Health Act 2007 (NSW) s 3.
<table>
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<tr>
<th><strong>Related Services Act (NT)</strong></th>
<th><strong>(definition of ‘ambulance officer’)</strong></th>
<th>or engaged as a volunteer ambulance officer, by an approved ambulance service at the level of qualified ambulance officer or above; or (b) appointed under section 24.</th>
<th>paramedic inclusion in the National Scheme and the new regulatory position which removes individual jurisdictions and employers from specifying qualifications and experience for paramedics.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Section 24 Ambulance officers</strong></td>
<td><strong>The Chief Health Officer may appoint a person who has qualification and experience that the Chief Health Officer considers appropriate to be an ambulance officer.</strong></td>
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</tbody>
</table>
| **Section 31 Detention by ambulance officer** | **(1) An ambulance officer may detain a person being conveyed in an ambulance for up to 6 hours where the ambulance officer believes, on reasonable grounds, that the person may fulfil the criteria for involuntary admission on the grounds of mental illness or mental disturbance.** (2) When detaining a person under subsection (1), an ambulance officer may use reasonable measures, including the use of restraints, on the person:… (3) An ambulance officer who detains a person under subsection (1):…** | **Omit ‘ambulance officer’, insert ‘paramedic’** | **Table 7.4 Examples of amendments to state and territory legislation**

135 This table should not be considered an exhaustive list of all legislation requiring amendment for paramedic inclusion in the National Law. It should be used to provide a range of examples highlighting where legislative amendment might be warranted.
7.5.4 Endorsement of a national course accreditation process

The *National Law* legislates for the development of accreditation\(^{136}\) standards for health professionals. An external accreditation entity or an accreditation committee established by the National Board may develop an accreditation standard. An accreditation authority must undertake a consultation process for the standard.\(^{137}\) The National Board is responsible for approving the health profession’s accreditation standard.\(^{138}\) Programs of study can also be accredited if they meet the standards.\(^{139}\) It is significant that the accreditation body is independent of government.\(^{140}\) Chapter 4 identified the conflicts of interest which arise when employers are involved in accreditation functions.

Each health profession has an independent accreditor. For example, the Australian Nursing and Midwifery Accreditation Council accredits ‘education providers and programs of study for the nursing and midwifery profession’.\(^{141}\) The Australian Medical Council is responsible for accrediting medical schools and specialist medical colleges.\(^{142}\) The purpose of the Australian Medical Council is to ‘ensure standards of education, training and assessment of the medical profession promote and protect the health of the Australian community’.\(^{143}\) They are an external accreditation entity which develops accreditation standards for tertiary educational institutions, assesses international tertiary qualifications, assesses the knowledge and skills of internationally practising doctors seeking registration in Australia and assesses the applications for recognition of medical specialties. The Australian Nursing and Midwifery Accreditation Council performs the same functions as the Australian Medical Council.\(^{144}\) It is interesting to note, the Australian Medical Council and the Australian Nursing and Midwifery Accreditation Council existed prior to the *National Law*’s implementation as medical practitioners and nurses were already partially regulated in some capacity prior to national registration.

There is no external accreditation body which governs the accreditation of paramedic education. Chapter 4 established accreditation processes within paramedicine. Despite Australian paramedicine already having a form of accreditation through the Australian and New Zealand Paramedic Professional Competency Standards, the National Scheme would require minimum accreditation standards of qualifications and skill for Australian paramedics seeking registration. It would also require an external

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\(^{136}\) For discussion of accreditation, as a regulatory tool, see Chapter 4 and Arie Freiberg, *The Tools of Regulation* (The Federation Press, 2010) 153.

\(^{137}\) *National Law* s 46.

\(^{138}\) Ibid s 47.

\(^{139}\) Ibid s 48.


accreditation body to avoid conflicts of interest as the Council of Ambulance Authorities, representing the primary paramedic employers, does not provide the independence needed for an external accreditor. As such, a regulatory standards body is also warranted for accreditation of paramedics under the National Scheme.

In order to provide independent accreditation and continuing professional development standards, a similar body to the existing health professional accreditation bodies would need to be created for paramedics. It is proposed this would be the Australian Paramedical Council. In addition to accrediting tertiary qualifications, the Australian Paramedical Council would assess bridging courses to allow vocationally trained paramedics to upskill to a tertiary level for registration.

7.6 Paramedics to adopt professional indemnity insurance

Insurance is an important consideration for all healthcare workers. Vicarious liability generally exempts employees from liability for negligent conduct committed during their employment negating the need for professional indemnity insurance.\textsuperscript{145} However, vicarious liability does not apply to employees acting outside the scope of their employment.\textsuperscript{146} Professional indemnity insurance adds an additional safeguard for healthcare professionals. If a health practitioner has insurance, they may not be personally liable to pay compensation to a patient if a civil liability action was commenced against them. However, without insurance, there is a risk that legal costs and any damages payable against the health practitioner will need to be personally met by the health practitioner. Alternatively, another risk is that a person who is injured as a result of a health practitioner’s negligence does not receive any compensation when the practitioner is unable to pay. A registered health practitioner is required to have appropriate professional indemnity insurance for the practice of their discipline.\textsuperscript{147} For annual registration to be renewed, applicants must declare they will not practise without professional indemnity insurance, nor had they practised without insurance in the preceding year.\textsuperscript{148} Health practitioners must also provide written notice to the National Board, within 7 days, if their professional indemnity insurance no longer provides coverage and failure to provide notice can result in disciplinary action against the health practitioner.\textsuperscript{149}

Medical practitioners, for example, must comply with the Medical Board of Australia’s registration standards for professional indemnity insurance.\textsuperscript{150} The registration standards require medical practitioners to be insured for each context of their practice; further details of these contexts are as

\textsuperscript{145} Stevens v Brodribb Sawmilling Company Pty Ltd (1986) 160 CLR 16.
\textsuperscript{146} New South Wales v Lepore; Samin v Queensland; Rich v Queensland (2003) 212 CLR 511.
\textsuperscript{147} National Law s 129.
\textsuperscript{148} Ibid s 109 (1)(a)(iv)-(v).
\textsuperscript{149} Ibid s 130.
\textsuperscript{150} An exhaustive list of approved insurers, for medical practitioners, meeting minimum product standards under the Medical Indemnity (Prudential Supervision and Product Standards) Act 2003 (Cth) are Avant, Medical Indemnity Protection Society Limited, Medical Insurance Group, MDA National and Guild Insurance Limited (for oral and maxillofacial surgeons only).
follows. Private practice requires professional indemnity insurance with run-off cover;\textsuperscript{151} a master policy or legislation can cover employment in the public sector, or by contractual arrangements; any nongovernmental employer, with appropriate insurance, can cover a medical practitioner without the need for professional indemnity insurance; medical practitioners can be exempted from liability under legislation; or, a practitioner working in an international jurisdiction does not need Australian professional indemnity insurance.\textsuperscript{152}

Nursing and midwifery have their own registration standard for professional indemnity insurance arrangements. Nurses and midwives, whether employed in a public or private capacity, must ensure they have professional indemnity insurance. Self-employed nurses and midwives are also required to have run-off cover.\textsuperscript{153}

If paramedics become registered under the \textit{National Law}, they may also require professional indemnity insurance to comply with the legislation. Compliance with their National Board’s registration standards, relating to insurance, would be required. The registration standards here would be dependent upon the nature of the National Board. If paramedics were adopted into a \textit{Nursing, Midwifery and Paramedical Board of Australia}, their professional indemnity insurance requirements would apply to paramedics. If a \textit{Paramedical Board of Australia} was created, it is recommended the insurance requirements be similar to the prescribed nursing and midwifery obligations given their skills, training and knowledge is similar. Paramedics may require professional indemnity insurance and privately employed paramedics might also need run-off cover. Ultimately, insurance is a decision for the National Board.\textsuperscript{154}

\textbf{7.7 A \textquoteleft grandparenting\textquoteright requirement for registered paramedics}

In addition to the requirements of COAG, it is recommended that tertiary education be the national minimum requirement for paramedic practice. Chapter 4 identified the justification for tertiary qualified paramedics including increased professionalism, professional skills and promoting minimum standards in the industry.\textsuperscript{155} While tertiary education is almost the minimum Australian standard for paramedics, New South Wales still operates on a vocational model, with new paramedics undertaking on-road

\textsuperscript{151} Run-off cover is insurance protecting against claims arising from previous practice which is no longer occurring.
\textsuperscript{152} Medical Board of Australia, \textquoteleft Professional indemnity insurance arrangements registration standard\textquoteright (1 July 2010) <http://www.medicalboard.gov.au/Registration-Standards.aspx>.
\textsuperscript{153} Nursing and Midwifery Board of Australia, \textquoteleft Professional indemnity insurance arrangements registration standard\textquoteright (10 January 2012) <http://www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx>.
\textsuperscript{154} Commonwealth of Australia, above n 2, 19.
\textsuperscript{155} Bill Lord, \textquoteleft The development of a degree qualification for paramedics at Charles Sturt University' (2003) 1(1) \textit{Journal of Emergency Primary Health Care} 1, 1; Australian Learning and Teaching Council, \textquoteleft Paramedic education: developing depth through networks and evidence-based research\textquoteright (Australian Government Department of Education, Employment and Workplace Relations, 2009) 9, 101, 105.
training with vocational study. Given the professionalism of the discipline, and the need for paramedics to be acknowledged as health professionals, requiring tertiary qualifications, as a minimum industry standard, can provide uniform requirements for all new graduates.

Further, as previously discussed in other chapters of this thesis, some practising paramedics have vocational qualifications only, having qualified prior to the requirement for tertiary education. As such, any subsequent requirement for tertiary qualifications upon inclusion in the National Scheme could be unfair to the vocationally trained paramedics as they have not needed additional qualifications to practise in the past. A ‘grandfather clause’ is one which exempts people from statutory provisions for conduct which they were engaging in at the time the legislation was passed. As some paramedics are practising paramedicine without tertiary qualifications, a grandfathering clause should be included in the National Law’s amendments to ensure competent paramedics can continue to work, even though they do not meet the minimum educational requirements.

A grandfathering clause could work in two ways. Firstly, a grandfathering clause could exempt vocationally trained paramedics from ever needing to undertake tertiary educational qualifications. Or, alternatively, it could require vocationally qualified paramedics to upskill to tertiary education, within a specified period, via a bridging course.

If New South Wales paramedics are undertaking industry vocational training, at the time of paramedicine’s inclusion in the National Scheme, the grandfathering clause should apply to them too. However, no additional vocational courses should be offered after the amending National Scheme applies if New South Wales seeks inclusion.

