

*The Role of Law in the
Professionalisation of Paramedicine
in Australia*

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LLB LLM

A thesis submitted for the degree of Doctor of Philosophy
of The Australian National University

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Statement of Originality

I certify that the thesis entitled, 'The Role of the Law in the Professionalisation of Paramedicine in Australia,' submitted for the degree of Doctor of Philosophy at the Australian National University is my own original work. Where reference is made to the work of others, due acknowledgement is given. I also certify that the material in this thesis has not previously been submitted for a degree or diploma at any university.

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Signature:

Date: December 2017

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Abstract

The paramedic discipline has developed over time from its humble beginnings as stretcher bearers and ‘drivers’ to now carrying out high-risk, highly skilled, life-saving interventions. Paramedics in Australia have not traditionally been regulated in the same way as other comparable health practitioners, despite performing similar tasks and playing a unique and essential role in healthcare delivery however they have undertaken a concerted campaign over the past 10 years to change their professional status and have looked to the law to facilitate that transition. This change is now underway. Despite the ambition of the paramedic discipline to be regulated as professionals, there has been relatively little analysis or discussion in the paramedic literature of the effect the discipline believes regulation as a profession will have on shaping the discipline in the future. This study examines how structural and legislative reform of the Australian healthcare workforce has coincided with the Australian paramedic professionalisation project to provide an opportunity for paramedics to gain professional status. It further analyses what the role of law could be in fostering a culture and ethos of professionalism in the discipline.

This socio-legal study investigates whether or not paramedics have the characteristics of a profession; how best the law can facilitate their transition to professional status; and why that matters. The analysis utilises a sociological framework informed by the work of sociologist Eliot Freidson in particular to define what a profession is and establish whether paramedicine is a profession according to common criteria. It will map those criteria against the primary piece of Australian legislation that regulates health professionals in Australia, the *Health Practitioner Regulation National Law Act 2009 (Qld)*. The study uses the same analytical framework to compare the Australian legislation to similar legislation in the United Kingdom (UK) where paramedics have been regulated as professionals for over a decade. The study analyses the implications of any significant differences between the two regulatory schemes for the UK and Australian paramedic professionalisation projects.

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Table of Abbreviations

ACAP	Australian College of Ambulance Professionals
ACO	Ambulance community officer
ACT	Australian Capital Territory
AEA	Ambulance Employees Association
AHMAC	Australian Health Ministers Advisory Council
AHPRA	Australian Health Practitioner Regulation Agency
AMA	Australian Medical Association
ANZCP	Australian and New Zealand College of Paramedicine
ASAC	Ambulance Services Advisory Committee
ASNSW	Ambulance Service of New South Wales
BFA	<i>Border Force Act 2015 (Cth)</i>
BPA	British Paramedic Association
CAA	Council of Ambulance Authorities
COAG	Council of Australian Governments
COP	College of Paramedics
EMS	Emergency medical service
GMC	General Medical Council
GP	General practitioner
HART	Hazardous area response teams
HCPC	Health and Care Professions Council
HMSO	Her Majesty's Stationery Office
HPC	Health Professions Council
HWA	Health Workforce Australia
ICP	Intensive care paramedic
JEPHC	<i>Journal of Emergency Primary Health Care</i>
MWU	Miscellaneous Workers' Union
National Law	<i>Health Practitioner Regulation National Law Act 2009 (Qld) Schedule 1.</i>

NCAU	National Committee of Ambulance Unions
NEPT	Non-emergency patient transport
NMC	Nursing and Midwifery Council
NHS	National Health System
NPPs	National Privacy Principles
NRAS	<i>National Registration and Accreditation Scheme</i>
NSW	New South Wales
PC	Productivity Commission
PEEP	<i>Paramedic Evidence Based Education Project</i>
PHA	<i>Public Health Act 1875 (UK)</i>
QAS	Queensland Ambulance Service
SORT	Special operations response teams
TAFE	Tertiary and Further Education
UK	United Kingdom
US	United States
VET	Vocational Education Training
WA	Western Australia

Preface

Once upon a time, before I was a lawyer, I was a paramedic. Before I trained to be a paramedic, I studied to be a registered nurse. To become a registered nurse I had to undertake a three-year degree at university. I was part of the first cohort in NSW to graduate with a Bachelor of Nursing from the University of Technology, Sydney. Prior to this, nursing training had largely been conducted in hospitals but leaders in nursing had determined that to improve the professional status of nursing, the education of nurses had to change.¹

Not only did nursing move from vocational training to tertiary-based training, but the curriculum was extended beyond competency-based knowledge and assessment. The tertiary curriculum was composed of many subjects including physics, chemistry, social studies, social determinants of healthcare, communication and counselling, pathophysiology, contexts of nursing, physiological psychology, introduction to nursing research, professional responsibilities in nursing and involved substantial practical skills-based training and time spent with patients. Once the course was completed, my fellow graduates and I applied to be registered on the state register of nurses—a task that required us to submit our qualifications from an accredited course, a character reference to say we were a fit and proper person to practise nursing, and a declaration that we were not criminals.

I worked as a nurse in the public hospital system for only a few months and realised very quickly that the work itself was fairly straightforward; although working with patients was rewarding, the politics of the healthcare system and particularly the health practitioner hierarchy was complex and frustrating. It seemed to me that doctors held a huge amount of power while nurses, despite holding a huge amount of responsibility, had surprisingly little power. For example, doctors could assess a patient and prescribe treatment that would then be administered by a nurse who would be expected to follow those orders. Until the early 1990s, nurses could follow the instructions of a doctor, even if they were inappropriate, and be exonerated for doing so.² However, several legal cases

¹ Megan-Jane Johnstone, *Nursing and the Injustices of the Law* (WB Saunders, 1994).

² Mary Chiarella, *The Legal and Professional Status of Nursing* (Churchill Livingstone, 2002) 11.

around this time suggested that the defence of ‘just following the doctor’s orders’ would no longer be acceptable because nurses had become recognised as professionals in their own right, and with professional status came legal responsibility.³

My dissatisfaction with my role as a nurse led me to apply for a job with the Ambulance Service of New South Wales (ASNSW) as a trainee ambulance officer in 1996. Within three days of applying I was contacted and asked if I could commence 12 weeks of training at the ASNSW training college at Rozelle the following Monday. I could, so I did. The contrast between the training to become a nurse and that to become a paramedic was stark. My fellow trainees came from a range of backgrounds. Of 20 or so recruits I was one of only two or three that had a university degree. The other trainees had, just the week before, been working in areas as diverse as green-keeping, building, plumbing and secretarial work. Our training consisted of spending seven hours a day, five days a week for 12 weeks being taught our ‘three Ps’—policies, procedures and protocols. Our training predominately required rote learning of the three Ps and regurgitating them back to the teacher—a paramedic with the same amount of training as us new recruits but with a few years of practical experience—at the end of each week in an exam. The clinical content—pathophysiology and pharmacology—was much more detailed than that in the nursing degree but the non-clinical content—for example, social determinants of health and mental health training to counsel patients in distress—was much less so. The curriculum had largely been developed by the medical director of the ASNSW. The emphasis was on minimising treatment at the scene and getting the patient to hospital as quickly as possible. There was little encouragement to use critical thinking skills except when required to solve a practice resourcing problem such as moving a patient who could not ambulate from a multi-story building with no lift to the ambulance.

I managed to complete the course and 12 weeks later my fellow trainees and I were let loose on an unsuspecting public. I say this because, unlike with nursing, then and now there is no state or national register for paramedics. There was no regulation beyond the *Ambulance Services Act 1990* (NSW) that stipulated that as employees of NSW we must

³ Megan-Jane Johnstone, *Nursing and the Injustices of the Law* (WB Saunders, 1994); Mary Chiarella *The Legal and Professional Status of Nursing* (Churchill Livingstone, 2002) 11.

follow orders and that we must wear a uniform—a typical early 20th century piece of paramilitary-style, command-and-control legislation.

We responded to calls for help at all times of the day and night from people from every group and class of society. My partner and I would attend a patient in a multi-million dollar home at Potts Point and our very next call might be to attend a patient who had overdosed in a dark alley just up the street in Kings Cross. We would not know what to find when we arrived at these jobs, regardless of the information our control room gave us. What I noted about this situation that was again distinct from my nursing role was that as paramedics we worked in an almost entirely uncontrolled and often dangerous environment. Unique to the role that we performed was that we ran towards danger when many others ran from it.

I was also surprised by the level of trust that existed in the community towards us, despite our lack of credentials. For example, I recall arriving at a Potts Point address to find the door open and our elderly female patient lying in her nightgown, at her most vulnerable. She did not even think to ask us for identification or verification of our qualifications, credentials or right to be there. She instead did anything we asked, including disrobing and allowing us to inject her with drugs and apply other treatments trusting that we knew what we were doing and that we would help make her better not worse. This woman probably had a GP or other physicians who were much more highly skilled and trained (and costly) than we were; yet she called us and we came. We did not just transport her to hospital like a taxi service would, we conducted an assessment of her and determined the most appropriate protocol and treatment to apply before and during transport.

In my capacity as a paramedic I was allowed to apply higher-risk interventions and had much more autonomy than I had as a nurse or indeed had any of the nurses with whom I had worked in the hospital. I had a three-year degree to help me understand what it was I was doing but the majority of paramedics I worked with did not. All they had was limited vocational training supported—eventually—by experience.

Significantly, my legal responsibility as a paramedic differed from my legal responsibility as a nurse, most notably because as a nurse I had to be registered for public protection and safety. This legal distinction was related to professional status. Nursing had evolved over time into a profession but paramedics, despite doing the same or in some cases more

advanced work, were still referred to as ‘drivers’ or viewed by the courts as non-experts in emergency care.⁴ This anomaly is what prompted me to undertake this research. Why is it still that paramedics can undertake such advanced, high-risk, highly skilled procedures in a largely uncontrolled and unmonitored environment after only a relatively short amount of largely competency-based training, when other health professionals who do comparable work—nurses and doctors—must complete at least a three-year university degree and be registered under a national registration scheme before they are able to do so? What is it to be a health ‘professional’ and does it matter? This thesis attempts to answer these questions.

⁴ *Worley v The Ambulance Service of New South Wales* [2004] NSWSC 1269.

Chapter 1: Why Should Paramedics be Regulated as Professionals?

1.1 Introduction

Studies of the relationship between paramedics and the law in Australia have highlighted the gap between how paramedics are regulated compared with other health professional groups who perform similar work for the sick and injured, for example nurses and doctors.⁵ Indeed, for just over a decade, paramedics in Australia have been lobbying to increase their professional and legal status by seeking to be regulated in the same way as other health professions.⁶

⁵ Michael Eburn and Jason Bendall, 'The Provision of Ambulance Services in Australia: A Legal Argument for the National Registration of Paramedics' (2010) 8(4) *Journal of Emergency Primary Health Care* <http://pandora.nla.gov.au/pan/37708/20111028-0123/www.jephec.com/issue_contents24e3.html?issue_id=45>; Michael Eburn, *Emergency Law* (Federation Press, 4th ed, 2013); Ruth Townsend and Michael Eburn 'Professional Discipline for Registered Health Professionals: Lessons for Australian Paramedics' (2014) 41(3) *Response* 41–3; Ruth Townsend and Michael Eburn, Submission to Health Workforce Principal Committee, Australian Health Ministers' Advisory Council (AHMAC), *Options for Regulation of Paramedics*, 2012 <https://law.anu.edu.au/sites/all/files/users/u4810180/2012_submission_to_the_australian_health_ministers_advisory_council.pdf>; Ruth Townsend and Morgan Luck, *Applied Paramedic Law and Ethics* (Elsevier, 2013); Ruth Townsend, Submission to Senate Legal and Constitutional Affairs Committee, Parliament of Australia, *The Establishment of a National Registration System for Australian Paramedics to Improve and Ensure Patient and Community Safety*, 2016 <https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Paramedics/Submissions>

⁶ Louise Reynolds, 'Is Pre-Hospital Care Really a Profession?' (2004) 2(1–2) *Journal of Emergency and Primary Health Care* <http://pandora.nla.gov.au/pan/37708/20051101-0000/www.jephec.com/full_articlefba3.html?content_id=155>; See also Peter O'Meara, 'Paramedics Marching Towards Professionalism' (2009) 7(1) *Journal of Emergency and Primary Health Care* <http://pandora.nla.gov.au/pan/37708/20091028-0000/www.jephec.com/full_articled603.html?content_id=511>; Rod Sheather, 'Challenges in Paramedic Practice: Professionalisation' in Peter O'Meara and Carol Grbich (eds), *Paramedics in Australia; Contemporary Challenges of Practice* (Pearson Education, 2009); Kerry Mahony, 'The Politics of Professionalisation: Some Implications for the Occupation of Ambulance Paramedics in Australia' (2003) 1(3) *Australasian Journal of Paramedicine* <<https://ajp.paramedics.org/index.php/ajp/article/view/198/216>>; Brett Williams, Ted Brown and Andrys Onsmann, 'From Stretcher-Bearer to Paramedic: The Australian Paramedics' Move Towards Professionalisation' (2009) 7(4) *Australasian Journal of Paramedicine* <<https://ajp.paramedics.org/index.php/ajp/article/view/301>>; Brett Williams, Ted Brown and Andrys Onsmann, 'Is the Australian Paramedic Discipline a Full Profession?' (2010) 8(1) *Australasian Journal of Paramedicine* <<https://ajp.paramedics.org/index.php/ajp/article/view/113>>; Tania Johnstone and Joe Acker, 'Using a Sociological Approach to Answering Questions About Paramedic Professionalism and Identity' (2016) 13(1) *Australasian Journal of Paramedicine* <<https://ajp.paramedics.org/index.php/ajp/article/view/301>>; Pip Lyndon James, 'Striving for the Professionalisation of Australian Paramedics' 3(3) *International Paramedic Practice* 74; Sue First, Lucy

Numerous representations in the literature by academics, paramedics, paramedic students and the paramedic industry (including state-based ambulance services, the defence force and private paramedic providers), make clear that a substantial proportion of paramedics believe that legal regulation as a profession can provide them with legitimate status and privileges that they, as an occupational group, currently do not enjoy.⁷

1.2 The Problem

Historically, paramedic (health treatment) services were inseparably linked with ambulance services (transport services). Ambulance officers, or ‘drivers’ as they were often called, would simply be required to attend the location of the patient, load them into the ambulance and accompany them to definitive care (‘load ‘n go’). They were vocationally trained at first and only required a first aid certificate to practise. However, over time and with advances in technology and medical science, the training and role of paramedics has expanded and evolved.

Today, paramedics make up a large proportion of health workers working in the out-of-hospital environment with approximately 16,000 full-time equivalent salaried personnel involved in the delivery of services and ~80% of those involved in patient care.⁸ They are

Tomlins and Andy Swinburn, ‘From Trade to Profession—the Professionalisation of the Paramedic Workforce’ (2012) 4(7) *Journal of Paramedic Practice* 378; Hugh Grantham, ‘Prehospital Care as a Profession—Are We There Yet?’ (2004) 2(1–2) *Journal of Emergency Primary Health Care* <http://pandora.nla.gov.au/pan/37708/20051101-0000/www.jephc.com/full_articleb3b7.html?content_id=156>; Angus C McDonell, ‘The Search and Development of Professionalism in “Ambulance”: A Multidisciplinary Journey’ (2009) 7(4) *Journal of Emergency Primary Health Care* <<https://ajp.paramedics.org/index.php/ajp/article/view/182/197>>; Paramedics Australasia (PA), Submission to Health Workforce Principal Committee, AHMAC, *Options for Regulation of Paramedics*, 2012; PA, ‘The Forgotten Health Profession’ (Report, September 2011); Australian and New Zealand College of Paramedicine (ANZCP), Ambulance Employees Australia Victoria, National Council of Ambulance Unions (NCAU), Council of Ambulance Authorities (CAA), Australian Paramedics Association Queensland, PA, Submissions to Senate Legal and Constitutional Affairs Committee, Parliament of Australia, *The Establishment of a National Registration System for Australian Paramedics to Improve and Ensure Patient and Community Safety*, 2016 <https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Paramedics/Submissions>.

⁷ For example, a survey conducted by PA in 2012 found that 87% of paramedic respondents supported being regulated under the National Registration and Accreditation Scheme, see PA, *Public Risk and Paramedic Regulation* (2012) <<https://www.paramedics.org/content/2012/09/PA-Submission-on-paramedic-registration-03082012.pdf>>; Alistair Quaille, ‘Paramedics and Professionalisation’ (2013) 3(3) *International Paramedic Practice* 57; Williams et al, ‘Are Paramedic Students Ready to be Professional? An International Comparison Study’ (2015) 23 (2) *International Emergency Nursing* 120-126; PA, *Public Risk and Paramedic Regulation* (2012) <<https://www.paramedics.org/content/2012/09/PA-Submission-on-paramedic-registration-03082012.pdf>>.

⁸ Productivity Commission (PC), *Government Services: Fire and Ambulance Services*, Report (2016) 9.34.

responsible for the bulk of emergency and trauma work undertaken in the out-of-hospital space.⁹ The majority of paramedics are now required to undertake a three-year university degree before being employed to practise. This level of training is necessary to perform the highly skilled and specialised tasks that paramedics undertake. The work paramedics do is inherently risky: they perform high-risk interventions in high-risk conditions with high-risk patients.¹⁰ Paramedics provide a broad range of care and treatment and perform some of the most invasive procedures, under the least oversight in the most uncontrolled environments with extremely vulnerable patients compared with other health workers in Australia.¹¹ They are often the first point of contact for access to the healthcare system for the provision of emergency care and unlike other healthcare practitioners, typically respond to unknown situations. They can and do work as healthcare practitioners with or without the addition of an ambulance.

The common identifiers that distinguish paramedics from other health practitioners are that:

1. they work in an uncontrolled out-of-hospital environment¹²
2. they most often provide emergency care.¹³

Paramedics perform advanced treatment skills that are at least equivalent in degree of difficulty and risk to those performed by nurses and doctors, including the administration of restricted substances like morphine and anaesthetic agents.¹⁴ As is demonstrated throughout this thesis, risk is a factor in considering the way in which an occupational group is regulated. Indeed, the Australian Health Ministers' Advisory Council (AHMAC) identified 13 risk factors that assist in evaluating the risk that a health occupational group

⁹ Ibid; PA *Public Risk and Paramedic Regulation* (2012)

<<https://www.paramedics.org/content/2012/09/PA-Submission-on-paramedic-registration-03082012.pdf>>.

¹⁰ Health Workforce Principal Committee, AHMAC, *Consultation Paper: Options for Regulation of Paramedics* (2012).

¹¹ Ibid.

¹² In this thesis, the term 'out-of-hospital' is used interchangeably with the term 'pre-hospital' care. Unlike most other healthcare professionals who work in indoor, largely controlled environments, paramedics perform unscheduled care in outdoor environments as well as indoor environments and always in uncontrolled environments unless they are working in the back of an ambulance.

¹³ In this thesis, the term 'emergency' is used interchangeably with 'urgent' and 'unscheduled'.

¹⁴ For details of skills matrix, intravenous fluids and medication administration by paramedics, see Tables 7 and 8 from Health Workforce Principal Committee, AHMAC, *Consultation Paper: Options for Regulation of Paramedics* (2012).

<http://ris.pmc.gov.au/sites/default/files/posts/2012/07/options_for_regulation_of_paramedics_consultation_paper.pdf>29.

might pose to the public to determine whether or not that group should be regulated.¹⁵ The most specialised paramedic performs 11 of those 13 interventions, making this the third-most risky health profession in Australia according to the AHMAC criteria.¹⁶

The nature of the practice of paramedicine is that it takes place predominantly in the pre-hospital, emergency care, time-critical space where there is little formal oversight, a lack of transparency and accountability, and limited infrastructure and other staff support. This means that paramedics often make decisions in the face of great uncertainty and with the potential for great effect, both positive and negative. They do not have the luxury of relying on a range of other specialists and experts to help them make clinical decisions, unlike healthcare practitioners working in hospitals. Paramedics must take responsibility for their clinical judgement and the consequences of the same, commonly when the stakes are at their highest—literally in life-and-death situations. Paramedics rely on their knowledge and skill and often the wisdom from their experience to help inform their decision making. Despite the risks that they pose and the responsibilities they have, paramedics are not yet regulated by the key body of legislation that regulates health professions in Australia: the *Health Practitioner Regulation National Law Act 2009 (Qld)*¹⁷ ('the National Law').

This lack of formal regulation means that paramedics are not currently registered health practitioners in any state or territory of Australia. In turn, there is no nationally uniform protection of the title of paramedic. There is also no easy way for the public to identify who is a suitably qualified paramedic and who is not. Indeed, there is no standard measure of a 'suitably qualified paramedic'. This is because there is no standardised accreditation of educational and professional criteria to be met to qualify as a paramedic. There is no transparent and consistent way to sanction poorly performing paramedics or to provide support to impaired paramedics. There is no way for the public and employers—either public or private—to check the registration status of individual paramedics because they

¹⁵ Ibid.

¹⁶ AHMAC, *Final Report: Options for the Regulation of Paramedics* (September 2015) 110–1 <<http://www.coaghealthcouncil.gov.au/Portals/0/Paramedics%20Decision%20RIS.pdf>>.

¹⁷ *Health Practitioner Regulation National Law Act 2009 (Qld)* Schedule 1. The law is an example of cooperative federalism and has been copied or adopted with amendments by all other states and territories see *Health Practitioner Regulation National Law 2010 (ACT)*; *Health Practitioner Regulation National Law 2009 (NSW)*; *Health Practitioner Regulation National Law (National Uniform Legislation) Act 2009 (NT)*; *Health Practitioner Regulation National Law (South Australia) Act 2010 (SA)* Schedule 2; *Health Practitioner Regulation National Law (Tasmania) 2010 (Tas)*; *Health Practitioner Regulation National Law 2009 (Vic)*; *Health Practitioner Regulation National Law 2010 (WA)*.

are not registered; there is no way of knowing a given paramedic's values or what can reasonably be expected of their conduct or competency, because they have no practice standards or code of ethics. There is also no simple way for paramedic practitioners to move across state and international borders to practise. This places limits on this group of healthcare workers with respect to contributing to increasing the flexibility of Australia's healthcare workforce.

Facilitating workplace mobility and flexibility is one of the main objectives of the National Law. Equally important under the National Law is managing risks to public safety posed by health practitioners.¹⁸ The National Law provides a regulatory mechanism that facilitates access to healthcare services 'in accordance with the public interest'¹⁹ and in a related fashion, a regulatory scheme that enables the development of a 'flexible, responsive and sustainable Australian health workforce that supports innovative service delivery'.²⁰ The objectives of the legislation arose from the recommendations of a Productivity Commission (PC) inquiry into Australia's health workforce in 2005, which identified lack of flexibility in health workforce roles and responsibilities as an issue that would limit the capacity of the future healthcare workforce to meet community needs.²¹ The PC recognised that health workforce restructuring in the form of 'broadening scopes of practice and more major job redesign' of non-medical healthcare practitioners—including physician assistants, surgical care practitioners, rural health practitioners, nurse anaesthetists, medical assistants and **paramedic practitioners**—may be a way to address this.²²

However, at the time of publication of the PC report, a number of legislative and structural barriers within the healthcare system limited the professional development of non-medical practitioners, including paramedics. In 2009 legislative reform was undertaken to facilitate the structural reform included in the introduction of the National Law. The technical purpose of this Act is to provide a coherent statutory framework at the Commonwealth, state and territory levels for its *National Registration and Accreditation Scheme (NRAS)*

¹⁸ *Health Practitioner Regulation National Law Act 2009* (Qld) s3 (2)(a).

¹⁹ *Ibid* s 3 (2)(e).

²⁰ *Ibid* s 3 (2)(f).

²¹ PC, *Australia's Health Workforce*, Research Report (2005).

²² *Ibid* 65 (emphasis added).

for health professionals in Australia.²³ It applies to 14 health professions including medicine, nursing, psychology, physiotherapy and podiatry. Paramedics may be thought of by the public, and even the industrial courts, as professionals.²⁴ However, they are not regulated as such. As a result, paramedics are not yet able to realise their professional development aspirations and enjoy the privileges associated with having professional status, nor are they able to contribute to the development of an accessible, flexible and sustainable healthcare workforce.

Although paramedics (treatment service) are likely to be regulated in future under the National Law, ambulance services (transport service) will not be covered by that legislation. Traditionally, ambulance services have been synonymous with the delivery of out-of-hospital emergency care, but as is shown in Chapter 3, there has been a growing divergence between the focus of the use of an ambulance vehicle and the duty to transport, and the work of paramedicine, which is the provision of high-quality out-of-hospital emergency care. After registration it will still be possible and may be appropriate for ambulance services to continue to operate with staff who are not registered paramedics to provide non-emergency patient transport or extended community care services. South Australia, for instance distinguishes between the role of ambulance officers and the role of paramedics and that can continue after the registration of paramedics.²⁵ However, the issue of the regulation of ambulance services is outside the scope of this thesis.

1.3 Aims and Scope of the Research

This study uses a socio-legal approach to answer the following questions:

- Why should paramedics be regulated as health professionals under the National Law?

²³ *Health Practitioner Regulation (consequential amendments) Bill 2010* (Cth). Second reading speech. Commonwealth, Hansards, House, 12 May 2010, 3250 (Nicola Roxon, Minister for Health and Ageing). <<http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;db=CHAMBER;id=chamber%2Fhansardr%2F2010-05-12%2F0083;query=Id%3A%22chamber%2Fhansardr%2F2010-05-12%2F0000%22>>.

²⁴ *Transport Workers Union v Department of Justice and Community Safety* (unreported Determination, Fair Work Australia, Commissioner Deegan, 29 March 2010) <<http://www.fair-go.com/docs/FWA2010decision.pdf>>.

²⁵ South Australian Ambulance Service, *On-road Staff* <<http://www.saambulance.com.au/Whoweare/Emergency/Onroadstaff.aspx>>.

- How can the National Law facilitate the professionalisation of paramedicine in Australia?
- What effect might professionalisation have on paramedicine in Australia?

This thesis was commenced before the regulation of paramedics under the National Law was considered. However, during the course of this research, paramedics (and others including myself²⁶) have lobbied for paramedics to be regulated under the National Law. This lobbying was successful and at the time of this thesis was being completed there was a Bill before the Queensland Parliament to amend the National Law to include paramedics under the Act.²⁷ This law will likely take effect in late-2017. This thesis reflects the law up until 31st August 2017.

This thesis makes both descriptive and normative claims. It primarily sets out to describe the nature of paramedic regulation as it is and as it will be under the National Law. It is the author's view that regulation under the National Law will benefit both patients and paramedics. This normative position is not specifically defended though at places it is referred to.

The hypothesis investigated in this study is that the National Law will facilitate the professionalisation of paramedics because the National Law will allow paramedics to be separated from the control of their employers (typically state-based ambulance services) and allow the discipline to self-regulate. This legal mechanism will also allow paramedicine to develop a culture and ethos of professionalism and offer paramedics an opportunity to work in a new and positive way.

²⁶ Ruth Townsend, Submission to Senate Legal and Constitutional Affairs Committee, Parliament of Australia, *The Establishment of a National Registration System for Australian Paramedics to Improve and Ensure Patient and Community Safety*, 2016 <https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Paramedics/Submissions>; Ruth Townsend and Michael Eburn, Submission to Health Workforce Principal Committee, Australian Health Ministers' Advisory Council (AHMAC), *Options for Regulation of Paramedics*, 2012 <https://law.anu.edu.au/sites/all/files/users/u4810180/2012_submission_to_the_australian_health_ministers_advisory_council.pdf>.

²⁷ *Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2017 (Qld)*

1.4 Overview of the Study

Broadly the thesis is structured as two main parts. Part I examines ‘professions’ and paramedicine as a profession. It is broken into three sub-sections (Chapters 2, 3 and 4). The first of these considers the sociological concept of professions as theorised by Flexner, Parsons, Greenwood, Johnson, Abbott, Larson and Eliot Freidson. Freidson researched and wrote prolifically on the sociological phenomenon of the professions for over two decades, so his work informs the development of an analytical tool used throughout this study.

The section on the theory of professions is followed by an historical and social analysis of the development of paramedicine and concludes with an analysis of the Australian paramedic literature to gain an understanding of what paramedics think a profession is and why professionalisation matters to them.

The second part of the thesis is broken into three sub-sections (Chapters 5, 6 and 7). The first examines the legislation that should regulate paramedics as health professionals in Australia from late 2018 and evaluates whether that legislation will complete the task of paramedic professionalisation in Australia, as paramedics hope it will. The second section compares the Australian regulatory regime to that in the United Kingdom (UK), where paramedics have been regulated as professionals for over a decade, to consider if there are any lessons that may be learned from that experience for Australian paramedics. The study concludes with an analysis of the development of a coherence for paramedicine between the acquisition of legal status as a profession and the development of a culture and ethos of professionalism.

Specifically, Chapter 2 provides a theoretical framework for the study. This is a socio-legal study and so this chapter will review the sociological literature on ‘professions’ and identify common criteria for recognising an industry group as a profession. It draws, in particular, on the work of Freidson and establishes how the literature defines the terms ‘profession’, ‘professionalisation’ and ‘professionalism’. It considers the ways in which ‘professionalism’ is used as a regulatory tool distinct from bureaucratic and free market controls. It discusses structural issues associated with medical dominance and professional closure and their effect on the development of a flexible and sustainable healthcare workforce. It concludes with the development of a theoretical analytical tool that will be used throughout this essay.

Chapter 3 critically analyses the historical development of paramedics as practitioners using the theoretical framework established in Chapter 2. This chapter examines who paramedics are, where they have come from, how they have evolved and the way in which they have been historically regulated to determine what characteristics of the discipline distinguishes paramedics from other healthcare workers.

Chapter 4 examines the more recent literature related to the paramedic professionalisation project. It uses Freidson's elements to analyse both the peer-reviewed literature and submissions made to various government inquiries by paramedics and paramedics groups to establish what elements of a profession the paramedic discipline currently has, what elements it seeks, why it wants them and how it thinks it is going to obtain them.

Chapter 5 uses Freidson's elements for a profession to analyse whether the legislation proposed to regulate paramedics—the National Law—will provide the key professional elements that paramedics currently lack and analyses how this form of regulation might shape future paramedic professional development.

Chapter 6 provides a comparative analysis of the way in which paramedics are regulated in the UK. The UK regulatory regime has been established for many years but is quite different from the proposed Australian model. This chapter uses Freidson's elements for a profession to analyse the UK regulatory scheme and consider the effectiveness of that scheme in facilitating the professionalisation of paramedics in the UK. It identifies the strengths and weaknesses associated with that model of regulation, which may provide lessons for Australian paramedicine as it moves towards regulation as a profession.

Chapter 7 examines two key areas of governance that will be available to the Paramedicine Board, once regulated under the National Law, to facilitate the development of a culture and ethos of professionalism. It considers the effect the law will have on unifying paramedicine to establish a clear professional identity in a way that paramedicine has not previously realised. It considers the responsibilities associated with their new role as a health profession.

Chapter 8 summarises the key themes arising from the research, details the implications of the findings and makes recommendations for the future.

Part I—Paramedicine as a Profession

Chapter 2: What is a Profession?

Over the past three decades, paramedics have been lobbying to improve their legal and professional status via the process of professionalisation so that they are better able to achieve a number of objectives. These include providing increased opportunities for individual practitioners to professionally develop; increasing the power of the paramedic industry to improve conditions for staff and patients; and meeting the objectives of the government and wider community in offering alternative health service delivery models that are both more effective and more efficient.²⁸ There is a scant literature on the topic of paramedic professionalisation in Australia and this is discussed in more detail in Chapter 4. However, it is interesting to note here that there is a consensus within that literature that while paramedicine is not yet a profession, it is in the process of professionalising.²⁹ This process has been referred to as the ‘paramedic professionalisation project’ in the UK.

²⁸ Brett Williams, Ted Brown and Andrys Onsman, ‘Is the Australian Paramedic Discipline a Profession? A National Perspective’ (2012) 2 *International Paramedic Practice* 161.

²⁹ Louise Reynolds, ‘Is Pre-Hospital Care Really a Profession?’ (2004) 2(1–2) *Journal of Emergency Primary Health Care*. See also Peter O’Meara, ‘Paramedics Marching Towards Professionalism’ (2009) 7(1) *Journal of Emergency Primary Health Care*; Rod Sheather, ‘Challenges in Paramedic Practice: Professionalisation’ in Peter O’Meara and Carol Grbich (eds), *Paramedics in Australia: Contemporary Challenges of Practice* (Pearson, 2009); Kerry Mahony, ‘The Politics of Professionalisation: Some Implications for the Occupation of Ambulance Paramedics in Australia’ (2003) 1(3) *Australasian Journal of Paramedicine*, Article 8; Brett Williams, Ted Brown and Andrys Onsman, ‘From Stretcher-bearer to Paramedic: The Australian Paramedics’ Move Towards Professionalisation’ (2009) 7(4) *Australasian Journal of Paramedicine*, Article 8; Brett Williams, Ted Brown and Andrys Onsman, ‘Is the Australian Paramedic Discipline a Full Profession?’ (2010) 8(1) *Australasian Journal of Paramedicine*, Article 3; Tania Johnstone and Joe Acker, ‘Using a Sociological Approach to Answering Questions About Paramedic Professionalism and Identity’ (2016) 13(1) *Australasian Journal of Paramedicine*; Pip Lyndon James, ‘Striving for the Professionalisation of Australian Paramedics’ (2013) 3(3) *International Paramedic Practice*, 74–78; Brett Williams, Andrys Onsman and Ted Brown, ‘Is the Australian Paramedic Discipline a Profession? A National Perspective’ (2012) 2(3) *International Paramedic Practice*, 77–84; Sue First, Lucy Tomlins and Andy Swinburn, ‘From Trade to Profession—the Professionalisation of the Paramedic Workforce’ (2012) 4(7) *Journal of Paramedic Practice*, 378–381; Hugh Grantham, ‘Prehospital Care as a Profession—Are We There Yet?’ (2004) 2(1–2) *Journal of Emergency Primary Health Care*; Angus C McDonell, ‘The Search and Development of Professionalism in “Ambulance”: A Multidisciplinary Journey’ (2009) 7(4) *Journal of Emergency Primary Health Care*; PA, *Public Risk and Paramedic Regulation*, Submission to Health Workforce Principal Committee, AHMAC, *Options for Regulation of Paramedics*, 2012; PA, *The Forgotten Health Profession* September 2011; ANZCP, Ambulance Employees Australia Victoria, NCAU, CAA, Australian Paramedics Association Queensland, PA, Submissions to Senate Legal and Constitutional Affairs Committee, Parliament of Australia, *The Establishment of a National Registration System for Australian Paramedics to Improve and Ensure Patient and Community Safety*, 2016

Sociologists have recognised professionals as a particular group of workers in society; professions as a particular way of structuring the workforce; and professionalism as a particular way of regulating that workforce. Given that paramedicine is seeking to be recognised as a profession and paramedics are seeking professional status, this chapter sets out the theoretical framework that is used to analyse the current professional status of paramedics and assess whether the proposed law to regulate paramedics - the National Law - will provide them with the professional status they are seeking. It examines the sociological literature on professions and establishes definitions for professions, professionalisation and professionalism. It offers some explanation as to why paramedics are seeking to be recognised as such and what benefits that status may bring to not only paramedics but society more broadly. The chapter concludes with a discussion of the way in which the five key elements commonly associated with professions are used as a tool in analyses throughout this thesis.

2.1 The Role of the Professions

The wide body of academic literature on professions reflects a broad view of the role, structure, function and importance of this classification of workers in our society. The word ‘profession’ originated from the Latin in or around 1175–1225AD and is today defined as:

a disciplined group of individuals who adhere to ethical standards and who hold themselves out as, and are accepted by the public as, possessing special knowledge and skills in a widely recognised body of learning derived from research, education and training at a high level, and who are prepared to apply this knowledge and exercise these skills in the interest of others. It is inherent in the definition of a profession that a code of ethics governs the activities of each profession. Such codes require behaviour and practice beyond the personal moral obligations of an individual. They define and demand high standards of behaviour in respect to the services provided to the public and in dealing with professional colleagues. Further, these codes are enforced by the profession and are acknowledged and accepted by the community.³⁰

<http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Paramedics/Report>.

³⁰ Professions Australia (ed) *What is a Profession?* <<http://www.professions.com.au/about-us/what-is-a-professional>>. Professions Australia claims to be “the voice of the professions to government since 1971.” Its vision is to operate as the recognised national authority on professional ideals, conduct, standards and practice in service of the community.

This definition incorporates key elements or traits that are commonly associated with a profession. The combination of these traits distinguishes professions from non-professions. The origin and relevance of these traits are discussed in more detail throughout this chapter.

The professions have undergone development varying in type and number across time.³¹ Historically, professions were derived from guilds.³² Guilds were groups of artisans and labourers who came together over their common skill set. For example, stonemasons bonded with other stonemasons, carpenters with other carpenters and so on in a type of union to control prices, regulate work hours, determine who could practise those skills and where, and generally protect the financial interests of its members. They were influential in society³³ and provided an important social role in the division of work by demarcating areas of work specialisation. They were also important for establishing a cohesion-building mechanism that allowed for an increasingly modernising society to remain unified rather than fragmenting into individual pieces.³⁴

The relationship between professions and codes of conduct is historically linked to monastic and religious codes including the *Priestly Code* found in the *Old Testament*, the 5th century Greek *Hippocratic Oath*, monastic codes of the middle ages and—significantly for paramedics—the rule of the Knights Hospitallers of St John of Jerusalem (during the Crusades). A code of ethics for physicians and surgeons in England was proposed by Thomas Percival in 1794 and by the early 20th century, codes of ethics were used as tools of regulation by most of the professions in the United States (US). This is how the code of ethics came to be associated with being a profession.³⁵

During the Industrial Revolution, when the guilds became threatened by industrial-scale workshops and mass production of goods, they began a half-century long process of shifting shape and carving out a unique space in society that would stand in contrast to

³¹ Abraham Flexner, 'Is Social Work a Profession?' (1915) 1 *School and Society* 904.

³² Elliott A Krause, *Death of the Guilds: Professions, States, and the Advance of Capitalism 1930 to the Present* (Yale University Press, 1996); John A Jackson, *Professions and Professionalisation* (Cambridge University Press, 1970) 4.

³³ Jan Lucassen, Tine De Moor and Jan Luiten van Zanden, *The Return of the Guilds* (Cambridge University Press, 2008).

³⁴ James R Lincoln and Didier Guillot, 'Durkheim and Organizational Culture' (Working Paper No 108-04, Institute for Research on Labor Employment, 1 June 2004).

³⁵ Seumas Miller, *Model Code of Ethics Principles*. Professional Standards Council.

<<https://www.psc.gov.au/sites/default/files/Model%20code%20of%20ethics%20principles.pdf>>.

uniform, homogenous industrial production of goods that became the norm within society from that point onwards. They promised to offer occupational, bespoke expertise.³⁶ The organisational structure of what then developed into what we now refer to as the ‘professions’ was also different from free markets—an ideological approach that was implemented by Western governments during this time—and a later approach to occupational control, bureaucracy.³⁷

Bureaucratic control is distinct from professional control in that the former consists of an external administration and hierarchy and the latter is controlled by the profession itself. Max Weber wrote that bureaucratic organisation of labour was about control via structure and routines; for example, detailed specification of administrative tasks, rationalisation, impersonal, hierarchical lines of authority, review of accuracy and efficiency of decision making. He said:

A fully developed bureaucracy embodies very specifically the principle of *sine ira ac studio* (i.e., without anger or frustration). This specific character of bureaucracy means the complete eradication of love, hate, and all purely personal sentiments from administrative tasks. Put bluntly, this means the eradication of all sentiments that are irrational and incalculable.³⁸

Free market control or a laissez-faire approach amounted to having faith that supply and demand market forces would ensure the provision of all that was needed by all in society.³⁹ However, the Industrial Revolution exposed issues with the maintenance of faith in the free market to address the health and social effects of industrialisation. One example of such an effect was the contamination of the water supply. During the early to mid-19th century in London there was a cholera outbreak. Cholera is a water-borne disease. At that time water in London was privately owned and water quality and supply unregulated as per the popular

³⁶ Edgar Alan Burns, ‘How Does a Short History of Professions Help Us Think About Professionalisation Today?’ (Paper presented at the 14th Australian Studies Conference in China, Mudanjiang Normal University, 11 July 2014).

³⁷ Milton Friedman, *Capitalism and Freedom* (University of Chicago Press, 1962) 158; Freidrich Hayek, *Law, Legislation and Liberty, Volume 2, The Mirage of Social Justice* (University of Chicago Press, 1976).

³⁸ Max Weber, ‘Bureaucracy’ in Tony Waters and Dagmar Waters (trans and eds), *Weber’s Rationalism and Modern Society: New Translations on Politics, Bureaucracy, and Social Stratification* (Palgrave Macmillan, 2014).

³⁹ Oxford Dictionary <<https://en.oxforddictionaries.com/definition/us/laissez-faire>>.

laissez-faire approach at the time.⁴⁰ The effect of the faith in free markets was such that many industries went unregulated and as a result, were able to pump pollutants into the River Thames. The river was the main water source for many Londoners and as this industry was also unregulated, it was not long before people became ill. Poor Law Commissioner Edwin Chadwick had undertaken a study of the ‘labouring population’ and recognised that there were ‘defective supplies in water’, which was making the population sick.⁴¹ He introduced the first *Public Health Act 1848 (UK)*, which to some extent regulated industry, most significantly addressing free market failures around working conditions in factories. Around this time doctors were also in the process of professionalising. They were gaining greater knowledge of human anatomy and physiology and although germ theory had not yet been discovered, epidemiology was developing as a specialty in public health. Doctor John Snow used epidemiological methods to link contaminated water with an outbreak of cholera in the mid-1800s.⁴² The social anxiety associated with the outbreak provided doctors with an opportunity to demonstrate their specialised knowledge and the benefits of having a workforce that was structured to include professionals, like doctors, who could work beyond the confines of the bureaucracy and with a morality lacking in the free market.⁴³

The possession of specialist knowledge legitimated the authority of would-be professions like medicine. This specialist knowledge required specialist learning and the sharing of occupational wisdom.⁴⁴ The education revolution that resulted has been considered as important as the industrial and democratic–social revolutions. This is because there

⁴⁰ EJ Hobsbawm, *The Age of Empire 1875–1914* (Vintage Books, 1987).
<<http://14.139.206.50:8080/jspui/bitstream/1/2435/1/Hobsbawm,%20E.J.%20-%20The%20age%20of%20empire.pdf>>.

⁴¹ Edwin Chadwick, *A Report on the Sanitary Conditions of the Labouring Population* (Publisher, 1842).

⁴² Lisa N Harning, *Comparing and Contrasting Social, Political, and Medical Reactions to 19th Century Cholera Epidemics in London and New York City* (Honors Thesis, University of New Hampshire, 2015) 229.

⁴³ Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001) noted that ‘the strengthening of the legitimacy of professionalism requires clear recognition of the ethical implications of professional privilege and strong resistance to the institutional arrangement for practice which emphasise economic incentives over others’ 218.

⁴⁴ The practical application of which has been referred to by Pitman as ‘phronesis’, a type of practical wisdom and reflective judgement using one’s knowledge in service of some good. Pitman suggested that there is a conflict for professionals between utilising this form of wisdom and conforming to protocols of practice mandated within a professional structure: Allen Pitman, ‘Professionalism and Professionalisation: Hostile Ground for Growing Phronesis?’ in Elizabeth Anne Kinsella and Allen Pitman (eds), *Professional Practice and Education: A Diversity of Voices* (Sense Publishers, 2012) vol 1, 131.

developed a growing reliance on specialisation and technical expertise by government, industry and society more broadly.⁴⁵ The rise and strategic importance of the professions was ‘the most important change that has occurred in the occupational system of modern societies’⁴⁶ with their role recognised as being so integral and important to the structure and function of society that their loss would likely cause disruption to societal solidarity.⁴⁷

Social solidarity, or the reasons why a community of people choose to form a society, was a concept examined by sociologist Emile Durkheim.⁴⁸ He observed the effects of modernity on the division of labour in society and hypothesised that in a complex modern society a division of labour serves the purpose of maintaining social order. He suggested that each member of society having their specialist role and function would ensure an interdependence on one another that would have a socially binding effect. He recognised that specialisation extended and applied to every area of society including political, administrative and judicial activities.⁴⁹ Importantly for this thesis, Durkheim noted that each speciality had not only its own purpose but also its own culture, created in part through education and shared values.⁵⁰

The division of labour is also an economic concept identified by Adam Smith. He observed the additional benefits of siloing occupations into specialist divisions. Specialisation allowed for improved efficiency by having a worker trained and experienced with a particular knowledge and skill set. The application of this specialised knowledge and skills led to improved quality, savings in time and other resources.⁵¹ There are two distinct types of specialisation: occupational groups that have higher professional value utilise

⁴⁵ Talcott Parsons, ‘Professions’ in David E Sills (ed), *International Encyclopedia of the Social Sciences* (MacMillan and Free Press, 1968) 290.

⁴⁶ Talcott Parsons, *The System of Modern Societies* (Prentice-Hall, 1971) 94; Talcott Parsons, ‘Professions’ in David E Sills (ed), *International Encyclopedia of the Social Sciences* (MacMillan and Free Press, 1968) 290.

⁴⁷ Talcott Parsons, ‘The Professions and Social Structure’ (1939) 17 *Social Forces* 457.

⁴⁸ Emile Durkheim, *The Division of Labour in Society* (Free Press, 1997); Dietrich Rueschemeyer, *Power and the Division of Labour* (Stanford University Press, 1986).

⁴⁹ Robert Alun Jones, *Emile Durkheim: An Introduction to Four Major Works* (Sage, 1986) 24–59.

⁵⁰ Emile Durkheim, *Professional Ethics and Civil Morals* (1958)

<<https://archive.org/details/professionalethi00durk>>; Keith M Macdonald, *The Sociology of the Professions* (Sage, 1995).

⁵¹ Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001) 38; Gary S Becker and Kevin M Murphy, ‘The Division of Labor, Coordination Costs, and Knowledge’ in Gary S Becker (ed), *Human Capital: A Theoretical and Empirical Analysis with Special Reference to Education* (University of Chicago Press, 3rd ed, 1994).

discretionary specialisation, as distinct from lower forms of specialisation referred to as *mechanical specialisation*.⁵² The notion of discretionary specialisation and its relationship to the professions is explored in more detail later in this thesis.

The specialist and essentialist nature of the work of particular groups meant that those groups also had power.⁵³ Each profession acted as the guilds had, to protect entry to their group by restricting the sharing of knowledge—skills and methods—to those selected by the group to receive it. They were able to monitor their own practice and discipline members of their own group for infractions in competency and matters of conduct. These particular traits, common to professions, were recognised by social scientists studying this sociological phenomenon in the early 20th century.⁵⁴

The most common form of early analysis of the professions was a trait-based or ‘structural’ approach,⁵⁵ which allowed for an examination of the organisation that would identify the configuration of these special occupational groups—what a profession looked like and what its function was.⁵⁶ This form of analysis tends to focus on the special character of the knowledge and skill of the profession, the specialised training involved and the professions’ special ethical or altruistic orientation.⁵⁷

There are a number of criticisms of the trait-based approach to identifying a profession, including that it is inductive.⁵⁸ Occupational groups may be classified in a range of ways depending on a variety of factors that extend beyond these characteristics and include, for example, issues of remuneration, status, power, autonomy and prestige.⁵⁹ These criticisms

⁵² Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001) 23.

⁵³ Eliot Freidson, *Professional Powers: A Study of the Institutionalisation of Formal Knowledge* (University of Chicago Press, 1988). Freidson argued that professions do not wield a monolithic power, but rather specific powers that are ‘historical, variable and structurally dispersed’; See also David Brain, ‘Book Review: Professional Powers: A Study of the Institutionalization of Formal Knowledge, (1988) 66 *Social Forces* 1119.

⁵⁴ Mike Saks, ‘Defining a Profession: The Role of Knowledge and Expertise’ (2012) 2 *Professions and Professionalism* 1.

⁵⁵ Meaning that there was an examination of the structure and function of this particular group in society.

⁵⁶ See Abraham Flexner, ‘Is Social Work a Profession?’ (1915) 1 *School and Society* 904; Talcott Parsons, ‘The Professions and Social Structure’ (1939) 17 *Social Forces* 457; Ernest Greenwood, ‘Attributes of a Profession’ (1957) 2 *Social Work* 45.

⁵⁷ Eliot Freidson, *Professional Powers: A Study of the Institutionalization of Formal Knowledge* (University of Chicago Press, 1986).

⁵⁸ *Ibid.*

⁵⁹ Gregg S Margolis, *The Role of Bachelor’s Degree Emergency Medical Service Programs in the Professionalisation of Paramedicine* (PhD Thesis, University of Pittsburgh, 2005).

are discussed in more detail in the next section of this chapter. The utility of this approach is that it allows for an examination of the organisation and configuration of an occupational group.

Social structure, in sociology, is a conceptualisation of society as being organised in particular ways with a reliance on, for example, particular institutions that have developed and endured over time and that act as an organising feature of society.⁶⁰ People may not be aware that these structures exist and act in such a way because they are so deeply normative. Social structure is often considered alongside functionalism, the theoretical perspective that attempts to explain not only how society is structured but also how it functions, for what purpose and with what effect.⁶¹ It has been argued that ‘the professions in modern society have assumed leading roles in the creation and tending of institutions. They are the pre-eminent institutional agents of our time’.⁶² This leading role extends to maintaining the functional operation of ‘core societal and economic institutions’.⁶³ In short, professions are a sociological phenomenon because they contribute to the structure and function of our society and this explains why they have attracted so much examination by sociologists.⁶⁴

More recent social scientific examination of the professions moved from considering what the structure and function of a profession was to provide an analysis of the way in which a group became a profession—the *process* of becoming a ‘profession’, or professionalisation—⁶⁵ which has been referred to as ‘the complex and continuous process by which disciplines construct the boundaries of a field and mark it as their own’.⁶⁶

⁶⁰ For example, legal institutions.

⁶¹ Robert van Krieken et al, *Sociology* (Pearson Publishing, 6th ed, 2017).

⁶² W Richard Scott, ‘Lords of the Dance: Professionals as Institutional Agents’ (2008) 29 *Organization Studies* 219, argued that professionals have a distinct ‘cognitive, normative and regulative’ capability and therefore play a role as ‘lords of the dance’—‘choreographing the restructuring’ of society and more particularly, restructuring contemporary political–economic systems. This can occur at both a micro and macro scale with ‘relationships existing between professional associations, multinational corporations and international organisation (such as the EU, WTO and OECD)’ that can affect the shape of the nation state. This is discussed further with respect to health service provision and paramedics in Chapter 6.

⁶³ John C Coffee Jr, *Gatekeepers: The Professions and Corporate Governance* (Oxford University Press, 2006).

⁶⁴ Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001).

⁶⁵ Including Eliot Freidson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (Dodd Mead, 1970); Magali Sarfatti Larson, *The Rise of Professionalism: A Sociological Analysis* (University of California Press, 1978); and Andrew Abbott, *The System of Professions: An Essay on the Division of Expert Labor* (University of Chicago Press, 1988).

⁶⁶ Magali Sarfatti Larson, ‘Book Review of “Professionalism: The Third Logic” by Eliot Freidson’ (2003) 46 *Perspectives in Biology and Medicine* 458.

Professionalisation can extend beyond just the attainment of the status of profession to include the actions associated with being a professional, namely professionalism. However, there is some evidence that an occupational group can attain the status of a profession without applying elements of professionalism. “Professionalism” refers to a professional’s qualities and characteristics, including self-responsibility, expertise, special skills and ethical behaviour. It is quite possible for professionals to lack professionalism since they can possess expertise but have no ethical predispositions (e.g. corrupt doctors)⁶⁷. This thesis argues that any group that may legally acquire professional status will not have fully professionalised unless there is a coherence between their legal status and their professionalism. This is because there must be a culture, identity and values; an understanding and appreciation of the power that a profession has by virtue of its specialised knowledge and unique purpose that makes others, including the state, dependent upon it to not abuse that power for self-interest or some other purpose.

To act with *professionalism* is to act within a set of moral norms, principles and standards of conduct and competency.⁶⁸ Specifically with regard to healthcare professionals, it has been defined as ‘a set of values, behaviours and relationships that underpins the trust [of] the public’.⁶⁹ Characteristics associated with healthcare professionalism include ‘clinical excellence, altruism, pursuit of patients’ best interests, patient advocacy, technical knowledge, professional responsibility, and self-governance’.⁷⁰ It has been said that ‘professionalism aspires to altruism, accountability, excellence, duty, service, honor, integrity and respect for others’.⁷¹ The standards of professionalism are determined by the professional group and reflect the values of the group. The standards and values of the group can be found in each profession’s code of conduct.

⁶⁷ Baliyar Sanghera and Aibek Iliasov, ‘Moral Sentiments and Professionalism in Post-Soviet Kyrgyzstan: Understanding Professional Practices and Ethics’ (2008) 23 *International Sociology* 447.

⁶⁸ Julia Evetts, ‘The Concept of Professionalism: Professional Work, Professional Practice and Learning’ in Stephen Billett, Christian Harteis and Hans Gruber (eds), *International Handbook of Research in Professional and Practice-based Learning* (Springer International, 2014).

⁶⁹ Royal College of Physicians of London (RCP), *Doctors in Society: Medical Professionalism in a Changing World*, Report of a Working Party of the RCP (RCP, 2005).

⁷⁰ Giovanna Vicarelli and Elena Spina, ‘Professionalisation and Professionalism: The Case of Italian Dentistry’ (2015) 5 *Professions and Professionalism* 12.

⁷¹ Walter Hendelman and Anna Byszewski ‘Formation of Medical Student Professional Identity: Categorizing Lapses of Professionalism, and the Learning Environment’ (2014) 14 *BMC Medical Education* 1.

Self-governance, or self-regulation by professionalism has arisen in response to the complexity of specialisation, which by its nature limits the number and type of person who could fairly assess the actions of a professional as either meeting the standards expected of the professional group or not. The complexity involved in effectively regulating health professions means that not all actions undertaken by health professionals can be prescribed in legislation. Regulation by professionalism allows for some of these gaps to be filled by instead relying on the moral, as well as clinical judgement of the health professional. The belief that health professions fulfil this moral objective is associated with being ‘trusted to self-regulate with the best interests of the public in mind.’⁷² Elements of this are an historical hangover that has become codified into Australian law. This is discussed in more detail in Chapters 5 and 7 but in short, the failure of health professionals to demonstrate adequate professional judgement in both competency and conduct matters can lead to sanctions by the professional peer group. This mechanism of self-regulating and disciplining members for breaches of professionalism is also consistent with another trait common to professions—occupational control.⁷³ In this case, regulation of the behaviour of members of the profession by the profession enables the profession to determine who enters and who exits the profession. The expectation that members will have the characteristics noted above and that they will apply them in their practice is a form of regulation of behaviour referred to in this thesis as regulation by professionalism.

2.2 Theories of Professions

2.2.1 Flexner and the Typology of a Profession

In 1915 Abraham Flexner, an educator in the US, first attempted to identify and define the characteristics of a profession. Flexner was interested in improving medical education.⁷⁴ This process of classification fuelled more than 50 years-worth of work on developing a typology of a profession that incorporates both traits-based and a functionalist approach to

⁷² Linda Heller, ‘Regulating the Professions’ in Peter Cane and Herbert M Kritzer (eds), *The Oxford Handbook of Empirical Legal Research* (Oxford University Press, 2012).

⁷³ Eliot Freidson, *Professional Powers: A Study of the Institutionalization of Formal Knowledge* (University of Chicago Press, 1986); Andrew Abbott, *The System of Professions: An Essay on the Division of Expert Labor* (University of Chicago Press, 1988); Talcott Parsons, ‘The Professions and Social Structure’ (1939) 17 *Social Forces* 457; Gerhard Minnameier, ‘Moral Aspects of Professions and Professional Practice’ in Stephen Billett, Christian Harteis and Hans Gruber (eds), *International Handbook of Research in Professional and Practice-based Learning* (Springer, 2014).

⁷⁴ Abraham Flexner, ‘Is Social Work a Profession?’ (1915) 1 *School and Society* 904.

identifying the key characteristics of a profession. Based on an empirical, case-based, comparative analysis, Flexner first identified six common traits that professions possess: (1) intellectual operation coupled with large individual responsibilities, (2) raw materials drawn from science and learning, (3) practical application, (4) an educationally communicable technique, (5) tendency towards self-organisation and (6) an altruistic motivation.⁷⁵ Put another way, a profession has large individual responsibilities, relies on materials drawn from science and learning, and can practically apply that knowledge.

Flexner sought to depict professionalism in its wider social context and recognised that professions have a social status tied to public recognition that carries with it cultural capital; that is, a form of social value or worth.⁷⁶ Flexner suggested that this status and worth was associated with the altruistic nature of professions. He stated that while professions are ‘not always in fact free from selfish purposes’ they do hold the ideal of being ‘devoted to the promotion of larger and nobler ends than the satisfaction of individual ambitions’.⁷⁷ Significantly, Flexner utilised the trait-based identifying criteria of a profession to develop a systems-based approach to medical education that reflected the traits he had identified.

Medical education in the US had been a for-profit system at the turn of the 20th century and as such, academic practitioners would first work in their practice for profit and then teach. Flexner proposed that academics be employed full time as salaried staff with the idea being that they would thus be free from the distraction of chasing patient fees and able to pursue research and create unique, profession-specific knowledge.⁷⁸ Flexner recognised that medicine was already a profession with not only a stronger formal knowledge and higher education base than other occupations, but an ability to create knowledge; more particularly, specialised knowledge. This process was defined by a new word, ‘professionalisation’.⁷⁹ Flexner conceptualised scholarship and research as a means to increase the professional capital of the medical profession; however, while he supported the notion of professionalisation, he believed that ‘the first, main and indispensable

⁷⁵ Ibid.

⁷⁶ Frederic W Hafferty and Brian Castellani, ‘The Increasing Complexities of Professionalism’ (2010) 85 *Academic Medicine* 288-301.

⁷⁷ Ibid 291.

⁷⁸ Abraham Flexner, ‘Medical Education in Europe: A Report to the Carnegie Foundation for the Advancement of Teaching’ (1912) 6 *Carnegie Bulletin*, cited in Hafferty, *ibid* 291; Thomas P Duffy, ‘The Flexner Report—100 Years Later’ (2011) 84 *Yale Journal of Biology and Medicine* 269.

