Background Paper to Presentation to Joint Committee on Health and Child

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In 2001 I was the Medical Director of the Royal Flying Doctor Service (RFDS) Queensland, which covered a population of 4 million. Ironically, a similar population and although geographically paradigms apart in land size and terrain, issues of access for patients to routine and emergency healthcare are very similar to Ireland.

I married my wife Hannah in 1994, she was living and working in Australia at the time. She said one day she'd "want to go back"; of course I thought that would pass. In 2001 she announced she was ready, I said "what for". She then proceeded to find me a job to apply for and in 2001 I was appointed the inaugural Director of the Pre-hospital Emergency Care Council (PHECC) in Ireland.

In establishing the offices in Naas, I soon started to build a small team around me. I thought a good idea, as well as to read the various reviews and reports that had been done into Ambulance Services and other Emergency Medical Systems in Ireland, I should really find out what is happening at ground level. So myself and the newly appointed PHECC Deputy/Registrar Barry O'Sullivan were facilitated by management of the Ambulance Service and Unions to visit every Ambulance Station in the country, approximately a hundred (100) in number. As you do, I had pre-conceptions as to what I'd find after reading the various reports and reviews. What took me by absolute surprise was that my and PHECC's priority in wanting to transition Ireland from having a Basic Life Support (BLS) Service, a very good BLS service, but nevertheless a BLS service with Ambulances manned by what health professionals and the communityregarded as "drivers" rather than fellow professionals, rather than and limited to administering over the counter (OTC) medications (3/4 only), to an Advanced Life Support (ALS) service, the likes of which the UK, North America and Australasia had in place for ten to fifteen years, was to address the issue of the dead and the dying.

What I found was that Ireland was handling the dead and the dying appallingly. I'm not talking about "wakes" that everyone knows Ireland do well. I'm talking about at the very sharp end of care for seriously ill and trauma patients, Ireland, unwittingly, was treating the dead and dying appallingly.

1. There was no procedure in place for recognition of death, so that people who were dead, clinically dead, were being resuscitated, or were they? So time was being wasted that could have been invested in preventing death, and optimising the chances of someone who could be saved.

   There is now a PHECC approved "Recognition of Death" Clinical Practice Guideline (CPG), see attached. **JOB DONE**.

2. There was no policy or procedure in place, as there is in most other western jurisdictions in the world, that when certain steps have been taken, certain interventions and medications have been given, and there is no possibility of this person surviving, that it was determined

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that resuscitation attempts should be ceased. So again time was being put into people that were unsalvageable. Again this time could have been invested in preventing death and optimising the chances of someone who could be saved.

There is now a PHECC approved "Cessation of Resuscitation CPG, see attached. **JOB DONE**.

3. I don't know how many cardiac arrests you have been at, or seen on TV. On TV two out of three are successful and they look dignified. The success rate is anything but that and they look anything but dignified.

   Despite attempts the scene is often covered in vomitus/mess, not something nice to have the relatives standing by watching, or the health professionals. PHECC introduced Advanced Airways, see picture attached, that protects the airway but has limited vomitus for most cardiac arrest scenes in the field and in Emergency Departments (EDs). We are one of the few jurisdictions that have introduced this skill into the scope of practice of certain Responders, as well as Practitioners. This may seem a small matter but in fact it's not in the context of dignifying a scene of death or potential death. **JOB DONE**.

4. Paramedics in other jurisdictions can pronounce death. In Ireland they don't. So, in the attached circumstances we now have CPGs where PHECC approves Paramedic/Advanced Paramedics to cease resuscitation attempts, but they cannot pronounce death. The Paramedics then have to, or should, wait on scene to do a handover to a Medical Practitioner, who might be busy with General Practice (GP) Co-operative or GP Practice or with other work and the Paramedics wait, and they may wait, and they may wait. The GP may pronounce death soon after, or hours after or even the next day. The relatives know the person died at a time and date. The official record is different. Again this time could have been invested in preventing death and optimising the chances of someone who could be saved. **WORK IN PROGRESS**. The City Coroner is a Member of the End of Life Forum and is being of assistance to bring the issue of pronouncement of death to broader consultation; we hope to engage with Coroner's more broadly soon.

5. We don't have universal national standardised Do Not Resuscitate (DNR) orders, and it is through Think Ahead that a draft is out there, a credible and legitimate draft. It is receiving criticism. That's okay but at least a draft is out there. The Health Service Executive (HSE) is in the process of developing national standardised DNR orders, this is great. **WORK IN PROGRESS.**

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I am a member of the National Forum of End of Life. It is both rewarding and humbling to be a part of the team, lead by Catherine McGuinness and supported by Sarah Murphy and Carolyn Lynch. Members of the forum are expert and interested stakeholders in death and dying.

My experience and interest is in acute emergency care. I am undoubtedly Irelands resident expert on snake bite and marine envenomation which my special interest/practice in Australia before I left 12 years ago.

My priority in both PHECCs remit and that of Think Ahead currently is both the pronouncement of death and DNR orders. And we need more Ambulances.

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