7.8 Conclusion

This thesis has established that the current framework for paramedical regulation is not sufficient to protect the public. Specifically, Chapters 2 and 4 outlined the disparate, jurisdictional regulation; Chapter 3 argued that paramedicine has evolved beyond employer regulation; and, Chapters 5 and 6 established the risk paramedics pose to the public which is not adequately addressed in current paramedicine regulation. As such, the National Scheme is proposed as a workable alternative. Indeed, the National Scheme is better equipped to respond well to the rapidly evolving profession of paramedicine. The National Scheme is already operational, and regulates other health professions, such as nurses and medical practitioners. Paramedic regulation under the National Scheme would bring paramedics in line with other registered health practitioners around Australia. As shown in 7.4 of this

156 Jillian Skinner, Submission No 13 to Senate Standing Committee on Legal and Constitutional Affairs, The establishment of a national registration system for Australian paramedics to improve and ensure patient and community safety, January 2016.
chapter, the paramedic discipline currently fulfils the COAG’s guiding principles, qualifying them for inclusion as an additional health profession within the National Law, as:

1. it is appropriate for the Health Ministers to be responsible for regulating the discipline;
2. paramedicine poses a significant risk of harm to the health and safety of the public;
3. existing regulatory mechanisms fail to address the health and safety issues;
4. regulation can be implemented for paramedicine;
5. it is practical to regulate paramedicine; and
6. the public benefits of regulation outweigh the potential negative impact of regulation.

Including paramedicine under the National Scheme would be relatively straightforward and would require only minor legislative changes only. The key to successfully including paramedics in the National Scheme is creation of a national board, national register and title protection. Changes needed to Queensland’s National Law would then be automatically adopted throughout Australia. Western Australia would also need to amend their legislation. Further, amendments to existing state and territory legislation governing paramedic practice and ambulance services are also needed to reflect the changed regulatory structure from employer and jurisdictional governance to national health professional regulation including consistent classification of paramedics as such, and disciplinary procedures to reflect the National Scheme’s involvement in paramedic registration.

Finally, a number of other operational changes need to be actioned. A National Board needs to be created for paramedics. As we saw in this chapter, a Paramedical Board of Australia is one option, while paramedics being absorbed into the existing Nursing and Midwifery Board is another option. State and territory boards will also be required for dealing with the local issues as is standard for the other registered health professions. Upon commencement of national registration, the paramedic industry would also need to endorse a national course accreditation process and ensure members obtain professional indemnity insurance.

Incorporating paramedics into the National Scheme is the most logical and suitable solution to address the public safety problems and potential problems of the paramedic industry. While the National Law has its challenges, including paramedicine as a regulated health profession is more advantageous to the community than current paramedic regulation.

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158 Chapter 1 identified the challenges of regulation within the National Scheme and highlighted how despite those challenges, the National Scheme is still a more suitable regulatory framework than the regulation for current Australian paramedics.
CHAPTER 8: CONCLUSION

8.1 Introduction

This thesis made three key arguments. Firstly, the thesis argued that the current Australian paramedic regulatory framework is not adequate. Secondly, that the inclusion of paramedics in the National Scheme is best way to more suitably regulate them. Finally, the thesis concluded that the regulatory requirements for including paramedics in the National Scheme are not onerous and can be met. Indeed, the benefits of including paramedics in the National Scheme outweigh any costs or challenges. This conclusion chapter summarises the main arguments and propositions made throughout this thesis.

8.2 Current paramedic regulatory framework is inadequate to protect the public

In order to evaluate the suitability of paramedic regulation, this thesis provided a brief overview of regulatory theory. In particular, Chapter 2 discussed health practitioner regulation and (based on existing literature) identified two primary objectives for regulators to consider when regulating paramedics, including: first, that regulation should reduce and mitigate risk to the public; and second, that regulation of paramedics should promote integrity and trust in the paramedic profession.¹

This thesis argues that current paramedic regulation is not working. More specifically, throughout this thesis, particularly Chapters 2 to 4, I showed how two key factors justify the conclusion that the current state of regulation is not functioning adequately. Firstly, the current regulatory framework – which relies heavily on employment contracts – means that existing paramedic regulation does not meet the key objectives of regulation identified above: to reduce risk; and promote trust and integrity. With these objectives in mind, Chapter 2 established that Australian paramedic regulation does not meet these objectives given that employers predominantly self-regulate the industry. More specifically, workplace industrial instruments apply to paramedics as employees, and set employment standards, while workplace clinical policies detail standards of care, practice and skills which practising paramedics must possess within the employer organisations. I argued that current paramedic regulation, being largely employer-based, promotes organisational self-interest above public interest, which suggests existing paramedic regulation does not adequately protect the public. The legislative instruments applicable to Australian paramedic regulation, in the form of codes of practice and ethics, differ between jurisdictions and employers without national uniformity and provide very little guidance on the regulation of paramedics.

Second, paramedicine has evolved, as a profession, beyond needing the current model of employer regulation to requiring professional health practitioner regulation. This thesis identified two parts to the evolution: evolution of paramedic practice; and evolution in the nature of paramedic practice. Both industry changes exacerbate the issues within the current regulatory framework. More specifically, Chapter 3 outlined four broad phases of paramedicine evolution in Australia. Australia’s paramedicine discipline began as civilian and military stretcher-bearers, transporting patients often without any medical expertise. With the introduction of motor vehicles, stretcher-bearers then progressed to ambulance drivers, although ambulance drivers were primarily transport workers still without health qualifications or skills. Ambulance drivers then became ambulance officers who received post-employment, vocational, medical-type training whilst on road. The final evolutionary transition occurred when ambulance officers progressed to paramedics who undertook more comprehensive training and educational pathways prior to paramedic employment, usually in the form of tertiary education. The increased skills and knowledge required of Australia’s paramedics raise a number of important implications for their role as Australian healthcare providers.

The paramedic role has expanded, and continues to expand beyond the traditional treat-and-transport model which still epitomises society’s view of paramedicine. Some Australian paramedics perform an extended care role which is considered analogous with other registered health professions in terms of scope and duties to patients. Some paramedics, for example:

1. are involved in community education;
2. provide a primary and ongoing care relationship to patients in rural and remote communities including performing home visits for patient healthcare maintenance; and
3. work as practitioner substitutes for nurses and medical practitioners as required.

Legislators have bestowed statutory powers on paramedics which highlight the community’s trust in paramedicine and the evolving role they perform in society. Paramedics have a broad range of

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2 Evan Willis and Liam McCarthy, 'From First Aid to Paramedical: Ambulance Officers in the Health Division of Labour' (1986) X Community Health Studies 57, 58.
6 See, eg, Peter O'Meara et al, 'Extending the paramedic role in rural Australia: a story of flexibility and innovation' (2012) 12 Rural and Remote Health 1, 5.
legislative powers which abrogate common law rights of patients in particular circumstances. As I outlined in Chapter 3 of this thesis, for example, many paramedics are authorised to:

1. treat patients without consent in emergencies or when a patient’s mental illness might pose a danger to themselves or others;
2. restrain patients physically, mechanically or pharmacologically; and
3. enter places without a patient’s consent in circumstances which might otherwise be considered a trespass.

Another indicator of Australia’s paramedic progression beyond the need for employer-based regulation, is the growing private industry. Paramedics can now seek employment outside the public ambulance services. Conservative estimates of Australian private paramedic practitioners suggest there could be beyond 40 per cent of the paramedic workforce employed in a private capacity throughout Australia.9 I concluded, in Chapter 3, that the prevalence of private Australian paramedicine suggests there is a growing need for paramedic skills and expertise in the community, and that the employer governance model, applicable mostly to public ambulance service employees, no longer adequately covers the entire industry.

My final argument in support of paramedicine’s evolution is to suggest paramedicine has evolved beyond the acceptability of employer governance towards paramedic professionalism. In other words, paramedicine has evolved from an occupation to a profession. Paramedics were once considered a blue collar occupation but they have now progressed to a blue collar profession.10 Paramedicine fulfils the characteristics for professional classification, including: exhibiting a sense of service or altruism to the community; a theoretical and technical knowledge from specialised education; and, professional autonomy in their practice.11 Professionalism is significant to the paramedic regulatory debate because inclusion in the National Scheme as an additional health professional group will professionalise the discipline.12

Chapter 4 contributed further discussion to support the proposition that current paramedic regulation is inadequate. In particular, it highlighted a number of notable features of Australia’s paramedicine regulatory framework. The training and educational requirements of paramedics demonstrate the

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disparate regulatory structure, highlighting discrepancies among employers and jurisdictions. Paramedic title, an important regulatory tool, is only protected in a few Australian jurisdictions, meaning there are no limitations in the other jurisdictions for paramedics calling themselves as such without possessing the requisite skills and/or training.\textsuperscript{13}

Paramedics have also been granted exemptions from the state and territory legislative drug regulation, enabling them to possess and administer particular dangerous drugs to patients. However, existing drug regulation has number of issues, which I highlight in Chapter 4, including:

1. public and private paramedics are subject to differing drug regulations;
2. the drugs which paramedics can administer have the potential to cause significant risk to the community; and
3. the legislative drug regulations are not as stringent for paramedics as for other health practitioners, such as there being no requirement for drug administration record keeping in certain Australian jurisdictions.\textsuperscript{14}

My final argument supporting the inadequacy of current paramedicine regulation arose from the complaints and disciplinary systems within the paramedic industry. Currently, public complaints about paramedic conduct can be made to paramedic employers or the jurisdiction’s health complaints commission which exercises power to investigate all healthcare complaints. The difference between paramedics and other healthcare practitioners registered under the National Scheme is that the health complaints commissions’ findings get communicated to the practitioners’ National Board, whereas there is often no positive power for the commissions to communicate decisions to paramedic employers. As such, paramedics may not be appropriately disciplined for inappropriate conduct. Where misconduct investigations are communicated to the paramedic’s employer, each employer prescribes differing procedures for disciplinary action and the decisions are not publicised. As such, disciplinary decisions are potentially arbitrary in nature, and paramedics who do not reach minimum standards of conduct and practice could potentially exploit the gaps in communication which exist between employer bodies to obtain employment elsewhere.

In summary then, Australia’s current paramedic regulatory framework is not adequate to protect the public. More needs to be done to improve paramedic governance. Having established that the current regulatory scheme of employer-based, self-regulation of paramedicine is inadequate, the question becomes what can be done to address the issues plaguing regulation of the paramedic industry? The thesis has sought to show that the most appropriate option for reform is to include paramedicine as a profession registered under the National Scheme.

\textsuperscript{13} Health Services Act 1997 (NSW) s 67ZDA(1); Health Practitioner Regulation National Law (South Australia) Act 2010 (SA) s 120A (1); Ambulance Service Act 1982 (Tas) ss 39A, 39B(5).

\textsuperscript{14} See, eg, Controlled Substances Act 1984 (SA); Poisons Regulations 2008 (Tas).
8.3 Paramedicine should be a registered health profession under the National Law

As we saw in the introduction chapter of this thesis, there are four main options for regulating Australian paramedicine: maintain the status quo; strengthen statutory health complaints mechanisms; improve jurisdictional regulation; or introduce national paramedic registration. This thesis has advocated for a nationally consistent regulatory framework in the form of national registration (the fourth option proposed).

Since I began this thesis in 2014, there has been governmental movement towards including paramedics as an additional health profession under the National Scheme. While the Council of Australian Governments has not yet initiated changes to the National Law to add paramedics, paramedics are closer to national registration than ever before. Nevertheless, paramedics have not yet reached the point of obtaining national registration despite fulfilling the Council of Australian Government’s (COAG) criteria for inclusion as a health professional group eligible for National Law governance. In Chapter 7, I considered the COAG’s guidelines for the inclusion of additional health professional groups in the National Scheme. In summary:

1. It is most appropriate for paramedics to be registered within the governments’ health ministry rather than as an emergency service. Paramedics are now more aligned with healthcare than emergency services and share many functions with the healthcare industry. As such, health ministers should have the responsibility for paramedic regulation rather than paramedicine being absorbed into the emergency services portfolio.

