



COLLEGE OF INTENSIVE CARE MEDICINE OF AUSTRALIA AND NEW ZEALAND

20 June 2025

Professor Stephen Gough ASM, Chair
Paramedicine Board of Australia
Via: paramedicineconsultation@ahpra.gov.au

Dear Professor Gough,

Re: Proposal to regulate advanced practice paramedics

The [College of Intensive Care Medicine, Australia and New Zealand](#) (CICM or the College) welcomes the opportunity to review and provide feedback on the *Proposal to regulate advanced practice paramedics*. The College remains opposed to this proposal.

About the CICM

Every year, over 200,000 children and adults are admitted to intensive care units (ICUs) across Australia and Aotearoa New Zealand.

The [CICM](#) is the body responsible for intensive care medicine specialist training and education in Australia and Aotearoa New Zealand. Bi-nationally, we have nearly over 1500 Fellows and approximately 1500 Trainees enrolled in our training program.

We set and maintain standards for intensive care units and provide continuing medical education, professional development, and advocate to governments and the community. We provide a high-quality training program, with supervision of clinical training, administration of assessments, and a range of workshops and courses.

CICM Position

The College previously participated in the Paramedicine Board's confidential consultation - regulating Advanced Practice Paramedics (APPs) in January 2025, raising significant concerns about the proposal's potential risks to patient safety. We are disappointed to find that the consultation paper has not been meaningfully updated since the preliminary phase. As a result, the College remains opposed to the proposal in its current form.

Paramedics play a vital and indispensable role within the healthcare system. When integrated into a multidisciplinary team with a clearly defined scope of practice and appropriate supervision, extended roles may offer value. However, we remain concerned that the proposed regulatory standards are overly broad, prioritising flexible future employment models for advanced practice paramedics rather than ensuring patient and public safety.

The College of Intensive Care Medicine acknowledges and pays respects to the traditional Custodians of the lands across Australia on which our members live and work, and to their Elders, past, present and future. We pay respect to the Wurundjeri Peoples as the Traditional Custodians of the land on which CICM's office stands. CICM acknowledges Māori as tangata whenua and Treaty of Waitangi partners in Aotearoa New Zealand.

Additionally, the proposal lacks sufficient detail on how paramedics would be integrated into critical care teams, increasing the likelihood of role duplication, confusion and operational inefficiencies

The College is deeply concerned that the proposal aims to introduce a workforce with significantly less training and a limited clinical background into the health system, granting them authority to prescribe, diagnose, and perform advanced clinical procedures typically reserved for intensive care specialists—who undergo six years of rigorous training (post medical training).

Furthermore, it remains unclear how this proposal would effectively address workforce shortages in regional, rural and remote areas. Data from the [Australasian College of Paramedicine Workforce Survey Report 2023-2024](#) indicates that most paramedics currently work in urban settings and prefer employment within jurisdictional ambulance services. CICM is concerned that this proposal is being driven by an oversupply of paramedics, rather than community need. More evidence is needed to demonstrate that this proposal will safeguard patient safety while meaningfully addressing workforce supply and maldistribution issues.

Recommendations

The CICM is concerned that this proposal represents a broader push to pursue band-aid solutions to health workforce shortages rather than solving ongoing systemic issues.

To help improve access to timely and safe quality care, the CICM recommends that:

1. All governments work with medical schools, medical colleges and workforce agencies to ensure doctors and specialists are supported and incentivised to work in areas of need
2. The Paramedicine Board work with the Australian Medical Council, Medical Board of Australia and medical schools to develop flexible pathways into medicine for APPs
3. The Paramedicine Board consider implement collaborative care agreements so APPs can work under the supervision of a medical practitioner
4. All stakeholders work to increase the efficacy of the paramedic workforce by utilising their skills more effectively.
5. Governments work to appropriately balance training positions with workforce demand and utilise surplus training funds to support professions with workforce shortages.

