

Who gets to be sick?

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Paramedicine

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Introduction

There is a particular kind of patient who paramedics find easy to recognise. The ‘classically sick’¹: they have an identifiable symptom, an observable physiological abnormality, a plausible diagnosis and a familiar pathway through the system. Their problem can be described in clinical language, documented in a patient care record and referred onwards in the system. Their illness is legible and visible. It fits our understanding of ‘being sick’ enough to warrant care. Then there are the others. The person who calls an ambulance because they cannot cope at home. The person who is intoxicated, frightened and alone. The person whose chest pain has been investigated repeatedly but persists. The older person who has fallen again and cannot get up. The person experiencing psychological distress in the context of homelessness. The person who calls because their primary care provider is unavailable or they simply do not know where else to go. These people are not necessarily less sick. They are often simply harder to classify under the umbrella of out-of-hospital care. This raises a question that paramedicine has rarely asked explicitly: who gets to be sick?

For us, this is not a question about who has a disease or illness, nor is it a question about who has a life-threatening presentation compared to a condition that can remain stable. It is a question about who is recognised as a legitimate recipient of healthcare, whose account of suffering is believed, whose needs are considered ‘appropriate’ for a particular service, and whose presentation is instead reclassified as social, behavioural, ‘inappropriate’ or misuse. Whether we like or acknowledge it – or not – we are gatekeepers, guarding the scarce resources of healthcare. Even if one chooses to transport every patient, the question is relevant because paramedics increasingly occupy the point at which human suffering is translated into pre-defined categories that the health system either takes seriously or doesn’t. A patient does not arrive at the hospital in an ambulance as a neatly defined clinical entity. They arrive as an individual with symptoms, unique circumstances, expectations, histories and needs. Paramedics must make these complex interactions intelligible to a system that demands categorisation: emergency or non-emergency; health or social; conveyance or

non-conveyance; high or low acuity; appropriate or inappropriate; sick or not sick.

Exercise

Say the title of this editorial aloud several times, placing emphasis on a different word each time. Follow along: *WHO* gets to be sick? Who *GETS* to be sick? Who gets to *BE* sick? Who gets to be *SICK*? This exercise highlights the main issues we will address throughout this editorial: the populations who are privileged (or not), the choices made during assessment and management, societal expectations of being sick and deserving of care, and the consequences of alignment (or not) with those norms.

Who is a ‘legitimate’ patient?

Sociology has long recognised that illness is much more complicated than pathology. Being ill is not simply a biological state; it is also a social construction.² Contemporary scholarship continues to examine how people establish the legitimacy of illness, particularly when their conditions are chronic, invisible, contested or poorly understood.^{1,3} Grue, for example, has recently revisited the relationship between disability, expectations associated with the sick role and social legitimacy, arguing that people with long-term conditions can encounter conflicting expectations about demonstrating both illness and productivity.¹

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This offers a useful way of thinking about paramedicine. The paramedic encounter is one of the places where the legitimacy of illness is socially negotiated. A person does not simply have an ‘ambulance-worthy’ problem. Their situation must become recognisable as one that warrants the mobilisation of an ‘emergency’ healthcare resource. Categorical, single symptom, telephone triage protocols have long been the ‘criteria to meet’. Increasingly, this negotiation occurs before a face-to-face paramedic encounter: contemporary clinical hubs, staffed by secondary triage clinicians, may determine that a patient’s needs can be more appropriately met through alternative pathways or system navigation. This does not mean that paramedics consciously decide who deserves care, nor does it imply that clinical triage is arbitrary. Paramedics make difficult decisions under uncertainty, frequently with incomplete information and substantial responsibility. The point is more subtle: the pre-existing categories through which such decisions are made are not neutral or free of bias.

