An exploration of the support needs of Ambulance Paramedics

This is a thesis submitted in fulfilment of the requirements of the degree of Doctor of Philosophy.

Sandra Porter
Bachelor of Psychology (Honours)
Master of Applied Psychology (Community)

Doctor of Philosophy

2013

College of Health and Biomedicine
Victoria University

Abstract

The work of ambulance paramedics is usually physically and emotionally draining and can place significant amounts of pressure on the emergency service worker. The work they do can impact their social life, their family and ultimately, their health. The primary aim of this research was to explore the psychological and social coping strategies of ambulance paramedics, in dealing with the day to day aspects of their work in the context of their long term health and well-being. A secondary aim was to examine the use of current peer support programs and other referral services used by paramedics. This study was a qualitative exploration of the experiences of ambulance paramedics through interviewing. Qualitative research has allowed the researcher to capture the stories of individuals, in their own words. This study included nine novice paramedics (first year) and 12 longer term employed (five plus years) paramedics within Rural Ambulance Victoria. Participants were also recruited to reflect the gender ratio in the paramedic workforce.

Findings indicate that: (1) despite length of service each paramedic has a story to tell which indicates they have been impacted by what they see, (2) their family and social lives are negatively impacted, (3) paramedics use many coping strategies -- both functional and dysfunctional, (4) paramedics have reservations about the type of support they request, and (5) there was evidence to suggest numerous participants have, or are, suffering from acute and/or chronic PTSD.

These findings will contribute to our understanding of the work life of paramedics. Outcomes will further inform the development of “best practices” in improving the health of paramedics by providing an informed consideration of what the paramedic themselves consider to be valuable and accessible within the context of organizational support.

Declaration

I, Sandra Porter, declare that the PhD entitled "*An Exploration of the Support Needs of Ambulance Paramedics*" is no more than 100,000 words in length including quotes and exclusive of tables, figures, appendices, bibliography, references and footnotes. This thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work.

Signature: Date:

Dedication

To the countless men and women in all emergency services around the world who put their lives at risk to serve, protect and save their communities.

Acknowledgements

I would like to thank Victoria University for giving me the opportunity to complete this PhD, and for the past 14 years when I first embarked on my academic journey as a 17 year old. I am resentful for still being here as a 31 year old-but at the same time feel very fortunate to be able to study at an institution where in my experience, students come first.

I owe a great deal of thanks to many people without whose support this project would not have been possible. I would like to take this opportunity to express my appreciation.

First and foremost the participants of this study who welcomed me sometimes into their homes, and engaged in the spirit of the research. I feel privileged to have been given the opportunity to listen to your story. I can only hope that this research benefits you, your colleagues and your families in some way.

My supervisor, Professor Adrian Fisher, whose support, encouragement and wisdom, brought this thesis to its completion. Adrian took this thesis on, a few years through and it's been amazing having his guidance, advice and support along the way. The last lap of the athletics track is finally complete!

Dr Marion Kostanski and Dr Michelle Towstoless whose enthusiasm and expertise helped to develop my research skills and started the ball rolling on what has been a cloud hanging over my head for 5 years.

The staff at Ambulance Victoria's Department of Research and Evaluation who have assisted over the years, Paul Jennings, Linton Harriss and more recently Dr Amee Morgans.

To the administration staff at Victoria University. Specifically Elizabeth Smith and Chris Raptopoulos who assisted at numerous times throughout the years with forms, paperwork, directing me to the appropriate staff, and procedures.

Finally personal thanks to my family and friends who kept me sane throughout this long process. Many of you were probably sick and tired of hearing about this research and towards the end I got sick of hearing "Are you still doing that?" or "I thought you already finished that." To my many amazing family members who helped with caring for our daughter, Arianna whilst I attempted to get this complete for examination before Baby Tsiotinas number 2 came along. For then stepping in again to help me with both Arianna and Jonathan during submission for classification.

My mother in law and father in law, Despina and John Tsiotinas. You are truly amazing individuals and if I am half the parent you both are, I will be a happy person. You are two of the most selfless people I have ever met and am eternally grateful for your support, encouragement and love.

To my sisters, Geri, Deirdre, Sinead and brother Sean. Thank-you for your encouragement and help throughout this long journey. I'm sure you're all sick and tired of hearing about me going to Uni, meeting with supervisions, working on my thesis. I don't know what I would do without all of you on a daily basis.

To my own amazing parents, Jim and Susan Porter. Without both of you and your selfless decision to move to Australia with such a young family in 1988, I would not have had the opportunities which I have been blessed with here in Australia. You both moved away from your own families, impacting your own lives, in order to enhance ours. I will forever be thankful. I'll be graduating 25 years, almost to the day of us arriving in Australia.

I will always be grateful for the amazing support I have from family and friends.

To my sweetheart Jim. Finally you will have me all to yourself, without any distractions. We made it! Thank-you. I love you MTA.

Table of Contents

List of Tables

List of Figures

Chapter 1

Setting the scene

Three people in the branch sit in silence. One reads the daily newspaper, another sits exhausted in a recliner, and the third busies himself by making a cup of tea. This is how shifts usually begin, especially if it is a few days into their roster rotation. As the morning goes by, conversation turns to recent jobs. Then, the pager goes off, seconds later the static begins followed by the voice of the radio dispatcher. Conversation ceases. One worker grabs the radio and some fruit from the bench, another is already out of the branch and in the van, the third remains at the branch, reviewing medications and medical procedures. This is the life of an ambulance paramedic.

It is easy to see how this change in pace is not suitable to all individuals. Such a dramatic shift from doing something low key and mundane to having your heart rate increased within seconds can have many long term negative physical and emotional effects if not handled appropriately. For these reasons, and many others, terms such as burnout, post-traumatic stress, and vicarious trauma are commonly used within helping professions.

Ambulance paramedics are unique in many ways. They are unlike other medical staff, who usually see patients in sterile, stable circumstances. Paramedics are usually the first helpers called in the state of a physical emergency of individuals. They run to the aid of all individuals and see things in many different settings, such as individual homes, on the street and under cars. Despite the importance of their role, there has been a lack of research relating to the health and wellbeing of paramedics both in Australia and globally. For this reason research on stress and coping, trauma regarding other emergency service workers will be used in this study.

Recent research has indicated that the work conducted by emergency service workers is highly stressful (e.g., Jonsson & Segesten, 2004; Robinson, 2002). The work of ambulance paramedics is usually physically and emotionally draining and can place significant amounts of pressure on the emergency service worker and his/her family (Regehr, 2005). Emergency service personnel, including police, fire fighters and ambulance paramedics use many different strategies in order to cope with this pressure. However, not all strategies are healthy. For example, it is not uncommon for emergency service personnel to go to the local pub for a few drinks after a shift to unwind or take their work home with them, negatively disrupting their family lives.

1.1 Impacts of the job

As noted by Miller (1995) and others (Regehr & Bober, 2005), after an extensive time working within the emergency services, levels of stress can accumulate to serious heights. According to these authors, many personnel working within emergency services take their own lives as a result of not managing the accumulation of stress. Miller also identified that relationship problems, financial difficulties, job failure, failure to achieve goals, and exposure to critical incidents were indicators of employees not coping well with the accumulated stresses of their work. To address these issues, Regehr (2005) proposed that, by developing an understanding of how the impact of work affects the worker, we can help employees by assisting emergency service personnel to manage the stress associated with their job and maintain good health and well-being over the longer term. This research will focus on paramedics within a rural ambulance service in Victoria, Australia.

1.2 The Agency

Rural Ambulance Victoria (RAV) at the time of data collection, provided pre-hospital patient treatment in emergency and non-emergency situations and ambulance transport services, along with various public education services. As such, RAV was a major contributor to minimising risk in rural and regional communities through the provision of high quality, timely and cost effective ambulance services.

At the time of data collection, RAV's workforce had grown to 1,340 comprising approximately 1,176 operational staff, the remainder consisting of support staff and volunteers. Staff used a fleet of 307 front line ambulance vehicles and 99 operational support vehicles. Staff were located across rural Victoria and work from 144 response locations. RAV's five Regions were Barwon South West, Grampians, Loddon Mallee, Hume and Gippsland. Each of the five Regions was managed by a Regional General Manager, with the five Regions further broken down into Districts, with each District overseen by a Group Manager.

The management structure of Rural Ambulance Victoria comprised a Board of Directors, the Chief Executive Officer and an Executive Team consisting of: Regional General Managers from RAV's five Regions, General Manager Logistics, General Manager Clinical Governance, General Manager Corporate Services, General Manager Human Resources, General Manager Information Services, General Manager Corporate Affairs, and Corporate Secretary.

During the data collection of this study, a merger occurred between the two major Ambulance services within Victoria. This caused a level of anxiety from employees and proved quite disruptive to their day to day work. The organisation climate during this time was more tense due to Enterprise Bargaining Agreement

(EBA) negotiations being carried out. An EBA is when wage and working conditions are being negotiated between Unions and employers and this process can be lengthy and frustrating due to the instability caused. In this case negotiations went on for several months with participants understandably wishing to discuss the greater impact this has on them and their working life.

1.2.1 Ambulance Paramedics - Who are they?

Ambulance paramedics are trained to provide emergency care to injured or sick people needing urgent assistance. The cohort of paramedics in Victoria, Australia includes ambulance paramedics, MICA (Mobile Intensive Care Ambulance) paramedics, and general transport teams (GTTs). Ambulance paramedics handle medical emergencies as they happen. These can range from complex hospital admissions, discharges and transfers, to serious incidents in a variety of environments. They work as part of a quick response unit, usually with support from other medical staff, such as doctors.

Ambulance paramedics respond when individuals in society call the emergency number, for example, 000 in Australia (911 in the United States of America; 999 in the UK). The operator receives the call, dispatches jobs according to location and priority, and informs the paramedics of the severity of the job. The paramedic then responds appropriately.

1.2.2 Paramedic training

It is important to note that training requirements of ambulance paramedics differs around the world. As such, the training of ambulance paramedics has changed dramatically in recent years in Victoria. Prior to 2006, ambulance paramedics took part in more on the job training. This training was referred to as a Diploma of

Ambulance and Paramedic Studies (DAPS). Students were not required to undertake formal university training and the DAPS involved periods of time on the job mixed with theoretical components. In order to become a qualified ambulance paramedic today, individuals must complete a three year university degree in programs such as Paramedic or Health Sciences. These courses offer an extensive theoretical base and recruits are also required to complete placements 'on the road', to get experience on the job.

Since as recently as 2006, the minimum qualification to become a paramedic in Victoria is a Bachelor Degree, or Post Graduate Diploma, or a Masters conversion course for professionals already qualified in other areas of health. In Victoria, all of the programs available are offered by universities. At the time of data collection for this current study, on completion of their course, individuals could apply to either Rural Ambulance Victoria (RAV) or the Metropolitan Ambulance Service (MAS) for Graduate Ambulance Paramedics positions. Universities running Paramedic courses in Victoria include Victoria University, Monash University, Australian Catholic University and Ballarat University (Table 1).

Table 1: Paramedics courses available in Victoria, Australia

Victoria	
Monash University	• Bachelor of Emergency Health (Paramedic) • Bachelor of Emergency Health (Paramedic) / Bachelor of Nursing – Dual Qualification
Victoria University	• Bachelor of Health Science (Paramedic)
University of Ballarat	• Post Graduate Diploma of Paramedicine • Conversion Program for Health Professionals with a 3-5 year Bachelor Degree only
ACU National (Australia National University)	• Bachelor of Paramedicine • Bachelor of Nursing – Dual Qualification

1.2.3 Work of Paramedics

The work of paramedics falls into several broad, but quite distinct categories. Each has its own training and experience requirements. Some have sub categories where further training is required.

1.2.3.1 Ambulance Paramedics

To qualify as an ambulance paramedic, one is required to undertake a bachelors degree at a University. They are then required to apply for work within Ambulance Victoria (AV)[1]. These paramedics are fully trained and equipped to deal with most medical emergencies. There are also Air Ambulance Paramedics, Bicycle Response Paramedics, Clinical Instructors, Duty Team Manager, Graduate Paramedics, Group Managers, Paramedic Community Support Coordinators. If the emergency is highly complex, a Mobile Intensive Care Paramedic (MICA) is usually called.

1.2.3.2 Mobile Intensive Care Ambulance (MICA) Paramedic

Mobile Intensive Care Ambulance (MICA) Paramedics, after a significant amount of years' experience, are required to undertake a Post Graduate Diploma in Emergency Health (MICA Paramedic). The course involves both theoretical and practical education as well as supervised clinical experience. This course is presently run by Monash University and is accessible to employees of Rural Ambulance Victoria and the Metropolitan Ambulance Service. Mobile Intensive Care Ambulance (MICA) officers have more advanced training with an emphasis on clinical decision-making. This includes a more detailed understanding of anatomy, physiology,

[1] During the write up phase of the current research MAS and RAV amalgamated and are now known as Ambulance Victoria (AV).

pathophysiology and pharmacology to greatly increase their capacity to make complex, critical clinical decisions without medical consultation.