⁷⁹ Bruce A Kimball, *The True Professional Ideal in America: A History* (Rowman and Littlefield, 1995).

criterion of a profession' was the application of 'professional spirit', saying that professions that do not value this element 'are ethically no better than trades'.⁸⁰

2.2.2 Parsons, the Professions and the Importance of Altruism

It was not until 1939 that the link between ethics and professions was examined in detail, by Talcott Parsons. Parsons had a strong focus on the effect of economic theories on society but also acknowledged that many of the most important features of a society—among which he included science, technology and learning—were 'dependent on the smooth functioning of the professions', in particular 'medicine, technology, law and teaching'.⁸¹ He argued that this contribution had a particular moral value that explained why professions remained separate from other ways of organising workers (e.g., via business or governmental structures). He examined the similarities between the organisational structure of professions and structure of hierarchical bureaucratic organisations. He recognised that the authority for both models rested on similar principles, which included having a specific function and power within a restricted domain and that each model applied 'universalistic' standards.⁸² However, unlike bureaucracies, professions were more democratic and not committed to 'the pursuit of self-interest' as 'one does in the case of business'.⁸³ He went on to support Flexner's view on 'professional spirit' but argued that the importance of elements other than 'the enlightened self-interest of economic and utilitarian theory' is the reason why professions continued to exist as a 'peculiar' social structure. Parson's argued that a profession's 'collegial organization and shared identity',⁸⁴ rooted in a service ideal, was more likely to allow it to 'fully subsume its self-interest in the public interest'.⁸⁵ Parsons seemed to suggest that although professions have a specific function within a restricted domain and that they apply normative standards of working, the inherently ethical

⁸⁰ Abraham Flexner, 'Is Social Work a Profession?' (1915) 1 *School and Society* <<http://socialwelfare.library.vcu.edu/social-work/is-social-work-a-profession-1915/>>.

⁸¹ Talcott Parsons, 'The Professions and Social Structure' (1939) 17(4) *Social Forces* 457.

⁸² *Ibid* 462;

Julia Evetts, 'The Concept of Professionalism: Professional Work, Professional Practice and Learning' in Stephen Billett, Christian Harteis and Hans Gruber (eds), *International Handbook of Research in Professional and Practice-based Learning* (Springer International, 2014) 36.

⁸³ Talcott Parsons, 'The Professions and Social Structure' (1939) 17(4) *Social Forces* 466.

⁸⁴ Julia Evetts, 'The Concept of Professionalism: Professional Work, Professional Practice and Learning' in Stephen Billett, Christian Harteis and Hans Gruber (eds), *International Handbook of Research in Professional and Practice-based Learning* (Springer International, 2014).

⁸⁵ Linda Heller, 'Regulating the Professions' in Peter Cane and Herbert M Kritzer (eds), *The Oxford Handbook of Empirical Legal Research* (Oxford University Press, 2012).

nature of a profession was what distinguished it from other occupations and it was this distinguishing element that afforded professions a higher social regard or status than non-professions.

Parson's work was consistent with Flexner's in that he identified that the 'central focus of the professional role lies in a technical competence' and as such the profession has a level of power and responsibility that demands 'a very great importance to universalism in the institutional pattern governing it'.⁸⁶ The nature of professions had traditionally been one of self-governance. There had been an assumption that because the professions have traditionally provided services that fulfil a moral objective, among other things, they could 'be trusted to self-regulate with the best interests of the public in mind'.⁸⁷ Documents like the *Hippocratic Oath* provided evidence that professions like medicine could regulate themselves using universal humanistic values, which included the expectation that a doctor would put the interests of their patients above their own and should never exploit their patient for their own advantage or profit.⁸⁸ The *Hippocratic Oath* is an early form of professional self-regulation, written for the public interest, which may also have been an attempt to raise trust among communities in the professionalism of doctors and in so doing allow medicine to develop as a profession and professionalise. The oath provides an historical association between the self-regulation of medicine and notions of altruism and trust.

2.2.3 The Professional Continuum

Medicine is not the only profession and by the late 1950s there was a growing recognition and interest in this group of workers who appeared to be distinct from others in that they enjoyed a different status and different power from other workers. This drove a period of academic examination of this group of workers.⁸⁹ There was a recognition that there were sub-cultural elements inherent in professions that shaped the way each particular group communicated and conducted themselves.⁹⁰ In 1957, Greenwood identified and published

⁸⁶ Talcott Parsons 'The Professions and Social Structure' (1939) 17(4) *Social Forces* 462.

⁸⁷ Linda Heller, 'Regulating the Professions' in Peter Cane and Herbert M Kritzer (eds), *The Oxford Handbook of Empirical Legal Research* (Oxford University Press, 2012).

⁸⁸ David Carr, 'Professionalism, Profession and Professional Conduct: Towards a Basic Logical and Ethical Geography' in Stephen Billett, Christian Harteis and Hans Gruber (eds), *International Handbook of Research in Professional and Practice-based Learning* (Springer International, 2014).

⁸⁹ Ernest Greenwood, 'Attributes of a Profession' (1957) 2 *Social Work* 45.

⁹⁰ *Ibid.*

a list of attributes he found were common to professions, which included that they each had:

1. A systematic body of theory—a body of knowledge and skill particular to the group;
2. Authority—which is derived from the specialised knowledge the profession holds and which is not known by others outside the group;
3. Community sanctions—power and privileges including monopoly over work derived from licensing;
4. Ethical codes—professions put client interest before self-interest; and
5. A culture—there are ways professionals communicate, dress and conduct themselves that are particular to their occupational group.⁹¹

Greenwood noted that the status of a ‘profession’ sits on a ‘continuum’ with the ‘less skilled and less prestigious occupations (e.g., watchman, truckloader, farm labourer, scrubwoman, bus boy)’ at one end and the ‘well-recognised and undisputed professions (e.g., physician, attorney, professor, scientist)’ at the other.⁹² Although Greenwood recognised that there may be ‘degrees’ of professionals, he did not raise the issue of whether there are degrees of professionalism. For example, surgeons may be said to highly professionalised because they have specialised knowledge of cutting edge technology; however, issues of when to use it, how to use it and on whom to use it—issues that go beyond competency to conduct and character—may be better categorised as matters of professionalism. Greenwood also failed to explicitly link degrees of professional authority with degrees of social, political and economic power.⁹³

A consideration of the work of Flexner, Parsons and Greenwood demonstrates a clear pattern forming of the characteristics that were commonly associated with professions in the first half of the 20th century in the US. These included technical competence, linked with functional specificity, a moral superiority and trust to exercise their job to the highest technical and moral standards while placing the client’s interests before self-interest. The combination of these elements appeared to provide professionals with a legitimate authority

⁹¹ Ibid.

⁹² Ibid.

⁹³ These issues were considered and discussed by scholars at a later time, including Freidson and Larson,

that allowed them to govern themselves in accordance with their own values (e.g., medicine regulated itself according to values first set out in the *Hippocratic Oath*). What had not been examined in great detail by these researchers was the way in which these attributes were able to be acquired.

2.2.4 The Process of Professionalising

In 1964 Harold Wilensky made a notable contribution to the literature after undertaking and publishing a simple empirical analysis of the process of professionalisation. The study noted that there was, more often than not, ‘a common trajectory’ for the evolution of a profession that included first establishing a training school, progressing to university, the establishment of a local association growing into a national association, regulation by state-level licensing laws and finally the development of a code of ethics.⁹⁴ Wilensky suggested that for an occupation to turn itself into a profession, professionalisation required something more than simply the power to monopolise a particular occupational area, which is something that can be facilitated by the law. He suggested that there needed to be a broader set of structural and historical systems that contributed to a group’s evolution to a profession,⁹⁵ a position consistent with those of Flexner and Parsons.

Wilensky’s recognition that there were ‘structural and historical’ elements that shape the professional development of occupational groups coincided with a growing recognition in the literature of the difficulties in distinguishing between professions and other occupations using a trait-based approach. A common question asked was whether there was any point in making such a distinction. The rather uncritical traits-based approach to classifying professions was criticised particularly with regard to the assumptions regarding their altruistic nature and the lack of acknowledgement of characteristics like power and privilege.

An examination of professions, professionalisation and professionalism necessitated an examination of the power of professions; the way in which power is acquired, maintained,

⁹⁴ Harold Wilensky, ‘The Professionalisation of Everyone?’ (1964) 70 *American Journal of Sociology* 137, 143. It is important to note that regulation by state-level licensing laws or registration is the only law associated with professionalisation; however, it is not enough to say that the law alone facilitates professionalisation. It is more complex than just registration or a license. What is the law prescribing and why?

⁹⁵ Ibid 137–58; Anne Witz, *Professions and Patriarchy* (Routledge, 1992).

exercised and monitored, for what purpose and with what effects. Both the knowledge and service claims of the professions and their privileges had to be understood in terms of power and political process.⁹⁶ It was at this time that Freidson wrote his seminal work on the power and dominance of medicine, which explored these concepts further.

2.2.5 Freidson and Self-regulation

In 1970 Freidson published a landmark study on the archetypal health profession—medicine.⁹⁷ He noted that the degree and kind of specialisation required for particular jobs, as well as their function, is used to establish their social, political and economic value and importantly, the degree of privilege and trust that they hold in society.⁹⁸ Freidson was interested in the way medicine had become a particularly highly regarded occupational group and the way in which it had established and maintained its professional power. He argued that to be a profession the nature of the work a group undertakes must be of ‘significant social interest ... be organized in such a manner as to attain and maintain its position of control ... must have a prolonged period of training in abstract and complex knowledge’ and must have ‘a service orientation’;⁹⁹ but more significantly, he argued it must have power, which he referred to as ‘professional autonomy’.¹⁰⁰ He said:

the most strategic distinction between the professions and other occupation groups lies in legitimate, organised autonomy—that a profession is distinct from other occupations in that it has been given the right to control its work.¹⁰¹

Freidson argued that professional groups relied on their specialist knowledge and their specific function as a leverage to gain control over their own work.¹⁰² He argued that the ‘occupationally controlled division of labor is an essential part of professionalism’ but that control ‘must involve direct determination and control of the work by those who perform

⁹⁶ Eliot Freidson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (Dodd Mead, 1970).

⁹⁷ Ibid; Eliot Freidson, *Doctoring Together* (Elsevier, 1975); George Ritzer and David Walczak, ‘Rationalization and the Deprofessionalisation of Physicians’ (1986) 67 *Social Forces* 1.

⁹⁸ Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001) 18.

⁹⁹ Eliot Freidson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (Dodd Mead, 1970); Eliot Freidson, *Regulation of the Professions* (1983)

<<https://www.jstor.org/stable/pdf/1393547.pdf?refreqid=excelsior:7bacc2f6b5604a36a0a998b9024ef2c8>>.

¹⁰⁰ Ibid

¹⁰¹ Eliot Freidson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (Dodd Mead, 1970) 20.

¹⁰² Ibid 20.

it'.¹⁰³ Freidson recognised that the professions, medicine in particular, could engage collectively to form political pressure groups that relied on the state's promise to provide health services to the community and in so doing consolidate or extend its position of privilege.¹⁰⁴

Freidson also recognised that the specialised nature of the work and knowledge that professions had acquired meant that it was difficult for outsiders to understand and more importantly judge them. This was the basis for the professions to claim the need to control their work through self-regulation. He argued that professional workers, with specialised knowledge and the ability to provide society with particularly important services, can and should organise and control their own work because only members of the group have the capacity to understand what educational requirements are required to enter the group and what elements of a person's character were necessary to possess to practise the profession.¹⁰⁵ Medicine had incorporated these elements into a culture of medical 'professionalism'. Professionalism was defined to include a sense of collegiality and community with peers, commitment and connection to the profession, life-long learning, research and the expansion of knowledge of the discipline. It was on this basis that medicine was able to claim professional autonomy—the right to self-regulate.¹⁰⁶ Freidson conceded that no profession, medicine included, is ever completely autonomous because all professions depend on the state for licensure and for the development of laws, statutes, policies and procedures that profoundly affect the social and economic organisation of their work.¹⁰⁷ However, he argued that it is the degree of autonomy that an occupational group attains that is the main characteristic of a profession, saying 'professions are deliberately granted autonomy, including the exclusive right to determine who can legitimately do its work, and how the work should be done'.¹⁰⁸ Freidson justified his position in three ways. First, the work is so complex and technical that no-one outside the profession is qualified to evaluate or regulate it; second, the profession claims it is suitably virtuous that it can

¹⁰³ Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001) 55 defined professionalism in this sense broadly as 'a set of interconnected institutions providing the economic support and social organization that sustains the occupational control of work'.

¹⁰⁴ Eliot Freidson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (Dodd Mead, 1970) 20.

¹⁰⁵ Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001).

¹⁰⁶ *Ibid.*

¹⁰⁷ *Ibid.*

¹⁰⁸ *Ibid.* 72.

police itself; and third, in conjunction with the second element, the profession can be trusted to restrict or remove members who perform incompetently or unethically.¹⁰⁹

Freidson further recognised ‘professional autonomy’ as not only a special means of organising labour but a way to counter the power of free markets and bureaucracies to dictate the way in which people work. He noted that bureaucracies remove control from professions and hand it to managers, and free markets place control in the hands of the consumer, which is contrary to the notion of professional autonomy and self-regulation.¹¹⁰ He argued that the specialised nature of the knowledge and skills that professions possess and the role that they play, particularly in healthcare, requires a more flexible form of regulation that allows professionals to exercise discretion and professional judgement. These requirements are not consistent with regulation by government bureaucracy—which is too rigid to meet these needs—or free markets, which are too amoral.¹¹¹ Freidson noted that ‘the strengthening of the legitimacy of professionalism requires clear recognition of the ethical implications of professional privilege and strong resistance to the institutional arrangement for practice which emphasises economic incentives over others’.¹¹²

The latter points are inherent to the concept of professionalism—the regulation of a professional group by reference to normative standards of behaviour associated with good moral conduct. These standards of expected behaviour are usually documented, originally as an oath and more recently as a code of conduct or code of ethics. Professionalism is strongly associated with public, rather than self, interest and in this way preferable to bureaucracy—because it avoids bureaucracy’s ‘dehumanising’ aspects¹¹³—and to free markets, because it avoids their amoral nature. Indeed the specific nature of the work that health professions do means that their relationship with their clients (patients) should never

¹⁰⁹ Ibid.

¹¹⁰ Ibid 12.

¹¹¹ For example, Rosen and Dewar argued that the introduction of a bureaucratic model of regulation in the United Kingdom (UK) was thought to limit the positive influence doctors exert through professionalism because it limited their freedom. Rebecca Rosen and Steve Dewar, ‘Redefining Medical Professionalism for Better Patient Care’ (Discussion Paper, King’s Fund, November 2004)

<https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/on-being-a-doctor-redefining-medical-professionalism-better-patient-care-rebecca-rosen-steve-dewar-kings-fund-1-november-2004.pdf>.

¹¹² Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001).

¹¹³ Max Weber, ‘Bureaucracy’ in Tony Waters and Dagmar Waters (trans and eds), *Weber’s Rationalism and Modern Society: New Translations on Politics, Bureaucracy, and Social Stratification* (Palgrave Macmillan, 2014).

be one of ‘buyer’ and ‘seller’ in a market place, but rather one that promotes the greater purpose of providing moral goods in the public interest.¹¹⁴

The sociological literature identified that public interest and professional self-interest are not always mutually exclusive, and that the pursuit of self-interests may be compatible with advancing the public interest.¹¹⁵ However, some sociologists contended that self-interest was a primary driver of professional organisational power that was used to advance their own ends. Terence Johnson was one critic who argued that the assumption that professionals acted without self-interest was flawed and more than that, the assumption served to legitimise professional privilege that in turn limited interrogation of these groups and their use of this power. He argued that the assumption that professions were altruistic and therefore entitled to privileges, like self-regulation, to which non-professionals were not, were harmful because the assumption acted to preserve the power of the group to maintain monopolies of practice and a lack of public accountability.¹¹⁶

By the late 1970s there was a shift away from the viewpoint that the professions transcended the ‘unbridled’ self-interest of non-professionals. Chamberlain suggested this was because:

evidence came to light showing how poorly performing doctors, and in some cases even criminals, were being shielded from public accountability by the ‘club rule’ of mutual protectionism inherent within medicine’s self-regulatory system.¹¹⁷

2.2.6 Larson, Knowledge and Self-interest

In 1977 Larson, building further on Johnson’s notion of the ‘legitimation of professional privilege’ as a means of protecting professional self-interest, published one of the most influential critiques of the professions.¹¹⁸ Larson was interested in understanding the way

¹¹⁴ Seumas Miller, *Model Code of Ethics Principles*. Professional Standards Council 9.

<<https://www.psc.gov.au/sites/default/files/Model%20code%20of%20ethics%20principles.pdf>>.

¹¹⁵ Mike Saks, *Professions and the Public Interest: Medical Power, Altruism and Alternative Medicine* (Routledge, 1995).

¹¹⁶ Terence Johnson, *Professions and Power* (MacMillan, 1972) 25.

¹¹⁷ John Martyn Chamberlain, *Medicine, Risk, Discourse and Power* (Routledge, 2015).

¹¹⁸ It should be noted that Johnson, Larson and Freidson were all Americans writing at a time when the American healthcare system was being reformed away from the limited 1965 national insurance model provided for over-65s (expansion of which was resisted by the American Medical Association) (Medicare) to a market-based private insurance model of Health Maintenance Organisations introduced in the United States (US) under the Health Maintenance Organization Act of 1973. Thus, any reference to healthcare

in which occupational groups called ‘professions’ organised themselves to obtain this power, status and authority in a process she referred to as the ‘professionalisation project’.¹¹⁹ Larson described professionalisation as:

the process to pursue, develop and maintain the closure of the occupational group in order to maintain the group’s own occupational self-interests, including terms of their salary, status and power as well as the maintenance of the monopoly protection of the group’s occupational jurisdiction.¹²⁰

Larson argued that professionalisation by occupational groups, or the process of acquiring power, was related to knowledge. She said that professions ‘attempt to translate one order of scarce resources—special knowledge and skills—into another—social and economic rewards,¹²¹ giving weight to the Latin aphorism, ‘*scientia potentia est*’ or ‘knowledge is power’. She recognised that by limiting access to this specialised knowledge, professional groups were able to maintain power and status. She went on to say:

To maintain scarcity implies a tendency to monopoly: monopoly of expertise in the market, monopoly of status in the system of stratification.¹²²

Larson critiqued this process as being driven by the self-interest of the professions; by the professions and for the professions, rather than the public interest. This differentiated Larson’s work from that of previous scholars who had uncritically accepted that professions always place public interest before self-interest. It was because of this association with self-interest that Larson suggested that professions and professionalism could not and should not be used as a normative value system of regulation despite the historical tendency to do so.¹²³

Larson recognised that the claim to have specialised knowledge that was unknowable by outsiders was what was relied upon to legitimise a profession’s privilege. She observed that

should be considered in this context. The US healthcare system had a completely different ideology and culture associated with it than the UK’s National Health System (NHS), which was a non-market-based, entirely publicly funded universal healthcare system.

¹¹⁹ Magali Sarfatti Larson, *The Rise of Professionalism: A Sociological Analysis* (University of California Press, 1978) xvii.

¹²⁰ Julia Evetts, ‘Professionalism: Value and ideology.’ *Current Sociology* 61.5-6 (2013) 782.

¹²¹ Ibid.

¹²² Ibid xii–xvii.

¹²³ Julia Evetts, ‘Trust and Professionalism: Challenges and Occupational Changes’ (2006) 54 *Current Sociology* 515.

the ‘uniformity and homogeneity’ of a group’s particular knowledge works to establish a commonality between members of the group. Larson suggested that group work to achieve the ‘standardisation or codification of professional knowledge’.¹²⁴ Larson argued that standardisation is essential because it serves to depersonalise the knowledge, thus making it ‘objectified, if not objective’.¹²⁵ This in turn allows the knowledge to transcend the subjective elements of the groups that produce it. This also make the knowledge more likely to ‘appear to be connotation-free and “objective”’ and thus credible. This appearance of neutrality works to legitimise the knowledge and by extension the group who are associated with it, who may be referred to as ‘experts’. This serves to further embed a line between professionals and laypeople and therefore an ability to preserve professional power and status.¹²⁶

Evidence to support Larson’s theory can be found in the Australian health professional context. Standardisation of curricula for health professionals in Australia is supported by legislation that authorises health professional groups to accredit particular professional educational programs as a pathway of entry to the profession.¹²⁷ The education of practitioners serves to not only teach them the practice skills and knowledge required to undertake the work but it also familiarises them with the normative culture and values of the profession.¹²⁸ Just as the legitimisation and monopoly of clinical knowledge is used as a way of garnering authority, so too the adoption and application of moral knowledge and values can be used to bind the group and develop public confidence. A successful ‘professionalisation project’, according to Larson, involves acquisition of a ‘monopoly of competence legitimised by officially sanctioned “expertise” and a monopoly of credibility with the public’.¹²⁹ The question as to how these monopolies were able to be legitimised via ‘official legal sanctioning’ led Freidson to examine the relationship between professional power and the law.

¹²⁴ Magali Sarfatti Larson, *The Rise of Professionalism: A Sociological Analysis* (University of California Press, 1978) 40.

¹²⁵ Ibid.

¹²⁶ Ibid.

¹²⁷ *Health Practitioner Regulation National Law Act 2009* (Qld).

¹²⁸ For example, medicine self-regulates a national standard of education requirements for entry to the profession that includes nationally standardised conduct and competency requirements.

¹²⁹ Magali Sarfatti Larson, *The Rise of Professionalism: A Sociological Analysis* (University of California Press, 1978) 40.

2.2.7 Professional Power and the Law

Freidson recognised that it is a privilege particular to professions that they are able to make a living while controlling their own work and that this privilege cannot exist if the tasks that they perform and the knowledge they use to perform them are not so specialised and important that they are unable to be regulated by anyone other than themselves.¹³⁰ He examined the process of acquiring power that went beyond the acquisition of specialised knowledge alone. He considered the relationship between professions and the law, including the mechanism of self-regulation; the interrelationships between the provision of occupational credentials and the accreditation of educational programs; professional-product standards; and the authority granted to doctors to provide public and private benefits to clients based on professional discretionary judgement (e.g., certifying people as eligible for sick leave). He demonstrated how different professions were able to gain their protected positions within society via these legal processes.¹³¹ He noted that legal protection from economic and political pressure was afforded to ‘professions’ like medicine, law and dentistry. The law provided legal protection from other occupations encroaching on the domain of the professions and it stopped the professions from encroaching on one another.¹³² He noted that this legal protection came from the implementation of statutory requirements relevant to the practice of the profession including licensing, certification, accreditation and credentialing. Those laws still have the effect not only of protecting the group from unwanted members and the power to establish their own standards of conduct and competence, but also protecting their independence to judge, criticise or refuse ‘employers, patrons and the laws of the state’ on the grounds that they do not conform to a fundamental value or purpose of the discipline.¹³³

Larson, and later Andrew Abbott,¹³⁴ suggested that a profession can use what it knows (its system of abstract knowledge) and what it does (its labour practices)¹³⁵ to acquire legal

¹³⁰ Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001) 17.

¹³¹ Eliot Freidson, *Professional Powers. The Study of the Institutionalization of Formal Knowledge* (University of Chicago Press, 1986).

¹³² Eliot Freidson, ‘The Reorganization of the Professions by Regulation’ (1983) 7(2/3) *Law and Human Behavior*, 279–290.

¹³³ Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001) 221.

¹³⁴ Andrew Abbott, *The System of Professions: An Essay on the Division of Expert Labor* (University of Chicago Press, 1988).

¹³⁵ *Ibid.*

rights that enable the profession to pursue, develop and maintain the closure of that group from outsiders (monopoly protection) for the purpose of maintaining the occupational self-interest—in terms of their salary, status and power—of each practitioner within that group.¹³⁶

This notion of the law and professional power was examined by Australian sociologist, Evan Willis. Willis examined the relationship between professional power and the law by examining the Australian medical profession in the late 1980s. He identified that at that time, the medical profession maintained control over the division of labour in the healthcare sector because medicine controlled not only its own work, but the work of other health groups and the broader health sector, including policy and law makers.¹³⁷ He referred to this power as ‘medical dominance’. Building on Freidson’s work,¹³⁸ Willis made particular note of the fact that it was the state that granted doctors this monopoly by passing legislation that protected them from competition. He argued that any attempt to limit the dominance of medicine in the healthcare workforce was rebuffed by medicine, which utilised its professional associations to make appeals to society’s dependence on their expert knowledge—including the use of modern medical technology—and appeals to moral authority on the basis that the profession always acted in the public interest by relying on a set of universal norms. He argued that this ideology was used to legitimise medicine’s claim to authority over patients but also over other health workers.

In 1994 Willis argued that the power of the medical profession had three core elements that were critical for any occupational group aspiring to acquire the professional power of medicine: autonomy (that they are not under the direction or control of another occupation); authority (the power to direct other health workers); and medical sovereignty (doctors are considered the experts on health-related matters).¹³⁹

¹³⁶ Magali Sarfatti Larson, *The Rise of Professionalism: A Sociological Analysis* (University of California Press, 1978); Andrew Abbott, *The System of Professions: An Essay on the Division of Expert Labor* (University of Chicago Press, 1988).

¹³⁷ Evan Willis, *Medical Dominance* (Allen & Unwin, 1983).

¹³⁸ Eliot Freidson, *Professional Dominance: The Social Structure of Medical Care* (Transaction Publishers, 1970).

¹³⁹ Evan Willis, *Medical Dominance* (Allen & Unwin, 1983); Evan Willis, *Illness and Social Relations* (Allen & Unwin, 1994).

Ellen Annandale¹⁴⁰ critiqued the notion of medical dominance further and found that only some doctors become dominant, as do only some nurses. She noted that governments (as law makers) can and do challenge these professions in response to political, economic, cultural and social demands for change, which means that although professional privileges like ‘market shelters’¹⁴¹ or monopolies as Larson referred to them, could be provided by the law, they could also be removed. There was no discussion of the particular circumstances in which this might happen, but medical scandals and a shortage of healthcare workforce resources are two examples that have since arisen that have led to structural and legislative reform that supports Annandale’s position.¹⁴²

The structural changes in the Australian healthcare landscape that began around this time included the shift of nursing training from the ‘following doctor’s orders’, vocation-based hospital training that nurses had historically undertaken, to critical thinking, autonomous professional training in universities and a decade later to civil liability legislation. This has resulted in a slow but significant lessening of medicine’s professional dominance in Australia.¹⁴³

The work of Wilensky, Freidson, Larson, Abbott and Willis identified that there appears to be a typical pathway or process that is followed for an occupational group to gain professional status and that this process intersects with the acquisition of a number of common characteristics. For example, the acquisition of a monopoly over work is often attained via the law but political power gained through sovereignty over work and specialist knowledge associated with work is required to lobby for those legal changes. However, Annandale acknowledged that those legal changes can materialise in response to other factors including political imperatives. In the case of the professionalisation of health professionals in Australia, the issue of public interest in public safety and economic factors drove the political imperative to reform healthcare workforce legislation in Australia. This is discussed further in Chapter 5. Despite the suggestion that the professions serve

¹⁴⁰ Ellen Annandale, *The Sociology of Health and Medicine: A Critical Introduction* (Wiley, 1998).

¹⁴¹ Eliot Freidson, ‘Occupational Autonomy and Labor Market Shelters’ in Phyllis Steward and Muriel Cantor (eds), *Varieties of Work* (Sage, 1982) cited in Julia Evetts ‘Trust and Professionalism: Challenges and Occupational Changes’ (2006) 54 *Current Sociology* 515.

¹⁴² See, for example, the ‘scandals’ associated with legislative reform in Australia.

¹⁴³ A PC inquiry into Australia’s healthcare workforce in 2005 highlighted the effect and inefficiencies of maintaining medical dominance. These were addressed by Nicola Roxon when she was appointed as health minister in 2007. This are discussed in more detail in this thesis in later chapters.

predominately their own interests before the public's interest, the professions remain a particular group of workers in society. Freidson was curious as to why.

2.2.8 Freidson and Professionalism as Occupational Control

Freidson suggested that it is the notion of professionalism, as a decentralised form of occupational control, that can explain the ongoing value of the professions. This is particularly true in healthcare because professionalism can offer benefits to both patients and society more broadly,¹⁴⁴ which may not be so easily provided via other systems of control. For example, Freidson argued that professionalism not only offers 'stability and freedom against the threat of encroaching industrial and governmental bureaucracies',¹⁴⁵ but also greater flexibility to deal with the complex matters associated with the complex nature of humans that naturally arise in healthcare.¹⁴⁶ He suggested that this flexibility would be difficult to attain via a rational legal bureaucracy because it is not able to adequately adapt to deal with complex human issues, particularly issues of discretion in decision making and morality.¹⁴⁷ Likewise, the free market is an amoral system and thus is also an inadequate system of control of human healthcare and healthcare workers.¹⁴⁸ He proposed that in the face of enormous pressure from political, economic and ideological

¹⁴⁴ Julia Evetts, 'Trust and Professionalism: Challenges and Occupational Changes' (2006) 54 *Current Sociology* 515.

¹⁴⁵ A notion first raised by Carr-Saunders and Wilson in 1933, see Phyllis Steward and Muriel Cantor (eds), *Varieties of Work* (Sage, 1982) cited in Julia Evetts 'Trust and Professionalism: Challenges and Occupational Changes' (2006) 54 *Current Sociology* 515.

¹⁴⁶ Fiona McDonald, 'Challenging the Regulatory Trinity: Global Trends in Health Professional Regulation' in Stephanie Short, Fiona McDonald and Charles Sampford (eds), *Health Workforce Governance* (Taylor and Francis, 2012). For example, healthcare systems are highly complex and their effects cannot always be removed from the actions of healthcare professionals; thus, to try to hold professionals responsible for actions that have complex causation chains is extremely difficult. This may go some way to explaining why there are so few successful prosecutions of healthcare practitioners or their employers under tort law; See also Pam Stewart and Anita Stuhmcke, 'High Court Negligence Cases 2000–10' (2014) 36 *Sydney Law Review* 585.

¹⁴⁷ Law Commission, Scottish Law Commission and Northern Ireland Law Commission, *Regulation of Health Care Professionals and Regulation of Social Care Professionals in England, A Joint Report*, Law Commission Report No 345 (2014), which recommended reforms to healthcare regulation that reduced bureaucracy to increase flexibility and lower costs; Clare Dyer 'Healthcare Regulation Will Change, Government Says' (2017) *BMJ* (online, 10 February 2017) <<http://www.bmj.com/content/356/bmj.j742>>.

¹⁴⁸ Louise Fitzgerald and Aoife M McDermott, *Challenging Perspectives on Organizational Change in Health Care Change in the Right Way* (Routledge, 2017). It appears that not much has changed with Fitzgerald and McDermott arguing that there is little statistical evidence to support the success of 'transformational' change in healthcare organisational structures because health systems are incredibly complex and there is no capacity (e.g., resources, knowledge, leadership, vision) within a system trying to cope with the pressures of budgetary constraints, rapid changes in technology, demographics and patient expectations.

forces, professionalism therefore offered a better way to manage complex—particularly public—socially significant services like healthcare.¹⁴⁹

2.3 The Benefits of Professionalism as a Form of Occupational Regulation

The ‘significant service’ aspect of the work of the professions has been viewed as ‘the pivot around which the moral claim to professional status revolves’.¹⁵⁰ It has been suggested that it is this aspect that differentiates a profession from a non-profession. This distinction can be understood more easily when comparing the service obligations of a barrister with those of a plumber. Although both are economically autonomous, have specialised knowledge and skill, are licensed and serve a unique societal role, a barrister is regulated by a code of conduct that extends their occupational obligations beyond those required of the plumber to maintain their license to practise. For example, a barrister in NSW is regulated by the *Legal Profession Uniform Conduct (Barristers) Rules 2015* (NSW), which sets out the professional requirement to put the client’s interest first:

A barrister must promote and protect fearlessly and by all proper and lawful means the client’s best interests to the best of the barrister’s skill and diligence, and do so without regard to his or her own interest or to any consequences to the barrister or to any other person.¹⁵¹

It also sets out the *Cab Rank Principle* that requires barristers to not discriminate against clients when accepting a brief. That is, the principle is designed to ensure that access to justice is not limited by the conflicting opinions or beliefs of counsel and client.¹⁵² These same broad principles apply to health professionals. Their autonomy is limited by their professionalism obligations. Nurses and paramedics are not able to choose which patient they will treat and which patient they will not treat on the basis of their own opinions on

¹⁴⁹ Eliot Freidson, *Professionalism Reborn: Theory, Prophecy and Policy* (Polity Press, 1994).

¹⁵⁰ Harold Wilensky and Charles Lebeaux, *Industrial Society and Social Welfare: The Impact of Industrialisation on the Supply and Organisation of Social Welfare Services in the United States* (Russell Sage Foundation, 1958).

¹⁵¹ *Legal Profession Uniform Conduct (Barristers) Rules 2015* (NSW), s 35.

¹⁵² *Ibid* s 17.

particular matters. To do so would be to not practise professionalism because it would limit a patient's access to healthcare that would equate to an injustice and potentially a harm.¹⁵³

Freidson recognised the critical importance of the professions in maintaining a moral standard in society. He argued that if professional moral ideology is weakened, this risks making the:

institutions that support the professions more vulnerable to market and bureaucratic forces and less able to resist their pressure toward the maximization of profit and the minimization of discretion.¹⁵⁴

These institutions include the legal, healthcare and economic agencies that provide the organisational framework around which professions can operate.¹⁵⁵ This notion has been somewhat supported in both in the UK and Australia where a series of medical crises and scandals, which resulted in harms to patients, was argued to be, in part, a failure of medical professionalism and self-regulation. This alleged failure of professionalism contributed to legislative reform of health professionals in both jurisdictions. In Australia the legislative change still allows for regulation by professionalism but the UK has moved to a more bureaucratic model, as discussed in more detail in Chapter 6. An explanation as to why Australia reformed legislation in response to political and economic pressure but did not remove the elements of professional self-regulation and professionalism is because professionalism is not merely a set of traits, or a distinct ethic, but is something that combines occupational value with ideological interpretation and is able to be used by the

¹⁵³ It should be noted that some doctors refuse treatment of some patients presenting with particular conditions on the basis of a conscientious objection to treat: for example, they may refuse to perform a termination of pregnancy. The right to make this particular objection is codified (see, e.g., *Health Act 1993* (ACT), s 84) but the right to refuse treatment to a patient on other grounds is not. Australian Medical Council, *The Good Medical Practice Guide: A Code of Conduct for Doctors in Australia* (2014), 2.4.7 says that good medical practice entails 'Not allowing your moral or religious views to deny patients access to medical care, recognising that you are free to decline to personally provide or participate in that care'. This provision places limitations on the right of doctors to conscientious object to the provision of lawful treatment; that is, that objection is permitted to the extent that it does not limit the right of a patient to access care. Most doctors accept this limitation to their personal right to object balanced against their professional obligations to not limit treatment to patients and will refer patients to a doctor who will provide the treatment. This is a form of professionalism.

¹⁵⁴ Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001).

¹⁵⁵ Noting this, it may be in paramedicine's best interests to avoid favouring advanced technology and expensive drugs and instead focus on teaching preventive medicine and a sound conception of health, both of which are more service- than profit-focused.

state as a tool of control of the professionals.¹⁵⁶ It does this by explaining and justifying state-imposed occupational regulation (both internal and external forms) as a means to *improve* professionalism. It provides professions with the opportunity to organise and regulate their own behaviour according to a socially accepted set of norms including clinical competency and good conduct, but threatens to sanction or remove the power of self-regulation from the group if it fails to meet these standards. Professionalism as a form of self-regulation also provides the state with an opportunity to abdicate responsibility for the management of these groups by relying on professions' own claims to moral and technical authority and abilities to govern without the need for state oversight. The Australian and UK legislative reforms and the way in which they influence healthcare workforce professionalisation, particularly paramedic professionalisation, is examined in more detail in Chapters 5 and 6.

Importantly for health professionals, professionalism provides them with the power, legitimacy and justification to advocate in the interests of their patients, even when this may challenge the power and authority of an employer of the state.¹⁵⁷ Regulation by professionalism works to protect patients where a conflict of laws may operate and have the effect of subjugating a patient's interests to those of another; for example, an employer or even the state.¹⁵⁸ This is discussed in more detail in Chapter 7.

2.4 The Elements Common to a Profession

Although there has been criticism of the use of criteria to identify a profession because the criteria alone provided little understanding of the power of particular groups and nor did it acknowledge the common characteristics between occupational groups,¹⁵⁹ it has nonetheless been recognised by others that the most frequently cited elements of a profession do provide a useful starting point to define and explore the shape and character

¹⁵⁶ Michel Foucault, (1979) *Governmentality. Ideology and Consciousness* 6(1): 5–21 cited in Julia Evetts, 'The construction of professionalism in new and existing occupational contexts: Promoting and facilitating occupational change.' *International journal of sociology and social policy* 23.4/5 (2003): 22-35.; Michel Foucault, *Power/Knowledge: Selected Interviews and Other Writings 1972–1977* (Harvester Press, 1980).

¹⁵⁷ Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001) 221.

¹⁵⁸ The *Declaration of Geneva* was developed in response to Nazi doctors 'just following orders'.

¹⁵⁹ Julia Evetts, (2014) The Concept of Professionalism: Professional Work, Professional Practice and Learning in Stephen Billett, Christian Harteis, Hans Gruber (eds.), *International Handbook of Research in Professional and Practice-based Learning*, Springer International.

of both a profession, the process of professionalisation and professionalism.¹⁶⁰ The empirical reality is that professions continue to be discussed as a sociological phenomenon.

The more than one hundred years of analysis of the way in which this particular group of workers (professions) is structured and the way they function in our society has provided a rich understanding of the way in which this category of workers is distinct from other workers, including the way in which they are regulated. Freidson's theory of professions, which was developed over a period of thirty years, identified that professionalism is a form of organising and controlling a group of workers that is still relevant today.¹⁶¹ It has provided an understanding both of why regulation by professionalism is important and useful, and of the evolutionary process occupational groups move through to acquire professional status. Therefore, this thesis will use a set of elements for a profession based on the work of Freidson as a lens through which to examine paramedics as an occupational group and to undertake a critical analysis of the group's professional evolution.

As outlined in Chapter 1, this thesis will examine paramedics and consider whether they are a profession, whether they are in the process of professionalising, and why they should be regulated by professionalism. This involves examination of *both* the attributes of paramedics and the 'process' of the professionalisation of paramedics, because they are not mutually exclusive.¹⁶² Freidson argues that placing an emphasis on the process of professionalisation rather than the attributes of a profession does not help define the subject of a discussion and renders the discussion about process 'virtually meaningless'.¹⁶³ As such, the criteria that form the analytical tool used in this thesis are made up of the attributes of a profession as acknowledged by Freidson¹⁶⁴ (hereinafter the 'Freidson elements'), supported by Wilensky's professionalisation trajectory. This tool will help provide an understanding of the way in which paramedics, as a unique group of workers in our society, have moved from being unorganised and inconsistently regulated, to evolve to become

¹⁶⁰ Eliot Freidson, *Professionalism Reborn: Theory, Prophecy and Policy* (Polity Press, 1994) 15; Mike Saks, 'Defining a Profession: The Role of Knowledge and Expertise' (2012) 2(1) *Professions and Professionalism* 1–10 <<https://journals.hioa.no/index.php/pp/article/viewFile/151/355>>; David Carr, 'Professionalism, Profession and Professional Conduct: Towards a Basic Logical and Ethical Geography' in Stephen Billett, Christian Harteis and Hans Gruber (eds), *International Handbook of Research in Professional and Practice-based Learning* (Springer International, 2014) 8.

¹⁶¹ Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001).

¹⁶² Eliot Freidson, *Professionalism Reborn: Theory, Prophecy and Policy* (Polity Press, 1994) 15.

¹⁶³ *Ibid.* 15.

¹⁶⁴ Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001).

organised by uniform piece of regulation that will have the effect of shaping the discipline both internally and externally.

The core comparative criteria of a profession are:

1. that the nature of their work serves a significant public service (**unique purpose**)
2. that they undertake a prolonged period of training and can apply discretionary specialised knowledge and skills (**specialised knowledge**); this service orientation and specialist knowledge provides them with
3. technical and moral authority (**power**) which allows them to
4. gain and maintain a system of control over their own work (**autonomy/self-regulation**) and
5. self-regulation includes regulation by professionalism (**a code of ethics**).

Wilensky's trajectory also intersects with other criteria identified through the work of the sociologists examined in this chapter as being associated with professionals. As professions develop their role and associated specialised knowledge and skills their education requirements shift from a merely competency-based training school to tertiary education where critical thinking is taught to facilitate the discretionary decision making required of a professional. This establishes the occupational group's technical and moral authority over their specialised area and allows them to organise into a local association, and later a national association, that can utilise the group's unique purpose and specialised knowledge as power to lobby for the legal authority to self-regulate on the basis that they provide a significant public service that requires specialised knowledge that non-professionals are not equipped to evaluate or regulate. As such, only members of the group can regulate others members of the group who fail to work competently or ethically to a standard set by the profession itself and captured in a code of conduct.¹⁶⁵

This study mapped Freidson's elements that are common to a profession against Wilensky's professionalisation trajectory (or process of becoming a profession), as outlined

¹⁶⁵ Tanina Rostain, 'Self-regulatory Authority, Markets, and the Ideology of Professionalism' in Robert Baldwin, Martin Lodge and Martin Cave (eds), *The Oxford Handbook of Regulation* (2010).

in Table 1, and found the correlation between professionalisation and the development of professionalism.

Table 1: Professionalisation-Professionalism Sociological Correlation

The Freidson elements for a profession¹⁶⁶	Wilensky's professionalisation trajectory
Significant public service/unique purpose ¹⁶⁷	
Specialised knowledge and skills ¹⁶⁸	Training school->university
Technical and moral authority becomes power ¹⁶⁹	Local association->national association
Gain and maintain control over work (autonomy/self-regulation) ¹⁷⁰	State licensing laws
Regulation by professionalism (code of ethics*) ¹⁷¹	Code of conduct

*Which incorporates virtues of trust and integrity.

Table 1 does not reflect the movement of the process of professionalisation but Wilensky's professionalisation trajectory moves in one direction from top to bottom. Freidson's elements are however less linear and more likely to move on a continuum that acknowledges the way in which the concept and various elements change in levels of importance to different groups over time.¹⁷² Freidson identifies that in order to become a profession, an occupational group must have the legal power to self-regulate delegated to it. In order to have this power delegated to it, the occupation must be organised as an identifiable group and the group must persuade the state that the group's purpose ('largely for the wellbeing of individuals or society at large'¹⁷³), specialised knowledge and skill is of 'such special character' that it warrants the privilege of self-regulation. It must

¹⁶⁶ Freidson did write about the 'elements of a theory of professionalism' where he identified that the elements are a synthesis of characteristics identified by a number of sociologists over many years and referred to be Freidson in order to provide some clarity and definition for a discussion on the professions. Eliot Freidson, *Professionalism Reborn: Theory, Prophecy and Policy* (Polity Press, 1994) 15, 47; also Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001).

¹⁶⁷ Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001) 59, 127, 217.

¹⁶⁸ Ibid 32 127.

¹⁶⁹ Ibid 56, 127, 214.

¹⁷⁰ Ibid 55, 127, 198.

¹⁷¹ Ibid. 197, 214.

¹⁷² Eliot Freidson, *Professionalism Reborn: Theory, Prophecy and Policy* (Polity Press, 1994) 16.

¹⁷³ Ibid. 200.

demonstrate that it will be organised in such a way as ‘to be able to control itself without abusing its privilege.’¹⁷⁴ This is because the nature of the work they do is likely to be difficult for others outside the profession to understand. However, the group must first have established that public purpose and specialised knowledge and skill in order to demonstrate its technical and moral authority to persuade the state that it can and should regulate itself. A ‘code of ethics’ and other policies and guidelines can then be developed by the group to ensure that the privilege is not abused. The code and other documents that reflect the elements of professionalism, provide members of the group with guidance as to expected standards of behaviour, they provide a benchmark to assist with the peer-review of member performance and they facilitate the development of a professional conscience, culture and ethos of professionalism within the group, all of which builds and protects the public’s trust in the profession.

Paramedics in Australia have been attempting to professionalise for around a decade. The next chapter of this thesis will use Freidson’s common elements for a profession, referred to in Table 1, to analyse the historical and social development to identify if paramedics are professionals. It will identify the elements that paramedics currently have and those they still must acquire to become a profession, and it will examine which stages of the professionalisation trajectory they have completed and those that remain to be achieved.

¹⁷⁴ Ibid 174.

Chapter 3: The Evolution of Paramedicine

The previous chapters provided an overview and theoretical framework to contextualise the study. This chapter examines the historical development of paramedicine. It provides a brief history of the evolution of the discipline and then sets out what paramedicine looks like today. The second part of the chapter critically analyses the application of the theoretical framework—in particular the five Freidson elements—to the current state of paramedicine to establish what professional characteristics paramedicine currently has and what elements it needs to professionalise.

Freidson recognised that archetypal professions like medicine develop an ideology that gives the group power to establish and maintain their positions of privilege.¹⁷⁵ This ideological construct includes reference to the occupation's purpose, their provision of a public service, allusions to altruism and in healthcare, commonly, an occupational identity associated with virtue—the angelic nurse, the God-like doctor. In the case of paramedics it may be the heroic rescuer running towards danger while others run from it.

This chapter examines the unique character of paramedicine and the way in which it has developed its role as a significant public service and solidified itself as an area of specialty not just in practice but in education and training standards. It examines the way in which the profession has had its moral core shaped by its historical associations with charitable services like the Order of St John. It considers how the combination of providing a significant public service that requires specialised knowledge and skills, delivered in accordance with an historical moral imperative, has contributed to the development of both technical and moral authority over their work.

3.1 The Development of a Unique Role and a Significant Public Service

There is general agreement among the scholars mentioned in Chapter 2 that there are core elements that can be used to identify a profession.¹⁷⁶ Those elements include that the nature

¹⁷⁵ Eliot Freidson, *Professional Dominance: The Social Structure of Medical Care* (Transaction Publishers, 1970).

¹⁷⁶ See, eg, Eliot Freidson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (Dodd Mead, 1970); Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001); Ernest Greenwood, 'Attributes of a Profession' in Barbara Faszard (ed), *Self-actualization for Nurses: Issues, Trends and*

of their work serves a significant public service; that they undertake a prolonged period of training and can apply specialised knowledge and skills; that they have a service orientation that is represented in a code of ethics, and because of this; they have technical and moral authority that allows them to organise and maintain a system of control over their own work. This section of the thesis considers the first criterion, a unique role and specific function, and how it applies to paramedicine.

The first formal ambulance service developed in Italy around 1240. The wool porters of Florence established the Compagnia della Misericordia, or Company of the Brothers of Mercy, with the role and purpose of removing ‘fevered or dead patients’ to a charity hospital or a chapel respectively. The Brothers would ‘hold themselves compelled to attend on any emergency’,¹⁷⁷ with each member taking an oath that they would respond:

to their houses, or to the hospital, all those who may be taken with sudden illness, or who fall from a scaffolding, or otherwise be grievously injured in our streets, and stand in need of their fellow creatures’ assistance; and we will also carry to the churches the bodies of such as may fall down dead, or be slain, or be drowned.¹⁷⁸

The Brothers would respond to a town bell that was rung whenever they were needed.¹⁷⁹ A number of men would arrive at the scene of the event carrying a litter ready to pick up and carry the injured person to hospital. If the patient was to remain at home, the Brothers would ‘perform every office of the kindest nurses’ at the bedside of the sick.¹⁸⁰ One report detailed the response of the Misericordiae to a woman who had fallen and broken her leg:

The litter, a covered one, was placed on the ground by her side; then, without a word, but with the utmost attention and gentleness, they placed her within it and immediately it was raised again on their shoulders. One of the Brothers asked her some question in a whisper, and she replied that she felt no pain but was very faint and they immediately bore her to hospital ... [with] a tender regard for the ease and comfort of this poor woman, [that]

Strategies for Job Enrichment (Aspen Systems Corp, 1984) 13; Andrew Abbott, *The System of Professions: An Essay on the Division of Expert Labor* (University of Chicago Press, 1988) 9; Professions Australia, *What is a Profession?* (2016) <<http://www.professions.com.au/about-us/what-is-a-professional>>.

¹⁷⁷ ‘Fratelli Della Misericordia—The Brotherhood of Mercy’ (1826) XVII *The New Monthly Magazine and Literary Journal* 1-584, 508.

¹⁷⁸ *Ibid* 506.

¹⁷⁹ The original siren perhaps.

¹⁸⁰ ‘Fratelli Della Misericordia—The Brotherhood of Mercy’ (1826) XVII *The New Monthly Magazine and Literary Journal* 1-584, 508.

showed the Brother to me in another light, and I was rejoiced to see that their kindness was equal to their heroism.¹⁸¹

This example of the Brothers of Mercy demonstrates not only the unique role in society played by the first ambulance service and the men who provided the service, it also the high esteem in which the men who performed the role were held. The significance of the Brothers of Mercy is that they moved to meet the need for the provision of an out-of-hospital service.

There is no record of any further organised civilian ambulance services in Europe for the next 500 years,¹⁸² although there were military ambulance services. For example, it is known that Queen Isabella of Spain introduced mobile field hospitals during the siege of Malaga in 1487 and that this is where the term ‘ambulancia’ is thought to have first been used.¹⁸³ Queen Isabella’s term ‘ambulancia’ did not refer to a vehicle of transportation, but rather a mobile field hospital that allowed medical attention to be provided close to the fighting rather than removed from it as it had previously. This is evidence of the recognition that early intervention without lengthy delay could benefit patients.

However, it was not until 300 years later that the concept of moving the wounded from the battlefield to the hospital via some form of transportation was introduced.¹⁸⁴ A French physician, Baron Dr Dominique Jean Larrey (1766–1842), recognised that simply moving the hospital closer to soldiers was not enough to improve care. He proposed that ambulance attendants recover the injured soldiers from the field and return them to the hospital for care in a more timely manner.¹⁸⁵ He wrote:

I now first discovered the inconveniences to which we were subjected in moving our ambulances, or military hospitals. The military regulations required that they should always be one league distant from the Army. The wounded were left on the field, until after the engagement, and were then collected at a convenient spot, to which the

¹⁸¹ Ibid 504.

¹⁸² Alexander Pollock, ‘Historical Perspectives in the Ambulance Service’ in P Wankhade and K Mackway-Jones (eds), *Ambulance Services* (Springer International, 2015).

¹⁸³ Henry Alan Skinner, *The Origin of Medical Terms* (Williams and Wilkins Co, 1949).

¹⁸⁴ Katherine Traver Barkley, *The Ambulance: The Story of Emergency Transportation of Sick and Wounded Through the Centuries* (Load n Go Press, 1978) 15.

¹⁸⁵ Panagiotis Skandalakis, Panagiotis Lainas, Odyseas Zoras, John E. Skandalakis, and Petros Mirilas “‘To Afford the Wounded Speedy Assistance’’: Dominique Jean Larrey and Napoleon’ (2006) 30 *World Journal of Surgery* 1392.

ambulances repaired as speedily as possible; but the number of wagons interposed between them and the army and many other difficulties so retarded their progress, that they never arrived in less than twenty-four or thirty-six hours, so that most of the wounded died for want of assistance. ... This suggested to me the idea of constructing an ambulance in such a manner that it might afford a ready conveyance for the wounded during the battle.¹⁸⁶

Apart from recognising the unique and important role that the retrieval of injured soldiers by ambulance and ambulance attendants could play in terms of health outcomes, this was also an early example of the use of empirical data to help inform not just healthcare practices but specifically ambulance practice. This example suggests that the particularities of ambulance work would require unique studies to inform ambulance service development to optimise the usefulness of the service.

3.1.1 New Technology and Paramedic Role Development

At this time, ambulances were a piece of new technology. They were two- or four-wheeled carriages, usually drawn by two horses, with a tube-like space on top of the carriage that could carry two patients.¹⁸⁷ The vehicle was inseparable from the men who operated it—the two acted together or not at all. The development and implementation of this technology therefore led to the development of a worker with a specified role to utilise this particular piece of technology.

This unique role was solidified over time. Within 50 years the *soldats d'ambulance* (ambulance soldiers) were the first formally noted workers to be exclusively associated with ambulances and although they were often men attached to the field hospital, they and their role were distinct from all other workers, including orderlies.¹⁸⁸ In 1869, Dr Thomas Longmore wrote:

¹⁸⁶ Dominique J Larrey, *Memoirs of Military Surgery and Campaigns of the French Armies* (RW Hall trans, Classics of Medicine Library, 1987) vol 1, 23–4 [trans of *Mémoires de chirurgie militaire* (first published 1814)].

¹⁸⁷ Panagiotis Skandalakis, Panagiotis Lainas, Odyseas Zoras, John E. Skandalakis, and Petros Mirilas “‘To Afford the Wounded Speedy Assistance’: Dominique Jean Larrey and Napoleon’ (2006) 30 *World Journal of Surgery* 1392.

¹⁸⁸ Thomas Longmore, *A Treatise on the Transport of Sick and Wounded Troops* (Her Majesty’s Stationery Office [HMSO], 1869); RCP, *Report upon the State of Hospitals in the Crimea and Scutari Together with an Appendix* (HMSO, 1855) 16.

The personnel of ambulance establishments, the men to whom the duty is *entrusted* of picking up and carrying the wounded to the field hospitals, of attending upon them under the direction of the surgeons while they are in hospital and during their subsequent removals, are so inseparably connected with their appliances, which are placed in their hands for carrying on this service, that a description of the one would be necessarily very incomplete without a description of the other.¹⁸⁹

Significantly, the size and shape of the conveyance popular at this time demonstrates that the ambulance attendants were in effect merely drivers and did not provide medical care en route to hospital as they do today. We can assume this because the tube in which patients were carried was too small to allow an attendant to sit with a patient and provide any care to them as they travelled. Definitive care did not commence until the patient arrived at the field hospital. Despite this, the ambulance attendant role was established with a unique purpose and specific function associated with it, and became an integral part of the military's response.

In fact, the role became so important to successfully undertaking a large-scale military campaign that the failure to provide adequate ambulance resources to support the British Army during the Crimean War (1854–85) was examined as a key issue by the British government. The Crimean War is famously linked with the professional development of nursing because of the critical role played by Florence Nightingale in recognising the importance of providing care, comfort, hygiene and nutrition to sick and injured soldiers.¹⁹⁰ However, the Crimean War also marked a point of professional development for ambulance officers, as assessed using the Freidson elements. The role of the ambulance officers at this time was, as it had been during the earlier era, the simple transportation of the sick to the definitive care of the nurse and the cure of the doctor. Nevertheless, this simple but vital role was recognised as being so significant that the failure of the British government to provide sufficient numbers of ambulance resources in the early part of the campaign was said to have contributed to significant losses.¹⁹¹ A parliamentary enquiry into the state of the hospitals in the Crimea heard that the lack of 'ambulance wagons' led to a delay in

¹⁸⁹ Thomas Longmore, *A Treatise on the Transport of Sick and Wounded Troops* (HMSO, 1869) 2–3.

¹⁹⁰ RCP, *Report upon the State of Hospitals in the Crimea and Scutari together with an Appendix* (HMSO, 1855) 343. (emphasis added).

¹⁹¹ *Ibid* 4.

‘collecting the wounded and dressing their wounds’.¹⁹² The inquiry identified that not only was there a problem with the ambulance vehicles, there was also an issue with ambulance staff who, according to the report, ‘did not answer expectations’.¹⁹³ Ambulance personnel and orderlies were taken from the rank and file of the army,¹⁹⁴ they were men who came from the lower classes of British society and who were, ‘forced into the Army by starvation, unemployment and poverty and occasionally as an alternative to prison’.¹⁹⁵ A Dr Hall gave evidence about the character of ambulance staff at the time, saying ‘from their habits and age they are quite unfitted for their situation’.¹⁹⁶ BW Marlowe, Surgeon for the 28th Regiment, wrote in his submission to the inquiry:

The men of the ambulance corps ... can scarcely ever be depended upon: they are insubordinate, disobedient and so perpetually drunk and noisy as to have become a public nuisance.¹⁹⁷

Another said that the ambulance men ‘do not prove the best attendants on the sick’.¹⁹⁸ A number of submissions to the enquiry made reference to the excellent provision of services offered to the British by the French, with Dr Thomas Longmore making particular note of the fact that the French had an ‘active, *trained and educated* ambulance corps’ and that ‘some similar establishment would be of great advantage in the British service’.¹⁹⁹ In part because of their character and in part because of the ambulance men’s lack of training for the purpose, Dr Hall recommended that ‘we ought to have a corps that is enlisted and trained for the purpose’.²⁰⁰

The unique skills and knowledge required to do the job well included blacksmithing and farrier skills, the ability to fix the wheels of the ambulance should they become damaged and animal husbandry skills to take care of the horses that pulled the carriages.²⁰¹ Without

¹⁹² Ibid 4–5.

¹⁹³ Ibid 4.

¹⁹⁴ Ibid 32.

¹⁹⁵ Harold E Raugh, *The Victorians at War, 1815–1914: An Encyclopedia of British Military History* (ABC-CLIO, 2004) xiv.

¹⁹⁶ Ibid 5.

¹⁹⁷ Ibid 117.

¹⁹⁸ Ibid 98.

¹⁹⁹ RCP, *Report upon the State of Hospitals in the Crimea and Scutari together with an Appendix* (HMSO, 1855) 101 (emphasis added).

²⁰⁰ Ibid 340.

²⁰¹ Ibid; It is interesting to note that the men were charged with and expected to be able to care for and treat horses but not human patients.

employing men with those skills the ambulance corps was considered ‘of no service whatever’.²⁰² This was an acknowledgement that not only was the ambulance service important, but perhaps the first recognition that specialised knowledge and skills were required to do the job well and thus the training of ambulance attendants in those albeit humble but nonetheless specialised skills and knowledge was critical. This is evidence of a move towards the development of the Freidson element that professions undertake a period of training and can apply specialised knowledge and skills for a public service. There was also a recognition that ambulance attendants could and should do more than maintain ambulances, that is, that their skill set should become more sophisticated. The Crimea parliamentary enquiry recommended that the men of the ambulance corps should also undergo some training as hospital orderlies, a job that required some ability to assess the health and health needs of patients; thus the role of the ambulance attendant began to expand.²⁰³

3.1.2 Recognition of the Need for Professionalism

Notably, it was also around this time that Henry Dunant, a Swiss businessman and social activist, contributed to the development of the 1864 Geneva convention that marked the inclusion of ambulance personnel into international humanitarian law²⁰⁴ mandating that field hospitals, medical personnel and infrastructure, ambulances and ambulance personnel provided in war were to be seen as neutral and inviolate.²⁰⁵ This was further acknowledgement of the importance of the service provided by the ambulance and ambulance staff, at least in the battlefield environment.