2. Paramedicine poses a significant risk of harm to the public’s health and safety. Chapters 5 and 6 of this thesis firmly established the extent of the risk that paramedics pose to the community including: the use of intrusive and dangerous equipment, materials, processes and pharmaceuticals; and the possibility that failure to practise in accordance with industry standards could result in patient injury or death. Paramedics can be considered more of a risk

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19 See, eg, Inquest into the death of Ruby Yan Chen (Coroner’s Court of Rockhampton, Coroner O’Connell, 12 December 2014).
to the public than some of the other health professions currently registered under the *National Law*.  

3. National registration for paramedics is the most appropriate to address health and safety issues posed by the profession. As discussed above and in Chapters 2 to 6, current paramedic regulation is inadequate. It is not suitable for another registered professional discipline to supervise paramedics given the autonomous and pre-hospital nature of their work. It is also not suitable for paramedics to be self-regulated given the propensity for self-regulation to be an inadequate regulatory framework for health professions because of its potential to result in failures of practitioner accountability.

To expand further, I proposed national regulation for a number of reasons. Specifically, reduction of public risk and encouraging industry transparency have been significant justifications for paramedicine to move towards a national regulatory framework.

8.3.1 Reduction of risk to the public

One of the most significant arguments made in this thesis is that paramedics pose a significant risk to the public. I explored a number of elements to paramedic regulation to conclude that the most suitable way to manage the risk paramedics pose to the public is for paramedics to be included as an additional health profession within the ambit of the *National Law* as a precautionary approach to risk regulation.

In Chapter 5 of this thesis, I introduced the concept of risk within a healthcare context and I identified a number of indicators that current paramedic regulation does not advance the public interest.

One indicator of paramedic risk to the community is the evidence that paramedics are undertaking high risk behaviour. According to a Paramedics Australasia study in 2011, a significant number of paramedics have observed their peers contribute to patient harm or death in some way. These findings are just one example of the potential for harm which paramedics pose to the community. Another indicator of paramedic risk lies in the increasing numbers of employed paramedics throughout Australia. While it is challenging to specify an exact number of employed Australian paramedics, particularly given the paramedic title is not protected in most Australian jurisdictions, there are still approximately 11,000 – 14,000 practising paramedics in Australia. This exceeds the numbers of practising podiatrists and chiropractors, other health professional groups already registered under the

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National Scheme.\textsuperscript{23} As such, there is a significant community need for the services which paramedics provide. Given paramedics are attending approximately 3.70 million incidents nationally each year,\textsuperscript{24} paramedics have frequent interactions with the public which highlights further risk to the community.

The other area of risk paramedics pose to the public, and outlined in Chapter 6, relates to paramedic misconduct. My research data identified a number of significant challenges with the current regulatory model’s ability to address these issues within paramedicine. Firstly, there is no consistent definition of misconduct, with the result that employers rely on their own policies to determine whether paramedic behaviour amounts to misconduct.\textsuperscript{25} Secondly, there are significant discrepancies in reporting paramedic misconduct. As I mentioned above, mandatory reporting of misconduct does not currently exist for Australian paramedics. Some jurisdictions mandate reporting criminal conduct which occurs prior to commencing employment, but the reporting requirements are not consistent between jurisdictions or employers. I provided a number of examples, in Chapter 6, which demonstrated that paramedics have been convicted of criminal offences. However, the current regulatory framework, and the transparency issues already identified, do not allow me to determine whether paramedic criminal conduct has any impact on paramedic employment or practising conditions, or whether paramedics continued to practise in the community following their criminal indictments. Comparatively, National Scheme regulation requires disclosure of criminal conduct to the relevant National Board. Paramedic inclusion in the \textit{National Law} would require paramedic compliance with this provision.\textsuperscript{26}

The failure of current paramedic regulation to require mandatory reporting also has significant implications for fitness-to-practice issues and the risk paramedics pose to patients. In Chapter 6, I provided further examples of paramedic misbehaviour falling below a reasonable standard of conduct as support for my argument that paramedics present a serious risk to the community. There is some data that paramedics have caused significant risk to patients through alcohol and drug abuse; and, failure to provide appropriate care to patients in the form of ineffective treatment, transport and/or provision of advice. While the National Scheme may not be able to prevent incompetent paramedics from practising, it provides an avenue for National Boards to investigate health practitioner conduct and discipline appropriately. While the National Scheme is still, in some respects, reactive to regulatory problems, its

\begin{itemize}
\item \textsuperscript{25} \textit{Mathew v Higgins & Anor} [2008] QSC 209.
\item \textsuperscript{26} \textit{National Law} ss 5 (definition of ‘criminal history’), 55 (1)(b), 77, 79, 130, 135.
\end{itemize}
transparent and accountable procedures ensure more community confidence, and potential patient risks are avoided due to better procedures, than current paramedic regulation.

Another way to address paramedic risk in the community is to undertake a precautionary approach to paramedic regulation. Chapter 6 proposed that paramedicine should follow the precautionary principle in its regulatory approach. A precautionary approach to paramedic regulation is suitable for this industry as it supports regulation in response to political and social concerns without needing empirical evidence of paramedic risk.\(^\text{27}\) Given the difficulties establishing the nature and scale of risk to the community which paramedics pose, and the absence of clear evidence of patient risk, a precautionary approach would justify National Scheme regulation.

However, Chapter 6 also provided examples of patient harm in the context of a precautionary approach to regulating paramedicine. Chapter 6 argued that the social and political response needed for precautionary regulation can be fulfilled through a number of examples of risk to patients. In particular, the areas of title, training and education, as well as misconduct and fitness to practise, suggest paramedics pose a significant risk to the public which can be best addressed through National Scheme regulation. As such, National Scheme regulation is consistent with a precautionary regulatory approach, which we saw in Chapter 6, and best addresses risk to patients under the National Scheme.

8.3.2 Encouraging industry transparency

Despite my research hypothesising the potential for paramedics to pose a risk to the community, risk prediction within paramedicine is particularly challenging. Specifically, it is the transparency issues in Australian paramedic regulation which make risk prediction quite difficult. While transparency is so crucial to health practitioner regulation, because it promotes public confidence in health practitioner ethical conduct,\(^\text{28}\) transparency is notably absent from paramedic regulation. Complaints and disciplinary data detailing paramedic conduct is not publicly available, which undermines the integrity and accountability of the discipline. Despite an administrative governmental review in 2009 recommending more transparent complaints and disciplinary processes for paramedics,\(^\text{29}\) the Australian paramedic regulatory framework still lacks the transparency and accountability needed for public confidence in the paramedic discipline. The National Scheme encourages industry transparency.

In order to establish the level of risk which paramedics pose to the community, this thesis considered two avenues to address the potential for risk: first, using paramedic risk from the United Kingdom as a comparable framework; and second, undertaking a precautionary approach to Australian paramedic

\(^{27}\) Julia Black, 'The Role of Risk in Regulatory Processes' in Robert Baldwin, Martin Cave and Martin Lodge (eds), The Oxford Handbook of Regulation (Oxford University Press, 2010) 318.


\(^{29}\) Government of Western Australia, 'St John Ambulance Inquiry: Implementation of Recommendations' (Department of Health, December 2010) 17.
regulation. The United Kingdom is a suitable comparative jurisdiction for the purposes of this research. British paramedics are registered on a national level and have similar roles and responsibilities to Australian paramedics.\(^{30}\) Given the British paramedicine regulatory body reports disciplinary outcomes on a public register, a number of significant conclusions can be drawn which inform paramedic risk in Australia. For example, the United Kingdom requires mandatory reporting of paramedic misconduct to a regulator external to employers; reporting is undertaken by peers, police, employers and the public.\(^{31}\) Only 4\% of all complaints against paramedics originated from the public\(^{32}\) which suggests public reporting of paramedic conduct is only a very minor part of the United Kingdom’s mandatory reporting regulation. As such, the lack of mandatory reporting for Australian paramedics highlights the significant potential for risk which Australian paramedics pose to the public, as public reporting is currently the only avenue for disclosing paramedic misconduct.

Regulating paramedics under the National Scheme would encourage industry transparency. Paramedics would be subject to a transparent complaints-handling system with legislatively prescribed disciplinary procedures for dealing with paramedic misconduct. The co-regulatory elements of the National Law incorporating industry National Boards with governmental regulation would provide a transparent system currently lacking in paramedic regulation.

### 8.3.3 Advantages of National Scheme paramedic regulation

The National Scheme regulates health practitioners using a co-regulatory framework. Specifically, the National Law provides the governmental authority for disciplines to operate a self-regulatory model of practitioner compliance while the National Boards provide the self-regulatory component under the overarching governance of the National Scheme. The National Scheme integrates the benefits of self-regulation in conjunction with the strengths of governmental regulation; the expertise of the discipline can be incorporated with the transparency and accountability of government regulation. The regulatory theory was addressed comprehensively in chapter 2.

Paramedic title and minimum educational requirements is one advantage of National Law regulation for Australian paramedics. While Chapter 4 outlined paramedic title and education under the current regulatory framework, Chapter 6 provided examples of title and educational regulatory failures. In particular, a lack of paramedic title, for jurisdictions without statutory protection of title, creates confusion for employers and the public about the minimum standards of skills and expertise of

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paramedics. When employers are responsible for prescribing educational requirements, a regulatory dichotomy exists within the industry as paramedics can practise publicly and privately with differing qualifications. Further, there is nothing to stop unqualified people from using the ‘paramedic’ title, causing further confusion for the public. The National Scheme protects title for registered health practitioners and would ensure national and consistent protection of title for paramedics.

Another National Scheme advantage comes from student practitioner registration. Paramedic students who may not be suitable for practise cannot currently be prevented from obtaining registration or reported to an external body under the current regulatory framework. However, the National Scheme allows for a National Board to take action to protect the public from students who pose a risk to patients and this provision would apply to paramedics upon registration as well.

The final title, training and educational challenge addressed in Chapter 6 related to continuing professional development (CPD). Paramedic CPD is currently prescribed on an individual employer basis which means there are no consistent requirements for paramedics to maintain their industry knowledge and skills. National Scheme inclusion would require CPD to occur periodically.

8.4 The regulatory requirements for paramedic inclusion in the National Scheme are not onerous and can be met

In addition to the reasons for paramedics to be included under the National Scheme, mentioned in 8.3, the Council of Australian Governments recommended a number of further regulatory requirements for paramedic inclusion in the National Scheme.

1. National Scheme regulation can be implemented for paramedicine. Paramedicine is a distinct health professional group which has clear parameters and a body of knowledge. In Chapter 7, I proposed a paramedic definition be created, if needed, to clearly define the discipline and suggested the following as a definition for paramedic: ‘a health practitioner who provides pre-hospital emergency care services or community-based alternative models of care including diagnosis, treatment or advice’. Implementing national regulation, under the National Scheme, would be straightforward given the National Law provides an existing framework allowing for the addition of subsequent professional groups.