These specialist paramedics perform advanced airways management, endotracheal intubation, complete complex management of patients with head injuries, including rapid sequence intubation, insert intra-osseous (into bone) cannula for advanced drug and fluid administration in paediatric patients. They also treat life threatening chest injuries including pneumothoraxes (collapsed lung) by inserting a chest tube and are qualified in advanced management of cardiac conditions. Where appropriate they are called out to back up ambulance paramedics and may take over if necessary.

1.2.3.3 General Transport Teams (GTT) or Non Emergency Patient Transport (NEPT)

These teams primarily transport patients to and from the hospital or their home when necessary, and generally do not deal with emergencies. Ambulance Victoria requires these employees to hold a lower level of training – a certificate in non-emergency patient transport, or its equivalent. Such courses include first aid training, correct patient movement, and understanding medical terminology.

1.2.3.4 First Aiders and Ambulance Community Officers

Community members in remote areas of rural Victoria can assist by volunteering as an Ambulance Community Officer (ACO) or as a member of a Community Emergency Response Team (CERT). ACO's are employed on a casual basis and provide advanced first aid. CERT volunteers are usually available to respond first within a community. ACO's are required to complete advanced first aid

courses as well as specialised training enabling them to support the ambulance service by responding to emergencies in their communities.

Ambulance paramedics, as well as other AV employees, are further trained by the Clinical and Education Services. Clinical and Education Services (CES) is responsible for supporting the clinical operations of AV. It also provides support to universities offering undergraduate and postgraduate paramedic education. Within AV, Clinical and Education Services provides learning and development programs for:

- Graduate Ambulance Paramedics
- Ambulance Community Officers
- Community Emergency Response Teams
- Ambulance and MICA Paramedics
- Public Access Defibrillation sites

1.2.3.5 Continuing Education

Clinical and Education Services are also responsible for AV's clinical and quality assurance program, the close supervision of approved clinical trials, operational staff credentialing, equipment evaluation and clinical accreditation and re-accreditation activities.

Qualified Ambulance and MICA paramedics participate in an In-Service Continuing Education Program (ISCEP) consisting of a minimum of two educational days per paramedic per year. This provides the opportunity to review previous training and introduce approved changes to paramedical clinical practice.

1.2.4 What work do they do?

Most occupations have a certain level of stress associated with them, but emergency service workers face extremely stressful situations every day (Regehr,

Goldberg, & Hughes, 2002). Paramedics are unique in many ways. Unlike other medical staff, paramedics engage with patients in a variety of different environments. They are usually the first to be called to the scene of an emergency. They respond to individuals in crisis, and work within a broad and diverse array of settings, such as individual homes, on the street, in the office or shopping centre and any other place where people attend or congregate (Alexander & Klein, 2001).

Paramedics respond to a diverse set of medical situations, ranging from minor injuries -- such as nose bleeds -- to causalities involved in serious road or train accidents. They aim to meet the needs of individuals, to care or treat illnesses and injuries. Paramedics are expected to assess a patient's health status, to decide on the appropriate course of action, make immediate decisions regarding transportation of patients, administer medicines and give injections. They also need to attend to physical trauma, dress wounds, attend to fractures and apply splints. As well as this, all paramedics are required to keep detailed and exact patient and medical records. Aside from the intensity of this 'on task' process, the paramedic team is also responsible for vehicle maintenance, which involves restocking of supplies in their vehicle between shifts and call-outs.

On a typical shift an ambulance paramedic may have to travel at high speeds through varying traffic and weather conditions to attend a road accident, tend to an elderly person who has had a fall, assist a woman who has gone into labour, a child drowning, house burning, etc. For the paramedic, no one day is the same, hence, even across time there is no opportunity to be settled or complacent about their role at work. Their exposure to critical incidents can happen at any time. Alexander and Klein (2001) define a critical incident as 'an incident that is sufficiently disturbing to overwhelm or threaten the individual's usual method of coping' (p.76).

A study of paramedics by Regehr et al. (2002) found that 80% of paramedics working in large urban areas had experienced a critical incident such as the death of a patient while in their care, the death of a child, multiple causalities, as well as violence perpetrated by one person onto another. These researchers also found that 70% of paramedics had been assaulted while on the job, and 56% said they had experienced an event which could have led to their own death.

1.2.5 Impacts of the job on the Paramedic

Past literature suggests that there is a strong relationship between exposure to traumatic events and physical and psychological well-being (Everley & Lating, 1995). According to Robinson (1997), professionals who aid victims, including police, ambulance officers and fire fighters, can become secondary victims of the trauma. In fact, helping professionals have often been known to exhibit symptoms exactly like those directly affected by the incident (Everley & Lating, 1995; Robinson, 1997).

Alexander and Klein (2001) authors found that 82% of paramedics in their study (n = 90) had experienced a disturbing or critical incident (self-harm, cases as well as suicides, were deemed most disturbing on a personal level and were more common. Traffic accidents and medical emergencies were deemed as most disturbing) in the previous 6 months. Most importantly, 69% of respondents stated that they 'never' had sufficient time to emotionally recover between traumatic events, highlighting the dramatic and real impacts their job has.

More recently, Gallagher and McGilloway (2008) conducted a qualitative study exploring the impacts of critical incidents on ambulance personnel. Their interviews with 27 participants, with varying years of experience, indicated that exposure to critical incidents had a significant impact on their health and well-being. A lack of support from management was also pertinent in their findings. Other authors

have had similar findings in their research (Robinson, 1984; Jonssen & Segesten, 2004). The gap in the research specific to paramedics means this study will need to draw on research regarding stress and coping, trauma as they relate to other emergency service workers.

Social support has been found to play an integral part in the health and wellbeing of paramedics (Fullerton, McCarroll, Ursano, and Wright, 1992; Brough & Frame, 2004). Researchers have found that emergency service workers have a better psychological well-being when they feel supported by their peers (Brough, 2005; Brough & Frame, 2004).

It is important to note that ambulance paramedics liaise with doctors and nurses on a daily basis. Therefore, anecdotal evidence suggests that how Ambulance Paramedics view themselves, their profession and the importance of their role, is a further important predictor of stress. Parallel to the changes to perceptions within the medical profession between doctors and nurses, ambulance paramedics are currently fighting for the respect of other medical professionals.

Day, Minichiello and Madison (2007) investigated the role of morale among a cohort of registered nurses in Australia. Lack of recognition for job performance and professional achievement were found to be predictors of negative self-worth. The authors asserted that how nurses perceive their professional worth and value within a health care system can have a substantial impact of their level of morale. Those nurses who believed they had a higher status or regard from doctors, has more self confidence in their abilities.

These findings may be likened to the feelings associated with ambulance paramedics and their relationship with members of the public, doctors, nurses and other professionals within the hospital and pre-hospital setting.

1.2.6 A Snapshot of the current state of Ambulance Paramedic Health

Current literature indicates that ambulance paramedics engage in a high level of dysfunctional, rather than functional behaviours (Regehr & Bober, 2005; Robinson, 2002). A longitudinal study conducted by the Victorian Ambulance Crisis Counselling Unit (now the Victorian Ambulance Counselling Unit (VACU)) between 1984 and 2002 indicated that 88% of those surveyed reported drinking alcohol, with 94% drinking up to 24 days per month and 91% drinking up to six glasses of alcohol in a single session.

As of June 2006, the Metropolitan Ambulance Service (MAS) employed 1,297 operational ambulance paramedics (VACU, 2006). At the same time Rural Ambulance Victoria (RAV) employed 1,274 operational ambulance paramedics (VACU, 2006). Of these, only 93 MAS paramedics voluntarily had a general health check between 2005-2006 and only 284 were vaccinated against Hepatitis B (MAS, 2006).

1.2.7 Aims of the project

The primary aim of this research was to explore the psychological and social coping strategies of ambulance paramedics, in dealing with the day to day aspects of their work in the context of their long term health and well-being. A secondary aim was to examine the use of current peer support programs and other referral services used by paramedics. These two aims were explored within the context of comparing participants during the first year of their career, novice paramedics, and those who have been employed for more than 5 years. The research also looked to understand the potential changes over time among paramedics with different levels of experience.

Although the data is cross sectional and not longitudinal in nature, it was hoped that some inferences may be able to be made.

1.2.8 Research Questions

The current research addressed the following questions;

1. What are the psychological and social coping strategies ambulance paramedics use to help manage the demands of their job?
2. What are the support services ambulance paramedics use to help manage the demands of their job?
3. Are there differences between novice paramedics compared with more experienced paramedics with regard to the coping strategies and resources they use/access?
4 (a) What are the obstacles faced by paramedics in the workforce?
   (b) What coping mechanisms are utilized to manage the obstacles faced?

1.2.9 Statement of Significance

The information gained from the proposed study will have the potential to:

1. Reduce ongoing or long term health problems for paramedics at differing stages of their career
2. Alter existing practices which lead paramedics to distress, depression and burnout
3. Provide information which can lead to improved peer support uptake in AV.
4. Inform curricula taught within Universities to better prepare student paramedics

The knowledge gained from the current doctoral research project will be used in a theoretical sense to:

1. Inform theory in relation to the well-being of emergency service personnel, specifically ambulance paramedics

2. Contribute to literature on workplace practices
3. Develop an understanding of paramedic work experiences and inform better ways of coping with the job
4. Contribute to knowledge of the clinical aspects of the ambulance paramedic's profession, specifically focusing on prevention and intervention modalities.

Chapter 2 of this thesis will provide an in depth summation of research on stress and coping in a general sense as well as how stress and coping relates to emergency service workers. Functional and dysfunctional coping, including burnout and Post traumatic stress disorder (PTSD) are also explored in chapter 2, as well as the non-coping profile of paramedics.

Chapter 3 looks at what has been done by the organisation so far. Community readiness is also examined as an anecdotal precursor to future directions. Chapter 4 outlines the study method. Results are included in chapters 5, 6 and 7. Chapter 5 provides a summation of demographic and training information of participants. Chapter 6 involves 3 intense case studies and chapter 7 explores themes in depth, tying in the case studies already explored in chapter 6. Reality of the work, sensitivity/impacts of the work of paramedics, coping strategies used and organizational support are all explored. Chapter 8 provides a discussion, conclusion and summation of the research.

Chapter 2

Stress and coping

2.1 Stress Defined

Stress is a topic which has been widely researched in psychology (Folkman, Lazarus, Gruen, & DeLongis, 1986; Hobfoll, Schwarzer, & Koo Chon, 1998). The definition of stress is contentious, but in a general sense stress refers to a situation where the needs of an individual exceed the means he or she can draw upon. The word stress is often used to describe the physical effects associated with anxiety or fear. Stress can be any negative psychological, emotional, physiological or physical impact on a person from an external or external source. Common effects include muscle tension, clamminess and an increased heart rate (Haseed, 2002). There are many negative responses to stress and, therefore, managing stress is important for individuals to be able to lead a happy, balanced life. Stress has been defined as "a negative emotional response which results from negative thoughts about our environment" (King, Stanley, & Burrows, 1987, p. 3).

Stress experts, Lazarus and Folkman (1984) defined stress as "constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of a person" (p. 141). This definition is important as is highlights the ever changing nature of stress, which indicates that individuals coping strategies must also be adaptable to different stressors. It must be noted, however, that although stress does depend, to some extent on the surrounding environment, the stress response is also dependent on the mediating role of each person's interpretation and appraisal of their surroundings.

According to Davidyan (2008), Walter Cannon and Hans Selye were the first researchers to explore the physiological process. Cannon was a physiologist at

Harvard University who was the first to use the term 'homeostasis'. He asserted that when a person is faced with different changes, such as different stressors placed on the body, (he focussed on physiological changes initially and then adapted his theory to include psychological changes and responses), the body's internal systems must compensate for the resources being exceeded. Cannon asserted that homeostatic processes were involved. The concept of homeostasis introduced by Cannon has been very valuable in explaining the link between acute and chronic stress responses (Davidyan, 2008).

Further research has been conducted into homeostatic models (Holmes & Rahe, 1967). Homeostatic models work on the premise that any change, whether positive or negative, brings about change in an individual or animal. Support for this model was premature as it was based more in a theoretical level, than practical. This model did, however, receive some support from Selye who was the first investigator to use the term 'stress' to describe the problems associated with homeostasis, adopted by Cannon. Although the term was previously utilised in physics, Selye was the first to use it with reference to the impact on the organism, rather than environmental stressors.