We hope that the information contained in our submission is helpful. Should you have any queries or comments regarding our feedback, please feel free to contact Ms Michelle Gonsalvez, General Manager, Policy and Strategy on (03) 9514-2837 or via policy@cicm.org.au.

Yours sincerely,



Assoc Prof Peter Kruger
President

The College of Intensive Care Medicine acknowledges and pays respects to the traditional Custodians of the lands across Australia on which our members live and work, and to their Elders, past, present and future. We pay respect to the Wurundjeri Peoples as the Traditional Custodians of the land on which CICM's office stands. CICM acknowledges Māori as tangata whenua and Treaty of Waitangi partners in Aotearoa New Zealand.

Public consultation questions template

April 2025

Consultation template questions

The Paramedicine Board of Australia (the Board) is conducting a public consultation as part of its proposal to regulate advanced practice paramedics. The Board invites your feedback on the proposal using the questions below.

Please record your responses to the questions in a word document (not PDF) and email the completed template to paramedicineconsultation@ahpra.gov.au by close of business on **Friday 20 June 2025**.

Stakeholder details

If you would like to include background information about your organisation, please do this in a separate word document (not PDF).

Publication of submission

The Board publishes submissions at their discretion. The Board will generally publish public consultation responses on its website to encourage discussion and inform the community and stakeholders. Unless otherwise requested, the Board will publish submissions on its website.

The Board will not publish on its website, or make available to the public, submissions that contain offensive or defamatory comments or which are outside the scope of this consultation. Before publication we may remove personally identifying information from submissions, including contact details.

The Board also accepts responses made in confidence. These responses will not be published on the website or elsewhere. Submissions may be confidential because they include personal experiences or other sensitive information. A request for access to a confidential submission will be determined in accordance with the *Freedom of Information Act 1982 (Cth)*, which has provisions designed to protect personal information and information given in confidence. Unless otherwise requested, published submissions will include the names of the individuals and/or organisations that made the submission.

Please let us know if you do not want your submission published or want all or part of your submission to be treated as confidential.

Contact information

Please include the contact person's name, position and email address

Ms Michelle Gonsalvez,
General Manager, Policy and Strategy
policy@cicm.org.au

<p>Organisation</p> <p>If completing the consultation response on behalf of an organisation. Please include the organisation name</p>
<p>College of Intensive Care Medicine of Australia and New Zealand</p>
<p>Individual</p> <p>If completing the consultation response as an individual. Please select one of the following options:</p> <ol style="list-style-type: none"> 1. I am a registered paramedic 2. I am a registered health professional. Please include your profession 3. I am a member of the public
<p>N/A</p>
<p>Publication of consultation response</p> <p>Would you like your submission to be published? Please select one of the following options:</p> <ol style="list-style-type: none"> 1. Yes, publish my submission with my name and organisation name 2. Yes, publish my submission with my organisation name but without my name 3. Yes, publish my submission without my name and organisation name 4. No, do not publish my submission
<p>2. Yes, publish my submission with my organisation name but without my name</p>

Response to consultation questions

<p>Consultation questions for consideration</p> <p>Please provide your responses to any or all questions in the blank boxes below. If you would like to include your response in a separate word document, please provide this in word format (not a PDF)</p>
<p>1. Do you support the Boards proposal to regulate advanced practice paramedics with the proposed regulatory model and why?</p>
<p>Paramedics are a valued and indispensable part of the healthcare system. While the CICM agrees that there is a need to explore and develop innovative models of care to meet community need, we are concerned that this proposal risks patient safety.</p> <p>The College is open to exploring innovative models of care, as long as patient safety and community need are front and centre of reform discussions and that new non-medically trained roles have comprehensive education and training with appropriate supervision by a qualified medical professional. There also needs to be careful consideration of how new roles will be integrated into the broader healthcare system. This proposal fails to meet these requirements.</p> <p>The College of Intensive Care Medicine (CICM/the College) does not support the Boards proposal to regulate advanced practice paramedics (APPs) for the following reasons:</p> <p>Risk to patient safety: APPs would assess, diagnose, and prescribe scheduled medicines despite lacking medical training, potentially leading to unsafe care.</p>

Unsafe and unrealistic scope of practice: the proposal assumes APPs can undertake advanced critical care procedures despite lacking the extensive six years of rigorous vocational post-graduate training required for intensive care specialists.

