Dear Editor,

I read Dr. Shane Knox’s commentary “Helicopter EMS in Cork” (1) in the current edition of the Journal with interest.

Firstly, to be clear, I have the utmost respect for paramedics. The commencement of an EMS helicopter in Cork is a landmark step forward in prehospital care. The ‘Toyota’ reference made in the Knox article is in relation to a misquote published in the Irish Times from a recent RTE Radio interview I gave around the staffing model of a Helicopter EMS (HEMS). The reference I made to Toyota was in fact with respect to the physician-paramedic HEMS model that is the norm in Australia, Northern Ireland, Scotland, England, Wales and mainland Europe. I don’t view a physician-paramedic team as a Rolls-Royce, platinum or gold standard model, but rather more like a Toyota; attainable and highly durable. In August 2015, the College of Paramedics (UK) stated “The College of Paramedics support proposals for a HEMS service in Northern Ireland, with a view that this service should be integrated within a trauma network in Northern Ireland and consist of a specialist pre-hospital Doctor and Paramedic team.” (2) The HEMS in Northern Ireland is now staffed with this model by the Northern Ireland Ambulance Service (NIAS).

The Irish government recently endorsed the development of a Trauma System for Ireland. Inherent to any trauma system is enhanced prehospital trauma care capability. Albeit the air ambulance will certainly bring speed, it will not bring enhanced skills without a doctor-paramedic team that will save additional lives, nor will it meet the PHECC dispatch standards for emergency calls by road (dual paramedic). The doctor-paramedic model can provide advanced prehospital critical interventions such as balanced emergency anaesthesia, mechanical ventilation, finger thoracostomy, blood transfusion and eye, life and limb-saving procedures (e.g. lateral canthotomy, resuscitative thoracotomy) as well as enhanced system activation such as prehospital massive transfusion activation and bringing a patient direct to theatre from helipad (code crimson).

Recently, Mark Winter, an operations manager of Wales Air Ambulance (doctor-paramedic EMRTS team) said: “One of the things we talk about in our world is ‘unexpected survivors’ -those patients who have had emergency front line treatment at the roadside or at the home who otherwise would have to be taken to the hospital, where it might have been too late.” (3) The similar EMRS in Scotland is increasing coverage as I write this to meet the demands of the newly developed Scottish Trauma Network. I’m sure the patient needs are the same in Ireland as they are in Northern Ireland or Great Britain.

A doctor-paramedic team extends critical care to life-threatening prehospital and medical emergencies such as STEMI with cardiogenic shock requiring safe intubation.
and ventilation, central inotropic support or controlled mechanical ventilation and targeted BP control in neurological emergencies (e.g. subarachnoid haemorrhage, stroke with coma). This team responds rapidly to prehospital or hospital tasking and can provide intensive care level stabilisation and support anywhere.

Certainly as Knox points out many of the interventions/skills that can be brought to the scene can also be performed by critical care paramedics (e.g. MICA in Victoria). This expertise does not occur overnight and takes years to develop. In my opinion, in Ireland a critical care paramedic model can only develop in the environment of a physician-paramedic team in terms of training, curriculum development and governance. There are excellent Irish advanced paramedics and prehospital specialist doctors in Ireland and abroad who together would make an excellent team that would serve the community and patient needs to the highest level. Now is the time.

References