According to Davidyan (2008) stress can be broken into three phases: stimulus, response and process. *Stimulus* refers to stress that can be categorised as originating from 3 sources: (1) Catastrophic events, (2) Major life events, or (3) Chronic Circumstances. *Response* refers to how a person responds to particular stress. Davidyan has also combined both physiological and psychological responses and related them to the response to the stressor and states that there are two main components of responding: physiological responses and psychological responses. The *Process* of stress is a series of transactions and adjustments between the person and

his or her environment. Stress is viewed as a process, not just a stimulus and response. An individual who is experiencing stress is seen as the agent by which his or her behaviour, cognitions and emotions can change the outcome of their response to the stressor (see Transactional Model for more).

According to many researchers (Burke, 1998; Davidyan, 2008) due to the fact that chronic stress responses involve physiological changes to the body, internally and externally, much attention has been paid to acute physiological stress and how acute stress may lead to chronic stress.

Stress and coping research has increased over time (Burke, 1998). Coping has been subject to scrutiny over the past 40 years, with much research documenting the concepts of stress and coping (Lazarus & Folkman, 1984; Resick, 2001), however, gaining a clear understanding of both concepts is difficult even today.

2.2 Coping Defined

Just like there are many definitions and concepts of stress, coping literature indicates that this term has also been explored thoroughly. According to Hood and Carruthers (2002) there are two types of coping: problem-focused coping (or active coping) and emotion-focused coping (passive coping). Problem-focused coping concentrates on finding a solution to the problem at hand. Strategies such as learning new skills to tackle the problem or changing one's motivation levels are examples of problem-focused coping. The strategies can involve changing internal and/or external factors to mitigate the problem. Emotion-focused coping tend to look more towards changing emotional responses to the problem. Avoidance, distraction and acceptance are strategies used in emotion-focused coping (Lazarus & Folkman). Lazarus (1993) indicated that problem-focused coping is more widely used and accepted in Western

society due to the perceived need for individuals to take responsibility for their own lives and actions.

There are many theories on stress and coping. There are stimulus-response theories such as those of Elliott and Eisdorfer (1982). Stimulus-response definitions of stress are based on experimental evidence that suggest that a certain stimulus produces a response which is a sign of distress in a person or animal. This relies on the response of the individual to the particular stressful stimuli. One must ask though, how are stimuli appropriately deemed stressful or stress producing? The stimulus response model was adapted from structural engineering theories (Elliot & Eisdorfer, 1982).

2.3 Selye's General Adaptation Syndrome (GAS)

Hans Selye played a vital role in the changes that have occurred over time and our present understanding of the term 'stress'. According to Goldstein and Kopin (2007), Selye is responsible for "popularising the concept of stress" (p. 110). Selye asserted that a variety of stressors provoke a general stress response. He believed that this response was not dependent on the actual stressor. In general, Selye's definition of stress was simply the body's response to the demands placed on it. Selye proposed three universal stages for coping with a stressor and labelled this the General Adaptation Syndrome (GAS). This involved: (1) an initial alarm reaction, (2) a stage of adaption or resistance, and (3) a stage of exhaustion.

The GAS is defined as the symptoms of stress in the whole body, as they develop over time. It must be noted that it is not imperative for all three stages to be reached before speaking about the GAS. Only the most severe stress leads to stage three, Exhaustion. Most of the physical and mental changes or challenges which we experience frequently, take us to stages 1 and 2. At first they alarm us, but then we

adapt to them. Animal experiments have indicated that when exposed to cold, muscular effort or haemorrhage, this can be handled for limited time periods. After the initial alarm reaction, the body becomes adapted and begins to resist, the length of the resistance period depends on the intensity of the stressor, as well as the body's in-built ability to adapt, as well as the intensity of the stressor (Selye, 1974). If the body perceives that it cannot cope with the demands placed on it, the body's processes may not fight and instead attempt to remove itself from the situation. This *fight or flight* response encourages the body to respond quickly to danger, but this state of higher arousal can lead to long term or chronic stress.

In the course of our lives we go through the first two stages many times, if this was not the case, we would never adapt and survive, given the myriad of demands placed on us every day. Also, not all experiences of stage 3 lead to an irreversible exhaustion.

Many of Selye's experiments involved injecting rats with formalin and found that once injected, the tissue of the animals would respond by increasing in size(Goldstein & Copin, 2007). It was later found that such changes are associated with activation of the hypothalamic-pituitary-adrenocorical (HPA) axis. Steroids which were released into the circulation from the adrenal cortex (in response to the stressor) contribute to resistance, but also may be the reason for pathological changes. Selye's concept that prolonged stress can produce physical disease and mental disorders is now widely accepted. This information indicates and supports the notion that increased stress over time can have detrimental effects on physical health and mental functioning (King, et al., 1987).

Davidyan (2008) believes the theory fails to take into account that different stressors elicit different emotional responses than others. The theory also does not take into account physiological changes, such as sudden compared with slower changes in the body's temperature. Because of these limitations, other theories of stress and coping have come to the fore.

The model which is most well accepted is the theory which takes into account appraisal of resources (Lazarus, 1966; Lazarus & Folkman, 1984, 1987). This model is known as the Transactional Model of Coping and Social Support (Lazarus, 1966).

2.4 Transactional Model of Coping and Social Support

The Transactional Model of Coping and Social Support asserts that a person first determines whether a situation or event is stressful or not. If it is deemed stressful, the person makes an appraisal to determine whether there are enough resources surrounding them in order to successfully manage this stress. Accessibility of these resources, as well as past experiences, are taken into account. If the person judges that they have the resources to cope, stress will not occur, or will occur at a more minor level. If the person does not have the resources to cope, stress will be the result (refer to Figure 1). The appraisal of potential stressors can be influenced by the person's perceptions of the support and resources around them. This model focuses balance, or homeostasis, and assumes that if a person returned to homeostasis, then the psychological stress would decrease (Resick, 2001).

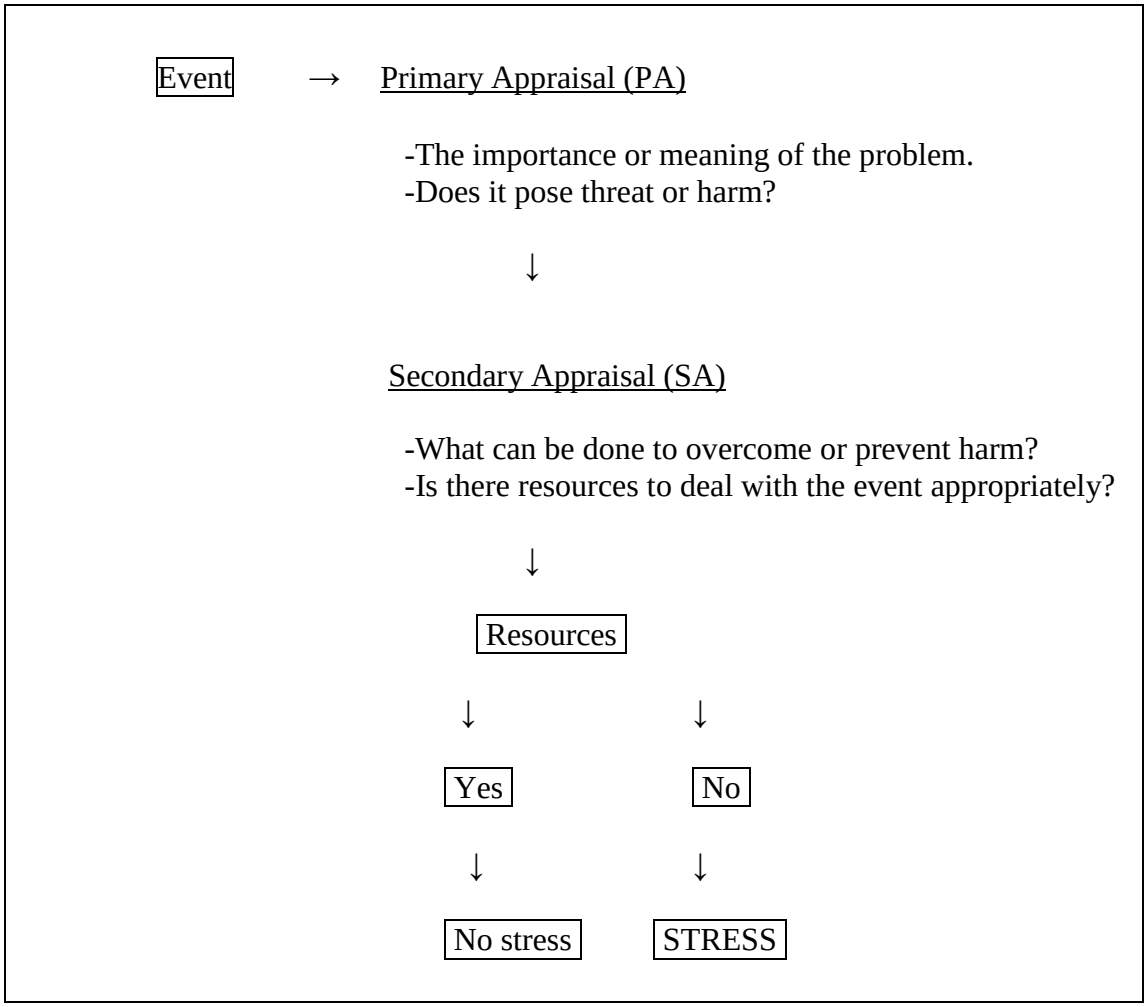


Figure 1: Transactional model of coping and social support (Resick, 2001)

Stress is thought to occur when there is an imbalance between the resources available and the demands placed on the individual. The larger the imbalance experienced, the greater the stress experienced. Lazarus (1966) argued that traditional theories of stress (such as the stimulus-response model) fail to see the relational aspects of the stress experience. In contrast, he believed that the Transactional Model emphasised the "constant interplay between the individual and the environment" (p.4). Within the Transactional Model, there are two stages to the judgement process, Primary Appraisal and Secondary Appraisal. Both stages are very distinct and when an event takes place, an individual will usually go through the two appraisal stages.

2.4.1 Primary Appraisal

Primary appraisal (refer Figure 1) occurs when an event first manifests itself and an individual makes a decision as to what is at stake. The event is evaluated in terms of its importance and meaning, as well as whether it poses threat or harm. This is the stage where the individual understands and makes sense of the event and whether or not to act or respond, and, if so, how to act or respond.

When an event takes place and the individual is evaluating their own response, many variables impact their decision to act or respond. Individual differences such personality factors, past experience, values, commitments, goals, beliefs about oneself, resilience and hardiness all impact how the individual responds.

Every individual has different mechanisms for evaluating events. Some individuals are able to manage multiple stressors at one time and not be affected, while others reach their 'breaking point' with one stressful situation (Spikard, Gabbe, & Christensen, 2002). A variety of social factors influence our ability to evaluate whether we can manage stress (Costa, 2003; Monk & Folkard, 1992). These include core individual differences, family and living conditions, working conditions, social conditions and working hours (refer Table 2). For example, if an individual has a supportive family and flexible, understanding workplace, they are more likely to perceive that they have the ability to respond appropriately.

Table 2: Factors which influence stress (Costa, 2003)

Individual characteristics	Family and living conditions	Working conditions and working hours	Social conditions
- age - gender - circadian structure - personality and behaviours - sleep strategies - state of health	- marital status - number and age of children - partner's (shift) work - housing conditions - family attitudes - incomes	- compensative measures - monetary compensation - work organisation - job satisfaction - work load - counselling - shift schedules - timetables - overtime - amount of night work	- shiftwork tradition - community organisation - social involvement - social support - commuting - public services

Factors such as age, gender and personality also play a part in influencing a person's ability to deal with or manage stress, directly impacting their appraisal of coping or not coping. Whether a person is single, married, has children and the support of loved ones also impacts how they manage stress (Costa, 2003). According to Costa, while negotiating what is at stake, a range of personality characteristics including values, commitments, goals and beliefs about oneself and the world helps to define the stakes that the person identifies as having relevance to well-being in a specific stressful encounter.

Similarly, many factors have an impact on stressful appraisals. Factors that relate to the person and factors that relate to the situation, both play an enormous part in whether the situation will be deemed stressful (Lazarus & Folkman, 1984). Personal factors include intellectual, motivational and personality characteristics. For example, an individual with self-confidence is likely to believe they have the resources available to them and, therefore, will be less inclined to stress. Whereas an

individual with low self-esteem may think they do not have the resources and be more likely to stress in the same situation as the individual with high self-confidence.

Personality characteristics play a vital role on this perception. For example, locus of causality, or how a person perceives they can control a situation, is also an important variable when making this initial appraisal about the risks to the self. Jonsson and Segesten (2004) reported how internal locus of control becomes an important factor in keeping individuals healthy. Those who are confident that they can control the situation have been found to handle a traumatic event more successfully than those who believe they are controlled by other external factors (Harrison & Kinner, 1998). When one has a belief that they can overcome the stressful event, they are more likely to succeed. This is especially apparent in the literature on aspects of control for emergency service workers. Findings have suggested that emergency service workers who feel they are in control of the situation they are in, are more likely to handle the situation successfully (Jonsson and Segesten, 2004; Harrison & Kinner, 1998).