Qualifications and standards: A master's in advanced paramedicine does not equate to intensive care specialist training.

Unsafe prescribing practices: the proposal allows APPs to prescribe, dispense, and administer scheduled medicines, despite lack of training in differential diagnosis, and also undermines the safeguard of separating prescriber and dispenser roles.

Lack of funding clarity: No detail is provided on how APP roles would be funded, potentially worsening existing financial pressures in MBS, PBS, and jurisdictional health departments.

Unclear integration into healthcare teams and wider workforce: there is a lack of detail on how APPs will operate within critical care and primary health teams, leading to inefficiencies, double handling and potential role duplication. There is also a lack of evidence to show that APPs would be more likely to work in areas of need.

2. Would the proposal result in any potential negative or unintended effects for people requiring healthcare, including members of the community at risk of experiencing poorer health outcomes? If yes, please explain why.

The CICM believes that this proposal would result in a number of negative effects for people requiring healthcare, particularly those at risk of poorer health outcomes. The College is greatly concerned that the broad scope of practice proposed would significantly compromise patient safety.

Unsafe Prescribing Model

The proposal recommends that APPs receive registration endorsements for prescribing scheduled medicines within their respective areas of practice. This expanded scope is concerning, as it grants APPs (who do not have medical training), the authority to assess, diagnose, and prescribe Schedule 2, 3, 4, and 8 medicines. We therefore believe that this proposal would result in critical care patients receiving dangerous or a lower standard of care. This proposal essentially expects paramedics to operate within a scope similar to that of medical practitioners, despite lacking equivalent knowledge and training.

There is strong evidence which highlights that non-medical prescribers are less accurate in diagnosis, tend to over-prescribe, and frequently over-order diagnostic tests.^{1 2} While the proposal suggests potential benefits in reducing hospital attendances, it is more likely to increase healthcare costs through unnecessary imaging, excessive testing, and inappropriate prescribing. Misdiagnosis not only places financial strain on the healthcare system but also leads to delays in appropriate care, negatively affecting patient outcomes and compounding costs.³

Furthermore, the proposal's assumptions regarding efficiency and reduced double handling appear flawed.

¹ Aledhaim A, Walker A, Vesselinov R, Hirshon JM, Pimentel L. Resource Utilization in Non-Academic Emergency Departments with Advanced Practice Providers. *West J Emerg Med.* 2019 Jul;20(4):541-548. doi: 10.5811/westjem.2019.5.42465. Epub 2019 Jul 1

² Hughes DR, Jiang M, Duszak R. A Comparison of Diagnostic Imaging Ordering Patterns Between Advanced Practice Clinicians and Primary Care Physicians Following Office-Based Evaluation and Management Visits. *JAMA Intern Med.* 2015;175(1):101–107. doi:10.1001/jamainternmed.2014.6349

³ Wilkinson-Stokes, M., Tew, M., Yap, C.Y.L. et al. The Economic Impact of Community Paramedics Within Emergency Medical Services: A Systematic Review. *Appl Health Econ Health Policy* (2024). <https://doi.org/10.1007/s40258-024-00902-3>

Patients with a history of drug abuse or drug-seeking behaviours are particularly vulnerable, as APPs may prescribe addictive substances without a complete medical history, increasing the risk of inappropriate treatment and patient harm. A fractured prescribing model also heightens concerns about antimicrobial resistance, posing a significant public health threat.⁴

The Board is potentially conflating “prescribing and dispensing” medicines with “supplying and administering” medicines. The College is not against APPs supplying and administering medicine in accordance with a prescription from a medically trained health professional.

