REGIONAL PARAMEDIC PROGRAM FOR EASTERN ONTARIO

MedicNEWS

Insight for paramedics in Eastern Ontario

March 2025

Trauma Day 2025

New format gives more opportunities for you to learn

Navigating the Pronouncement of Death

Get Involved!

OBHG Seeks Advisors

Spring 2025 CME Program

The Competency Challenge

Mastering Rare but Essential Skills

In this issue

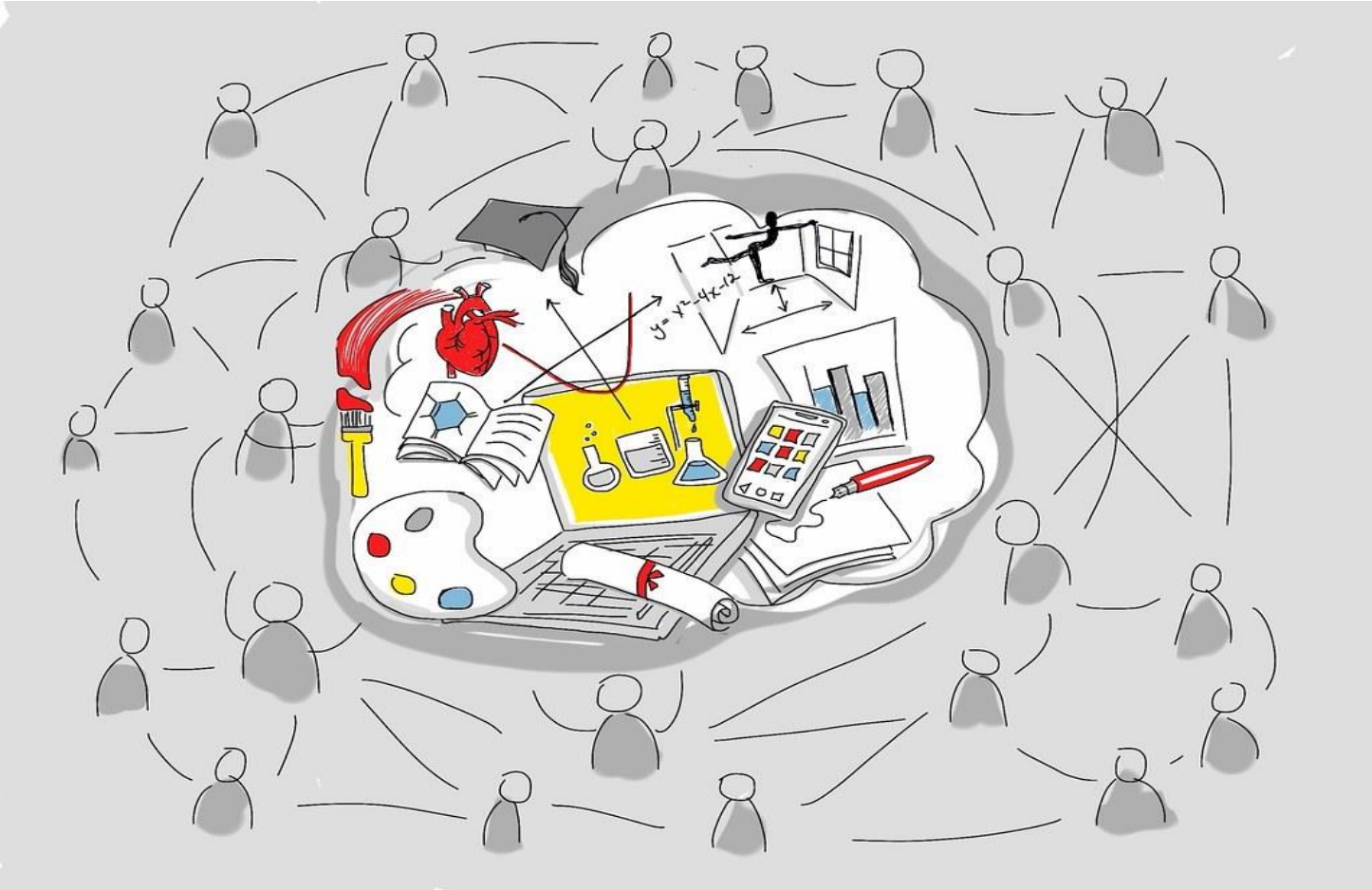
Welcome to the **March 2025 issue of MedicNEWS!** This edition brings you **clinical updates, continuing education opportunities, and system-level developments** that impact paramedic practice in our region and beyond.