It is important to decipher the difference between internal and external locus of control. Internal referring to the innate control a person has over a situation, external referring to factors external to the individual (i.e., other individuals, circumstance, fate). Historically, Haley and Strickland (1977) reported on past studies and theoretical perspectives regarding the relationship between internal-external locus of control and depression. As Haley and Strickland pointed out, Rotter conducted a study in 1966 and predicted that a relationship existed between positive adjustment and internal locus of control and that too much internal or external locus of control could lead to maladjustment.

In 1984, Burger surveyed 99 college students and found a relationship existed between desire for control and locus of control and depression. Six months after their original survey screening, 71% of participants completed a further survey reporting their experience with depression. Participants who thought their lives were controlled by chance (in relation to the locus of control scores) reported significantly greater levels of depression. Subjects who initially scored high for desire for control, who also thought their lives were controlled by external factors, were more likely to have suicidal thoughts. Despite locus of control playing a major role in managing stress, individual differences are also an important predictor. We all have our own ways of coping with and responding to stimuli.

Overholser (1992) discussed the role of humour in coping and highlighted the importance of humour as another psychological resource for coping. The author indicated that using humour in stressful situations decreases loneliness, lowers depression and increases self-esteem. He did stress, however, that these outcomes were short term, and that perhaps humour is more of a tool one can use to distract oneself from the situation at the time. Kuiper, Martin, and Olinger (1993) also suggested that humour was an important coping strategy. However, the authors stated that humour can impact both the initial appraisal of the situation as well as the perception of a person's ability to cope. Individuals, who use humour, seemed to view situations as less stressful and less personally relevant than individuals who did not use humour as a strategy to cope. Also individuals with a sense of humour in a difficult or challenging situation seemed to see the situation more of a positive challenge, rather than a stressful encounter. Moran and Massam (1997) evaluated the use of humour in emergency work. The writers discussed the use of humour in language and communication contexts, as well as highlighting that emergency

workers use humour as a form of cognitive reframing and reinterpretation. Palmer (1983) also found language alteration and the use of humour and comedy as a 'safety-valve' for emergency service workers. Fullerton and colleagues (1992) also found that the use of humour helped rescuers in their study form an alliance and in turn aided in their recovery.

Physical resources, such as health, fitness levels and energy levels, according to Lazarus (1984), are also very important elements to whether one can cope or not. Depression is a major metal health issue both in Australia and around the world. Beyond Blue (beyondblue.org.au, 2012) report that on average one in five Australians will experience depression at some point in their life. Despite more widespread pharmaceutical responses to depression, past research has indicated that exercise can significantly assist in helping individuals cope with and manage stress and depression (Landers, 1997). Exercise releases chemicals into the body which helps increase our self-esteem and the way we feel about ourselves. Despite these findings, Lazarus and Folkman (1987) highlighted that some individuals who are lacking physical resources, (such as a person with a chronic illness) are still able to cope well. Therefore, it can be said that physical resources are important for coping, they are not completely necessary for successful coping.

2.4.2 Secondary Appraisal

Within the Transactional Model, coping is a central element. According to Lazarus and Folkman's theory (1984), coping is the "things people do to manage stress" (Hobfoll, et al., 1998, p. 187). Therefore, a person's resources are viewed as aspects of the person's environment, which in turn influence their ability to cope. Secondary appraisal occurs when the person evaluates what, if anything, can be done to overcome or prevent harm, or to improve their prospects for benefit. Secondary

appraisal involves determining whether there are enough coping resources to deal with the event appropriately. Various coping options are explored and acted upon, including accepting the situation, getting more information or holding back from acting immediately.

According to Hobfoll and colleagues (Hobfoll et al., 1998, p. 187) coping has two major roles: dealing with the problem that is causing the distress (problem-focused coping), and regulating emotion (emotion-focused coping). Individuals use both types of coping in every stressful encounter they experience. Problem-focused coping includes aggressive interpersonal efforts to change the situation, such as starting an argument with a colleague, as well cool, rational or deliberate efforts to solve the problem, such as presenting a colleague with numerous options to compromise. Emotion-focused coping includes distancing, self-controlling, seeking social support, escape-avoidance, accepting responsibility and positive reappraisal. Cognitive appraisal and coping are transactional variables, in that they rely on integration between the person and the environment in any given transactional or stressful circumstance.

There are many other variables, which despite their importance and impact on coping behaviours, cannot be discussed at length in this thesis. Variables such as personality, social variables (including social support), past experience and an individual's attitude, have a very real impact on how they cope with a stressful situation (Lazarus & Folkman, 1984). One variable which will be discussed is the importance of social support for ambulance paramedics. Social support will be discussed in terms of the importance of support from the family and friends of paramedics, support within the paramedic organisation (management, team leader) as well as peer or colleague support (Regehr et al., 2002; Robinson, 2002). Social

support, especially from peers, has been found to assist individuals at work, and help them cope more effectively with stressful situations (Fullerton, et al., 1992; Jonsson & Segesten, 2004; Regehr, Hill, Knott and Sault, 2003). Heller and Swindle (1983) discuss the social support stress buffering hypothesis. This hypothesis asserts that social support acts as a defence or barrier to stress. That individuals with positive relationships with others, strong family networks and supportive friendship circles, will be less likely to suffer symptoms of stress. Therefore strong, positive social support can be a positive coping response to stress. It must be noted however, that the interpersonal relationships between the person and their family and friends must be healthy and positive.

There are also different types of social support. These include, Emotional (physical comfort, empathising, listening), Instrumental (material aid, provision of tangible resources, Information or education and Appraisal (evaluation or confidence building from others) (Myers, 1982). Social support has been found to positively impact on individual and organisational outcomes (Brough & Frame, 2004). Researchers have found that psychological well-being is positively influenced when individuals from emergency service organisations feel supported by their peers (Brough, 2005; Brough & Frame, 2004). The impact social support has on each individual is again highly dependent on many variables including personality, safety and resilience.

2.5 Stress and coping in Emergency Services

Resilience, or hardiness, is an important individual difference when discussing the stressors encountered by emergency service workers. Resilience refers to ‘a dynamic process encompassing positive adaptation within the context of significant

adversity' (Luthar, Cicchetti, & Becker, 2000, p. 543). This includes how they cope, manage or deal with pressure or stress. Alexander and Klein (2001) using the Hardiness Scale, conducted a study of 160 Scottish ambulance personnel and found that those with a 'hardy' personality were less likely to display general psychopathology, burnout or post-traumatic stress symptoms. Similarly Bennet, Williams, Page, Hood and Wollard (2004) found that among a cohort of U.K ambulance officers, women who were 'hardy' were more likely to self-select for the ambulance profession and, therefore, women who took part in the survey had lower rates of PTSD compared to the general population. Consistent with this idea, recent interviews with student paramedics indicated that they believed that it took a specific personality type to be a successful paramedic. Words such as 'tough' 'independent,' 'easy going' as well as a 'sound ability to problem solve and think quick' were mentioned by the students (Kostanski & Porter, 2007).

Early work by Mitchell (1983; 1988) on Critical Incident Stress Management (CISM) explored the physical, emotional, cognitive and behavioural responses to witnessing a traumatic event by emergency service workers. Mitchell completed a large body of work in this area and developed a model highlighting the emotional cost of stress on trauma workers (1983). His work suggested that emergency service workers were more likely to develop clinical depression, than the general population, when faced with trauma. The effect of critical incident stress, according to Mitchell, if left unacknowledged, could develop into physical, emotional, cognitive and behavioural issues for employees. Mitchell also highlighted that the culture within emergency services allow workers to suppress their true responses and reactions in order to continue with the work they do. From this model Critical Incident Stress Debriefing (CISD) was developed.

Operational, as well as psychological, debriefing is vital for the positive psychological functioning of paramedics. Debriefing, in a general sense, involves the coming together of individuals who have directly or indirectly been exposed to a critical or traumatic incident. This usually takes place within a few days after the incident and can be led by a person internal or external to the organisation. Raphael and Wilson (2000) discussed comrade support in relation to persons experiencing exposure to trauma. The authors claim that the emotional and evaluative support received by peers is important. This is specifically the case when informally debriefing after an incident.

There are different forms of debriefings. There is *Crisis intervention* or *emotional first aid,* which is informal and immediate, *Defusings,* which usually takes place between 8-12 hours after the event, are also informal and can be conducted by peers or management. *Critical Incident Stress Debriefing (CISD)* is a very formalised, 'comprehensive, systematic and multicomponent approach' (Raphael & Wilson, 2000, p. 74)[2]. This approach involves interventions for the individual, the group and the environment (including support for families, organisations and community). It is usually a place where a group comes together to discuss the traumatic event, its impacts and is carried out between 24-72 hours after the incident (Raphael & Wilson, 2000). The organisation must take responsibility for its staff in terms of the procedural aspect of their job. As such, during training each student is responsible for their actions so that they are aware of his/her responsibility to act and do all they can for each patient. Did they act in an appropriate manner? Did they respond appropriately? Did they do all they could for the patient? But the organisation also must take some responsibility for the psychological wellbeing of the paramedic, and it is vital for

managers and team leaders to check in with their staff on a regular basis. Unsupported staff in any organisation or industry, let alone a high pressure industry such as the emergency services, will eventually lead to unsatisfied, and sometimes stressed and staff who are not coping.

Police officers as well as other emergency service workers have been found to be negatively impacted by their job, when compared to other professions (Zimmerman, 2012; Regehr & Bober, 2005). As a direct result of the work they undertake, police officers experience a variety of stress symptoms. Stressors they experience include, boredom, lack of respect from members of the public, excessive paperwork, shiftwork, threats of violence, as well as the bureaucratic structure. Reactions to these stressors include absenteeism, low morale, emotional burnout, frustration, depression, anger, as well as psychosomatic and physical conditions. Because of these reasons, it can be important for individuals as well as organisations to monitor the amount and levels of stress they are feeling or experiencing and to manage this appropriately. There are many physiological benefits of relaxation and stress reduction. Such benefits include a reduction in blood pressure and heart rate, improved immune function and improved reflexes, response times and improvements in perception of the senses (Haseed, 2002).

Fullerton, McCarroll, Ursano, and Wright (1992) explored the impact of major casualties on fire fighters. The study investigated the psychological responses of two groups of fire fighters. One group from Iowa helped in the rescue of an air disaster; the other group was performing rescues within New York City. The fire fighters from Iowa were debriefed 2-4 days after the event. The New York City fire fighters were interviewed in groups. There was no comparison between the effectiveness of whether

[2] Within the agency being studied, these were provided by a range of personnel, including peers,

the fire fighters were interviewed or debriefed. Response themes from both groups included:

1. Identification with the victim (Fullerton, et al., 1992). Identification is a complex, cognitive process whereby we come to see others as being similar to ourselves. In these cases the fire fighters were able to identify something in their own life with someone they were helping. For example, the worker may have been rescuing a child the same age as one of their own children.
2. Helplessness and guilt. The feeling of 'I could have done more' was left with most of the participants in this study. Some fire fighters fought internally with themselves thinking they had over looked something which may have resulted in a different, more favourable outcome.
3. Fear of the unknown: Environment played a large part in this finding, with the disastrous nature of the incidents having responders questioning whether they were driving over dead bodies.
4. Physiological reactions: Many fire fighters continued to smell the burning flesh after they had returned home. One participant stated "we call some of the bodies a roast" (p.374) again highlighting Palmer's (1983) finding regardin the use of language and humour and similar to Jonsson and Segesten's (2004) findings with reference to the massive impact the senses have on one's responses and reactions.

All fire fighters in the Fullerton et al. (1992) study spoke of the fatigue they experienced during the rescue work. Fatigue, as well as physical, emotional and psychological exhaustion are the norm in rescue work.

Previous research has shown that exposure to traumatic events can have negative effects on one's psychological and physical well-being, as well as one's relationship with others. Emergency service personnel, as a result of the work they complete and the nature of the events to which they are exposed, are extremely

---

management or VACU – depending upon the timeliness and severity of the incident.

vulnerable to the damaging and harmful effects of stress and work. Research findings have indicated that work stress may impact of family functioning, however, there is evidence to suggest that the resources an individual has may mediate this impact (McCammon, Durham, Allison, & Williamson, 1988).

Regehr et al. (2002) collected quantitative survey data from a sample of 86 paramedics in one organisation in Canada. Participants who took part in the quantitative survey were asked if they would like to take part in an interview to more fully explore their experiences. Eighteen of the original responders took part in in-depth interviews. Interviews followed a semi-structured interview guide including questions surrounding stressors encountered as part of their jobs, the effects of stress, organisational supports and strategies for dealing with stress.