33 National Law, s 113.
34 Ibid ss 89-90.
2. It is practical to regulate paramedics under the National Scheme. As mentioned above, the *National Law* has been amended previously to allow for additional health professional groups to join.\(^{38}\) I predict that members would be willing to contribute to regulatory costs in the form of registration fee payments and that all governments, with the exception of New South Wales, agree to inclusion in the National Scheme.\(^{39}\) COAG suggested an ‘opt out’ system to allow national regulation to proceed in the absence of New South Wales agreement.\(^{40}\)

3. The benefits of National Scheme regulation outweigh the potential negative impact of regulation. The most significant benefit, that health practitioner regulation protects the public, should be the paramount consideration for paramedic inclusion in National Scheme regulation, above negative impacts such as costs.\(^{41}\)

In addition to COAG’s six principles for additional health practitioner inclusion under the National Scheme, mentioned in 8.3 and above, there are a number of other specific regulatory requirements for paramedics to be included in the National Scheme. These were addressed briefly in Chapter 7.\(^{42}\) The *National Law* would require minor amendments to include paramedics as an additional health profession, and I outlined some examples of the amendments needed in Table 7.3. Further, a National Board would be needed for paramedicine. To this end, a new board called the ‘Paramedical Board of Australia’ or ‘Paramedic Board of Australia’ would to become the fifteenth National Board. Alternatively, paramedics could be absorbed into the existing Nursing and Midwifery Board which may reduce cost to regulators. However, I noted the philosophical models of practice differ between paramedicine and nursing,\(^{43}\) so there may be industry objections to this option.

Regulation of paramedics under the National Scheme would require amending state and territory legislation. I suggested the main amendments needed to state and territory legislation would be to change the practitioner legislative titles from ‘ambulance officer’ to ‘paramedic’ or ‘registered paramedic’, and cross refer to the *National Law* for disciplinary action. Some examples of the changes needed are set out in Table 7.4.

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38 Aboriginal and Torres Strait Islander Health Practice, Chinese Medicine, Medical Radiation and Occupational Therapy.
41 *Health Practitioner Regulation National Law Act*, s 3A.
42 Australian Health Ministers’ Advisory Council, ‘Consultation paper: Options for regulation of paramedics’ (Health Workforce Principal Committee, July 2012) 73.
I also discussed the need to endorse a national course accreditation process in order to transition to National Scheme regulation. Chapter 7 suggested the establishment of the Australian Paramedical Council may fulfil this role to become an external accreditation body in compliance with National Scheme accreditation requirements.

Finally, Chapter 7 proposed an arrangement for professional indemnity insurance and a ‘grandparenting’ transitional clause. Professional indemnity insurance may be required for paramedics intending to practise privately, although I acknowledged the need for professional indemnity insurance may be limited, given paramedics are employees who are exempt from civil liability under employer vicarious liability. In relation to a grandparenting clause, I proposed that some paramedics may need an opportunity to upskill from vocational to tertiary educational qualifications in order to fulfil National Board training requirements. A grandparenting clause may either work to exempt vocationally trained paramedics from needing to upskill, and only allowing graduating paramedics with tertiary qualifications entry to the profession; or, provide a time period for vocationally qualified paramedics to upskill with a bridging course.

8.5 Conclusion and future opportunities for research

This thesis has provided the first systematic examination of paramedic regulation in Australia. In doing so, it provides insights into how Australian paramedics can be better regulated. While paramedics, and their governing structures, have received comprehensive public, parliamentary and academic scrutiny, particularly in recent years, an in-depth analysis of the current regulatory framework, which was attempted in this thesis, has not previously been undertaken. As such, this thesis has made a significant contribution to health practitioner regulatory scholarship. Most importantly, informed by the precautionary approach to paramedic regulation and given the propensity for risk which paramedics pose to the community, it is clear that paramedics need to be included in the National Scheme.

Before finishing, I would like to say something, albeit tentatively, about future research. Given paramedic regulation, under the National Scheme, is likely to occur as early as 2017, the regulatory landscape for paramedicine is changing rapidly. As such, the opportunities for further research are vast. Once paramedics are included as an additional health profession in the National Law, the transparency issues which currently plague the industry will lessen, and researchers will be able to more thoroughly address the suitability of the National Scheme in protecting the public from paramedic risk and promoting trust in the paramedic profession. Inclusion in the National Scheme is, therefore, a necessary first step and it is clear that paramedics meet the requirements for inclusion in the National Scheme and must be included.

BIBLIOGRAPHY

A Articles/Books/Reports

ACAP Standards Committee, 'Submission to the Review of Health Practitioner Regulation in Victoria' (2003) 1(3) *Journal of Emergency Primary Health Care* 1


ACT Government, 'Legislation Handbook' (September 2009)


Allan, Sonia and Meredith Black, *The Patient and the Practitioner: Health Law and Ethics in Australia* (LexisNexis Butterworths, 2014)

Ambulance Service Association, 'UK Ambulance Service Clinical Practice Guidelines' (Joint Royal Colleges Ambulance Liaison Committee, October 2006)


Ambulance Service of New South Wales, 'Protocols and Pharmacology' (Clinical Governance, July 2012)


Ambulance Service of New South Wales, '2013 Extended Care Paramedic: Pathways and Pharmacology' (Clinical Governance, May 2013)

Ambulance Tasmania, 'Clinical Practice Guidelines for Paramedics and Intensive Care Paramedics' (August 2012)


Ambulance Victoria, 'Clinical Practice Guidelines for Ambulance and MICA Paramedics' (July 2014)

Arneman, Jim 'Paramedic National Registration' (National Council of Ambulance Unions, 2012)


Australian Government, 'The Australian Government Guide to Regulation' (Department of the Prime Minister and Cabinet, 2014)

Australian Health Ministers' Advisory Council, 'Regulatory Impact Statement for the Decision to Implement the Health Practitioner Regulation National Law' (3 September 2009)

Australian Health Ministers' Advisory Council, 'Consultation Paper: Options for regulation of unregistered health practitioners' (February 2011)


Australian Health Ministers’ Advisory Council, 'Consultation paper: Options for regulation of paramedics' (Health Workforce Principal Committee, July 2012)


Ayers, Ian and John Braithwaite, Responsive Regulation: Transcending the Deregulation Debate (Oxford University Press, 1992)


Baldwin, Robert, Martin Cave and Martin Lodge (eds), The Oxford Handbook of Regulation (Oxford University Press, 2010)

Baldwin, Robert, Martin Cave and Martin Lodge, Understanding Regulation: Theory, Strategy and Practice (Oxford University Press, 2nd ed, 2012)

Barkley, Katherine Traver, *The ambulance: the story of emergency transportation of sick and wounded through the centuries* (Load N Go Press, 2nd ed, 1990)


Behrend, B J et al, 'Articulating Professional Nursing Behaviours' (1986) 16 *Journal of Nursing Administration* 20


Benton, David, Máximo Antonio González-Jurado and Juan Vicente Beneit-Montesinos, 'Professional regulation, public protection and nurse migration' (2014) 21(1) *Collegian* 53


Bixler, G K and R W Bixler, 'The professional status of nursing' (1959) 59 *American Journal of Nursing* 1142

Black, Julia, 'Decentring Regulation: Developing Strategies of Self Regulation' (2001) 54 *Current Legal Problems* 103

Black, Julia, 'Decentring Regulation: Understanding the Role of Regulation and Self-Regulation in a 'Post-Regulatory' World' (2001) 54 *Current Legal Problems* 103


Black, Julia, 'The Role of Risk in Regulatory Processes' in Robert Baldwin, Martin Cave and Martin Lodge (eds), *The Oxford Handbook of Regulation* (Oxford University Press, 2010)


Blacker, N, L Pearson and T Walker, 'Redesigning paramedic models of care to meet rural and remote community needs' (Paper presented at National Rural Health Conference, Cairns, 2009)


Bowles, Ronald, 'From learning activities to the meaning of life: Fostering professionalism in Canadian


Braithwaite, John, To Punish or Persuade: Enforcement of Coal Mine Safety (State University of New York Press, 1985)

Braithwaite, John, 'Institutionalising Distrust, Enculturating Trust' in Valerie Braithwaite and Margaret Levi (eds), Trust and Governance (Russell Sage Foundation, 1998) 343


Braithwaite, John, 'Responsive regulation and developing economies' (2006) 34 World Development

Braithwaite, John, 'The Essence of Responsive Regulation' (2011) 44 University of British Columbia Law Review

Braithwaite, John, Toni Makkai and Valerie Braithwaite, Regulating Aged Care: Ritualism and the New Pyramid (Edward Elgar, 2007)


Breen, Kerry J et al, Good Medical Practice: Professionalism, Ethics and Law (Cambridge University Press, 2010)


Breines, E B, 'Redefining Professionalism for Occupational Therapy' (1988) 42 American Journal of Occupational Therapy

Brennan, Troyen A, 'Physicians' Professional Responsibility to Improve the Quality of Care' (2002) 77 Academic Medicine


Bruhn, J G, 'Being good and doing good: the culture of professionalism in the health professions' (2001) 19 Health Care Management

Bullen, Beverley, St John Ambulance: the history of the Broadford-Kilmore division 1962-1990 (St John Ambulance, 1992)

Burford, Bryan, Gill Morrow, Charlotte Rothwell, Madeline Carter and Jan Illing, 'Professionalism education should reflect reality: findings from three health professions' (2014) 48 Medical Education

Carlton, Anne-Louise, 'Regulation of the health professions in Victoria' (Department of Human Services, October 2003)

Carlton, Anne-Louise, 'National Models for Regulation of the Health Professions' in Law in Context (The Federation Press, 2006) vol 23, 21


Castel, Robert, 'From Dangerousness to Risk' in Graham Burchell, Colin Gordon and George Miller (eds), The Foucault Effect: Studies in Governmentality (University of Chicago Press, 1991) 281


Chitty, Kay Kittrell, 'Nursing's Pathway to Professionalism' in Kay Kittrell Chitty and Beth Perry Black (eds), Professional Nursing: Concepts and Challenges (Saunders Elsevier, 2011) 60


Commonwealth of Australia, 'Establishment of a national registration system for Australian paramedics to improve and ensure patient and community safety' (Senate Legal and Constitutional Affairs Committee, 5 May 2016) <http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Const_Affairs/Paramedics/Report>


Council of Ambulance Authorities, 'Expanding roles: An Australasian overview of emerging paramedic models of care' (December 2008)


Council of Ambulance Authorities, 'Guidelines for the Assessment and Accreditation of Entry-level Paramedic Education Programs' (January 2014)
Cox, Carol L, 'Professionalism in Advanced Practice: The Professional role' in Carol L Cox, Marie C Hill and Victoria M Lack (eds), Advanced Practice in Healthcare (Routledge, 2012) 137

Creighton, Breen and Andrew Stewart, Labour Law (Federation Press, 5th ed, 2010)


Cullen, Enid Joy, Ready always: the history of the Bundaberg Ambulance (Bundaberg Local Ambulance Committee, 1999)

Current, John D, Pharmacology for Anesthetists: Anesthetics and Adjuvants (PediaPress)

Davies, Janice, 'Legislation surrounding the administration of medicines by paramedics' (2011) 3 Journal of Paramedic Practice 424