- **News Nuggets** – Quick, relevant updates from the world of paramedicine, including a critical look at a recent study on **physician-paramedic teams** and what it really tells us about interdisciplinary care in the field.
- **Continuing Education** – Everything you need to know about **Spring 2025 CME**, where the focus is on **mastering rare but essential skills** through hands-on learning and cognitive rehearsal techniques. Plus, we're excited to announce the return of **Trauma Days**, now with Level 1 and Level 2 sessions tailored to different experience levels.
- **Medical Direction: BHP Corner** – A deep dive into the **complex process of pronouncing death** and what paramedics must consider when making this critical determination in the field.
- **Get Involved** – The **Ontario Base Hospital Group (OBHG)** is seeking **Paramedic Advisors** to join key committees shaping **education, medical direction, and data quality standards**. Find out how you can contribute to provincial decision-making.

As always, we want to hear from you! If you come across **news items relevant to paramedic clinical care**, send them to info@RPPEO.ca with "MedicNEWS" in the subject line.

Enjoy the issue!

Continuing Education



Spring 2025 CME Announcement

The Competency Challenge – Mastering Rare but Essential Skills

By now, you should have received in your email the official announcement about **Spring 2025 CME**, and we're excited to share more details about what's in store. This year's CME is all about **skill mastery, cognitive preparedness, and hands-on learning**, helping you **stay sharp in high-acuity but low-frequency interventions**.

What's New This Year?

- **Focus on Rare but Critical Skills** – This CME prioritizes **hands-on practice** with skills you may not use often but need to perform with confidence when required.
- **Cognitive Training & Mental Visualization** – A guest lecturer will introduce **cognitive rehearsal techniques** to give you another tool for honing your skills.
- **Reintroducing Evaluation** – A **formative assessment** during the practical session will help you track skill retention and competency in a structured, supportive environment.

Key Topics Covered

✓ **Advanced Airway Management** – Securing, confirming, and troubleshooting airway placement.

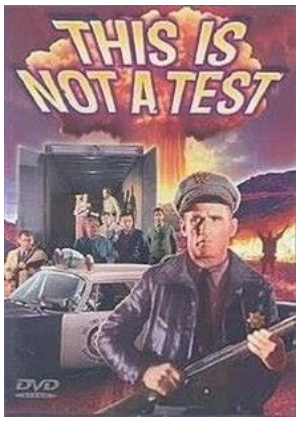
✓ **CVAD Access** – Safe medication administration through central venous access devices.

✓ **Cardioversion -** Practising synchronized cardioversion

✓ **Pacing** – Enhancing technical execution for transcutaneous pacing.

✓ **Magill Forceps Use** – Improving airway obstruction management techniques.

How the Evaluation Component Works



- **This is NOT a test** – It's a structured **learning experience** to reinforce skill proficiency.
- Instructors will observe and provide feedback on hands-on skill execution.
- Paramedics will complete skill sheets for their own learning and review.
- Why it matters: RPPEO provides training and feedback, but *competency is a personal responsibility*. Medical Directors delegate controlled acts only to paramedics competent in those skills—staying up to date is part of professional accountability. Our data shows many paramedics have not performed high-acuity skills in years—this CME is a safe space to refresh and refine your practice.

Mandatory Participation & Certification

- **ACP Participation:** Mandatory, contributing to annual **Maintenance of Certification requirements**.
- **PCP Participation:** Voluntary, but strongly encouraged for skill development.
- **Online Component:** All paramedics must complete the online module via MedicLEARN before attending the in-person session.
- **In-Person Component:** Your paramedic service will coordinate scheduling for the hands-on practice session.

Your Role in Staying Competent

- **RPPEO** and your Medical Director provide the tools, but paramedics must take ownership of their competency.
- This CME is a chance to assess where you stand, sharpen your skills, and ensure you're ready when it counts.

For more details, visit RPPEO.ca or refer to the announcement in your inbox. **We look forward to seeing you in class!**

Elective CME

Trauma Days Are Back in 2025!

The Regional Paramedic Program for Eastern Ontario (RPPEO) is excited to announce the return of Trauma Days for 2025! Following another year of success, Eric Gagnon is back to deliver his popular and informative Trauma Day Continuing Medical Education (CME) sessions.