All 86 ambulance paramedics reported that they had been exposed to at least one critical incident during the course of their career, including the death of a colleague, injury on duty, mass causalities, or the death of a child. The mean length of time since their last critical incident was 3.6 years with a range of 2 weeks to 9 years. Eighty-two per cent of participants indicated that they had been significantly overwhelmed or disturbed by an incident or incidents. It seemed the more experienced the paramedic the more likely they were to report distress. This is consistent with earlier findings by Miller (1995) and is an important finding for the current research. This implies that the more time spent in an emergency service occupation, the more likely the individual is to: (a) feel more stress and pressure, or (b) feel more comfortable to admit the impact of the job.

During the interviews in the Regehr et al. (2002) study, paramedics were asked to rate what they thought others would deem the most traumatic and a significant number claimed that ‘blood and gore…’ are not the incidents that ‘have

left me sleepless' (p.3). The most common response was suicide or violence against children. With reference to child abuse or neglect, many respondents were able to recall a great amount of detail with regard to specific cases. The major reason given as to why these incidents had the greatest effect was due to the paramedics being unable to comprehend why some people are able to do what they do. Others claimed that seeing people who are lonely affected them greatly. Surprisingly, violence directed toward the paramedics themselves was not deemed as traumatic.

Most studies on stress, trauma and coping within emergency services have been based on small sample sizes. One of the most prominent researchers within the Australian context in recent years has been Robyn Robinson. She has spent time exploring and evaluating the psychological health and well-being of paramedics in Victoria, Australia.

In 1982, the Chief Medical Officer, Frank Archer of the, then, 16 Ambulance Services which were operating in Victoria, committed to assessing the health and stress of staff. Following much investigation by Robinson and her colleagues a questionnaire was administered to employees and their partners. This survey became the first base-line measurement of stress and health in the ambulance profession in the world. The results of this study lead to the development of some of the programs which still exist today.

A way of tracing individual participant responses was developed by enabling participants to leave a number on their questionnaires. This was used only to trace each participant's change over time and also provided a way for the authors to follow-up, understand major themes over time as well as predict health and stress variables using longitudinal data. The inclusion of spouses allowed the authors to get an indication of the impacts of the job not only for the individual, but also their families.

The authors also decided to include administration and support staff in order to acknowledge the fact that these people provide support to ambulance staff, as well as to use this group a means of comparison.

In 1993, the first follow-up study was conducted. This occurred at a time of severe budgetary constraints and organisational changes were rife. The authors (Robinson, 1993) believed administering the follow-up questionnaire at this time would allow them to capture the impact of organisational change on employees, as well as gathering the data on health and stress. The 1993 study also included ambulance paramedics from 6 other countries to allow for wider international comparison (Robinson, 1993). The other countries included the United States, Canada, Great Britain, New Zealand, Norway and India. The broad aims of the 1993 follow-up study were to: (1) gain an understanding of health and stress in Ambulance Services in Victoria, (2) enable a longitudinal study of health and stress utilising the 1984 data, and (3) make cross-cultural comparisons of base-line health and stress information.

The response rate from ambulance paramedics and their partners was positive (60% and 52% respectively). A total of 823 ambulance officers responded, as well as 640 of their partners. Perhaps the most outstanding finding from the 1993 study was that 65% of participants reported that they experienced trauma reactions as a result of prior ambulance jobs. A substantial 17% reported a strong response and, despite not formally assessing the prevalence of Post Traumatic Stress Disorder (PTSD), there was an indication that symptoms of PTSD did exist in this cohort. It is important to note that symptoms of PTSD can be present over a short period of time. However, to be diagnosed with PTSD, these symptoms must persist over time (Association, 2003).

Robinson (1993) identified a personality profile of ambulance officers, finding that the profile of a paramedic is someone who is dedicated, practical, caring of others and able to handle pressure well. Despite 98% of staff reporting that they found their job interesting, 89% stated that the job interfered with their home and social life. It is unclear whether this interference relates to job content or was more directly related to shiftwork. This will also be explored further in this thesis.

Findings of Robinson's (1993) study also indicated that the paramedics surveyed in this study adopted dysfunctional coping strategies. Eighty-four per cent of employees reported that they drink alcohol, 30% reported that they usually drink between 1-4 days per month, 5% reported that they drink daily, while 52% reported that they have 2-4 drinks per month. Twenty-two per cent claimed they were on some kind of medication. This included pain killers, vitamins and other prescription and non-prescription items. Physical ailments reportedly experienced by paramedics included backache (22%), fatigue (20%) and sleep problems (20%). These findings can be likened to the general population and may not seem significant separately. However, overall, 71% stated that they regularly had sleep difficulties and 16% of respondents claimed that they had experienced an injury while on duty.

A follow-up of the original study was conducted by Robinson in 2002. This was nine years after the first follow-up study in 1993, and 18 years after the initial study in 1984. From 1993 to 2002 there were a number of changes. Results indicated that there was an increase in the number of women, but a decrease in the number of employees born outside of Australia participating in the workforce. The average length of employment was 15 1/2 years. There were fewer senior staff, more MICA paramedics and more students in 2002 when compared to 1993. There was a reduction in on-call, one-person crewing, relieving and control room work (all of these were

positions deemed to be stressful in previous studies). There was also an increase in shiftwork and overtime shifts.

Staff reported decreased rates of smoking, higher rates of exercise and better fitness in 2002. Taking time off work for Workcover[3] was reported for the first time. Rates of medicinal use increased considerably. Despite the increase in physical fitness and rates of exercise, the number of individuals who reported being overweight increased and there was an increase in the number of people who reported drinking alcohol. More paramedics who participated in the study reported that they had consulted with a professional for psychological issues. Stress ratings had decreased and major stressors were reported to be threats to personal safety and witnessing the death or serious injury to a colleague.

Coping skills for general stress were measured and compared to 1993. There was a reduction from 24% to 21% who reported to 'bottling things up' to cope. Eighty-seven per cent of paramedics reported that they talked to a colleague after exposure to a critical incident. Seventy-five per cent of employees reported having sleeping difficulties and 55% stated they exercised (compared with 49% in 1993). Eighty-eight per cent of employees stated they drank alcohol and most drinkers (94%) claimed that they consumed alcohol up to 24 days a month, a further 91% reported that they drank up to 6 standard drinks in one sitting – which meets the definition for binge drinking. Thirty-four per cent conveyed that they were on some kind of medication, with pain relievers reported as the most common (76%). Thirty-three percent of staff reported they had an injury (marginally up from 32% in 1993) and 32% stated this injury was a direct result from ambulance duties (markedly down

[3]Workcover is a state government backed insurance scheme which provides compensation for injured employees.

from 70% in 1993). Twenty per cent of respondents reported that they took up to 5 days off work per year due to psychological stress.

It seems that many improvements have been made to the health and psychological well-being of ambulance paramedics from 1993 to 2002. More ambulance paramedics reported accessing professional help, but there were also some increases in dysfunctional or negative behaviour. However, some changes, such as the coping strategies utilised, have been minimal, and alcohol consumption and the number of paramedics on medication increased. Overall, the findings of these studies indicate that there is a need to continue to develop and improve the health and well-being of ambulance paramedics. It seems the more aware organisations and professionals are of the implications of work stress on individuals working within emergency services, the better off all involved will be.

International data seem to corroborate these findings. For example, Bennett et al. (2005) conducted a study examining the prevalence of post-traumatic stress disorder (PTSD), depression and anxiety in a sample of emergency service personnel in the United Kingdom. Participants were emergency medical technicians (EMTs) and paramedics working within one ambulance service, serving a population of approximately 3,000,000 people in a combination of rural and urban settings. Two questionnaires were sent to all 1029 potential participants and with a response rate of 55%, 617 questionnaires were returned. The final sample included 194 EMTs and 380 paramedics. Forty three respondents did not report their position within the ambulance service. The sample comprised of 513 males and 91 females, 13 respondents did not report their sex.

The male/female ratio in this study was similar to that found in the overall ambulance service; therefore, there was no sex bias in responding to the

questionnaire. The mean age of respondents was 39.58 years (SD = 10.60). The questionnaire included two single yes/no items measuring the presence of intrusive work related memories either in the present or the past. Participants with intrusive work related memories lasting at least one month, completed the Posttraumatic Diagnostic Scale (PDS) (Foa, Cashman, & Jaycox, 1997). This scale is validated against psychiatric ratings and achieves an 82% concordance with psychiatric interview. Scores on this scale indicate severity, while the pattern of symptoms reported contributes to the diagnosis of PTSD.

Thirty-two women and 261 men completed the PDS. All participants completed the Hospital Anxiety and Depression Scale (HADS), which has 14 items each with a four point severity scale. Findings of this study indicated that about two thirds (n = 383) of the sample reported experiencing intrusive and troubling work related thoughts, either recently or in the past. A higher percentage of paramedics reported having had troubling memories when compared to EMT's. Twenty-two per cent of the sample had PDS scores indicative of a diagnosis of PSTD, however, there was no difference found between the high occurrence of PTSD between paramedics and EMT's. Almost 10% of participants reported having possible clinical levels of depression and 22% reported probable clinical levels of anxiety based on the HADS scores. There were no sex differences in the reported levels of anxiety or depression, however, men had a higher prevalence rate on PTSD than women.

Limitations to this study include the fact that the questionnaires were self-report and a response bias may have been present, for example, those individuals with high PTSD may have avoided completing the survey. For women who took part in the survey, rates of PTSD were significantly lower than for men, however, rates of anxiety and depression did not differ. It is possible that women who self-select into

the role of ambulance paramedics are more *hardy* and also those women within the paramedic field have more access to support services. It must be noted, however, that this study only contained a relatively small sample of women, but it was representative of the population ration of women and men working within the service.

Similar to Bennett et al. (2005), earlier research by Regehr et al. (2002) found that paramedics had increased alcohol consumption, went on more stress leave and took more psychiatric medication to help deal with a traumatic event, when compared to members of the general public. Interviews with paramedics confirmed that they suffered post traumatic symptoms including intrusion symptoms (such as reliving the event) and arousal symptoms. Others described being over-emotional, experiencing shortness in breath, night terrors and flashbacks.

The impact of emergency service work has more than just an impact on the individual themselves. Impacts can also be experienced by family. Regehr and Bober (2005) explored the impact of trauma exposure on spouses of paramedics. Findings suggest that discussing their work with family can and does have detrimental effects on the worker and their partner (Regehr & Bober, 2005; Robinson, 2002). Fourteen spouses took part in the study by Regehr. Two of those interviewed were women in same-sex relationships with a paramedic. One participant was a male married to a female paramedic. Two reported that this was a second marriage and the mean time together was 14.5 years. Five of the participants had no children. Nine of the participants were employed full time, two were part time, and one was retired. Interviews followed a semi-structured interview schedule and included questions about family situation, effects of shiftwork, the paramedic role, and specific traumatic effects on the family; social supports and social challenges were also explored, as were the strategies utilised by the family to manage these challenges.

Daily hassles reported included inappropriate calls from work, changes to schedule, changing co-workers, and dealing with shiftwork. The unpredictability of overtime was also cited as a hassle encountered on a regular basis. Several participants stated that they never knew if their spouse was coming home for dinner. This unpredictability reinforced concerns for the safety of their loved one. A primary concern related to shiftwork surrounded the degree to which family time is compromised and the fact that family responsibilities are not equally shared. This was also relevant for the rearing of children. Several participants stated they sometimes feel like a single parent.

'Couple time' was also stated as a negative. Many respondents stated that they rarely get time to spend with their partner. In part, this is due to the long shifts paramedics complete so that by the time they arrive home, they are fatigued and usually do not wish to enter into mundane discussions about what they may deem trivial issues after what they have witnessed throughout their shift.

Concerns regarding dangers of the job was also a pertinent theme. This issue was also found in Robinson's (2002) study. Partners of the paramedics indicated that their spouses often shown symptoms such as withdrawal, nightmares, chronic sleep deprivation and avoidance. These are symptoms consistent with PTSD. The impact on the family was tremendous with the partners stating that the paramedics returned home moody, often closed down (emotionally), or were emotionally distant.

The impact of traumatic exposure on workers has been explored in the past (Regehr et al., 2002; Robinson, 2002). Several variables highlight that workers within the ambulance services experience more health problems than the general population (Sterud, Elkeberg, & Hem, 2006). Symptoms of post-traumatic stress disorder, burnout, depression and anxiety have been found to be prevalent in many studies

(Bennett et al., 2004; Regehr et al., 2002; Robinson, 1997, 2002). It is clear that the nature of the work, involving a high percentage of time spent responding to traumatic incidents, is debilitating for ambulance paramedics and their families. Robinson captured insightful data which can be utilised as a base-line for paramedics and other emergency service workers for decades to come. These studies highlighted the necessity for change within emergency services and the importance of the support members receive. In response to these findings, many emergency organisations have implemented counselling, training and debriefing programs (Robinson, 1997). However, more needs to be done in order to capture the day to day stresses paramedics and other emergency service personnel experience on a day to day basis. As well it is important to explore the coping strategies paramedics find helpful which may be implemented on a day to day basis.

