Greg
PARAMEDIC
Rural Queensland.

"Then there are the 'out-of-town' calls—the long distances, vague directions, faltering communication systems, and significant isolation. This is where I feel (medically) most alone. Backup is hours away. My 'phone a friend' consult line is redundant. My transport time to definitive care grows with each kilometre I drive (and hopefully I am driving in the right direction)".

Picture for illustration purposes

Today's story comes from Greg, a paramedic working in a small town in rural Queensland. Greg describes the different models within which paramedics operate, highlighting the key challenges and risks associated with operating within these models. Often responding to call-outs solo due to workforce shortages in small rural areas, Greg describes how he takes advantage of his knowledge of the local area to respond swiftly—but is quick to point out the combined effects of the multiple challenges of distance, connectivity issues, and isolation on any response. Greg paints a vivid picture of the daily realities for paramedics in small rural settings, and the constant need for them to think on their feet and make quick decisions about the different situations they encounter.

Greg's story:

I work as a paramedic in a small rural town about five hours west of Brisbane. Two paramedics service the town. Our roster is an eight days on and six days off cycle. We both work Thursdays. Thursday is the only day we have a two-paramedic response. All other days of the week, I respond alone and am continually available for immediate dispatch. My nearest backup (another single paramedic) is usually more than an hour away.

The town and its surrounds has a population of about 800 people. It's largely a farming community that is currently suffering the impact of a severe drought. Animal stocks are very low and water for crops is very scarce.

We have a single General Practitioner (GP) in town. The GP is also the Medical Superintendent of the small rural hospital. The hospital is staffed with local or agency nurses who cover the hospital around the clock. Generally, on duty at any one time are a Registered Nurse and an Endorsed Enrolled Nurse.

We try and maintain routines, and a typical day begins with some form of exercise. We are always available for immediate dispatch, so this exercise is always static (treadmill, free weights, etc) and in close proximity to the dispatch phone. Often these routines are hijacked by a 'call-out' during the night, or even during exercise.

At 0800 hours we shift from an 'on-call' model of deployment to an 'on-shift' model. Generally we will commence 'shifts' at the ambulance station. We touch base with our communication centre and perform routine maintenance tasks such as checking equipment, stock levels, battery life and use-by dates.

Call-outs can occur at any time within the 24-hour cycle. Most are in town and our responses are usually very quick, as there is often no traffic and we know the streets well. Quite often too, we know the patient.

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PARAMEDIC PERSONAL STORY

Delivering paramedicine alone can be a significant challenge for a rural paramedic. History taking, physical examinations, and obtaining base vital signs are all pretty straightforward. Working on your own just takes longer. Care planning is different—I am on my own. Do I 'stay and play' or 'load and go'? Stay and play decisions are easy when the patient forces your hand. Active seizures need to be stopped, intractable pain needs to ameliorated, and fractured bones need to be splintered.

The resilience and connectedness of rural folk often reveals itself when a paramedic is called to an in-town house. The patients often state, "I'll be right—just get me to hospital". This is said despite the intractable pain or deformed limb. Friends and neighbours will suddenly appear and, of course, extrication of immobile or obtunded patients would be impossible if it were not for the rural fire brigade. These folk are often my drivers—allowing me to continue providing care in the back of the ambulance.

Then there are the 'out-of-town' calls—the long distances, vague directions, faltering communication systems, and significant isolation complicating responses. This is where I feel (medically) most alone. Backup is hours away. My 'phone a friend' consult line is redundant. My transport time to definitive care grows with each kilometre I drive (and hopefully I am driving in the right direction). On scene, I work through my standard processes and hatch a treatment/transport plan. These plans can be the most challenging. The logistics are different—aeromedical evacuation, finding a driver when someone needs to stay behind and look after the animals, giving opioids or cardioactive medication to a patient and leaving them on their own in the back of an ambulance whilst I drive—all with their own risks. But these are issues I deal with every week.

A rural paramedic is a member of the community. We are the conduit between the community, their acute presentations, and the health system.