The experiences of ambulances and ambulance staff in war demonstrated the unique and critical role that they were able to play on the field of war. War then, as now, contributes to the development of pre-hospital technology that, over time, has been recognised as being more and more critical to better outcomes for patients.²⁰⁶ The development of the ambulance arose from the observation of the need for wounded soldiers to access medical help faster and the technology that enabled this—the ambulance—required maintenance

²⁰² Ibid.

²⁰³ Ibid 5.

²⁰⁴ *Geneva Convention I: For the Amelioration of the Condition of the Wounded in Armies in the Field*, opened for signature 22 August 1864 (entered into force 22 June 1865). This was revised later Conventions of the League of Nations and UN.

²⁰⁵ Ibid art 1–2.

²⁰⁶ Ellen Hampton, ‘How World War I Revolutionized Medicine’ (2017) *Journal of Medicine*.

and management by staff with a unique set of skills and knowledge. It was recognised that these skills and knowledge could be taught and that the role best suited a person who was ‘carefully selected’, in the prime of life, was dependable and obedient and able to do more than just drive the ambulance. A good ambulance attendant needed to be clever enough to be trained to assess the health needs of patients. The lessons of war were translated to use at the non-wartime front. Urbanisation and industrialisation in England were associated with a rapid rise in death and disease²⁰⁷ and so the role of the ambulance and ambulance officer was developed and adapted to provide for the first civilian ambulance services, which is consistent with the Freidson criterion for the development of the nature of the paramedic role to provide a significant public service; in this case, a significant public health service.²⁰⁸

3.2 Industrialisation and Professionalisation

The rapid increase in death and disease, in London in particular, was linked with the mid-19th century revolution in the way industry worked. Recognition of the importance of protection of public health and safety to ensure the working population remained productive led to the development of the first public health laws aimed at improving the sanitary conditions of the working classes.²⁰⁹ There was recognition that ambulance services were necessary and important but there were no laws that authorised the establishment of a charitable, coordinated, city-wide ambulance service.²¹⁰ In lieu of this, public cabs commenced operating as a proxy ambulance service. However, in 1832 the city was hit by a cholera outbreak and from this grew a recognition that a public cab was an inappropriate means by which to transfer sick and contagious people to hospital. Fire

²⁰⁷ John Haller, ‘The Beginnings of Urban Ambulance Service in the United States and England’ (1990) 8 *Journal of Emergency Medicine* 743. The Middlesex Hospital Board provided a horse-drawn wheeled sedan chair to transport injured persons around 1777, and in 1796 the Manchester Board of Health also provided a sedan chair to transport fevered patients to the newly established quarantine hospital. By 1852, the Chelmsford Board of Health in Essex had also commenced using a modified cart to convey cholera patients to hospital.

²⁰⁸ Roger Cooter and Bill Luckin (eds), *Accidents in History: Injuries, Fatalities and Social Relations* (Editions Redopi, 1997) 116.

²⁰⁹ Edwin Chadwick, *A Report on the Sanitary Conditions of the Labouring Population* (Publisher, 1842).

²¹⁰ The *Poor Law Amendment Act 1834*, 14 Geo 4, created 30 autonomous boards to oversee London’s charitable services. See Ryan Corbett Bell, *The Ambulance: A History* (McFarland and Co, 2009) 24; Matthew L Newsom Kerr, ‘“Perambulating Fever Nests of our London Streets”: Cabs, Omnibuses, Ambulances, and Other “Pest-Vehicles” in the Victorian Metropolis’ (2010) 49 *Journal of British Studies* 283, 287.

services were considered an alternative because they could place a stretcher on their fire wagon but it was recognised this was also not ideal because the infected person would be exposed to the community, thus risking further spread of disease.²¹¹ City officials realised the unique role and vital purpose that ambulance services could play in the protection of public health and began establishing a dedicated ambulance service fit for purpose.²¹² Growth in the sector was rapid over the next 15 years as the recognition of the benefits and the importance of the service as a public health tool grew. Along with this recognition came the first elements of ambulance authority—the culmination of an acknowledgement of the significant nature of ambulance work and the need to have that work performed in a particular way. This growing authority was most obviously demonstrated in the inclusion of ambulance services in the law.

3.2.1 Ambulances and the Law

By 1856 the medical journal *The Lancet* was publicly advocating the benefits of and need for each workhouse to have its own ambulance.²¹³ Continuing outbreaks of infectious diseases including smallpox and a shortage of suitable conveyances for the diseased led to the passing of the *Sanitary Act 1866* (UK). The law was responsible for the development of the ambulance into a legitimate, unique and vital public health service by requiring local communities to ‘construct suitable ambulances for contagious cases’.²¹⁴ Although the term ‘ambulance’ is not used in this piece of law nor the *Public Health Act 1875* (‘the PHA’) that followed it, section 123 of the PHA does encourage local sanitary authorities to provide a ‘conveyance for infected persons’.²¹⁵

At this time ambulances often resembled cabs and so the local metropolitan authorities were invited to mark ambulances with the word ‘AMBULANCE’ in ‘conspicuous letters’

²¹¹ Sally Wilde, *From Driver to Paramedic: A History of the Training of Ambulance Officers in Victoria* (Ambulance Officers Training Centre, 1999).

²¹² Manchester officials realised the importance of this justified the use of public funds to purchase a special van to carry victims. Unfortunately, the van resembled a hearse and so scared patients that they were afraid to call for it. See Ken Smith, ‘The Ambulance Service Past, Present and Future’ (1988) 232 *Practitioner* 879, 882; Ryan Corbett Bell, *The Ambulance: A History* (McFarland and Co, 2009) 25.

²¹³ ‘*The Lancet*: London: Saturday, 12 April 1856: “Street Cabs and Contagious Diseases”’ (1856) 67 *Lancet* 389, 409.

²¹⁴ Ryan Corbett Bell, *The Ambulance: A History* (McFarland and Co, 2009).

²¹⁵ *Sanitary Act 1866*, 29 Vict 1, c 90; *Public Health Act 1875* 38 Vict 1,

to differentiate them.²¹⁶ Although ambulance services did not have a complete monopoly on the conveyance of the sick and injured to hospital, the PHA did provide legitimacy to the term and notion of a particular vehicle being associated with the transportation of particular types of people—namely the diseased.²¹⁷ Although cabs could still be used for the conveyance of the sick and injured, it became an indictable offence for any cab to transport a non-infectious person unless the cab had been adequately disinfected.²¹⁸ This provision raised concern by the medical establishment that such a law would ‘[convert] the cabman into a pathologist’;²¹⁹ perhaps in so doing, it inadvertently identified the need for such a person. If such a role were to be developed, then further education of those staff would be required. This was the first time the law was used to provide ambulance services with a monopoly or at least an authority to provide a service for a particular purpose in a particular way, and disallowed others from doing so. This is further evidence of the progression towards the professionalisation of paramedicine as it is consistent with the Freidson criterion that identifies that having special knowledge and skills to adequately and arguably safely apply a unique and significant public service is a trait common to professions.

3.2.2 The Need for Further Education

In 1878 the *London Standard* reported that the Order of St John would not only provide relief for the sick and wounded of the British Army; it would also commence instructing individuals ‘not belonging to the Medical Profession’ in ways of ‘tending and relieving persons injured by accident in a time of peace’.²²⁰ The organisation relied on the principles of care delivered on the battle field: the preservation of life, prevention of further harm and promotion of recovery. The type of care provided was largely adopted from the St John Ambulance Association training manual *First Aid to the Injured*, which was first published

²¹⁶ Matthew L Newsom Kerr, “Perambulating Fever Nests of our London Streets”: Cabs, Omnibuses, Ambulances, and Other “Pest-Vehicles” in the Victorian Metropolis’ (2010) 49 *Journal of British Studies* 283.

²¹⁷ Ibid.

²¹⁸ Ryan Corbett Bell, *The Ambulance: A History* (McFarland and Co, 2009) 27.

²¹⁹ ‘Conveyance of Fever Patients in Public Vehicles’, (1853) XXVII *Medical Times and Gazette* 651, 652 cited in Matthew L Newsom Kerr “Perambulating Fever Nests of our London Streets”: Cabs, Omnibuses, Ambulances, and Other “Pest-Vehicles” in the Victorian Metropolis’ (2010) 49 *Journal of British Studies* 283, 295.

²²⁰ *The London Standard* (2 January 1878) cited in Murdoch Wales and John Pearn, *First in First Aid: The History of St John Ambulance in Queensland* (Amphion Press, 1999) xxvi.

in 1879. Shepherd wrote the first text on first aid. He had been a surgeon-major in the British Army and had quickly transposed the essential elements of first aid utilised in battle to the text. This event marked the beginning of the recognition of the need for an organised, trained and progressive civilian ambulance service.

By 1879 the Metropolitan Asylums Board had centralised the metropolitan ambulance operations. It sought to deliver a swift response via a sophisticated communication system that involved a call being placed to the ambulance station where a uniformed crew of drivers and a special nurse would be dispatched to the patient.²²¹ It established principles of service including ‘efficiency, safety and discipline’ to promote confidence in the service.²²² It also introduced purpose-built technology to ambulances, which further set them apart from other modes of transportation. For example, specially constructed ventilation shafts treated with ‘germicide solution’ were built into the ‘patent safety fever van’.²²³ However, there was still a lack of suitably qualified staff and vehicles available to meet demand. In 1881 a letter written by a doctor about his ill son and his efforts to find an appropriate conveyance to remove him to hospital and published in the *British Medical Journal* highlighted this gap:

the whole square was deeply shocked at the sight of the conveyance. I can only describe it as a cross between a hearse and a dirty linen cart, painted black and with funereal side glass; a black horse ... and a driver of the most woeful aspect, also in deep black ... surely the metropolis will not long delay this much needed *proper* ambulance provision.²²⁴

This case demonstrates that although paramedic professionalisation was incidentally benefiting from advances in technology arising from industrialisation and the associated increase in trauma and disease; in terms of a recognition of the importance of their role as a public health service, there was still some concern over the level of knowledge and skill they possessed to provide an ‘efficient, safe and disciplined’ workforce. There appeared to

²²¹ Matthew L Newsom Kerr, “Perambulating Fever Nests of our London Streets”: Cabs, Omnibuses, Ambulances, and Other “Pest-Vehicles” in the Victorian Metropolis’ (2010) 49 *Journal of British Studies* 283.

²²² Ibid.

²²³ “Safety Fever Ambulance,” *Lancet*, 23 August 1884, 330; “Safety Fever Ambulance Vans,” *Camden and Kentish Towns Gazette*, 23 August 1884, 3.

²²⁴ Samuel Stretton, ‘Ambulance Conveyances in London’ (1881) 2 *BMJ* 187 (emphasis added).

be some suggestion that to acquire a moral authority over their work, ambulance attendants had to improve their standards of professionalism.

3.3 Early Australian Ambulance Services

3.3.1 Not Just Transport

For the first 50 years after settlement, medical care in the Australian colony was provided to all—convict and free settler alike—by the Colonial Medical Service.²²⁵ Public health laws were adapted almost verbatim from Britain, the first of which commenced in 1854. Sydney, the most populous city, did not experience the same level or type of infectious disease outbreak as London,²²⁶ but the colony had experienced several outbreaks of contagion and had put in place some public health control measures.²²⁷ This included establishing an ambulance service, first formed by the Board of Health in Sydney in 1881, for the same public health reasons as in London—to transport patients with infectious diseases to hospital.²²⁸ The ambulance corps was not only required to transport infectious patients, it was also required to ‘fumigate’ and cleanse houses, bedding and other household items believed to be contaminated with disease, particularly smallpox.²²⁹ Staff were supplied with ‘disinfectants, hammocks, tarpaulins, oilcloths for this purpose’; they were also, significantly supplied with the text, ‘*materia medica*’²³⁰ - the collected body of knowledge of substances used for healing. The 1915 version of the text reveals that the skills of the ambulance personnel at the time included the assessment and treatment of fractures, dislocations and sprains; treatment of haemorrhage and wounds; assessment of foreign bodies in the eye, nose and ear; treatment of bruises, burns, bites and stings; assessment of ‘insensibility’ and poisoning; and how to perform artificial respiration. It

²²⁵ Milton Lewis & Roy MacLeod, ‘Medical politics and the professionalisation of medicine in New South Wales, 1850–1901’, (1988) *Journal of Australian Studies*, 12:22, 69-82.

²²⁶ For example, the *Public Health Act 1896* (NSW) made reference to dysentery rather than cholera and the plague.

²²⁷ For example, this included making laws with regard to the keeping of pigs near waterways, particularly the Tank Stream, Sydney’s main water source. See Milton Lewis, *The People’s Health: The History of Public Health in Australia, 1788 to 1950* (Greenwood Press, 2003) vol 1.

²²⁸ Gerard Fitzgerald, ‘“Don’t Play with the Sirens”: The Role of the Emergency Physician in Pre-Hospital Care’ (1991) 4 *Emergency Medicine* 237, 243; *Ambulance Service (NSW) v Federal Deputy Commissioner of Taxation* [2003] FCAFC 161, [4].

²²⁹ ‘Small-pox in Sydney’, *Maitland Mercury and Hunter River General Advertiser* (Maitland), 28 July 1881, 3.

²³⁰ ‘Small-pox Ambulance Outfit’, *Newcastle Morning Herald and Miners’ Advocate* (Newcastle), 13 August 1884, 3.

also provided information on methods of lifting or carrying the sick or injured on stretchers, on rail or in carts.²³¹

The call for ambulance services continued to grow; however, the major provision of service still fell to voluntary organisations: the St John Ambulance Association (which provided treatment) and the Civil Ambulance Transport Brigade (which provided transport). The service in NSW, as elsewhere around the country, was a dedicated community-based organisation largely made up of volunteers who provided services free of charge for the user. The NSW Brigade was staffed with just two permanent officers; hence, in the sense of being paid to do the job, they were professionals and not amateurs or volunteers.²³² The organisation was required to raise money from the community to fund the service. This suggests that the service did not have sufficient community support to warrant government funding or that the demands on the service were not great enough at this stage to warrant that funding. For economic reasons the two services were amalgamated to become the Civil Ambulance *and* Transport Brigade, which commenced operations on 1 April 1895 with the interesting motto, ‘For love and life’,²³³ suggesting that the ambulance service was both a calling for staff and a life-saving service for users that embodied something like a moral imperative to perform the role.

The extension of the scope of practice of the ambulance staff beyond just the transportation of patients to hospital demonstrates not only the unique public health service they provided in the out-of-hospital environment, but also the need for ambulance staff to have specialised knowledge and training to perform that service. The knowledge of substances for healing provided further evidence of the expanding role of the ambulance staff and their increasing professionalisation according to the Freidson elements. Ambulance staff were now performing a significant public service, using specialised knowledge and skills under, admittedly restricted, legal authority.

²³¹ James Cantlie, *First Aid to the Injured* (St John Ambulance Association, 1915). It was also so in Western Australia (WA), see Ian Howie-Willis, *St John Ambulances and Western Australia 1892–1992* (St John Ambulance Australia, 1992) 29.

²³² Public service records from 1894 show that ambulance men were paid more than nurses but less than artisans (e.g., carpenters), and about the same as cooks, giving us an indication of how they were valued by society. New South Wales (NSW) Public Service Lists 1894, 37.

²³³ I thought this might be a misprint of ‘For love *of* life’ (emphasis added) but it is not. NSW State records archives investigator <<http://investigator.records.nsw.gov.au/Entity.aspx?Path=\Agency\58>>.

3.3.2 The First Ambulance Act in Australia

The *Ambulance Transport Services Act 1919* (NSW) gave control of NSW ambulance services to the NSW Ministry for Public Health and separated the ambulance from the hospital, which was thought to result in much greater progress for the service in part because the service would be organised centrally and able to isolate funding from other areas of health.²³⁴ The Act also articulated the purpose of the service at law, for the first time saying that a statutory board was responsible for the organising and controlling of ‘the work of rendering first aid to and transport of sick and injured persons’,²³⁵ making clear that the role of the service was not just to transport but to provide some care. This board also took control of the funding of ambulance services, which was sourced from contributions attributable both to the public and to consolidated revenue.²³⁶ In 1921 the number of permanent ambulance staff had doubled to four. They provided transport while the 41 nurses employed by the service provided the treatment. The then NSW Ambulance Transport Service Board attended over 12,000 cases. Although the service was widely used, it was not valued by the community to the extent that it was prepared to pay for the service.²³⁷ In 1924 a front page newspaper report made an appeal for community financial support by referring to the ambulance officers as ‘angels of mercy’, suggesting that they were virtuous and thus deserving of support.²³⁸ This appeal to the virtue of the ambulance officers traded somewhat on their association with the nursing sisters employed to treat the patients and thus had the effect of magnifying the role and status of the ambulance officers beyond just the pragmatic role and identity of a ‘driver’ to the more altruistic role of the ‘hero’. This was another appeal to moral authority— an element of the Freidson elements— that was used to raise the profile of the service and the work it performed. This element was necessary to acquire to acquire political power that would allow them to later lobby for legislative control over their own work.

²³⁴ ‘First Aid to the Sick and Injured: The Story of the Ambulance’, *Northern Champion* (Taree), 5 November 1938, 3.

²³⁵ *Ambulance Transport Services Act 1919* (NSW).

²³⁶ The issue of funding for the service was raised in the case *Ambulance Service (NSW) v Federal Deputy Commissioner of Taxation* [2003] FCAFC 161, which sought to determine if the Ambulance Service of NSW (ASNSW) was a publicly benevolent institution or a government body for the purposes of taxation.

²³⁷ ‘Civil Ambulance’, *Sydney Morning Herald* (Sydney), 15 December 1921, 10.

²³⁸ ‘Angels of Mercy’, *Sunday Times* (Sydney), 16 November 1924, 1.

3.3.3 Mandatory Qualification

In Victoria around the turn of the 20th century, demands on the service were also increasing—evidence in and of itself of the service’s community value—and funding was becoming an issue. The Fire Brigade stated they were no longer prepared to perform both the role of fire fighter and ambulance officer without adequate financial support. Neither the St John Ambulance Association or, significantly, the government, were prepared to provide that support.²³⁹ As a result the service was placed into the private hands of Mr AJ Nance who was paid six pounds per week by St John to provide the service while tenders were called for. The tender was won by the Fiske Brothers, who owned a livery stable. They commenced the service in 1903. It was a condition of the contract that all staff employed were to complete the St John Ambulance First Aid training course.²⁴⁰ This was the first time in Australia that a qualification had been legally linked to employment for ambulance officers and it is notable that the requirement was set by the employer and not the ambulance officers themselves. This demonstrates that although paramedic professionalisation was occurring in terms of developing their body of knowledge and increasingly formalising that knowledge, ambulance officers did not yet have control over their own work—a key criterion to be recognised as professionals.

3.3.4 Working Under Doctor’s Orders

Brisbane’s City Ambulance Transport Brigade, established in 1892, also required the St John Ambulance First Aid certificate as a minimum qualification for its ambulance officers.²⁴¹ The brigade employed some paid staff and a large contingent of voluntary staff and the purpose of the service was clear:

1. to render first aid and subsequently to undertake the careful removal of the injured to the home, doctor or hospital; and

²³⁹ Sally Wilde, *From Driver to Paramedic: A History of the Training of Ambulance Officers in Victoria* (Ambulance Officers Training Centre, 1999) 13.

²⁴⁰ *Ibid.*

²⁴¹ That later became known as the Queensland Ambulance Transport Brigade; it also required ambulance attendants to commit to the principles of the Ambulance Cross. This is the first example of the discipline requiring a code of ethics of sorts be used as a standard for service delivery; see more later in this chapter; Enid Cullen, *Ready Always: The History of the Bundaberg Ambulance* (Edgars Printers and Stationers, 1999).

2. to transport *when directed under the doctor's orders* persons suffering from any form of sickness or disease.²⁴²

It was clear in these early stages of Australian civilian ambulance services that although ambulance officers were controlled by their employer and were required, at times, to follow a doctor's orders, there were other occasions when they used the St John First Aid manual to inform their treatment of patients, and were also able to use their discretion to determine whether a patient should be transported back to their 'home, a doctor or a hospital'. This suggests there was a degree of autonomy to their practice. However, this autonomy was likely not a product of professionalism—that is, a decision informed by specialist knowledge and a code of ethics—but rather a discretion borne of pragmatism; that is, a decision needed to be made and the ambulance officer was in a position to make it. This is a decision resulting from circumstance rather than anything else. This also suggests that the nature of the work performed by ambulance officers did lend itself to working autonomously, outside the control of others (as noted by Willis and outlined in Chapter 2). This required discretionary decision making and identifies that the work that ambulance officers do suits regulation by professionalism. This is because ambulance officers work within an area where the prescription of particular actions for all cases that could potentially arise is impossible and that, therefore, it is necessary to rely on the professionalism of the practitioner to ensure the best outcome for the patient.

3.3.5 Growth in Demand but not Role

By the mid-1930s the Central District Ambulance Service in NSW was being referred to as one of the most efficient of the essential public services²⁴³ with ambulance officers referred to as 'highly trained staff' and the service as delivering a 'humanitarian' service to a standard that was 'second to none in the world'.²⁴⁴ There was also growth in the service itself. By 1953 there were 606 employees and 425 ambulances and the NSW service was

²⁴² Murdoch Wales and John Pearn, *First in First Aid: The History of St John Ambulance in Queensland* (Amphion Press, 1999) 103. Similar prescriptive details of the purpose of the state-based ambulance services are included in various pieces of legislation (emphasis added).

²⁴³ 'Ambulance Efficiency', *Sydney Morning Herald* (Sydney), 25 July 1935, 14.

²⁴⁴ 'First Aid to the Sick and Injured: The Story of the Ambulance', *Northern Champion* (Taree), 5 November 1938, 3.

thought to be able to reach every home in the state.²⁴⁵ However, ambulance personnel were still mostly volunteers who were referred to as ‘driver’, ‘bearer’ or ‘collector’ to reflect the nature of their work—driving the ambulance, bearing the stretcher and collecting subscription fees. Although standardised—in that those doing the training followed the St John First Aid curriculum—the level of training really only mirrored the function the service provided: basic first aid skills followed by driver training that would ensure ambulance personnel were able to move the sick and injured from the pre-hospital environment to the hospital environment as quickly as possible.²⁴⁶ Doug Woodhouse, a superintendent of the North West Ambulance Service said:

if the doctor felt the ambulance services had a problem in looking after that patient, he dropped everything and went with you. Or if he didn’t do it, we got a senior sister from the hospital, bear [sic] in mind that you were in fact the driver of the ambulance you knew how the nuts and bolts went but you weren’t really particularly good at looking after the sick and injured...²⁴⁷

This demonstrates that the ambulance officer’s role as a healthcare practitioner had not developed to a point where they were the primary care provider. Despite the fact that the unique role and value of the emergency pre-hospital care service was well and truly secured, it was not until the late 1960s and early 1970s, in response to social and technological changes, that the purpose of the paramedic role extended beyond the traditional ‘load ‘n go’, advanced first aid response to morph into an almost entirely different occupation. Advances in medicine and medical research were able to demonstrate the critical role that high-quality and highly skilled pre-hospital care could play in improving patient outcomes and this resulted in an extension of the purpose of the paramedic beyond just providing advanced first aid. To keep pace with the change in role, there needed to be a change in education and training.

²⁴⁵ Although a government report recognised that the ambulance service was the only industry in NSW where staff worked a 48-hour week. See ‘Ambulance is a 48-hr Week Job’, *Goulburn Evening Post* (Goulburn), 21 April 1953, 7.

²⁴⁶ Evan Willis and Liam McCarthy, ‘From First Aid to Paramedical: Ambulance Officers in the Health Division of Labour’ *Australian and New Zealand Journal of Public Health* 10.1 (1986): 57-67.

²⁴⁷ Sally Wilde, *From Driver to Paramedic: A History of the Training of Ambulance Officers in Victoria* (Ambulance Officers Training Centre, 1999) 34.

3.4 Advanced Training and the Development of a Unique Body of Knowledge

Before the 1960s the training of ambulance personnel anywhere in Australia was sporadic. It varied in quality and quantity between communities and largely took place on the job.²⁴⁸ A meeting of the Victorian Ambulance Services Association in 1957 sought to resolve the issue regarding multiple training programs. A resolution was passed at that meeting that a request should be made to the local Hospitals and Charities Commission for a school to be established for the ‘preliminary training of ambulance officers to a defined standard’.²⁴⁹ In 1961 the first Ambulance Officers Training Course commenced in Geelong. Instruction was provided by nurses and doctors from the Geelong and District Hospital. Driving instruction was provided by ambulance superintendents.²⁵⁰ This was the first course specifically developed for ambulance officers, and not members of the public (as was the case with first aid training), that covered material specific to the unique nature of paramedic work.

By the 1960s there had been radical advances in medical knowledge and technology. In the US, Dr RA Cowley published a number of articles outlining the importance of an integrated and coordinated emergency care team that extended from pre-hospital to hospital. He developed a concept referred to as the ‘golden hour’, which claimed that trauma patients who received definitive care within an hour of injury had significantly better outcomes than those who did not.²⁵¹ This type of medical research on the effect of ambulance intervention in the pre-hospital space was only just beginning to be undertaken in any organised way and with the objective of shaping paramedic practice. Although paramedics were not doing the research themselves, at least the environment in which they worked was being researched and the potential for paramedics to play a greater role in healthcare outcomes was being considered. The ‘golden hour’ concept became foundational in identifying the value of care provided in the pre-hospital space and raised awareness among the medical

²⁴⁸ Ibid.

²⁴⁹ Ibid.

²⁵⁰ Ibid.

²⁵¹ E Brooke Learner and Ronald Moscatti, ‘The Golden Hour: Scientific Fact or Medical “Urban Legend”?’ (2001) 8 *Academic Emergency Medicine* 758.

fraternity that ambulance officers were well placed to deliver that care provided they were properly trained.²⁵²

In Victoria, Dr Graeme Sloman became aware of advances in the US where ambulance attendants were taking a ‘quantum leap’ from applying first aid skills to becoming ultra-skilled ‘physician extenders’ qualified to administer advanced medical care in the field.²⁵³ He believed that a similar approach could be developed in Victoria. He won support from the College of Surgeons and funding from the Victorian minister of health to create a similar model referred to as a pre-hospital intensive care model. There was no formal emergency medicine speciality in Australia at this time but there were a number of doctors interested in emergency care and their work was informed by the experiences of doctors and medics during the Korean and Vietnam Wars.²⁵⁴ Strong links developed between those clinicians and the ambulance service who were the frontline for the majority of trauma at that time. The Ambulance Services Advisory Committee (ASAC) was formed and facilitated the clinical and professional development of paramedics. This was successful to the extent that Victorian ambulance officers had shifted from being essentially highly skilled first aiders with a restricted set of skills at the start of the decade, to administering pain relievers like the mild anaesthetic agent, trichloroethylene, which was previously only administered by doctors—a mere four years later.²⁵⁵

The extension of the role and practice of paramedics did not result from demands made by paramedics themselves; rather, it was a response to an increase in the number of traumatic incidents they were attending. Over the preceding 30 years or so car ownership had grown and with it the number of car accidents.²⁵⁶ Drink driving was common and seat belts were rarely worn; indeed seat belts and other safety features within cars were virtually non-

²⁵² Ibid.

²⁵³ Ryan Corbett Bell, *The Ambulance: A History* (McFarland and Co, 2009) 254.

²⁵⁴ For example, it was observed that if a soldier was alive when ‘stretcher bearers’ reached him, it was thought that he could be kept alive until he reached definitive care; See Sally Wilde, *From Driver to Paramedic: A History of the Training of Ambulance Officers in Victoria* (Ambulance Officers Training Centre, 1999) 86; Louise Reynolds and Madeleine O’Donnell. "The role of pre-hospital care and paramedics: the emerging professionalisation of urgent care." *Understanding the Australian Health Care System* (2016): 271.

²⁵⁵ Sally Wilde, *From Driver to Paramedic: A History of the Training of Ambulance Officers in Victoria* (Ambulance Officers Training Centre, 1999) 88.

²⁵⁶ From 1925 until 1979, over 100,000 road users were killed and 2.2 million injured prior to the introduction of compulsory seat belts in 1971, see PW Milne, *Fitting and Wearing of Seat Belts in Australia: The History of a Successful Countermeasure* (Department of Transport (Cth), 1985).

existent as authorities focused mitigation efforts on accident reduction rather than improved safety.²⁵⁷ As a result, ambulance personnel attended a large number of car accidents that resulted in significant trauma, well beyond that normally seen outside of a battlefield. Prior to this there were no specific accident and emergency departments in hospitals, but the increase in road users and subsequent road accidents necessitated their development.

Emergency medicine developed as a specialty area and this contributed further to the clinical development of paramedicine working at the coal-face of road trauma. This move was supported by the head of the Standing Committee on Road Trauma, ESR Hughes, who wrote to the chair of the Hospitals and Charities Commission in Victoria stating ‘that there should be an increase in the standard of training of Victorian Ambulance Officers at all levels to enable them to fulfil an increased role’.²⁵⁸ This slow increase and expansion in training and scope of practice was contributing to the development of the profession beyond just being ‘drivers’. The expanded scope of practice meant that paramedics now had expanded professional responsibilities. The old approach of just turning up to the scene, loading the patient into the ambulance and letting someone else deal with the situation in hospital was changing. Ambulance officers were now required to know when to use these advanced skills and treatments and when not to. That is, they were required to use professional judgement and discretion and to consider how they could act in patients’ interests.

3.4.1 Calls for Recognition

The flow-on effect of increasing road trauma for ambulance services and personnel was the recognition that the application of basic first aid and the ‘load ‘n go’ approach that had previously applied to pre-hospital care was now insufficient. The public health impact of road trauma was so great that in 1969 the Royal Australasian College of Surgeons held a seminar on the management of road traffic casualties. The seminar was significant and influential because it led to the Australian Medical Association’s (AMA’s) support not only for compulsory seat belts but, relevantly, for research to identify what greater role ambulance officers could play in providing care to road trauma victims.²⁵⁹ This point has

²⁵⁷ Ibid.

²⁵⁸ Sally Wilde, *From Driver to Paramedic: A History of the Training of Ambulance Officers in Victoria* (Ambulance Officers Training Centre, 1999) 88.

²⁵⁹ Ibid.

further significance because it demonstrates that although the medical fraternity were driving the scope and development of knowledge and practice for ambulance officers at this time, they believed ambulance staff were only capable of delivering this type of care and treatment if they had the necessary training. A number of doctors who presented at the seminar, including Frank Archer—who was to become a seminal leader in the development of paramedicine in Australia—had worked as ambulance officers during their holidays.²⁶⁰ Archer identified that of all the practitioners in the care chain it was only ambulance officers, those right at the frontline who were ‘one of the few who deals with the life of the patient’, who had not undergone any type of intensive training. This situation prompted Archer to call for more and better training, recognising that this would only be possible if there was also a corresponding improvement in the ‘status of ambulance officers, and recognition of their skills and their value by the medical profession’.²⁶¹

The second important clinical development that drove paramedics’ educational development and extension of their practice was an increased knowledge of and changes to the practice of cardiology. Ambulance personnel were frequently called to patients having cardiac episodes and there was some suggestion that early and effective treatment of these patients could also result in better outcomes.²⁶² Cardiopulmonary resuscitation was developed in 1960²⁶³ and advances in technology such as the development of an affordable portable defibrillator, electrocardiograph monitors and research into the use of various pharmaceuticals including glyceryl trinitrate (trade name Anginine) also changed what could be done for cardiac patients in the pre-hospital setting. A three-month trial designed to assess if paramedics were capable of being trained and operating at this higher level was commenced; those paramedics who were selected underwent training that was previously thought to be only suitable for the higher status ‘trained nurse’.²⁶⁴

²⁶⁰ The title of Archer’s paper was ‘Care Before Casualty—Current Shortcomings;’ Frank Archer, ‘Dr. Peter O’Meara—Ambulance to Academia and back again.’ (2003) *Australasian Journal of Paramedicine* 1.1.

²⁶¹ Sally Wilde, *From Driver to Paramedic: A History of the Training of Ambulance Officers in Victoria* (Ambulance Officers Training Centre, 1999) 87.

²⁶² Michael F O’Rourke, ‘Reality of out of Hospital Cardiac Arrest’ (2005) 91 *Heart* 1505; Sally Wilde, *From Driver to Paramedic: A History of the Training of Ambulance Officers in Victoria* (Ambulance Officers Training Centre, 1999).

²⁶³ Michael Criley, James T Niemann and John P Rosborough, ‘Cardiopulmonary Resuscitation Research 1960–1984: Discoveries and Advances’ (1984) 11(9)(Pt 2) *Annals of Emergency Medicine* 756.

²⁶⁴ Sally Wilde, *From Driver to Paramedic: A History of the Training of Ambulance Officers in Victoria* (Ambulance Officers Training Centre, 1999) 91.

In the late 1970s a Tertiary and Further Education (TAFE) course was prepared for the Victorian Ambulance Service's Ambulance Officers' Training Centre.²⁶⁵ It was titled the Certificate of Applied Science (Ambulance Officer). The course was developed by ambulance officers and doctors and reflected the unique work done by ambulance officers.²⁶⁶ The implementation of the Victorian TAFE program allowed an agreed standard of qualification for paramedics to be established. This program was later adopted by other state ambulance services.²⁶⁷

Ambulance officers had gradually been recognised by other members of the healthcare fraternity as providing a significant public health service. 'Ambos', as they were affectionately referred to, were recognised as working in a unique environment with a unique set of patients. This in turn required the application of a unique approach to healthcare. To achieve this, ambulance officers were now required to undertake a prolonged period of training to acquire specialised knowledge and skills. The St John First Aid certificate was no longer a sufficient qualification to perform the role. Ambulance officers now required a Certificate of Applied Science (Ambulance Officer), a qualification developed by the discipline for the discipline but with input from medicine. This shows the beginning of the development of paramedic professional autonomy. With regard to Wilensky's trajectory of professional development, paramedics had achieved the first goal—the establishment of a training school.

3.5 Radical Change—the Introduction of Mobile Intensive Care Ambulance Units

In the early 1970s further changes to the size and shape of the ambulance vehicles facilitated advancements in the treatment offered by paramedics before reaching hospital. The ambulance as a mobile intensive care unit was flagged as a model that could help produce better outcomes for patients. The model was trialled for three months. The training required ambulance officers to work a roster alongside a doctor at the hospital in

²⁶⁵ Technical and Further Education Board, *Certificate of Applied Science: Ambulance Officer: Course Prepared for Ambulance Officers' Training Centre, Ambulance Service of Victoria* (Education Department (Vic), 1979).

²⁶⁶ Sally Wilde, *From Driver to Paramedic: A History of the Training of Ambulance Officers in Victoria* (Ambulance Officers Training Centre, 1999).

²⁶⁷ Ian Kaye-Eddie, *A Short History of the Convention of Ambulance Authorities 1962–1995* (St John Ambulance Australia, 1996).

cardiology, emergency, coronary and intensive care before going out on the road. The type of skills that paramedics were performing had previously been performed only by doctors. These included intubation and cannulation. Initially doctors attended patients along with the ambulance officers. Eventually it was acknowledged that the ambulance officers were suitably skilled to carry out the protocols and procedures the doctors had developed without medical oversight.²⁶⁸ Confidence in the ability of the ambulance staff increased and the range of work they attended broadened. It was recognised that they could play an instrumental role in assisting patients to better outcomes if definitive and advanced interventions were applied early, in cases not only of motor accidents and cardiac events but also in drug overdoses, gunshot wounds and industrial accidents.²⁶⁹ This was evidence of the discipline's continuing professionalisation. Not only were paramedics extending their knowledge, skills and training to undertake their unique work; they were slowly gaining control over their own work in the sense that although they were legally required to adhere to their employer's clinical practice guidelines, paramedics were not working under the immediate authority of a doctor or a nurse.

By 1975 NSW had begun trialling the model of an extended scope of practice ambulance officer who was referred to, for the first time, as a 'paramedic'.²⁷⁰ Tasmania, South Australia, Queensland, Northern Territory and the Australian Capital Territory (ACT) all followed with various forms of advanced life support training.

3.5.1 A Shift to the Tertiary Sector

The early 1990s saw a standardisation of skills and training that was designed to allow for national recognition and mobility.²⁷¹ The qualification was undertaken in an apprentice-style, vocation-based approach with people being employed by the various state ambulance authorities and then enrolled in the course; thus, the process was not controlled by the discipline but rather by the employers of ambulance officers. Ambulance personnel undertook the course while working full time. There was a stratification of skill level and title within most state-based ambulance services. In NSW for example, the preliminary

²⁶⁸ Sally Wilde, *From Driver to Paramedic: A History of the Training of Ambulance Officers in Victoria* (Ambulance Officers Training Centre, 1999) 90.

²⁶⁹ Ibid.

²⁷⁰ ASNSW <<http://www.ambulance.nsw.gov.au/about-us/History.html>>.

²⁷¹ Gerry Fitzgerald and Ray Bange, 'Defining a Regulatory Framework for Paramedics: A Discussion Paper', (2007) 5(2) *Journal of Emergency Primary Health Care*. 243.

training at the base level was undertaken by all paramedics with staff moving from level I to level III over three years of vocational curriculum work supported by practical experience. Staff could remain at level III and be considered a fully qualified ambulance officer. If staff wished to extend their scope of practice they were able to apply in a competitive process to undertake advanced training at level IV and intensive care training at level V. However, the credential awarded had shifted beyond a certificate-level qualification to a diploma with a base-level ambulance officer requiring a Diploma of Paramedical Science (Pre-Hospital Care). More advanced levels of practice with greater skills required higher qualifications, the highest being the Advanced Diploma of Paramedical Science (Pre-Hospital Care) for Level V officers.²⁷²

In 1994 the first degree qualification was developed for ambulance officers at Charles Sturt University in NSW; a similar program was offered by Victoria University the following year.²⁷³ The degree qualification was offered as a full pre-employment qualification, a model that had not been previously offered. Nursing had moved to the tertiary sector only five years previously to increase the professional status of nurses. Another reason for the move was that apprenticeship-based form of nursing education was too costly for the state to continue to subsidise and so the training shifted to the tertiary sector where it could receive federal funding and be subsidised by the student.²⁷⁴ The same financial pressures did not apply to paramedics because there were fewer of them and therefore training costs were lower; but as with nursing, there was a decision to shift paramedic education to the tertiary sector to progress the professionalisation of the discipline.²⁷⁵ However, unlike the situation with nursing, this decision was not made by members of the discipline; it was made in NSW by Charles Sturt University and the ASNSW.

²⁷² ASNSW <<http://www.ambulance.nsw.gov.au/about-us/History.html>>.

²⁷³ Bill Lord, 'The Development of a Degree Qualification for Paramedics at Charles Sturt University' (2003) 1 *Australasian Journal of Paramedicine*.

²⁷⁴ Steering Committee for the National Review of Nurse Education in the Higher Education Sector, Parliament of Australia, *Nursing Education in Australian Universities: Report of the National Review of Nurse Education in the Higher Education Sector—1994 and Beyond* (1995) *Collegian* 2.2: 18-22.

²⁷⁵ Bill Lord, 'The Development of a Degree Qualification for Paramedics at Charles Sturt University' (2003) 1 *Australasian Journal of Paramedicine* <<https://ajp.paramedics.org/index.php/ajp/article/view/40/47>>

3.6 High-level Skills and Vulnerable Patients—the Development of Professionalism

Advancements in paramedic practice have continued to increase exponentially in the last decade with paramedics now performing skills that once only doctors could perform,²⁷⁶ including the intubation of a patient, the administration of anaesthetic agents, and the performance of assessment skills to determine not only what is wrong with a patient, but the treatment priorities, the appropriate transport options (e.g., trauma, cardiac or stroke bypass) or the suitability for non-transport. These literally can be life-and-death decisions. Indeed, a recent case heard by the Fair Work Commission recognised that it had received a ‘considerable volume of evidence about the nature of the changes to paramedic work since 2005’ that justified increases in paramedic salaries.

The provision of paramedic treatment occurs largely out of sight of the public or other professionals as it is undertaken in the patient’s home or elsewhere in the pre-hospital environment. The emergent nature of the work of paramedics means that the patient is likely to be particularly vulnerable and unable to protect themselves from an incompetent or unprofessional practitioner. Those practitioners are working in an ever-increasing number of areas beyond just the more tightly regulated state-based ambulance services, including in:

the mining and offshore oil and gas industries, entertainment events, in-house medical services in hotels and casinos, international air medical retrievals, combat medic roles in defence forces and private inter-facility patient transport services. Paramedics are also engaged in non-clinical roles to support the advancement of the profession, including clinical education, research, administration, management, university academia, professional advocacy and clinical governance.²⁷⁷

The expanded and increasingly onerous role of the modern-day paramedic has necessitated a change to the way in which paramedics are educated and regulated. All state-based ambulance services—which employ the majority of paramedics in Australia—operate via

²⁷⁶ Urgent and Emergency Care Team, NHS England, *High Quality Care for All, Now and for Future Generations: Transforming Urgent and Emergency Care Services in England—Urgent and Emergency Care Review: End of Phase 1 Report* (2013).

²⁷⁷ PA, Submission No 9 to Senate Legal and Constitutional Affairs References Committee, Parliament of Australia, *Establishment of a National Registration for Australian Paramedics to Improve and Ensure Community Safety*, 2016.

clinical practice guidelines originally developed from protocols developed by medical practitioners. However, the introduction of tertiary education programs has allowed paramedics to develop critical thinking skills that have enabled them to move beyond the reliance on prescriptive protocol-based decision making, to assessing and determining appropriate treatment for patients under less strict guidelines.²⁷⁸

Today there are more than a dozen Australian universities offering paramedic degree programs developed and largely delivered by paramedics.²⁷⁹ The objective of the shift to tertiary education has been to provide paramedics with an opportunity to develop their ability to engage in higher-order thinking and appropriately apply their professional discretion to patient treatment options; thus making them capable of working with professionalism.²⁸⁰

However, unlike in medical and nursing education, there is currently no external accrediting body in paramedicine. Hugh Grantham argued that this issue is politically fraught because ‘accreditation has been seen to be synonymous with control and standardisation’.²⁸¹ The Council of Ambulance Authorities (CAA)—an industry group representing employers who are mainly state-based ambulance services—developed and initiated a process of accreditation that was trialled in 2007 at Charles Sturt and Edith Cowan Universities. The process allowed for institutional diversity and the delivery of materials using a variety of educational philosophies and methods. However, this model was unable to produce standardisation of curricula that would allow paramedics to develop

²⁷⁸ For example, in complex clinical decision making about end-of-life care and treatment, the Queensland Ambulance Service (QAS) has provided paramedics with guidelines that allow them to make an assessment of the appropriate treatment of the patient. See QAS, *Clinical Practice Guidelines Patient Refusal of Treatment* (2016) <<https://www.ambulance.qld.gov.au>>.

²⁷⁹ Auckland University of Technology NZ—Bachelor of Health Science (Paramedicine); Charles Sturt University NSW—Bachelor of Clinical Practice (Paramedic); Edith Cowan University WA—Bachelor of Science (Paramedical Science); Federation University Vic—Graduate Diploma of Paramedicine; Flinders University SA—Bachelor of Science (Paramedic); Monash University Vic—Bachelor of Emergency Health (Paramedic); Queensland University of Technology Qld—Bachelor of Paramedic Science; University of Sunshine Coast Qld—Bachelor of Paramedic Science; Victoria University Vic—Bachelor of Health Science (Paramedic); Australian Catholic University ACT—Bachelor of Paramedicine; Curtin University WA—Bachelor of Science (Health Sciences); University of Southern Queensland Qld—Bachelor of Paramedicine.

²⁸⁰ Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001) 23.

²⁸¹ Hugh Grantham, ‘Ambulance Education—Past, Present and Future’ (2004) 2 *Australasian Journal of Paramedicine* <<https://ajp.paramedics.org/index.php/ajp/article/view/260/268>>

the same base level of knowledge and skills that would allow them to move freely among states and territories to find suitable employment without the need for additional training.²⁸²

In short, paramedics have developed a unique body of knowledge but there are several barriers to the translation of this knowledge into training and practice. The minimum qualification to work as a paramedic within almost every state-based ambulance service in Australia is a bachelor degree; however, there are still some services and private providers who will employ paramedics with sub-degree qualifications (a diploma or advanced diploma).

3.7 A Proud History of Public Service

Plato wrote that not only does a professional possess practical skills and knowledge but that they should be disciplined in moral excellence.²⁸³ This is because the specialised knowledge that professionals hold gives them power over clients. In healthcare particularly, professionals are commonly working with vulnerable people without the resources to know or understand the complexities of their care or treatment. They are required to trust that their treating practitioner will do what is in their best interests because they are not in a position to advocate that for themselves.

As discussed in Chapter 1, a discipline is thought to be a profession when it is able to regulate itself with regard to determining education, training and discipline standards; who can and cannot enter the profession; and the way in which the work should be done (i.e., the setting of conduct and competency standards). The other common element strongly associated with a discipline being considered a ‘profession’ is that it has, at its foundation, a commitment to the service of others before self or altruism. Altruism, originating from the Latin *alteri huic* or ‘to this other’, refers to an act of selflessness and concern for the wellbeing of others.²⁸⁴

²⁸² Review Article: Paramedic Education Opportunities and Challenges in Australia’ (2013) 25 *Emergency Medicine Australasia* 114; Bill Lord, ‘The Development of a Degree Qualification for Paramedics at Charles Sturt University’ (2003) 1 *Australasian Journal of Paramedicine*.

²⁸³ George Beaton, *Why Professionalism is Still Relevant* (Legal Studies Research Paper No 445, University of Melbourne, January 2010).

²⁸⁴ *English Oxford Living Dictionaries* (Oxford Dictionaries, 2017)

<<http://www.oxforddictionaries.com/definition/english/altruism>> (definition of ‘altruism’).

Paramedicine, like medicine with its history of altruism captured in the *Hippocratic Oath*, and nursing with its equivalent historical *Nightingale Pledge*, has a history of association with altruism. An historical overview of paramedicine shows that paramedicine has a rich historical association with charity organisations and has demonstrated altruism; however, the moral element of the profession is rarely discussed and the profession in Australia does not have one clear, uniform, overarching set of moral principles that informs its character or practice.

3.7.1 Early Evidence of Virtue

As discussed earlier in this chapter, the first formal ambulance service developed in Italy around 1240. The Compagnia della Misericordia or Company of the Brothers of Mercy demonstrates not only the unique role and purpose of paramedics but also provides evidence of their altruistic roots. The Brothers would ‘hold themselves compelled to attend on any emergency’,²⁸⁵ with each member of the Brotherhood taking an oath to respond even when they risked placing themselves in a dangerous situation.²⁸⁶ There was recognition from the community that their work was done not only with heroism but also with kindness.²⁸⁷ The provision of definitive care and succour to those they were called to attend was highly valued by both the community and the Brotherhood itself. Indeed, these elements formed the very foundation of the nature of the service. Initially only wool porters with good character were admitted to the Brotherhood and an examination of the traditional prayer delivered by the Brothers identifies the virtues that informed their practice: ‘We go forth, Lord, with charity, humility, and courage’.²⁸⁸

The Brothers agreed that the service would be provided *gratis* as it would be ‘better for their souls’;²⁸⁹ therefore, the Brothers were permitted to accept nothing from the public for their service except a ‘draught of water’.²⁹⁰ Humility was facilitated via the donning of a costume or ‘uniform’ of black robes and a mask to maintain the anonymity of the members

²⁸⁵ ‘Fratelli Della Misericordia—The Brotherhood of Mercy’ (1826) XVII *The New Monthly Magazine and Literary Journal* 1-584, 508.

²⁸⁶ *Ibid* 506.

²⁸⁷ *Ibid* 504.

²⁸⁸ Ryan Corbett Bell, *The Ambulance: A History* (McFarland and Co, 2009) 5.

²⁸⁹ ‘Fratelli Della Misericordia—The Brotherhood of Mercy’ (1826) XVII *The New Monthly Magazine and Literary Journal* 1-584, 503; *Ibid* 7.

²⁹⁰ *Ibid* 508.

and to ensure that their charitable actions were not ‘contaminated by the sin of pride’.²⁹¹ They received many bequests of money and property ‘in recompense for their work during the plagues of the 1300s’²⁹² but received no money for themselves.

The Order of St John, perhaps the most universally recognised group associated with ambulance services, has a long altruistic history dating to around 600AD. Around 1000AD, the Amalfitans’ flag—an eight-pointed white cross that is today recognised as the symbol of the Order of St John—was adopted by the Benedictine monks who staffed Charlemagne’s hospital, which cared for poor and sick Latin pilgrims.²⁹³ The symbol itself and what is represented by each point of the cross is perhaps the first codification of the ethical values by which ambulance personnel work. The points capture characteristics, principles and virtues associated with the order that traditionally have been translated as observation, tact, resource, dexterity, explicitness, discrimination, perseverance and sympathy.²⁹⁴ The ASNSW adopted the Maltese Cross as its emblem in 1920 and other states soon advertised for staff who not only had a first aid certificate but also demonstrated a commitment to the principles of the Maltese Cross,²⁹⁵ which today includes the promotion of the virtues of charity and brotherhood by providing services to the sick without distinction of religion, race, origin or age.²⁹⁶ The adoption of the Maltese Cross and the four virtues and eight beatitudes is said to trace from the original altruistic approach to paramedicine in the ancient religious Order of St John of Rhodes and Malta, to modern-day paramedicine.

Indeed, the altruistic nature of ambulance services and the importance of a code of ethics for paramedics has been acknowledged at law. In *Ambulance Service of New South Wales v Deputy Commissioner of Taxation for the Commonwealth of Australia*,²⁹⁷ the Full Federal Court considered the character of the public ambulance service. It said:

²⁹¹ Ryan Corbett Bell, *The Ambulance: A History* (McFarland and Co, 2009) 8.

²⁹² *Ibid* 9.

²⁹³ Murdoch Wales and John Pearn, ‘*First in First Aid. The History of St John Ambulance in Queensland.*’ (1998) Department of Paediatrics and Child Health, Queensland.

²⁹⁴ The ASNSW adopted the Maltese Cross as its emblem in 1920 and lists these eight chivalric values as representing the character of the service; see Ambulance Service of NSW, *History of the Maltese Cross* <<http://www.ambulance.nsw.gov.au/about-us/History/History-of-the-Maltese-Cross.html>>.

²⁹⁵ Enid Cullen, *Ready Always: The History of the Bundaberg Ambulance* (Edgars Printers and Stationers, 1999).

²⁹⁶ Order of St John of Rhodes and Malta Annual Report <https://www.orderofmalta.int/wp-content/uploads/2017/02/Order-of-Malta_Report-2013_web.pdf>.

²⁹⁷ *Ambulance Service (NSW) v Federal Deputy Commissioner of Taxation* [2003] FCAFC 161.

The activities of the Ambulance Service include rescue, administration of emergency medical attention, as well as transport to and from hospital. The Ambulance Service is represented on many community committees, especially in relation to areas relevant to the need for, and provision of, emergency medical services. The primary judge observed that the activities of the Ambulance Service often involve, for instance, the giving of relief to the distressed and the suffering, incidental to its usual services. His Honour further observed that ambulance officers are expected to adhere to the high ideals identified in a code of ethics, and may be called upon to deal with stressful and sometimes dangerous situations involving members of the public subjected to illness or injury, and to do so with skill, courage and compassion.²⁹⁸

3.7.2 A Modern Code

Despite this rich historical association and the assumption at law that ‘ambulance officers are expected to adhere to the high ideals identified in a code of ethics’,²⁹⁹ there is still no unified and standardised code of ethics that applies to all Australian paramedics. Each ambulance service in Australia has its own code of ethics that it requires its staff to follow but each is found in various pieces of legislation and most are derived from and applicable to broader public service employees and are non-specific to ambulance services and paramedics.³⁰⁰ Ambulance associations such as Paramedics Australasia (PA) have a code of conduct that can inform the practice of members of the association who are working outside the state-based services but provides no guidance on the way in which the principles it espouses should be applied and has no legal force, except perhaps as evidence of the conduct that might be expected from a ‘reasonable’ paramedic.³⁰¹

For those who are working in private industry with no professional association, there is no paramedic-specific code to which they are required to adhere. For example, in NSW, there is a broad, non-discipline-specific code that is required to be followed by unregistered health practitioners practising in the state.³⁰² The need for a discipline-specific code can be argued on the basis that not only does a code of conduct represent the values of a profession

²⁹⁸ Ibid 11.

²⁹⁹ *Ambulance Service (NSW) v Federal Deputy Commissioner of Taxation* [2003] FCAFC 161.

³⁰⁰ South Australia Ambulance Service, *Code of Ethics 2015*; ASNSW, *Code of Conduct 2007*; Queensland Public Service, *Code of Conduct 2010*; *Code of Conduct for Victorian Public Sector Employees (No. 1) 2007*; St John Ambulance Western Australia *Motto, Mission and Values*; Tasmania State Service *Code of Conduct*; ACT *Public Service Code of Ethics*.

³⁰¹ PA, *Code of Conduct* <<https://www.paramedics.org/code-of-conduct/>>.

³⁰² *Public Health Regulation 2012* (NSW), sch 3.

but with regard to paramedicine and other health professions like physiotherapy and chiropractic, there are elements to practice that are distinctly different, including that they have a much higher number of interactions with patients who may be incompetent to make decisions for themselves and often do not have a surrogate decision maker available to do it for them. The lack of autonomy to make decisions arises not only as a result of a lack of understanding of the complexities of the treatment offered to them, but also because commonly the type of patients seen by paramedics (e.g., emergency patients in life-threatening situations) lack the capacity to make decisions in their own best interests. The emergency nature of a large amount of paramedic work in largely uncontrolled and unobserved spaces means that the public is wholly reliant on the professionalism of the paramedic to act in the patient's best interests. This is a significant point that supports the argument for the professional regulation of paramedicine and is discussed in more detail in further chapters; in particular in Chapter 6, which examines paramedic professionalism in the UK.

Both the medical and nursing profession in Australia have developed unique and prescriptive codes of conduct that clearly outline the expectations that the public may have as to the behaviour of these respective health practitioners and provide an understanding to practitioners and the public alike of the professional identity of each group. The codes are standardised and uniformly applicable across jurisdictions, thus providing a sense of coherence to the shape and values of those professions.³⁰³ This can facilitate the establishment of a culture of professionalism within these groups.

A code of ethics can reflect the culture of an occupational group or organisation. Culture refers in part to the attitude of the members of the group to their clients; or customers to one another.³⁰⁴ Ethics refers to the actions that an individual person or member of a group *ought* to perform; the sort of character traits an individual who is part of a particular occupational group *ought* to have; and the features an organisation *ought* to apply (e.g.,

³⁰³ Medical Board of Australia, *Good Medical Practice Guide: A Code of Conduct for Doctors in Australia* (March 2014) <<http://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx>>;

Nursing and Midwifery Board of Australia, *Code of Ethics for Nurses* (8 May 2013)

<<http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx>>;

Nursing and Midwifery Board of Australia, *Code of Professional Conduct for Nurses* (7 May 2013)

<<http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx>>.

³⁰⁴ Seumas Miller, *Model Code of Ethics Principles*. Professional Standards Council.

<<https://www.psc.gov.au/sites/default/files/Model%20code%20of%20ethics%20principles.pdf>>.

fairness, honesty).³⁰⁵ A code of ethics therefore incorporates and reflects these elements of an occupational group and its culture. Australian paramedics have not yet identified, and thus not articulated, who they are and what they stand for. Although paramedics have a proud history of public service, which meets one of the key elements of a profession established by Freidson, according to Wilensky they cannot complete their professionalisation trajectory without developing their own code of conduct.³⁰⁶ Further, if paramedics are going to be regulated as professionals, then a nationally standardised and agreed code of ethics and conduct representing the paramedic understanding of professional practice is needed. The code will not only provide guidance to practitioners when they are faced with morally ambiguous situations; it will also clearly set out the behavioural expectations that both the peer group and public can have with regard to professional identity and behaviour. Without it, paramedics will have great difficulty objectively and transparently judging the standard of conduct and competence delivered by its members. Further, because it is suggested that the formation of a professional identity is considered an important element in the development of an ‘internal compass’ that acts to regulate a professional’s work in a way that serves the patient’s best interests, it is logical to conclude that a lack of professional identity is evidence that paramedicine is not yet a profession and may result in the absence or reduction of the regulatory benefits professionalism would otherwise provide.³⁰⁷

3.8 The Professional Association and the Development of Political Power

As noted in Chapter 2, Freidson recognised that the professions have a large degree of political power that accompanies their expert knowledge, unique body of practice and altruistic tendencies (which generates wide community trust and endearment [social power]).³⁰⁸ These elements buy the profession political power and thus the ability to lobby the political classes not only for the community’s interests (e.g., increased funding for services, increased staffing) but also for the profession’s own interests (e.g., better pay and

³⁰⁵ Seumas Miller, *Model Code of Ethics Principles*. Professional Standards Council. <<https://www.psc.gov.au/sites/default/files/Model%20code%20of%20ethics%20principles.pdf>>.

³⁰⁶ Eliot Freidson, *Professionalism, The Third Logic* (Polity Press, 2001); Harold Wilensky, ‘The Professionalisation of Everyone?’ (1964) 70 *American Journal of Sociology* 137.

³⁰⁷ Hedy S Weld, ‘Professional Identity (Trans)Formation in Medical Education: Reflection, Relationship, Resilience (2015) 90 *Academic Medicine* 701.

³⁰⁸ Eliot Freidson, *Professionalism, The Third Logic* (Polity Press, 2001).

conditions and self-regulation). Further, Wilensky recognised that the development of a professional association is common to occupations as they professionalise.³⁰⁹ Ambulance attendants in Australia have a long history of successful displays of industrial power that provides perhaps the best evidence of how strong the paramedic discipline is in meeting this particular element of professionalisation and why they have so much power.