According to Jonsson and Segesten (2004), the post-trauma experience is characterised by periods of chaos, guilt and shame, healing and re-orientation and can be likened to the Secondary Appraisal phase of Lazarus and Folkman's Transactional Model of Coping and Social Support. When ambulance personnel fail in their attempts to help and heal, feelings of guilt and shame may result.

2.5.1 Application of Primary Appraisal in relation to Paramedics

Jonsson and Segesten (2004) claimed that ambulance paramedics experience stress at different stages of each job they attend. The authors' first two stages (pre-trauma and mid-trauma) can be likened to the Primary Appraisal stage within Lazarus and Folkman's Transactional Model. The pre-trauma experience is characterised by an 'inner dialogue' the individual uses to prepare and increase alertness by trying to imagine a mental picture of what is to be faced even though it may be unknown, and, therefore, impossible to fully prepare for. The mid-trauma experience can be

understood in terms of episodes that are instant, intense and overwhelming. A stress building factor begins when the expectation of how the experience should be, conflicts with the reality.

Initial management of the stress is done through the use of the inner dialogue when the individual attempts to comprehend and understand the experience they face. This stage occurs almost automatically in response to the event occurring and a response is required immediately as well.

Jonsson and Segesten (2004) constructed themes to explain the processes ambulance paramedics can go through when responding to a job. *Preparing for the unknown* refers to when paramedics are preparing for a situation without having all the information. They use the 'inner dialogue,' a technique used to evaluate stress by having a conversation within oneself and by creating a picture of how it will be, 'the outcome'. This initial inner dialogue is based upon earlier experiences and can be described as a reflection based on previous knowledge and understanding. The pre-event stress increases when the pre-understanding of how it will be, conflicts with the other information, for example getting the wrong information from the dispatcher or call centre. The ambulance officer is very sensitive and the information given by the dispatcher directly influences how they imagine the incident will be.

Those with more experience in the trauma field seem to mediate their stress and the evaluation by increasing their alertness. They know it is ineffective to construct too much detail in their mind prior to getting to the scene. Pre-event stress increases rapidly if there are difficulties locating the place of the incident or it is not possible to get in contact with the dispatcher.

The touchdown: The first encounter with the victim is characterised by the discrepancy between pictures of how it will be, compared with how it really is. The

ambulance personnel, therefore, have to create a new mental picture. It is also at this stage when ambulance personnel begin to identify with the patient and begin to relate to them. Ambulance personnel also stated that it is at this point when they begin to worry about whether they will be able to help the patient. Therefore, the possible outcomes and whether they will be able to respond appropriately is evaluated. Numerous participants in the study by Jonsson and Segesten (2004) stated during this time, paramedics can attempt to distance themselves from many variables, but feel more and more enmeshed in the situation. A feeling of anxiety can begin at this stage and workers can get overwhelmed with emotion. This again is dependent on a number of variables, including personality.

As noted, it has been well documented that individual or personality factors can influence how well individuals evaluate different experiences (Harrison & Kinner, 1998). Some individuals seem to be less prone to develop symptoms of stress. Self-confidence, self-esteem and the image one has of his or herself have a major impact on how an evaluates the event (Harrison & Kinner, 1998). How one displays or suppresses their emotions has also been linked to health outcomes (Lowery & Stokes, 2005). After experiencing the pre- and mid-trauma phases of Primary Appraisal individuals then progress on to the Secondary Appraisal phase of the Transactional Model of coping and social support.

2.5.2 Application of Secondary Appraisal in relation to Paramedics

Secondary appraisal involves the individual weighing up whether they have the resources to manage the event. Jonsson and Segesten (2004) used a phenomenological approach to their study to gain insight into the ways ambulance staff experience and handle traumatic events. Ten people, both male and female working as ambulance nurses and ambulance technicians from a variety of

backgrounds participated in the study. All had experience with traumatic events. The study was described, the extent of participation was explained and potential risks were explored with participants.

Jonsson and Segesten (2004) developed themes regarding the coping strategies utilised by paramedics. These included (1) to stay with the risk of failing; (2) to be caught in turmoil and (3) guilt and shame. These themes by Jonsson and Segesten will be further explored here.

2.5.2.1 To stay with the risk of failing

The risk of making mistakes is expressed by ambulance personnel in terms of fear of misjudging or of failing in their desire to help the patient. The feelings of not doing enough for the patient and their family's makes the worker feel helpless and useless. This feeling can arise even if they have done everything they can.

Participants in Jonsson and Segesten's (2004) study described how they attempted to raise an emotional shield between themselves and the patient. They stated that they approached the scene by concentrating and focusing on the victim alone, in an attempt to distance themselves from impressions which may distract them from performing their duty. They stated that they can be concentrating so hard on the tasks at hand that afterwards it is not uncommon for ambulance personnel to be unsure how many patients and or vehicles were involved. In an attempt to release tension, ambulance personnel, similar to other emergency service workers use humour, jokes and jargon in order to alleviate stress on site (Harrison & Kinner, 1998). However, it is deemed unacceptable to use humour when a child or children are involved. Similarly, the participants in Regehr's (2005) study stated that humour played a big part in coping. One participant stated "We've developed a very left field sense of humour" (p.108). Shared responsibility helps relieve stress to a certain

extent. Paramedics feel more comfortable when they have social support or someone to share their worries. This is consistent with findings by Catterall and Dean (2003), Fullerton et al.(1992) and Regehr (2002).

2.5.2.2 To be caught in turmoil

According to Jonsson and Segesten (2004) ambulance paramedics go through many emotions after they have left the patient in the emergency room or at the scene of an accident. At this time ambulance personnel can feel confused, upset, exhausted, sad and distressed, and that the world is chaotic. To be in a chaotic world is characterised by confusion, guilt, shame and post-traumatic distress symptoms. All participants in their study expressed and shared the same feelings, but the intensity and duration of these feelings varied considerably. Some of their participants passed the feelings and symptoms within a few hours after the incident, but others felt they took years or even decades to overcome certain experiences. Some stated they felt they had still not recovered from the experience. Feelings varied from overpowering feelings of chaos to reflection over what had happened. Others experienced more subtle feelings of being rejected by relatives or fellow workers, feelings of anger, frustration, resentment and bitterness, betrayal and rejection, self-loathing, guilt and humiliation, being out of control, trapped, feelings of helplessness.

The participants in the study by Jonsson and Segesten described that to be in turmoil means being overwhelmed by feelings that they cannot escape from, characterised by confusion, chaos, loss of control and isolation from the world. They also described that it was impossible to think about anything else because they were so preoccupied with intrusive memories from the event. They felt a sense of unreality as if they did not belong to the normal world. Images of what they had witnessed

could occur without warning. They tried to leave the experience behind them but they discovered that it was impossible to do and they found that frightening.

Jonsson and Segesten stated that the participants showed a variety of post-traumatic stress disorder symptoms including; re-experiencing trauma, numbing of compassion and distortion in social or professional performance, and symptoms of increased arousal. Some of them described how they would feel terrified when they approached the place of the accident, but when they were asked by fellow workers if they felt comfortable, they always tried to hide their feelings. It is clear then that if paramedics are going through all of these things, it is bound to have an impact on their work and personal/family lives.

2.5.2.3 Guilt and shame

This theme involved feelings of guilt, shame and self-loathing reported by participants. They expressed that the traumatic event was accompanied by guilt-related memories of the event, which triggered a negative response. The cohort of participants in the study by Jonsson and Segesten said that they felt guilty when they thought they had failed in their attempt to save the life of a victim, especially if they had given a promise to the patient or relatives that the outcome would be positive. The feelings of guilt appear even if they know they did everything possible to help and support the patient. Questions such as ‘could I have done anything different?’ And ‘had it been possible to do more?’ are always there.

The most shameful thing according to some of the participants was not that they failed in caring or giving attention to the patient, but that they were also overwhelmed by all the impressions from the scene of the incident. The image that they had built up of themselves and for others was different. This again relates to the pre-trauma, mid-trauma and post-trauma stages described by Jonsson and Segesten

(2004). Before the event they thought they could work well under pressure and would cope with high levels of stress and that nothing could shake them. Afterwards they discovered that they had been terrified and still are, and they suffer from sleeping disturbance, nightmares and intrusive memories. They express their feelings of shame in terms of uselessness, shortcomings and powerlessness as well as in relation to how others see them.

Participants in Jonsson and Segesten's study further stated that they never talked to anyone about their feelings of shame and failure since. Instead they did everything to hide these feelings. The participants expressed feelings of shame in association with negative self-perceptions and see themselves as inferior to others as a result. It takes a great effort to conceal feelings of shame, when you have failed to be someone you wanted to be.

Sometimes respondents were rejected when they tried to share their experienced of guilt and shame, and this increased their feelings of self-loathing and blame. They felt that it was their fault that their patient did not survive or that they did not do enough to support and help the victims' families. There are also strong expression of isolation and feelings of a lack of understanding from their closest social network (Jonsson and Segesten, 2004).

Participants in other studies described how they were reminded of the traumatic experience by smell, sight and sound as well as frequent episodes of intrusive memories. Many other researchers have highlighted this also (Fullerton, et al., 1992; Miller, 1995; Regehr & Bober, 2005; Robinson, 2002). The smell of petrol, a hat or other object of the same colour as that of child victim could trigger recollections of the original event and it had the power to evoke mental images, emotional responses and psychological reactions associated with the trauma. For

some, feelings of memories were so prevailing that they dominated their lives. Re-experiencing occurred most commonly in the form of nightmares and flashbacks that continually developed into traumatic memories. Some of the participants tried to numb their feelings of empathy towards patients as a coping and preventing strategy in an effort to distance themselves from the traumatic experience.

The participants in Regehr's study (2005) highlighted other coping strategies including avoiding highly emotional interactions with their partner and developing independent interests and friends. Support from colleagues was viewed by participants as very important to the spouses. Participants identified that a great deal of peer counselling took place during a shift. Several reported that their spouses had friends who were paramedics and provided one another with mutual support, highlighting the importance of peer support. Many partners found that discussing medical issues with their paramedic partner helped. This was especially possible for partners who were also employed in the medical or health field.

In response to all of these experiences, individuals make decisions to manage their experiences. These coping strategies can be either helpful (functional) or unhelpful (dysfunctional). Functional coping includes exercise, communicating with others, healthy eating or taking up hobbies. Dysfunctional coping refers to behaviours which impact the individual or their family members in a negative way, such as excessive alcohol consumption, irregular eating habits, avoidance, or increased drug use. It must be noted again that all individuals are different and utilise and respond to these different strategies in different ways.

2.6 Functional and dysfunctional coping

Fullerton et al. (1992) conducted a study on fire fighters and noted that the fire fighters identified several factors that helped alleviate their stress. These included social support, type of leadership, level of training, and use of ritual.

According to Fullerton et al. (1992), several fire fighters highlighted how helpful it was to work in pairs. One fire fighter stated he could not talk to his family about the disaster, but could his colleague. Some highlighted the fact that "we provided psychological first aid and reassurance to one another" (p. 374). Similarly, Harrison and Kinner (1998) found that social support, the network paramedics have at work (their peer support) and their capacity to relate to others play a major role in how they handle stress after a traumatic event. Fullerton et al. (1992) found that all of their participants stated that being backed up by colleagues was necessary to help them handle any situation more successfully. The most important factor, according to the participants in this study, was to have someone to talk to about the horrific events that they have attended. If an emergency service worker deems they have the support they need to deal with the event, then the stress appraisal will be so and the result will be a reduction in stress due to either having the resources available to them or the perception of having the resources available to them. This is consistent with the Transactional Model of Stress and Social Support (Lazarus, 1966; Lazarus & Folkman, 1984, 1987). All fire fighters spoke of the importance of their buddies while working and they all described humour as an important aspect of sharing and understanding one another.

Similarly, Corneil, Beaton, Murphy, Johnson, and Pike (1999) found through their research of 828 fire-fighters that work support, rather than family support, provided the participants with greater psychological support. McCarrol, Ursano,

Wright and Fullerton (1993) also found that colleague support facilitated coping among their sample of body handlers. This is supported by Gallagher and McGilloway's 2009 study, whose respondents reported that consistent daily support from colleagues and family members was helpful.

In contrast to the above authors, Lowery and Stokes (2005) discussed a 'reverse buffering' effect, which refers to the presence of support which does not enhance coping abilities, but instead increases the relationship between work and individual stressors. In terms of the reverse-buffering effect, the actual amount of support provided is not important. What is important, however, is whether the presence of support (of any kind) makes the trauma experience worse. Within this model, social support includes emotional support, informational support, social companionship and instrumental support. An example of this was illustrated in a study with student nurses by Parkes (1986) which found that while an increase in instrumental support and informational support facilitated coping among nurses who were deemed extroverts, provision of this type of support had a negative impact (increased psychological stress) on nurses classified as introverts. This highlights the impact and importance of other variables mentioned earlier, such as personality traits and other individual differences. Each person has their own personalities, ways of coping with things and responses to stimuli. Stress produced by being in pre-hospital surroundings and personality factors can influence how well individuals cope with different experiences. Some individuals seem to be less prone to develop symptoms of stress (Harrison & Kinner, 1998). Self-confidence, self-esteem and the image one has of his or herself have an a major impact on how an individual handles stress (Harrison & Kinner, 1998).