Davies, Martin and Ian Malkin, Focus: Torts (LexisNexis, 7th ed ed, 2015)


Dennis, George T, Maurice's Strategikon: Handbook of Byzantine Military Strategy (University of Pennsylvania Press, 1984)

Dennis, Margaret, It's not all lights & sirens!: a brief history of ambulance services in the Avoca/Royal George & Rossarden/Stroys Creek area (2010)

Dent, Mike 'Disciplining the medical profession? Implications of patient choice for medical dominance' (2006) 15 Health Sociology Review 458

Department of Health, 'The Allied Health Professions Project: Demonstrating competence through continuing professional development' (August 2003)


Devenish, Anthony, Experiences in Becoming a Paramedic: A Qualitative Study Examining the Professional Socialisation of University Qualified Paramedics (PhD Thesis, Queensland University of Technology, 2014)

Donnelly, Elizabeth and Darcy Siebert, 'Occupational risk factors in the emergency medical services' (2009) 24 Prehospital and Disaster Medicine 422

Douglas, Mary, Risk and Blame: Essays in Cultural Theory (Routledge, 1992)


Eburn, Michael, Australian Emergency Law <https://emergencylaw.wordpress.com/>

Eburn, Michael and Ruth Townsend, 'Restricting Paramedic Practice - An Issue of Professional Practice' (2014) 41(2) Response 33

Elkin, Katie, 'Medical practitioner regulation: Is it all about protecting the public?' (2014) 21 *Journal of Law and Medicine* 682


Epstein, Richard J and Epstein, Stephen D, 'Modernising the regulation of medical migration: moving from national monopolies to international markets' 13(26) *BMC Medical Ethics* 1


Evotts, J, 'Short note: the sociology of professional groups' (2006) 54 *Current Sociology* 133


Feintuck, Mike, 'Regulatory Rationales Beyond the Economic: In Search of the Public Interest' in Robert Baldwin, Martin Cave and Martin Lodge (eds), *The Oxford Handbook of Regulation* (Oxford University Press, 2010) 39

Field, Amelia, *The Order of St John in Victoria: our first hundred years* (St John Ambulance Australia, 2004)


First, Sue, Lucy Tomlins and Andy Swinburn, 'From trade to profession - the professionalisation of the paramedic workforce' (2012) 4 *Journal of Paramedic Practice* 378

FitzGerald, Gerry, 'Guest Editorial - Research in Prehospital Care' (2003) 1(3) *Journal of Emergency Primary Health Care* 1


Fitzgerald, Gerry, 'The Road to Professional Regulation' (Paper presented at the Board Meeting for
Australian College of Ambulance Professionals, Gold Coast, 2007)


Flexner, Abraham, 'Is social work a profession?' (Paper presented at the National Conference of Charities and Corrections, Baltimore, Maryland, 12-19 May 1915)

Forrester, Kim, 'National Regulation and Accreditation of Australian Health Practitioners' (2009) 17 *Journal of Law and Medicine* 190


Freckelton, Ian, 'The Margins of Professional Regulation: Disjunctions, Dilemmas and Deterrence' (2006) 23(2) *Law in Context* 148

Freckelton, Ian, 'Regulation of Health Practitioners' in Ian Freckelton and Kerry Peterson (eds), *Disputes and Dilemmas in Health Law* (The Federation Press, 2006)

Freckelton, Ian, 'Regulating Health Practitioner Professionalism' in *Law in Context* (The Federation Press, 2006) vol 23, 1

Freckelton, Ian, 'Regulation of health practitioners: opportunities and developments for plaintiffs' (2007) 17(79) *Precedent* 29

Freckelton, Ian, 'Trends in Regulation of Mental Health Practitioners' (2008) 15 *Psychiatry, Psychology and Law* 415

Freckelton, Ian, 'Regulating the unregistered' (2008) 16 *Journal of Law and Medicine* 413

Freckelton, Ian, 'Good Character and the Regulation of Medical Practitioners' (2008) 16 *Journal of Law and Medicine* 488


Freckelton, Ian, 'Legal Implications for Complementary Medicine Practitioners of the New South Wales Health Practitioner Code of Conduct' (2013) 20 *Journal of Law and Medicine* 734


Freckelton, Ian, 'The Ethics and Regulation of Overcharging: Issues in the Commerciality of the Health Practitioner-Patient Relationship' (2014) 21 *Journal of Law and Medicine* 497

Freckelton, Ian, 'Aboriginal and Torres Strait Islander Health Practitioner Regulation' (2014) 21 *Journal of Law and Medicine* 550


Freidson, Eliot, *Professionalism, the third logic* (Cambridge, 2004)


Goiran, Nick et al, 'Mandatory reporting of health professionals: The case for a Western Australian style exemption for all Australian practitioners' (2014) 22 *Journal of Law and Medicine* 209

Government of South Australia, 'Clinical Practice Guidelines - Paramedic' (South Australian Ambulance Service, July 2008)

Government of South Australia, 'Better Regulation Handbook' (Department of the Premier and Cabinet; Department of Treasury and Finance, January 2011)

Government of South Australia, 'Controlled Substances Licensing of First Aid Providers' (Department for Health and Ageing, June 2012)

Government of South Australia, 'Code of Practice for the Storage and Transport of Drugs of Dependence' (Department of Health and Ageing, November 2012)

Government of Western Australia, 'St John Ambulance Inquiry: Report to the Minister for Health' (Department of Health, October 2009)

Government of Western Australia, 'Regulatory Impact Assessment Guidelines for Western Australia' (Regulatory Gatekeeping Unit, July 2010)

Government of Western Australia, 'St John Ambulance Inquiry: Implementation of Recommendations' (Department of Health, December 2010)

Grabosky, Peter, 'Beyond Responsive Regulation: The expanding role of non-state actors in the regulatory process' (2013) 7 *Regulation & Governance* 114
Grabosky, Peter, 'Using Non-Governmental Resources to Foster Regulatory Compliance' (1995) 8 Governance 527

Grafton Ambulance Branch, History: Grafton Ambulance Branch (1995)


Grantham, Hugh, 'Prehospital Care as a Profession - Are we there yet?' (2004) 2(1) Journal of Emergency Primary Health Care 1


Greenwood, E, 'Attributes of a profession' (1957) 2 Social Work 45


Gunningham, Neil, 'Enforcement and Compliance Strategies' in Robert Baldwin, Martin Cave and Martin Lodge (eds), The Oxford Handbook of Regulation (Oxford University Press, 2010) 120


Hall, Richard, 'Professionalization and Bureaucratization' (1968) 33 American Sociological Review 92

Hall, Richard, Occupations and the Social Structure (Prentice-Hall, 1969)

Haller, Linda, 'Regulating the Professions' in Peter Cane and Herbert Kritzer (eds), The Oxford Handbook of Empirical Legal Research (Oxford University Press, 2010) 216


Harding, Ronnie and Elizabeth Fisher, 'Introducing the precautionary principle' in Ronnie Harding and Elizabeth Fisher (eds), Perspectives on the Precautionary Principle (The Federation Press, 1999)

Harlow, Carol and Richard Rawlings, Law and Administration (Cambridge University Press, 3rd ed, 2009)


Health and Care Professions Council, ‘Standards of Proficiency: Paramedics’ (August 2014)


Health and Care Professions Council, 'Continuing Professional Development and Your Registration'


Health Professions Regulatory Advisory Council, 'A Rapid Literature Review on Patient Safety and Non-Physician EMS Providers: Part 1' (Ministry of Health and Long-Term Care, November 2012)


Jill Hennessy, Submission No 15 to Senate Standing Committee on Legal and Constitutional Affairs, The establishment of a national registration system for Australian paramedics to improve and ensure patient and community safety, 2016

Heslin, Anthony and Selwyn Watt, Visions accomplished: an 80 year history of ambulance services in the Shoalhaven (NSW Ambulance, 1992)


Hindress, Barry, Discourses of Power (Blackwell Publishers, 1996)

Hodges, David, John McLachlan and Gabrielle Finn, 'Exploring reflective 'critical incident' documentation of professionalism lapses in a medical undergraduate setting' (2009) 9 BioMed Central Medical Education 44


Horsley, Mike and David Thomas, 'Professional regulation & professional autonomy: Benchmarks from across the professions, the New South Wales experience' (2003) 6(1) Change: Transformations in Education 34

Houle, C, Continued Learning in the Professions (Jossey-Bass, 1980)

Howie-Willis, Ian, A Century for Australia: St John Ambulance in Australia 1883-1983 (Priory of the Order of St John in Australia, 1983)

Howie-Willis, Ian, South Australians and St John Ambulance 1885-1985 (St John Council for South Australia, 1985)

Howie-Willis, Ian, The St John Ambulance in Western Australia: an outline history (1990)

Howie-Willis, Ian, St John, ambulances and Western Australia: a centenary anthology 1892-1992 (St John Ambulance Australia, 1992)

Hunt, Alan, Explorations in Law and Society: Toward A Constitutive Theory of Law (Routledge, 1993)

Huston, Carol, 'Professional Identity and Image' in Carol J Hutson (ed), Professional Issues in Nursing: Challenges and Opportunities (Wolters Kluwer, 2014) 327


Hutchinson, Terry, Researching and Writing in Law (Thomson Reuters, 3rd ed, 2010)

Hutchinson, Terry, 'Doctrinal research: researching the jury' in Dawn Watkins and Mandy Burton (eds), Research Methods in Law (Routledge, 2013)

Hutchinson, Terry and Nigel Duncan, 'Defining and Describing What We Do: Doctrinal Legal Research' (2012) 17 Deakin Law Review 83


Irvine, Donald, 'Everyone is entitled to a good doctor' (2007) 186 Medical Journal of Australia 256


Jammal, Walid, Cameron Stewart and Malcolm Parker, "'CAM Creep": Medical practitioners, professional discipline and integrative medicine' (2014) 22 Journal of Law and Medicine 221

Jewell, David, 'Supporting Doctors, or the Beginning of the End for Self-regulation?' (2000) 50 British Journal of General Practice 4


Kaneria, Anshuni M, 'The history and development of trauma and emergency care in England' (2014) 17 *Trauma* 52

Kay Ross, Jennieffer Barr and John Stevens, 'Mandatory continuing professional development requirements: what does this mean for Australian nurses' (2013) 12 *BMC Nursing* 9


Kedgley, Sue, 'Inquiry into the provision of ambulance services in New Zealand' (House of Representatives, July 2008)

Keelty, M J, 'Sustaining the Unsustainable: Police and Community Safety Review - Final Report' (Queensland Department of the Premier and Cabinet, 29 August 2013)

Kell, Clare and Gwyn Owen, 'Physiotherapy as a profession: where are we now?' (2008) 15 *International Journal of Therapy and Rehabilitation* 158

Kellermann, Arthur, Renee Hsia, Charlotte Yeh and Kristine Morganti, 'Emergency Care: Then, Now, and Next' (2013) 32 *Health Affairs* 2069


Ladinsky, Jack and Joel Grossman, 'Organizational Consequences of Professional Consensus: Lawyers and Selection of Judges' (1966) 11 *Administrative Science Quarterly* 79


LaSala, Kathleen and Jenenne Nelson, 'What Contributes to Professionalism?' (2005) 14 *Medsurg Nursing* 63