***NEW* - Level 1 Trauma Day & Level 2 Trauma Day**

We recognize that there is a varying level of training across paramedics in our region. With this, we want to ensure that you can attend a day that best suits your learning needs and wants so that you can get the most out of the day. Below is a breakdown of the differences between the different levels of Trauma Day. All paramedics can sign up for either level, but we encourage you to look at and follow our recommendations. We also encourage you to watch the following video (click on the caption) for further explanation:

1 - Eric Gagnon presents Trauma Days 2025!

About Levels

Level 1

- Recommended for those who have not attended a previous Trauma Day
- New entry-to-practice paramedics (<5 years recommended)
- Higher focus and time spent on skills review and practice
- Less focus on scenarios

Level 2

- Recommended for those who have attended previous Trauma Days
- Experienced paramedics (5+ years recommended)
- Higher focus and time spent on bringing a variety of skills together
- Higher focus on scenarios with high fidelity simulations

Continued Hybrid Format for Greater Accessibility

To make the training accessible to more learners, Trauma Days will continue to be offered in a hybrid format. This includes:

- **4 hours of online pre-learning**
- **4 hours of in-class hands-on practice and scenarios**

How to Register

1. **Complete the Online Pre-Learning** Begin by completing the 4-hour online pre-learning module: MedicLEARN>>Elective CME>>2025>>Trauma Days 2025
2. **Register for the In-Class Portion** After completing the online modules, you can register for the in-class session. The registration form can be found within the online course in MedicLEARN.

Earn CME Credit

- **In-Class Participation:** Earn a total of 8 CME credits by completing both the online and in-class components.
- **Online-Only Option:** If you are unable to attend the in-class portion, you can still earn 4 elective CME hours by completing the online modules.

In-Class Course Details and Locations

Each session is limited to 12 paramedics.

Session Times:

- Morning: 8:00 AM - 12:00 PM
- Afternoon: 1:00 PM - 5:00 PM

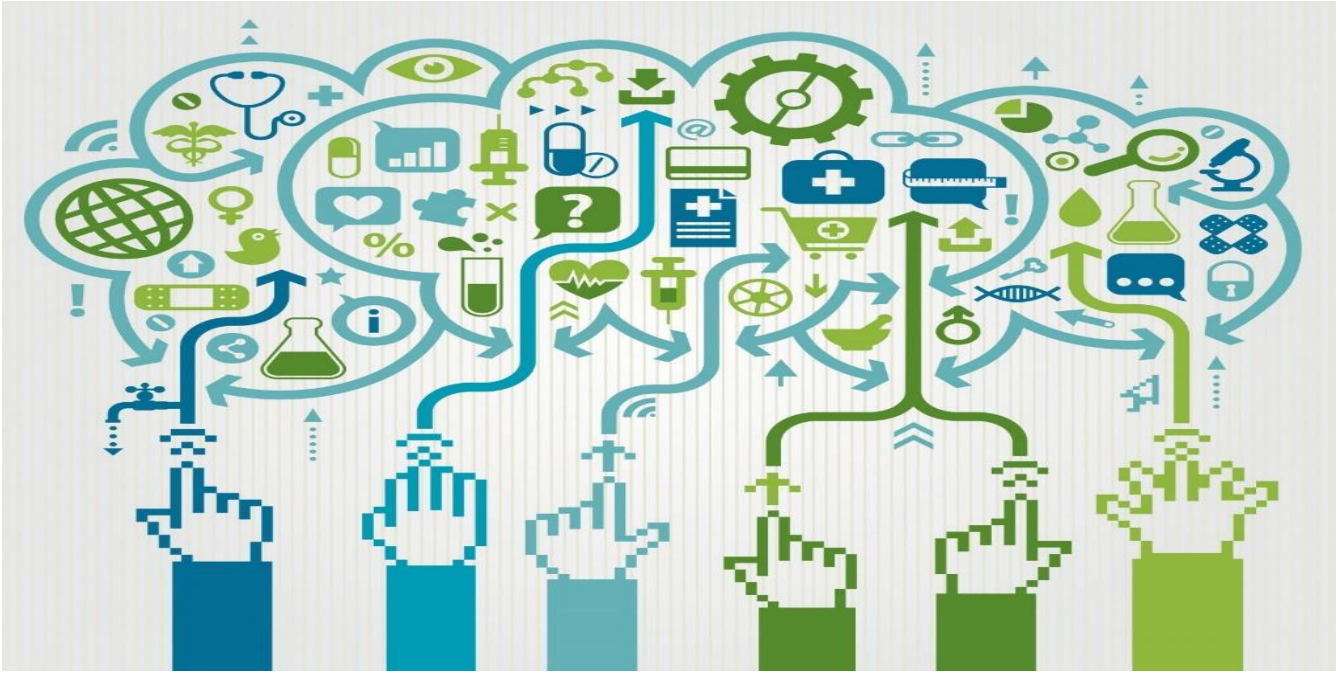
Available Dates and Locations:

- **Tuesday, May 6, 2025 - Level 1:** Prescott-Russell Paramedic Service 1350 Cameron St., Hawkesbury, ON K6A 3T1
- **Friday, May 16, 2025 - Level 1:** RPPEO Kingston 400-1471 John Counter Blvd., Kingston, ON K7M 8S8
- **Tuesday, June 3, 2025 - Level 2:** RPPEO Ottawa 2475 Don Reid Dr., Ottawa, ON K1H 1E2

If the session is full, you can request to be placed on the waiting list through the registration form.

Don't miss out on this valuable opportunity to enhance your trauma care skills with hands-on practice and expert guidance. Sign up today!

Medical **Direction**



BHP Corner

Bringing you the current state of the science and medicine of emergency health care, BHP Corner is where the RPPEO's Base Hospital Physicians discuss the clinical trends, issues and cases that the region's paramedics are facing.

A Guide for Paramedics

by **Michael Austin**

In the dynamic and high-pressure realm of emergency medical response, few responsibilities carry as much weight as the accurate pronouncement of death. Terminating or withholding resuscitation after cardiac arrest has enormous consequences for patients, families, the legal system, and society. The accurate determination of death demands our unwavering attention and meticulous care. Here, we will discuss some important learning points to help paramedics carry out this sacred duty.

Confirming the absence of vital signs requires more than mere visual observation. While initial visual cues may offer hints, they often fall short of providing conclusive evidence.

As healthcare providers, the determination that death has occurred requires our satisfaction that a person has **no vital signs** *and* that there is **no expectation of survival if resuscitation efforts begin or continue**.

But, this is not always an easy determination to make.

At the base, we must conduct a thorough assessment, documenting evidence such as rhythms, pulses, heart sounds, breath sounds, and signs of breathing. This evidence and physiological parameters serve as our guiding beacons in determining whether life still lingers within a patient.

Once our assessment gives up its evidence, we should often undertake reasonable efforts at resuscitation (if consistent with the patient's wishes), and assess the response to these efforts before determining that resuscitation is futile, and the patient is dead.

"We must exhaust every avenue to verify the absence of vital signs."

Yet, there are many situations warranting a different approach. For one, there might be times when withholding or terminating resuscitation on a potentially salvageable patient is appropriate. For example: if it's not safe to resuscitate a patient with no vital signs, you are empowered to make the call to withhold or terminate the resuscitation. And, if you are at the scene of a mass casualty incident (MCI) and there are not enough resources to look after the patients you are faced with, you implement MCI triage. If a patient with no vital signs does not start breathing with a basic maneuver to open the airway, you tag them "black" and move on to those you can help. This should be reassessed when your resources become adequate. The decision at the initial triage stage does not need to be final.

Patients who are currently inaccessible, such as those who are trapped after blunt trauma, or visibly underwater with rescue attempts underway, and believed to be VSA, pose a particular challenge. On one hand, paramedics may be reticent to ask fire departments and other rescuers to undertake rapid attempts to access a patient when the scene is not safe, and extrication is going to be prolonged or seemingly impossible. On the other hand, there is an imperative for a trained professional to access the patient to determine if there are no vital signs (after clearing and opening the airway if possible), and ideally obtaining a cardiac rhythm, prior to determining that irreversible death has occurred and pronouncement of death is declared.

In these cases, coordination with rescue agencies is key. Resist the urge to call and request a withhold resuscitation order from a Base Hospital Physician (BHP). Can somebody get to the patient and perform an assessment? How long will it take to get the patient out? How are we going to satisfy ourselves that irreversible death has occurred before determining that no further efforts are warranted? These are important questions, and the answers to them may take time to gather. Paramedics should resist the temptation to withhold resuscitation simply because the answers to these questions are not readily obtainable. You are empowered to take whatever time is required to carry out the sacred duty of determining survivability or death. In all cases, the safety of first responders is paramount, and you must take whatever time you need to protect yourself and others.

"You are empowered to take whatever time is required to carry out the sacred duty of determining survivability or death."