Advanced Clinical Procedure Risks

The proposal suggests that APPs should perform "advanced clinical procedures required for advanced critical care" and "lead the response of a multidisciplinary team in managing critical care patients and implement advanced management and treatment options." This implies that APPs would take on roles akin to intensive care specialists who undergo a rigorous six-year training program (post medical training) to ensure they can provide high-quality care to the sickest patients in Australia.

Qualification Equivalency

The CICM does not consider most overseas intensive care specialist qualifications to be equivalent to those obtained in Australia. Additionally, Master’s degrees are academic degrees which assess graduates’ knowledge through academic papers and research projects. Intensive care specialist training is vocational – developing and assessing clinical skills in independent critical care practice. A Master’s degree and up to two years supervised practice is insufficient basis for APPs to safely practice autonomously. Therefore, it is highly unlikely that a Master’s qualification in advanced paramedicine would provide the same level of care.

Given these risks, more evidence is required to demonstrate how this proposal will safeguard patient safety while ensuring cost-effective and efficient healthcare delivery

Workforce distribution in rural areas

The proposal claims that APPs will alleviate workforce shortages in regional, rural and remote areas. However, there is no details in the proposal regarding how these practitioners will be incentivised to work in these areas. Data from [Australasian College of Paramedicine Workforce Survey Report 2023-2024](#)⁵ indicates that

- 69% of Australian paramedics work in an MM1 or MM2 area
- 79% of Australian paramedicine students want to work in a jurisdictional ambulance service
- Only 1% of Australian paramedicine students surveyed wanted to work in healthcare outside of an ambulance service

Moreover, [poor housing and infrastructure in rural and remote areas continues to be a barrier when addressing healthcare shortages](#). Scope of practice reforms will not significantly improve workforce distribution issues until quality-of-life issues are addressed properly. The proposal does not provide evidence as to how APPs would be incentivised to work rurally in a scope of practice, they potentially have little interest in.

⁴ Llor C, Bjerrum L. Antimicrobial resistance: risk associated with antibiotic overuse and initiatives to reduce the problem. *Therapeutic Advances in Drug Safety*. 2014;5(6):229-241. doi:10.1177/2042098614554919

⁵ Thyer L, Baldry S, Hernandez Grande A, Sharafizad F, Aiello S, Howie G, Miles, A, & Farr-Wharton B. *Australasian Paramedicine Workforce Survey Report 2023-2024*. Sydney: Australasian College of Paramedicine 2024.

Two Tier Healthcare System

This proposal will likely lead to a two-tier healthcare system, where patients who cannot access a doctor or specialist due to geographical location or financial considerations are cared for by a practitioner who does not have the same level of medical training.

This has the potential to reduce equity of access to high-quality healthcare and increase health disparities for already disadvantaged communities.

Lastly, without any detail on how this model will be funded, it may lead to significant out-of-pocket costs for patients, further creating barriers to care.

3. Would the proposal result in any potential negative or unintended effects for Aboriginal and/or Torres Strait Islander Peoples? If yes, please explain why.

We believe this proposal would result in negative and unintended effects for Aboriginal and Torres Strait Islander peoples. Aboriginal and Torres Strait Islander peoples are at significant risk of the vulnerabilities listed above. Gaps in patient history including missing identification data could result in poorer quality care for Aboriginal and Torres Strait Islander peoples.⁶

The consultation paper does not mention whether any of the Aboriginal and Torres Strait Islander peak bodies were consulted when developing this proposal. Considering that Aboriginal and Torres Strait Islander peoples make up a large proportion of the regional, rural and remote communities, this proposal purports to serve, we would be extremely concerned and disappointed if they were not adequately consulted.