3.8.1 Ambulance ‘Driver’

There have been several instances during the last century of ambulance officers being involved in industrial action around Australia. A number of examples of industrial action are used to facilitate the professionalisation of the discipline. In 1925 the West Australian Carters and Drivers Industrial Union of Workers and the St John Ambulance Association commenced an action over wages. At the time ambulance officers were essentially drivers but they were paid less than others who performed a similar function, including taxi drivers and bus drivers. The complaints argued that because they performed a similar function they should be paid the same. The case was decided in the Court of Arbitration in 1926³¹⁰ where the majority decided that ambulance drivers were neither bus drivers nor taxi drivers and because they were not covered by an award or industrial agreement could be paid significantly less than taxi drivers. This case demonstrates that there was an initial challenge for ambulance officers to show that they had technical skills and a social purpose that were different from others and deserving of recognition as such. The case suggests that at the time there was a belief that the role of the taxi driver and that of an ambulance officer were similar, despite the obviousness of the distinction as noted by Nolan, who said that:

the role and responsibility of an ambulance officer compared to a taxi driver might suggest that the former be paid the higher wage. The difference in transporting a sick or badly injured person from an accident scene to hospital, and a passenger from the shops to home, seem fairly obvious.³¹¹

The court’s decision that a lower level of pay for ambulance drivers was appropriate suggests that the professional status of ambulance officers was low and there was not yet

³⁰⁹ Ibid.

³¹⁰ *WA Carters’ Union v. St John’s Ambulance* (1926) 6 WAIG 134.

³¹¹ Mark Nolan, ‘The Ambulance Services Union: Its Formation and Amalgamation with the Federated Miscellaneous Workers Union’ in Michael Hess and C Fox (eds), *Papers in Labour History No 4* (Perth Branch of Australia Society for the Study of Labour History, November 1989) 62, 63.

sufficient evidence that their role, knowledge, skills and professionalism warranted acknowledgement as being anything beyond that associated with taxi drivers.

3.8.2 What is in a Name? Driver to Officer

In 1964 the first Ambulance Services Union of Workers of Western Australia group met to draft a claim for an ambulance award. The 13 members were determined to fight for improved working conditions, wages and higher status. There was some resistance by non-members, including ambulance officers Allum and Brown, who believed that the union would have no chance of improving their conditions and having their first aid skills recognised as being distinctly and significantly different from the skills of truck drivers.³¹² Despite these concerns, the union committee commenced working on drafting an award even before the union was formally registered by the Industrial Commission. In June 1965 the union lodged a log of claims with the Industrial Commission asking for a reduction in their 72-hour working week, an increase in wages and a name change. The decision was handed down in August of that year with the new award providing a reduction in hours to an average of 56 hours per week. They also won an increase in wages to a level significantly higher than the amount their employer, St John's Ambulance, had offered them. This was the ambulance industry's first award. Perhaps even more significantly than the win on pay and hours of work, staff were awarded the title of 'ambulance officer' and were no longer to be referred to as 'attendants' or 'drivers'. The officers believed that this change reflected a recognition not only of their skills but of the importance of their work, and that it recognised the technical authority that they could consequently claim.³¹³ This industrial action was the key to their professional advancement.

3.8.3 Industrial Action Driving Professionalisation

In 1981 South Australia's Ambulance Employees Association (AEA) was formed after breaking away from the Miscellaneous Workers' Union (MWU). Ambulance officers felt they were not receiving the service they needed from the MWU and that they were confronting many significant issues including lobbying for professionalisation of the service; the lifting of clinical standards; a proper career and wages structure; increased

³¹² Ibid.

³¹³ Ibid.

staffing and acceptable rosters.³¹⁴ In 1989 the AEA had all its members suspended from duty without pay because of an ongoing dispute with the government over professional standards, but within six months its demands had been met and the discipline began transitioning to become a professional service with a supported shift to tertiary education and associated improved clinical standards. The AEA claims that without its action:

The Ambulance Service ... would still be run by St John, still have inappropriate levels of volunteer involvement, still have Third World clinical standards and still be the worst paid Service in Australia.³¹⁵

On 4 February 1993 the National Committee of Ambulance Unions (NCAU) determined, among other things, that there should be national training standards and, possibly, a pursuit of consistent classifications and rates of pay to ensure that conditions and pay were not eroded by various iterations of state government or ambulance employers. This would preserve a minimum standard of pay for a 'qualified' ambulance officer and not have that reduced by non-qualified competition in the market.³¹⁶ This action was significant in establishing a key issue that had plagued other professions such as nursing. The stratification of qualifications required to undertake the job and the multitude of titles that allowed employers to skirt around title protection legislation was something that ambulance officers needed to avoid to ensure that they did not make themselves redundant. This was because at this time there was only one avenue for employment as an ambulance officer and that was with state-based ambulance services. The trade-off for negotiating the preservation of the ambulance officer role and credential was pay and conditions that lagged behind other comparable health practitioners.

This changed in April 2010. Intensive care paramedics (ICPs) in the ACT received a substantial pay rise as a result of a three-year application by the Transport Workers' Union to Fair Work Australia. Significantly, the Fair Work Commissioner referred to submissions made by the union based on research into paramedic work by paramedic scholar Dr Louise Reynolds. Reynolds had published a paper identifying the significant change in a number

³¹⁴ South Australia Ambulance Employees Association, *About the AEA* <<http://www.aeasa.com.au/index.php/about/aboutaea>>.

³¹⁵ Ibid.

³¹⁶ See details in *The State of Victoria and the Minister for health for the State of Victoria and the Honorable Joseph Martin Riordan and the Australian Liquor Hospitality and Miscellaneous Workers Union* [1995] IRCA 293; 63 IR 317 <<https://jade.io/article/327609>>.

of areas to the nature of the work by paramedics that were consistent with the criteria associated in the sociological literature as being common to the work of professionals. The decision by Fair Work Australia acknowledged that over time and in response to technological and clinical scientific developments, ICPs were now required to:

- (i) critically think, appraise, judge and act independently in novel and complex situations;
- (ii) the fact that ICPs have an increasing body of specialist knowledge, are working in a multi-disciplinary and integrated health care system, and are required to exercise clinical judgement;
- (iii) the move to undergraduate degree pre-employment education; and
- (iv) community acceptance and recognition of paramedics in terms of trust and authority.³¹⁷

In accepting the claim for an increase in entitlements and conditions for ICPs in the ACT, Fair Work Commissioner Deegan found, and the parties agreed that, ACT ICPs are:

required to perform their work in a professional manner and are required to exercise professional judgment when performing their duties. The parties acknowledge that the work of the ACTAS ICPs currently has many of the recognised hallmarks of a profession. The ambulance paramedic industry in Australia is currently in a period of transition towards formal professional recognition. This appears broadly based on the industry:

- developing a systemic body of theory and knowledge
- introducing formal qualifications based on education and examinations by tertiary institutions and required by employers with
- support of the peak body representing Australasian ambulance services now engaging with a number of tertiary institutions which to provide undergraduate degrees in Paramedicine Science with this qualification now forming the minimum entry level point into some services

³¹⁷*Transport Workers Union v Department of Justice and Community Safety* (unreported Determination, Fair Work Australia, Commissioner Deegan, 29 March 2010) <<http://www.fair-go.com/docs/FWA2010decision.pdf>>.

- the emergence of regulatory bodies with codes of ethics and powers to admit and discipline members
- ongoing work to establish common guiding principles and standards of nationally accredited education and continuous professional development for ICPs.³¹⁸

The agreement between the parties went further to say that:

consistent with the requirements of professional recognition, it is agreed between the parties that the expectations of ICPs as professionals are that they engage in:

- work-based learning (including reflective practice, clinical audit and significant event analysis);
- professional activity (including mentoring, expert witness and teaching);
- formal education (including courses, involvement in research);
- self-directed learning (reading journals, updating personal knowledge); and
- other activities including public service and volunteer work.

The parties also acknowledged that it would be the responsibility of individuals (not their employer) to undertake ‘self-directed professional development’. All the elements relied upon by the union to make their case and by Commissioner Deegan in making her decision were consistent with the characteristics associated with a profession as identified in the sociological literature, bar self-regulation. Although paramedics were not yet recognised under the National Law as health professionals the way other equivalent health practitioners were, they were acknowledged in employment law, in at least one Australian jurisdiction, as transitioning ‘towards formal professional recognition’.

The ACT decision was closely followed by paramedic industrial action in Victoria. In 2011 in an attempt to remedy the pay inequity and to restore the status of paramedics, the Victorian Ambulance Association commenced a two-year industrial action against the government over pay, conditions and staffing. This action included opposing the plan by

³¹⁸ Ibid appendix A.

the government to expand its use of ambulance community officers (who only have around 96 hours of training) in rural areas because Ambulance Victoria deemed it uneconomical to maintain stations staffed with fully qualified paramedics.³¹⁹ The campaign by the paramedics was so successful that it contributed significantly to a change of state government.³²⁰ This gave paramedics, and indeed the entire community, an insight into just how politically powerful the discipline had become, due in no small measure to the level of trust and endearment in paramedics held by the public.³²¹ With the establishment of a new Labor government the dispute came to an end. The new Premier Daniel Andrews stated:

Paramedics are some of our most trusted professionals and an Andrews' Labor Government will treat them that way. They are what's right with our ambulance system and we need to fix what's wrong.³²²

In 2016 Victorian paramedics received a massive pay raise of 20–28% after the Fair Work Commission heard evidence of the decade-long increase in skills and responsibilities that paramedics were required to obtain to practice. The commission found that paramedics have had their qualification requirements increased to degree level; and have had their responsibility for the care and treatment of complex patients including mental health patients extended along with an expansion in the range of medications and other treatments. As such, the commission recommended and the government agreed that those changes warranted a wage increase.³²³ The success of this campaign highlighted how the discipline had continued to professionalise in response to a number of factors including technological and medical advancements and associated shifts in educational requirements, along with an increased demand for and recognition of the unique and critical role that paramedics

³¹⁹ Julia Medew, 'Paramedics Set to Take More Industrial Action', *The Age* (online, 3 February 2014) <<http://www.theage.com.au/victoria/paramedics-set-to-take-more-industrial-action-20140203-31x16.html>>.

³²⁰ Barrie Cassidy and Alison Savage, 'Cue the blame game', *ABC News* (online, 28 November 2014) <<http://www.abc.net.au/news/2014-11-28/cassidy-and-savage-cue-the-blame-game/5922818>>.

³²¹ Andrew Korner, 'Annual poll reveals angels and demons of professions.' *Queensland Times* (online, 24th June 2014) <<https://www.qt.com.au/news/annual-poll-reveals-demons/2296210/#10 Most Trusted>>

³²² Victoria Labor, 'Premier to Paramedics: The War is Over' (Media Release, 1 December 2014) <<https://www.viclabor.com.au/media-releases/new-premier-to-paramedics-war-is-over>>.

³²³ *United Voice v Ambulance Victoria* (unreported, Recommendation, Fair Work Commission, President Justice Ross, Senior Deputy President O'Callaghan, Commissioner Cribb and Commissioner Lee, 23 March 2016) <<https://www.fwc.gov.au/documents/sites/ambulance2016/decisions-statements/c20153378-recommendation-230316.pdf>> 7; Richard Willingham, 'Victorian Paramedics Handed Huge Pay Rise', *The Age* (online, 23 March 2016) <<http://www.theage.com.au/victoria/victorian-paramedics-handed-huge-pay-rise-20160323-gnp7m3.html>>.

play in the healthcare workforce. However, the campaign also highlighted the fact that paramedics were not and still are not regulated the same way as other similar professions. The industrial campaign raised awareness of the job that paramedics do and the change of government in Victoria provided an opportunity for the professional associations representing paramedics to successfully lobby for support from the Victorian government for paramedics to be included under the NRAS.³²⁴

3.8.4 Professional Associations

Wilensky recognised that in the process of professionalisation, a discipline will develop a professional association.³²⁵ Beyond strong industrial associations, paramedics have also developed a number of professional bodies that represent the interests of paramedics across the country with the purpose of establishing practice standards, training and ethics and the hope of increasing paramedics' professional status.³²⁶ For example, the Institute of Ambulance Officers of Australia, which was first formed in 1969–70 and later (2000) became the Australian College of Ambulance Professionals (ACAP), which identified itself as a learned society:

democratic in election and administration, which has as its primary term of reference both the development and maintenance of best practice benchmarks of professional practice: at the same time acts as stakeholder in terms of quality of training, outreach, potential research and the monitoring of standards.³²⁷

Over time ACAP has changed its identity and structure. During the 2000's it existed as a number of independent state chapters united under a national body. These groups were amalgamated in 2011 with each chapter, except NSW, folding their assets and intellectual property into a new national body now known as Paramedics Australasia (PA). The NSW chapter was the most well-resourced chapter with the largest number of members some of whom were concerned about what the new national entity might look like particularly because, for example, the NSW chapter had traditionally had a focus on continuing

³²⁴ Minister for Ambulance Services, 'Victoria Welcomes Paramedic Registration' (Media Release, 6 November 2015) <<http://www.premier.vic.gov.au/victoria-welcomes-paramedic-registration-protection>>.

³²⁵ Harold Wilensky, 'The Professionalisation of Everyone?' (1964) 70 *American Journal of Sociology* 137, 143.

³²⁶ Ian Howie-Willis, *St John Ambulances and Western Australia 1892–1992* (St John Ambulance Australia, 1992) 84.

³²⁷ Allan Marr, 'The Australian College of Ambulance Professionals—Who and What is ACAP?' (2003) 1 *Australasian Journal of Paramedicine*. 1.

professional development (CPD) and providing services to members like scholarships and grants. These functions were not as strongly supported by other chapters. Additionally, ACAP (NSW) had been a company limited by guarantee since 2001. As such it has responsibilities under the *Corporations Act* that meant that it could not incorporate into another body without meeting those responsibilities, including conducting due diligence to better understand the implications of changing the governance structure, and addressing concerns regarding the solvency of the new amalgamated body. The NSW chapter had a profitable ‘paramedic shop’ and high membership but other chapters had lower revenue and thus potential issues regarding solvency. ACAP (NSW) remained a separate entity but, as a show of good faith, entered into a partnership with PA that granted voting rights to members. However, PA called an extraordinary general meeting in early 2012 where it was decided that ACAP (NSW) cease the partnership arrangements with PA because of issues related to timeframes for amalgamation. The ACAP (NSW) chose to then change its name to the Australian & New Zealand College of Paramedicine (ANZCP) and thus commenced the existing arrangement of two professional bodies working to develop the profession. PA has stated that it seeks to provide a voice in ‘determining how changes in health service provision, legislation and clinical practice are shaped and implemented to enhance the quality of patient care’.³²⁸ ANZCP states that it is committed to

providing high quality professional development learning and educational opportunities for our members and the profession...and to provide industry leadership and advocacy for the benefit of the profession working with stakeholders including Federal and State/Territory governments, and State/Territory Ambulance Services.³²⁹

Both ANZCP and PA have developed a code of conduct, professional standard expectations, and ongoing education programs. However, neither body has any statutory powers or regulatory functions that could mandate or enforce certain behaviours or actions beyond what that required to be met for membership. As such, the group commenced, in its earlier iteration as ACAP, and despite its split into two from 2012, continued the paramedic professionalising process by unifying members of the group

³²⁸ PA, *About* <<https://www.paramedics.org/about>>.

³²⁹ ANZCP, *About* <<https://www.anzcp.org.au/about-anzcp/>>

with shared specialist knowledge and skills and harnessing that knowledge as political power.

Both PA and ANZCP are made up of paramedics who are seeking to further the profession's ends via political lobbying rather than industrial action; they have been instrumental in furthering the professionalisation of paramedicine in Australia. This is discussed further in the next chapter on the Australian professionalisation project. It should be noted however, that the fact that there are two professional bodies who are providing 'leadership and advocacy' and 'professional development' suggests that there is the potential for conflict between the two with regard to what paramedic leadership and professional development should be. Additionally there are other associated bodies like the CAA (state ambulance services), the Union (APA and HSU), and the Board as well as various private commercial operators, who may also have particular views on how paramedicine as a profession should function and what its values should be. There is currently no clear overarching, national or united paramedic group that can act in a political way by harnessing the moral and technical power of the profession to its own advantage and that of the public.

This power vacuum could have serious consequences for the profession if, for example, the CAA were appointed as the accrediting body of paramedic programs and then chose to alter components of paramedic curriculum to suit industry but not necessarily the interests of the profession in the long-term. Or, if NSW Health decided that they would, as they reasonably could, introduce a new category of worker who, for all intents and purposes is trained and does similar work to a paramedic but is not one according to the Paramedicine Board's standards. The potential for rifts in the profession to develop exists in part because there is no clear political body – that is an inherently political organisation in the strict sense that it makes decisions that apply to members of the group and it exercises positions of governance and organised control over a group in the best interests of the group - tasked with protecting the interests of paramedics. The medical profession has tackled this problem with the development of a very strong advocacy group – the Australian Medical Association (AMA). Although there are other medical groups, like those that represent each of the specialty colleges, that do engage in political lobbying, the AMA is particularly adept at harnessing the power – the identity, moral and technical authority - of the medical profession to work in the interests of individual practitioners and the profession more

broadly whenever conflict between the particular professional associated groups have arisen.³³⁰ There are potential lessons for paramedicine to learn from medicine with regard to harnessing its technical and moral authority as political power.

3.9 Autonomy and Self-regulation

Freidson suggests that the true mark of a profession is autonomy—the ability to self-regulate.³³¹ The power of self-regulation includes the profession establishing its own standards of education and training; who can enter the profession; how the profession is practised; and the responsibility to ensure that those standards are met and that those who fail to meet them are remediated or disciplined.³³² The only area in which paramedicine is currently regulating itself is in education and even then the discipline is working with employers and the industry accreditation body, the CAA, to develop courses that best serve industry. This is limiting in that it is the employer who determines the scope of practice of the paramedic and this then determines the training that paramedics undertake; in that way, it undermines the autonomy of paramedicine to determine its own education and practice standards. This is distinct from medicine where it is the profession, not industry or even government, that drives practice. Freidson recognised this power as the mark of a true profession and it is something that paramedicine currently lacks.

3.9.1 Lack of Self-regulation and Risk

The lack of an education and practice standard has been hampered by the lack of agreement on the identity of a paramedic. There currently is no nationally agreed definition of what a paramedic is and what a paramedic does. In addition, there is an absence of a consistent, nationally standardised or agreed mechanism for the identification and management of a paramedic who may be suffering from a significant health, conduct or performance issue. This raises the risk posed by that paramedic to the public and the profession more broadly.

There is also no standardised complaints data collection mechanism available. While it is acknowledged that it is an employer's prerogative and indeed right and sometimes duty to

³³⁰ Stephen Duckett, Patient advocate or doctors' union? How the AMA flexes its political muscle. *The Conversation*, 9 June 2016 < <https://theconversation.com/patient-advocate-or-doctors-union-how-the-ama-flexes-its-political-muscle-60444> >

³³¹ Eliot Freidson, *Professional Dominance: The Social Structure of Medical Care* (Transaction Publishers, 1974).

³³² Ibid.

follow up and manage any complaint of unprofessional conduct, the lack of transparency to the public as a necessary element of protecting the confidential nature of information afforded to an employer about an employee means that public protection and safety may be afforded less importance than if a complaint was made to an external third party. This limits transparency and accountability and in so doing undermines the social contract the public has with this group of healthcare practitioners, particularly those employed by state-based and/or funded services.³³³ Further, under employer-managed complaints systems there is no mechanism for a practitioner to report themselves or another if they are suffering from an impairment that may affect the standard of care they provide to a patient, or if they engage in unprofessional conduct. This places the reputation of the discipline in the hands of the employer and suggests that paramedicine is not yet a profession.

Paramedicine's lack of ability to self-regulate is evidenced by the lack of mobility of paramedics across jurisdictions; the lack of a national minimum standard of education and training for paramedics and agreed qualification; the inability for the peer group to set and manage the behavioural standards and disciplinary issues of their own members; the inability of the discipline to manage the health and wellbeing of practitioners and the practice standards of practitioners, including the management of incompetent or impaired practitioners who risk damaging their own and the profession's reputation.³³⁴

Although paramedics cannot currently regulate themselves, they have been recognised industrially as a critical component of the healthcare workforce, at least in Victoria and the ACT, and as such have translated some of that capital into successfully lobbying to be regulated under the NRAS; as shown below, this will allow them to self-regulate.

3.10 The Professional Shape of Paramedicine

Medical work and subsequently the work of paramedicine changed profoundly since the 20th century. Paramedics have developed from being stretcher bearers and horse-cart drivers equivalent in social status to cab drivers, to become among the most highly skilled clinicians within society with a unique and important role to deliver emergency healthcare

³³³ L Blanchard, C Hinnant and W Wong, 'Market-Based Reforms in Government: Toward a Social Subcontract' (1998) 30 *Administration and Society* 483, 488, state that 'One of the most important factors in our conceptualisation of the social contract relationship is the presence of appropriate accountability and control mechanisms'.

³³⁴ *Ibid* s 3(2).

in the pre-hospital setting. The professional development of paramedicine has been driven by a number of factors including the need for a transportation service for the sick and injured separate from public transportation; provision of definitive care for those with injury and disease as a purely charitable exercise; saving the lives of injured soldiers by removing them from the field of battle to definitive care as quickly as possible; and addressing the public health effects of industrialisation in a rapidly growing urban environment and the effects of technological and societal advances like the motor car.

As demands from society, medical knowledge and technology has advanced so too has the role of the paramedic. This has necessitated an increase in education and training and, consequently, the need for an organised professional body to represent the discipline to improve wages, working conditions and status. Paramedics has therefore developed a number of the characteristics associated with professionals: expert knowledge; a unique public purpose; and a special relationship of trust with clients. They have not established a strong sense of professionalism or decision making guided by a code of conduct; rather they have relied on protocols developed by medical advisory boards. The reliance on employment largely by state-based ambulance services has also served to limit the autonomous development of paramedicine as has a lack of regulation to support paramedic self-regulation.

As noted in Chapter 2, Wilensky suggested that for an occupation to turn itself into a profession, there needed to be a broader set of structural and historical systems that contributed to a group's transition to a profession.³³⁵ These included the establishment of a training school that evolved into university-based training, followed by the establishment of a local association that would grow into a national association.³³⁶ This chapter has shown that paramedics have clearly followed these steps but have yet to achieve the final two steps on Wilensky's professionalisation trajectory: regulation by state-level licensing laws and the development of a code of ethics. It is not until these final elements are acquired that paramedics will be able to meet the five elements associated with being a profession: the provision of a public service fulfilling a unique purpose; that requires specialised knowledge and training; that provides them with technical and moral authority; which

³³⁵ Harold Wilensky, 'The Professionalisation of Everyone?' (1964) 70 *American Journal of Sociology* 137–58; Anne Witz, *Professions and Patriarchy* (Routledge, 1992).

³³⁶ *ibid* Wilensky, 143.

allows them to organise and maintain a system of control over their own work and regulate with professionalism (code of ethics).

The aspiration to acquire ‘professional’ recognition has been considered the ‘gold standard’ of occupational status.³³⁷ In large part this is because, as discussed in Chapter 2, the privilege of self-regulation and having control over their work is something that many occupational groups seek. The professionalisation process for paramedics has not always been driven by paramedics, having at first commenced by necessity and in an ad hoc way in response to societal public health needs, and later been driven by medicine and medical research. However, over time paramedics have developed a unique public purpose and specialised knowledge and skills that have provided them with a moral and technical authority that they have leveraged into power to improve pay and conditions of work.

This chapter has confirmed that paramedicine from its inception has displayed unique characteristics that involve working routinely in conditions that are to some extent unpredictable and uncontrolled, involving personal danger and risk. The next chapter explores how paramedics finally organised that power well enough to commence a formal professionalisation project with the aim of driving their professional status forward to gain control over their own work.

³³⁷ David Carr, ‘Professionalism, Profession and Professional Conduct: Towards a Basic Logical and Ethical Geography’ in Stephen Billett, Christian Harteis and Hans Gruber (eds), *International Handbook of Research in Professional and Practice-based Learning* (Springer International, 2014) 6.

Chapter 4: Are We There Yet? The Australian Paramedic Professionalisation Project

The previous chapter identified that paramedicine, as a discipline, has evolved over time in a fairly ad hoc way in response to a variety of unrelated factors including societal need, advances in medical knowledge and technology, and industrial action taken at a discrete time and place for a relatively small group of practitioners. Despite the fact that a professional association commenced in 1970, and that paramedics organised to work collectively to have their skills and responsibilities appropriately recognised and remunerated through workplace agreements, there was little overarching organised, strategic national professional development of paramedicine.

Chapter three also established that the paramedic professionalisation process was, until relatively recently, largely driven by circumstances and groups other than paramedics. For example, their education evolution was driven by medicine, and later industry (ambulance service) and the tertiary education sector (shift to university learning). As noted in chapter three, the shift to the tertiary sector followed Wilensky's professionalisation trajectory and although the shift was initiated by ASNSW and CSU, it was nonetheless, a significant step forward in the paramedic professionalisation process because it recognised the unique nature of paramedic work, their specialised knowledge and skill and their need for critical thinking capabilities in order for the discipline to move beyond protocol-driven practice.

As described in the previous chapter, during the early 2000s, the profession gradually produced tertiary-qualified graduates who were able to conduct research into the specialised area of paramedic work. The discipline recognised the need for a discipline-specific journal in which to publish and disseminate this specialised knowledge. The *Journal of Emergency Primary Health Care* (JEPHC),³³⁸ produced by the Australian College of Ambulance Professionals (now PA), was launched in September 2003 with the intention of 'publishing to advance and promote the science of pre-hospital care research, management, education, clinical practice, policy and service delivery, providing a forum to respond to the professional interests of the multidisciplinary pre-hospital care

³³⁸ (Volume 1 Issue 1–2).

community'.³³⁹ This provided a mouthpiece for the profession to discuss and raise awareness of issues of professionalisation in a much more organised and collegiate way and in so doing created a public record of the Australian paramedic professionalisation project.

This chapter identifies what it is that paramedics hope to achieve from the professionalisation project. It does so by examining the literature and other data presented to various governmental inquiries on the professional development of paramedics. It uses the Freidson elements for a profession identified in Chapter 2 to assess how the paramedic discipline understands professionalisation, what they believe professionalisation will do for them and how they think they are going to professionalise. It then describes the push for professionalisation from within the sector and how governments have responded to claims for increased professionalisation by paramedics.

4.1 What paramedics hope to achieve from the professionalisation project

As discussed in the previous chapter, paramedics were once merely stretcher bearers who carted bodies to the morgue or to the hospital. They later expanded their practice to become first aid providers and then drivers meeting a unique societal need—a coordinated first aid response to an out-of-hospital emergency. The professionalisation of paramedics has continued as technology and demands on the healthcare system have changed. The paramedic literature has largely taken a trait-based approach to identifying first if the discipline is a profession and second, if it is not yet a profession, identifying how it can become one; that is, how it can acquire the status and control over its own work that professions typically have a key element identified by Freidson as common to professions. Currently they are not able to determine their own educational standards or who enters and exits the profession, or control other aspects of their work; these are objectives that paramedics have been seeking to meet over the past decade or so.³⁴⁰

This chapter will examine the paramedic professionalisation project that is currently being undertaken in Australia by thematically analysing the available literature and the publicly

³³⁹ PA, 'Journal History' (2017) *Australasian Journal of Paramedicine* <<https://ajp.paramedics.org/index.php/ajp/about/history>>.

³⁴⁰ Eliot Freidson, 'The Reorganisation of the Professions by Regulation' (1983) 7 *Law and Human Behaviour* 279.

available submissions made to various government inquiries on the regulation of paramedics according to the Freidson elements for a profession, as set out in Chapter 2.³⁴¹ The majority of submissions and representations in the literature suggest that paramedics do not yet view themselves as an autonomous profession but believe they are in the process of professionalising.

In 1998 the first piece on paramedic professionalism was published in Australia.³⁴² It was five years before another piece was published in the then newly established JEPHC. In the first paper published in the journal on the topic, Mahony argued that for paramedics to fully professionalise they should follow five political strategies that had been successfully used by other healthcare occupations to ‘enhance their autonomy and further their professional status’.³⁴³ Those five strategies were to:

Develop a role and expertise different from and independent of general medical practitioners; recognise and capitalize on your experience and skills; protect and maintain your occupational boundaries from encroachment; own and control the technology of your profession; have the professional association take control of education, qualification and registration.³⁴⁴

A number of these strategies use language that is similar to that used in the Freidson elements for professions. The most common theme among the five is the importance of establishing and embracing a profession’s specialised knowledge and skills as distinct from the knowledge and skills of others; the second-most common theme is control over work. A number also intersect with Wilensky’s professionalisation trajectory; namely step three, the establishment of a professional association and step four, state licensing or registration,

³⁴¹ This method is a common qualitative research method that examines ‘themes’ or patterns within data sets and that identifies and then provides a description of a phenomenon. See James Thomas and Angela Harden, *Methods for the Thematic Synthesis of Qualitative Research in Systematic Reviews* (Working Paper No 10/07, ESCR National Centre for Research Methods)

<http://eprints.ncrm.ac.uk/468/1/1007_JTAHthematic_synthesis.pdf>; GR Gibbs, *Analyzing Qualitative Data* (Sage, 2007) 38, says coding, as a form of content analysis ‘involves identifying and recording one or more passages of text or other data items such as the parts of pictures that, in some sense, exemplify the same theoretical or descriptive idea. Usually several passages are identified and they are then linked with a name for that idea—the code’.

³⁴² A Wyatt, ‘Toward Professionalism: An Analysis of Ambulance Practice’ (1998) 5 *Australasian Journal of Emergency Care* 16.

³⁴³ Kerry Mahony, ‘The Politics of Professionalisation: Some Implications for the Occupation of Ambulance Paramedics in Australia’ (2003) 1(3) *Australasian Journal of Paramedicine*, Article 8.<<https://ajp.paramedics.org/index.php/ajp/article/view/198>>.

³⁴⁴ Ibid.

which Mahony argued would give the paramedic discipline political power to protect occupational control from encroachment by others, including those not legally qualified to hold the title 'paramedic'. This would also give the discipline power to determine pay and other employment conditions. However, Mahony's model inverted the professionalisation process by suggesting that registration would be a tool to deliver paramedics political power when it was the gaining of political power that, according to Wilensky's trajectory of professionalisation, was necessary to be achieved through the shift of education to the tertiary sector followed by the development of a national professional association.³⁴⁵ The gaining of political power on the basis of the occupational group holding some sort of technical authority is necessary to lobby for registration or the recognition of professional status at law.

In 2004 Reynolds³⁴⁶ built on the work of Mahony and suggested that an examination of the professional status of paramedics was necessary to determine what measures still needed to be taken for paramedicine to be recognised as a profession. The paper did not address why becoming a profession was important; rather it was implied that it was a natural evolutionary step for the discipline. Reynolds set about the task of trying to measure whether paramedics were yet a profession or not by making reference to the work of Greenwood, who wrote a seminal piece entitled 'Attributes of a profession'³⁴⁷ (discussed in Chapter 2) which he identified as 'a systematic body of theory, authority, community sanctions, ethical codes and a culture'.³⁴⁸

Reynolds examined these criteria against past and current developments in Australian paramedicine and ambulance service provision. She identified that paramedics do have a systematic body of theory but that it is not wholly their own because it is derived from medicine. She argued that it is not until paramedic education shifts to mandate that all paramedics have a degree qualification and generate research specific to the discipline that reflects the specialised nature of the work paramedics do and the specialist knowledge required to do it that they will meet the systematic body of theory attribute.³⁴⁹ The

³⁴⁵ Harold Wilensky, 'The Professionalisation of Everyone?' (1964) 70 *American Journal of Sociology* 143.

³⁴⁶ Louise Reynolds, 'Is Pre-Hospital Care Really a Profession?' (2004) 2(1-2) *Journal of Emergency and Primary Health Care* <<https://ajp.paramedics.org/index.php/ajp/article/view/254>>.

³⁴⁷ Ernest Greenwood, 'Attributes of a Profession' (1957) 2 *Social Work* 45.

³⁴⁸ Louise Reynolds, 'Is Pre-Hospital Care Really a Profession?' (2004) 2(1-2) *Journal of Emergency and Primary Health Care* <<https://ajp.paramedics.org/index.php/ajp/article/view/254>>.

³⁴⁹ Ibid.

recognition of the need for specialist knowledge is consistent with the Freidson element. However, Reynolds argues for an additional component in suggesting that the minimum paramedic qualification required for entry to the profession be a degree qualification. She does not mention that the law could be used to set this minimum standard.

Reynolds noted that Greenwood believed that in attaining professional authority, an occupational group would strive to ‘acquire a monopoly’ in a market-based sense of the concept.³⁵⁰ This was referred to by Freidson as the ‘professional market’, which is organised and controlled by professions.³⁵¹ The power to organise and control their own work, and determine who enters the profession, is, according to Freidson, a critical element for a profession. Reynolds questioned whether paramedics could achieve this given that most paramedics provide their services via state governments. At the time that Reynolds was writing, the only place a paramedic could work was with a state-based ambulance service. There was no opportunity for paramedics to work elsewhere and they were entirely beholden to their employer to control all elements of their work.³⁵² The National Law was not written at the time of Reynold’s work, but once paramedics are regulated as professionals under the National Law, they will be able to work beyond the control of state-based ambulance services. With regard to the notion of monopoly, Freidson argued that a system of monopoly does not only refer to closed markets. It can also refer to a system that allows only those suitably qualified and credentialed people entry to the profession in order to maintain the “integrity of a craft that is of value to others.”³⁵³ Freidson’s analysis is consistent with the objective of the regulation of health professionals in Australia that requires those who possess a monopoly on specialised knowledge and skills to use that monopoly for public protection and safety.

Reynolds also considered Greenwood’s notion of the culture of a profession. Culture is defined as the ‘language, customs and traditions, group norms, espoused values, formal philosophy, implicit rules for getting along in the organisation, unique paradigms, shared meaning and symbols’.³⁵⁴ Reynolds argued that the establishment of a culture can promote

³⁵⁰ Ibid 3.

³⁵¹ Eliot Freidson, *Professionalism Reborn: Theory, Prophecy and Policy* (Polity Press, 1994).

³⁵² Louise Reynolds, ‘Is Pre-Hospital Care Really a Profession?’ (2004) 2(1–2) *Journal of Emergency and Primary Health Care* <<https://ajp.paramedics.org/index.php/ajp/article/view/254>>.

³⁵³ Eliot Freidson, *Professionalism Reborn: Theory, Prophecy and Policy* (Polity Press, 1994).181.

³⁵⁴ Ibid.

the development of a normative value system of professionalism in work because a shared work culture assists in the production and reproduction of a common identity through professional socialisation, shared education and vocational experiences and occupationally exclusive institutions.³⁵⁵ Freidson did not refer to culture in professionals the way Greenwood did but he did refer to the need for the establishment of a normative value system to inform the way professional decisions are made.³⁵⁶ Indeed a normative value system forms the foundation that allows for professions to be regulated by professionalism rather than some other form of regulation like bureaucracy or free markets.³⁵⁷ Flexner suggested that professions that do not value ‘professional spirit’ ‘are ethically no better than trades’.³⁵⁸ Freidson argued that for a profession to lose its ‘values’ would be for it to lose a defining characteristic.³⁵⁹ Reynolds identified that paramedics have a unique culture that includes abbreviated communication that is only able to be interpreted by other paramedics, and particular ways of dealing with the unique and often traumatic situations to which paramedics are exposed.³⁶⁰ The unique nature of the work of paramedics was identified in Chapter 3. This unique public purpose requires specialised knowledge and skills and a set of values. However, Reynolds noted that paramedics did not have a code of ethics that listed what those values might be.

Reynolds recognised the lack of a consistent compulsory code that applied nationally to all paramedics, although there were various codes found in industry groups such as the ACAP and various employer groups. On this basis, Reynolds claimed this element of professionalism was also missing and necessary to acquire if paramedics were to become professionals.³⁶¹ This is consistent with the Freidson element, but according to Wilensky’s trajectory, this step in the process of professionalising will not occur until after the discipline has gained legal status and is regulated as a profession.

³⁵⁵ Ibid 4.

³⁵⁶ Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001).

³⁵⁷ Ibid 173.

³⁵⁸ Abraham Flexner, ‘Is Social Work a Profession?’ (1915) 1 *School and Society* <<http://socialwelfare.library.vcu.edu/social-work/is-social-work-a-profession-1915/>>

³⁵⁹ Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001).

³⁶⁰ Louise Reynolds, ‘Is Pre-Hospital Care Really a Profession?’ (2004) 2(1–2) *Journal of Emergency and Primary Health Care* <<https://ajp.paramedics.org/index.php/ajp/article/view/254>>.

³⁶¹ Ibid.

Grantham, writing at the same time as Reynolds, argued that paramedicine was already a profession—not because it had established a unique territory or ‘formulation of ethical boards or other process issues’ but rather because paramedics have earned ‘the respect of other health professionals in the system’ as evidenced by the seeking of ambulance opinion at not only the ‘hospital handover’ but also ‘at the strategic committee level’.³⁶² Grantham, unlike Reynolds, did not make any reference to any tool to assess the professional status of paramedics. Grantham’s position was challenged by O’Meara, who argued that ‘there is a world of difference between presenting ourselves as health professionals and being formally recognised as such’.³⁶³

The early paramedic literature focused very generally on the process and purpose of professionalising. It suggested that political strategies were necessary to ‘enhance their autonomy and further their professional status’³⁶⁴ but did not set out what was meant or expected by ‘autonomy’ or ‘professional status’. Self-regulation is a key Freidson criteria and although it could be implied from the literature that the expectation for paramedics was to move beyond the control of their employers and beyond the status of ‘drivers,’ this was not stated explicitly. Instead the literature discussed the process via the political strategies needed to be utilised to gain autonomy namely development of a unique role, embrace of specialised knowledge and skills, protection of their domain of work, control of the profession including the establishment of a professional body to ‘take control of education, qualifications and registration’.³⁶⁵ The implication was that if paramedics were to ‘take control of education, qualifications and registration’ then autonomy and professional status would follow but according to Wilensky, it is the establishment of a training school that allows for the teaching of specialised knowledge to perform a unique service, that would build the technical and moral authority to justify the establishment of a national association that could harness its political power generated from its unique purpose and specialised skills, to lobby for laws that would allow the group to self-regulate and thus protect the domain by only allowing those suitably qualified to enter the profession. The qualifications

³⁶² Hugh Grantham, ‘Prehospital Care as a Profession—Are We There Yet?’(2004) 2(1–2) *Journal of Emergency Primary Health Care*.

³⁶³ Peter O’Meara, ‘Paramedics marching towards professionalism.’ *Journal of Emergency Primary Health Care* 7.1 (2009): 1-3.

³⁶⁴ Kerry Mahony, ‘The Politics of Professionalisation: Some Implications for the Occupation of Ambulance Paramedics in Australia’ (2003) 1(3) *Australasian Journal of Paramedicine*, Article 8.<
<https://ajp.paramedics.org/index.php/ajp/article/view/198>>

³⁶⁵ Ibid.

suitable for registration with the group would be determined by the group as sanctioned by the law.

Reynolds recognised that paramedics do have a unique role and specialised knowledge but suggested they did not have control over their work because they were employed predominately by state-based ambulance services who regulated their education, qualifications, title, code of conduct and indeed all other aspects of their work. Thus although paramedics shared a common culture, there was, at that time, no nationally uniform description of what a paramedic was or what a paramedic did. In short, Reynolds recognised that paramedics were professionalising but they were not doing so in any organised way.

The paramedic professionalisation project appeared to lie dormant until, in 2007, the ACAP (now PA) Board unanimously resolved ‘to seek recognition of paramedics as a regulated profession under the COAG [Council of Australian Governments] regulatory structure’.³⁶⁶

4.2 An Organised Movement

In 2007 the ACAP Board commissioned Dr Gerry Fitzgerald from the Faculty of Health at the Queensland University of Technology, and Ray Bange to deliver an ‘action plan for professional regulation’ of paramedics. This signalled a change in approach for the discipline, which, until this time (as discussed in Chapter 3), had attempted to introduce elements of professionalisation such as through development of a professional association, an educational shift to the tertiary sector and improved wages and conditions via a number of largely uncoordinated routes. The engagement of a team to focus on the development and roll-out of a formal professionalisation project marked a maturation point for the discipline. The ACAP Board outlined the key priority areas on which it wished to focus. They included:

1. Establishment of a **coherent model or concept of the role and responsibilities of a professional paramedic** that provides a firm basis for discussion with regulators and other stakeholders;

³⁶⁶ Australian College of Ambulance Professionals (ACAP), *Paramedics in Transition (Operation Phoenix) An Action Plan for Professional Regulation*. Fitzgerald and Bange. Faculty of Health, Queensland University of Technology (December 2007) 7.

2. Development of a submission seeking **regulated status within the COAG framework based on a national set of criteria** adapted from other jurisdictions and comparable situations;
3. Active and sustained **promotion of the professional role of the paramedic** at state and national levels targeted at all significant stakeholder groups and designed **to enhance the perceived value and professionalism of practitioners.**³⁶⁷

The report recognised for the first time that to fully professionalise, the discipline would need to look to the law to ‘gain regulatory status’ and ‘acceptance as a regulated profession’, stating that there was an ‘opportunity for the profession to crystallise its role and prosecute the case for regulation in a receptive environment’.³⁶⁸ The key priorities of the ACAP Board suggests that the discipline was seeking to actively promote and enhance its moral and technical authority in order to progress its development and status as a profession.

The report went further than to suggest that paramedics merely look to the law only for licensing purposes (i.e., registration). It suggested that ‘primary legislation for regulation should provide ... definitions of the services and professional role of paramedics’³⁶⁹ and should protect the paramedic title. The report differed from the literature that had come before it in terms of not only setting out a process of professionalisation that mapped the key elements identified and discussed in the sociological literature but also acknowledging that professional status would only come with ‘regulatory status’ and that the only way to gain regulatory status was if the discipline could demonstrate that it had political legitimacy in the form of respect from other ‘professions, the community and government’. The report’s authors suggested that paramedics could develop this political legitimacy if they could show they were ‘verifiably competent’ in knowledge and skills to ‘ensure safe and effective practice’, and that they achieved this in part because of the development of ‘a strong professional ethos and sense of self-worth’.³⁷⁰

³⁶⁷ Ibid 3 (emphasis added).

³⁶⁸ Ibid 5–6.

³⁶⁹ Ibid 7.

³⁷⁰ Ibid 7.

The authors' rightly identified that it was important for the discipline to have a strong and clear idea of who paramedics are, what roles they perform and what responsibilities they have. This is consistent with the Freidson elements as being common to a profession. As noted in Chapter 2, paramedics have a very clear and distinct role and purpose in the healthcare sector and they have unique responsibilities that set them apart from other healthcare workers that are particular to the provision of emergency healthcare in the out-of-hospital space. Fitzgerald and Bange recommended that this unique role and purpose be promoted by recommending in their professionalisation report that paramedics be referred to as paramedics in all literature and that the title paramedic should be linked with the term 'professional'.³⁷¹ Despite this, there is still no clear and widely agreed definition of the term 'paramedic' and no agreement within the discipline or elsewhere as to what a paramedic does and what values paramedicine holds.

The report then defines the goals of regulation as:

- setting minimum entry standards and training;
- formulating professional roles and standards to which individuals are expected to adhere;
- monitoring of the individuals providing services;
- enforcement of professional roles where necessary;
- implementing an effective complaints procedures; and
- implementing a disciplinary procedure for individuals who are negligent or breach the professional code of practice.³⁷²

The goals of regulation as outlined by the report writers reflect some of the key elements for professional development recognised in the sociological literature. Notably, the discipline having control over its own work via legislation that allows paramedics, not their employers, to determine the minimum training standards required for entry into the profession; and the discipline establishing the roles and standards of practice required by a

³⁷¹ Ibid 7.

³⁷² Gerry Fitzgerald and Ray Bange, 'Defining a Regulatory Framework for Paramedics: A Discussion Paper', (2007) 5(2) *Journal of Emergency Primary Health Care*. From a report prepared for ACAP, Brisbane.

professional paramedic and a mechanism to address complaints about paramedic performance, including a disciplinary procedure. These ideas were floated before the introduction of the National Law, which does contain some of these elements although the reasons for developing a national legislation to regulate healthcare professionals, (including economic and political objectives) had already been flagged.³⁷³

In short, the paramedic professionalisation project was slowly bringing together the elements of a profession and a process that would facilitate the acquisition of those elements, the process being use of the law.

4.2.1 Looking to the Law

The same issue of the JEPHC as the report by Fitzgerald and Bange³⁷⁴ included an editorial by the national president of ACAP, Ian Patrick, who wrote that the peak professional body for paramedics in Australia was looking to the law to help paramedics professionalise. He said:

Regulation has been viewed as a necessary adjunct in the evolution of a profession now requiring enhanced educational foundations, and with practitioners engaged in clinical roles and exercising professional independence in unpredictable environments ... new roles for paramedics employed outside the traditional state-based agencies also demand greater mobility and portability of professional recognition that is likely to be facilitated by regulation.³⁷⁵

Up to this time there had been little to no reference linking paramedic professional development with the law, which suggests there was a lack of understanding within the discipline about ways in which the law could be used as a tool to further that end and also a lack of understanding about how to have the law changed to meet the discipline's needs. The tool for professional development that had been most commonly referred to up until this point was education.³⁷⁶ However, there was no evidence of deliberate links being made

³⁷³ This is discussed in more detail in Chapter 5.

³⁷⁴ Gerry Fitzgerald and Ray Bange, 'Defining a Regulatory Framework for Paramedics: A Discussion Paper', (2007) 5(2) *Journal of Emergency Primary Health Care*. From a report prepared for ACAP, Brisbane.

³⁷⁵ Ian Patrick, 'National Regulation' (2007) 5(2) *Journal of Emergency Primary Health Care*.

³⁷⁶ See also Gregg S Margolis, *The Role of Bachelor's Degree Emergency Medical Service Programs in the Professionalisation of Paramedicine* (PhD Thesis, University of Pittsburgh, 2005) in which the opening line is 'The vision for the future of EMS [emergency medical services] involves a broader public health role and

between education, paramedics' specialised knowledge and skills and their unique purpose to develop the moral and technical authority to lobby for legal recognition as a profession. There was also no mention in the early literature that without legal 'professional' status paramedics would remain as employees with no control over their work.

Consistent with the discipline's focus on education as a tool for professional development, in 2009 Williams, Onsman and Brown³⁷⁷ argued that if progress to professional status was to continue, paramedics would need to 'co-ordinate the various education and training providers to educate future paramedic practitioners with a nationally agreed-upon set of graduate attributes'.³⁷⁸ This was a recognition that the profession believed they should set a minimum standard of entry by establishing a standardised educational curriculum that would reflect that minimum standard; but that the control to do so still did not rest with the discipline. However, the authors recognised that agreeing to 'a distinct pool of knowledge and skills' that applied only to paramedics would:

define and delineate the extent of paramedics' sphere of influence and recognised expertise. The manifestation of that expertise, once made apparent in the field, will allow paramedics a position of greater strength from which to negotiate its relationship with the traditionally highly placed professions in medicine and health care.³⁷⁹

There was, for the first time, a linking of the need to acknowledge the specialised knowledge and skills particular to the unique work of paramedics and ensure that it was contained in all educational curricula for student paramedics. The authors recognised that the discipline's claim to expertise could provide support for their calls to be regulated,³⁸⁰ which would result in the discipline gaining 'professional self-control and accreditation'.³⁸¹ This reflects Freidson's argument that specialised knowledge and skills should be only be regulated by the holders of that knowledge and those skills because only the holders of that knowledge and those skills understand them. This was the first time that there was recognition that the law could and should be used as a tool to facilitate paramedic

will require an increase in the professionalisation in the field of paramedicine ... Bachelor's degree EMS programs are in a unique position to affect the future of paramedicine'.

³⁷⁷ Brett Williams, Andrys Onsman and Ted Brown, 'From Stretcher-bearer to Paramedic: The Australian Paramedics' Move Towards Professionalisation (2009) 7(4) *Journal of Emergency Primary Health Care*.

³⁷⁸ *Ibid* 9.

³⁷⁹ *Ibid* 9.

³⁸⁰ *Ibid* 5.

³⁸¹ *Ibid* 1.

professionalisation because it was the law that could provide the mechanism and authority for the discipline to self-regulate—a key Freidson element common to the professions.

Paramedics had identified that they were not quite yet a profession; not because they did not have a distinct social purpose or have specialised knowledge acquired through a long period of training but because they were not regulated as such. Although they had organised a more formal and less ad hoc approach to becoming regulated, they had not yet recognised and therefore not harnessed the power they had as technical experts serving a unique public purpose to lobby to be recognised at law as professionals and thus be able to organise and maintain a system of control over their own work.

It was not until 2009, following an inquiry into St John Ambulance in Western Australia (WA), that paramedicine fell under a political gaze. The inquiry raised awareness of the issue of paramedic regulation in that state, particularly to the then state health minister, Dr Kim Hames who would later be instrumental in undertaking a review of the options available for the regulation of paramedics.³⁸² It may be significant that WA does not operate a state ambulance service and is instead a ‘consumer’ of ambulance services. This suggests that the minister had an interest in ensuring that WA citizens would receive a professional service as determined by an independent regulator; that is, not the private provider of the service. This would offer a political benefit by allowing the minister to demonstrate that he was lobbying for a quality assurance mechanism for paramedics.

Much of the paramedic commentary around this time began to make mention of the need to protect the public from unqualified practitioners. During this period there was a broader political imperative to address the public safety concerns that had arisen from a number of healthcare scandals including the inquiry into the actions of overseas-trained former surgeon Jayant Patel at Bundaberg Hospital.³⁸³ Coincidentally the paramedic rhetoric suddenly began to refer to its own practice as posing a risk to patients and paramedics began to argue that they should be regulated in the same way as other risky health professions. Freidson noted this is a common appeal made by occupation groups to warrant the privilege

³⁸² St John Ambulance Inquiry, Report to the Minister for Health (October 2009) <https://www.health.wa.gov.au/ambulance_inquiry/docs/SJA_Inquiry_Report.pdf>; Hames supported the AHMAC *Options for the Regulation of Paramedic* inquiry in 2012.

³⁸³ See Geoffrey Davies, *Queensland Public Hospitals Commission of Inquiry* (2005).<http://www.qphci.qld.gov.au/final_report/Final_Report.pdf>

of self-regulation ‘for the well-being of some significant segment of society...and that there would be grave danger to the public if there were no control over those who offer their services.’³⁸⁴

However, there was no real evidence that paramedics posed a threat to the public. This was in part because data on complaints and adverse events related to paramedics were difficult for paramedics to obtain because they were held by state-based ambulance services or private ambulance services, if they were kept at all. Additionally, there are only five reported cases where people have sued alleging negligence by paramedics. Two were not found negligent, two were and in one the result is unknown.³⁸⁵ Despite their wish to be regulated on the basis that it would improve patient protection and safety, there was a lack of evidence to suggest that they posed a significant risk. This may in part explain why paramedics were not among the first groups of health practitioners to be regulated by the National Law in 2010. This did not stop paramedics from continuing to organise for inclusion in the national regulatory scheme. They utilised the relationship they had developed with Dr Hames following the St John Ambulance inquiry, and moved to call for a consultation on paramedic regulation in Australia.

4.2.2 Options for Regulation

The WA health minister in July 2012, on behalf of the AHMAC, established a consultation to consider the way in which paramedics are and should be regulated. Submissions were sought from interested parties on the ‘Options for the regulation of paramedics’.³⁸⁶ AHMAC was interested in exploring the regulatory framework that existed to protect the public and ‘provide sufficient assurance of the quality of paramedic practice’.³⁸⁷ The call

³⁸⁴ Eliot Freidson, *Professionalism Reborn: Theory, Prophecy and Policy* (Polity Press, 1994) 174.

³⁸⁵ *Worley v The Ambulance Service of New South Wales* [2004] NSWSC 1269; *Ambulance Service of New South Wales v Worley* [2006] NSWCA 102; *Neal v Ambulance Service of New South Wales* [2008] NSWCA 346; *State of Queensland v Roane-Spray* [2017] QCA 245; *Peter Raymond Smart, Geoffrey Robert Whatley, Anna Marie Flynn and St. John Ambulance Australia (NT) Inc v Dulcie Stuart (as personal representative of the estate of Jennifer May Shillingworth)* (1992) 83 NTR 1; *Metropolitan Ambulance Service v State of Victoria* [2002] VSC 222 the latter two being cases where a paramedic was found to have been negligent; and 3 coronial enquiries over an 18 year period see AHMAC, *Consultation Paper: Options for the Regulation of Paramedics* (2012) <<https://www.paramedics.org/content/2012/07/Consultation-Paper-Paramedic-Registration.pdf>>

³⁸⁶ AHMAC, *Consultation Paper: Options for the Regulation of Paramedics* (2012)

<http://ris.pmc.gov.au/sites/default/files/posts/2012/07/options_for_regulation_of_paramedics_consultation_paper.pdf>.

³⁸⁷ *Ibid* 3.

for submissions resulted in the publication of a flurry of material and research on why registration of paramedics under the NRAS would be the best regulatory ‘option’. The NRAS³⁸⁸ is essentially an overarching term used to refer to the suite of policy objectives underpinning the introduction of the National Law across all jurisdictions, which includes:

- protecting the public by ensuring that only suitably trained and qualified practitioners are registered;
- facilitating workforce mobility across Australia; and
- enabling the continuous development of a flexible, responsive and sustainable Australian health workforce.³⁸⁹

The majority of submissions, including those by the two professional bodies representing paramedics in Australia—the Australian and New Zealand College of Paramedicine (ANZCP)³⁹⁰ and PA³⁹¹—as well as the NCAU,³⁹² argued for regulation under the national scheme on the basis that it would provide the best model for ‘patient safety’. The argument for regulation under the national scheme on the basis of patient safety had some correlates with arguments for professionalisation because, as noted earlier, Freidson recognised that the call for the privilege of self-regulation by occupation groups is often heard with a somewhat contradictory appeal to protect the public from risks associated with the practice of those groups – that is, the public needs protection from us but we can provide that protection better than other groups.³⁹³

The lack of a national register for paramedics meant that not only could employers and consumers not check the qualifications and registration status of poorly performing

³⁸⁸ The *National Registration and Accreditation Scheme* (NRAS) is discussed in more detail in the next chapter.

³⁸⁹ Australian Federal Department of Health, ‘*National Registration and Accreditation Scheme (NRAS)*’ <<http://www.health.gov.au/internet/main/publishing.nsf/content/work-nras>>.

³⁹⁰ ANZCP, Submission to Health Workforce Principal Committee, AHMAC, *Options for Regulation of Paramedics*, 2012 <<https://www.anzcp.org.au/wp-content/uploads/2016/01/ANZCP-Submission-Options-for-Regulation-of-Paramedics.pdf>>.

³⁹¹ PA, Submission to Health Workforce Principal Committee, AHMAC, *Options for Regulation of Paramedics*, 2012 <<http://www.paramedics.org.au/content/2012/09/PA-Submission-on-paramedic-registration-03082012.pdf>>; PA, *Paramedics in the 2011 Census* (2011) <<https://www.paramedics.org/content/2012/11/Paramedics-in-the-2011-census-final.pdf>>.

³⁹² NCAU, Submission to Health Workforce Principal Committee, AHMAC, *Options for Regulation of Paramedics*, 2012 <<http://www.ambulanceactive.com.au/wp-content/uploads/2015/08/NCAU-Submission-Options-for-the-Regulation-of-Paramedics.pdf>>.

³⁹³ Eliot Freidson, *Professionalism Reborn: Theory, Prophecy and Policy* (Polity Press, 1994) 174.

paramedics, but also that employers could not easily check a register to determine if a potential employee was suitably qualified; this was limiting movement of staff ‘across state borders’. Additionally there were concerns that the regulations that did exist were inconsistent and that there was ‘little to no regulation of the private sector’ despite the fact that the sector was experiencing growth. Unlike nursing and medical students, the lack of regulation of paramedics meant there was also ‘no regulation of students’³⁹⁴ who were in contact with patients while on clinical training placement. These all posed risks to the public. The paramedic discipline made a political decision to embrace the risk to the discipline’s reputation by claiming that it posed a potential risk to the public and should therefore be regulated.

Other arguments related to public safety—that coincidentally intersected with the acquisition of legal professional status—were that there was a lack of a protected title for paramedics that meant that anyone, qualified or not, could call themselves a paramedic without penalty and that this posed a risk to patients. Protecting the title of paramedicine was also seen as a way for the occupational group to gain control over who can and cannot enter the profession and thus use the title. The submissions also noted that currently paramedics had ‘no clearly defined scope of practice’ and that this posed a risk to the public. They argued that there was no ‘nationally consistent qualification’ or nationally standardised core curriculum that would ensure that those trained as paramedics had adequate skills and knowledge to perform the role safely. The submissions identified that there was ‘no ongoing professional development requirement’ for paramedics and no standardised accreditation of any professional development courses. These elements are also elements that characterise a profession as having control over its own work. The submissions identified that there was an ‘inadequate public protection mechanism’ and a ‘poor consumer complaint mechanism’, meaning that there was no specific process for a patient to make a complaint about a paramedic, unlike with doctors and nurses who could be reported to the Australian Health Practitioner Regulation Agency (AHPRA), established under the National Law. Regulation as professionals would mean that paramedics would be able to conduct peer-to-peer assessment of the conduct and performance of other paramedics; again, a control over their own work that was not otherwise available to them. Freidson claimed that an effective claim for professionalisation of an occupational group

is to persuade the state that their work is so ‘complex and esoteric’ that ‘lay people are not well enough informed’ to be able to recognise the competent from the incompetent and thus regulation is necessary.³⁹⁵

The inquiry recognised that paramedics have ‘complex and esoteric’ knowledge and skills and that among all healthcare professions regulated by the National Law, paramedics perform the third-highest number of high-risk interventions (less than medicine and nursing and equal to Chinese medicine) and as such pose a high risk to the public and therefore should be regulated under the national scheme.³⁹⁶ The fact that paramedics were recognised as posing a high risk to the public but had low numbers of complaints suggested that they could be trusted with the power to self-regulate and not abuse this privilege. Freidson submits that persuading the state of the group’s trustworthiness is a necessary step in professionalisation.³⁹⁷ The fact that some lower-risk health groups have been regulated long before the inclusion of paramedics in the scheme suggests that public protection and safety is not only objective of the national scheme.³⁹⁸ Indeed, other objectives include the creation of a flexible workforce.