A myocardial infarction fits comfortably within the institutional language of out-of-hospital care and paramedicine more broadly. Loneliness does not. Hypoglycaemia does. Housing insecurity does not. A fractured neck-of-femur does. The inability to safely manage at home does not. Severe head trauma does. Chronic social distress does not. Yet the person experiencing the latter forms of suffering may be no less desperate, no less in need of care and help. This is particularly apparent in research concerning people who repeatedly contact emergency ambulance services. A previous scoping review described substantial inconsistency in how ‘*frequent callers*’ and ‘*frequent users*’ are defined, with thresholds varying dramatically across studies.⁴ More recent work has illustrated that people who frequently contact ambulance services are a heterogeneous group and that difficulty navigating healthcare systems is a central common feature of their experiences.⁵ Language used here matters. ‘*Frequent caller*’ and ‘*frequent user*’ (and other synonyms such as ‘*high intensity user*’) foreground behaviour and utilisation. We ourselves are guilty of using such language. ‘*A person with unmet care needs*’ foregrounds need. This phrase describes the same person but does not invite the same response.

When the patient becomes the problem

This is where the language of ‘*inappropriate use*’ becomes particularly interesting (and highly problematic). There is an obvious and legitimate concern about finite resources. Ambulance services cannot respond simultaneously to every request, and emergency systems must be able to prioritise those at greatest risk. We do not deny this reality. However, ‘*inappropriate*’ is not simply a clinical descriptor; it is a judgement about the relationship between a person’s need and an institution’s intended function. An ambulance response may be an inappropriate substitute

for primary care while being the only accessible healthcare service available to someone at 0200. Conveyance to an emergency department may be inappropriate for someone whose principal problem is loneliness, but describing the call (or caller) as inappropriate does not make the loneliness disappear. A person repeatedly calling after falls may be framed as a high-utilisation problem when the underlying issue is frailty, an unsafe home, and an absence of social support. Recent research illustrates this tension. A study in Oslo reported that 13% to 32% of ‘*frequent callers*’ were taken to hospital, needing further assessment and treatment (i.e., what would be considered appropriate use of the service). The same study also revealed a systematic shortcoming; as many as 22–34% were categorised under the chief complaint ‘unidentified problems’. It is within this category one finds codes such as ‘psychosocial issues’. Hence, their challenges are not unidentified, they are simply not included in the current medical dispatch protocols.⁶ People who access services with relative high frequency are more likely to have complex health needs and unmet medical or social needs, including loneliness, poverty, food insecurity, anxiety and depression.⁷ Community paramedicine programmes have emerged partly in response to precisely this population: people who are paradoxically described as ‘*inappropriate*’ users of ambulance services, yet sufficiently in need of healthcare to justify a dedicated alternative ambulance service response.⁸ Perhaps the contradiction is not located in the patient, but in the system?

Who gets believed?

There is another dimension to the bigger question: who gets believed? Contemporary healthcare scholarship has increasingly turned to the concept of epistemic injustice, that is, the unfair treatment of people in their capacity as knowers, creating a ‘credibility deficit’.^{9–12} This testimonial injustice occurs when someone’s account is given less credibility because of prejudice or assumptions about their identity. For example, a person experiencing intoxication may report severe pain, but their account may be discounted because paramedics interpret their presentation primarily through the lens of substance use. Hermeneutical injustice occurs when people lack, or are denied, the interpretive resources needed to make their experiences understood.¹² For example, a patient may struggle to describe a complex or poorly understood experience because the healthcare system lacks the language or concepts needed to recognise what they are experiencing. This body of literature is now substantial enough that a 2026 scoping review identified epistemic injustice as an important yet still insufficiently explored feature of healthcare professional practice, particularly in relation to hierarchies of epistemic credibility, institutional power and constrained agency.¹⁰ A 2024 systematic review of epistemic justice in healthcare similarly identified invalidation of patient testimony as a

recurring problem, particularly among marginalised people and those living with contested conditions (e.g., fibromyalgia, long COVID, or medically unexplained symptoms).¹¹