Leflar, Robert, 'Public Accountability and Medical Device Regulation' (1989) 2 *Harvard Journal of Law and Technology* 1

Legg, Michael, *Regulation, Litigation and Enforcement* (Thomson Reuters, 2011)

Lin, Vivian and Debra Gillick, 'Does workforce regulation have the intended effect? The case of
Chinese medicine practitioner registration' (2011) 35 *Australian Health Review* 455

Lodge, Martin and Christopher Hood, 'Regulation inside Government: Retro-theory vindicated or outdated?' in Robert Baldwin, Martin Cave and Martin Lodge (eds), *The Oxford Handbook of Regulation* (Oxford University Press, 2010) 590

Lord, Bill, 'The development of a degree qualification for paramedics at Charles Sturt University' (2003) 1(1) *Journal of Emergency Primary Health Care* 1


Lu, Y, X Meng and L Beck, 'Professional Behaviour of Medical School Graduates: an Analysis' (1994) 28 *Medical Education* 296


Macdonald, Keith, *The Sociology of the Professions* (Sage, 1995)

Macklin, Robert, 'Moral judgment and practical reasoning in professional practice' in Bill Green (ed), *Understanding and researching professional practice* (Sense Publishers, 2009) 83

Mahony, Kerry, 'The Politics of Professionalisation: Some Implications for the Occupation of Ambulance Paramedics in Australia' (2012) 1(3) *Journal of Emergency Primary Health Care* 1


Manning, Joanna, 'Changing Disciplinary Responses to Sexual Misconduct by Health Practitioners in New Zealand' (2014) 21 *Journal of Law and Medicine* 508


Mascini, Peter, 'Why was the enforcement pyramid so influential? And what price was paid?' (2013) 7 *Regulation & Governance* 48


McCann, Leo, Edward Granter, Paula Hyde and John Hassard, 'Still Blue-Collar after all these Years? An Ethnography of the Professionalization of Emergency Ambulance Work' (2013) 50 *Journal of Management Studies* 750

McCreery, Christopher, *The Maple Leaf and the White Cross* (Dundurn Press, 2008)


McDonald, Fiona, ‘Challenging the Regulatory Trinity: Global Trends in Health Professional Regulation’ in Stephanie Short and Fiona McDonald (eds), *Health Workforce Governance: Improved Access, Good Regulatory Practice, Safer Patients* (Ashgate, 2012) 97

McDonald, Fiona, 'The Regulation of Health Professionals' in Ben White, Fiona McDonald and Lindy
Willmott (eds), *Health Law in Australia* (Thomson Reuters, 2010) 509

McDonell, Angus, 'The Search and development of professionalism in "Ambulance"' (2009) 7(4) *Journal of Emergency Primary Health Care* 1

McIntyre, Dennis, 'Technological determinism: A social process with some implications for Ambulance Paramedics' (2003) 1(3) *Journal of Emergency Primary Health Care* 1

McQuillen, Pat, "Saved any lives today?: a history of St John Ambulance in Alice Springs, NT" (St John Ambulance (NT), 2004)

McSherry, Bernadette and Juan Jose Tellez, ‘Current Challenges for the Regulation of Chemical Restraint in Health Care Settings’ (2016) 24 *Journal of Law and Medicine* 15

Medical Board of Australia, 'Professional indemnity insurance arrangements registration standard' (1 July 2010) <http://www.medicalboard.gov.au/Registration-Standards.aspx>


Medical Board of Australia, 'Medical Practitioner Registrant Data' (Australian Health Practitioner Regulation Agency, June 2014 2014)


Medical Board of Australia, 'Health Profession Agreement: Medical Board of Australia and The Australian Health Practitioner Regulation Agency 2015/16' (Australian Health Practitioner Regulation Agency, 23 July 2015)


Miller, Barbara, Donna Adams and Lasca Beck, 'A Behavioural Inventory for Professionalism in Nursing' (1993) 9 *Journal of Professional Nursing* 290

Ministry of Health, 'Saskatchewan Emergency Treatment Protocol Manual' (Acute and Emergency Services Branch, 3 September 2014)

Ministry of Health and Long-Term Care, 'Basic Life Support Patient Care Standards' (Emergency Health Services Branch, January 2007)

Ministry of Health and Long-Term Care, 'Advanced Life Support Patient Care Standards' (Emergency Health Services Branch, November 2011)


Morauta, Louise, 'Implementing a COAG Reform Using the National Law Model: Australia's National Registration and Accreditation Scheme for Health Practitioners' (2011) 70(1) *Australian Journal of Public Administration* 75

Morgan, Bronwen and Karen Yeung, *Introduction to Law and Regulation* (Cambridge University Press,
Moritz, Dominique, 'Protection of Title - Associated Issues for Paramedics and the Community' (2014) 41(4) *Response* 22

Mowat, Jerome, 'Paramedics: the blue-collar profession with white-collar ambitions?' (2014) 6 *Journal of Paramedic Practice* 45

Mulholland, Peter et al, 'Multidisciplinary Practice in Action: The Rural Paramedic - It's Not Only Lights and Sirens' (2009) 7(2) *Journal of Emergency Primary Health Care* 1

Muller, M, *Nursing Dynamics* (Heinemann, 2nd ed, 1998)


National Audit Office, 'Transforming NHS ambulance services' (Department of Health, 10 June 2011)


NSW Government, 'Guide to Better Regulation' (Department of Premier and Cabinet, November 2009)


Nursing and Midwifery Board of Australia, 'Nurse and Midwife Registrant Data' (Australian Health Practitioner Regulation Agency, June 2014)


Nursing and Midwifery Board of Australia, 'Health Profession Agreement: Nursing and Midwifery Board of Australia and The Australian Health Practitioner Regulation Agency 2015/16' (5 November 2015)


O'Meara, Peter, 'Professional and community expectations of rural ambulance services in Australia' (2001) 5(1) *Pre-Hospital Immediate Care* 27

O'Meara, Peter et al, 'Extending the paramedic role in rural Australia: a story of flexibility and innovation' (2012) 12 *Rural and Remote Health* 1

O' Riordan, Timothy and James Cameron, *Interpreting the Precautionary Principle* (Routledge, 2002)

O'Meara, Peter, 'Paramedics marching towards professionalism' (2012) 7(1) *Journal of Emergency Primary Health Care* 1


Palfreeman, Linda, *Aristocrats, adventurers and ambulances: the work of the Scottish Ambulance Unit and the George Young Ambulance Unit in Spain during the Spanish Civil War 1936-1939* (Sussex Academic Press, 2014)


Paramedic Association of Canada, 'National Occupational Competency Profile for Paramedics' (October 2011)


Paramedics Australasia, Submission No 9 to Senate Standing Committee on Legal and Constitutional Affairs, *The establishment of a national registration system for Australian paramedics to improve and
ensure patient and community safety, 2016


Parham, D, 'Toward Professionalism: The reflective therapist' (1987) 41 American Journal of Occupational Therapy 555

Parker, Christine, Just Lawyers (Oxford University Press, 1999)

Parker, Christine, 'Regulator-Required Corporate Compliance Program Audits' (2003) 25 Law and Policy 221

Parker, Christine, 'The Pluralization of Regulation' (2008) 9 Theoretical Inquiries in Law 349

Parker, Christine, 'Twenty years of responsive regulation: An appreciation and appraisal' (2013) 7 Regulation and Governance 2

Parker, Christine and John Braithwaite, 'Regulation' in Peter Cane and Mark Tushnet (eds), The Oxford Handbook of Legal Studies (Oxford University Press, 2005) 119


Paterson, Ron, 'Regulation of Health Care' in PDG Skegg and Ron Paterson (eds), Medical Law in New Zealand (Thomson Brookers, 2006)


Pavalko, R, Sociology of Occupations and Professions (F E Peacock Publishers, 1971)

Pearce, Dennis, Enid Campbell and Dan Harding ('Pearce Committee'), 'Australian Law Schools: A Discipline Assessment for the Commonwealth Tertiary Education Commission' (1987)

Petersen, Geoff, A brief history of the Maryborough Ambulance Transport Brigade (Queensland Ambulance Service, 1997)

Podiatry Board of Australia, 'Podiatry Registrant Data' (Australian Health Practitioner Regulation Agency, June 2014)

Pollock, Alexander, 'Ambulance services in London and Great Britain from 1860 until today: a glimpse of history gleaned mainly from the pages of contemporary journals' (2013) 30 Emergency Medicine Journal 218


Rowberg, Margaret, 'Advanced Practice Nursing' in Carol J Huston (ed), Professional Issues in Nursing: Challenges and Opportunities (Wolters Kluwer, 2014) 343

Ryan, J, History of Queensland ambulance service, 1892-1950: history of Rockhampton Ambulance Brigade (Rockhampton Ambulance Committee, 1950)


Sanson, Michelle and Thalia Anthony, Connecting with law (Oxford University Press, 3rd ed, 2014)

Saskatchewan College of Paramedics, 'Paramedic Clinical Practice Protocols' (September 2014)

Schwirian, Patricia M, Professionalization of Nursing: Current Issues and Trends (Lippincott Williams & Wilkins, 1998)

Seibert, Krystian, 'Rethinking Professional Regulation' (2009) 25(1) Policy 27

Sheather, Rod, 'Professionalisation' in Peter O'Meara and Carol Grbich (eds), Paramedics in Australia: contemporary challenges of practice (Pearson, 2009) 62

Sheehy, Benedict and Donald Feaver, 'Designing Effective Regulation: A Normative Theory' (2015) 38 UNSW Law Journal 392


Jillian Skinner, Submission No 13 to Senate Standing Committee on Legal and Constitutional Affairs, The establishment of a national registration system for Australian paramedics to improve and ensure patient and community safety, January 2016

Smith, Joy, 'Ambulance - a short history', Dunsborough & District News & Reviews (Dunsborough, Western Australia), March/April 2005, 16

Social Development Committee, 'Inquiry into Bogus, Unregistered and Deregistered Health Practitioners' (Parliament of South Australia, 2009)

Sofianopoulos, Sarah, Brett Williams, Frak Archer and Bruce Thompson, The exploration of physical fatigue, sleep and depression in paramedics: a pilot study' (2011) 9(1) Journal of Emergency Primary Health Care 1

St John Ambulance Australia (Northern Territory), 'Drug Handling' (1 July 2011)

St John Ambulance Australia (Northern Territory), 'Graduate Paramedic Internship' (30 October 2014) <http://www.stjohnnt.org.au/careers/ambulance/graduate>
St John Ambulance Australia (Western Australia), 'Annual Report 2009' (2009)  

St John Ambulance Australia (Western Australia), 'Clinical Guidelines for Ambulance Care in Western Australia' (22 July 2011)

St John Ambulance Service Northern Territory, 'Clinical Practice Manual' (March 2013)

St John Ambulance Western Australia, '2012/13 Annual Report' (2013)  


State of Queensland, 'The Queensland Legislation Handbook' (Department of Premier and Cabinet, 2014)

State of Queensland (Queensland Health) and the Royal Flying Doctor Service (Queensland Section), *Primary Clinical Care Manual* (8th ed, 2013)

State of Victoria, 'Victorian Guide to Regulation' (Edition 2.1, Department of Treasury and Finance, August 2011)