The inquiry exposed that the lack of national regulation of paramedics was limiting the ability of this particular group of healthcare workers to contribute to the NRAS objectives of creating a mobile and flexible healthcare workforce. The report recommended the discipline’s inclusion in the scheme.

4.3 Path to Regulation

In late 2015 it was announced that the federal government’s Senate Legal and Constitutional Affairs References Committee would hold an inquiry into the national registration of Australian paramedics *to improve and ensure patient and community safety*.³⁹⁹ The terms of reference of the inquiry included not only a consideration of the role

³⁹⁵ Eliot Freidson, *Professionalism Reborn: Theory, Prophecy and Policy* (Polity Press, 1994) 174.

³⁹⁶ AHMAC, *Final Report: Options for the Regulation of Paramedics* (September 2015) Appendix 1: Risk Factor Assessment for Health Professions under the *National Registration and Accreditation Scheme*, 110 <<http://www.coaghealthcouncil.gov.au/Portals/0/Paramedics%20Decision%20RIS.pdf>>.

³⁹⁷ Eliot Freidson, *Professionalism Reborn: Theory, Prophecy and Policy* (Polity Press, 1994) 174.

³⁹⁸ Mike Saks, ‘Defining a Profession: The Role of Knowledge and Expertise’ (2012) 2(1) *Professions and Professionalism* 1–10 <<https://journals.hioa.no/index.php/pp/article/viewFile/151/355>>.

³⁹⁹ Emphasis added because patient safety is only one reason for regulating paramedics.

of paramedics but the comparative regulatory frameworks that currently exist between paramedics, doctors and registered nurses. The inquiry would also consider if there should be a national system of accreditation for paramedics, if the AHPRA (the administrative arm of the National Law) was the appropriate agency to administer that task, and if registration could facilitate the unhindered movement of paramedics across the country as required.⁴⁰⁰

Significant numbers of submissions suggested that it was in the public interest, for protection and safety, that paramedics be regulated under the national scheme. For example, one submission advocated for ‘enhanced professional standards’ of paramedics in the ‘interests of the public’.⁴⁰¹ They argued that the adoption of professional standards of best practice of healthcare by paramedics would be in the interests of the public and that regulation is an example of such a professional standard.⁴⁰² The development of professional standards would require the discipline to develop a code of ethics to establish conduct and competency standards that would reflect paramedicine’s unique identity.⁴⁰³ According to Wilensky’s trajectory, the development of a code of conduct comes after the discipline has become regulated.

More notable was the public declaration that paramedics play an important, unique and specialised role in the healthcare sector; for example, ANZCP submitted that:

⁴⁰⁰ Federal Senate Legal and Constitutional Affairs References Committee, *Chapter One: Final Report into the National Registration of Australian Paramedics to Improve and Ensure Patient and Community Safety*, 2016, 1

<http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Paramedics/Report/e01>.

⁴⁰¹ Ray Bange, Richard Brightwell and Brian Maguire, Submission to Senate Legal and Constitutional Affairs Committee, Parliament of Australia, *The Establishment of a National Registration System for Australian Paramedics to Improve and Ensure Patient and Community Safety*, 2016, 13.<
https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Paramedics/Submissions>

⁴⁰² Ibid 13.

⁴⁰³ Federal Senate Legal and Constitutional Affairs References Committee, *Chapter One: Final Report into the National Registration of Australian Paramedics to Improve and Ensure Patient and Community Safety*, 2016.

<http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Paramedics/Report/e01>.

Paramedics predominantly perform a specialised medical function within the Australian health system. Paramedics are best known for the provision of an out-of-hospital and front line health service.⁴⁰⁴

This was a powerful use of the unique purpose and specialist nature of the role and knowledge of paramedicine that is consistent with the Freidson elements. There was a broad recognition that the omission to regulate paramedics under the national scheme was anomalous. In sum, the bulk of the submissions from paramedics or their associated organisations argued that regulation would facilitate paramedic professionalisation because it would promote patient safety (public interest),⁴⁰⁵ and allow for self-regulation (autonomy and power)⁴⁰⁶ and the development of a standardised body of knowledge (education).⁴⁰⁷

Some submissions noted that regulation under the national scheme would create ‘an improved professional environment for paramedics’ by improving paramedic professional status.⁴⁰⁸ This improved professional status would come about as a result of the law giving

⁴⁰⁴ ANZCP, Submission to Senate Legal and Constitutional Affairs Committee, Parliament of Australia, *The Establishment of a National Registration System for Australian Paramedics to Improve and Ensure Patient and Community Safety*, 2016, 5.

<https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Paramedics/Submissions>

⁴⁰⁵ Submissions to Senate Legal and Constitutional Affairs Committee, Parliament of Australia, *The Establishment of a National Registration System for Australian Paramedics to Improve and Ensure Patient and Community Safety*, 2016, ANZCP 5; Ambulance Employees Australia Victoria 3; NCAU 4,8; Michael Eburn 7; CAA 4, PA 1.4; RFDS 1, Ruth Townsend, 19, Victorian Department of Health and Human Services 1,5. 5.

<https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Paramedics/Submissions>

⁴⁰⁶ Submissions to Senate Legal and Constitutional Affairs Committee, Parliament of Australia, *The Establishment of a National Registration System for Australian Paramedics to Improve and Ensure Patient and Community Safety*, 2016, ANZCP 11, 13, 15,17; Bange, Brightwell and Maguire 22,33,35,37; Ruth Townsend 19,22,23,25; Ambulance Employees Australia Victoria 8; NCAU 5,10;CAA 4,6; PA 3; Victorian Department of Health and Human Services

6<https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Paramedics/Submissions>

⁴⁰⁷ Federal Senate Legal and Constitutional Affairs References Committee, *Chapter One: Final Report into the National Registration of Australian Paramedics to Improve and Ensure Patient and Community Safety*, 2016. ANZCP 5,11,13,17; Australian Medical Association 1; Australian Health Practitioner Regulation Agency 4; Ambulance Employees Australia Victoria 4-6; NCAU 4,5,8,10; Michael Eburn 7; CAA 4-7; Australian Paramedics Association Queensland 3; PA 1-5; Bange, Brightwell and Maguire 5,8,13,17,22,34,48; Royal Flying Doctor Service 1; Ruth Townsend 17,19; NSW Health; Victorian Department of Health and Human Services 1-6;

<https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Paramedics/Submissions>

⁴⁰⁸ PA, Submission to Senate Legal and Constitutional Affairs Committee, Parliament of Australia, *The Establishment of a National Registration System for Australian Paramedics to Improve and Ensure Patient and Community Safety*, January 2016, 1.

paramedics authority to control the quality of the profession via education and accreditation standardisation; establishment of an independent disciplinary body to oversee complaints made against paramedic practitioners; and increased paramedic autonomy.⁴⁰⁹ These are consistent with the elements of professionalisation identified by Freidson.

This was further supported by, for example, the submission from the CAA who explicitly linked professionalisation to education:

Over recent decades, the professionalisation of the paramedic role has been positively influenced by a move from post-employment Vocational Education Training (VET) training conducted by State/Territory Ambulance Services, to the university sector, with undergraduate and postgraduate degrees as the general qualification requirement for 'entry to practice'. This is a key step in becoming a professional health workforce.⁴¹⁰

There was some suggestion that regulation under the national scheme would be a way for paramedics to raise awareness of and contribute to a broadening of the allied healthcare workforce because paramedics would be capable of performing a broad range of skills in a broad range of environments. The lack of regulation under the NRAS was limiting the discipline's ability to contribute to the scheme's objective of increasing the 'flexibility' of the workforce.⁴¹¹

The submission of the employer representative—the CAA, a peak industry body comprising 10 public ambulance services in Australia and New Zealand whose purpose is to advance ambulance services to 'develop superior pre-hospital care and ambulance

⁴⁰⁹ ANZCP, Submission to Senate Legal and Constitutional Affairs Committee, Parliament of Australia, *The Establishment of a National Registration System for Australian Paramedics to Improve and Ensure Patient and Community Safety*, 2016, 5.

⁴¹⁰ CAA, Submission to Senate Legal and Constitutional Affairs Committee, Parliament of Australia, *The Establishment of a National Registration System for Australian Paramedics to Improve and Ensure Patient and Community Safety*, January 2016, 4.
<https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Paramedics/Submissions>

⁴¹¹ Peter O'Meara, Submission to PC, *Australia's Health Workforce*, 2005
<<http://www.pc.gov.au/inquiries/completed/health-workforce/submissions/sub160/sub160.pdf>>; Peter O'Meara, 'Would a Prehospital Practitioner Model Improve Patient Care in Rural Australia?' (2003) 20(2) *Emergency Medicine Journal* 199–203; Christine Stirling et al, 'Expanding the Scope of Practice for Rural Engaging Rural Communities in Health Care through a Paramedic Expanded Scope of Practice' (2007) 7(4) *Rural and Remote Health* 1–9; Kelly Sheffield, Peter O'Meara and Glenda Verrinder, 'Decision-making Processes When Paramedics Refer Patients Away From Hospital: A Scoping Review' (2016) *Irish Journal of Paramedic Practice*.1.1.

services to communities across Australasia⁴¹²—also covered the core elements of a profession. It expressed that registration of the profession will result in benefits including ‘the protection of title’; ‘the accreditation of paramedic “entry-to-practise” education programs’; ‘the regulation of the standard of persons deemed “fit-to-practise” as a paramedic’; and the ‘application of the health professional “Code of Conduct” obligations to include paramedics’.⁴¹³ Again, in an ad hoc and fairly unstructured way, paramedics had identified the key elements common to professions and suggested that they may be able to realise all these elements—including those they do not currently have—if they were to be regulated by the National Law.

The type of support offered by non-paramedic bodies for paramedic regulation under the NRAS suggests that paramedicine has high standing within the healthcare sector, an objective identified by Fitzgerald and Bange in their action plan for paramedic professional regulation.⁴¹⁴ For example, submissions by the AMA⁴¹⁵ and the Royal Flying Doctor Service⁴¹⁶ were supportive of paramedic inclusion in the scheme. This is unlike the lack of support offered by the AMA to the objective of the development of the NRAS in the first place.⁴¹⁷ This is discussed further in chapter 5. It is likely that the AMA supported paramedicine’s move to be regulated under the National Law because they consider paramedicine to be a legitimate profession worthy of such status. The AMA’s submission to the Senate inquiry that states that

⁴¹² CAA, Submission to Senate Legal and Constitutional Affairs Committee, Parliament of Australia, *The Establishment of a National Registration System for Australian Paramedics to Improve and Ensure Patient and Community Safety*, January 2016, 2.

<https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Paramedics/Submissions>

⁴¹³ Ibid 4.

⁴¹⁴ Australian College of Ambulance Professionals, *Paramedics in transition.*

⁴¹⁵ AMA Submission to Senate Legal and Constitutional Affairs Committee, Parliament of Australia, *The Establishment of a National Registration System for Australian Paramedics to Improve and Ensure Patient and Community Safety*, January 2016, 1.

⁴¹⁶ Royal Flying Doctor Service Submission to Senate Legal and Constitutional Affairs Committee, Parliament of Australia, *The Establishment of a National Registration System for Australian Paramedics to Improve and Ensure Patient and Community Safety*, January 2016, 1.

⁴¹⁷ Australian Doctor, ‘Roxon wants end to GP ‘dominance’

<<https://www.australiandoctor.com.au/news/latest-news/roxon--8216;diminishing-role-of-gps--8217>>

the AMA does not generally support new practitioner groups joining the NRAS unless the *practice has a scientific basis* and there are potentially significant safety risks for patients...paramedics' practice meets these criteria.⁴¹⁸

The regulating body, AHPRA, submitted that regulation under the National Law would work for both the profession and the public saying that the profession would benefit from having barriers removed and allowing 'practitioners to meet nationally consistent registration standards for the profession'.⁴¹⁹ The benefits for the public include:

better protection through ensuring that only health practitioners who meet the national registration standards for that profession and who have the skills, qualifications and knowledge to provide safe care, are registered.⁴²⁰

These submissions demonstrated the political legitimacy of paramedicine and reflect the value attributed by others within the healthcare sector to the discipline.

4.3.1 Opposition by NSW

There was one notable group that objected to paramedics being regulated by the National Law and that was NSW Health, which operates the Ambulance Service of NSW. The submission by NSW Health in opposition to the national regulation of paramedics provides a clear example of why paramedics have fought to be regulated under the National Law:

In NSW, the majority of paramedics are employed by NSW Health through NSW Ambulance, which exercises strict clinical governance over paramedics through protocols, policies and procedures, as well as setting training and education standards for those who are entitled to call themselves paramedics. In addition, these employees are subject to NSW Health policies, including the NSW Health Code of Conduct, recruitment policies governing such matters as criminal record and reference checking, clinical

⁴¹⁸ AMA Submission to Senate Legal and Constitutional Affairs Committee, Parliament of Australia, *The Establishment of a National Registration System for Australian Paramedics to Improve and Ensure Patient and Community Safety*, January 2016, 1. Emphasis added.

⁴¹⁹ AHPRA, Submission to Senate Legal and Constitutional Affairs Committee, Parliament of Australia, *The Establishment of a National Registration System for Australian Paramedics to Improve and Ensure Patient and Community Safety*, January 2016, 5.

⁴²⁰ Ibid 5.

governance oversight and a range of other policies (such as those on bullying and harassment, grievance procedures and complaints policies).⁴²¹

The model set out by NSW Health offers paramedics no autonomy of practice, no autonomy with regard to setting education and practice standards and no paramedic-specific code of conduct that reflects the identity and values of the discipline—all the elements associated with professional status and that may potentially be acquired by paramedics regulated under the National Law. The NSW Health position suggests an attempt to maintain power and control over the paramedic workforce and curriculum which stands in stark contrast to the other submissions made by a range of paramedic representatives - as distinct from the employer – from around the country, lobbying for paramedic autonomy and self-regulation.

4.3.2 Inclusion

At the October 2016 COAG meeting, the health ministers agreed to proceed with amendments to the *Health Practitioner Regulation National Law Act 2009 (Qld)* (the ‘National Law’) that will require paramedics to be regulated by the NRAS alongside the 14 other health professions that are currently regulated by the scheme. A draft amendment Bill is tabled to be presented to the Queensland Parliament in September 2017. Despite the initial expression by NSW Health of its reluctance to participate in the scheme, all health ministers agreed that paramedics will be registered by the scheme in all jurisdictions.⁴²²

The agreement by the health ministers to include paramedics in the national regulatory scheme is a significant step forward in the paramedic professionalisation project. This step recognised the potential power of the law to facilitate the professionalisation project by providing a mechanism for paramedics to regulate themselves, to gain control over their own work and to meet their objective of being granted the same legal status as other comparable healthcare professions.

⁴²¹ NSW Health, Submission to Senate Legal and Constitutional Affairs Committee, Parliament of Australia, *The Establishment of a National Registration System for Australian Paramedics to Improve and Ensure Patient and Community Safety*, January 2016, 8.

⁴²² Council of Australian Governments (COAG), Health Council Communiqué 7 October 2016 [http://www.health.gov.au/internet/main/publishing.nsf/content/4EF9C42740F7FC4ECA258045001C0397/\\$File/dept006.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/4EF9C42740F7FC4ECA258045001C0397/$File/dept006.pdf).

This descriptive chapter has described why paramedics wanted to be regulated as professionals, what they hoped that would provide and has explained the process by which they successfully navigated to inclusion in the NRAS.

The discussion in chapter 2 outlined the discourse of professionalisation within the sociological literature. The chapter has demonstrated that paramedics whether they knew it or not, identified the essential aspects of being a profession and recognised the value of those aspects to their standing and practice. Over time the paramedic workforce moved from an ad hoc approach to professional development to an organised professional project that has resulted in achieving the discipline's objective of being regulated as health professionals. The discourse moved from a focus on educational reform to a focus on legislative reform, which occurred somewhat opportunistically, in response to social and political circumstances.

Paramedics successfully used the national social and political discourse on patient safety (discussed further in Chapter 5) to argue for regulation under the national regulatory scheme not just because they thought they posed a threat to the public. The discourse shows that paramedics believed regulation as professionals was the next step in their occupational evolution towards professionalism. That is, it would result in their ability to control their own work by allowing them to standardise qualifications for entry to the profession, accredit educational programs that would reflect the unique and specialised knowledge and skills of the discipline, protect the title to limit use by outsiders, increase the mobility and thus work opportunities for paramedics to work beyond the control of traditional state-based ambulance services, and to monitor and hold to account paramedics who might work below the standard expected and set by the profession. This would in turn contribute to the continuing development of paramedic moral and technical authority and associated political power that would allow the discipline to engage in the development of healthcare and healthcare workforce policy - something that they had complained was missing from their practice in their *Forgotten Profession* report – and that would provide evidence of their professional legitimacy.⁴²³

⁴²³ PA, *The Forgotten Health Profession: A Commentary Highlighting the Omission of Paramedics and Paramedic Services From National Health Care Policy Considerations*, 2010
<https://www.paramedics.org/content/2010/08/PA_ForgottenProfession_single-page_191011.pdf>

The discussion in chapters 2 and 3 have demonstrated that paramedicine has achieved most of the elements of a profession and deserves the remaining elements. It is argued in the rest of this thesis, that regulation under the NRAS will achieve that objective. National regulation will allow paramedics, via the Paramedicine Board, to complete the final steps towards their establishment as a profession. It can be expected that the benefits argued for by paramedics, both to them, their patients and the community, will flow with that professional standing.

The next chapter provides a brief history of the National Law. It then examines the body of the Act and maps it against the attributes associated with professions (unique purpose, specialised skills and knowledge, moral and technical authority, self-regulation and a code of ethics (professionalism)) to consider if the law can facilitate the professionalisation of non-professional healthcare disciplines; more particularly, to consider if the law can provide paramedics with the professional status that they are seeking, particularly with autonomy over their work, mobility, flexibility and control over education, practice and conduct standards.

Part II—The Regulation

Chapter 5: The Health Practitioner Regulation National Law Act

The previous chapters identified elements common to a profession, and then outlined the social and historical development of paramedicine and examined the discourse on paramedic professionalisation against those elements. It identified that while the discipline has had ambitions to professionalise and has been slowly professionalising it has not yet fully realised that goal. It also identified that the profession believes that regulation under the National Law will help them achieve this objective.

This chapter provides a brief history of the National Law and why it was developed. It then examines the body of the Act and maps it against the attributes associated with professions (unique purpose, specialised skills and knowledge, moral and technical authority, self-regulation and a code of ethics (professionalism)) to consider the role of the law in the professionalisation of paramedics in Australia.

5.1 Defining the Terms

At law, the term ‘regulation’ has, on some occasions, strictly referred to delegated legislation (‘The Regulations’) but for the purpose of this thesis, regulation will extend to refer to primary legislation, the National Law⁴²⁴ Regulation is a tool of social control and in healthcare it has a number of purposes including to protect the users of healthcare from the power imbalance that can exist between vulnerable patients and practitioners so as to preserve trust and therefore the function of the healthcare system. Regulation can also be used to control and organise the healthcare workforce. There are different forms of regulation as noted in Chapter 2. Freidson argued that regulation by professionalism is preferable in healthcare to regulation by bureaucracy or free market regulation because it offers a mechanism to ‘nurture and control occupations with complex, esoteric knowledge

⁴²⁴ And, in Chapter 6, the equivalent legislation in the UK.

and skill, some of which provide us with critical personal services'.⁴²⁵ This form of regulation is distinct from free market and bureaucratic forms of regulation because it allows for both morality and discretion in professional decision making. These are both necessary elements when working in the area of healthcare where workers are routinely confronted with complex clinical and moral dilemmas that require the specialist knowledge and skills of expert practitioners to ensure good outcomes. This specialised knowledge and skill makes the work these professionals do difficult for others to understand. Regulation by professionalism offers the opportunity for those specialist workers to regulate themselves by determining who enters the profession, the education standards required to enter and the conduct and competence standards expected to be met in practising the profession.

The National Law is the piece of legislation that regulates health professionals in Australia. It is drafted to support professionalism as regulation and it contains particular provisions that essentially codify professional rules and behavioural norms that govern the behaviour of healthcare professionals, including codes of conduct. It is likely that paramedics will be regulated by this legislation from late 2018. For paramedics, being regulated by this law will represent a significant shift away from the employment and common law regulatory model that has hitherto applied to them (as outlined in Chapter 4), and will, for the first time, offer them an opportunity to regulate themselves.

5.2 A Short History of the Development of the National Law

In 2005, the PC was requested by the COAG and then federal treasurer, Peter Costello, to undertake a 'broad, whole-of government perspective', in examining issues affecting Australia's health workforce in the context of 'the need for efficient and effective delivery of health services in an environment of demographic change, technological advances and rising health costs'. The PC was to consider 'the supply of, and demand for, health workforce professionals', and to 'propose solutions to ensure the continued delivery of quality health care over the next 10 years'.⁴²⁶ COAG requested that the PC consider the

⁴²⁵ Eliot Freidson, *Professional Powers: A Study of the Institutionalisation of Formal Knowledge* (University of Chicago Press, 1988).220

⁴²⁶ PC, *Australia's Health Workforce*, Research Report (2005) Terms of Reference, iv

health and education issues that apply to ‘the full range of health workforce professionals’; in particular, the health workforce needs of rural areas.⁴²⁷

With regard to the term ‘health workforce professional’, the commission adopted an expansive definition saying:

‘health workforce professional’ is defined to cover ‘the entire health professional workforce’, from a number of education and training backgrounds, including vocational, tertiary, post-tertiary and clinical. Without attempting to be exhaustive, examples of relevant occupations covered include: doctors, nurses, midwives, physiotherapists, podiatrists, pharmacists, psychologists, occupational therapists, dentists, radiographers, optometrists, Aboriginal Health Workers, *ambulance officers and paramedics*. Generally, people must be registered before they can practise in most of these occupations.⁴²⁸

The PC was required, among other things, to ‘consider the institutional, regulatory and other factors across both the health and education sectors affecting the supply of health workforce professionals such as their entry, mobility and retention’, which included the relationships between health service planning and health workforce planning; the already existing cohesion across organisations and sectors in relation to health workforce education and training and appropriate accountability frameworks; workforce preparation through VET, undergraduate and postgraduate clinical training; net returns to individuals, professional mobility, skill portability and recognition, workforce satisfaction; and the scope of productivity enhancements that could be made to the health workforce sector.⁴²⁹

The PC recommended the establishment of a national board for accreditation of educational curriculum and registration for health practitioners.⁴³⁰ The report found that there was evidence that the jurisdictional and siloed approach to regulation that existed prior to the establishment of a national agency undermined the capacity for the development or expansion of roles that might best and flexibly provide the healthcare of the future. The Queensland government’s submission acknowledged that ‘role expansion will certainly

⁴²⁷ Ibid COAG Resolution, v

⁴²⁸ Ibid 2–3. (emphasis added)

⁴²⁹ Ibid Scope, v.

⁴³⁰ Ibid Recommendation 6.1 (xxxix) and Recommendation 7.1 (xL)

include some work practices moving from one occupational group to another. ... the current system will not provide for this change'.⁴³¹ The PC acknowledged that:

the current fragmented and uncoordinated multiplicity of registration boards with their variable standards inhibits workforce efficiency and effectiveness, hinders workforce innovation and flexibility across jurisdictional borders, and increases administrative and compliance costs.⁴³²

The recognition by the PC of this structural inefficiency was fundamental in the development and drafting of the National Law. There was a suggestion that the law could be reformed to provide a means to co-ordinate the healthcare workforce to provide flexibility for the system that was otherwise missing whilst at the same time making the regulatory structure more efficient. That is, there was an understanding that innovations in the utilisation of the healthcare workforce could be facilitated by a reform of the regulatory structure. Innovations included 'broadening scopes of practice and more major job redesign'.⁴³³

5.2.1 Scandals and Public Safety

The establishment of a national board for accreditation of educational curriculum and registration for health practitioners was also recommended in the PC report.⁴³⁴ This recommendation was made in response to a number of public health safety concerns including the difficulty of the existing state-based regulatory system to apply a nationally consistent baseline standard of qualification and experience by which to determine an overseas practitioner's suitability to practise in Australia; and a nationwide mechanism by which all health practitioners could have their competency and fitness to practice consistently assessed, monitored and managed.⁴³⁵ This issue was identified following a number of scandals involving hospitals and doctors across Australia during the 2000s,

⁴³¹ Queensland Government, Submission to PC, *Australia's Health Workforce*, 2005
<<http://www.pc.gov.au/inquiries/completed/health-workforce/submissions/sub171/sub171.pdf>>.

⁴³² PC, *Australia's Health Workforce*, Research Report (2005) Recommendation 6.1 (xxxix) and Recommendation 7.1 (xL)

⁴³³ Ibid.

⁴³⁴ Ibid Recommendation 6.1 (xxxix) and Recommendation 7.1

⁴³⁵ Fiona Pacey et al, (2012) 'National Scheme for Health Practitioner Registration and Accreditation: The Case of Australia' in Stephanie Short and Fiona McDonald (eds) *Health Workforce Governance: Improved Access, Good Regulatory Practice, Safer Patients* (Ashgate, 2012).

which had the effect of weakening the public's confidence in the professionalism of doctors.⁴³⁶

Inquiries into these 'scandals' revealed significant problems with the internal and external regulation of practitioners and institutions.⁴³⁷ This had the effect of undermining confidence in medical self-regulation, which, it appeared, had resulted from an abuse of the profession's discretionary powers associated with self-regulation that had allowed for the application of 'weak' and inconsistent standards.⁴³⁸ Doctors were accused of protecting the reputation of the profession above the wellbeing of patients by failing to sanction poorly performing peers. The regulatory system that existed at the time was said to have failed to adequately address issues of a lack of professionalism and ensure that patient interests were prioritised over practitioner interests.⁴³⁹ Self-regulation was associated with a lack of transparency, which led to calls for greater involvement by the state and the public in the regulation of medicine.⁴⁴⁰

As was discussed in Chapter 2, the acquisition of expert knowledge combined with the performance of a morally good service contributed to the legitimisation of medicine as a profession by providing it with moral and technical authority and thus the power to lobby

⁴³⁶ Fiona McDonald, 'Scandals, Public Inquiries and Health Professional Regulation' in Stephanie Short and Fiona McDonald, *Health Workforce Governance: Improved Access, Good Regulatory Practice, Safer Patients* (Ashgate, 2012); Mary Dixon-Woods, Karen Yeung and Charles Bosk, 'Why is UK Medicine No Longer a Self-regulating Profession? The Role of Scandals Involving "Bad-Apple" Doctors' (2011) 73 (10) *Social Science and Medicine* 1452-1459; David Bruce, 'Regulation of Doctors' (2007) 334 *BMJ* 436-437; Bridget M Hutter, 'Risk Regulation and Health Care', (2008) 10(1) *Health, Risk and Society* 1-7 <<http://www.tandfonline.com/doi/pdf/10.1080/13698570701782338?needAccess=true>>.

⁴³⁷ Thomas Faunce and Stephen Bolsin, 'Three Australian Whistleblowing Sagas: Lessons for Internal and External Regulation' (2004) 181 *Medical Journal of Australia* 44-47; F Pacey et al, (2012) 'National Scheme for Health Practitioner Registration and Accreditation: The Case of Australia' in Stephanie Short and Fiona McDonald (eds) *Health Workforce Governance: Improved Access, Good Regulatory Practice, Safer Patients* (Ashgate, 2012); Fiona McDonald, 'Scandals, Public Inquiries and Health Professional Regulation' in Stephanie Short and Fiona McDonald, *Health Workforce Governance: Improved Access, Good Regulatory Practice, Safer Patients* (Ashgate, 2012); Mary Dixon-Woods, Karen Yeung and Charles Bosk, 'Why is UK Medicine No Longer a Self-regulating Profession? The Role of Scandals Involving "Bad-Apple" Doctors' (2011) *Social Science and Medicine*; Bridget M Hutter 'Risk Regulation and Health Care' (2008) 10 *Health, Risk and Society* 1-7 <<http://www.tandfonline.com/doi/pdf/10.1080/13698570701782338?needAccess=true>>.

⁴³⁸ Sylvia Cruess and Richard Cruess, 'The Medical Profession and Self-regulation: A Current Challenge' (2005) 7(4) *Virtual Mentor*.

⁴³⁹ Justin Waring, Mary Dixon-Woods and Karen Yeung, 'Modernising Medical Regulation: Where Are We Now?' (2010) 24(6) *Journal of Health Organization and Management* 540-555.

⁴⁴⁰ Fiona McDonald, 'Scandals, Public Inquiries and Health Professional Regulation' in Stephanie Short and Fiona McDonald, *Health Workforce Governance: Improved Access, Good Regulatory Practice, Safer Patients* (Ashgate, 2012).

to be self-regulating. Self-regulation was argued to be necessary in part because, as Freidson had identified, no other group was qualified to assess the application of that specialised knowledge and skill within the particular scope of practice of a unique profession.⁴⁴¹ This expertise, coupled with a claim to use their power responsibly by acting with professionalism, allowed medicine to govern itself rather than be subject to ‘extensive state oversight and involvement’.⁴⁴² However, medical scandals were said to diminish confidence in medical experts to regulate themselves in the public interest, which in turn prompted politicians to act to preserve public safety and healthcare quality and also to restore confidence in the healthcare system by enacting regulatory reforms that would remove some of the discretionary powers held by professions such as medicine.⁴⁴³ This produced a political imperative to maintain public confidence in healthcare because healthcare is recognised as a critical arm of governance necessary for social stability.⁴⁴⁴ The ‘scandals’—combined with difficulties identified in the existing state-based regulatory system associated with determining an overseas practitioner’s suitability to practise in Australia, and a recognition of the lack of a nationwide mechanism by which all health practitioners could have their competency and fitness to practise consistently assessed, monitored and managed—contributed to the calls for reform.⁴⁴⁵ Issues of safety and confidence in the system associated with the desire to develop and expand healthcare workforce roles beyond traditional silos and to address issues of structural inefficiency, contributed to the political need and political will to reform healthcare workforce regulation.⁴⁴⁶

⁴⁴¹ Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001).

⁴⁴² Justin Waring, Mary Dixon-Woods and Karen Yeung, ‘Modernising Medical Regulation: Where Are We Now?’ (2010) 24(6) *Journal of Health Organization and Management* 540–555, 541; Mary Dixon-Woods, Karen Yeung and Charles Bosk, ‘Why is UK Medicine No Longer a Self-regulating Profession? The Role of Scandals Involving “Bad-Apple” Doctors’ (2011) 73 (10) *Social Science and Medicine* 1452–1459.

⁴⁴³ Gwyn Bevan, ‘Changing Paradigms of Governance and Regulation of Quality of Healthcare in England’ cited in Bridget M Hutter ‘Risk Regulation and Health Care’, (2008) 10(1) *Health, Risk and Society*, 1–7.

⁴⁴⁴ Ellie Scrivens *Quality, Risk and Control in Health Care* (McGraw-Hill, 2005).

⁴⁴⁵ F Pacey et al, (2012) ‘National Scheme for Health Practitioner Registration and Accreditation: The Case of Australia’ in Stephanie Short and Fiona McDonald (eds) *Health Workforce Governance: Improved Access, Good Regulatory Practice, Safer Patients* (Ashgate, 2012).

⁴⁴⁶ It has been noted that professionalism regulation does not ‘inevitably lead to better health outcomes’ and that it is in fact utilised for other reasons including political objectives. Working Party of the RCP, ‘Doctors in Society. Medical Professionalism in a Changing World’ (2005) Nov–Dec;5 (6 Suppl 1) *Clinical Medicine* (Lond) S5–40.

In November 2008, COAG established Health Workforce Australia (HWA) as the Commonwealth statutory authority recommended in the PC report and it worked in conjunction with the AHMAC on the reforms. The agenda of the proposed agency was to consider various workforce innovations including expanding the scopes of practice of various allied health professionals like physiotherapy, podiatry, radiography and pharmacy and revising the skill mix in emergency departments to allow for practitioners other than doctors and nurses to provide care. The recommendation was for the agency to examine ways to undertake ‘major job redesign such as the development of physician assistants, surgical care practitioners, rural health practitioners, nurse anaesthetists, medical assistants and **paramedic practitioners**’.⁴⁴⁷

To give health practitioners other than doctors the expanded role, mobility and flexibility recommended in the PC report, legislative reform was necessary. The then national health minister and member of COAG, Nicola Roxon, supported the establishment of the national regulatory scheme, which, on the surface appeared to address issues of public concern about safety while also establishing another objective—to create a national ‘flexible and mobile’ workforce. Under the scheme, all health practitioners – doctors, nurses, chiropractors, and podiatrists – would be equally regulated. There would be no special treatment for medicine.⁴⁴⁸ It is interesting to note that the AMA was particularly vocal about perceived tensions between the two primary objectives of the legislation – public safety and the development of a flexible and mobile workforce – arguing that the focus on workforce planning objectives could potentially compromise public safety.⁴⁴⁹ Roxon was accused of ‘dismembering’ GPs in favour of nurse practitioners and other non-medical providers⁴⁵⁰ but there were no other similar concerns raised by other health workforce stakeholders. Patient groups and the nursing profession supported the scheme.⁴⁵¹ The reforms amounted to the introduction of a regulatory mechanism that

⁴⁴⁷ Ibid 65 (emphasis added).

⁴⁴⁸ COAG Communiqué, 13 April 2007 <http://www.coag.gov.au/coag_meeting_outcomes/2007-04-13/index.cfm#health>

⁴⁴⁹ *Health Practitioner Regulation (Consequential Amendments) Bill 2010* (Cth) <http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/2008-10/health_practitioner_reg/report/c01>

⁴⁵⁰ Australian Doctor, ‘Roxon wants end to GP ‘dominance’’ <<https://www.australiandoctor.com.au/news/latest-news/roxon---8216;diminishing-role-of-gps--8217>>

⁴⁵¹ Rhonda Jolly and Angus Martyn, *Health Workforce Australia Bill 2009*, 27 May 2009 <http://parlinfo.aph.gov.au/parlInfo/download/legislation/billsdgs/QNOT6/upload_binary/qnot60.pdf;fileType=application%2Fpdf#search=%22Health%20%202000s%22>.

would address medical dominance – referred to in Chapter 2 by Willis as the medical profession maintaining control over not only their own work but the work of other health groups and the broader health sector, including policy and law makers.⁴⁵² This had been noted by the PC as an inefficiency. The structural and regulatory reform of the healthcare workforce proposed by COAG would facilitate “access to services provided by health practitioners in accordance with the public interest,” a core objective of the NRAS.⁴⁵³

The objectives of the NRAS became more comprehensive than simply providing a national mechanism for registering health professionals. The scheme was established to achieve multiple objectives listed in the National Law, including to:

- a) provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered; and
- b) to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction; and
- c) to facilitate the provision of high quality education and training of health practitioners; and
- d) to facilitate the rigorous and responsive assessment of overseas-trained health practitioners; and
- e) to facilitate access to services provided by health practitioners in accordance with the public interest; and
- f) to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.⁴⁵⁴

⁴⁵² Evan Willis, *Medical Dominance* (Allen & Unwin, 1983).

⁴⁵³ Rhonda Jolly and Angus Martyn, *Health Workforce Australia Bill 2009*. 27 May 2009
<http://parlinfo.aph.gov.au/parlInfo/download/legislation/billsdgs/QNOT6/upload_binary/qnot60.pdf;fileType=application%2Fpdf#search=%22Health%20%202000s%22>.

⁴⁵⁴ *Health Practitioner Regulation National Law Act 2009* (Qld) s3 (2).

The National Law is an example of cooperative federalism having first been introduced in Queensland, as the lead state,⁴⁵⁵ and then either adopted or copied by all states and territories to provide largely uniform, national regulation of health professionals.⁴⁵⁶ Notwithstanding the attempt at uniformity, there are some anomalies between jurisdictions. NSW and Queensland have their own complaints and disciplinary mechanisms and as such are considered co-regulatory jurisdictions.⁴⁵⁷ Co-regulatory jurisdiction refers to a participating jurisdiction that has declared that the jurisdiction will not participate in the ‘health, performance and conduct process’⁴⁵⁸ and has instead established their own process for managing health, performance and conduct as a separate section of their Act.⁴⁵⁹ In NSW this entity is referred to as the Health Care Complaints Commission.⁴⁶⁰

There were initially 10 health professions regulated by the National Law, which was later expanded to 14. A health ‘profession’ at law is only a health occupation that is regulated by the National Law, which defines ‘health professions’ as ‘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.⁴⁶¹

Paramedicine will become the 15th health profession regulated by the Act.

⁴⁵⁵ *Health Practitioner Regulation (Consequential Amendments) Bill 2010* (Cth) <
https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/2008-10/health_practitioner_reg/report/c01>

⁴⁵⁶ *Health Practitioner Regulation National Law Act 2009* (Qld) Schedule 1; *Health Practitioner Regulation National Law 2010* (ACT); *Health Practitioner Regulation National Law 2009* (NSW); *Health Practitioner Regulation National Law (National Uniform Legislation) Act 2009* (NT); *Health Practitioner Regulation National Law (South Australia) Act 2010* (SA) Schedule 2; *Health Practitioner Regulation National Law (Tasmania) 2010* (Tas); *Health Practitioner Regulation National Law 2009* (Vic); *Health Practitioner Regulation National Law 2010* (WA).

⁴⁵⁷ In NSW, the health professional councils work with the NSW Health Care Complaints Commission to assess and manage concerns about practitioners. In Queensland, the Office of the Health Ombudsman manages concerns about practitioners.

⁴⁵⁸ As per Divisions 3–12 of Part 8 of the *Health Practitioner Regulation National Law Act 2009* (Qld).

⁴⁵⁹ For example, *Health Practitioner Regulation National Law Act 2009* (NSW).

⁴⁶⁰ Constituted under the *Health Care Complaints Act 1993* (NSW).

⁴⁶¹ [s 5] Schedule *Health Practitioner Regulation National Law Act 2009* Part 1 Preliminary Page 32.

The coinciding of three elements—politics, problems and policy⁴⁶²—led to the introduction of regulatory reform, which has the benefit of providing paramedics with an opportunity to be regulated under a piece of legislation that, as outlined in Chapter 4, they believe will facilitate the professionalisation of paramedicine, most notably in giving them control over their own work.

5.3 The Structure of the Law

The NRAS commenced operations in June 2010 under the authority of the National Law. The NRAS established a single system for administering health professional education and training that abolished the previous system of state- and territory-based registration boards for each health profession. It also provided the regulatory framework that allows for the key healthcare workforce objectives to be met, including providing the mechanism by which health professions, other than medicine, could expand their role by enabling ‘innovation in the education of, and service delivery by, health practitioners’.⁴⁶³ This broadening of roles with respect to healthcare work is a critical and highly important element of the legislation because it supports the breakdown of traditional demarcation lines between the providers of healthcare that have limited flexibility and accessibility to care, and gives the professional privilege of self-regulation to all health professions governed by the Act. This is distinct from, for example, the UK model where medicine still enjoys its own legislation and regulatory regime separate from all other health professions.⁴⁶⁴ The significance of this is discussed further in Chapter 6.

Under the NRAS, all health practitioners are equally regulated. The law is designed to ensure that the scheme is able to meet its objectives of facilitating the development of a flexible and mobile workforce and allow for movement of workers beyond the traditional siloed domain of their speciality area. This would facilitate the objective of the legislation to extend access to healthcare by allowing professions to extend their traditional role into the professional domain of others. Freidson noted that this was traditionally something that

⁴⁶² John W Kingdon, *Agendas, Alternatives and Public Policies* (Pearson, 2nd ed, 2011); See also Fiona Pacey et al, ‘National Scheme for Health Practitioner Registration and Accreditation: The Case of Australia’ in Stephanie Short and Fiona McDonald (eds), *Health Workforce Governance: Improved Access, Good Regulatory Practice, Safer Patients* (Ashgate, 2012).

⁴⁶³ *Health Practitioner Regulation National Law Act 2009* (NSW) s 3 (2)(f).

⁴⁶⁴ See, eg, the General Medical Council established under the *Medical Act 1983* (UK) s 1.

the law protected against and provided one of the privileges of professional status—monopoly over practice.⁴⁶⁵ There is thus a risk to the unique identity and role of the health professions associated with the Australian legislation because it supports ‘flexibility’ and the generalisation of skills between groups. This could result in a loss of specialised knowledge and skills. Indeed this was fear of doctors when the legislation was drafted, with one saying ‘If the podiatry board independently said their members could operate on ankles ... the government could agree they have adequate training to do that’.⁴⁶⁶ There is also some evidence that although the legislation is designed to break down these traditional structural barriers between areas of work it is not able to do so completely. For example, nurse practitioners have experienced some challenges from medicine in attempting to expand their scope of practice and remain, to some extent controlled by medicine in this extended space.⁴⁶⁷ There is some suggestion however that this is slowly changing.⁴⁶⁸

While there appears to be an obvious benefit to broadening the scope of the practice of health professionals to help improve access to healthcare, there is a risk that the approach may make generalists of members of the healthcare workforce that should be specialists. In the case of paramedics, that is specialists in out-of-hospital emergency care. As outlined in Chapter 2, Freidson noted that professionalism regulation offers ‘flexibility’ of a kind not offered by bureaucratic and free market regulation; in the sense that it allows professionals to exercise their specialist knowledge, skill and discretion, informed by a moral duty to place patient before self. This type of flexibility is distinct from the flexibility afforded by generalising skillsets to broaden the numbers of members of the healthcare workforce who can undertake particular tasks. Rather than flexibility in this latter sense, it is instead cooperation between highly specialised workers that can deliver the benefits that the legislation is seeking to achieve.

⁴⁶⁵ Eliot Freidson, ‘The Reorganization of the Professions by Regulation’ (1983) 7(2/3) *Law and Human Behavior*. (Sep., 1983), pp. 279–290.

⁴⁶⁶ H Ferguson, ‘Regulation Threatens CPD Standards’ 14 November 2008 *Australian Doctor* <<http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22library%2Fjrnart%2FNLN3S6%22>>.

⁴⁶⁷ Clare Harvey, Andrea Driscoll, and Dirk Keyzer. ‘The discursive practices of nurse practitioner legislation in Australia.’ (2011) 67 (11) *Journal of advanced nursing*, 2478-2487; Clare Harvey. ‘Legislative hegemony and nurse practitioner practice in rural and remote Australia.’ *Health Sociology Review* 20.3 (2011): 269-280.

⁴⁶⁸ Lorna MacLellan, Isabel Higgins, and Tracy Levett-Jones. ‘Medical acceptance of the nurse practitioner role in Australia: a decade on.’ (2015) 27 (3) *Journal of the American Association of Nurse Practitioners*, 152-159.

The NRAS is administered by the AHPRA. AHPRA provides support to the national boards by administering the registration process, accepting and investigating complaints about professional conduct, performance or the health of registered health practitioners⁴⁶⁹ and working with the Health Care Complaints Commission in each state and territory to ensure community concerns are being appropriately dealt with. AHPRA provides material to the respective boards to be dealt with by a professional standards panel or a tribunal depending on the type and seriousness of the allegation made against a practitioner. The complaint will be investigated and if deemed to have substance will be sent to either a performance and professional standards panel to hear allegations of ‘Unsatisfactory professional performance’ or ‘Unprofessional conduct’; or to a tribunal for allegations of professional misconduct, the most serious allegation.⁴⁷⁰

The professional standards panel and tribunal are constituted differently. The panel is compiled of members from the respective profession and a community member with at ‘least half, but no more than two-thirds, of the members of the panel being persons who are registered health practitioners in the health profession for which the board is established’.⁴⁷¹ The ‘tribunal’, however, refers to an administrative tribunal or a court in any jurisdiction that is constituted.⁴⁷² For example, in Queensland it is the Queensland Civil and Administrative Tribunal.⁴⁷³ The most serious matters, namely professional misconduct matters, which carry the most significant consequence for the registrant—for example removal from the register—are heard by a tribunal.⁴⁷⁴ Panels and tribunals can find that a practitioner has no case to answer and no further action is taken. If, conversely, the panel or tribunal finds that the allegation is proved, there is a tiered approach to sanctions to ensure that the severity of the sanction is commensurate with the level of risk posed to the public or the profession by the practitioner. For example, it would not be appropriate for a practitioner to be struck off the register for a one-off error that does not fall substantially below the standard expected of a reasonable practitioner in circumstances and does not

⁴⁶⁹ Except in NSW, where this is undertaken by the Health Professional Councils Authority and the Health Care Complaints Commission and in Queensland where this is undertaken by the Queensland Health Ombudsman from 1 July 2014.

⁴⁷⁰ *Health Practitioner Regulation National Law Act 2009* (Qld) s 6.

⁴⁷¹ *Ibid* s 182 (4).

⁴⁷² *Ibid* s 5.

⁴⁷³ *Ibid* s 9.

⁴⁷⁴ *Ibid* s 190 (b).

demonstrate that the practitioner is not a ‘fit and proper person’ to hold registration. Only the tribunal can find a practitioner guilty of professional misconduct and that is the only finding that can result in a practitioner being removed from the register. This highlights the nature of professionalism regulation as a tool of occupational control as Freidson referred to it.⁴⁷⁵ Not only are health practitioners governed by employment, criminal and civil liability laws, as professionals they are governed by an additional layer of regulation, accountability and responsibility beyond other workers and that is overseen by their peer-group. This is a form of self-regulation in the sense that members of the profession judge other members (as distinct from their employer). As identified in Chapter 4, this form of regulation will be new for paramedics.

The National Law allows all health professions regulated by it to self-regulate via the national board.⁴⁷⁶ The primary role of the national board is to make decisions regarding the regulation of a profession in the public interest. The board does this by setting national registration requirements and standards and approving accreditation standards and qualifications for entry into the profession. The board is also responsible for overseeing various regulatory processes including registration. The board is responsible for the ‘receipt, assessment and investigation of complaint and other notifications’ about the practitioners they regulate. The National Law provides for a national board to establish state, territory and regional boards to exercise its functions in the jurisdiction in a way that provides an effective and timely local response to health practitioners and other persons in the jurisdiction. Some national boards have state, territory or regional boards in each jurisdiction; some have state boards and multi-jurisdictional regional boards; and others do not have state or territory boards. These boards make individual registration and notification decisions, based on national policies and standards set by the relevant national board. The national board delegates the necessary powers to the state, territory and/or regional boards.⁴⁷⁷ Once paramedics are regulated under the National Law they will establish their own board, the Paramedicine Board of Australia.

⁴⁷⁵ Freidson referred to this as ‘mandated collegial regulation’. Eliot Freidson, ‘The Reorganization of the Professions by Regulation’ (1983) 7(2/3) *Law and Human Behavior*, 281.

⁴⁷⁶ *Health Practitioner Regulation National Law Act 2009* (Qld) Part 5.

⁴⁷⁷ *Ibid.*

5.4 The Law, Professionalisation and Paramedic Professionalism

Freidson's sociological elements are common to a profession. Regulation under the National Law gives to an occupational group such as paramedicine either grants those elements (for example, by regulating title), or gives to the occupational group the power to grant those elements to themselves (eg self-regulation of code of conduct). It is argued that being regulated under the National Law will allow paramedics to become a profession as defined by Freidson. Table 2 below, highlights how the National Law will confer Freidson's criteria of a profession on paramedicine.

Table 2: Professionalisation-Professionalism Legal Correlation

The Freidson elements for a profession	National Law
Significant public service/unique purpose ⁴⁷⁸	Unique purpose upheld by title protection (s113)
Specialised knowledge and skills ⁴⁷⁹	Education & accreditation standards determined by Paramedicine Board (s5) and continuing professional development (s38)
Technical and moral authority becomes power ⁴⁸⁰	Establishment of a Paramedicine Board (s35)
Gain and maintain control over work (autonomy/self-regulation) ⁴⁸¹	Section 35 allows for the establishment of a Paramedicine Board that will have the power to determine conduct and competency standards, registration standards (s38), over-seas trained practitioner standards.
Regulation by professionalism (code of ethics) ⁴⁸²	Code of conduct (s41) and Paramedicine Board authorised to develop other guidelines, codes and policies to be 'used as evidence of what constitutes appropriate professional conduct or practice' and allows for disciplinary matters to be heard by peer-group (s182)

⁴⁷⁸ Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001) 59, 127, 217.

⁴⁷⁹ Ibid 32, 127.

⁴⁸⁰ Ibid 56, 127, 214.

⁴⁸¹ Ibid 55, 127, 198.

⁴⁸² Ibid 197, 214.

Paramedics in Australia have been lobbying to be self-regulated for over 10 years and to be regulated under the national scheme since its inception in 2009. As identified in Chapter 4, being regulated will allow them to:

- set minimum entry standards and training;
- formulate professional roles and standards to which individuals are expected to adhere;
- monitor individuals providing services;
- enforce professional roles where necessary;
- implement an effective complaints procedures; and
- implement a disciplinary procedure for individuals who are negligent or breach the professional code of practice.⁴⁸³

Regulation under the National Law will allow paramedics to achieve all these goals. In addition to helping paramedics to achieve these goals as set out in their ‘professionalisation’ project, the law also provides an important mechanism that allows paramedics, for the first time, to establish a culture and ethos of professionalism.

Each criteria is explored in more detail below.

5.5 Proposed Regulation: The National Law and Paramedics

Proposed amendments to the Act (contained in ‘the *Health Practitioner Regulation National Law Amendment Bill 2017*’) to include paramedics under the scheme are tabled to be passed through the Queensland Parliament in September 2017. The amendment will likely be adopted in all States and Territories. The law will authorise the national regulation of paramedics. The Ministerial Council will appoint paramedic members to a national board who have the relevant skills and experience in paramedicine to undertake the board’s

⁴⁸³ Gerry Fitzgerald and Ray Bange, ‘Defining a Regulatory Framework for Paramedics: A Discussion Paper’, (2007) 5(2) *Journal of Emergency Primary Health Care*. From a report prepared for ACAP, Brisbane.

functions.⁴⁸⁴ This will be referred to as the Paramedicine Board of Australia ('The Paramedicine Board'). The appointment of board members by the Ministerial Council is necessary because until 'the participation day' – the first day on which paramedics will be registered under the legislation - there will be no registered paramedics. The National Law allows that at least half, but not more than two-thirds, of the members of the national board *must* be practitioner members.⁴⁸⁵ The establishment of independent professional boards that are able to regulate their respective profession suggests that if paramedics are regulated by the National Law they will have an opportunity to attain elements of professionalisation as identified by the Freidson elements, and consistent with the trajectory identified by Wilensky, which they have yet to acquire, as identified in Chapter 2. This includes self-regulation, the power to set their own education and accreditation standards that reflects their unique purpose, specialist knowledge and skills and the development of a national code of conduct.

5.5.1 Protection of Title—Unique Purpose

The history of paramedicine demonstrates clearly their dominance and monopoly of the pre-hospital **emergency** care space and the Paramedicine Board of Australia should keep this in mind when trying to determine the identity of the profession and answer the question as to who, at law, is a paramedic. There are many other pieces of legislation that currently refer to and provide authority for 'ambulance officers', rather than paramedics, to act in particular ways. For example, in the ACT an 'ambulance officer' is authorised to store controlled medicines;⁴⁸⁶ under the *Mental Health Act 2007* (NSW), an 'ambulance officer' is someone authorised to perform the functions of an 'ambulance officer' as set out in the Act, which includes transporting a person whom they believe, on 'reasonable grounds', is 'mentally ill or disturbed' to a 'mental health facility' and that they may request 'police assistance' to do so.⁴⁸⁷ This is an enormous power to wield against vulnerable people and should therefore only be available to those who are suitably trained and qualified to do so.

⁴⁸⁸ Title protection is therefore useful and important because it relates not only to domain

⁴⁸⁴ *Health Practitioner Regulation National Law Act 2009* (Qld) s 33 (1)(2)(3).

⁴⁸⁵ *Ibid* s 33 (4).

⁴⁸⁶ *Medicines, Poisons and Therapeutic Goods Regulation 2008* (ACT) s 532.

⁴⁸⁷ *Mental Health Act 2007* (NSW) s 20.

⁴⁸⁸ For more discussion about this see Ruth Townsend and Morgan Luck, 'Protective Jurisdiction, Patient Autonomy and Paramedics: The Challenges of Applying the NSW *Mental Health Act*' (2009) 7(4) *Australian Journal of Pharmacy*; Ellen Bradley, Ruth Townsend and Michael Eburn, 'Paramedics and ACT Mental Health Legislation' (2015) 12(4) *Australian Journal of Pharmacy*.

protection and power but intersects with the issue of public protection. A lack of a protected title for paramedics means that anyone, qualified or not, can call themselves a paramedic without penalty and this poses a risk to patients and to the profession. Protecting the title of paramedicine was also seen as a way for the occupational group to gain control over who can and cannot enter the profession and thus use the title.

Regulation under the National Law will allow paramedics to protect the title ‘paramedic’. Title protection has already occurred in some Australian jurisdictions: NSW, South Australia and Tasmania⁴⁸⁹ and the inconsistencies between these jurisdictions supports the call for national regulation.⁴⁹⁰ For example, the prescribed qualifications in Tasmania to call oneself a ‘paramedic’ are different to those of South Australia. For example, in Tasmania the qualification is ‘a Bachelor of Paramedic Science,’⁴⁹¹ in South Australia the required qualification includes, ‘a Diploma or Advanced Diploma in Paramedical Science obtained prior to 1 February 2017 from a training organisation registered under the Training and Skills Development Act 2003 of the Commonwealth or a corresponding law.’⁴⁹² In NSW a person will be authorised to use the term ‘paramedic’ if they have either a Bachelor of Paramedicine, a Graduate Diploma of Paramedicine conferred by a university or a nationally-recognised Diploma of Paramedicine issued by a registered training organisation.⁴⁹³

Under the National Law, the Paramedicine Board will have to establish the minimum standard of qualification required to use the title ‘paramedic’. It is likely that this qualification will be a Bachelor of Paramedicine although there will likely be a ‘grand-parenting’ provision that will allow paramedics with Diploma-level qualifications (as currently recognised by South Australia and NSW) to become registered. This is because the bulk of paramedics currently working do not have a Bachelor-level qualification but the discipline is moving towards standardising this as a minimum level entry qualification for the profession. The National Law provides for title protection with high level fines able

⁴⁸⁹ *Health Practitioner Regulation National Law (South Australia) Act 2010* (SA) s 120A; *Ambulance Service Act 1982* (Tas) ss 3AB and 39A; and *Health Services Act 1997* (NSW) s 67ZDA.

⁴⁹⁰ Submissions to Health Workforce Principal Committee, AHMAC, *Options for Regulation of Paramedics*, 2012.

⁴⁹¹ *Ambulance Service (Paramedic) Regulations 2014* (Tas) reg 3.

⁴⁹² *Health Practitioner Regulation National Law (South Australia) Regulations 2010* (SA) s 11.

⁴⁹³ *Health Services Act 1997* (NSW) s 67ZDA.

to be applied to an individual (\$30,000) or a corporation (\$60,000) for ‘knowingly or recklessly’ taking or using a title that is protected by the section, ‘in a way that could be reasonably expected to induce a belief the person is registered under this Law’.⁴⁹⁴

In Australia currently, there are a number of titles used to describe the various types of paramedic roles including paramedic, intensive care paramedic, retrieval paramedic, general care paramedic and extended care paramedics.⁴⁹⁵ The primary issue of concern here is that multiple titles could cause confusion which has the potential to cause harm to patients and the profession. There is also the potential for this inconsistency to undermine the reputation of the group as a whole, and thus the political power and control of the group to effectively and efficiently do the job and to develop trust in the community.⁴⁹⁶

The National Law does not define what a paramedic does and how they are distinct from other health professionals regulated by the Act. However, the Paramedicine Board will have the power to define the term ‘paramedic’ and ‘paramedicine’ and describe what and who paramedics are; this is consistent with the Freidson criterion of professional self-regulation because it gives the discipline the opportunity to shape and control itself and its own work by establishing professional boundaries via title protection integrated with education and accreditation standards and a code of conduct, as to who paramedics are and what they do. The legislation supports ‘flexibility’ for professions to determine their own scope of practice via these various measures because the intention of the Act was to break down traditional silos of practice that were causing structural inefficiencies within the healthcare system. This will allow the Paramedicine Board to extend the scope of practice of paramedics to, for example, allow registrants to establish their own business or to work for private insurance companies providing GP house call-like services for the members of those insurance companies. This would be consistent with the maintenance of their specialist area of practice if they were responding to urgent, unscheduled or emergency calls. The Paramedicine Board may be tempted to utilise this regulatory power to extend

⁴⁹⁴ *Health Practitioner Regulation National Law Act 2009* (Qld) s 113.

⁴⁹⁵ Paramedics Australasia, ‘Paramedicine role descriptions.’ < https://paramedics.org/wp-content/uploads/2016/09/PRD_211212_WEBONLY.pdf>

⁴⁹⁶ Evan Willis and Liam McCarthy, ‘From First Aid to Paramedical: Ambulance Officers in the Health Division of Labour’ (1986) 10(1) *Australian and New Zealand Journal of Public Health* 57-67; Brian Brown, Paul Crawford, and Jurai Darongkamas, ‘Blurred roles and permeable boundaries: the experience of multidisciplinary working in community mental health.’ (2000) 8 (6) *Health & social care in the community* 425-435; Alison Leary, Katrina Maclaine, Paul Trevatt, Mark Radford, and Geoffrey Punshon. ‘Variation in job titles within the nursing workforce.’ (2017) *Journal of Clinical Nursing*.1-6.

its reach by registering those who provide non-emergency medical care, such as those that provide first-aid, non-emergency patient transport (NEPT) or even perhaps community paramedics. However, to do so may dilute the unique purpose and specialised knowledge and skills that sets paramedics apart from other health professions and undermine the profession's claim to moral and technical authority in their discrete practice domain.

Protection of the title is a method of acknowledging the importance and unique nature of paramedics and paramedicine, and providing the profession with an opportunity to clearly define who they are, what they do and what they stand for. Title protection is distinctly linked to recognising paramedics' specialised knowledge and skills and supports the technical and moral authority paramedics' claim over their work. Title protection is clear way in which the law can recognise and facilitate the professionalisation of paramedicine.