Even when faced with patients meeting the criteria for a Code 5 designation, indicating a slim chance of signs of life, our duty remains steadfast. We must exhaust every avenue to verify the absence of vital signs. This determination of death marks a critical transition in our response, sometimes shifting from life-saving interventions to the delicate process of handling the deceased with respect and dignity, and in some cases

maintaining the integrity of what could be a forensically important scene for criminal investigators and the coroner.

It's crucial to recognize that you are not alone in carrying out these assessments. The BHPs can serve as a vital support system, offering their expertise to assist in discerning futile resuscitation efforts and validating the absence of vital signs. Their collaboration not only bolsters the thoroughness and accuracy of our evaluation but also provides ongoing guidance and reassurance until you attain confidence and comfort in this essential skill. During these conversations, BHPs are asking themselves the same questions that paramedics are:

1. Are we satisfied that there are no vital signs?
2. Are there any efforts that can be undertaken to reverse the cause of death?
3. What has the response been to these interventions?

If these answers are not currently available, it's likely the BHP will reserve rendering an opinion on survivability until more information is available.

Furthermore, it's vital to underscore the disparity between the *pronouncement* of death and the *certification* of death. While the former acknowledges the evidence of cessation of life, the latter entails a legal process that includes the identification of the deceased, determining the date and cause of death, and the completion and registration of the death certificate. Both components are integral to the end-of-life journey, underscoring the gravity of our role in this pivotal moment.

In conclusion, as paramedics entrusted with the solemn duty of pronouncing death, we must leverage all available resources and tools at our disposal. Our unwavering commitment to precision and thoroughness during a resuscitation should be the same approach during the pronouncement or determination of life extinct. This not only upholds the highest professional standards but also pays homage to the dignity of those whose earthly journeys have come to an end. Let us approach this responsibility with the gravity and reverence it commands, ensuring that each pronouncement of death is an accurate, documented reflection of reality.

Together, let us uphold the sanctity of life and honour the culmination of each individual's journey with unwavering dedication and boundless compassion.

Dr. Michael Austin, MD, FRCPC, DRCPSC (PTM), is RPPEO's Medical Director.

News **Nuggets**

Easily digestible short summaries of news impacting paramedic clinical care, from the region, the country and around the globe.

More Isn't Always Better: Why Specialized Teams May Not Be the Answer

by **Charlene Vacon**

A recent meta-analysis published in the Scandinavian Journal of Trauma, Resuscitation and Emergency Medicine on January 6, 2025, found that integrating physicians into paramedic teams significantly improved patient outcomes, particularly in rural and remote areas. The study reported a **49% increase in survival rates** and a **20% decrease in mortality risk** when physicians were included in prehospital response teams.

The results are compelling, but they raise an important question: **Just because something works, does that mean it's the right solution for the system as a whole?**

More Resources, Better Outcomes — But at What Cost?

It's no surprise that adding highly trained medical professionals to emergency response teams improves outcomes. Physicians bring advanced diagnostic skills, procedural expertise, and expanded pharmacologic options that paramedics typically don't have within their scope.

But improving outcomes by adding specialized resources is a hugely expensive and logistically complex approach. More personnel, specialized vehicles, and advanced equipment come at a steep cost — and they demand staffing models that are already stretched thin in EMS systems and acute healthcare services across the country.

The issue isn't whether specialized teams improve outcomes — they do. The issue is scalability and sustainability.

Localized models that rely on specialists — whether they're physicians, nurses, or other healthcare professionals — may deliver **excellent results in targeted areas**. But scaling that model across an entire EMS system has not yet demonstrated practicality. Specialized resources, no matter how effective, are costly and challenging to expand without compromising other vital EMS services. What are we not doing when we chose to develop a resource intensive specialized solution like physician response?

Local Solutions vs. System-Wide Models

This reminds me of an initiative I was involved with during my tenure in the EMS portfolio for the Alberta government. Researchers developed a specialized ambulance equipped with a portable CT scanner, known as a Mobile Stroke Unit (MSU), to rapidly diagnose and treat stroke patients before hospital arrival. The results were positive — earlier diagnosis led to faster treatment, and outcomes improved.

But again, is that surprising? Of course, adding specialized people and equipment improves outcomes. If I had millions of dollars to spend, I could design an ambulance staffed with a cardiologist, respiratory therapist, social worker, and pharmacist, plus the latest diagnostic equipment — and I have no doubt that outcomes would improve for those people lucky enough to get that ambulance.

The real challenge is whether these approaches are **scalable** across an entire EMS system. Specialized care models are resource-intensive, and replicating them widely is difficult.