In terms of student paramedics, due to lack of previous research, it is impossible to determine the effects of peer social support. Prior research by Palmer (1983) and Genest, Levine, Ramsden and Swanson (1990) does, however, indicate that emotional distance usually utilised by more experienced paramedics makes it unlikely that student paramedics will receive the levels of peer support when they do encounter work difficulties.

Getting support from others is an important coping strategy when diminishing stress. It helped make the experience understandable and it was possible to internalise the experience. All of the respondents in Fullerton et al's (1992) study thought that in order to handle a traumatic experience it was necessary to have someone to share the worries with and talk to about their feelings. The need to have someone to talk to was usually instant and urgent. Participants thought it was helpful to hand over all the anxiety to someone who could hold and enclose it. If they could not show their feelings, they sometimes chose arenas where it is more acceptable to show feelings such as through sport. If they felt rejected by relatives when they wanted to share their experiences by talking about what they had experienced, then feelings of being wrong, anger, bitterness, betrayal, self-loathing, guilt and humiliation would surface.

All participants said they had received social support, but the quality of it had varied. One of the most important factors was to have a really good and genuine friend to share the traumatic experience with. Participants stated it was not necessary to get answers to their questions, they just needed someone who could really deal with all the agony. These studies again highlight that social support, personal networks and relational capacity play major roles in how well ambulance personnel handle post-traumatic stress.

Participants stressed that endorsement from others was necessary to handle their traumatic experience, to make it understandable and possible to leave behind. The most important factor is to have someone close to talk to about horrific and difficult situations. Therefore, support from family and friends, individuals within the team and from closest colleagues is of great importance. In recent studies, a vast majority of ambulance personnel stated that they had good support from colleagues (Jonsson, Segesten, & Mattsson, 2003), but less than 50% stated they felt they could talk with their supervisor or manager.

As previously stated, an individual's perception of their social support, and the cognitive rationalisations in which they engage are said to have an influence on coping strategies (Fullerton et al., 1992; Jonsson & Segesten, 2004). Therefore, the specific effects of coping in Shakespeare-Finch et al.'s (2002) study, as measured by four personal resource subscales (social support, rational/cognitive coping, self-care and recreation), were examined in relation to family functioning (intimacy, conflict and parenting style). Shakespeare-Finch et al. (2002) hypothesised that social support and rational cognitions would emerge as significant predictors of family functioning. Shakespeare-Finch et al. used a cross-sectional design in which a population of operational ambulance paramedics was compared to a control group of individuals from a range of occupations in which trauma is not a major part of their role. Matching was used in recruiting potential participants to ensure they were compatible with the population of interest with respect to shift-work status and demographic characteristics.

The sample of Queensland Ambulance Service (QAS) workers in Shakespeare-Finch et al.'s research (2002) comprised 39 males and a control group comprised 32 males. The study was limited to males as there were insufficient female

ambulance workers meeting the selection criteria. The ages of the QAS sample ranged from 27-51 years with a mean age of 40.05 (SD =5.46). The control group participants ranged from 27-52 years with a mean age of 39.15 years (6.68). The study was limited to married men with dependent children in order to control the effects of the life cycle stage. The control group was composed of individuals from a variety of occupations requiring shiftwork (chef, radiographer, telecommunications officer, hotel employee), but not exposure to traumatic events (no police, fire fighters, nurses). Education levels were not controlled for in the study, as the control group, like the ambulance paramedic group, had a myriad of different education levels. The participants in the control group were also married with dependent children. The study utilised a single questionnaire with two biographical questions and two published test instruments. The full questionnaire took approximately 15 minutes to complete.

Findings of the Shakespeare-Finch et al.'s study indicated that personal resources significantly influenced variables such as family functioning, intimacy, conflict and parenting style. Differences also emerged in the way the two groups utilised personal resources. For ambulance personnel, both social support and rational/cognitive strategies emerged as significant correlates of conflict and parenting style. Social support, rational/cognitive strategies and self-care were all found to have a statistically significant relationship with conflict, intimacy and parenting styles. Additionally, rational/cognitive strategies were found to be significantly associated with conflict for ambulance personnel, and social support was found to be significantly associated with intimacy. As expected, the personal resources that 'predict' aspects of family functioning differed between the ambulance and control

groups. Social support was found to be the sole 'predictor' of both conflict and intimacy for the control group.

The ambulance officers in Shakespeare-Finch et al.'s (2002) study seemed to use a broader range of coping resources than the control group, and that range impacted differentially on the various scales of family functioning. Due to the cross sectional design of this study, causal inferences cannot be made, however, the repertoires of coping and training resources which have been implemented within QAS seem to be of some benefit for the paramedics. Emergency service workers often report that previous experiences with trauma help prepare them to deal better with future traumas (Everley & Lating, 1995). Therefore, it can be assumed that both the formal training and work experience completed by the QAS sample has allowed them to cope better than the control group.

Cross sectional data have limitations as it restricts the ability to draw concrete conclusions concerning the direction of effects and issues relating to the control of potential confounding variables. However, matching participants as rigorously as the participants were matched in this study, (on variables such as age, exposure to shiftwork, gender and family life cycle issues) does control for potentially confounding variables.

Early research has indicated that specific coping techniques have been developed by emergency service workers (Robinson, 1984, 1993). Palmer (1983) conducted an ethnographic study and using a participant observation methodology, the author immersed himself within the culture of paramedics from South Western United States and found that workers used six major coping aids. These were: educational desensitisation, humour, language alteration, scientific fragmentation, escape into work, and rationalisation.

1. Educational desensitisation: this refers to the terms used by paramedics, as well as the procedures and practices paramedics are exposed to during their training.
2. Humour: the way in which it is used by paramedics over time acts as a buffer to stress. Paramedics use dark and sarcastic humour in ways members of the general public wouldn't dare.
3. Language alteration: the technical language, numbers and figures paramedics speak on a day to day basis when discussing patients among one another and with radio dispatchers.
4. Scientific fragmentation: the terminology paramedics use for patients, places, times and illnesses. They use language to keep a distance from patients. For example, when remembering a specific job, a paramedic may say to a colleague 'the miscarriage we did, that was on Fourth Street the other night yeah?' (Palmer, 1983, p. 85) The patient is seen as an object, who has a part broken and needs to be fixed.
5. Escape into work: involves such concentration from the paramedics that Palmer stated "one paramedic related to me a story about he had been so busy working on a patient that he did not realise he was tending to an old friend" (Palmer, 1983, p. 85).
6. Rationalisation: the justification paramedics often use to deal with an event, for example "he/she is better off that way".

Palmer stressed that these strategies do not mean that the paramedics are not sensitive to their patients' situations, rather he proposed that they have developed these aids to alleviate and minimise the impacts of work stressors on themselves. In coping with death, as well as other horrific traumatic events, paramedics use many different strategies to help them cope. Desensitisation processes which are a part of some paramedics training include the use of black humour and joking. Miller (1995)highlights that some paramedics also engage in the overuse of technical terminology in order to distance themselves from the emotional side of their job.

Catterall and Dean (2003) interviewed 8 paramedics, transcribed and analysed their data. The thematic analysis of their data found that coping mechanisms and social support are important. They found that coping mechanisms employed by paramedics were categorised as in-work, out of work, the barriers to accessing coping mechanisms and the professional constraints placed upon paramedics. One paramedic felt that professional constraints can occur from "if you are not working with someone who you feel has felt the same - then you have to hold it in until you get home" (p. 95).

Another theme constructed from their findings comprised of the support available to paramedics. The components explored included support available from their managers, within the pre-hospital care culture, from counselling services available at their workplace and from their experience with critical incident stress management services. One paramedic highlighted a flaw in the system, "I don't think going off to stress counsellors, counsellors or outside people to be helpful, they don't understand the environment we work in" (p. 95). This highlights the need for professional support with and between the organisation and staff. Alexander and Klein (2001) aimed to identify the prevalence of psychopathology among ambulance personnel and its relationship to personality and exposure to critical incidents. Surveys were collected and the authors found that after critical incidents, fellow workers were considered supportive by 40 of the 90 respondents (44%), whereas senior colleagues were considered supportive by only 7% of participants. Sixty-six of the 90 participants (73%) stated that their organisation or employer was 'never' concerned about the welfare of staff. Over a third of the individuals surveyed claimed that better training may have helped them cope more successfully with past traumatic

events. Despite these findings, 81% of the sample reported to have a high level of job satisfaction.

Some of the coping strategies discussed by Palmer (1983) and utilised by paramedics, may come across as callous or cold. However, it must be noted that these are merely strategies which help them deal with the job they do. Types of leadership or leading by example was also found by Fullerton and colleagues (1992) to have an impact on coping. In their study exploring the psychological responses of two groups of fire fighters, one who helped in the rescue of an air disaster in Iowa; the other group was performing rescues within New York City. A senior member who openly showed his emotions and vulnerable side began a trend with all others within the team also opening up and speaking up about how the disaster had affected them. Many participants spoke of the importance of a training exercise they had done a year before. The training helped give them the knowledge and past experience they needed to deal with the traumatic experience better. One fire fighter thought it was disrespectful when work ceased trying to recover the bodies, especially the fact that some bodies were exposed overnight. He felt the dead deserved the same respect as everyone else. Again, this highlights the point made by Miller (1995) and Palmer (1983) about the fact that the work they do, does have an impact on the paramedic, despite the seemingly 'uncaring' coping strategies utilised on the job (Palmer, 1983, p. 86).

More specifically, Jonsson and Segesten (2004) also indicated that their participants revealed a variety of different methods used to cope with their traumatic experiences. In an inner dialogue, the participants asked questions that they themselves answered based on their own experience. It is this inner discussion that guides them when deciding how to act. In this inner conversation, the participants

discuss the pros and cons of how to handle their experience and the inner stress. The stress becomes manageable when they see the meaning of the experience and potential solutions. The inner dialogue is more likely to be successful if the person had had a similar experience to that of the one they are encountering and they have tried different coping strategies before.

2.6.1 Burnout and PTSD

After experiencing a disaster, emergency service personnel can be at risk of acute stress disorder, which in turn can lead to post traumatic stress disorder (PTSD). In order for a person to be diagnosed with Post traumatic Stress Disorder (PTSD) they must meet the criteria outlined in the DSM-IV (2003). For example Criterion A states that the person has been exposed to a traumatic event in which (1) the person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury AND the persons response involved intense fear, helplessness or horror. Importantly the symptoms should occur over a period of more than one month. Symptoms of PTSD can include depression, anxiety, sleep deprivation, avoidance behaviours, arousal behaviours and worry.

Bennet, Williams, Page, Hood, Woollard, and Vetter (2005) examined the prevalence of PTSD, anxiety and depression among emergency ambulance personnel. Their sample comprised 617 Emergency Medical Technicians and paramedics working for the UK Ambulance Service. Questionnaires were sent to all employees and comprised of the Ambulance Work Stressors Questionnaire (AWSQ), the hospital Anxiety and Depression Scale (HADS), Post-Traumatic Diagnostic Scale (PDS) and the Cognitive Appraisal Questionnaire (CAQ). The mean age of respondents was 39.5 years, with an average of 12 years within the service.

Just under half of the respondents reported currently having troubling memories of an event which occurred at work. Also 205 of respondents reported having had troubling memories at some time in the past. This study by Bennet and colleagues was the first large scale study of the prevalence of PTSD, anxiety and depression in UK emergency ambulance personnel. The overall prevalence of PTSD (22%) within this study was consistent with findings from previous studies with ambulance personnel.

It is has been well documented in the past that the work of emergency service workers is tough on the individual and has impacts on the person; their relationships with colleagues and family members, as well as being emotionally and physically exhausting (Bennett, et al., 2004; Bennett, et al., 2005; Regehr & Bober, 2005).

Alexander and Klein (2001) reported that 33% of their sample of ambulance personnel (n = 160) reported high levels of general psychopathology, burnout and post-traumatic symptoms. Burnout was associated with less job satisfaction, longer time in service, less recovery time between incidents, and more frequent exposure to incidents. The authors aimed to identify the prevalence of psychopathology among ambulance personnel and its relationship to personality and exposure to critical incidents. Numerous pencil and paper tests were utilised to determine the presence of psychopathology.

Data were gathered from ambulance personnel in the United Kingdom by means of an anonymous questionnaire and standardised measures. After visiting 14 of the 16 ambulance branches and posting notices of their study, the researchers invited all 160 personnel carrying out accident and emergency duties for a Scottish regional ambulance service to participate. The sample did not include personnel whose duties

were confined to patient transportation. Of the respondents 40 were paramedics, while 70 were ambulance technicians. There were 15 women (14%) and 95 men (86%).