4. Would the proposal result in any potential negative or unintended effects for paramedics? If yes, please explain why.

Paramedics who wish to diagnose and manage patients over the long term would benefit more from a pathway to medicine, where they can receive the appropriate training and education to safely operate within this complex scope. Alternatively, their existing skills could be more effectively utilised in the community.

Additionally, upskilling experienced paramedics to become APPs (who might predominantly work in primary care) will reduce the level of experience in the emergency care sector, where Paramedics are a vital and well-respected part of the emergency team.

5. Are there any other potential regulatory impacts the Board should consider? If yes, please provide details.

This proposal fails to account for the commercial incentives that drive universities to promote further education programs among professionals, often without aligning these programs with actual workforce demands. By prioritising enrolments and course completion rates, tertiary institutions may encourage professionals to pursue advanced qualifications that do not necessarily address existing skill shortages or industry gaps.

This proposal overlooks the potential risks associated with university-driven education pathways. Tertiary institutions operate within a framework where they are incentivised to ensure student success, which may inadvertently lead to a dilution of academic rigor and training standards. It is crucial to consider whether universities are sufficiently motivated to maintain a high and safe standard of education, rather than simply facilitating course completion.

Furthermore, the Board has not provided a sufficient explanation of how APPs are expected to "fill the gaps" in healthcare services. Without clear evidence or strategic planning, the assumption that these professionals will choose to work into areas of need remains unsubstantiated.

CICM is concerned that this proposal is being driven by an oversupply of paramedics rather than community need, and believe increasing their role and scope is an inappropriate way to manage this

⁶ Australian Institute of Health and Welfare 2010. National best practice guidelines for collecting Indigenous status in health data sets. Cat. no. IHW 29. Canberra: AIHW.

oversupply. The Board and governments should consider more strategic approaches; balancing training positions with workforce demand and utilising surplus training funds to support professions with workforce shortages.
6. Do you have any other feedback on the proposal?
No further comments.
Proposed registration standard
1. Do you support the proposed requirements for initial and ongoing registration and why?
<p>The CICM does not support the requirements for initial and ongoing registration.</p> <p><u>Recency of Practice</u></p> <p>Requiring three years full-time (5,000 hours) experience as a paramedic in a direct patient care role over the past 10 years is problematic. This could allow paramedics who have not practiced in a direct patient role for up to seven years to diagnose, create treatment plans, and prescribe medications—similar to medical professionals.</p> <p>The Medical Board of Australia requires additional requirements for medical practitioners who haven't practiced for over 12 months. It requires 450 hours of practice in the past three years, 150 hours in the past 12 months, or 750 hours in the past five years, with no continuous absence greater than two years. Given that AAPs would operate at a higher level than general registration paramedics, this discrepancy between the recency of practice standards is confusing.</p> <p><u>Board-approved qualification</u></p> <p>There is a lack of information in the proposal as to what qualifications the Board would consider appropriate for this scope of practice. The CICM is unconvinced that such a qualification that would lead to a paramedic being able to safely practice in the broad scope of professional capabilities proposed exists, but if the Board has any information on such qualifications, this should be detailed in the registration standard. We are unsure how the Board will determine what qualifications are substantially equivalent when they are yet to adequately define a Board approved qualification in the first instance.</p>
2. Is the content, language and structure of the proposed registration standard clear, relevant and workable? If no, please describe why.
<p>No, the registration standard isn't clear, relevant or workable.</p> <p><u>Scope of endorsement</u></p> <p>The scope of endorsement is far too vague and broad to be workable. The registration standard does not define what is meant by "advanced" or "advanced practice" which is a key oversight that makes the registration standard difficult to interpret.</p> <p><u>Supervision requirements</u></p> <p>The proposed supervised practice conditions are overly vague, and do not adequately identify roles and responsibilities. It is unclear who will be responsible for supervising APPs or whether workforce capacity exists to safely train and supervise this new workforce. Additionally, the proposed supervision is very short (1 year) with no provision for an ongoing relationship with a medical practitioner to oversee and support their practice.</p> <p><u>Endorsement for scheduled medicines</u></p> <p>The CICM does not support endorsing APP registration for the full use of all scheduled medicines. While we acknowledge that paramedics may benefit from limited prescribing powers under the supervision of a medical practitioner, more dangerous drugs, such as Schedule 8 drugs, are heavily restricted for a reason—they pose significant risks to the community. Additionally, undermining the separation of prescribing and dispensing compounds these risks and increases the potential for</p>