Ontario's Proven Model: Investing in Paramedics with Enhanced Skills

In Ontario, we've taken a different path — one that reflects a deliberate commitment to **paramedics as the experts in out-of-hospital emergency care**.

The Ornge air ambulance service is a prime example. Ornge's Critical Care Paramedics deliver some of the most advanced prehospital care in the country — without the need for onboard physicians, critical care nurses, or respiratory therapists. Critical Care Paramedics provide this high-acuity care because Ontario has chosen to invest in paramedics, giving them the enhanced skills, training, and protocols they need to provide outstanding critical care independently.

The Ornge model demonstrates that paramedics — when empowered with expanded skills and scope — can successfully deliver high-end, complex care in some of the most challenging environments imaginable.

We've also seen success with localized paramedic teams that are tailored to meet specific regional needs. Specialized EMS teams — like bike medics, tactical teams, airport and subway response units, and water or rural rescue teams — have proven highly effective in addressing targeted gaps in emergency response. These models work precisely because they are designed to meet specific, localized needs — not to replace system-wide EMS deployment models.

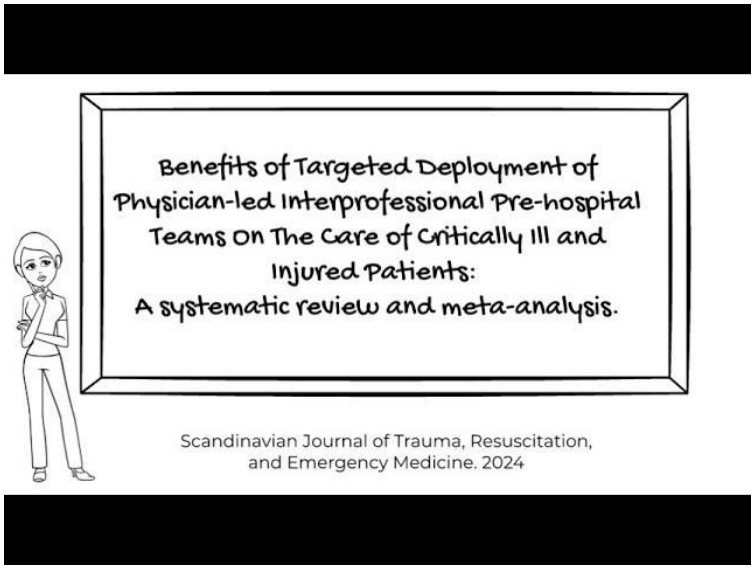
Similarly, interdisciplinary partnerships that bring paramedics together with other healthcare providers can enhance local emergency care without requiring costly structural overhauls.

The key is to ensure these specialized approaches remain **targeted and purposeful**, not a blueprint for system-wide EMS reform. Instead of adding costly specialist teams to prehospital care, Ontario's investment in building paramedic capabilities has shown that we can achieve excellent outcomes with a more scalable, sustainable model.

More Specialists or Smarter Solutions?

Expanding specialized EMS teams is not scalable — and it's not the only way to innovate and improve care. Investing in paramedics may provide a better model than adding more highly specialized people to every call.

If we had respiratory therapists, nurses, psychologists, or social workers integrated into EMS teams, we would likely see improvements in various aspects of patient care as well. Would these approaches improve outcomes? Absolutely. But these models are also costly, difficult to sustain, and impractical on a large scale. Realistically, EMS services can't simply add specialists to every ambulance.



The UBC put together this explainer video about their project.

Paramedics Are Already the Experts

The reality is that paramedics don't have the luxury of calling in a specialized team on every call. As Paramedic Will Johnston says in RPPEO's Spring 2025 CME module, paramedics are **"specialized generalists."**

You, the paramedics, are the ones standing in for all of these disciplines, every day, on every shift.

When a patient is struggling to breathe, **you're the respiratory therapist.**

When a patient is in severe pain, **you're the nurse,** calculating the right dose and route of administration.

When a patient is in cardiac arrest, **you're the physician** making split-second life-or-death decisions**.**

When a patient is in crisis, **you're the psychologist,** de-escalating and making transport decisions that will impact their entire course of care.

This study — along with initiatives like the Mobile Stroke Unit — confirms what we already know: Specialized care improves outcomes. But the reality of EMS is that paramedics provide specialized care every day, working with limited resources in unpredictable environments. The better path forward for system-wide innovation is to **invest in the paramedics we already have** — giving them the training, resources, and support they need to continue excelling as the true specialists they are.