Staunton, Patricia and Mary Chiarella, *Law for Nurses and Midwives* (Elsevier Australia, 7th ed, 2012)


Stirling, Christine et al, 'Engaging rural communities in health care through a paramedic expanded scope of practice' (2007) 7 *Rural and Remote Health* 1

Stone, Julia, 'Regulating Complementary Medicine' (1996) 312 *British Medical Journal* 1492


Thomas, David, 'Peer Review as an Outdated Model for Health Practitioner Regulation' in *Law in Context* (The Federation Press, 2006) vol 23, 52


Townsend, Ruth and Michael Eburn, 'Professional Discipline for Registered Health Professionals: Lessons for Australian Paramedics' (2014) 41(3) Response 41

Townsend, Ruth and Morgan Luck, Applied Paramedic Law and Ethics: Australia and New Zealand (Elsevier Australia, 2013)


Turner, Bryan S, Medical Power and Social Knowledge (Sage, 1987)


van der Gaag, Anna and John Donaghy, 'Paramedics and professionalism: Looking back and looking forwards' (2013) 5 Journal of Paramedic Practice 8

Veljanovski, Cento, 'Economic Approaches to Regulation' in Robert Baldwin, Martin Cave and Martin Lodge (eds), The Oxford Handbook of Regulation (Oxford University Press, 2010) 17

Victoria University, Bachelor of Health Science (Paramedic) (Conversion Degree) <http://www.vu.edu.au/courses/bachelor-of-health-science-paramedic-conversion-degree-hbpa#units-and-electives-structure>


Victorian Government, 'Review of Regulation of the Health Professions in Victoria' (Department of Human Services, April 2005)

Victorian Government Department of Health, 'Ambulance transport of people with a mental illness protocol 2010' (September 2010)

Vollmer, H and D Mills, Professionalization (Prentice-Hall Incorporated, 1966)

Wales, Murdoch and John Pearn, First in first aid: the history of St John Ambulance Australia in Queensland (Amphion Press, 1995)

Wallis, Jaime and Malcolm Boyle, 'From stretcher bearer to "Paramedic"' (2014) 11(3) Journal of Emergency Primary Health Care 1

Wardle, Jon, 'Holding unregistered health practitioners to account: An analysis of current regulatory and legislative approaches' (2014) 22 Journal of Law and Medicine 350

Warfe, Laurie, 'Determining the risk of recidivism in previously de-registered health practitioners' (2013) 21 Journal of Law and Medicine 67
Weir, Michael, 'Regulation of Complementary and Alternative Medicine Practitioners' (2006) 23(2) Law in Context 171

Weiss, Steve, Karl Peterson, Paul Cheney, Phil Froman, Amy Ernst and Micha Campbell, 'The use of chemical restraints reduces agitation in patients transported by emergency medical services' (2012) 43 Journal of Emergency Medicine 820


Wilde, Sally, From Driver to Paramedic: A history of the Training of Ambulance Officers in Victoria (Ambulance Officers' Training Centre, 1999)

Wilensky, Harold, 'The Professionalization of Everyone?' (1964) 70 American Journal of Sociology 137

Williams, Brett, Ted Brown and Andrys Onsman, 'From stretcher-bearer to paramedic: the Australian paramedics’ move towards professionalisation' (2009) 7(4) Journal of Emergency Primary Health Care 1

Williams, Brett, Ted Brown and Andrys Onsman, 'Is the Australian Paramedic Discipline a Full Profession?' (2010) 8(1) Journal of Emergency Primary Health Care 1

Williams, Brett, Chris Fielder, Gary Strong, Joe Acker and Sean Thompson, 'Are paramedic students ready to be professional? An international comparison study' (2014) International Emergency Nursing 1

Williams, Brett, Andrys Onsman and Ted Brown, 'Is the Australian paramedic discipline a profession? A national perspective' (2012) 2 International Paramedic Practice 77


Willis, Evan and Liam McCarthy, 'From First Aid to Paramedical: Ambulance Officers in the Health Division of Labour' (1986) X Community Health Studies 57

Willis, Karen and Shandell Elmer, Society, Culture and Health: An Introduction to Sociology for Nurses (Oxford University Press, 2nd ed, 2011)

Willmott, Lindy and Ben White, ‘Mandatory Reporting of Health Professionals’ (2010) 30 Queensland Lawyer 172

Wilson, Bill, To be faithful, true and brave: a history of St John Ambulance in the Northern Territory from 1928 to 2002 (St John Ambulance (NT), 2003)

Winders, John Robert, A short history of the Coolangatta-Tweed Heads Centre of the Queensland Ambulance Transport Brigade (1973)

Woods, Glen, 'Laying the foundations for a South Australian ambulance service' in Glen Woods (ed), Two pennies and a piece of wire (SA Ambulance Service Retired Association Incorporated, 2012) 5


Yam, Bernard, 'From Vocation to Profession: The Quest for Professionalization of Nursing' (2004) 13 British Journal of Nursing 9

Youdelman, Sharon, 'Strategic Bankruptcies: Class Actions, Classification and the Dalkon Shield Cases' (1986) 7 Cardozo Law Review 817

Zinn, Jens (ed), Social Theories of Risk and Uncertainty (Blackwell Publishing, 2008)
B Case Law

Airedale NHS Trust v Bland [1993] AC 789

Ambulance Service of NSW v Worley [2006] NSWCA 102


Bropho v Western Australia [2007] FCA 519

Ciranoush Aird AND Department of Community Safety, Queensland Ambulance Service (TD/2012/11)

Clyne v New South Wales Bar Association (1960) 104 CLR 186

Drury v Medical Board of Australia (Occupational and Business Regulation) [2011] VCAT 858 (10 May 2011)

Dumont v Miller (1873) 4 AJR 152

Fletcher v Queensland Nursing Council [2009] QDC 129

Garanovic v Queensland Nursing Council [2003] QDC 416

Halliday v Nevill (1984) 155 CLR 1

HCCC v Hinde [2013] NSWPHT 5 (11 September 2013)

HCCC v Litchfield (1997) 41 NSWLR 630

HCCC v Pierce [2010] NSWNMT 23 (26 July 2010)

Health Care Complaints Commission v Gillett [2007] NSWNMT 7 (1 August 2007)


Health Care Complaints Commission v Hutchinson [2014] NSWCATOD 151 (18 December 2014)

Hoile v The Medical Board of South Australia (1960) 104 CLR 157

Hughes and Vale Pty Ltd v New South Wales (No 2) (1955) 93 CLR 27

Hunter and New England Area Health Service v A (2009) 74 NSWLR 88

Immediate Assistants Pty Ltd v Chief Executive, Queensland Health [2012] QCAT 245 (21 June 2012)

Inquest into the death of Gemma Geraldine Thoms (Coroner’s Court of Western Australia, Coroner Mulligan, 8 March 2013)


Inquest into the death of Nola Jean Walker (Coroner’s Court of Cairns, Coroner Barnes, 23 November 2007)

Inquest into the death of Ruby Yan Chen (Coroner’s Court of Rockhampton, Coroner O’Connell, 12 December 2014)

Inquest into the deaths of Monica and Trent Speering (Coroner’s Court of New South Wales, Magistrate Jerram, 3 September 2010)

In Re F (Mental Patient: Sterilisation) [1990] 2 AC 1

Keller v Metropolitan Ambulance Service of Victoria [2002] VSC 222

Kevin Walsh v Ambulance Victoria [2013] FWC 1999

Kirk v Gregory (1876) 1 Ex D 55
Mathiew v Higgins & Anor [2008] QSC 209
Neal v Ambulance Service of New South Wales [2007] NSWDC 123
NSW Bar Association v Cummins (2001) 52 NSWLR 279
New South Wales v Lepore; Samin v Queensland; Rich v Queensland (2003) 212 CLR 511
Nursing and Midwifery Board of Australia v Brennan [2011] QCAT 328 (2 June 2011)
Nursing and Midwifery Board of Australia v Brereton [2011] QCAT 578 (11 October 2011)
Nursing and Midwifery Board of Australia v Farley [2012] QCAT 447 (18 September 2012)
Nursing and Midwifery Board of Australia v Feeney [2012] QCAT 330 (23 July 2012)
Nursing and Midwifery Board of Australia v Omant (Review and Regulation) [2013] VCAT 1679 (13 September 2013)
Nursing and Midwifery Board of Australia v Pethic [2011] SAHPT 15 (31 May 2011)
Orchard v Medical Board of Australia (Review and Regulation) [2013] VCAT 1729 (9 October 2013)
Paramedical Services Pty Ltd v Ambulance Service of New South Wales (1999) 217 ALR 502
Pharmacy Board of Australia v The Registrant [2012] QCAT 515
Police v Zammit [2007] SASC 37
Ratcliffe v Evans [1892] 2 QB 524
Re: Dr Abraham Stephanopoulos [2006] MPBV 12 (16 August 2006)
Re T (Adult: Refusal of Treatment) [1993] Fam 95
Roane-Spray v Queensland [2016] QDC 348
Rogers v Whitaker (1992) 175 CLR 479
Schloendorf v Society of New York Hospital 195 NE 92 (1914)
Secretary, Department of Health and Community Services (NT) v JWB and SMB (Marion’s Case) (1992) 175 CLR 218
Slaveski (by his litigation guardian Slaveska) v Victoria [2010] VSC 441
Sobey v Commercial and Private Agents Board (1979) 22 SASR 70
Stevens v Brodribb Sawmilling Company Pty Ltd (1986) 160 CLR 16
Stuart v Kirkland-Veenstra (2009) 237 CLR 215
Wilks v The Medical Board of South Australia [2010] SASC 287
C Legislation