Paramedicine deserves to be part of this conversation

The out-of-hospital environment places extraordinary demands on rapid knowledge production. Paramedics must make sense of patients ‘in the moment’. They assess physiology, symptoms, behaviour, context and collateral information while simultaneously managing risk. But the structure of the encounter may privilege particular forms of knowledge over others. For example, objective findings are readily sourced and documented, while patient narratives are often compressed and abridged to key items. Context becomes ‘social history’. Behaviour becomes ‘presentation’. Repeated attendance becomes ‘utilisation’. Refusal of care becomes ‘non-compliance’. Distress can become ‘behavioural’. Something is gained through this act of classification, but something is also lost; nuance, context, the essence of the knowledge. A patient knows something about their illness that the paramedic does not. They may know that today’s symptoms differ from previous episodes, that apparent agitation is actually fear, or that repeated ambulance use reflects an absence of alternative support rather than an intrinsic desire to misuse emergency services. This is not an argument that every patient account should override clinical judgement. Clinical expertise exists for a reason. It is an argument that the patient’s account and the clinician’s interpretation are different forms of knowledge, and that the latter has considerable institutional authority. So, we must now ask: do the structures of paramedic practice determine which patient accounts can count as knowledge?

The problem of the ‘social’ patient

Perhaps nowhere is this more visible than in the arbitrary distinction between health and social problems. Healthcare systems have become increasingly interested in the social determinants of health, and paramedics occupy a particularly interesting position because they encounter people in the environments where health is actually produced. Recent scoping reviews of social determinants within out-of-hospital care found that the literature increasingly recognises paramedics as uniquely positioned to identify and respond to social needs.^{13,14} However, identifying a social determinant does not make it a social problem rather than a health problem. Consider the person who cannot safely remain at home because they have no caregiver. The person who repeatedly falls because their housing is unsafe. The person who calls an ambulance because they have nowhere else to go. The person experiencing severe distress because of social isolation. At what point does

the adjective ‘social’ become a way of saying ‘not our problem’? This is particularly interesting because paramedicine appears to be increasingly moving in the opposite direction. Community paramedicine, social prescribing by paramedics, and other emerging models explicitly recognise that health cannot be separated from social context.^{8,14} Recent work in *Paramedicine* has similarly argued for greater social responsiveness within paramedic education and for recognising the profession’s responsibility to address structural health disparities.^{15–17}

Yet there remains a conceptual tension. We tell paramedics that social determinants matter, we stress the importance of the health-social continuum, and we continue to respond to cover gaps in the existing provision of services. Inexplicably, we then continue to build systems in which patients whose needs are primarily social become ‘*inappropriate*’ because those same needs do not fit our conventional healthcare pathways. We recognise the social determinants of health without recognising the social legitimacy of the person or their reason for seeking help. This pattern repeats throughout the system: we continue to worship process measures of emergency care performance (e.g., response times) over person-centred outcome measures. We remain somewhat committed to an identity as first responders while doing the work of integrated and primary care. And so on.

Who is deserving?

This brings us to an uncomfortable concept from the sociology of welfare and healthcare: deservingness. People do not always receive identical moral judgements about the circumstances in which they become ill. Recent experimental work on healthcare deservingness found that people attributed greater responsibility for health outcomes to individuals exposed to behavioural risks than to those exposed to environmental, institutional or biological risks.¹⁸ This is important because paramedics routinely encounter illnesses and injuries for which responsibility is ambiguous. The person who smokes with respiratory distress, the person intoxicated with liver cancer, the person whose mental illness has resulted in repeated crises, the person who repeatedly calls for help. The professional response may remain clinically appropriate, but the social interpretation of the person can change. Some forms of illness appear to be unfortunate, while others can appear to be self-inflicted or deserved. Some people are understood as victims of circumstances, while others are understood as being responsible for them. The clinical consequences of these distinctions deserve greater scrutiny. This question of deservingness can enter healthcare without anyone explicitly deciding or declaring that a patient is undeserving. It can operate through language, expectations, documentation, resource allocation, assumptions about credibility and the interpretation of repeated service use. A person does not have to be denied care for their legitimacy to be diminished.