In Ontario, we've already proven this approach works on the front lines.

***Charlene Vacon**, BA(H), MA, PhD, AEMCA is an RPPEO EMS Specialist focused on culture and communication.*

Charlene is a Scientist with the McNally Project for Paramedicine Research and enjoys contributing to the paramedicine knowledge base. She has worked in paramedic operations, administration, quality, education and research in Quebec, Alberta and Ontario. Charlene received her training as a critical care emergency medical technician in New York State and is currently a Primary Care Paramedic in Quebec. She holds a PhD in Communications from Concordia University in Montreal, as well as an MA and a BA(H) in sociology from Acadia University.

Send your bite-sized news items to MedicNEWS! If you find interesting news relative for the clinical practice of paramedicine, send it along to info@RPPEO.ca for consideration in an upcoming issue of MedicNEWS. Please include the link to the original story (if there is one) and mention "MedicNEWS" in the subject line of your message.

Announcing...

OBHG Seeking Paramedic Advisors – Get Involved in System-Wide Decision Making

The **Ontario Base Hospital Group (OBHG)** is recruiting **Paramedic Advisors** to provide frontline paramedic perspectives on key provincial committees. This is an opportunity for paramedics to directly influence **education, data quality, and medical advisory decisions** that shape paramedic practice across Ontario.

What is OBHG?

OBHG provides medical and operational advice to the Ministry of Health Emergency Health Services Division (MOH EHS). Paramedics are essential members of OBHG committees, ensuring that policy and clinical decisions reflect the realities of prehospital care.

Which Committees Need Paramedic Advisors?

1. **Medical Advisory Committee (MAC)** – Advises on patient care, leadership, funding, and EMS operations.
2. **Data Quality Management (DQM) Subcommittee** – Oversees paramedic data collection and reporting standards.
3. **Education Subcommittee (ESC)** – Reviews paramedic education standards and delivery.

Why Get Involved?

- Represent frontline paramedics and ensure **your voice is heard** at the provincial level.
- Help shape paramedic education, clinical guidelines, and data quality initiatives.
- Gain experience in leadership, policy development, and system-level decision-making.

Who Can Apply?

- Active Primary or Advanced Care Paramedics with several years of experience.
- Candidates should have **a letter of support from their Regional Base Hospital and EMS service**.
- OBHG aims for diverse representation from urban and rural paramedic services across Ontario.

What's the Commitment?

- **Three-year term** (with flexibility for career changes).
- Attendance at **quarterly in-person meetings** plus additional teleconferences as needed.
- Travel expenses for meetings may be reimbursed, but the role is **voluntary**.

How to Apply

Applicants must submit:

✓ A **cover letter** outlining their paramedic level, region, and interest in specific committees.

✓ A **brief CV** summarizing their experience.

✓ **Letters of support** from their EMS employer, Base Hospital, and at least one paramedic colleague.

Applications are due March 12, 2025. They open every three years. If you're interested in contributing to provincial decision-making and paramedic practice improvements, this is your chance to step forward.

For full details, see the official call for applications below or visit RPPEO.ca to download the invitation memo.

ONTARIO BASE HOSPITAL GROUP MEDICAL ADVISORY COMMITTEE

Ontario Base Hospital Group (OBHG) Paramedic Advisor Representation

Paramedics are important members of all OBHG committees. Many paramedics have asked questions over the past few years related to these committees and we would like to share some questions and answers with you.

1) What is the role of OBHG?

OBHG's function is to provide advice to the Ministry of Health Emergency Health Services Division (MOH EHS)

2) How many committees are there and what are their respective functions?

1: **Medical Advisory Committee (MAC)**

Advises the MOH EHS on matters relating to patient care provided by paramedics and other relevant allied professionals. The committee is responsible for making recommendations which represent the interest of the patients and citizens of Ontario through matters relating to leadership, administration, operation, funding and program delivery, in the interest of patient safety. They also advise the MOH EHS on medical issues and the role of Base Hospitals related to the delivery of EMS-based out of hospital care.