5.5.2 Education and Accreditation standards – Specialised Knowledge and Skills

With regard to accreditation, the national board will have the authority to determine whether accreditation of programs of study will be undertaken by an external accreditation entity or a committee established by the board.⁴⁹⁷ The way in which the accreditation function will be exercised by the respective body authorised to undertake it must be made public.⁴⁹⁸ The accreditation standard can be determined by the profession but must follow on from 'wide-ranging consultation' about the content of the standard.⁴⁹⁹ The board will have the authority to approve or refuse to approve the accreditation of a program of study.⁵⁰⁰ An accreditation standard is used to assess whether a program of study and the education provider of that program are able to provide students within the program with the 'knowledge, skills and professional attributes necessary to practise the profession in Australia'.⁵⁰¹ Paramedics have historically had and will continue to have (until the commencement of regulation under the National Law), their educational programs accredited by their employers. While it is likely that there will continue to be collaboration about industry needs and paramedic professional development needs, ultimately, the decision to accredit a particular educational program and credential will no longer be a

⁴⁹⁷ *Health Practitioner Regulation National Law Act 2009* (Qld) s 42.

⁴⁹⁸ *Ibid* s 45.

⁴⁹⁹ *Ibid* s 46.

⁵⁰⁰ *Ibid* s 47.

⁵⁰¹ *Ibid* s 5 Definitions 'accreditation standards'.

matter for the employer but for the paramedic profession itself to determine.⁵⁰² This is another way in which paramedicine will meet the Freidson elements for a profession—that they will undertake a prolonged period of training specific to their purpose, that will develop specialised knowledge and skills that will allow them to apply discretionary decision making in the best interests of the public.

As discussed in Chapter 2, paramedic training programs historically were conducted by employers or, more recently, a range of universities; this has resulted in a variety of differences in curriculum and in the qualification awarded. This provides some challenges for the national board, which will have to determine what the minimum standard of entry to the profession is going to be. It is likely that it will be a bachelor degree and, for the first three years of regulation under the National Law, it is likely that the board will develop a standardised core curriculum that sets out the minimum number and types of subjects that will need to be covered in an accredited paramedic course that will result in entry to the register. To accommodate the large numbers of practising paramedics who will not have as yet acquired that core qualification, there will be a ‘grand-parenting’ provision that will provide the existing paramedic workforce with an opportunity to gain that qualification.⁵⁰³

Control by the board of the requisite credential from an accredited institution not only formalises the particular kind of knowledge and skill claimed by the profession, it also provides the profession with the intellectual basis to make its jurisdictional claims in relation to other occupations. A university degree-level qualification is authoritative and provides a legitimacy to the value of the knowledge and work of the profession. It is a source of status, and status is a source of power.⁵⁰⁴ If nursing and medicine both require university degree-level qualifications to adequately teach the specialised knowledge and skills required to perform that work, then it is necessary for paramedicine to also seek to set a degree-level qualification as a minimum requirement for practise of the profession.

Despite these aims there is one significant limitation to the profession’s ability to self-regulate that was necessary to bring NSW into the scheme.⁵⁰⁵ The proposed Act will require

⁵⁰² Ibid s 47.

⁵⁰³ Ibid s 53.

⁵⁰⁴ Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001) 84.

⁵⁰⁵ *Health Practitioner Regulation National Law and Other Legislation Amendment Bill (Qld)* (13 Jun 2017) second reading speech <
<http://www.parliament.qld.gov.au/documents/tableOffice/BillMaterial/170613/Health.pdf>> 1543

the Paramedicine Board to recognise qualifications issued by the ASNSW as meeting the requirements for registration as a paramedic. This will mean that NSW graduates holding a Diploma of Paramedical Science, Diploma of Paramedical Science (Ambulance), Advanced Diploma of Paramedical Science (Ambulance), Diploma in Paramedical Science (Pre-Hospital Care) or Advanced Diploma Paramedical Sciences (Pre-Hospital Care) issued by the ASNSW will be registered regardless of the standards set by the Paramedicine Board for graduates in other jurisdictions. There are different expectations with respect to knowledge, skills and ability to act autonomously with respect to Australian Qualifications Framework level 4 and level 7 qualifications⁵⁰⁶ and this anomaly may potentially pose a risk to claims of professional status by paramedics because the professional itself is unable to establish the entry level qualification. As an aside it is interesting to note that ASNSW is a member of CAA who supported paramedics being regulated by the NRAS, but NSW Health opposed it on the grounds that if the profession set its own qualifications it would limit the ability of NSW Health to manage its own workforce.⁵⁰⁷

The creation of a training credential that is a prerequisite for entry to the profession is an element of occupational control common to professions.⁵⁰⁸ It establishes the defined set of tasks that are unique to the profession; that requires specialised knowledge and skills to understand and perform; and that provides the basis for the argument for self-regulation—that no-one but members of the profession are able to evaluate the work.

5.5.3 Moral and Technical Authority—Power

The specialised nature of paramedics' knowledge and skills, and their unique role, has provided them with the power to not only improve their pay and working conditions⁵⁰⁹ (as outlined in Chapter 3), but also to organise and lobby to be included in the NRAS and be

⁵⁰⁶ Australian Qualifications Framework Council, *Australian Qualifications Framework* (2nd ed, January 2013), pp. 12-13

⁵⁰⁷ NSW Health, Submission to Senate Legal and Constitutional Affairs Committee, Parliament of Australia, *The Establishment of a National Registration System for Australian Paramedics to Improve and Ensure Patient and Community Safety*, 2016
<https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Paramedics/Submissions>

⁵⁰⁸ Ibid 84.

⁵⁰⁹ *Transport Workers Union v Department of Justice and Community Safety* (unreported Determination, Fair Work Australia, Commissioner Deegan, 29 March 2010)
<<http://www.fairgo.com/docs/FWA2010decision.pdf>>.

regulated by the National Law⁵¹⁰ (see Chapter 4). Being regulated by the National Law is evidence that paramedics have demonstrated via a number of routes that they are a group that do hold moral and technical authority as a result of their specialised knowledge and skills and unique role, and should therefore be granted the power to self-regulate. Freidson noted that the power to self-regulate is awarded to those occupations that can demonstrate that their specialised knowledge and skill is of such special value that it is important for the ‘well-being of individuals or of society at large’.⁵¹¹ That technical and moral authority is a power that can and is used by the professions to lobby for their own interests, but can also be a power used for and against their patient’s interests. The practice of professionalism seeks to mitigate against the latter concern.

Paramedics’ specialised knowledge and the nature of paramedic work is such that patients are not able to always understand it or accurately assess it. This, in itself is a power because patients must ‘place naïve trust’ in the paramedics who treat them.⁵¹² This issue is particularly acute in paramedic work because they work with extremely vulnerable patients (often unconscious) and with little oversight by others. This position of power requires paramedics to act with professionalism – to not abuse trust, to act with integrity and to put the patient’s interests before others. This is perhaps the best example of the way in which the acquisition of the power to self-regulate by an occupational group on the basis that they have specialised knowledge and skills that are unknowable by others but upon which others are dependent, is only worth something if it is applied responsibly in the interests of those who depend on it. In other words, this is the point at which an occupational group fully professionalises because it represents a synthesis of the process of professionalisation with the exercise of professionalism. Although ‘professionalism’ per se is not prescribed within the National Law, some elements of professionalism are codified within it.

For example, there are provisions within the National Law that ensure that only those practitioners possessing the necessary professional skills to competently and safely practise the profession (technical authority) *and* who have the necessary character and are deemed

⁵¹⁰ AHMAC, *Final Report: Options for the Regulation of Paramedics* (September 2015) Appendix 8: Written Submissions to the National Consultation

<<http://www.coaghealthcouncil.gov.au/Portals/0/Paramedics%20Decision%20RIS.pdf>>.

⁵¹¹ Eliot Freidson, *Professionalism Reborn: Theory, Prophecy and Policy* (Polity Press, 1994). 200-201.

⁵¹² *Ibid.*, 200-201.

a 'suitable person' to hold registration as a health professional (moral authority), are admitted to the profession.⁵¹³ Who is a 'suitable person' is determined by the board. The legislation provides a list of those who are unsuitable for registration as a health professional including a person that has an impairment that may place the public at risk;⁵¹⁴ that it is not in the public interest to have a person with a particular criminal history on the register;⁵¹⁵ that the prospective registrant is not competent in communicating in English;⁵¹⁶ that the qualification of the prospective registrant is not adequate, or that the prospective registrant fails to meet the 'nature, extent, period and recency of practice requirements' to an approved standard;⁵¹⁷ or the person in the board's opinion, is 'not a fit and proper person for general registration'⁵¹⁸ or is 'unable to practise the profession competently and safely'.⁵¹⁹

The term 'fit and proper' person is largely subjective and has no precise legal meaning. The NSW Supreme Court has determined that the concept of 'fit and proper' involves three elements: honesty, knowledge and ability.⁵²⁰ In essence, a practitioner must have the knowledge, skills and character to practise their profession safely and effectively; but it extends further to encompass the way in which an individual practitioner's behaviour may affect the public's perception and confidence in the profession. The National Law allows for the 'conduct of the practitioner, *whether occurring in connection with the practice of the health practitioner's profession or not*',⁵²¹ to be examined when determining whether or not a practitioner is a fit and proper person to hold registration. This is designed to ensure a maintenance of public trust in the system that those admitted to the register are honest and trustworthy and someone in whom the public and other professionals may therefore have confidence.⁵²² This element of trustworthiness is consistent with the Freidson element of professionalism. Again, it is a matter for the Paramedicine Board to determine whether a practitioner is likely to be a 'fit and proper person' to practise as a paramedic and be

⁵¹³ *Health Practitioner Regulation National Law Act 2009* (Qld) s 52.

⁵¹⁴ *Ibid* s 55(a).

⁵¹⁵ *Ibid* s 55(b).

⁵¹⁶ *Ibid* s 55(d).

⁵¹⁷ *Ibid* s 55(f).

⁵¹⁸ *Ibid* s 55(h)(i).

⁵¹⁹ *Ibid* s 55(h)(ii).

⁵²⁰ *Hughes & Vale Pty Ltd v New South Wales* (No. 2) (1955) 93 CLR 127, CJ Dixon, JJ McTiernan and Webb decided [at 156].

⁵²¹ *Health Practitioner National Law Act 2009* (Qld) s 5 (emphasis added).

⁵²² *Edelsten v Medical Practitioners Board (Vic)* [2000] VSC 565, 36.

allowed entry to the profession. The power of the Board to make determinations as to who can and cannot represent the profession is another example of self-regulation.

5.5.4 Self-regulation

In the academic literature the term ‘self-regulatory’ has referred to a broad mix of regulatory arrangements including the level of state involvement, the formality and degree to which arrangements are enforced, the level of autonomy exerted over a particular area of regulated activity and the level of regulation of social behaviour.⁵²³ There is no such thing as true self-regulation of professions because ultimately the state determines which groups have the power to self-regulate and which do not. However, a degree of self-regulation does exist in the National Law because it will authorise the establishment of a Paramedicine Board.⁵²⁴ The law will authorise the Paramedicine Board—not their employers of paramedics as has traditionally been the case—to make decisions about the profession, including education and practice standards that reflect the unique purpose and specialised knowledge and skills common to paramedics; disciplinary standards that reflect the conduct expected of a paramedic; and the power to determine who enters, and to some extent exits, the profession.

The functions of the Paramedicine Board are set out in section 35 of the Act and were discussed above⁵²⁵ but in short the National Law will give paramedicine the opportunity to determine who will be deemed suitably qualified and competent to enter the profession. With the assistance of AHPRA the board will maintain a publicly accessible register of registered paramedic practitioners. It will be authorised to impose conditions on registration; to decide the requirements for registration and registration standards for approval by the Ministerial Council; to develop or approve standards, codes and guidelines for the profession including approval of accreditation standards; to accredit programs of study to provide suitable qualification for registration in the profession; to assess the knowledge and skills of overseas applicants for registration; to receive notifications about persons who are registered with the profession (including students) and who are subject to conduct hearings on health, performance and professional standards; to establish panels to deal with conduct and performance issues and to refer matters to respective tribunals for

⁵²³ Anthony Ogus, ‘Rethinking Self-regulation’ (1995) 15 *Oxford Journal of Legal Studies* 97–108.

⁵²⁴ *Health Practitioner Regulation National Law Act 2009* (Qld) s 33 (4).

⁵²⁵ *Ibid* s 35.

hearing (with the exception that complaints handling and disciplinary functions in Queensland and NSW will be undertaken by their respective co-regulatory mechanisms); to manage registered practitioners who have conditions or undertakings on their registration; to provide financial or other support for health programs for registered practitioners and students; and to make recommendations to the Ministerial Council about specialist recognition and to give advice to the Ministerial Council about issues related to national registration and accreditation. These are all elements of being an autonomous profession able to regulate itself by setting its own standards—which paramedics, until they commence under the national regulatory scheme, are unable to do.

A registration standard is distinct from an accreditation standard. With regard to the registration standards (section 38), the national board must develop and recommend to the Ministerial Council registration standards; that is, what is required for a practitioner to be registered with the profession, with relation to professional indemnity insurance,⁵²⁶ matters of criminal history of applicants for registration and whether an individual’s criminal history is relevant to the practice of the profession,⁵²⁷ the requirements for continuing professional development,⁵²⁸ minimum English language skill requirements for registration,⁵²⁹ and requirements in relation to the ‘nature, extent, period and recency of any previous practice of the profession by applicants for registration’.⁵³⁰ ‘Recency of practice’ as the health practitioner having “maintained an adequate connection with, and recent practice in the profession since qualifying for, or obtaining registration.”⁵³¹ The recency of practice provision developed by the Paramedicine Board may be important in determining who can be registered as a paramedic. There may be paramedics who hold the required qualification but who have not practiced as paramedics for a lengthy period of time. The Board will have the power to determine the requisite amount of time in hours for example, that is required to be met to show ‘recency’ of practice. This will be an element of determining who can enter the profession and be listed on the register. Determining entry to the profession is a core self-regulatory element common to all

⁵²⁶ Ibid s 38 (1)(a).

⁵²⁷ Ibid s 38 (1)(b).

⁵²⁸ Ibid s 38 (1)(c).

⁵²⁹ Ibid s 38 (1)(d).

⁵³⁰ Ibid s 38 (e).

⁵³¹ AHPRA, ‘Recency of practice.’ < <http://www.ahpra.gov.au/Registration/Registration-Standards/Recency-of-practice.aspx>>

health professions⁵³² and this will allow paramedicine to remove itself from the control of ambulance services who have previously made determinations as to who and who is not a paramedic.

The Paramedicine Board will also have the power to develop a registration standard with regard to the physical and mental health requirements for registration of practitioners⁵³³ and the suitability of individuals to competently and safely practise.⁵³⁴ This is an important element of professionalism that paramedics have not, until now, had to consider. The National Law sets out mandatory notification requirements for health practitioners suffering from an impairment or a lack of knowledge, skill or judgement that may cause the practitioner to practice ‘below the standard reasonably expected.’⁵³⁵ This notification may be voluntary,⁵³⁶ it may be made by an employer,⁵³⁷ or by another health practitioner⁵³⁸ or by an education provider.⁵³⁹ There have been several issues raised by other health practitioners about the way in which the mandatory notification provisions should operate because it raises concerns about the way in which practitioners who become patients should be managed.

As established in earlier chapters of this thesis, paramedics are specialist emergency service workers who are routinely exposed to high-risk and high-stakes situations in uncontrolled and unobserved environments. This places them at high risk of developing mental health conditions.⁵⁴⁰ Under the National Law, the Paramedicine Board will be authorised to develop mandatory reporting guidelines that help individual paramedics decide whether they need to make a mandatory notification to the Board or not. It is likely that the Board will adopt the generic guidelines already developed by AHPRA and adopted by all National Boards.⁵⁴¹ A range of studies have discussed the mental health risks and mandatory

⁵³² Eliot Freidson, *Professional Dominance: The Social Structure of Medical Care* (Transaction Publishers, 1970).

⁵³³ *Health Practitioner Regulation National Law Act 2009* (Qld) s 38 (2)(a).

⁵³⁴ *Ibid* s 38 (c).

⁵³⁵ *Ibid* s144 (1)(b).

⁵³⁶ *Ibid* s144.

⁵³⁷ *Ibid* s142.

⁵³⁸ *Ibid* s141.

⁵³⁹ *Ibid* s143.

⁵⁴⁰ Paramedics Australia Mental Health and Wellbeing Special Interest Group <<https://www.paramedics.org/mental-health-wellbeing/>>.

⁵⁴¹ AHPRA, ‘*National Board guidelines for registered health practitioners, Guidelines for mandatory notifications.*’ March 2014, <<http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines/Guidelines-for-mandatory-notifications.aspx>>

reporting requirements embedded in the National Law⁵⁴² because the requirements raise a potential for professional conflicts to arise between competing duties. For example, practitioners have an obligation to maintain patient confidentiality but also a duty to report practitioners they believe may place patients at risk because of their own impairment. This potentially creates a tension between the treating practitioner's duty to their patient and their duty to the safety of the public and it is regarding this point that a number of health practitioners and their representative bodies have raised concerns. There is some suggestion that mandatory reports of mental illness to the respective health practitioners' board have been made vexatiously or unnecessarily, serving only to increase problems such as anxiety that have not reached the level of endangering public safety and this has resulted in some lobbying to have the law changed.⁵⁴³

However, at this time the law remains that a notification to the National Board should be made *only* when a reasonable belief is formed⁵⁴⁴ that the practitioner–patient has behaved in a way that constitutes notifiable conduct,⁵⁴⁵ which means that the practitioner–patient's impairment 'affects or is *likely to detrimentally affect* ... the person's capacity to practice the profession.'⁵⁴⁶ Monitoring of a paramedic's own or a colleague's mental health has not

⁵⁴² Elise Worthington and Paige MacKenzie, *Doctor Suicides Prompt Calls for Overhaul of Mandatory Reporting Laws* ABC 730 Report <<http://www.abc.net.au/news/2017-04-13/doctor-suicides-prompt-calls-for-overhaul/8443842>>; 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; Marie M Bismark et al, 'Reporting of Health Practitioners by Their Treating Practitioner under Australia's National Mandatory Reporting Law' (2016) 204 (1), *Medical Journal of Australia*; 24; Avant Position Paper on Mandatory Reporting (2015) and Beyondblue are currently conducting a study called *National Mental Health and Wellbeing Study of Police and Emergency Services* <<https://www.headsup.org.au/news/2017/04/26/measuring-police-and-emergency-services-workers-wellbeing-at-work>>.

⁵⁴³ Elise Worthington and Paige MacKenzie, *Doctor Suicides Prompt Calls for Overhaul of Mandatory Reporting Laws* ABC 730 Report <<http://www.abc.net.au/news/2017-04-13/doctor-suicides-prompt-calls-for-overhaul/8443842>>; 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; Marie M Bismark et al, 'Reporting of Health Practitioners by Their Treating Practitioner under Australia's National Mandatory Reporting Law' (2016) 204 (1), *Medical Journal of Australia*; 24; Avant Position Paper on Mandatory Reporting (2015) and Beyondblue are currently conducting a study called *National Mental Health and Wellbeing Study of Police and Emergency Services* <<https://www.headsup.org.au/news/2017/04/26/measuring-police-and-emergency-services-workers-wellbeing-at-work>>. For a more comprehensive discussion of this issue see Gabrielle Wolf, 'Compelling Safety: Reforming Australian Treating Doctors' Mandatory Reporting Obligations' (2017) 39 *Sydney Law Review* 199.

⁵⁴⁴ '[T]he assent of belief is given on more slender evidence than proof. Belief is an inclination of the mind towards assenting to, rather than rejecting, a proposition': *George v Rockett* (1990) 170 CLR 104.

⁵⁴⁵ *Health Practitioner Regulation National Law Act 2009* (Qld) s 140.

⁵⁴⁶ *Health Practitioner Regulation National Law Act 2009* (Qld) s5.

previously been a mandatory requirement for paramedics but it will become a matter of professionalism that they will need to become aware of once they become registered under the National Law.

The Paramedicine Board will also have the power to develop a scope of practice for practitioners.⁵⁴⁷ This is a critical element for the Board in shaping the future of the profession because it clearly sets out the unique and specialised knowledge and skills required to be registered paramedic. This is what distinguishes paramedics from other health practitioners and establishes the professional boundaries of paramedicine. The National Law does not allow Boards to set unreasonable standards of practice or work without limits because the underlying principle of compliance with the regulation is patient safety. This means that a Board must set a scope of practice for the profession that is consistent with their specialised knowledge and skills. However, there is provision within the National Law for a Board to establish a scope of practice beyond what might be considered the traditional scope for the profession. This is because a purpose of the law is to increase health workforce flexibility. However, this must be weighed against another objective of the law which is to ensure the public is treated by practitioners who are suitably qualified and have the skills necessary to do so competently and safely. If an area of practice of a profession results in poor patient outcomes there are provisions within the law that give the Health Ministers' Council the authority to issue a 'please explain' to that particular discipline. This has occurred last year when the Ministers agreed to ask for information from the Chiropractors Board of Australia and the Australian Health Practitioner Regulation Agency (AHPRA) about the evidence for chiropractic treatments that may be inappropriate and unsafe for patients.⁵⁴⁸

The self-regulatory nature of the legislation will allow the Paramedicine Board to run its own accountability systems, including complaints and discipline systems. Peer review is a fundamental element of professional practice because it allows for acceptance of the specialisation and expertise of the professional group. This peer-to-peer disciplinary process is also consistent with the Freidson elements of self-regulation, which supports the notion that any assessment of specialised knowledge and skill or conduct of the unique

⁵⁴⁷ Ibid s 38 (2)(b).

⁵⁴⁸ See COAG Health Council incorporating the Australian Health Workforce Ministerial Council Communique 7 October 2016

nature of the profession can only be assessed by others who hold that same knowledge and skill and have knowledge of the profession's role, purpose and values. The National Law will allow paramedics, for the first time, to undertake peer-to-peer review of conduct and performance. There are several categories of unprofessional conduct and performance classified under the National Law:⁵⁴⁹ 'Unsatisfactory professional performance', 'Unprofessional conduct' and 'Professional misconduct'. The National Law states that:

These three categories of unprofessional behaviour clearly outline the way in which a health professional should behave. They should practice with:

the knowledge, skill or judgment possessed, or care exercised by, the practitioner ... to a standard reasonably expected of a health practitioner of an equivalent level of training or experience.⁵⁵⁰

The standard of a 'reasonable paramedic' at law is determined by an objective test whereby the court considers what skills and knowledge a person professing to be a paramedic might have and what actions they may take when faced with similar circumstances to those experienced by the paramedic in question. The court or Tribunal will call other paramedics ('expert witnesses') to give their opinion as to whether or not the actions taken by the paramedic in question were reasonable under the circumstances.⁵⁵¹ This is known as the *Bolam* principle because it was articulated in that case by McNair J who said,

...the test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well established law that it is sufficient if he exercise the ordinary skill of an ordinary competent man exercising that particular art.⁵⁵²

⁵⁴⁹ *Health Practitioner Regulation National Law Act 2009* (Qld) s 6.

⁵⁵⁰ *Ibid* s 6.

⁵⁵¹ *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

⁵⁵² *Ibid* 586-587.

This principle has in part been modified and codified in Civil Liability law around Australia.⁵⁵³ For example, the *Civil Liability Act 2002 (NSW)*⁵⁵⁴ says,

(1) A person practising a profession (“a professional”) does not incur a liability in negligence arising from the provision of a professional service if it is established that the professional acted in a manner that (at the time the service was provided) was widely accepted in Australia by peer professional opinion as competent professional practice.

The standard of a ‘reasonable paramedic’ will therefore be determined by the peer group and will be supported by material contained in educational curricula, codes of conduct, clinical practice guidelines, textbooks and from disciplinary conduct Tribunal and Committee hearings. Whether a person is practising as a paramedic is not the legal test as to the standard of a reasonable paramedic, rather it is that the practitioner practises to a standard widely accepted by their peers as the practice that a reasonable paramedic would undertake in similar circumstances. In order to ensure that the identity of a paramedic is clear and distinct from other registered and non-registered health practitioners, the Paramedicine Board should set out a clear description of the type of work, knowledge, skills and conduct that is expected of a paramedic.

The legislation does not explicitly set out the characteristics, skills and knowledge that make a healthcare practitioner a ‘professional’. It does, however, set out what is NOT acceptable professional behaviour and from this we can deduce what professional behaviour *is*. The definition of ‘unprofessional conduct’ is the same in all jurisdictions with the exception of NSW which uses the term ‘unsatisfactory professional conduct’. The type of conduct that would be ‘unsatisfactory’ (in NSW) or ‘unprofessional’ (in the other states and territories) include:-

- (a) Engaging in conduct that is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience;
- (b) A contravention of the National Law or regulations;

⁵⁵³ *Civil Liability Act 2002 (NSW)*s50; *Civil Liability Act 2003 (Qld)*s22; *Civil Liability Act 1936 (SA)* s41; *Civil Liability Act 2002 (Tas)*s22; *Wrongs Act 1958 (Vic)*s59; *Civil Liability Act 2002 (WA)*s5PB; *Civil Law (Wrongs) Act 2002 (ACT)*.

⁵⁵⁴ S50.

- (c) A contravention of conditions of registration or undertaking given to the National Board;
- (d) Failure to complete with a decision or order of a committee or Tribunal in relation to the practitioner;
- (e) Accepting a benefit for referral or recommendation to a health service provider as an inducement or reward
- (f) Accepting a benefit for recommendation of a health product as an inducement or reward
- (g) Offering a benefit for a referral or recommendation as an inducement or reward
- (h) Failing to disclose a pecuniary interest when making a referral or recommendation to use a health service or product;
- (i) Engaging in over servicing;
- (j) Allowing a non-registered assistant to attend or treat a patient in matters requiring professional discretion or skill;
- (k) Other improper or unethical conduct relating to the practice of the practitioner's profession.⁵⁵⁵

In short, the National Law sets out that a professional would not contravene conditions or undertakings imposed on their registration;⁵⁵⁶ be convicted of an offence 'the nature of which may affect the practitioner's suitability to continue to practise the profession';⁵⁵⁷ provide a person with health services that are 'excessive, unnecessary or otherwise not reasonably required for the person's well-being';⁵⁵⁸ act in a way that would compromise patient care;⁵⁵⁹ or accept or offer an inducement related to a health service.⁵⁶⁰ A paramedic

⁵⁵⁵ *Health Practitioner Regulation National Law 2010*(ACT)s 5; *Health Practitioner Regulation National Law* (No 86a) (NSW) s139B; *Health Practitioner Regulation National Law 2009* (NT) s5; *Health Practitioner Regulation National Law Act 2009* (Qld), Schedule, s5; *Health Practitioner Regulation National Law (South Australia) Act 2010* (SA) Schedule 2, s5; *Health Practitioner Regulation National Law (Tasmania) No 2A of 2010* (Tas) s5; *Health Practitioner Regulation National Law 2009* (Vic) s5; *Health Practitioner Regulation National Law 2010* (WA) s5. With the exception of NSW that uses the term 'unsatisfactory professional conduct' where other jurisdictions use the term, 'unprofessional conduct'. The definition of unprofessional conduct and unsatisfactory professional conduct is set out in the respective sections listed above.

⁵⁵⁶ *Ibid* s 5 (a)(b).

⁵⁵⁷ *Ibid* s 5 (c).

⁵⁵⁸ *Ibid* s 5(d).

⁵⁵⁹ *Ibid* s 5(e).

⁵⁶⁰ *Ibid* s 5 (f)(g)(h).

regulated under the Act must be competent in their work according to standards set and assessed by their peers, they must be law abiding, they must keep their promises, they must put the patients' and public health services' interests ahead of their own, they must not take bribes or be corrupted, they must not avoid or abdicate their professional responsibilities to a non-professional and they must act ethically. To act in this way is to act with professionalism.

There is a significance in the fact that the terms used in professional disciplinary matters use the term 'professional' to describe the behaviour being judged. For most part, issues of unprofessional conduct to one degree or another focus on issues of behaviour rather than technical issues. 'Professionalism' in terms of the application of the behaviours listed in the legislation (above) is about behaviour that can be observed more than it is about something less objective, like a practitioner's 'attitude'. It has been described as a 'performative element' of professional identity suggesting that professionalism is an action.⁵⁶¹ Professionalism issues may not be captured by competency testing. Professional conduct and professional competency are two different but sometimes related elements of a professional's practice. It should be noted that paramedic participants—among other health professionals—in a UK study on professionalism suggested that 'being a professional' and being part of a 'profession' influenced their behaviour at work and, for some, beyond work (an issue that is particularly relevant in the social media age and is discussed further in Chapter 7).⁵⁶² This suggests that the sociological construct of 'professions' and 'professional status' and 'professional power' is something tangible, that the title itself and the historical association of the term 'professional' with moral behaviour has the power to shape the behaviour of those who consider themselves to be professionals. The link between behaviour both inside and outside of work is consistent with the regulatory mechanism, which has the power to take account of both.⁵⁶³

Although there is no paramedic data in the Australian regulatory context that would provide an indication of what type of behaviour might constitute unprofessional conduct, there is

⁵⁶¹ HCPC, *Professionalism in Healthcare Professionals* <<http://www.hpc-uk.org/assets/documents/10003771ProfessionalismInHealthcareProfessionals.pdf>>.

⁵⁶² Ibid 17.

⁵⁶³ For example, professional misconduct (c) shown above includes 'conduct of the practitioner, whether occurring in connection with the practice of the health practitioner's profession **or not**, that is inconsistent with the practitioner being *a fit and proper person* to hold registration in the profession' (emphasis added). This usually applies to the practitioner who has been charged with an indictable offence and found guilty; for example, of illegal drug possession, use or supply.

data from professions who practice similar skills in Australia, namely nurses and doctors. Behaviour that has been deemed to be unprofessional conduct and/or professional misconduct by doctors and nurses includes inadequate or inappropriate testing or investigations or treatment, inadequate, inaccurate, misleading documentation/ health records; missed, incorrect or delayed diagnosis or referral, communication in a disrespectful manner, inappropriate prescribing; inaccurate prescribing; failure to cooperate with the investigation, breach of undertaking, inappropriate sexual comments and inappropriate sexual conduct; unacceptable breach of confidentiality; inappropriate collection, use or disclosure of patient information, failure to provide adequate or accurate information, failure to assess patient's capacity to consent, inappropriate sexual or aggressive behaviour, assault, failure to disclose or properly manage a conflict of interest and having a health impairment that put the public at risk.⁵⁶⁴ These behaviours have one element in common and that is that they have all resulted from a failure of the health practitioner to put their patient's interest first. Putting the patient's interest first is at the heart of professionalism. There is nothing to suggest that some paramedics will not also engage in some of these behaviours. It will be necessary for the Paramedicine Board to ensure that professionalism, and patient-centred care, is incorporated throughout the paramedic curriculum so that a culture and ethos of professionalism in paramedicine is developed.⁵⁶⁵

The tiered mechanism offered by the National Law scheme to allow degrees of breaches of professionalism to be identified and dealt with according to the severity of the breach. It also offers an opportunity for regulators to alert poor performers to issues with their behaviour; allows the regulator to continue to monitor practitioners' performance;⁵⁶⁶ and gives practitioners an opportunity to learn and to change poor behaviour without suffering the loss of their career. Being regulated according to a set of behavioural standards as set out in the National Law and adjudicated by a panel of peers or a tribunal, is a form of regulation that paramedics have not hitherto experienced.

⁵⁶⁴ AHPRA Panel Decisions 2012-2013 <http://www.ahpra.gov.au/Publications/Panel-Decisions.aspx>

⁵⁶⁵ Ruth Townsend and Morgan Luck, *Applied Paramedic Law and Ethics* (Elsevier, 2013).

⁵⁶⁶ For example, recent amendments to the law allow a disciplinary panel to set a timeframe within which the practitioner is monitored and able to meet the terms of remediation as set out by the panel.

The mechanism allows for a set of fundamental standards that still allows each profession regulated by them to apply an understanding of the context and particularities that are unique to the role and responsibilities of each profession in their judgement as to whether a member of the profession fell below the required standard. A study⁵⁶⁷ in the UK found that ‘professionalism’ is ‘context specific’ and ‘dynamic’, recognising that a static, inflexible generic set of ‘rules’ that govern behaviour would not allow for the application of professionalism in healthcare. This is consistent with the distinction between professionalism as a form of regulation and other forms such as bureaucratic regulation that promote conformity and rules as a means of control, which is distinct from the laissez-faire, less-regulation-is-better approach of free markets. The biggest challenge facing paramedics in Australia is determining what their standards of behaviour are or will be. In knowing what the standard of a ‘reasonable paramedic’ is, it is critical that paramedicine first defines what a paramedic is. This is still unclear but the development of a code of ethics will help.

As noted above, either a performance and professional standard panel or a tribunal will hear the case. Panels and tribunals are independent of national boards and are made up of a range of members, including members from the practitioner’s own profession, a non-health practitioner (usually a community member). The importance of having an adjudication panel made up of members of the peer group is seen as being critical to the effectiveness of the process as a way of reforming professional behaviours. The experience in the UK, where professional conduct panels do not necessarily include members of the same profession as the practitioner being judged, has resulted in some pushback from practitioners who claim that there is a risk that their context-specific decision making will be misunderstood.⁵⁶⁸ There is some evidence to support this, as discussed further in the next chapter. The Australian regulatory model has the advantage of allowing the specialised knowledge and skills and unique role of each health profession to be considered in professional disciplinary issues within the context of consideration of the risks posed by a practitioner’s behaviour to the public. The legislative framework allows for the particularities of each unique profession’s practice to be assessed by members of that profession. This allows for the differences between the behaviour of a paramedic working

⁵⁶⁷ HCPC, *Professionalism in Healthcare Professionals* <<http://www.hpc-uk.org/assets/documents/10003771Professionalisminhealthcareprofessionals.pdf>>.

⁵⁶⁸ HCPC, *Professionalism in Healthcare Professionals* 21 <<http://www.hpc-uk.org/assets/documents/10003771Professionalisminhealthcareprofessionals.pdf>>.

under a high-pressure, time-critical situation in an uncontrolled external environment and those of a chiropractor working in a low-risk, non-time-critical, internal, controlled environment, to not just to be taken into account, but taken into account by those who have an experiential understanding of what it is to work in such a way. This principle of peer-determined and assessed standards of practice is consistent with civil law provisions in each state and territory that rely on the same legal standard.⁵⁶⁹ This differs from the professional disciplinary process in the UK that does not rely on peer-to-peer assessment or adjudication. This is discussed further in the next chapter.

5.5.5 Code of Ethics

Freidson argues 'professionalism' is based on professions claiming both a technical and moral authority to their work. Professions claim they hold knowledge and skill that is so specialised and of such special value to the public or state that only they can understand and assess it and they should therefore be granted the power to regulate themselves and apply their knowledge and skills with discretion.⁵⁷⁰ Freidson argues further that the application of discretionary decision-making is essential to ensure that services are able to be adapted to meet individual needs and is what makes the professionalism model of regulation distinctly different from and more suitable to healthcare than a bureaucratic model.⁵⁷¹ Additionally, he argues that the placing the patient's needs and benefits before the practitioner's is 'the soul of professionalism' and what distinguishes the professional from the non-professional categorising those practitioners who do not exercise professionalism as merely 'technicians'.⁵⁷² This discretionary power is given to professionals on the basis that professionals will not abuse it and that they will utilise their special knowledge and skills for the public good. This discretionary power is not limitless and a codes of ethics can serve to provide guidance to practitioners on the boundaries of that power. Codes are designed to 'complement regulations embodied in law' by providing guidance to practitioners as to how to manage particular aspects of their specialised work.⁵⁷³ Codes of ethics not only reflect the values of a profession but also prescribe and

⁵⁶⁹ See civil liability laws in each state and territory.

⁵⁷⁰ Eliot Freidson, *Professionalism Reborn: Theory, Prophecy and Policy* (Polity Press, 1994). 213.

⁵⁷¹ *Ibid*, 194.

⁵⁷² Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001).

⁵⁷³ Eliot Freidson, *Professionalism Reborn: Theory, Prophecy and Policy* (Polity Press, 1994). 214.

proscribe the specific actions of individuals and professional organisations. An additional purpose of a code of ethics is to instil public trust that a profession will act in accordance with a particular set of values. A code of ethics may be incorporated into a code of conduct that provides a ‘detailed description of the specific actions that are to be performed and not performed under given conditions, and of the sanctions that attach to non-performance’.⁵⁷⁴ For the remainder of this thesis, the terms ‘code of ethics’ and ‘code of conduct’ may be used interchangeably.

Codes of ethics are not just rules that prescribe what actions should or should not be performed, they should also aim to establish cultural standards of character and attitudes, like compassion, expected of a member of a professional group. For example, under the National Law, the national board may develop and approve codes and guidelines that will provide guidance to paramedics about the values and behaviours expected of the profession and individuals registered to practise the profession.⁵⁷⁵ Section 40 of the Act requires that the codes/guidelines be developed after ‘wide-ranging consultation’ has taken place.⁵⁷⁶ Miller argued that not only should members of the group be involved in consultation regarding the basic principles and ideals, but that the group should research the ethical problems that have confronted members to ensure these problems are adequately addressed by the code.⁵⁷⁷ Section 41 of the Act provides that these codes/guidelines can be admissible in legal proceedings against a registered paramedic ‘as evidence of what constitutes appropriate professional conduct or practice for the health profession’.⁵⁷⁸

The code of conduct has a wider benefit in that it allows the profession to list its values and the way in which it defines itself. The nature of the exchange between the paramedic and the patient means it most commonly occurs during a time of crisis for the patient. The patient has experienced some sort of event that has prompted them, or someone else, to call for help. The paramedic meets the patient for the first time in a circumstance where they are unlikely to engage in normal social introductions. The patient is likely to expose some intimacy of information and or physical self that they would normally only show to a very

⁵⁷⁴ Seumas Miller, *Model Code of Ethics Principles*. Professional Standards Council
<<https://www.psc.gov.au/sites/default/files/Model%20code%20of%20ethics%20principles.pdf>>.

⁵⁷⁵ *Health Practitioner Regulation National Law Act 2009* (Qld) s 40.

⁵⁷⁶ *Ibid.*

⁵⁷⁷ Seumas Miller, *Model Code of Ethics Principles*. Professional Standards Council
<<https://www.psc.gov.au/sites/default/files/Model%20code%20of%20ethics%20principles.pdf>>.

⁵⁷⁸ *Health Practitioner Regulation National Law Act 2009* (Qld) s 41.

limited number of well-vetted others. Paramedics are virtually unique among healthcare workers in our society—emergency room clinicians being the only others—in experiencing this level of relationship with a patient so quickly. The patient is at their most vulnerable and dependent on the trustworthiness and competence of the paramedics treating them. The particular interventions that paramedics can perform add to the level of risk to which both the patient and the paramedic are exposed. Paramedics appear to hold a high level of trust within the community.⁵⁷⁹

The nature of the trust relationship expected between a patient and a practitioner of a particular profession can be set out within a code of conduct. For example, the *Good Medical Practice Guide—a Code of Conduct for Doctors in Australia* sets out the standards of ‘ethical and professional’ conduct and set of principles that are expected of registered doctors by their ‘professional peers and the community’.⁵⁸⁰ It makes reference to the trust relationship between doctors and their patients several times, including:

Patients trust their doctors because they believe that, in addition to being competent, their doctor will not take advantage of them and will display qualities such as integrity, truthfulness, dependability and compassion...

Relationships based on respect, openness, trust and good communication will enable you to work in partnership with your patients...

In professional life, doctors must display a standard of behaviour that warrants the trust and respect of the community...

The community places a great deal of trust in doctors...

Patients rely on the independence and trustworthiness of doctors.⁵⁸¹

Individual members of each profession have ethical responsibilities in relation to the behaviour of other individuals. For example, a practitioner who becomes aware that one of their peers is incompetent or engages in serious wrongdoing does have an obligation to

⁵⁷⁹ ASNSW, June 2014 <<http://www.ambulance.nsw.gov.au/Media-And-Publications/Latest-News/Paramedics-voted-most-trusted-profession.html>>.

⁵⁸⁰ Medical Board of Australia, *Good Medical Practice Guide: A Code of Conduct for Doctors in Australia* (March 2014) <<http://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx>>.

⁵⁸¹ Ibid.

report that conduct.⁵⁸² This duty exists by virtue of a collective responsibility to ensure that minimum standards of conduct are complied with. The ‘soft’ carrot regulation offers a way for practitioners to be reminded of and protect the relationship of trust that they develop with individuals, and the harder ‘stick’ of disciplinary action, for risking the reputation of the profession and the consequence of limiting the patient’s access to healthcare because of a mistrust in the profession. The legislation not only allows for a code of conduct to be developed but provides the institutional mechanism by which it can be disseminated and enforced.⁵⁸³

Codes can be a useful tool for reforming and educating the population of a group about ‘the basic principles and ideals of an occupation’.⁵⁸⁴ However, ethical education needs to be included in the core curriculum set as a minimum standard of entry to the profession. The codes themselves can serve both a ‘regulative and an educative function’⁵⁸⁵ but on their own they are not enough to guarantee the practise of professionalism. They must be used to build a culture and ethos of professionalism within the professional group to build and maintain public trust so that they can continue to claim and utilise technical and moral authority over their work ‘so that they can resist economic and political restrictions’ that may limit their power to act with discretion in the best interests of others.⁵⁸⁶ The way in which the code can contribute to the building of a culture of professionalism in paramedicine will be discussed in more detail in Chapter 7.

The inclusion of paramedics under the NRAS is a huge step forward for the professionalisation of paramedicine because it is the closest the profession has yet come to self-regulation. Where formerly paramedics have been beholden to their employer to make determinations about education, accreditation, character, conduct, competency, performance, ethical and entry-to-the-profession standards, it will now be the members of the profession itself that make those determinations.

⁵⁸² *Health Practitioner Regulation National Law Act 2009* (Qld) Division 2.

⁵⁸³ *Ibid* Division 11 and s 190.

⁵⁸⁴ Seumas Miller, *Model Code of Ethics Principles*. Professional Standards Council
<<https://www.psc.gov.au/sites/default/files/Model%20code%20of%20ethics%20principles.pdf>>.

⁵⁸⁵ *Ibid*.

⁵⁸⁶ Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001).222.

5.6 Conclusion

Freidson noted that to be a professional was not just to be part of a profession but to act with professionalism, defined in chapter two as qualities and characteristics which include self-responsibility, expertise, special skills and ethical behaviour. He recognised that the most “critical test of professionalism” is a demonstration that the profession will not use its position of professional power for “selfish advantage.”⁵⁸⁷ Chapter 3 identified that paramedicine has a long history associated with altruism. This chapter identified that altruism is not just a feel-good virtue that health professionals talk about but are not held accountable for delivering. The National Law provides a mechanism to hold practitioners to account for their actions and has an expectation that regulated practitioners will act with professionalism.⁵⁸⁸ The National Law acknowledges the importance and centrality to professional health practice of acting with professionalism. For example, the accreditation standards for paramedicine that will be required to be developed by the Paramedicine Board will require all paramedic programs of study to provide persons who complete the program not only with knowledge and skills but also *professional attributes* necessary to practise the profession in Australia. The identification of those attributes and the way in which they are relayed throughout the paramedic community will be a matter for the Board to determine. This mechanism demonstrates how self-regulation under the National Law will provide paramedics via the Paramedicine Board with an opportunity to develop not only education and accreditation standards that define what and who a paramedic is but also what paramedic professionalism looks like. The Board can also use other guidelines, codes and policies (discussed in more detail in chapter 7) to shape a culture and ethos of paramedic professionalism. This is entirely consistent with Freidson’s suggestion that the ideology of professionalism regulation is that a professions’ specialist knowledge and skills should be used for public benefit, as distinct from bureaucratic or free-market regulation which both have alternative objectives.⁵⁸⁹

Paramedics have benefited from the push for structural reform in Australia’s healthcare workforce and the introduction of legislation that facilitates that reform at a time when they had sufficiently professionalised to take advantage of the legislative change. There

⁵⁸⁷ Eliot Freidson, *Professionalism Reborn: Theory, Prophecy and Policy* (Polity Press, 1994). 217.

⁵⁸⁸ For example, as discussed previously in this chapter, definitions and power to act to sanction unprofessional conduct.

⁵⁸⁹ Eliot Freidson, *Professionalism Reborn: Theory, Prophecy and Policy* (Polity Press, 1994).

may be registered health practitioners who, in a popular view, may not be considered as a profession but it is beyond the scope of this thesis to identify this. To consider if all health occupational groups are considered a profession according to the Freidson criteria would require a separate thesis for each profession and so it is beyond the scope of this thesis to consider if, for example, the less well recognised professions like Indigenous Health, Chinese medicine or Chiropractic are in fact a profession according to the Freidson criteria. However, it is an argument in this thesis that regulation under the National Law maps closely against the Freidson criteria and thus grants to any occupational group that is regulated by it, sufficient authority to establish themselves as a profession. The final steps to professional status require conduct by the profession itself, for example, their respective boards to establish enforceable competency and conduct standards that reflect the profession and establish expectations of what it is to act with professionalism. The law vests this power in the Board and if they undertake the tasks that the law authorises, then it carries the occupational group over the threshold to professional status. It follows that if paramedics are regulated by this law, and the Paramedicine Board undertakes the tasks authorised by the law, paramedicine will become a profession.

The literature and submissions made by the profession noted in Chapter 4 outline why paramedics were seeking this form of regulation and demonstrates that they were looking for self-determination, to be free to establish for themselves their standards of education, competency and conduct, to determine who is and who is not eligible to be a part of the occupational group. As per table 2 above, it is evident that regulation under the National Law will grant paramedics the legal and professional status that they have been seeking. This chapter has demonstrated that the National Law will facilitate the professionalisation of paramedicine according to the Freidson elements for a profession, as demonstrated in table 2 above, by recognising their unique purpose, specialist knowledge and skills and allowing them to self-regulate. In so doing the Paramedicine Board will have an opportunity to set education and accreditation standards that will develop and disseminate paramedics' specialist knowledge and skills. The law will not prescribe paramedic professionalism but it will provide a mechanism for the Paramedicine Board to determine what paramedic professionalism should look like via the development of education and accreditation standards, clinical guidelines, a code of conduct and associated policies.

With respect to identity and power, a goal of the paramedic professionalisation project was to establish ‘a coherent model or concept of the role and responsibilities of a professional paramedic that provides a firm basis for discussion with regulators and other stakeholders’.⁵⁹⁰ This has not yet been achieved but is essential that the Paramedicine Board develop this if the discipline hopes to effectively transition to not only being legally recognised as a profession but to utilise the power it gains in becoming a profession. The Paramedicine Board will face some challenges in attempting to establish its governance framework over the 12 months from the time the Board is constituted, in large part because there is no agreed or clear definition of what a paramedic is and what a paramedic does. There is no nationally consistent uniform protection of paramedic title legislation that sets out the definition of a paramedic. There are no nationally agreed practices or education standards; the reluctance of NSW to relinquish its control on its education model will make the establishment of a uniform standard even more difficult. Additionally, the discipline has no code of conduct and as such no evidence of any agreement on the profession’s values and culture. The lack of a code will make establishing core educational curriculum criteria difficult as well as limiting the ability of the discipline to determine the legal standard of a ‘reasonable paramedic’ for the purposes of disciplinary matters or even to establish the character requirements to be met by those seeking to be registered for the first time.

Once paramedics are regulated under the *National Law*, their obligation to act with professionalism – which in essence is to put the patients’ interests first – will be codified (that is, it will be made legally consistent, transparent, explicit, binding and enforceable) in a way that it has not been before. It is therefore essential that paramedics develop an understanding of what it is to be a professional paramedic and to act with professionalism to ensure that they act with the required standard of conduct and competency as set by their peers. There are very many similarities between medicine and nursing but unlike those professions, paramedicine has struggled to define itself. Chapter 3 provided clear evidence that paramedicine has slowly been developing its role and character over a few hundred years and just as nursing did, it jumped forward in establishing its unique purpose and specialised knowledge during the Crimean War. However, despite its attempts to professionalise and ambitions to do so, as described in Chapter 4, the

⁵⁹⁰ Gerry Fitzgerald and Ray Bange, ‘Defining a Regulatory Framework for Paramedics: A Discussion Paper’, (2007) 5(2) *Journal of Emergency Primary Health Care*. From a report prepared for ACAP, Brisbane.

discipline has still not set out clearly who it thinks it is and what it stands for. This is an issue that will need to be addressed by the Paramedicine Board once the board is convened and constituted. It is essential for the success of the professional development of the profession that it utilise the power of self-regulation it has gained by being regulated under the National Law, to unite together as one discipline and determine clearly its identity as a group that has specialised knowledge and skills in the area of emergency out-of-hospital care; and that it establishes a core set of competency and conduct standards that reflects who the profession is and what the profession does and in so doing being to develop a culture and ethos of professionalism.

The UK undertook similar legislative reform in response to similar scandals and falling confidence in the health professions a number of years ago. The UK regulatory scheme includes paramedics. The next chapter examines the way paramedics are regulated in the UK and identifies lessons that can be learned from the UK's experience of paramedic professionalisation that may be helpful for Australian paramedics as they move to become regulated as a profession.

Chapter 6: Lessons from the United Kingdom Paramedic Regulatory Experience

The UK has had paramedic registration in place for 15 years, providing an opportunity to compare its regulatory scheme with that proposed for Australia, and also with the Freidson elements for a profession, to determine whether the UK model would be more likely or better able to provide the elements of professionalism that are missing from Australian paramedic practice. This chapter provides a comparative analysis of the way in which paramedics are regulated in the UK and the effectiveness of that regulatory regime for the professionalisation of paramedics.

6.1 United Kingdom Model of Regulation

Reform of the UK model of healthcare workforce regulation was one of a number of healthcare reforms commenced under the Blair Labour Government from the time of its election in 1997 and continues under the current Conservative government. Reform was initiated in response to a number of factors that were similar to those underpinning the reform of the Australian regulatory system, including pressure to address a decline in tax revenue to pay for the almost entirely publicly funded National Health System (NHS), by shifting to a more market-based model;⁵⁹¹ a need to address the overly bureaucratic management of the NHS;⁵⁹² and a need to restore public confidence in the health professional regulatory system following a number of high-profile medical scandals.

Changes to the regulation of health professionals in the UK came about with the introduction of the *Health and Social Care Act 2008*, which, it is claimed, amounted to a ‘revolutionary paradigm shift in the regulation of quality and healthcare in the UK’⁵⁹³ by

⁵⁹¹ Richard Lewis, Judith Smith, and Anthony Harrison. ‘From quasi-market to market in the National Health Service in England: what does this mean for the purchasing of health services?’(2009) 14 (1) *Journal of Health Services Research & Policy* 44-51.

⁵⁹² For example, Rosen and Dewar argued that the introduction of a bureaucratic model of regulation in the United Kingdom (UK) was thought to limit the positive influence doctors exert through professionalism because it limited their freedom. Rebecca Rosen and Steve Dewar, ‘Redefining Medical Professionalism for Better Patient Care’ (Discussion Paper, King’s Fund, November 2004).

⁵⁹³ Gwyn Bevan, ‘Changing Paradigms of Governance and Regulation of Quality of Healthcare in England’ cited in Bridget M Hutter ‘Risk Regulation and Health Care’, (2008) 10(1) *Health, Risk and Society*, 1-7

effectively ending 150 years of medical self-regulation.⁵⁹⁴ The changes were made in response to a number of political, economic and social issues that included concerns about the effectiveness of medical self-regulation in light of a number of medical scandals. The most prominent of these were the inquiries into the high rate of child deaths in the children's heart surgery unit at the Bristol Royal Infirmary hospital⁵⁹⁵ and the actions of Harold Shipman, a British general practitioner (GP) convicted in January 2000 of the murder of 15 of his patients.⁵⁹⁶ Again, this was not dissimilar to the drivers for reform of the Australian healthcare workforce as discussed in Chapter 5.

It was suggested that these high-profile instances of regulatory failure in medicine contributed to 'a declining trust in expertise (and those claiming expertise)' and led to a rise in 'risk management ideology',⁵⁹⁷ which was incorporated into UK legislative reform. Market liberalisation and the accompanying pressures on public health service delivery also contributed to reform towards a more shared model of professional regulation between the state, the healthcare sector and healthcare professions.⁵⁹⁸

As was the case in Australia, the key principles of the UK reform were to not only address economic issues with the NHS, but to also address political issues caused by the scandals. The regulatory reform had, as its 'overriding interest' a focus on safe, high-quality care for patients but it also looked to develop a system that would provide for an independent regulatory process removed not only from government but also removed from the professions and employers. An independent regulator was viewed as a way to sustain the confidence of the public and the professions, educators and other healthcare stakeholders with the regulatory system. The regulatory reform would also seek to improve the professional standards of health professionals and the capacity to identify and address poor practice or bad behaviour in a way that would be proportionate to the risks the reform was

⁵⁹⁴ Martyn Chamberlain, 'Reforming Medical Regulation in the United Kingdom: From Restratisation to Governmentality and Beyond' (2014) 8(1) *Medical Sociology* (online) 32–43.

⁵⁹⁵ *The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984–1995*, July 2001. The Bristol Royal Infirmary Inquiry.

⁵⁹⁶ Safeguarding Patients: Lessons from the Past—Proposals for the Future <<http://webarchive.nationalarchives.gov.uk/20090808154959/>>; http://www.the-shipman-inquiry.org.uk/5r_page.asp> ; Richard Baker, 'Implications of Harold Shipman for General Practice' (2004) 80 *Postgraduate Medical Journal* 303–306 <<http://pmj.bmj.com/content/postgradmedj/80/944/303.full.pdf>>.

⁵⁹⁷ Justin Waring, Mary Dixon-Woods and Karen Yeung, 'Modernising Medical Regulation: Where Are We Now?' (2010) 24(6) *Journal of Health Organization and Management* 540–555, 543.

⁵⁹⁸ *Ibid.*

designed to manage, while not limiting the potential benefits reform could bring. As in Australia, these benefits included the development of a flexible healthcare workforce that could more readily adapt to future healthcare and health system needs.⁵⁹⁹

The UK approached the structural inefficiencies of an inflexible health workforce in a similar way to the Australian model. For example, applied psychologists, healthcare scientists, psychotherapists and counsellors and other psychological therapists who had not previously been included in a national regulatory scheme were included⁶⁰⁰ because their practice was ‘well established and widespread in the delivery of services’, and what they do ‘carries significant risk to patients and the public if poorly done’.⁶⁰¹ The approach to expanding the roles of other practitioners was taken ‘with a view to enriching the skills mix and reinforcing the capacity of the workforce to deliver timely, high-quality services’.⁶⁰² The reforms offered an opportunity for lower profile health disciplines like paramedicine to gain privileges associated with professionalisation that they could not otherwise acquire. This included registration, which would allow paramedics to become independent of their employer because their authority to practise would be linked to their registration and not be wholly dependent upon their employment as a paramedic. Paramedics were, until this time, classed as employees either working in an NHS organisation or a licensed private or independent sector provider; not independent practitioners or self-employed contractors like dentists. Reform offered the prospect of gaining recognition of their role as autonomous practitioners who would be able to independently contract their services to the state to provide emergency out-of-hospital care services.

6.2 United Kingdom Paramedic Professionalisation

Paramedics in the UK had been engaged in a professionalisation project over a long period driven in part by societal needs along with advances in science and technology, just as it was in Australia. Paramedics in the UK slowly acquired an increasing array of complex skills that they applied in their specialist area of emergency out-of-hospital care. The greatest shift in paramedic professionalisation occurred at roughly the same time and for

⁵⁹⁹ *Trust, Assurance and Safety—the Regulation of Health Professionals in the 21st Century*
<https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228847/7013.pdf>.

⁶⁰⁰ *Ibid.*

⁶⁰¹ *Ibid.*

⁶⁰² *Ibid* 82 at 7.7.

the same reasons as it did in Australia. Around the 1970s, emergency medical knowledge and technology had improved and this knowledge was shared with paramedics following acknowledgement that the paramedics worked in a specialised area, often being the first on the scene of an accident or cardiac arrest, for example; therefore, it was ‘logical to train them’ to be able to provide the best care possible.⁶⁰³

Paramedics first voted to become registered in the UK in 1999. The *Health Professions Order* (2001) authorised the establishment of a professional body, the British Paramedic Association (BPA), which later became the College of Paramedics (COP). The COP is the peak professional body for paramedics in the UK and is the primary voice for paramedics on matters relating to professional practice and the development of the profession. The COP works to promote the profession; represent members; develop curriculum frameworks, post-registration education and training programs; and develop and deliver continuing professional development programs.⁶⁰⁴

In 2002, the Health Professions Council (HPC) was established under the *National Health Service Reform and Health Care Professions Act*.⁶⁰⁵ The HPC was established to regulate 16 groups of health practitioners including arts therapists; biomedical scientists; chiropodists/podiatrists; clinical scientists; dieticians; occupational therapists; operating department practitioners; orthoptists; paramedics; physiotherapists; prosthetists and orthotists; radiographers; and speech and language therapists. The reason for the regulatory grouping of these diverse health professions together is thought to be largely historical.⁶⁰⁶ The inclusion of paramedics in this group may reflect their history as ‘drivers’ or ‘first aiders’ rather than the highly skilled practitioners they are today. It should also be noted that this regulatory model was introduced over 15 years ago when paramedicine was not the same as it is today. However, regulation in 2003 did commence the recognition of paramedicine as a ‘profession’ with the introduction of statutory registration and the promotion of the graduate entry-to-practice requirement (although this was not

⁶⁰³ College of Paramedics, *Paramedic Curriculum Guidance* 2015
<https://www.collegeofparamedics.co.uk/downloads/Paramedic_Curriculum_Guidance_2015.pdf>.

⁶⁰⁴ HCPC *Paramedics* <<http://www.hcpc-uk.org/aboutregistration/professions/index.asp?id=10>>

⁶⁰⁵ 2002 (UK).