Current legislation
Ambulance Service Act 1982 (Tas)
Ambulance Service Act 1991 (Qld)
Ambulance Services Act 1986 (Vic)
Ambulance Service Amendment Bill 2013 (Tas)
Ambulance Service Bill 1991 (Qld)
Ambulance Service (Paramedic) Regulations 2014 (Tas)
Australian Road Rules (SA)
Civil Liability Act 2003 (Qld)
Civil Liability Regulation 2014 (Qld)
Controlled Substances Act 1984 (SA)
Crimes (Controlled Operations) Act 2004 (Vic)
Crimes (Controlled Operations) Act 2008 (ACT)
Crimes (Forensic Procedures) Act 2000 (ACT)
Crimes (Sentencing Procedure) Act 1999 (NSW)
Crimes (Surveillance Devices) Act 2010 (ACT)
Criminal Code (Qld)
Criminal Code (Tas)
Criminal Code (WA)
Criminal Investigation Act 2006 (WA)
Criminal Investigation (Identifying People) Act 2002 (WA)
Criminal Law Consolidation Act 1935 (SA)
Criminal Law (Forensic Procedures) Act 2007 (SA)
Drugs Misuse Act 1986 (Qld)
Drugs Misuse Regulation 1987 (Qld)
Drugs, Poisons and Controlled Substances Regulations 2006 (Vic)
Education (Queensland College of Teachers) Act 2005 (Qld)
Emergencies Act 2004 (ACT)
Government Sector Employment Act 2013 (NSW)
Guardianship and Administration Act 2000 (Qld)
Health and Community Services Complaints Act 2004 (SA)
Health and Community Services Complaints Act (NT)
Health and Community Services Complaints Regulations 2005 (SA)
Health and Disability Services (Complaints) Act 1995 (WA)
Health Care Act 2008 (SA)
Health Care Complaints Act 1993 (NSW)
Health Complaints Act 1995 (Tas)
Health (Drugs and Poisons) Regulation 1996 (Qld)
Health Ombudsman Act 2013 (Qld)
Health Practitioner Regulation National Law Act 2009 (Qld)
Health Practitioner Regulation National Law Act 2009 (Vic)
Health Practitioner Regulation National Law Act 2010 (ACT)
Health Practitioner Regulation National Law Act 2010 (SA)
Health Practitioner Regulation National Law Act 2010 (Tas)
Health Practitioner Regulation National Law Act 2010 (WA)
Health Practitioner Regulation National Law Act (NSW)
Health Practitioner Regulation National Law (South Australia)(Protection of Title – Paramedics) Amendment Act 2013 (SA)
Health Practitioner Regulation National Law (South Australia)(Protection of Title – Paramedics) Amendment Bill 2013 (SA)
Health Practitioner Regulation National Law (South Australia) Regulations 2010 (SA)
Health Practitioner Regulation (National Uniform Legislation) Act (NT)
Health Services Act 1997 (NSW)
Health Services Amendment (Paramedics) Bill 2015 (NSW)
Health Services (Conciliation and Review) Act 1987 (Vic)
Health Services Regulation 2013 (NSW)
Human Rights Commission Act 2005 (ACT)
Industrial Relations Act 1999 (Qld)
Integrity Commission Act 2009 (Tas)
Integrity Reform (Miscellaneous Amendments) Act 2010 (Qld)
Law Enforcement (Powers and Responsibilities) Act 2002 (NSW)
Legal Profession Act 2007 (Qld)
Legislation Act 2001 (ACT)
Listening and Surveillance Devices Act 1972 (SA)
Medical Indemnity (Prudential Supervision and Product Standards) Act 2003 (Cth)
Medicines, Poisons and Therapeutic Goods Act 2008 (ACT)
Medicines, Poisons and Therapeutic Goods Act (NT)
Medicines, Poisons and Therapeutic Goods Regulation 2008 (ACT)
Medicines, Poisons and Therapeutic Goods Regulations (NT)
Mental Health Act 2007 (NSW)
Mental Health Act 2009 (SA)
Mental Health Act 2013 (Tas)
Mental Health Act 2014 (Vic)
Mental Health Act 2014 (WA)
Mental Health Act 2015 (ACT)
Mental Health Act 2016 (Qld)
Mental Health and Related Services Act (NT)
Mental Health Regulation 2017 (Qld)
Paramedics Registration Bill 2014 (Vic)
Penalties and Sentences Act 1992 (Qld)
Penalty Units Act (NT)
Poisons and Therapeutic Goods Regulation 2008 (NSW)
Poisons Act 1971 (Tas)
Poisons Act 1964 (WA)
Poisons Regulations 1965 (WA)
Poisons Regulations 2008 (Tas)
Poisons Standard 2011 (Cth)
Police Powers and Responsibilities Act 2000 (Qld)
Police Powers (Assumed Identities Act) 2006 (Tas)
Police Powers (Controlled Operations) Act 2006 (Tas)
Police Powers (Public Safety) Act 2005 (Tas)
Police Powers (Surveillance Devices) Act 2006 (Tas)
Police Powers (Vehicle Interception) Act 2000 (Tas)
Police Service Administration Act 1990 (Qld)
Police (Special Investigative and Other Powers) Act 2015 (NT)
Public Administration Act 2004 (Vic)
Public Sector Act 2009 (SA)
Public Sector Employment and Management Act (NT)
Public Sector Ethics Act 1994 (Qld)
Public Sector (Honesty and Accountability) Act 1995 (SA)
Public Sector Management Act 1994 (ACT)
Public Sector Management Act 1994 (WA)
Public Health Act 2010 (NSW)
Public Health Regulation 2012 (NSW)
Road Rules 2008 (NSW)
Road Rules 2009 (Tas)
Road Safety Road Rules 2009 (Vic)
Road Traffic Code 2000 (WA)
Road Transport (Safety and Traffic Management) Regulation 2000 (ACT)
South Australian Public Health Act 2011 (SA)
State Service Act 2000 (Tas)
Therapeutic Goods Act 1989 (Cth)
Traffic Regulations (NT)
Transport Operations (Road Use Management – Road Rules) Regulation 1999 (Qld)

Repealed legislation
Ambulance Service Act 1972 (NSW) (repealed)
Chiropractors Registration Act 2001 (Qld) (repealed)
Dental Practitioners Registration Act 2001 (Qld) (repealed)
Dental Technicians and Dental Prosthetists Registration Act 2001 (Qld) (repealed)
Health Practitioner Registration Boards (Administration) Act 1999 (Qld) (repealed)
Health Practitioners (Professional Standards) Act 1999 (Qld) (repealed)
Medical Practitioners Registration Act 2001 (Qld) (repealed)
Medical Radiation Technologists Registration Act 2001 (Qld) (repealed)
Mental Health Act 2000 (Qld) (repealed)
Nursing Act 1992 (Qld) (repealed)
Occupational Therapists Registration Act 2001 (Qld) (repealed)
Optometrists Registration Act 2001 (Qld) (repealed)
Osteopaths Registration Act 2001 (Qld) (repealed)
Pharmacists Registration Act 2001 (Qld) (repealed)
Physiotherapists Registration Act 2001 (Qld) (repealed)
Podiatrists Registration Act 2001 (Qld) (repealed)
Psychologists Registration Act 2001 (Qld) (repealed)
Speech Pathologists Registration Act 2001 (Qld) (repealed)
International legislation

*Ambulance Act*, RSO 1990, c A-19
*Constitution Order 2009* (UK)
*Criminal Justice Act 1982* (UK)
*Emergency Medical Technicians Regulation, Alta Reg 48/1993*
*Health Act 1999* (UK)
*Health and Social Work Professions Order 2001* (UK)
*Health Disciplines Act*, RSA 2000, c H-2
*Health Practitioners Competence Assurance Act 2003* (NZ)
*Health Professions Act*, RSA 2000, c H-7
*Human Medicines Regulations 2012* (UK)
*Medical Act 1983* (UK)
*Medicines (Standing Order) Regulations 2002* (NZ)
*Nursing and Midwifery Order 2001* (UK)
*Paramedic Act*, RSNB 2005-2006
*Paramedics Act*, RSS 2008, c P-0.1

Legislative Material

Explanatory Memorandum, Ambulance Service Bill 1991 (Qld)
Explanatory Memorandum, Health Practitioner Regulation National Law Bill 2009 (Qld)
New South Wales, *Parliamentary Debates*, Legislative Assembly, 3 June 2015
New South Wales, *Parliamentary Debates*, Legislative Council, 26 August 2015
Queensland, *Parliamentary Debates*, House of Representatives, 4 June 2013
South Australia, *Parliamentary Debates*, Legislative Council, 31 October 2013
Tasmania, *Parliamentary Debates*, Legislative Council, 26 September 2013
United Kingdom, *Parliamentary Debates*, House of Lords, 10 June 1999
D  Other Sources

Instruments and Agreements


Ambulance Service Employees Award - State 2016 (Queensland, 1 August 2016)

Ambulance Tasmania Industrial Agreement 2016 (11 August 2016)

Ambulance Victoria Enterprise Agreement 2015 (7 May 2015)

Council of Australian Governments, Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions (at 26 March 2008)

Operational Ambulance Officers (State) Award (New South Wales, 26 February 2014)

Queensland Ambulance Service – Determination 2013 (2 December 2013)

SA Ambulance Service Enterprise Agreement 2011 (3 February 2012)

St John Ambulance Australia (Western Australia) Inc Ambulance Officers'/Paramedics Enterprise Agreement 2011-2014 (18 January 2012)

St John Ambulance (NT) Inc. Ambulance Enterprise Agreement 2010-2013 (10 October 2011)

Websites

Aboriginal and Torres Strait Islander Health Practice Board of Australia, Fees


Ambulance Service of New South Wales, Ambulance Year in Review 2012/13

Atkins, Mary, Australia's Most Trusted Professions 2008 (8 September 2010) Reader's Digest

Australian and New Zealand College of Paramedicine, About <https://www.anzcp.org.au/about/>

Australian and New Zealand College of Paramedicine, Submission 1: the establishment of a national registration system for Australian paramedics to improve and ensure patient and community safety
<http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Paramedics/Submissions>

Australian Bureau of Statistics, Australia and New Zealand Standard Classification of Occupations - Unit Group 4412 Fire and Emergency Workers (25 June 2009)

Australian Catholic University, Bachelor of Nursing/ Bachelor of Paramedicine (24 November 2015)


Australian Medical Association, *AMA submission - Senate inquiry into the establishment of a national registration system for Australian paramedics* (January 2016)
<http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Paramedics/Submissions>


Australian Nursing and Midwifery Accreditation Council, *About ANMAC* 

Australian Paramedics Association of New South Wales, *About APA NSW* 


Care Quality Commission, *Memorandum of understanding between the Care Quality Commission and the Health and Care Professions Council* (22 September 2014)

Care Quality Commission, *Regulated activities* (28 October 2014)
<http://www.cqc.org.uk/content/regulated-activities#accordion-1>

Chiropractic Board of Australia, *Chiropractic registrant data* (March 2016)

COAG Health Council, *Communique* (6 November)

College of Paramedics, 'Paramedic - Scope of Practice Policy' (May 2015)
<https://www.collegeofparamedics.co.uk/>


Eburn, Michael, *The establishment of a national registration system for Australian paramedics to improve and ensure patient and community safety* <http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Paramedics/Submissions>


Government of Alberta, Regulated health professions
<http://www.health.alberta.ca/professionals/regulated-professions.html>

Government of Western Australia, St John Ambulance Inquiry: Report to the Minister for Health
(October 2009) Department of Health

Government of Western Australia, Guidelines for concerts, events and organised gatherings
(December 2009) Department of Health


Health and Care Professions Council, Check the Register (2015) <http://www.hcpc-uk.org/check/>


Kerr, Judith and Stephen Jeffery, 'Wellington Pt woman pleads guilty to $6m Cleveland ambulance fire', Redland City Bulletin (online), 18 November 2014


Medicines and Healthcare Products Regulatory Agency, Patient Group Directions in the NHS (27 August 2014)
<http://www.mhra.gov.uk/Howweregulate/Medicines/Availabilityprescribingsellingandsupplyingofmedicines/ExemptionsfromMedicinesActrestrictions/PatientGroupDirectionsintheNHS/index.htm>

Ministry of Health, Responsible Authorities under the Act (17 April 2014)

Northern Ireland Ambulance Service Health & Social Care Trust, Emergency Response
<http://www.niamb.co.uk/>

Nursing and Midwifery Board of Australia, Fees for Nurses and Midwives (8 September 2014)

Nursing and Midwifery Board of Australia, Accreditation

Nursing and Midwifery Board of Australia, Fees for Nurses and Midwives
Ross, James and Matthew Callaway, *Position Statement: South Australian Protection of Title - Paramedic Bill* Private Paramedicine Australia