Committee Membership:

- *Eight Regional Medical Directors, representing the seven land and one air Regional Base Hospital Programs*
- *Eight Regional Program Director/Managers, representing the seven land and one air Regional Base Hospital Programs*
- *Four appointed Paramedic Advisors*
- *Three Paramedic Chief Representatives*
  - *One member representing Toronto Paramedic Services*
  - *Two members representing the remainder of the province (ideally both an urban and rural service)*
- *One patient/family representative*
- *Directors of EHRAB and EHPMDB (or delegate)*
- *Senior Manager, EHPMDB and Regulatory and Standards Oversight (EHRAB)*
- *The Chair and Physician Representative of the OBHG MAC Education Subcommittee (if not already a Voting Member)*
- *The Chair and Physician Representative of the OBHG MAC Data Quality Management Subcommittee (if not already a Voting Member)*
- *One College Paramedic Program Representative*
- *One Central Ambulance Communications Centre (CACC) Medical Director*
- *One Central Ambulance Communications Centre (CACC) Representative*

ONTARIO BASE HOSPITAL GROUP MEDICAL ADVISORY COMMITTEE

2: **Data Quality Management (DQM) Subcommittee**
Advises on information gathering and database issues relating to the provision of ambulance based out of hospital care in Ontario. Reviews current patient data collection and date reporting standards and practices and regularly updates the patient's related data gathering and reporting requirements and practices necessary to meet the current and emerging needs of stakeholders. The DQM is also responsible for assisting Base Hospital Programs to monitor the quality of patient care and service delivery in Ontario.

Committee Membership:

- Chair
- Representatives from the 8 Regional Base Hospitals; with data or quality expertise
- Medical Advisory Committee (MAC) Operational representative
- Paramedic Advisors (ACP & PCP and/or rural and urban)
- MOH Emergency Health Services Division representatives
- Paramedic Chief Representative
- OBHG Education Subcommittee Chair
- Physician Advisor
- Research and Epidemiologist representative

3: **Education Subcommittee (ESC)**
Reviews current paramedic education delivery and development standards and practices. ESC also provides educational objective development resources, delivers plans or programs necessary to maintain and improve the current and emerging needs of stakeholders.

Committee Members:

- Chair
- Representatives from the 8 Regional Base Hospital; Education lead or designate
- Medical Advisory Committee (MAC) Operational rpresentative
- Paramedic Advisors (ACP & PCP and/or rural and urban)
- MOH Emergency Health Services Division representatives
- Paramedic Chief representative
- OBHG Data Quality Management (DQM) Subcommittee Chair
- Paramedic Program College representative

3) **How often do these committees meet?**
Most committees meet face to face four times a year with additional teleconferences and project meetings scheduled in addition; depending on the issues or projects at hand.

4) **What is the role of the Paramedic Advisors on these OBHG committees?**
Paramedics are the front line providers of patient care, and having their point of view heard and be part of the advice that is being forwarded to EHS is essential.

5) **How can I apply to become an OBHG Paramedic Advisor? What qualifications are required to apply?**

ONTARIO BASE HOSPITAL GROUP MEDICAL ADVISORY COMMITTEE

Every three years OBHG will distribute a call for applicants for Paramedic Advisors for the committees. Each applicant can indicate for which (or all) committee(s) they are applying to.

Selection criteria will include the following:

- They must meet the basic criteria which includes a letter of support from both the appropriate Regional Base Hospital and EMS service; we prefer candidates who are front line paramedics with at least a few years of experience. We aim for both urban and rural representation (and or PCP and ACP representation); we aim for representation from across Ontario, across all Regional Base Hospitals.

Submissions should include the following:

1. Cover letter (specifically indicating your paramedic level I.E PCP, ACP; whether you work for rural or urban service, and where you practice I.E northern or southern Ontario; your interest in one or more committee(s), and identifying why you would be a good candidate to represent your peers).
2. Brief Curriculum Vitae
3. A letter of support from your respective ambulance service operator(s)/employer(s)
4. A letter of support from your Regional Base Hospital Program
5. At least one letter of support from a paramedic colleague

6) **What is the commitment of the Paramedic Advisor? What am I supposed to do?**
The commitment of the Paramedic Advisor is to attend the respective committee meetings in person or via teleconference; we ask for the support from your EMS services for all applicants to optimize the chances of you being able to attend the majority of meetings.

7) **How long is the term of a Paramedic Advisor on any OBHG committee?**
Each Paramedic Advisor will sit for a three-year term; in certain circumstances this will be amended due to changes in employment or position status. It is imperative that front line paramedics are represented.

8) **Do I receive compensation as a Paramedic Advisor?**
Travel expenses incurred to attend any of these committee meetings will be reimbursed only as preapproved. Your participation is strictly voluntary; there is no financial compensation available for wages.

MedicNEWS Back Issues

You can browse the MedicNEWS catalogue or find articles on topics you're interested in by visiting the MedicNEWS page on RPPEO.ca.