The wrong patients may be the right patients?

There is a paradox here. People who appear to be the ‘*wrong*’ patients for paramedicine may be the people who reveal the boundaries of contemporary paramedicine most clearly. The ‘*frequent callers*’ and ‘*frequent users*’ reveal the boundary between healthcare need and service utilisation. The person who uses drugs reveals the boundary between illness and responsibility. The person experiencing homelessness reveals the boundary between health and social care. The person with chronic pain reveals the boundary between subjective suffering and objective evidence. The person in distress calling repeatedly reveals the boundary between emergency care and the absence of alternatives. These patients are often treated as problems of service demand. We argue that perhaps they should be treated as sources of knowledge about the health system. A recent mixed-methods study of frequent callers to ambulance services illustrated that difficulty navigating the healthcare system was a central theme across different sources of data.⁵ This suggests we need to reframe the ‘*frequent caller*’. Instead of asking only why this person keeps calling, we might ask what repeated calling tells us about the pathways available to that person.

So, who gets to be sick?

Perhaps the answer is those whose suffering can be translated into the categories our systems recognise. That is not necessarily because clinicians lack compassion, nor because healthcare professionals deliberately discriminate against people whose needs are difficult to classify. It is because healthcare institutions require categories. The problem is that categories have consequences. Low acuity can become ‘not our problem’. Frequent user can become ‘misuse’. Social can become ‘doesn’t need healthcare’. Each category may have a legitimate operational purpose, yet each can also create a distance between suffering and legitimacy. The challenge for paramedicine is therefore not to eliminate categorisation. That would be impossible. It is to become more conscious of what categorisation does. Who becomes visible? Who becomes invisible? Whose knowledge is privileged? Whose behaviour is moralised? Which needs are considered clinical? Which are delegated elsewhere? And what happens to people whose needs fall between these boundaries?

The role of Paramedicine

This is also where a journal has a particular responsibility. If *Paramedicine* is to contribute to the intellectual development of the discipline, it should not only publish research about the patients that our existing categories already allow us to see. It should interrogate the categories themselves and whether they are fit for purpose. We should be asking how

concepts such as frequent user, inappropriate use, low acuity, behavioural, social, complex and appropriate disposition are constructed and operationalised. We should ask what becomes invisible when these labels are applied, and as a result, what inequities are created or reinforced. As such, we must welcome scholarship that examines paramedicine through sociological, anthropological, philosophical, disability studies, ethical, political, and critical research lenses; not as an alternative to clinical science, but as ways of understanding the complex contexts in which paramedicine operates.

We should be interested in patients who challenge the boundaries of our conventional research designs. And we should be willing to publish uncomfortable findings. If patients from particular social groups are less likely to have their accounts believed, then we need to know. If some forms of suffering are systematically (mis)classified as social rather than health (or both), then we need to know. If the language of inappropriate use inadvertently hides (or ignores) unmet needs, then we need to know. If our definitions of patient complexity describe complexity in the person rather than complexity in the system, then we need to know.

The journal must also play a role in expanding who participates in the production of paramedicine knowledge. Epistemic justice requires more than inviting patients to describe their experiences after the important conceptual decisions have already been made. It requires questioning who gets to define the problem, establish the categories and determine what constitutes valid evidence in the first place. This is not an argument that every person who calls an ambulance should receive one, that every patient should be conveyed, or that every person’s account should override clinical judgement. It is an argument for intellectual humility. Paramedics make decisions about illness at the point where pathology, personal experience, social circumstances and institutional capacity collide. Those decisions may be clinically necessary, but they are never entirely detached from the systems and categories within which they occur. The same considerations should be given to our research.

Perhaps, then, the issue is not simply whether paramedicine treats illness. It is whether paramedicine now takes time to reflect, and then actively and knowingly participates in redefining what counts as illness, whose suffering becomes visible, whose knowledge is believed, and whose needs are considered legitimate enough to receive care.

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