⁶⁰⁶ Gerry Larkin, ‘The Regulation of the Professions Allied to Medicine’ in Judith Allsop and Mike Saks, *Regulating the Health Professions* (Sage, 2002).

standardised as a requirement of entry to the register).⁶⁰⁷ The combination of the development of a professional body, a graduate degree program and registration under the law were all indicators that UK paramedics were following the professionalisation trajectory identified by Wilensky.⁶⁰⁸

In August 2012, the HPC became the HCPC under changes made to the *Health and Social Care Act 2012*. The Act which makes provision for the *Health and Social Work Professions Order 2001* (UK) which sets out much of the detail regarding the powers and responsibilities of the regulator. The principal functions of the HCPC as the regulator are ‘to establish standards of education, training, conduct and performance for members of the relevant professions and to ensure the maintenance of those standards’.⁶⁰⁹ The HCPC is responsible for administering the regulation of paramedics in the UK alongside the 15 other professions listed above. The notable distinction with this as it compares to Australia is that paramedics do not regulate themselves.⁶¹⁰ The HCPC is responsible for regulating individual registrants and not the services registrants work in, but unlike Australia, the UK law provides for the HCPC to ‘cooperate with services’.⁶¹¹ The legislation authorises the council to regulate the health professional conduct and competence requirements for registrants.⁶¹²

6.2.1 Education Standards and Specialised Knowledge

Despite the role of the HCPC in monitoring and managing education and training standards, paramedic education in the UK has been inconsistent and ad hoc for a number of years.⁶¹³ As noted above, education standards are not set by the profession alone. The *Health and Social Work Professions Order 2001* (UK) authorises the HCPC, in the exercise of its functions, to ‘co-operate, in so far as is appropriate and reasonably practicable, with public

⁶⁰⁷ L Ball, ‘Setting the Scene for the Paramedic in Primary Care: A Review of the Literature’ (2005) 22 *Emergency Medical Journal* 896–900 <<http://emj.bmj.com/content/emjmed/22/12/896.full.pdf>>.

⁶⁰⁸ Harold Wilensky, ‘The Professionalisation of Everyone?’ (1964) 70 *American Journal of Sociology* 137, 143.

⁶⁰⁹ *Health and Social Work Professions Order 2001* (UK) Part II, s3 (2). <<http://hpc-uk.org/Assets/documents/10003BB0HCPC-CONSOLIDATEDHSWPORDER.pdf>>

⁶¹⁰ HCPC, *Number of Registrants* 6 September 2016 <<http://www.hcpc-uk.org/aboutregistration/professions/index.asp?id=10>>.

⁶¹¹ *Health and Social Work Professions Order 2001* (UK) Part II, s5 (b)(iv).

⁶¹² *Ibid*, s3 (2).

⁶¹³ Andy Newton, ‘The Ambulance Services: The Past, Present and Future’ (2012) 4(5) *Journal of Paramedic Practice*; John Donaghy, ‘The Role of the Health and Care Professions Council’ (2013) 5(7) *Journal of Paramedic Practice*.

bodies or other person concerned with the employment of registrants, the education or training of registrants, the regulation of health professionals, and the provision, regulation and management of health services'⁶¹⁴ but it is the regulator, not the profession that sets the standards. The paramedic profession's association provides 'guidance' that is 'strongly' influenced by material from external agencies including the Quality Assurance Agency framework for higher education qualifications, and the HCPC for standards of proficiency, conduct, performance and ethics.⁶¹⁵ The minimum education level to become registered as a 'paramedic' in the UK is that the registrant must have completed a program of study approved by the Education Committee of the HCPC. The program of study is not standardised and can be determined at a local level but all should meet the threshold requirements of the profession as set out in the HCPC's *Standards of Proficiency—Paramedics*.⁶¹⁶

The HCPC's *Standards of Proficiency* for paramedics, includes both generic and paramedic-specific standards of practice written by the HCPC after consultation with members of the profession.⁶¹⁷ Unfortunately the document does not help produce standardisation in paramedic education. The document is a 16-page, almost 4,000-word document that lists the word 'paramedic' only 16 times. There is no way of knowing from reading the document what a paramedic is or what they do that is distinct from a nurse or a doctor except where there is a brief and specific mention of paramedics working in the pre-hospital and out-of-hospital space,⁶¹⁸ in an emergency or urgent care environment,⁶¹⁹ within particular timeframes,⁶²⁰ or working at hazardous or major incident sites.⁶²¹ The content of the document suggests that the HCPC views the role of the paramedic as a broad one with many areas of cross-over between the paramedic role and the role of other similar health professionals like doctors and nurses. This would also be consistent with the objective of

⁶¹⁴ *Health and Social Work Professions Order 2001* (UK) Part II, s5 (b).

⁶¹⁵ College of Paramedics, *Paramedic Curriculum Guidance 2015* <https://www.collegeofparamedics.co.uk/downloads/Paramedic_Curriculum_Guidance_2015.pdf>.

⁶¹⁶ HCPC, *Standards of Proficiency—Paramedics* <http://www.hpc-uk.org/assets/documents/1000051CStandards_of_Proficiency_Paramedics.pdf>.

⁶¹⁷ HCPC, *Standards of Proficiency—Paramedics* <http://www.hpc-uk.org/assets/documents/1000051CStandards_of_Proficiency_Paramedics.pdf>.

⁶¹⁸ *Ibid* 14.5.

⁶¹⁹ *Ibid* 14.6.

⁶²⁰ *Ibid* 14.8.

⁶²¹ *Ibid* 15.8.

the regulatory scheme, to ‘enrich the skills mix’⁶²² of the healthcare workforce, which is another way of arguing for ‘flexibility’ as consistent with the bureaucratic notion of generalising skills rather than preserving and valuing specialisation.⁶²³ The lack of an agreed education standard for paramedics that is determined by paramedics undermines their technical claim to authority and thus their status as a profession. This lack of recognition of their unique and specialised knowledge limits the use of discretionary decision-making in their practise and their moral authority to act in the patient’s best interest. This argument is supported by Wilensky who suggested that ‘bureaucracy may enfeeble the service ideal more than it threatens autonomy.’⁶²⁴ Freidson suggests that a bureaucratic regulatory method that values generalisation over specialisation may help manage costs but it also ‘undermines the flexible discretionary judgement that is necessary to adapt services to individual needs’⁶²⁵ which is particularly necessary in healthcare.

In 2013 the UK Department of Health, National Allied Health Professional Advisory Board and the COP commissioned the *Paramedic Evidence Based Education Project* (PEEP).⁶²⁶ The project report highlighted great variation in the current education and training models, which were locally, rather than nationally, determined. This was contributing to wide differences in learning outcomes.⁶²⁷ The study also identified that structural issues between the education provider and the paramedic employer have resulted in paramedic educators being dependent on employers to agree to paramedic curricula, with the effect of limiting the autonomy of the profession to standardise the education program. As a result, there are currently 50 HCPC-approved paramedic programs delivered by 32 providers that would provide graduates eligible to register as paramedics. The significance of this hotchpotch of training programs and providers is that there is no standardised approach to paramedic

⁶²² *Trust, Assurance and Safety—the Regulation of Health Professionals in the 21st Century* 82 at 7.7 <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228847/7013.pdf>.

⁶²³ Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001) 9.

⁶²⁴ Harold Wilensky, ‘The Professionalisation of Everyone?’ (1964) 70 *American Journal of Sociology* 137.

⁶²⁵ Eliot Freidson, *Professionalism Reborn: Theory, Prophecy and Policy* (Polity Press, 1994). 193.

⁶²⁶ Mary Lovegrove and June Davis, *Paramedic Evidence Based Education Project Report* (2013) (‘the PEEP Report’) <<https://www.collegeofparamedics.co.uk/downloads/PEEP-Report.pdf>>.

⁶²⁷ Paresh Wankhade, ‘Staff Perceptions and Changing Role of Pre-Hospital Profession in the UK Ambulance Services’ (2016) 5(2) *International Journal of Emergency Services* 126–144 <<https://search-proquest-com.virtual.anu.edu.au/docview/1843790439?accountid=8330>>; Paresh Wankhade ‘Different Cultures Of Management And Their Relationships With Organizational Performance: Evidence From The UK Ambulance Service’ (2012) 32(5) *Public Money and Management* 381–388; Mary Lovegrove and June Davis, PEEP Report (2013) 7 <<https://www.collegeofparamedics.co.uk/downloads/PEEP-Report.pdf>>.

education, which in turn was having an effect on the consistency of practice standards.⁶²⁸ It has been recognised in other health professions—namely the nursing profession in the UK—that a lack of national training standards is thought to have contributed to a failure within the profession to deliver consistent care standards.⁶²⁹ Thus, although the COP stipulates that paramedic curricula must include teaching about clinical leadership, patient interests and advocacy, confidentiality, capacity, consent and anti-discrimination,⁶³⁰ the lack of consistent, uniform education standards delivered by education providers and employers and the lack of autonomy for the profession itself to lead the development of a standardised, national paramedic core curriculum that reflects their specialised knowledge and cultural values appears to be limiting the professional development of paramedics in the UK.⁶³¹ The PEEP report recommended taking a standardised approach to all aspects of education and paramedic training and urged the COP in partnership with national leaders of education to take the paramedic profession to an all-graduate status by 2019. This will aim to set a minimum level qualification for entry to the paramedic register that will reflect the unique and specialised knowledge and skills of paramedicine.⁶³²

Tertiary education can promote the development of critical thinking skills which, combined with specialist knowledge and skills, is essential for a professional because it allows the practitioner to use discretionary decision-making rather than having their decisions limited by standardised protocols. Critical thinking skills were recognised as necessary for the paramedic discipline to develop.⁶³³ Freidson would argue that they are critical for the development of the discipline to a profession because it provides them with technical and

⁶²⁸ Ibid, *ibid*, *ibid*.

⁶²⁹ Ann Bradshaw, 'What is a Nurse? The Francis Report and the Historic Voice of Nursing' (2017) 24(4) *Nursing Inquiry* 1.

⁶³⁰ College of Paramedics, *Paramedic Curriculum Guidance* (2015)

<https://www.collegeofparamedics.co.uk/downloads/Paramedic_Curriculum_Guidance_2015.pdf>.

⁶³¹ Mary Lovegrove and June Davis, PEEP Report (2013)

<<https://www.collegeofparamedics.co.uk/downloads/PEEP-Report.pdf>>.

⁶³² Ibid 9; indeed the authors noted the current lack of regulation of paramedics in Australia. As part of its review of regulation of the paramedic workforce in Australia, the Australian College of Emergency Medicine's (2012) submission to *Consultation Paper: Options for Regulation of Paramedics* called for a 'Nationally consistent definition of a "paramedic"; Uniform definition of the scope of practice for paramedics; Appropriate clinical governance model; and National consistency in education and training for paramedics'. The PEEP study suggested that the same should apply to paramedics in the UK.

⁶³³ Mary Lovegrove and June Davis, PEEP Report (2013) 62

<<https://www.collegeofparamedics.co.uk/downloads/PEEP-Report.pdf>>; J Janing, 'Critical Thinking: Incorporation into the Paramedic Curriculum' (1994) 9(4) *Prehospital and Disaster Medicine* 238–242.

moral authority over their work.⁶³⁴ Critical thinking ‘requires knowledge, assumes maturity, is more than a set of skills, it also involves deductive reasoning and inductive reasoning, analysis and synthesis and includes feelings and reflection and challenges the status quo’.⁶³⁵ As has already been discussed, paramedicine is a unique profession in that it requires practitioners to work in high-stress, largely uncontrolled, high-stake, time-critical environments with little infrastructure or human resource support. This makes the acquisition and application of critical thinking skills all the more important to provide efficient, effective and safe care. The extension of learning from competency-based rote learning of prescribed guidelines, to tertiary-based education that encourages the development of critical thinking that can be used in discretionary decision making and professional judgement is an example of the professionalisation of paramedics.⁶³⁶ This development of advanced knowledge and skills and the application of discretionary decision making is consistent with professions seeking to self-regulate and practise autonomously and is free of the restrictions of bureaucratic regulation.⁶³⁷ Indeed, the COP believes that paramedics educated in a higher education environment to a minimum of postgraduate certificate or diploma level or equivalent are capable of working either at a specialist level—described as a paramedic who delivers ‘a more complete level of assessment and care to patients with urgent, emergency, and unscheduled healthcare requirements’⁶³⁸—or as an ‘advanced paramedic’.

Advanced paramedics are experienced paramedics who have acquired an expert knowledge base with a relevant master degree qualification, and who are able to exercise ‘complex decision-making skills, competence and judgement in their area of advanced practice’.⁶³⁹ Advanced paramedics have developed ‘high-level critical reasoning and diagnostic skills’ that enable them to independently assess and provide a wide range of care and treatment to patients including those with complex urgent, emergency and unscheduled healthcare

⁶³⁴ Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001) 23.

⁶³⁵ Mansooreh Tajvidi, Shahrzad Ghiyasvandian, and Mahvash Salsali. Probing Concept of Critical Thinking in Nursing Education in Iran: A Concept Analysis. (2014) 8(2) *Asian Nursing Research* 158–164.

⁶³⁶ Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001) 23.

⁶³⁷ Malcolm Woollard, ‘The Role of the Paramedic Practitioner in the UK’ (2006) 4(1) *Journal of Emergency Primary Health Care*.

⁶³⁸ Allied Health Professions Medicines Project Team ‘Summary of the Responses to the Public Consultation on Proposals to Introduce Independent Prescribing by Paramedics across the United Kingdom’ (26 February 2016). < <https://www.england.nhs.uk/wp-content/uploads/2016/02/Paramedics-summary-consult-responses.pdf>>.

⁶³⁹ Ibid.

needs. They are able to work in a range of healthcare settings including walk-in centres, urgent care centres, GP surgeries, accident and emergency departments or a patient's home.⁶⁴⁰ This extension of the paramedic role is consistent with the notion of a unique purpose and specialised knowledge, provided paramedics continue to restrict their field of expertise to emergency, urgent or unscheduled care. This form of extension of the role of paramedics is consistent with not only the Freidson elements for a profession, but also the objective of the regulatory scheme to increase the 'flexibility' of the workforce. Rather than extending the role of paramedics to cover the skills and knowledge and purpose of other similar professions like medicine and nursing, paramedics can instead contribute to the flexibility of the healthcare workforce by maintaining their own discrete area of specialist practice in emergency out-of-hospital care by making themselves available to provide urgent, emergency and unscheduled care in places that they would not have historically worked, namely an urgent care centre or GP surgery. However, there are risks associated with doing this, including creating confusion among the public and other practitioners as to who and what a paramedic is and does. This confusion is evidenced in the PEEP report⁶⁴¹ and more problematically, the HCPC.⁶⁴² Although this extension of the paramedic role appears attractive, particularly in terms of creating new opportunities for paramedics to work beyond traditional ambulance services, there may be risks for the profession associated with the stratification and extension of their traditional role as providers of emergency out-of-hospital care. Indeed this appears to have been the case with nursing in the UK where over-stratification has resulted in confusion to the public, employers and regulators as to what a 'nurse' is, what they do and who they are.⁶⁴³

Nursing has, for many decades, slowly been extending the scope of practice of registered nurses beyond their traditional role as 'carers' and into the provision of high-level complex treatments that were previously performed by doctors. Again, this is consistent with the government's objective of creating healthcare workforce structural reform by regulating to allow for health professions to 'enhance the skills mix'. However, the extension of the role

⁶⁴⁰ Ibid.

⁶⁴¹ Mary Lovegrove and June Davis, PEEP Report (2013) 40
<<https://www.collegeofparamedics.co.uk/downloads/PEEP-Report.pdf>>.

⁶⁴² Mike Brady, 'Health and Care Professions Council: Protecting Whom?' (2013) 5(5) *Journal of Paramedic Practice*.246-247.

⁶⁴³ Alison Leary, Katrina Maclaine, Paul Trevatt, Mark Radford, and Geoffrey Punshon. 'Variation in job titles within the nursing workforce.' (2017) *Journal of Clinical Nursing*.1-6.

of the registered nurse in the UK has resulted in claims that they have become divorced from the delivery of care and compassion; two traits commonly associated with nursing's unique purpose and specialised knowledge and skills.⁶⁴⁴ The criticism by Robert Francis QC, who conducted an inquiry into reports of systemic failures by nurses to 'care' for their patients at Staffordshire, was an echo of the historical principles underpinning the development of the profession of nursing by Florence Nightingale during the Crimean War. Francis recommended that nursing embrace the value of providing care and compassion and that this be included in all nursing training and national standards of competence.⁶⁴⁵ This and other evidence demonstrates the risks of adverse outcomes when a specialist is tasked with expanding their practice beyond their traditional core.⁶⁴⁶ This is a position that was earlier noted by Wilensky who said,

the optimal "technical" base for professionalism suggests that knowledge or doctrine which is too general and vague or too narrow and specific provides a weak base for an exclusive jurisdiction.⁶⁴⁷

This is what I refer to as the Goldilocks position. The development of professional practice to the 'just right' point that optimises the exclusive jurisdiction and thus power of a profession. Expanding practice has benefits but there are some risks including risks of harming the patient but also risks of harming the profession. The criticism of nurses in the Staffordshire case supports the argument that a health profession should stay true to two key Freidson elements - its unique purpose and specialised knowledge and skills - in order to maintain its moral and technical authority.

6.2.2 Autonomy and Self-regulation

As noted above, UK paramedics do not only work in traditional ambulance services; they also work as practitioners in GP clinics, hospitals and walk-in-clinics and at industrial

⁶⁴⁴ Robert Francis, *Report of the Mid Staffordshire NHS Foundation Trust public inquiry: Robert Francis QC (Chair)*. HC 898 I-III (HMSO, 2013); Ann Bradshaw, 'What is a Nurse? The Francis Report and the Historic Voice of Nursing' *Nursing Inquiry*, 1.

⁶⁴⁵ Robert Francis, *Report of the Mid Staffordshire NHS Foundation Trust public inquiry: Robert Francis QC (Chair)*. HC 898 I-III (HMSO, 2013).

⁶⁴⁶ NHS England, *Urgent and Emergency Care Review—Evidence Base Engagement* (2013) Section 4.1.

⁶⁴⁷ Harold Wilensky, 'The Professionalisation of Everyone?' (1964) 70 *American Journal of Sociology* 137.

sites.⁶⁴⁸ They work in a diverse range of locations including primary, urgent and emergency care centres; minor injury and walk-in centres; GP out-of-hours services; telephone triage and 111 systems, NHS Ambulance Trusts; mental health and community settings; higher education; military; research; management; offshore and remote; hazardous area response teams; special operations response teams (in Scotland); and helicopter emergency medical services.⁶⁴⁹ The diversity of work sites in which paramedics can find work is evidence of their autonomy. The UK regulatory structure has allowed paramedics to increase their ‘flexibility’ by permitting them to work outside of state-based ambulance services. However, NHS ambulance services employ ~84% of paramedics and so the bulk of their work is associated with their traditional role and purpose.⁶⁵⁰

The more skilled a paramedic becomes, the more autonomy the paramedic has which is something that paramedics value.⁶⁵¹ However, the more skilled they become the more likely they are to be authorised to work in roles beyond the traditional paramedic role. This risks the skills and role of the paramedic becoming increasingly generic which in turn results in staff being less clear about the limits of their professional responsibilities and professional identity.⁶⁵² The development of advanced skills and knowledge for a paramedic should involve adopting advanced skills and knowledge in treatments or tests that make the paramedic better able to perform their specialised role as out-of-hospital emergency care providers.⁶⁵³ Only interventions that are relevant to the provision of high-quality out-of-hospital emergency care should be considered an extension of paramedic

⁶⁴⁸ College of Paramedics, ‘*Post-registration career framework*’ (3rd ed) (2015)

<https://www.collegeofparamedics.co.uk/downloads/Post-Reg_Career_Framework_3rd_Edition.pdf>.

⁶⁴⁹ Ibid; College of Paramedics, ‘*Paramedic - Scope of practice policy*’ (2015)

<https://www.collegeofparamedics.co.uk/downloads/Paramedic_Scope_of_Practice_Policy_May_2015.pdf>.

⁶⁵⁰ Centre for Workforce Intelligence, *Workforce Risks and Opportunities—Paramedics* (2012)

<<http://www.cfw.org.uk/publications/paramedics-workforce-risks-and-opportunities-education-commissioning-risks-summary-from-2012>>.

⁶⁵¹ College of Paramedics, ‘*Post-registration career framework*’ (3rd ed) (2015)

<https://www.collegeofparamedics.co.uk/downloads/Post-Reg_Career_Framework_3rd_Edition.pdf>.

⁶⁵² Brian Brown, Paul Crawford, and Jurai Darongkamas. ‘Blurred roles and permeable boundaries: the experience of multidisciplinary working in community mental health,’ (2000) 8.6 *Health & social care in the community*, 425-435.

⁶⁵³ Examples of this advancement in relevant skills are the adoption of cannulation or intraosseous infusion of fluids in a life-threatening situation, or pre-hospital rapid sequence intubation. One study suggested that for adults with severe traumatic brain injuries, pre-hospital rapid sequence intubation increases the rate of favourable neurological outcome at six months. BA Bernard et al, ‘Prehospital Rapid Sequence Intubation Improves Functional Outcome For Patients With Severe Traumatic Brain Injury: A Randomized Controlled Trial’ (2010) 252(6) *Annals of Surgery* 959–965.

practice; otherwise paramedics risk generalising their work and losing their point of professional distinction, unique purpose and specialised knowledge.

The UK regulatory regime has facilitated the professionalisation of paramedics to the extent that it allows paramedics to work autonomously and compete in the market place for jobs in a range of healthcare settings and this appears as those paramedics have achieved professional status, but this is a paradox.⁶⁵⁴ A few individual paramedics have achieved autonomy but the discipline as a whole has not. The UK regulation does not allow the occupational group to control standards, to determine who enters the profession, and ‘the procedures and criteria by which the performance is organised and evaluated’ and in this regard the discipline is still not a profession according to the Freidson elements.⁶⁵⁵

An objective of the regulatory regime was to reduce demarcation and the monopoly on some areas of healthcare practice held by some professional groups and to promote the development of a more flexible and generic workforce in order to enhance patient access to healthcare. In this regard the method has been successful. However, this regulatory approach runs counter to the division of labour as an organisational approach to work recognised as necessary in a society where there are increasingly specialised levels of knowledge and skills as discussed in Chapter 2. There are other groups in the UK that have argued for a dedicated regulator including osteopaths⁶⁵⁶ and social workers who have argued that being self-regulating would allow the profession to focus on the ‘profession, its education and practice and contribute to the debates and changes that are necessary for it to grow in confidence and standing.’⁶⁵⁷

The adoption of the generic approach to regulation implies a failure on the part of law makers to recognise how dependent society is on organised bodies who hold specialised knowledge and skills.⁶⁵⁸ Additionally, it risks reducing the unique identity of paramedics

⁶⁵⁴ Although it should be noted that their autonomy is limited by their service obligations contained in their code of conduct.

⁶⁵⁵ Eliot Freidson, *Professionalism Reborn: Theory, Prophecy and Policy* (Polity Press, 1994) 173.

⁶⁵⁶ Gerry McGivern, Michael D. Fischer, Tomas Palaima, Zoey Spendlove, Oliver Thomson, and Justin Waring. ‘Exploring and explaining the dynamics of osteopathic regulation, professionalism and compliance with standards in practice. (2015) General Osteopathic Council, 4.<V
https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2564898>

⁶⁵⁷ Brid Featherstone, ‘*Social workers might not miss the HCPC. But we’ll miss its independence.*’ Community Care (June 13, 2016) < <http://www.communitycare.co.uk/2016/06/13/social-workers-might-miss-hcpc-well-miss-independence/>>

⁶⁵⁸ Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001).197.

and the important specialised role of paramedicine. The reason why this matters is because it could potentially limit the power of the discipline to maintain its unique domain of practice from encroachment by others and risk a loss of specialisation which in turn could impact patient care, safety and health care quality.⁶⁵⁹ This is notable because patient safety and protection are another objective of the regulation and in fact the core reason for the establishment of standards, disciplinary panels and indeed, a national register of qualified practitioners. There is the potential for conflict between the two regulatory objectives of developing an increasingly flexible workforce and patient protection and safety that may be exacerbated because paramedicine cannot self-regulate.

In Australia, as outlined in Chapter 5, there will be a Paramedicine Board, of which two-thirds of members will be registered paramedics. The board will have the power to determine many particulars about the profession as a whole, including the education and accreditation standards for entry to the profession; it will also have the power to develop a code of conduct that reflects the particular identity and value of the paramedic profession. This is not the case in the UK; rather the HCPC is made up of 12 members—six registrant members and six lay members—⁶⁶⁰ and currently none are paramedics.⁶⁶¹ The UK system does not have a single overarching body to administer the regulation of all the health professions as the Australian model does. In the UK, nurses and doctors are regulated separately by separate legislation and by their own councils: the Nursing and Midwifery Council (NMC)⁶⁶² and the General Medical Council (GMC).⁶⁶³ This clearly demonstrates the most immediate difference between the UK system of regulation and the Australian system. In the latter, all health professionals are regulated by the same piece of legislation and thus share the same legal and professional status. In the UK, nurses and doctors are able to self-regulate and thus have a different legal and professional status. The reason for this is not related to the size of the professions. For example, there are over 190,000 licensed

⁶⁵⁹ Ann Page, ‘*Keeping patients safe: Transforming the work environment of nurses.*’ (ed) (2004) National Academies Press; Brian Brown, Paul Crawford, and Jurai Darongkamas, ‘Blurred roles and permeable boundaries: the experience of multidisciplinary working in community mental health.’ (2000) 8 (6) *Health & social care in the community* 425-435; Alison Leary, Katrina Maclaine, Paul Trevatt, Mark Radford, and Geoffrey Punshon. ‘Variation in job titles within the nursing workforce.’ (2017) *Journal of Clinical Nursing*.1-6.

⁶⁶⁰ HCPC, *Council Members* (2017) <<http://www.hpc-uk.org/aboutus/council/councilmembers/>>.

⁶⁶¹ *Ibid.*

⁶⁶² Established under the *Nursing and Midwifery Order 2001* authorised by the *Health Act 1999*.

⁶⁶³ Established under the *Medical Act 1983* (UK) s 1.

doctors in the UK⁶⁶⁴ but only 3,109 chiropractors were registered in the UK in 2015;⁶⁶⁵ yet both have their own council and regulation, separate from other health professions.

Thus, while a small number of paramedics in the UK have been able to utilise their technical authority to become regulated to the extent that they are authorised to work autonomously, (i.e., their authority to practice rests with them, not with their employer as it currently does with Australian paramedics), the occupational group as a whole has not been able to persuade the state that the holding of that authority should allow them to regulate themselves and give them control over their own work. This is in part because it is the intention of the state to broaden and flatten the healthcare workforce and reduce silos of specialisation in an attempt to make the workforce more flexible.

6.2.3 Code of Conduct

A code of conduct written by the profession for the profession is another feature that distinguishes the paramedic regulatory regime in the UK from that in Australia. The UK regulatory regime does not allow paramedics to establish their own unique code of conduct rather it allows for the application of a generic code that is applicable equally to all 16 ‘professions’ the HCPC regulates.

An objective of the regulation and regulator is to provide for ‘public protection.’ Public protection is provided in part by ensuring that the professions regulated by the law promote and maintain ‘public confidence and proper standards of conduct and behaviour’.⁶⁶⁶ These standards—which include practitioner ‘fitness-to-practise’ standards, and the establishment of education and training standards—are governed by four statutory committees governed by the HCPC, not by paramedics.⁶⁶⁷

⁶⁶⁴ General Medical Council, ‘*List of Registered Medical Practitioners – statistics.*’ (2016) <https://www.gmc-uk.org/doctors/register/search_stats.asp>.

⁶⁶⁵ General Chiropractic Council, ‘*Annual registration report*’ (2015) <<http://www.gcc-uk.org/UserFiles/Docs/Registrations/Report%20on%20the%202015%20registration%20year%20160616.pdf>>.

⁶⁶⁶ Law Commission, Scottish Law Commission and Northern Ireland Law Commission *Regulation of Health Care Professionals and Regulation of Social Care Professionals in England, A Joint Report*, Law Commission Report No 345 (2014) at 3.17.

⁶⁶⁷ *Health and Social Work Professions Order 2001* (UK) Part II, s9; HCPC, *Council* (2017) <<http://www.hcpc-uk.org/aboutus/council/>>.

To be registered as a health professional by the HCPC, a registrant must have completed a professional education program that has included core units of knowledge including life and physical sciences, social and behaviour sciences, clinical leadership, *ethics and law*. This material should include reference to and an understanding of the standards of conduct, performance and ethics set out in the HCPC *Standards of Conduct, Performance and Ethics*.⁶⁶⁸ This document contains conduct and performance standards that are generic in nature and not specifically written by or for paramedics. The explanation for this is that the standards applied to protect the public by each health profession should be the same regardless of the particular role that each profession plays.⁶⁶⁹ This is also consistent with the objective of the healthcare workforce reform, which is to increase the flexibility of the workforce and in so doing, standardise core professional elements like a code of conduct so that healthcare professionals can work across traditional silos of practice. This broad form of standardisation is consistent with a typical bureaucratic approach to management by the state and it is at odds with professionalism because it aims to reduce discretion and maximise predictability and limits the power of the profession to rely on its specialist knowledge and skills particular to its unique purpose to make decisions in the best interests of the patient.⁶⁷⁰ Indeed, an argument had been made that the introduction of a bureaucratic model of regulation in the UK was thought to have limited the positive influence doctors were previously able to exert through professionalism, because it limited their freedom to do so.⁶⁷¹ Submissions made to the Law Commission, Scottish Law Commission and Northern Ireland Law Commission, support this view. The commission examined the regulatory system and identified that further reforms to the system were necessary to reduce bureaucracy to increase flexibility.⁶⁷² Taking a generic approach to the development of a code of conduct for all health professions regulated by the HCPC removes some points of distinction between the professions that are often found in the code of conduct and this is a

⁶⁶⁸ HCPC, *Standards of Conduct, Performance and Ethics* (2016) <<http://www.hcpc-uk.org/publications/standards/index.asp?id=38>>.

⁶⁶⁹ HCPC, *Standards of Proficiency—Paramedics* <http://www.hpc-uk.org/assets/documents/1000051CStandards_of_Proficiency_Paramedics.pdf>.

⁶⁷⁰ Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001) 217–218.

⁶⁷¹ Rebecca Rosen and Steve Dewar, ‘Redefining Medical Professionalism for Better Patient care’ (Discussion Paper, King’s Fund, November 2004)

<https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/on-being-a-doctor-redefining-medical-professionalism-better-patient-care-rebecca-rosen-steve-dewar-kings-fund-1-november-2004.pdf>.

⁶⁷² Law Commission, Scottish Law Commission and Northern Ireland Law Commission *Regulation of Health Care Professionals and Regulation of Social Care Professionals in England, A Joint Report*, Law Commission Report No 345 (2014).

concern because the code of conduct is a document that often reflects a profession's unique values and identity⁶⁷³ or, as Freidson suggested, its 'soul'.⁶⁷⁴ Indeed, a study commissioned by the HCPC found that the bulk of health professionals interviewed for the study (which included paramedics) believed that 'professionalism' was, at time, specific to context. The study indicated that:

professionalism has a basis in individual characteristics and values but is also largely defined by context. Its definition varies with a number of factors including organisational support, the workplace, the expectations of others and the specifics of each service user/patient encounter.⁶⁷⁵

This latter point supports the argument that applying a generic set of values that does not take account of the particulars of each health profession's unique role, responsibilities and culture, risks an effect on professionalism.

As discussed in Chapter 5, codes of conduct are devices that are used to gain public trust, to reinforce desirable behaviour and change undesirable behaviour; to do so effectively, they need to address not only issues of behaviour but also issues of character and 'affective attitudes that condition and motivate that behaviour'.⁶⁷⁶ However, if codes of conduct are to be effective in shaping behaviour, identity and the culture of a group then 'regulation and education, including ethical education, need to go hand in hand'.⁶⁷⁷ The lack of standardisation in UK paramedic education, including ethics education, combined with the lack of a discrete code of conduct that applies only to paramedics could be contributing an inconsistency in practice standards and learning outcomes.⁶⁷⁸

⁶⁷³ Seumas Miller, *Model Code of Ethics Principles*. Professional Standards Council. <<https://www.psc.gov.au/sites/default/files/Model%20code%20of%20ethics%20principles.pdf>>.

⁶⁷⁴ Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001) 220.

⁶⁷⁵ HCPC, *Professionalism in Healthcare Professionals* <<http://www.hpc-uk.org/assets/documents/10003771ProfessionalismInHealthcareProfessionals.pdf>>.

⁶⁷⁶ Seumas Miller, *Model Code of Ethics Principles*. Professional Standards Council 7 <<https://www.psc.gov.au/sites/default/files/Model%20code%20of%20ethics%20principles.pdf>>.

⁶⁷⁷ Ibid.

⁶⁷⁸ Paresh Wankhade, 'Staff Perceptions and Changing Role of Pre-Hospital Profession in the UK Ambulance Services' (2016) 5(2) *International Journal of Emergency Services* 126–144 <<https://search-proquest-com.virtual.anu.edu.au/docview/1843790439?accountid=8330>>; Paresh Wankhade, 'Different Cultures of Management and Their Relationships With Organizational Performance: Evidence From the UK Ambulance Service' (2012) 32(5) *Public Money & Management* 381–388; Mary Lovegrove and June Davis, PEEP Report (2013) 7 <<https://www.collegeofparamedics.co.uk/downloads/PEEP-Report.pdf>>.

In the UK, art therapists are regulated in the same way as paramedics. The two groups, along with 14 other professions, share a code of conduct. However, there are strongly distinct differences between the role of the art therapist and that of a paramedic. Although it is agreed that some standards between the professions should be universal and there are some elements of practice of each profession that may also be shared, there remains and will continue to remain a need for each profession to practise in a distinct way and according to their own specialist knowledge. This is consistent with the theory of the division of labour as discussed in Chapter 1, which allows for improved efficiency, improved quality, savings in time and other resources; more significantly, it is consistent with the Freidson elements for a profession. The lack of self-regulatory power for paramedics suggests that the State – the entity that can bestow that power – has not been persuaded that paramedics hold the technical and moral authority to warrant self-regulation.

The argument for having standardised codes is that all health professionals regulated by the HCPC should apply the same professional standards.⁶⁷⁹ Broadly, this is true because the notion of ‘professionalism’ is to act within a set of moral norms, principles and standards of conduct and competency. However, professionalism also refers to ‘a set of values, behaviours and relationships that underpins the trust [of] the public’.⁶⁸⁰ Freidson recognised that it is the preservation of trust that can lead to the preservation of the power of a profession to use its discretion. Without trust that the profession will use its specialised knowledge and skills for good, then it is likely that the group’s power will be diminished because their professional discretion will be limited by the imposition from the state of a set of bureaucratic practice criteria.⁶⁸¹ It is a profession’s relationship with the public that can set it apart from others. For example, the relationship between the public and an art therapist is, by its nature, significantly different to that of a patient and a paramedic. This is because the nature of contact with the paramedic commonly occurs not through patient choice but at a time of crisis. Paramedic encounters, unlike those with art therapists, are commonly literally a matter of life and death in time-critical situations. The patient is often required to disrobe and share intimate information with the paramedic for the paramedic to

⁶⁷⁹ Julia Evetts, ‘The Concept of Professionalism: Professional Work, Professional Practice and Learning’ in Stephen Billett, Christian Harteis and Hans Gruber (eds.), *International Handbook of Research in Professional and Practice-based Learning* (Springer International, 2014).

⁶⁸⁰ RCP, *Doctors in Society: Medical Professionalism in a Changing World*. Report of a Working Party of the RCP (RCP, 2005).

⁶⁸¹ Eliot Freidson, *Professionalism Reborn: Theory, Prophecy and Policy* (Polity Press, 1994) 192.

effectively diagnose and treat the patient. This is quite distinct from the nature of the encounter between a patient and an art therapist. The distinction between the two professions demonstrates there is some merit in arguing that paramedics should have a separate code of conduct that acknowledges the professional requirements that are unique to them. Freidson argued that the specialised nature of the work that professionals do requires an approach to ethical decision making that takes the particulars of the circumstance into account.⁶⁸² Indeed, the HCPC's generic code of conduct has been criticised as being 'somewhat less sophisticated' than the profession-specific codes of the GMC and the NMC because it is required to apply to a broad range of professions and does not provide for the particulars of the professions it regulates.⁶⁸³

6.3 Managing Poor Performance and Conduct

In addition to meeting conduct standards, UK practitioners are required to meet fitness-to-practice standards. 'Fitness to practise' is defined as having the skills, knowledge, character and health needed to practise the profession safely and effectively.⁶⁸⁴ 'Fitness to practise' does not just entail having the 'skills, knowledge and character to practise the profession safely and effectively'. It also includes 'acts by a professional which may affect public protection or confidence in the profession'.⁶⁸⁵ These standards were developed by the Joint Royal Colleges Ambulance Liaison Committee, whose members have specialist knowledge of paramedic care. The document states that the registrant must be able to maintain fitness to practise; be able to practise as an autonomous professional and exercise their own professional judgement; be aware of the effect of culture, equality and diversity on practice; be able to practise in a non-discriminatory manner; understand the importance of and be able to maintain confidentiality; be able to communicate effectively; be able to work appropriately with others; be able to maintain records appropriately; be able to reflect on and review practice; be able to assure the quality of their practice; understand the key concepts of the knowledge base relevant to their profession; be able to draw on appropriate

⁶⁸² Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001) 215.

⁶⁸³ Robert Francis, *Report of the Mid Staffordshire NHS Foundation Trust public inquiry: Robert Francis QC (Chair)*. HC 898 I-III (HMSO, 2013) vol II, 1044.

⁶⁸⁴ HCPC, *Standards of Conduct, Performance and Ethics* (2016) <<http://www.hcpc-uk.org/publications/standards/index.asp?id=38>>.

⁶⁸⁵ HCPC, *Fitness to Practise Annual Report 2016* <<https://www.hcpc-uk.org/assets/documents/100051F3Fitnessstopractiseannualreport2016.pdf>>.

knowledge and skills to inform practice; and understand the need to establish and maintain a safe practice environment.⁶⁸⁶ Failure to do so may indicate that the practitioner is unfit to practise.

In 2015–16, 239 allegations of a breach of a paramedic’s ‘fitness to practise’ were made against paramedics by the HCPC. The total number of registrants in that year was 22,380. Paramedics make up only 6.55% of the total number of registrants yet they made up the second-highest number of complaints (1.07%) of all the professions registered.⁶⁸⁷ The group to raise the largest number of concerns against paramedics was the public (42.8%), followed by the employer (25.2%) and then self-referral (20.2%).⁶⁸⁸ The UK results cannot be explained simply because of the number of paramedics and the intimate type of work that they do. Physiotherapists are the second-largest profession, yet have a much lower rate of concerns raised than paramedics or social workers in England.⁶⁸⁹ An explanation is that paramedics are being required to meet broader government-prescribed performance timeframes that are undermining the ability of the profession to sustain a high quality of service.⁶⁹⁰ There is also a suggestion that media portrayals of paramedics (e.g., on the reality TV program, *Casualty*) and the work they do creates unachievable public expectations as to what they can do; when they fail to meet these expectations, complaints are made.⁶⁹¹ There is some suggestion that the generic nature of healthcare conduct standards and cross-over of professional roles has contributed to a lack of clarity as to who is responsible for what, creating public confusion that could also be driving complaints.⁶⁹²

The HCPC commissioned a report to examine why paramedics were complained about in late 2016.⁶⁹³ The report was titled, ‘*People like us? Understanding complaints about*

⁶⁸⁶ HCPC, *Standards of Proficiency—Paramedics* at 15.8 <http://www.hpc-uk.org/assets/documents/1000051CStandards_of_Proficiency_Paramedics.pdf>..

⁶⁸⁷ HCPC, *Fitness to Practise Annual Report 2016* 14<<https://www.hpc-uk.org/assets/documents/100051F3Fitnessstopractiseannualreport2016.pdf>>.

⁶⁸⁸ *Ibid* 46.

⁶⁸⁹ *Ibid* 16.

⁶⁹⁰ HCPC, *Professionalism in Healthcare Professionals* 32 <<http://www.hpc-uk.org/assets/documents/10003771Professionalisminhealthcareprofessionals.pdf>>.

⁶⁹¹ *Ibid*.

⁶⁹² Robert Francis, *Report of the Mid Staffordshire NHS Foundation Trust public inquiry: Robert Francis QC (Chair)*. HC 898 I-III (HMSO, 2013) vol II, 1044.

⁶⁹³ HCPC, *Fitness to Practise Annual Report 2016* 14<<https://www.hpc-uk.org/assets/documents/100051F3Fitnessstopractiseannualreport2016.pdf>>.

paramedics and social workers.'⁶⁹⁴ It was released on 31st August 2017 after the majority of the work on this chapter of the thesis was complete. The study uses a different methodology to that used in this thesis but it did identify a number of the same issues identified here. It identified that paramedics work in challenging practice environments and situation of 'extremis' with 'heightened situations of emotional and physical distress' and in uncontrolled environments like 'the side of a road, tight spaces in homes, off a cliff or on beach' that require them to rely on and use a range of high level clinical and non-clinical skills that are distinctly different from other healthcare practitioners.⁶⁹⁵ This 'front line' response to crisis can also results in heightened emotions that 'can result in misperceptions and miscommunication' that can result in complaints.⁶⁹⁶ This demonstrates the unique purpose and specialised skills and knowledge of paramedics and perhaps highlights why it is that paramedics should be regulated in a way that recognises these unique factors and the way in which they effect practice.

The study also identified that paramedic education is inconsistent and does not cover all the specialist skills and knowledge that paramedics are now required to perform.⁶⁹⁷ The report identified that 'the quality of ethics education is not strong enough'⁶⁹⁸ and that employers are not supportive of paramedic professional development.⁶⁹⁹ It is suggested that this is because this would mean staff would no longer be under the control of employers.⁷⁰⁰ The report suggested that the HCPC as the regulator needs to clarify the criteria by which paramedics are held to account,⁷⁰¹ that the peak paramedic association, the College of Paramedics, and employers need to promote and develop a culture of professionalism in practice.⁷⁰² These findings in the UK study are significant for Australian paramedics. This

⁶⁹⁴ Anna van der Gaag, Ann Gallagher, Magda Zasada, Grace Lucas, Robert Jago, Sarah Banks, Zubin Austin, '*People like us? Understanding complaints about paramedics and social workers.*' Final Report. 31 August 2017. <<http://www.hcpc-uk.org/assets/documents/1000558EPeoplelikeusFinalReport.pdf>>.

⁶⁹⁵ Ibid, 43, 68.

⁶⁹⁶ Ibid, 44.

⁶⁹⁷ Ibid, 69.

⁶⁹⁸ Ibid, 41.

⁶⁹⁹ Ibid, 39.

⁷⁰⁰ Leo McCann, Edward Granter, Paula Hyde and John Hassard. Still blue-collar after all these years? An ethnography of the professionalisation of emergency ambulance work (2013) 50:5 *Journal of Management Studies*, 750-776.

⁷⁰¹ Anna van der Gaag, Ann Gallagher, Magda Zasada, Grace Lucas, Robert Jago, Sarah Banks, Zubin Austin, '*People like us? Understanding complaints about paramedics and social workers.*' Final Report. 31 August 2017. <<http://www.hcpc-uk.org/assets/documents/1000558EPeoplelikeusFinalReport.pdf>>.80.

⁷⁰² Ibid, 75.

is because there was resistance by a major employer of paramedics in Australia – the Ambulance Service of NSW –to join the national scheme.⁷⁰³ This suggests that some potential structural issues remain that may limit the professional development of paramedics in Australia, particularly in NSW, despite the introduction of legislative reform aimed to remove structural barriers that should allow paramedics to self-regulate under National Law.

Additionally, the study confirmed what has been alluded to earlier in this chapter, that the public has false expectations of what a paramedic is and does and so when paramedic practice does not match public expectations, the public complain.⁷⁰⁴ For example, the public may have an expectation that when they call for a paramedic they will be transported to hospital to be seen by a doctor, or that paramedics will be able to save all lives or limit significant injury.⁷⁰⁵ When this does not happen they may feel that they are being denied access to hospital care and vent their frustration at the paramedics. This is exacerbated by an apparent lack of resources and ‘cost effective’ approach to service delivery that limits the practise of paramedics and contributes to complaints being made that are actually about issues beyond the paramedic’s control including time, supervision and high workloads.⁷⁰⁶

The report did not recommend a change to the regulatory structure but interestingly paramedics interviewed in the report suggested a shift to a regulatory model ‘such as the General Medical Council’ (a self-regulatory model more like the Australia model) would provide better outcomes for paramedics.⁷⁰⁷ This is in part because there is a belief amongst paramedics that the current regulator does not know what paramedics do and does not understand the particularities of their practice as identified in the ‘People like us’ report and mentioned above. Brady argues that paramedics are being sanctioned by the HCPC

⁷⁰³ NSW Health, Submission to Senate Legal and Constitutional Affairs Committee, Parliament of Australia, *The Establishment of a National Registration System for Australian Paramedics to Improve and Ensure Patient and Community Safety*, 2016

<https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Paramedics/Submissions>

⁷⁰⁴ Anna van der Gaag, Ann Gallagher, Magda Zasada, Grace Lucas, Robert Jago, Sarah Banks, Zubin Austin, ‘*People like us? Understanding complaints about paramedics and social workers.*’ Final Report. 31 August 2017. <<http://www.hcpc-uk.org/assets/documents/1000558EPeoplelikeusFinalReport.pdf>>.80.42, 66.

⁷⁰⁵ Ibid, 42.

⁷⁰⁶ Ibid, 39.

⁷⁰⁷ Ibid, 81.

for perceived deviations from guidelines—working outside their scope of practice—because the disciplinary panel does not know what paramedics actually do.⁷⁰⁸ This is consistent with Freidson’s suggestion that professional practitioners are likely to view administrators who do not or have not undertaken the daily work of the profession as being unable to understand their work and that the practitioner’s work is made more difficult by ‘abstract technical norms and bureaucratic requirements designed to guide and record their activities’ but that do not necessarily cohere with or prioritise the moral intention of the work they do.⁷⁰⁹ The confusion over role, identity, purpose and values is consistent with the lack of clarity about who paramedics are in terms of their education programs, their gradually expanding range into non-traditional areas of practice and their lack of profession-specific code of conduct. Lovegrove and Davis identified that a major driver of the paramedic push to professionalisation is a desire to raise awareness of the capabilities of paramedics among others.⁷¹⁰ In the Australian regulatory model at least half the members of the panel must be registered as members of that profession.⁷¹¹ Peer review is a fundamental element of professional practice because it allows for acceptance of the specialisation and expertise of the professional group. This peer-to-peer disciplinary process is also consistent with the Freidson criterion for self-regulation that supports the notion that any assessment of specialised knowledge and skills or conduct of the unique nature of the profession can only be assessed by others who hold that same knowledge and skill and have knowledge of the profession’s role, purpose and values.

The explanation for the findings of the ‘People like us?’ report differs from that given in this thesis and could be explained by the different methodologies used. The ‘People like us?’ report identifies that the issues identified in the report are a result of a number of discretely different causes. This thesis argues that UK paramedics do not meet the Freidson elements for a profession. Although paramedics were referred to as professionals they are not regulated like professionals. The regulatory model is a bureaucratic, rather than a professionalism, model. This form of regulatory approach might be considered paternalistic

⁷⁰⁸ Mike Brady, ‘Health and Care Professions Council: Protecting Whom?’ 5(5) *Journal of Paramedic Practice*.

⁷⁰⁹ Eliot Freidson, ‘The Reorganisation of the Professions by Regulation’ (1983) 7 *Law and Human Behaviour* 279.

⁷¹⁰ Mary Lovegrove and June Davis, PEEP Report (2013) 36
<<https://www.collegeofparamedics.co.uk/downloads/PEEP-Report.pdf>>.

⁷¹¹ *Ibid* s 182 (4).

in the sense that it does not allow paramedics to regulate themselves. Admittedly the model was developed almost two decades ago when paramedics worked differently and the expectations and understanding of what paramedics did amongst the public, law and policy makers and the regulator were different. They could not and still cannot regulate their education and accreditation standards and so are unable to set a minimum paramedic curriculum, that covers paramedicine's unique and specialised skills and knowledge, that reflects paramedicine's current minimum scope of practice and that includes a clear outline of who paramedics are, what they do and what they value – a culture and ethos of paramedic professionalism - that would apply to all paramedic courses throughout the UK regardless of the institution that delivers it. Setting such a standard would address issues of confusion, particularly amongst the regulators who are also responsible for disciplining paramedics. The lack of power to self-regulate demonstrates that paramedics are not yet professionals. This point was a common finding with the 'People like us?' report who suggested that the profession was still evolving.⁷¹²

This findings in this report support the argument in this thesis that the Australian model of regulation of paramedics is preferred over the UK model of regulation because the Australian model is a professionalism model that recognises the technical and moral authority of paramedicine. This recognition will allow the profession to regulate itself and in so doing, it will allow the Paramedicine Board to set consistent minimum education standards that reflect the unique work and specialised skills that paramedics have and it will allow the Paramedicine Board to develop codes, guidelines and policies that will contribute to the development of a culture and ethos of professionalism that is understood both within and outside of the profession.

6.4 The Effectiveness of the Professionalisation Project

A 2013 study highlighted the limitations of the UK paramedic professionalisation project. It identified multiple reasons for why paramedics had failed to professionalise despite the appearance of professionalisation in the form of the development of higher education training and certification, discipline-specific research journals, codes of practice and a

⁷¹² Ibid, 74.

professional body.⁷¹³ Limitations to the study included a failure to identify and define the core elements of professionalisation. The elements of professionalisation and professionalism were identified in Chapter 2 of this thesis it is clear that a number of those elements are missing for paramedics in the UK.⁷¹⁴ It was argued over a decade ago that progressing the autonomy of paramedics and the development of a paramedic practitioner role would require the development of appropriate education curricula, industry support and legislative and other regulative changes, including prescribing laws; otherwise the potential of paramedicine to meet expanded and increasing public health needs and develop fully as an autonomous profession would be limited.⁷¹⁵ Indeed, there is even evidence that paramedics in the UK have called for ‘guidance and limitations’ to their practice via practice guidelines to ensure the protection of the public as they consider themselves not ‘professionals’ but rather an ‘aspirant and emergent group of people trying to understand what it is to be professional’.⁷¹⁶ It has been argued that the failure to professionalise is in part the fault of the regulatory authority –which is a product of the regulation - which continues to view paramedics as non-professionals.⁷¹⁷ The findings of this thesis would support that view.

The UK experience demonstrates how the imposition of a form of bureaucratic regulation that prioritises flexibility and standardisation in working practice and service organisation over specialisation and discretion, challenges professional power because it limits key elements of a profession including having a unique purpose with specialised knowledge and skills that contributes to the development of moral and technical authority.⁷¹⁸ The bureaucratic model of flattening the healthcare workforce and making it more generic (flexible) may be cost effective and useful for standardising workforce control but it could also eventually result in the equivalent of a butcher trying to fix your car.

⁷¹³ Leo McCann et al, ‘Still Blue-collar After All These Years? An Ethnography of the Professionalisation of Emergency Ambulance Work’ (2013) 50(5) *Journal of Management Studies*. 750-776.

⁷¹⁴ Andy Newton, ‘The Ambulance Services: The Past, Present and Future’ (2012) 4(5) *Journal of Paramedic Practice*. 365-368.

⁷¹⁵ Malcolm Woollard, ‘The Role of the Paramedic Practitioner in the UK’ (2006) 4(1) *Journal of Emergency Primary Health Care* 1; Ian Duffy and Colin Jones, ‘Exploratory Study Into the Views of Paramedics on Paramedic Prescribing’ (2017) 9(7) *Journal of Paramedic Practice*.296-301.

⁷¹⁶ John Donaghy, ‘The Role of the Health and Care Professions Council’ (2013) 5(7) *Journal of Paramedic Practice*.370-371.

⁷¹⁷ Mike Brady, ‘Health and Care Professions Council: Protecting Whom?’ (2013) 5(5) *Journal of Paramedic Practice*. 246-247.

⁷¹⁸ Susan A Nancarrow and Alan M Borthwick, ‘Dynamic Professional Boundaries in the Healthcare Workforce’ (2005) 27(7) *Sociology of Health and Illness*. 897-919.

6.5 Lessons Learned

The UK regulatory regime was designed in response to a number of social, political and economic events. The model differs significantly from the Australian model in that it moved away from ‘professionalism’ as regulation, to a bureaucratic model. This model has been criticised as being limited in its utility in terms of healthcare workforce regulation because it does not allow for flexibility and discretionary decision making required to effectively deal with the complexities that arise in healthcare workforces. The UK model was introduced, in part, to reduce costs and provide an efficient way of controlling the healthcare workforce. This has led to the introduction of the standardised, bureaucratic approach to health workforce management which may have the effect of limiting cost but it works to undermine the flexible discretionary judgment of the professional, practised with professionalism, to ensure the best outcomes for their patient.⁷¹⁹

An examination of the UK regulatory regime has identified that paramedics do not have a standardised curriculum and thus their specialised knowledge and skills specific to their unique purpose of providing emergency/urgent/unscheduled out-of-hospital/pre-hospital care are not able to be taught effectively; that there is no code of conduct that clearly captures the unique role and purpose of paramedics, their identity, culture and values; that the role, purpose and scope of practice of paramedics is unclear to others including those they treat and those that adjudicate their professional disciplinary matters; that paramedics are unable to self-regulate with regard to curriculum, code of conduct and disciplinary matters; and that paramedics do have a unique purpose and specialised knowledge and skills but in a regulatory regime that promotes flexibility and the broadening of the workforce, that purpose and those skills are at risk of being lost.

There is a risk that this same outcome could occur in Australia where the regulatory system is also structured to allow for workforce flexibility as discussed in Chapter 5. Paramedics in Australia have already trialled a ‘paramedic practitioner’ role that was designed to move paramedic practice beyond the delivery of emergency health care and extend paramedic practice to include providing treatment for patients in their place of residence, thus reducing

⁷¹⁹ Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001) 23; Eliot Freidson, *Professionalism Reborn: Theory, Prophecy and Policy* (Polity Press, 1994) 192.

emergency department presentations and inter-facility transfers.⁷²⁰ NSW Ambulance developed an extended care paramedic role that seeks to provide ‘aged care, aged care screening, falls risk assessment, wound assessment and management, minor injury presentations, minor illness presentations, and musculoskeletal and sporting injuries.’⁷²¹ There is support within the paramedic literature to extend the role of paramedics into community paramedicine.⁷²² Community paramedicine includes extending paramedic practice beyond just emergency out-of-hospital care to primary health care and, particularly, community engagement in rural areas where other health professionals may be absent. The idea of community paramedicine is to ‘integrate existing paramedic models with other health agencies and health professionals to ensure that paramedic care is part of a seamless system that provides patients with well-organized and high quality care.’⁷²³

Wilensky noted that there was a risk that ‘bureaucracy may enfeeble the service ideal more than it threatens autonomy’ and that having ‘knowledge or doctrine which is too general and vague or too narrow and specific provides a weak base for an exclusive jurisdiction.’⁷²⁴ There is some evidence that this may have occurred in the UK. The risks for Australian paramedics are that the Paramedicine Board who will have the power under the National Law to broaden the scope of practice of paramedics will do so and in so doing risk diluting the discipline’s unique purpose and associated specialised knowledge and skills and undermine the new profession’s moral and technical authority. It could also challenge paramedicine’s professional identity, culture and ethos.

The next chapter will consider the way in which the Paramedicine Board of Australia might approach the challenge of developing a culture and ethos of professionalism within the

⁷²⁰ Cristina Thompson, Kate Williams, and Malcolm Masso. ‘HWA Expanded Scopes of Practice Program Evaluation: Extending the Role of Paramedics subproject: final report’ (2014). Australian Health Service Research Institute, Wollongong, Australia.

⁷²¹ NSW Ambulance, ‘*Extended care paramedic*’ (Fact sheet) <

http://www.ambulance.nsw.gov.au/media/docs/ECP_V3-7e0f7019-8d7b-41a1-9999-34f4b9573bb6-0.pdf>

⁷²² Christine Stirling, Peter O’Meara, Daryl Pedler, Vianne Tourle, & Judith Walker, (2007). Engaging rural communities in health care through a paramedic expanded scope of practice. *Rural and Remote Health*, 7(4); Peter O’Meara, ‘Would a prehospital practitioner model improve patient care in rural Australia?’ *Emergency Medicine Journal* 20.2 (2003): 199-203; Peter O’Meara, Vianne Tourle, Christine Stirling, Judith Walker, and Daryl Pedler. ‘Extending the paramedic role in rural Australia: a story of flexibility and innovation.’ *Rural and remote health* 12.2 (2012): 1-13.

⁷²³ Peter O’Meara, Vianne Tourle, Christine Stirling, Judith Walker, and Daryl Pedler. ‘Extending the paramedic role in rural Australia: a story of flexibility and innovation.’ *Rural and remote health* 12.2 (2012): 1-13.

⁷²⁴ Harold Wilensky, ‘The Professionalisation of Everyone?’ (1964) 70 *American Journal of Sociology* 137.

Australian paramedic fraternity – the final stage in the Wilensky professionalisation trajectory.

Chapter 7: Where To From Here? The Development of a Culture and Ethos of Professionalism

This thesis has identified that the work that paramedics do is complex and requires specialised knowledge and skills. It has identified that their work is not only specialised but essentialist in nature and as such the profession holds a significant amount of power. This power is tempered by the profession's responsibility to act with professionalism. As identified in Chapter 2, both Freidson and Wilensky⁷²⁵ suggest that any group that may legally acquire professional status will not have fully professionalised unless there is a coherence between their legal status and their professionalism. Freidson argues that 'the functional value of a body of specialised knowledge and skill is less central to the professional ideology than its attachment to a transcendent value that gives it meaning and justifies its independence.'⁷²⁶

This transcendent value, herein referred to as professionalism, allows the professions to claim moral as well as technical authority to control their discipline and the right to 'resist economic and political restrictions' that might 'limit its benefits to others.'⁷²⁷ This is a power paramedicine, as a new profession, has had no experience of developing or wielding but under the National Law the Paramedicine Board will acquire responsibility for developing a culture and ethos of professionalism for paramedics to ensure that they wield that power responsibly.

Professionalism was defined in Chapter 2 as acting within a set of moral norms, principles and standards of conduct and competency.⁷²⁸ Chapter 5 identified how the National Law codifies some elements of professionalism particularly in listing what is *not* professional conduct; the requirement for an individual to maintain their own health and continuing professional education (self-governance); and in establishing a character standard that is necessary for those people seeking to meet registration.⁷²⁹ It also identified that the law

⁷²⁵ Harold Wilensky, 'The Professionalisation of Everyone?' (1964) 70 *American Journal of Sociology* 137.

⁷²⁶ Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001) 221.

⁷²⁷ Ibid 222.

⁷²⁸ Julia Evetts, 'The Concept of Professionalism: Professional Work, Professional Practice and Learning' in Stephen Billett, Christian Harteis and Hans Gruber (eds), *International Handbook of Research in Professional and Practice-based Learning* (Springer International, 2014).