financial conflicts of interest. We do not believe that an additional 10 CPD hours per year related to scheduled medicines adequately addresses these risks
3. Is there any content that needs to be changed, added or removed in the proposed registration standard? If yes, please provide details.
Yes. The CICM might be more amenable to supporting this proposal if references to “independent practice” were removed in favour of a “supervisory model”, where APPs are supported by a medical professional as part of a specialist led, multidisciplinary care team. As the proposal currently stands, the scope of practice needs to be significantly curtailed, or the requirements for entry and maintenance must be significantly strengthened. The training requirements proposed do not safely meet the scope of practice currently proposed.
4. Do you have any other feedback about the proposed registration standard?
No further comments
Proposed professional capabilities for advanced practice paramedics
5. Do the proposed capabilities identify the minimum knowledge, skills and professional attributes for safe and competent practice as an advanced practice paramedic? If no, please provide details.
We do not believe the proposed professional capabilities are workable. <u>Domain 1: Clinical Practice</u> This domain significantly and dangerously overextends the appropriate scope of practice for paramedics. 1. <i>Perform a comprehensive patient assessment drawing on extended knowledge of broad diagnostics and experience to develop a diagnosis for patients spanning age and acuity</i> Expecting paramedics to develop comprehensive diagnoses without the same level of training as medical practitioners is unsafe. This could lead to missed or incorrect diagnoses. Medical specialists in Australia undergo over a decade of training, compared to the proposed five years for paramedics. Without adequate training and a complete medical history, paramedics cannot perform comprehensive assessments. Other issues include: <ul style="list-style-type: none"> • lack of clarity and role delineation around when “higher levels of assistance [are] needed” • paramedics are not trained to interpret diagnostic results, risking over-investigations or missed diagnoses • unclear how paramedics will assess high acuity medical, trauma, and surgical cases, which require extensive training • unclear how paramedics will perform advanced assessments of various systems without the same level of training as specialists • unclear how paramedics will synthesise history, clinical assessment, and diagnostics to develop a diagnosis given potential fragmentation in patient health information. 2. <i>Partner with patients to develop and implement an evidence-based, holistic and personalised treatment plan to achieve meaningful goals</i> Three years of experience and an undefined Master's degree do not adequately prepare paramedics to understand pharmacological and non-pharmacological treatments. If paramedics are to develop holistic

treatment plans, they need the same training as medical professionals. The scope of practice must be clearly defined to ensure safe patient care.

Domain 3: Communication and Collaboration

2. Communicate and collaborate with paramedics, students, members of the healthcare team, groups of healthcare practitioners and agencies within the broader healthcare system

Constructive communication is likely to be challenging in an increasingly fragmented health system with overlapping scopes of practice and different levels of training. This lack of role delineation is problematic. It is unclear from this capability at what point APPs should refer patients to other healthcare professionals considering how broad and all-encompassing *Domain 1: Clinical Practice* is.

The capability also does not define when a condition is “long-term” or when use of medicines becomes “extended or long-term”. Unclear standards on when to refer on to medical practitioners is likely to lead to fragmented and delayed care.

6. Is the content, language and structure of the proposed capabilities clear, relevant and workable? If no, please describe why.

Please see above.

7. Is there any content that needs to be changed, added or removed in the proposed capabilities? If yes, please provide details.

Please see above.

8. Do you have any other feedback about the proposed capabilities?

NA