⁷²⁹ *Schedule Health Practitioner Regulation National Law Act 2009* (Qld) Part 1 Preliminary s5.

does not prescribe a profession's scope of practice, or education standards. It does not prescribe a code of conduct for a profession nor does it prescribe a social media policy. The National Law does however allow the national boards and in the case of paramedicine, the Paramedicine Board, to develop codes, guidelines and policies that could contribute to the development of a culture and ethos of professionalism and establish a 'set of values, behaviours and relationships that underpins the trust [of] the public.'⁷³⁰ The types of codes, guidelines and policies that the Paramedicine Board could develop include mandatory notification guidelines, a code of conduct and a social media policy 'to provide guidance to the profession'.⁷³¹ As these are specific professional standards that can be determined by each respective Board,'they will form the basis of discussion in this chapter.

7.1 Mandatory notifications

Paramedics are at high risk of developing a mental health condition in response to the nature of their work. Being regulated under the *National Law Act* will mean that those paramedics in NSW who seek mental health assistance may have their matter referred to the National Board and risk having involuntary restrictions placed on their practice. This risk arises as a direct result of being regulated under the *National Law Act*. As noted in chapter 5, recommendations have been made the NSW Health Minister to consider adopting the recommendations of Mr Kim Snowball from the National Independent Review on the National Health Practitioner Regulatory Scheme and amend the NSW law in order to provide protection for practitioner-patients and allow treating practitioner to (a) use their considerable expertise in making an assessment as to the risk or not posed by their practitioner-patients; and (b) preserve the doctor-patient relationship so as to ensure that the patient, who in this case is also a health practitioner, can be provided with the care that they need so they can get back to caring for others and themselves. However, there has been some reluctance to do so for a range of reasons that are beyond the scope of this section.⁷³² At this point it remains the case that once paramedics are registered under the

⁷³⁰ RCP, *Doctors in Society: Medical Professionalism in a Changing World*, Report of a Working Party of the RCP (RCP, 2005).

⁷³¹ AHPRA, '*Paramedicine Board Professional Standards*' <<http://www.paramedicineboard.gov.au/Professional-standards.aspx>>

⁷³² For a more comprehensive discussion of this issue see Gabrielle Wolf, 'Compelling safety: reforming Australian treating doctors' mandatory reporting obligations.' *Sydney Law Review*, Vol.39: 199.

National Law those practicing in NSW will be subject to it. As was discussed in Chapter 5, it is likely the Board will adopt the AHPRA Guideline on Mandatory Reporting⁷³³ as all other National Boards have. This is because these requirements are uniform across all professions and do not need to accommodate individual professional particularities.

However, the Paramedicine Board will likely be required to develop a Code of Conduct and a Social Media Policy because these documents could reflect the unique challenges associated with practising as a paramedic that make it distinct from other professions.

This chapter will use these two areas as illustrative examples of the way in which the Board can use these documents, along with the development of education and scope of practice standards, to develop a national culture and ethos of paramedic professionalism.

Characteristics associated with healthcare professionalism were listed in Chapter 2 as including ‘clinical excellence, altruism, pursuit of patients’ best interests, patient advocacy, technical knowledge, professional responsibility, and self-governance’.⁷³⁴ To act with professionalism is to act within a set of moral norms, principles and standards of conduct and competency.⁷³⁵ Specifically with regard to healthcare professionals, it has been defined as ‘a set of values, behaviours and relationships that underpins the trust [of] the public’.⁷³⁶ There is some evidence that paramedics already practise with professionalism because they have been regularly cited as enjoying high levels of public trust⁷³⁷ and, as identified in Chapter 4, there have been relatively few legal cases that would suggest paramedics practise with a lack of professionalism.⁷³⁸ It could be said that paramedic professionalism in Australia has developed much like the profession itself, in an ad hoc way, with the culture

⁷³³ AHPRA, ‘National Board guidelines for registered health practitioners, Guidelines for mandatory notifications.’ March 2014, < <http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines/Guidelines-for-mandatory-notifications.aspx>>

⁷³⁴ Giovanna Vicarelli and Elena Spina, ‘Professionalisation and Professionalism: The Case of Italian Dentistry’ (2015) 5 *Professions and Professionalism* 12.

⁷³⁵ Julia Evetts, ‘The Concept of Professionalism: Professional Work, Professional Practice and Learning’ in Stephen Billett, Christian Harteis and Hans Gruber (eds), *International Handbook of Research in Professional and Practice-based Learning* (Springer International, 2014).

⁷³⁶ RCP, *Doctors in Society: Medical Professionalism in a Changing World*, Report of a Working Party of the RCP (RCP, 2005).

⁷³⁷ Ambulance Service of NSW, ‘Paramedics voted the most trusted profession again,’ 22 June 2011.< <http://www.ambulance.nsw.gov.au/Media-And-Publications/Latest-News/Paramedics-voted-the-most-trusted-profession-again.html>>

⁷³⁸ Although it is accepted that there is relatively little data available for this claim because there have been few administrative mechanisms available to collect this data. The NSW Health Care Complaints Commission has collected some data over the past 5 years that shows only 8 ambulance personnel have been the subject of complaints during that period. HCCC, ‘Protecting public health and safety Health Care Complaints Commission Annual Report’ (2016-17)< <http://www.hccc.nsw.gov.au/Publications/Annual-Reports>>

and ethos varying from employer to employer. Regulation under the National Law will allow paramedicine as a profession to develop a unified national identity and set of values that reflect the profession for the first time.

7.2 Developing a Code of Conduct

As identified throughout this thesis, a code of conduct for paramedics is a form of regulation that informs professional behaviour. A code of conduct reflects an occupational group's identity, ethos, culture and values; its professionalism. A code can provide guidance for practitioners on how to manage ethical issues that inevitably arise in their work. Once regulated as professionals, paramedics will take on different responsibilities and accountabilities for their competencies and also their conduct. As professionals paramedics will be expected to harness their specialist knowledge and skills, to make decisions for their patients based on their patient's best interests. This may appear to be paternalistic and contrary to bioethical notions of patient autonomy. However, the unique nature of the work paramedics do - working in extremis, often with patients who are not competent to make decisions for themselves and in time critical situations - means that the paramedic's duty to professionalism is paramount.⁷³⁹ Patients need to trust that paramedics will work for them in their best interest when patients are unable to look after themselves.

Freidson argued that the 'ideology of professionalism asserts above all else, devotion to the use of disciplined knowledge and skill for the public good.'⁷⁴⁰ The power to use discretion in decision making is particularly important in the provision of healthcare in order to ensure that care decisions are made according to each individual patient's needs and in their best interest. The work that healthcare workers do, including the work of paramedics, is special not only because it is complex but because it is commonly provided to people who are at a vulnerable moment in their lives. The vulnerability of patients combined with their lack of understanding of the specialised knowledge that healthcare professionals have mean that there is a potential for patients to be exploited or harmed. It is the element of professionalism exercised by healthcare practitioners that supports trust within the community and a belief that those providing care will do good and act in the interests of the patient.

⁷³⁹ Ibid 43, 68.

⁷⁴⁰ Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001) 217.

The unique nature of the work of paramedics in dealing commonly with people who are at their most vulnerable means that paramedics must understand and apply principles of professionalism to their work. Professionalism extends beyond accountability as set out in the National Law, to also include responsibility. The identification of those responsibilities and the expected attitude of paramedics towards accepting and enacting those responsibilities in circumstances that are particular to paramedics is how a code of conduct could assist paramedics to work with professionalism. This code works to establish a culture that can be disseminated through education and clinical leadership.⁷⁴¹

A feature distinguishing between a non-profession and a profession is the obligation on the professional to act with professionalism, which, at its core, is about putting the patient's interests before the practitioner's. This principle eliminates conflicts of interest for professionals between their own interests and that of the patient, or the interests of another party that may conflict with that of the patient. This requirement is not something that the gaining of legal professional status alone will confer; rather it is often established in conjunction with the ethos of professionalism. Indeed, for paramedics as incipient health professionals, their status as professionals—holding specialised expert knowledge and skills in a particular area of healthcare and their peer-to-peer governance by principles of professionalism—combined with their power to self-regulate, will provide them with an independence that allows and may at times *require* them to judge, criticise or disobey 'employers, patrons and the laws the state'.⁷⁴²

Putting a client's interests ahead of personal interests and employer's directions is an essential aspect of being a profession. Freidson argues that professions, as a powerful, collegial body can and should provide a strong voice in 'broad policy-making forums,' including in situations where services are not able to be provided to those who may benefit from them, which, in the case of paramedics may be healthcare, as professionally unethical.⁷⁴³ An example of this professional advocacy can be seen in the actions of Doctors for Refugees. This group of health professionals challenged a government policy that restricted their role as patient advocates. In 2015 the federal government attempted to

⁷⁴¹ Sue First, Lucy Tomlins, and Andy Swinburn. 'From trade to profession-the professionalisation of the paramedic workforce.' (2012) 4 (7) *Journal of Paramedic Practice*, 378-381.

⁷⁴² Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001) 221.

⁷⁴³ *Ibid* 217.

introduce legislation that would limit the right of health professionals to raise issues of concern about patients who were refugees. It was in effect a provision that would gag healthcare staff from speaking out on the effects of the detention regime on their patients or risk being terminated for misconduct or imprisoned for up to two years.⁷⁴⁴ Doctors for Refugees prepared a High Court challenge to question if the gag provisions breached the constitutional freedom of health professionals to engage in political communication, and to ‘determine whether doctors and nurses are allowed to advocate in the interests of their patients’.⁷⁴⁵ The healthcare staff argued that they would continue to advocate for their patients ‘despite the threats of imprisonment’ because they had a professional obligation to do so.⁷⁴⁶ Healthcare staff were faced with the prospect of potentially breaking the law to protect their patients or, alternatively, complying with the law and abrogating their professional obligation to put their patients’ interests first.

An example from paramedic practice where patient advocacy is required may be where a paramedic is required to assess the competency of a patient to determine their own treatment and transport choice in a difficult case, like that of a terminally ill patient who wishes to die at home but who may receive some benefit from care in hospital. Clinical practice guidelines include contingencies for situations like these. They allow paramedics to make assessments of both a patient’s competence⁷⁴⁷ and their clinical needs. If necessary, paramedics can contact another clinical specialist, for example a doctor, to ask for further advice. If, however, the doctor advises that the paramedics should transport the patient to hospital despite the competent patient’s objections, and the paramedics follow this advice, then the paramedics could find themselves in breach of their professional responsibilities and potentially committing a battery, engaging in behaviour that is both unethical and unlawful.⁷⁴⁸ As independent health professionals they are required to make an assessment

⁷⁴⁴ *Border Force Act 2015* (Cth) s 42.

⁷⁴⁵ NSW Nurses and Midwives Association, ‘Brave Stand Leads to Back Down on *Border Force Act*’.
<<http://www.nswnma.asn.au/brave-stand-leads-to-back-down-on-border-force-act/>>.

⁷⁴⁶ <<https://www.theguardian.com/australia-news/2015/jul/01/open-letter-on-the-border-force-act-we-challenge-the-department-to-prosecute>>.

⁷⁴⁷ *In Re C (Adult: Refusal of Treatment)* [1994] 1 WLR 290.

⁷⁴⁸ *Rogers v Whitaker* (1992) 175 CLR 479, Mason CJ at [14]: ‘except in cases of emergency or necessity, all medical treatment is preceded by the patient’s choice to undergo it’; and on necessity, *In Re F* [1990] 2 AC 1 found, ‘officious intervention cannot be justified by the principle of necessity. So intervention cannot be justified when ... it is contrary to the known wishes of the assisted person, to the extent that he is capable of rationally forming such a wish’. Tom L Beauchamp and James F Childress, *Principles of Biomedical Ethics*, (Oxford University Press, 7th ed, 2013).

as to the action that is in the patient's best interest and a defence of 'just following doctor's orders' will not be available to the paramedics with regard to their responsibilities under the National Law.

There may be some risk to paramedics who might refuse to abide by a doctor's advice, that their employer will sanction them for not following directions, but employees are only required to obey the 'reasonable' direction of an employer. The direction to commit a crime would not be considered 'reasonable'.⁷⁴⁹ It could be argued that this is simply a situation where strong legal regulation will give the patient the most rights; but the reality is that in the grainy detail of daily encounters, it is a culture of commitment to ethical values that determines the quality and safety of the care provided.

This form of advocacy as a product of their regulation by professionalism is something that paramedics as a nationally unified healthcare profession have not had any previous experience. Chapter 3 discussed how paramedics have advocated for themselves to improve their pay and conditions but the practice of professionalism will require them to act beyond their own interests and work in the interests of others. A code of conduct written specifically for paramedics by the Paramedicine Board after extensive consultation with stakeholders will help the profession to understand its unique role and responsibilities and provide guidance as to the limits of the exercise of specialist discretionary judgement.⁷⁵⁰ In this way the code can have both an educative and cultural integration function, particularly if it is incorporated into education standards required to be met by all accredited paramedic programs. The code can be supplemented and taught using devices and educational tools like 'explanatory material, case studies, models of practical ethical reasoning', and include 'concrete examples of ethical problems and solutions, and where appropriate, by a code of practice'.⁷⁵¹

⁷⁴⁹ Michael Eburn, Emergency Law Blog, <<https://emergencylaw.wordpress.com/2017/08/16/ambulance-transport-against-patients-will/>>

⁷⁵⁰ *Health Practitioner Regulation National Law Act 2009* (Qld) 40 (1).

⁷⁵¹ Seumas Miller, *Model Code of Ethics Principles*. Professional Standards Council 7 <<https://www.psc.gov.au/sites/default/files/Model%20code%20of%20ethics%20principles.pdf>>.7; see for example the particular ethical paramedic case studies in Ruth Townsend and Morgan Luck, *Applied Paramedic Law and Ethics* (Elsevier, 2013).

Woollard supports this by arguing that education changes not only knowledge and skills but also attitudes and this can lead to the development of a collective culture.⁷⁵² He argues that this form of teaching can take place in classrooms as well as in practice settings and suggests that a graduate paramedic is more likely to be able to learn to think independently than a vocationally-trained paramedic and suggests therefore that ‘learning to think’ is a point of distinction between a professional and non-professional. He argues that professionalism – the application of not only skills and knowledge but the appropriate attitude – is able to be demonstrated by ‘mentors and preceptors’ within the ‘real-world’ setting that would provide the new paramedic with an opportunity to witness and discuss ‘attitudes and beliefs with another experienced professional.’⁷⁵³ The types of paramedic beliefs and attitudes adopted by the experienced paramedic professional and disseminated within the classroom should be informed by and reflect the profession’s history with altruism.

As noted in Chapter 3, paramedics have a long association with altruism. The chapter identified the way in which the discipline has evolved from Paramedicine, like medicine with its history of altruism captured in the *Hippocratic Oath*, and nursing with its equivalent historical *Nightingale Pledge* has an historical association with charitable services like the Order of St John; however, the moral element of the profession is rarely discussed and the profession in Australia does not have one clear, uniform, overarching set of moral principles that informs its character or practice.

When paramedics draft their own code of conduct, they should give consideration to the notion that the purpose of their work is to do a moral good. This should be included in their code of conduct alongside an acknowledgement that they have discretionary powers that can be used to potentially harm patients, which should also be noted in their code of conduct and in this way, address issues of paramedic culture and identity as well as patient safety. A paramedicine professional code of conduct should contain two particular elements. The first is the ‘requirements, rules, principles, ideals’ of the group and the second is the ‘commitment of the members to uphold those rules and ideals’.⁷⁵⁴ As discussed in Chapter

⁷⁵² Malcolm Woollard, ‘Professionalism in UK paramedic practice.’ (2009) 7 (4) *Australasian Journal of Paramedicine* <<https://ajp.paramedics.org/index.php/ajp/article/viewFile/181/198>>

⁷⁵³ *Ibid.*

⁷⁵⁴ Seumas Miller, *Model Code of Ethics Principles*. Professional Standards Council 7 <<https://www.psc.gov.au/sites/default/files/Model%20code%20of%20ethics%20principles.pdf>>.

5, the development of the code is important in order to help paramedics understand what constitutes professional conduct or practice, not only because this information is admissible in disciplinary proceedings.⁷⁵⁵

According to Miller, a good code of conduct should not only describe the minimum standards of conduct expected of a particular professional group, but should also stipulate the occupational ideals of that group.⁷⁵⁶ Thus a code of conduct should include not only the principles guiding an action, but also the virtues or desirable attitudes that explain the reason for the action.

The code should set out what it will do and what it will not do. For example, the *Good Medical Practice Guide—a Code of Conduct for Doctors in Australia* says:

the code describes what is expected of all doctors registered to practise medicine in Australia. It sets out the principles that characterise good medical practice and makes explicit the standards of ethical and professional conduct expected of doctors by their professional peers and the community ... no code or guidelines can ever encompass every situation ... this code is not a substitute for the provisions of legislation and case law ... this code is not an exhaustive study of medical ethics ... this code is not a charter of patient rights.⁷⁵⁷

The code should reflect the unique value of paramedicine and note its distinction from other health professions. That is, medicine might identify itself as a healthcare profession that seeks to offer a cure or relief of patient suffering and so its code of ethics reflects this purpose and objectives.⁷⁵⁸ Likewise, midwifery seeks to provide woman-centred practice and so has developed a code of conduct that reflects this role and the way in which the profession seeks to undertake it.⁷⁵⁹ An examination of a set of Ambulance Service Codes of Conduct identifies some common themes that suggest a commonality of values and principles for paramedic practice. They include respect, accountability, competence, integrity, honesty and fairness and although these are universal virtues, they could be

⁷⁵⁵ Ibid 41.

⁷⁵⁶ Ibid.

⁷⁵⁷ Medical Board of Australia, *Good Medical Practice Guide: A Code of Conduct for Doctors in Australia* (March 2014) 4 <<http://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx>>.

⁷⁵⁸ Ibid, 2.2.7, 6.

⁷⁵⁹ Nursing and Midwifery Board of Australia, 'Code of Conduct for Midwives' (Effective March 2018) 6 <<http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx>>

adopted by the Paramedicine Board to reflect the unique nature of the work paramedics do and therefore the context in which these virtues would apply.⁷⁶⁰

The code of conduct should contain the minimum standards of conduct that ought not to be compromised, even in the face of pressure from others. Examples of principles common to many codes include a fundamental goal that is particular to the profession that states the profession's commitment to the public, a statement expressing commitment to the principle of individual autonomy rights of patients, a commitment to non-discrimination on the basis of gender, race or religion;⁷⁶¹ a commitment to integrity, and that paramedics should only undertake work that they are competent to perform and a commitment to ongoing professional education and development. The code of conduct should contain a statement in relation to the collective responsibility of members to report on any failure of their peers to meet minimum standards and a commitment to act with professionalism and in the interests of their patient.⁷⁶²

Since practical knowledge of ethical principles and ideals, and practical knowledge of their application, is not static (as ethical problems and the solutions to them undergo change) there is a need for ongoing revision of the code of ethics, ongoing education in relation to changes to the code of ethics, and especially ongoing education in relation to the application of the principles and ideals expressed in the code of ethics.⁷⁶³

The development of a code of ethics or conduct is paramount for the Paramedicine Board because it will help the new profession define itself, and offer a way of publicly reflecting its unique identity, purpose and role. A code can encapsulate the essence of what a paramedic is, not just what they are called or what they do. It should reflect the unique purpose of paramedics as a group who work in an uncontrolled space, usually under time-

⁷⁶⁰ South Australia Ambulance Service, *Code of Ethics 2015*; ASNSW, *Code of Conduct 2007*; Queensland Public Service, *Code of Conduct 2010*; *Code of Conduct for Victorian Public Sector Employees (No. 1) 2007*; St John Ambulance Western Australia *Motto, Mission and Values*; Tasmania State Service *Code of Conduct*; ACT Public Service *Code of Ethics*.

⁷⁶¹ Australian Human Rights Commission, *A Guide to Australia's Anti-discrimination Laws*. <<http://www.humanrights.gov.au/employers/good-practice-good-business-factsheets/quick-guide-australian-discrimination-laws>>.

⁷⁶² Seumas Miller, *Model Code of Ethics Principles*. Professional Standards Council 7 <<https://www.psc.gov.au/sites/default/files/Model%20code%20of%20ethics%20principles.pdf>>.

⁷⁶³ Ibid.

critical conditions with matters of life and death. The power and responsibility reflected in this document can be used to establish and maintain a culture of professionalism.

7.3 Developing a Social Media Policy⁷⁶⁴

Freidson recognised that the most ‘critical test of professionalism’ is a demonstration that the profession will not use its position of professional power for ‘selfish advantage’.⁷⁶⁵ For the most part, the professional duty and associated principles are codified in various ways: legally via practitioner regulation⁷⁶⁶ and as discussed above via professional codes of conduct;⁷⁶⁷ and disseminated through educational standards that allow for the teaching of universal ethical principles like respect for autonomy, beneficence, justice and non-maleficence.⁷⁶⁸ These elements of professionalism can also be shaped by policies and guidelines developed by the profession and allow the profession to develop standards and expectation of conduct in a more flexible and responsive way than via legislation. An example of this would be the development of a policy to address the use of constantly changing technology in paramedic practice.

Chapter 3 of this thesis discussed how the professionalisation of paramedicine has occurred in large part because of advances in technology. The type of technological advances likely to disrupt the role of paramedics and the way in which they perform that role now and in the near future include the use of telemetry, drones, automated driving of vehicles, electronic medical records/tablet use,⁷⁶⁹ medical apps⁷⁷⁰ and social media.⁷⁷¹ Technology is likely to continue to disrupt paramedic norms of work and this poses a contemporary challenge for present and future paramedics with regard to safely managing the increasing complexity of their practice and the duty to their patients. Addressing these complexities

⁷⁶⁴ Some elements of this section of the thesis have been previously published Ruth Townsend and Aidan Baron, ‘Live Tweeting by Ambulance Services: a growing concern.’ *Journal of Paramedic Practice*. Vol. 9, Iss. 7, 07 Jul 2017, pp 282 – 286.

⁷⁶⁵ Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001) 217.

⁷⁶⁶ For example, *Health Practitioner Regulation National Law Act 2009* (Qld).

⁷⁶⁷ In Australia, various codes of conduct for nurses and doctors.

⁷⁶⁸ Tom L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (Oxford University Press, 7th ed, 2013); Ruth Townsend and Morgan Luck, *Applied Paramedic Law and Ethics* (Elsevier, 2013).

⁷⁶⁹ Keron Davison, *Malcolm P Forbes*, ‘Pre-hospital medicine: A glimpse of the future,’ (2015) *Australasian Journal of Paramedicine*. Vol 12, No 5

⁷⁷⁰ Catherine Hayes and Yitka NH Graham, ‘Future of digital technology in paramedic practice: blue light of discernment in responsive care for patients?’ (2017) *Journal of Paramedic Practice*, 9:6, 240-242

⁷⁷¹ Ruth Townsend and Aidan Baron, ‘Live Tweeting by Ambulance Services: a growing concern.’ *Journal of Paramedic Practice*. Vol. 9, Iss. 7, 07 Jul 2017, pp 282 – 286.

will require a commitment to not only the maintenance of clinical competencies but also a commitment to the teaching and practice of professionalism, which is particularly important in times of technological and cultural change.⁷⁷²

This issue of managing advances in technology in the workplace has particular implications for paramedics because of the particular nature of the work they do. Unlike other health professionals, paramedics work in public places and with public crises, like terrorist attacks,⁷⁷³ that attract public interest. There is an appropriate way in which paramedics can utilise this technology to protect the public interest whilst at the same time protecting individual patient privacy. However, there have been many examples, particularly in the UK, where paramedics have been encouraged by their employers to use technology like social media as a tool that serves to benefit the organisation rather than the public interest. This has resulted in both the public and the profession being placed at risk of harm.

Using Twitter to ‘live tweet’ patient care and medical cases was begun by charitable air ambulance services in the UK in an effort to increase their profile, thereby increasing fundraising successes and donations.⁷⁷⁴ This use of patient information for a marketing benefit is strictly limited under the National Law.⁷⁷⁵ There are other laws that limit the use of patient information by public agencies in Australia including the *Privacy Act 1988* (Cth).⁷⁷⁶

The UK example is interesting because similar laws apply in the UK but despite this, and the existence of local policies and guidelines that do not support this behaviour, a culture of live tweeting was allowed to develop and then transition to use by publicly funded NHS

⁷⁷² Ian Wilson, Leanne S. Cowin, Maree Johnson, and Helen Young. ‘Professional identity in medical students: pedagogical challenges to medical education.’ (2013) 25 (4) *Teaching and learning in medicine* 369-373.

⁷⁷³ Linda Sibson. ‘Paramedics: ready for terrorism?’ (2012) 4 (8) *Journal of Paramedic Practice*, 439-439.

⁷⁷⁴ Leonie Mercedes (27 July 2015) London’s air ambulance to live tweet day-to-day work in fundraising drive. Charity Digital News <http://www.charitydigitalnews.co.uk/2015/07/27/londons-air-ambulance-to-live-tweet-day-to-day-work-in-fundraising-drive/>; Sarah Steele, Christopher Adcock and Alistair Steele. Ethical, legal and professional issues arising from social media coverage by UK Helicopter Emergency Medical Services - <http://emj.bmj.com/content/early/2015/05/17/emered-2014-204048.short>

⁷⁷⁵ *Health Practitioner Regulation National Law Act 2009* (Qld) s133

⁷⁷⁶ Privacy law in Australia does not provide for comprehensive publication of health data through social media or other mechanisms, with National Privacy Principle 2 for example providing a clear prohibition on disclosure of personal information other than in exceptional circumstances or as authorised by the person to whom the information is about see for example National Privacy Principles *Information Privacy Act 2009* (Qld).

ambulance trusts and their paramedic employees.⁷⁷⁷ Twitter is used as a medium for public health promotion, including the appropriate use of emergency medical services, and education between practitioners. However, there have been some cases where the use of social media has been used to inform the public of details of private patient cases attended by paramedics that had no public interest, served no benefit for the patient and indeed put the patient at risk of increased harm, alongside the reputation of the profession to maintain patient confidentiality and trust.⁷⁷⁸

There is little justifiable purpose in live tweeting of one's personal involvement in specific patient cases other than to promote oneself or provide a sense of 'spectacle', for a public following. Educational activities are not bound by time, and the development of interagency relations, peer networks, and a public health message simply do not require the detailed specifics on one's involvement in a patient care encounter. The argument that contemporaneous tweeting of specific interventions provides public education around the role of emergency medical services simply does not withstand careful scrutiny or analysis of risk-to-benefit. This argument also appears to conflate the object with the subject. That is, these service providers are suggesting that because the Tweet's primary purpose is to educate, then they are exempted from data protection laws and principles of privacy.⁷⁷⁹ However, this appears to incorrectly conflate the object of the Tweet – to educate – with the subject of the Tweet – the patient – so that the fact that the patient's data is being shared is no longer the issue.

The risk of the same culture of paramedic misuse of patient information on social media developing in Australia is a real one in part because, like the UK, there may be issues of enforceability that allows the practise to continue unsanctioned. This is in part because Australia's privacy laws are relatively weak. As such, there is debate among the paramedic

⁷⁷⁷ *Data Protection Act 1998* (UK); *General Data Protection Regulation 2016* (EU); London Ambulance Service, 'Policy for the use of social media' (2013); Health and Care Professions Council (2016) 'Standards of conduct, performance and ethics.' London.

⁷⁷⁸ Aidan Baron and Ruth Townsend, 'Live Tweeting by Ambulance Services: A Growing Concern' (2017) 9(7) *Journal of Paramedic Practice* 282–286.

⁷⁷⁹ *Data Protection Act 1998* (UK); Younger Committee. Report of the Committee on Privacy. (Cmmd. 5012.) London: Stationery Office, 1972 cited by Jay Woogara (2001) Human rights and patients' privacy in the UK hospitals. *Nursing Ethics* 8 (3). <http://journals.sagepub.com/doi/pdf/10.1177/096973300100800308>

community about the ethical, not just the formal legal aspects, of incident reporting through social media.⁷⁸⁰

The risk of the misuse of social media is that it could compromise the reputation of paramedics, confidence in ambulance services and the ability of paramedics to maintain the trust of patients, which could have an adverse effect on the ability of paramedics to perform their vital role; or worse, limit vulnerable patients from accessing the healthcare system given that ambulance services are often the first point of entry.⁷⁸¹ This is a key issue of professionalism.

The distinction between the UK experience and the Australian experience is that the regulator in Australia is the Paramedicine Board itself which is made up of members of the profession. As such the Board and the individuals that comprise it have a vested interest in enforcing the policy because it has a duty to ensure the protection of the reputation of the paramedic collective. Managing the reputation of the profession is essential not just so the profession maintains its moral authority, but because maintaining its moral authority is linked to maintaining public trust and confidence in paramedics. A loss of public trust and confidence risks the public choosing not to use paramedics as a first point-of-access to the healthcare system and calling an Uber or a taxi instead. In developing a social media policy specific to paramedics, the Board could contribute to the development of a culture within the Australian paramedic community about the appropriate use of social media in the workplace that would be distinct from that in the UK where it has become such a problem.

There is some question over whether tweeting about a patient case breaches the law. However, in cases where that ambiguity exists, the culture and ethos of professionalism should step in to act to protect the interests of patients by requiring paramedics to not engage in similar behaviour and further, to lobby either individually or collectively to stop healthcare services from doing so. Such an application of professionalism is particularly important to develop in paramedics a sense of commitment to consistently apply ethical obligations not necessarily congruent with the profit-driven needs or priorities of their employers.

⁷⁸⁰ Aidan Baron and Ruth Townsend, 'Live Tweeting by Ambulance Services: A Growing Concern' (2017) 9(7) *Journal of Paramedic Practice* 282–286.

⁷⁸¹ *Ibid.*

In developing a culture and ethos of professionalism, the Paramedicine Board cannot just rely on codes, policies and guidelines alone. These documents will go some way to helping paramedics understand who they are, what they do and what they stand for by socialising paramedics towards this aspect of their professional development. However the process of developing a professional identity that embodies principles of professionalism is a learning process that ‘connects all aspects of professional practice’⁷⁸² including not only formal teaching of paramedic professional values and practices, but also experiences and expressions of a community of paramedic practice.⁷⁸³

The learning processes for paramedic professionalism development also includes reflective practices. It is not enough to rely on the prescriptive detail of a code of conduct for paramedics to practice with professionalism. Being a professional requires the practitioner to reflect on their experiences, ‘make sense of, clarify, and develop knowledge and performance.’⁷⁸⁴ Ironically the requirement to reflect is included in some codes. For example, the Good Medical Practice guide refers to ‘self-reflection’ as a elements of maintaining professional performance,⁷⁸⁵ and the Code of Conduct for Midwives sets out three main principles of professional conduct that includes ‘practising reflectively’⁷⁸⁶ however, it is not merely the act of reflecting that is important, it is understanding why and for what purpose reflection is useful. Reflection is related to the development of professional character and a professional conscience – the soul of professionalism.⁷⁸⁷

⁷⁸² Ibid, 6.

⁷⁸³ Ibid, 6; Ian Wilson, Leanne S. Cowin, Maree Johnson, and Helen Young. ‘Professional identity in medical students: pedagogical challenges to medical education.’ (2013) 25 (4) *Teaching and learning in medicine* 369-373; Malcolm Woollard, ‘Professionalism in UK paramedic practice.’ (2009) 7 (4) *Australasian Journal of Paramedicine* <

<https://ajp.paramedics.org/index.php/ajp/article/viewFile/181/198>>; Sue First, Lucy Tomlins, and Andy Swinburn. ‘From trade to profession-the professionalisation of the paramedic workforce.’ (2012) 4 (7) *Journal of Paramedic Practice*, 378-381.

⁷⁸⁴ Hannah Turner, ‘Reflective practice for paramedics: a new approach.’ (2015) 7 (3) *Journal of Paramedic Practice*, 138-144.

⁷⁸⁵ Medical Board of Australia, *Good Medical Practice Guide: A Code of Conduct for Doctors in Australia* (March 2014) 4 <<http://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx>>.17.

⁷⁸⁶ Nursing and Midwifery Board of Australia, ‘Code of Conduct for Midwives’ (Effective March 2018) 6 <<http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx>>1.

⁷⁸⁷ Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001) 217.

7.4 The Soul of Professionalism: Beyond Codes and Policies

Codes and policies play an important role in establishing, coordinating and making known the expected standards of professional behaviour and values of a group. Codes are a form of conceptual coherence – the attempt to align values and aspirations to virtuous actions. The National Law does allow for an enforcement mechanism to use these norms in adjudication and thus they play an important role in paramedic professional regulation.

However, professionalism is not just generated from a set of rules or following a code of conduct. Freidson suggests that some professionals ‘do not merely exercise a complex skill, but identify themselves with it.’⁷⁸⁸ For some professional conscience is developed and for others it is something ontological. It is ‘being, thinking and acting as a professional’ and ‘knowing what one stands for because knowing what one stands for clarifies...making judgements and decisions and taking responsibility for these judgements and decisions.’⁷⁸⁹ This notion of professionalism as something beyond codes and policies is likely more related to the notion of professional conscience. Codes of conduct and other behavioural standard-setting documents may be able to be used, in conjunction with other teaching and mentoring, to stimulate development of health professional character and conscience.⁷⁹⁰ Faunce argues that professional ethos, like individual character, develops from the accretion of virtues themselves maintained by the consistent application of altruistically-focused principles.⁷⁹¹

The National Law seeks to promote professionalism as both an element of an individual’s professional conscience⁷⁹² shaped by codes, universal ethical norms, policies, professional identity and role, purpose, specialised knowledge and skills, as well as strictly legal concepts of rules and procedures (positivist). The National Law is therefore an example of an ‘integrated’ professional regulatory system that provides for a

⁷⁸⁸ Eliot Freidson, *Professionalism Reborn: Theory, Prophecy and Policy* (Polity Press, 1994).200.

⁷⁸⁹ Franziska Trede and Celina McEwen. ‘Developing a critical professional identity.’ In *Practice-based education*. (SensePublishers, Rotterdam, 2012) 6.

⁷⁹⁰ Thomas Faunce, ‘*Who owns our health?*’ (UNSW Press, 2007).244; Sue First, Lucy Tomlins, and Andy Swinburn. ‘From trade to profession-the professionalisation of the paramedic workforce.’ (2012) 4 (7) *Journal of Paramedic Practice*, 378-381.

⁷⁹¹ Thomas Faunce, ‘*Who owns our health?*’ (UNSW Press, 2007).244.

⁷⁹² As distinct from personal conscience often referred to as individual morals. Ruth Townsend and Morgan Luck, *Applied Paramedic Law and Ethics* (Elsevier, 2013).

coherence between the regulation of the profession's specialised knowledge and skills and the power that is associated with it, and the profession's conscience and character developed by culture and education so that they are both harnessed for the public good and in the public's interest.

Ultimately the National Law provides a protection of the title 'paramedic' that suggests that the title is worth protecting because it signifies something beyond just a reference to a group of workers with a particular set of knowledge and skills and a particular qualification. It suggests a focus on not just *doing* the work of a paramedic but actually *being* a paramedic. As the occupational transforms from a trade to a profession, so to must paramedics transform from technicians to professionals. This will be a dynamic process that requires the profession to develop a professional identity that reflects the group's values and principles.

The issues discussed in this chapter identify how regulation under the National Law will present paramedics with new professional powers and responsibilities, including acting to protect their own health and that of their colleagues, and the power to protect the interests of their patients where there are conflicts of duty. Regulation as professionals will also require paramedics to shape their own identity and values and to set standards of not only competence but also conduct. This is critical to ensure coherence between their legal status as professionals and their obligation to act with and be regulated by principles of professionalism.

The next chapter summarises the key themes identified in this thesis and provides a final discussion on the way in which the law has facilitated the professional development of paramedics. It also provides a list of recommendations for future action.

Chapter 8: Conclusion and Future Directions

This thesis began with the proposition that despite having highly specialised knowledge and skills and providing a unique and critical public service, paramedics have not been regulated the same way as other health professionals in Australia. Until paramedics commence being regulated by the National Law there will continue to be no regulatory requirements that establish a minimum standard of education for entry to the paramedic profession, nor a consistent management process for incompetent paramedics or those who have engaged in misconduct. There is no standardised, transparent disciplinary proceedings for untrained, unqualified, incompetent or unethical paramedics. Indeed, until paramedics are regulated under the National Law anyone—bar in a few states— can call themselves a paramedic without any medical training at all, and not be in breach of the law. Because paramedics in Australia are not regulated as other health professionals are, they have also been unable to advance their professional aspirations of becoming self-regulating, which would allow them to work removed from the control of their state ambulance service masters or to develop a unified cultural ethos or social esteem, here termed professionalism.

This study has used a socio-legal approach to answer the following questions:

- Why should paramedics be regulated as health professionals under the National Law?
- How can the law facilitate the professionalisation of paramedics in Australia?
- What effect might professionalisation have on paramedicine?

The hypothesis of this thesis was that paramedics should be regulated under the National Law because this will facilitate the development of a culture and ethos of professionalism of paramedicine and offer paramedics an opportunity to work in a new and positive way.

This thesis has made both descriptive and normative claims. It has primarily set out to describe the nature of paramedic regulation as it is and as it will be under the National Law. It is the author's view that regulation under the National Law will benefit both patients and

paramedics. This normative position is not specifically defended though at places it is referred to.

The basic elements for professionalism were identified in Chapter 2 as a result of a review of the existing literature. Chapter 2 analysed how early sociologists identified that professions were a sociological phenomenon;⁷⁹³ a group of workers distinct from others. They identified that this group of workers had a number of common characteristics. These included technical competence linked with functional specificity; and a moral superiority and trust to perform their job to the highest technical and moral standards while placing the client's interests before self-interest. The combination of these elements appeared to provide professionals with a legitimate moral and technical authority that allowed them to regulate themselves using a set of values that they determined.⁷⁹⁴

Chapter 3 analysed how paramedics in Australia historically embodied—in addition to characteristics common to professions as identified in the Freidson elements—the quality of being routinely exposed in the course of work to substantial threats of personal harm or danger. Chapter 3 showed how the nature of paramedic work is unique among health professions in that it takes place in a largely uncontrolled, out-of-hospital environment and is usually in response to an emergency call for help. Paramedics attend the call with very little idea of what it is they will find when they arrive. This unique role demands that paramedics be resourceful, malleable, instinctive and intuitive. They need to be able to assess a scene quickly to determine if the risk of them entering the scene is greater than the benefit that may come from them doing so. Unlike their medical or nursing counterparts, who, for the most part work in controlled and well-resourced environments, paramedics are required to assess a patient with very little by way of sophisticated technological or human resources and this is often required to be done in a time-critical way. The stakes are often high, with paramedics literally managing life-and-death situations. To do this job well

⁷⁹³ Abraham Flexner, 'Is Social Work a Profession?' (1915) 1 *School and Society* 904; Talcott Parsons, 'The Professions and Social Structure' (1939) 17(4) *Social Forces* 466; Ernest Greenwood, 'Attributes of a Profession' (1957) 2 *Social Work* 45; Harold Wilensky, 'The Professionalisation of Everyone?' (1964) 70 *American Journal of Sociology* 137, 143; Terence Johnson, *Professions and Power* (MacMillan, 1972) 25; Magali Sarfatti Larson, *The Rise of Professionalism: A Sociological Analysis* (University of California Press, 1978) xvii; Julia Evetts, 'Professionalism: Value and ideology.' *Current Sociology* 61.5-6 (2013) 782; Eliot Freidson, *Professionalism Reborn: Theory, Prophecy and Policy* (Polity Press, 1994); Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001).

⁷⁹⁴ Eliot Freidson, *Professionalism Reborn: Theory, Prophecy and Policy* (Polity Press, 1994); Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001).

paramedics have, over time, developed a complex and specialist body of knowledge and skills that are unlike those of other health practitioners.

As has been shown, over the past 40 years, with advances in technology and medical research, the role of the paramedic has expanded substantially to now include a broad range of high-risk interventions performed in largely uncontrolled and unobserved environments. These interventions include invasive and technical procedures, working with patients who are often disrobed, delivering babies and administering restricted drugs like anaesthetic agents and opioids via injections under the skin and into the bone marrow; yet they are not subject to the same regulation as other health professionals are. These interventions place them as the healthcare group that performs the fourth-highest number of risky tasks out of all the health practitioners in our society, just behind nursing and medicine.⁷⁹⁵ Other health professions involving much less risk—chiropractors and psychologists—are regulated in the same way as doctors and nurses.

Chapters 3 and 4 revealed how this unique role and body of knowledge has provided paramedics with political legitimacy and power that drove them on the journey to legal professionalisation. This power has most commonly been reflected in the discipline's harnessing and utilisation of industrial law to at first have their role recognised as something distinct from a taxi service, and their skills recognised as being distinctly different from those of a taxi driver. Paramedics went on to use this power to argue for better pay and conditions for staff; above those paid to other commensurate professionals such as nurses. Finally, paramedics were able to take advantage of the social, political and economic factors that contributed to the structural and legislative reform of the healthcare workforce by arguing that they posed a risk to the public in the performance of their highly specialised role and that they were capable of expanding that role to meet the objectives of the legislation. Paramedics were able to harness their moral and technical authority (power) as a specialised group of workers performing a unique and significant public purpose to lobby successfully to be regulated as other health professions are, and in so doing acquire autonomy and the power to self-regulate but there are challenges ahead for the profession

⁷⁹⁵ AHMAC, *Final Report: Options for the Regulation of Paramedics* (September 2015) 110–1 <<http://www.coaghealthcouncil.gov.au/Portals/0/Paramedics%20Decision%20RIS.pdf>>.

with regard to organising the governance structure of the associated professional bodies in order to continue to harness and utilise paramedicine's political power.

Chapter 4 also identified that paramedics were able to acquire regulation and professional status under the National Law on the basis that they play a unique and important public service role as emergency out-of-hospital providers; that they have specialist knowledge and education; and that they pose a risk to the public when they perform their role as emergency out-of-hospital providers. This should inform the decisions of the Paramedicine Board when deciding what qualifications should lead to registration as a paramedic and what standard, and scope, of practice should be expected from a registered paramedic. Their unique purpose informs their education requirements and their code of conduct, which should in turn reflect their identity. This is what sets paramedics apart from other health practitioners and allows them to maintain their professional status, which includes not only elements of professionalism in practice, but also elements common to those occupational groups that are recognised as professions as distinct from non-professions. They should resist the temptation to broaden their scope of practice beyond the skills and knowledge to perform emergency out-of-hospital work. This is not to say that paramedics' skills and knowledge will not continue to develop as it has over the past few hundred years. What it does suggest is that paramedics should restrict the increase or shift in knowledge and skills only where that knowledge and those skills are necessary to perform their unique role better, more efficiently, more effectively and more safely. To stray into the work domain of others, beyond the emergency out-of-hospital care response, would be to risk losing their point of distinction.⁷⁹⁶

The hypothesis of this thesis was that being regulated by the National Law will facilitate the professionalisation of paramedics by providing them with powers including the power to self-regulate, and responsibilities including to act with professionalism, that would not have been possible without the law. The legal process of professionalisation and the fundamental professionalism elements common to all health professions under the National Law were set out in Chapter 5. The argument in chapter five that regulation under the National Law will grant to any occupational group that is regulated by it, sufficient authority to establish themselves as a profession. This is indeed is a purpose of

⁷⁹⁶ Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001).

the legislation - to utilise legislative reform for structural reform. The intended effect of the law is to empower health groups that may previously been unable to professionalise the authority to do so and thus allow them to utilise this status to compete with the dominance of medicine in the healthcare policy and practice space.

In Chapter 6, an examination of the UK regulatory regime and its effects on the legal professionalisation of paramedics identified that the UK regulatory model has not facilitated the cultural professionalism or professional ethos of paramedics as effectively as the Australian model is likely to do for Australian paramedics. Although paramedics in the UK followed the same professionalisation trajectory as identified by Wilensky,⁷⁹⁷ a trajectory common to the professions and that includes a profession becoming regulated at law, the UK regulatory model did not cohere with the Freidson elements for a profession. The UK model does not allow for paramedics to self-regulate by establishing a standardised educational curriculum that is accredited by paramedics, there is no peer-to-peer disciplinary model and there is no code of conduct that is particular to paramedics. This has resulted in UK paramedics believing that they have not fully professionalised and complaining that those in the HCPC—who sit in judgement of them—do not fully understand what paramedics do.

Chapter 6 explained that although paramedics in the UK were recognised as professionals at law (i.e., they are regulated by the HCPC), the regulatory structure is essentially a bureaucratic one; that is, paramedics are regulated in a generalised way rather than a specialised way. They do not have control over their own knowledge, they do not self-regulate and they do not have their own code of conduct. The UK regulatory model, like the Australian model, was designed to break down historically established structural barriers that were limiting the flexible development of the healthcare workforce. UK paramedics embraced the opportunity to expand their scope of practice beyond their traditional and unique role as emergency out-of-hospital care providers. Paramedics are now able to work in a wide variety of settings including hospitals and medical clinics in a role that could have been performed by any number of other health professionals including nurses and physician assistants. However, this apparent extension of the paramedic role has

⁷⁹⁷ Harold Wilensky, 'The Professionalisation of Everyone?' (1964) 70 *American Journal of Sociology* 137.

actually resulted in confusion regarding the professional identity of paramedics by those who sit in judgement of paramedic performance, and others. The structure of the regulatory scheme does not help to provide clarity as to purpose. Discretionary specialisation associated with professionals allows for flexibility in the practice of specialised skills for a unique purpose. This notion of flexibility and the valuing of specialisation has been lost in the UK's restructure of the workforce that was implemented as an attempt to increase the skills mix of the healthcare workforce. The adoption of a bureaucratic regulatory regime that values uniformity in the form of generic standards of conduct and assessment of professional behaviour has hampered the ability of paramedics as professionals to regulate themselves and has not recognised the unique role and responsibilities that paramedics have and that set them apart from other health professionals.

Instead, paramedics in the UK are regulated the same way as art therapists. They are subject to a generic code of conduct. They do not have control over the nature of their work, which is evidenced by their lack of control over their curriculum. Their work performance is judged not by their peers but by outsiders. All of these elements have contributed to a lack of professional development for paramedics in the UK, despite the introduction of regulation to facilitate professionalisation over a decade ago. This demonstrates the paradox of the bureaucratic model of regulation that, *prima facie* appears to give paramedics professional status but has had the effect of leading them to believe that they have not fully professionalised because they do not have control over their own work. This dilution of the paramedic role and identity as a specialist in emergency out-of-hospital care and has contributed to those sitting in judgement of paramedic performance not fully understanding who or what paramedics do or are; this is in part because paramedics themselves do not seem to know who they are or what they do.

The broadening of their role may have provided paramedics with interesting job opportunities but it has arguably come at the cost of the profession's identity and power by shifting them outside the 'Goldilocks zone' of having their jurisdictional practice boundaries 'just right'. There is a value in discretionary specialisation that allows for professionals to use their expert knowledge and skills and commitment to professionalism (putting the patient's interest first) because it allows paramedics the flexibility to determine the best course of treatment and care for emergency out-of-hospital patients and not be

beholden to rigid bureaucratic governance structures. However, the UK experience provides a warning for Australian paramedics.

The objective of the Australian legislation provides the same temptation for paramedicine in Australia as it did in the UK. An objective of the legislation is to facilitate the development of a flexible healthcare workforce by expanding the scope of practice and authority of allied health groups who have traditionally not enjoyed the same professional privileges as, for example, medicine. However, although this provision may appear to provide paramedics with an opportunity to extend their work and open up new areas of practice, Chapter 6 highlighted a concern that if they were to do so, they would risk losing touch with the elements upon which they have relied to gain professional status; diluting their unique purpose as emergency out-of-hospital care providers and the specialist knowledge and skills that they have acquired to undertake that role.

Chapter 7 considered Freidson's view that the acquisition of professional status does not equate to an occupational group having fully professionalised unless there is a coherence between their legal status and their professionalism.⁷⁹⁸ This chapter examined the way in which the profession once regulated under the National Law, will, for the very first time have to develop a clear professional identity. It recognised that the National Law will provide a mechanism for the Paramedicine Board to develop this identity through a process of consultation, and reflect that identity in codes, guidelines and policies that will in turn facilitate the development of a culture and ethos of professionalism. Chapter 7 also considered how regulation under the National Law will provide paramedics with new power and responsibilities associated with their new role as a health profession.

This thesis set out to determine whether, in light of this, paramedics in Australia should be regulated the same way as other health professionals; whether the law could facilitate paramedicine's transition from stretcher bearer to health professional—a goal of this particular occupational group; and what effect legal professionalisation of paramedicine might have on the ethos or culture of the discipline (its professionalism). To address these issues, this thesis examined and analysed the process towards legal professionalisation of Australian paramedics over the past 150 years. It identified that the development of the idea

⁷⁹⁸ Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001).

that paramedicine should be a profession began slowly and in an ad hoc, informal way in response to a series of unrelated factors. Those factors included societal needs, advances in medical knowledge and technology, education, industrial action and the law. It is only in the past decade that Australian paramedics have organised themselves with the intention of furthering the development of their profession in a more formal or legal way. Despite the largely unintentional evolution of paramedic professionalisation in Australia, the trajectory that has been followed is consistent with that identified by Wilensky as being common to the development of professions.⁷⁹⁹

8.1 Summary Findings

In overall terms, this study has confirmed that the awarding of a legal ‘licence to practise’ or ‘registration’ is, on its own, not enough to grant a discipline the power of self-regulation or to create within it a culture and ethos that will attract young people wishing to shape character by disciplining personality to the commands of altruistic duty. The Australian regulatory model provides evidence of the way in which the law can be drafted to provide occupational groups with the power to self-regulate and the UK model provides evidence of the way in which the law can be drafted to limit the power of a discipline to self-regulate. For the legal process of professionalisation to serve as a tool for fostering cultural professionalism, it must provide the key elements of professional status; namely the power to control their own work through self-regulation of education, conduct and competency standards and the power to assess and enforce them. The lesson of the UK case study presented in Chapter 6 is that National Law will need to give paramedics the opportunity to realise their goal of acquiring all the elements associated with professionals: a unique purpose, specialist knowledge and education, a code of conduct, self-regulation and with it, power. However, there is a risk that they may mimic the UK’s experience and dilute their professional status by defining themselves too broadly. If paramedics decide that the work of others in emergency or out-of-hospital healthcare (e.g., first aiders, NEPT officers and community care paramedics) is ‘paramedic’ work, they risk undermining the very unique element that sets them apart from other healthcare practitioners and being hampered

⁷⁹⁹ Harold Wilensky, ‘The Professionalisation of Everyone?’ (1964) 70 *American Journal of Sociology* 137.

by a lack of understanding by other professionals and the public as to who paramedics are and what they do. This could weaken their professional power.

An examination of the history of paramedicine in Chapter 3 found that there has been a legal distinction between the work of a paramedic and other similar workers—including, for example, taxi drivers—as the need for a specialist out-of-hospital care provider became recognised. The significance of this historical development should not be overlooked. Although the rate of emergency ambulance work has decreased over recent decades, the rise in the aging population remaining at home,⁸⁰⁰ and the dual external public health threats of climate change⁸⁰¹ and terrorism⁸⁰² require paramedics to consider if the specialist role in emergency out-of-hospital care will, in the near future, become more important than ever before.

In short, paramedics have, over time, developed their unique and important public purpose as emergency out-of-hospital care providers. They have acquired specialist knowledge and education that allows them to perform this unique role. Because of this unique role and specialist knowledge they have developed some power that has allowed them to lobby to be recognised and regulated as are other health professionals. Regulation under the National Law will give them the opportunity to finally regulate themselves and determine for themselves who they are, what they stand for and what they do. They would be wise to heed the lessons of history and know that in preserving or monopolising a specialist area of knowledge and role, an occupational group maintains power to control their own work because it provides them with a moral and technical authority. A loss of focus on the preservation of that specialist area of knowledge and power risks diluting that power over their own work.

This study found that:

⁸⁰⁰ Judy Lowthian, Damien J. Jolley, Andrea J. Curtis, Alexander Currell, Peter A. Cameron, Johannes U. Stoelwinder, and John J. McNeil. 'The challenges of population ageing: accelerating demand for emergency ambulance services by older patients, 1995–2015.' (2011) 194 (11) *The Medical Journal of Australia*, 574-578.

⁸⁰¹ Janet Richardson, Peter Allum, and Jane Grose. 'Changing undergraduate paramedic students' attitudes towards sustainability and climate change.' (2016) 8 (3) *Journal of Paramedic Practice*, 130-136.

⁸⁰² Linda Sibson. 'Paramedics: ready for terrorism?' (2012) 4 (8) *Journal of Paramedic Practice*, 439-439.

1. Paramedics have evolved over time from a group of workers who have developed their occupation in an ad hoc, unorganised and inconsistently controlled way to become a group who will be organised and controlled by a unifying piece of legislation that will, for the first time, allow them to be regulated consistently both externally and internally.
2. The National Law can facilitate the professionalisation of paramedics because it will, for the first time, give them the power to regulate themselves, separate from their employer; something they currently cannot do. Once paramedics are regulated by this law they will be able to determine their own education, conduct and competency standards. Regulation under this law values the discretionary specialisation of paramedics. They will have the power to judge the performance of others within their professional group as to whether they meet the standards of practice of a 'reasonable paramedic' and they will gain autonomy of practice, which for paramedics means being licensed to practise paramedicine outside traditional ambulance services.
3. The National Law will give the paramedic profession, specifically the Paramedicine Board, the power to develop a culture and ethos of professionalism within the occupational group as whole, unified entity, with the use of a range of national standards of education, conduct and competency. However, in order to begin to draft up its governance standards, the profession needs to determine its own identity. It needs to be clear about what a paramedic is, what a paramedic does and what values and culture paramedicine holds. At the time of writing, all of these issues remain unclear.
4. An objective of the National Law professional regulatory system was to structurally reform the healthcare workforce to make it more 'flexible' and thus challenge and limit medical dominance. The National Law does this by allowing all health professions regulated by it to expand their scope of practice and to not only move beyond traditional silos of practice but also to be held independently accountable for their own actions. This thesis has argued that whilst there are benefits in making the Australian healthcare workforce more flexible, there are associated risks including that it will reduce the specialisation and unique purpose of healthcare professions. Specialisation of knowledge and a unique purpose are two critical elements of the legal process of professionalisation that provide an occupational group

with professional power. A shift away from specialisation and towards generalisation would be to forget the value of the division of labour in healthcare. Healthcare is complex and therefore specialisation is necessary for practitioners to practise safely, effectively and efficiently. Safety is essential for public trust. Trust garners power.

5. Not all models of legal regulation of health practitioners facilitate the development of cultural professionalism, a sense of group identity or ethos of those occupational groups. The UK model promotes ‘flexibility’ in the form of increasing the skill mix of each health profession in an attempt to broaden access and lower costs.⁸⁰³ However, as with the Australian model, the term ‘flexibility’ really means ‘generalist’. The UK regulatory model is a bureaucratic model of regulation that promotes standardisation and generalisation rather than specialisation. The use of a generic regulatory model is too rigid to accommodate the particularities of each profession it regulates and gives control of the health professions to managers rather than the professions themselves. This model of regulation has allowed paramedics to expand their practice beyond their traditional role as emergency out-of-hospital care providers but in so doing has created confusion among the public and the regulator, and frustration among paramedics as to who paramedics are, what paramedics do and how they should do it.
6. In gaining status as professionals, paramedics will have the power to provide protection for vulnerable patients and members of the community in a new way. The holding of specialised expert knowledge and skills in a particular area of healthcare, and being governed by a peer-to-peer system that relies on principles of professionalism—combined with their power to self-regulate—provides health professionals with an independence that allows them and at times requires them to judge, criticise or disobey ‘employers, patrons and the laws the state’.⁸⁰⁴ Regulation by professionalism works to protect patients where a conflict of laws may operate that has the effect of subjugating the

⁸⁰³ Law Commission, Scottish Law Commission and Northern Ireland Law Commission, *Regulation of Health Care Professionals and Regulation of Social Care Professionals in England, A Joint Report*, Law Commission Report No 345 (2014).

⁸⁰⁴ Eliot Freidson, *Professionalism: The Third Logic* (Polity Press, 2001) 217.

patient's interests to those of another; for example, an employer or even the state.

7. Regulation under the National Law alone will not guarantee that paramedics will be able to establish an autonomous practitioner model—that is, one that is removed from traditional ambulance services—because the experience of nurse practitioners suggests there are still structural barriers to working in non-traditional roles and spaces. Additionally, there may be other structural barriers, including the resistance of state based ambulance service employers like NSW, to support and promote the professional development of paramedics.

8.2 Recommendations

The recommendations for the paramedic discipline from this study include:

- a) The Paramedicine Board should resist the temptation to expand the scope of practice of paramedics beyond their traditional emergency out-of-hospital care response to preserve the unique purpose of the profession and the specialist knowledge and skills that are associated with it. Any broadening of the role risks losing this unique purpose and specialist knowledge, which could result in a loss of power for the profession.
- b) The Paramedicine Board should develop a code of conduct that reflects the identity, culture and values of paramedicine and this should be disseminated widely; both internally to paramedics and the health industry more broadly, and to the public. This should be accompanied by an explanation of how the code should be used.
- c) The code of conduct should be mandated as a requirement of any accredited paramedic education course so that it becomes intrinsic to the foundation of the profession's future by helping to shape the identity of paramedics as professionals and development of a culture and ethos of paramedic professionalism.

8.3 Future Directions

There are several avenues for future work and research that can build on this study. There are a number of international jurisdictions considering the regulation of paramedics.⁸⁰⁵ This study could help inform the regulatory model to be developed in those jurisdictions. This study suggests that the Australian model of regulation is more likely than the UK model to support the professionalisation of paramedicine because it allows paramedics to self-regulate, and in so doing utilise their specialist knowledge and skills with discretion, in the best interests of the public – a clear marrying of professionalisation with professionalism. This finding could be tested with further research. A few years from now Australian paramedics will have been regulated in this way for a number of years and there will be data available to identify how effective this form of regulation has been for paramedics in Australia, and that data may also help inform an empirical comparative analysis with the UK model of regulation to identify which model produces the best outcomes for patients and practitioners.

⁸⁰⁵ For example, Canada and New Zealand. See Secretariat of Ontario Health Professions Regulatory Advisory Council, ‘Regulation of paramedics and emergency medical attendants: a jurisdictional review.’ December 2012 <
http://www.hprac.org/en/projects/resources/ParamedicsandEMAJurisdictionalReview_EN_2013_04_02.pdf
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