Overall psychopathology was assessed by the General Health Questionnaire (GHQ-28). This questionnaire identifies minor psychiatric disorders in community samples and allows assessments to be determined by overall score. For this study, scores of 5 and above were deemed maximal in terms of sensitivity and specificity.

The Impact of Event Scale (IES; (Horowitz, Wilner, & Alvarez, 1979) was used to determine the frequency of the self-reported post-traumatic stress symptoms of avoidance behaviour and intrusive events (i.e., nightmares) in relation to a specific critical incident (information given by the subject). Therefore, the IES was only given to those subjects who reported having experienced a disturbing event in the 6 months prior to participating in the study. Of the 90 respondents (82%) who had experienced a personally disturbing incident in the previous six months, 36 (40%) were classified as low, 27 (30% as medium and 27 (30%) as high. Self harm and suicide were reported as the most common incidents to attend. However, road accidents and medical emergencies were considered to be the most disturbing. 'Most disturbing' incidents were: (a) a child victim, (b) the victim is known to the paramedic, (c) ambulance crew feel helpless at the scene, (d) particularly severe injuries, (e) lack of prompt back-up from colleagues, and (f) the ambulance crew were given false information about the victim or site of the accident. Sixty-nine (69%) of subjects reported they had 'never' had sufficient time to recover emotionally between critical incidents. Forty-four of 89 participants (49%) reported that the more frequent their exposure to critical incidents the better they coped. In contrast, 2% felt they coped less well.

Burnout was assessed by the Maslach Burnout Inventory (MBI; (Maslach & Jackson, 1986). This scale measures the accumulative effects of work-related pressures on three states: 'depersonalised,' 'emotional exhaustion' and 'personal accomplishment'. Thirty-seven per cent of respondents had experienced a personally disturbing incident, which had the potential to lead to symptoms of burnout.

Limitations of this study include the fact that a majority of participants were not paramedics but ambulance technicians. This study indicates that the emotional and psychological well-being of ambulance personnel seem to be at risk by accident and emergency work.

Jonsson, Segesten, and Mattsson (2003) investigated the prevalence of PTSD among Swedish ambulance personnel. In order to estimate the prevalence of trauma related disorders, a representative group of 362 ambulance personnel from the county of VastraGotland, Sweden, was surveyed through the use of a Swedish version of Antonovsky's 13 item short version of Sense of Coherence Scale. In order to measure reactions to traumatic events the Impact of Events Scale (IES-15) and Post-Traumatic Symptoms Scale (PTSS-10) were also administered. A total of 223 participants reported they had experienced what they themselves would describe as traumatic situations. Of those who reported a traumatic experience, 15.2% scored 31 or more of the IES. Scores of 31 or more indicate a stress reaction with an increased likelihood of post-traumatic disorder. On the PTSS subscale, 12.1% scores 5 or more, indicating a relatively strong reaction. The study also found that a lower sense of coherence is a predictor of post-traumatic stress. Others predictors of the extent of the traumatic stress were longer job experience, age, physical and psychological workload.

In conclusion, the authors believe that high prevalence of PTSD symptoms in ambulance personnel indicates an inability to cope with daily stress at work. The

strong correlation between post-traumatic stress and Sense of Coherence Scale may be useful in predicting vulnerability for post-trauma symptoms among recently employed ambulance personnel. In order to manage the impacts of this stress, the authors believe that workers should be able to take a leave of absence or be transferred to non-emergency duties for the long or short term. It must be noted that the prevalence of PTSD among the Swedish sample is lower than that of other countries. For example Bennett et al. (2005) conducted a study examining the prevalence of post-traumatic stress disorder (PTSD) in a sample of emergency service personnel in the United Kingdom and found that 22% of the sample had PDS scores indicative of a diagnosis of PSTD. Similarly, of the Australian paramedics surveyed by Robinson in 1993, 65% of participants reported that they experienced trauma reactions as a result of prior ambulance jobs. A substantial 17% reported a strong response however formal diagnosis of Post Traumatic Stress Disorder (PTSD) was not completed.

Recent literature indicates that ambulance paramedics are engaging in a high level of dysfunctional rather than functional behaviours (Regehr, 2005; Robinson, 2002). A longitudinal study conducted by the Victorian Ambulance Crisis Counselling Unit (now the Victorian Ambulance Counselling Unit (VACU)) between 1984 and 2002 indicated that 88% of those surveyed reported drinking alcohol, with 94% drinking up to 24 days per month, and 91% drinking up to six glasses of alcohol in a single session (Robinson, 2002).

According to Catterall and Dean (2003), stress can have both positive and negative outcomes. However, the perceptions of the paramedic often hampered their ability to access help and support services.

Further evidence by Genest, Levine, Ramsden, & Swanston (1990), as well as Palmer (1983), suggested that the emotional distance that experienced paramedics usually adopt makes it unlikely for student paramedics to receive a sufficient level of support. This is especially relevant should the student experience work-related difficulties (Clohessy & Ehlers, 1999) -- thus substantiating the need to determine the differences between both inexperienced and experienced paramedics.

A more recent analysis study by Sterud, Elkberg, and Hem (2006) reviewed 49 literature pieces on health problems, work related and individual health predictors in the ambulance services, after searching electronic databases such as Medline and Psychinfo. Their thorough analysis indicated that ambulance workers have a higher standardised mortality rate, higher level of fatal accidents, higher level of accident injuries and a higher standardised early retirement on medical grounds when compared to the general working population. The prevalence of PTSD symptoms was more than 20% in one in 5 studies, and high rates of anxiety and general psychopathology were reported in 4 out of 5 studies. This analysis highlights the wide range of potential health problems in the ambulance services.

2.7 Non coping profile of Paramedics

Past literature indicates that chronic stress can seriously impair the biological, psychological and social health of the individual (Robinson, 2002). Research has shown that ongoing stress can lead to depression (Tyssen, Vaglum, Gronvold, & Ekeberg, 2001) affect inter-personal relationships (Alexander & Klein, 2001), and cause individuals to adopt maladaptive coping strategies (Robinson, 2002).

Results of a study (Regehr, et al., 2002) indicated that paramedics increased their alcohol consumption, went on stress leave, and took more psychiatric medication to help deal with a traumatic event when compared to the general population. The

interviews confirmed that paramedics suffered post traumatic symptoms, including intrusion symptoms (such as reliving the event) and arousal symptoms. Others described being over-emotional, experiencing shortness in breath, night terrors and flashbacks.

Further research in this area (Harrison & Kinner, 1998; Jonsson & Segesten, 2004; Miller, 1995; Robinson, 1993, 2002) has shown that paramedics also use alcohol consumption, prescription medication, avoidance strategies, humour, and desensitisation as aids to manage their work related stress. Despite the majority of findings indicating that most coping strategies utilised by paramedics are dysfunctional, according to Robinson (Harrison & Kinner, 1998; Jonsson & Segesten, 2004; Miller, 1995; Robinson, 1993, 2002) a small proportion of paramedics use more positive and functional aids to help them cope (for example exercise and healthy eating).

Ambulance officers make efforts to avoid thoughts and feelings associated with the trauma. They also avoid any people, places or activities which may spark recollections of tough experiences. They can show feelings of detachment from others, avoid social events, restrict their range of emotional responses and have a bleak sense of the future when compared with the general population (Alexander & Klein, 2001; Jonsson, et al., 2003). Individuals in this line of work must learn to adopt a sense of empathy when required as well as compartmentalise the job at hand and switch off when necessary. This avoidance in the longer term is a dysfunctional coping strategy. Ambulance personnel commonly make concerted efforts to avoid thoughts or feelings associated with trauma and to avoid places, people or activities which may remind them of the event (Jonsson & Segesten, 2004). Ambulance personnel develop an ability to detach themselves from others.

Having discussions with paramedics who have been in the job for extensive periods of time, confirms the research which states that it is often the smaller jobs which trigger the most emotion within an individual (Regehr, et al., 2002). However no matter the trigger, according to Miller (1995), many personnel working within the helping professions, such as fire fighters, police and paramedics, often take their own lives as a result of many contributing factors. Relationship problems, financial difficulties, job failure or failure to achieve goals, or humiliation in the presence of their peers are some of the reasons. The stresses encountered on a day to day basis which lead to this are multiple and diverse and different for each individual. Miller states that it is rarely isolated work incidents which cause such as response. Suicide is the ultimate negative consequence of stress and non-coping behaviours.

From the research (Harrison & Kinner, 1998; Jonsson & Segesten, 2004; Miller, 1995; Robinson, 1993; 2002), it is evident that we are becoming more and more aware of the need to support emergency service workers. The research, however, fails to distinguish between a critical incident and the everyday work and the impacts of everyday work on the emergency service worker.

It must be noted that this author believes more needs to be done to respond to the everyday needs of the worker. Paramedics need to be supported on a regular basis, not simply when there is a crisis or a particular 'tough job'. Questions such as the following need to be addressed. What is the meaning of a critical incident? Doesn't this depend entirely on the person? Their own personal experiences and what they do and do not relate to? Does the longer length of time on the job indicate resilience with an emphasis on whether the individual used desensitisation or avoidance as a major coping strategy?

There are many other important aspects to explore and which play a part in placing demands and stress on an individual. All of which cannot be examined in this current study. It must be noted however that the ambulance service has attempted to make changes and respond to the support needs of its workers over the years. The success of this is unknown.

Chapter 3

Organisational responses – What has been done?

There is widespread public concern that the current state of the wellbeing of ambulance paramedics in Victoria needs attention (see Appendix 7). This wellbeing includes the support required by paramedics from management, the organisation as a whole, as well as the paramedics themselves on a day to basis, working with one another. It must be noted that these issues have been addressed over the years. Ambulance Victoria has developed its support services over time and continues to do so. This chapter serves to discuss what has been done in response to the needs of ambulance paramedics, how effective this has been, as well as some recommendations around what should be taken into account for future direction.

The Victorian Ambulance Crisis Counselling Unit (VACCU) (now known as the Victorian Ambulance Counselling Unit (VACU)) was started in 1986 in response to a survey, conducted by Robyn Robinson, evaluating the health and stress of ambulance paramedics and their partners throughout Victoria. As a result of these studies, a number of services were implemented, at different times.

Specialist intervention techniques were used in the late 1980s to help staff following an especially traumatic event or crisis. **Defusings** (led by peers) and **debriefings** (led by a group of peers, as well as internal or external clinicians) are still offered after a major traumatic event. Depending on the traumatic event Ambulance Victoria will provide the appropriate level of support for all involved.

As discussed earlier, Robyn Robinson has been a dominant source of information within the area of paramedics' health and well-being for the past few decades. Robinson conducted many studies over a number of years, surveying

paramedics and following up on their needs. The first survey conducted in 1984 provided a plethora of information regarding ambulance paramedics which could be used as a comparison over the years. Robinson conducted a more in depth study in 1993, a follow-up in 1997 and again in 2002. More services were then implemented.

For example a **crisis line staffed by qualified psychologists** is available to staff and their families. VACU began as a 24 hour crisis line which operated every day of the year. Officers and their families can still access immediate telephone help from qualified and experienced psychologists. Some of these psychologists are employed directly by AV and others are external to the organisation and sub-contracted to provide trustworthy, confidential counselling and support to employees and their families. These psychologists respond immediately to all calls, and initial telephone counselling can lead to face-to-face counselling, depending on the need of the individual. Many qualified clinicians, located all over metropolitan and regional Victoria, are available for paramedics and their families. They are not direct employees of the ambulance service, but are contracted to provide professional, confidential support.

As a means of addressing the issues of stress and trauma associated with the role of being an emergency service provider, and as a direct result of a 1984 survey conducted by Robinson, both MAS and RAV implemented a **peer support team**. This team of experienced paramedics attends regular peer support training, covering topics such as how to deliver psychological first aid and debriefing. They provide front line support to other ambulance paramedics and now include education and support. If necessary, the peer support officers also provide their paramedic colleagues with the contact details of the crisis line and encourage a colleague to access ongoing professional support.

The peer support program consists of a team of experienced paramedics who are trained as peer supporter workers. A person is rostered on as the primary peer support worker for a one month period, and is responsible for responding to colleagues who have experienced recent traumatic events. The peer support worker generally makes calls to colleagues or drives directly to branches. There are numerous paramedics trained as peer support workers and they work on a rotating roster. This person is responsible for debriefing paramedics who have experienced a 'tough job' within the previous few days.

Identified paramedics are contacted by the peer support person and offered the opportunity to informally discuss aspects of the identified 'tough job' and explore any personal reactions they may have experienced. Alternatively the peer support person may drop in to a branch where members have handled one of these 'tough jobs' recently, for an informal chat. The paramedic who has experienced the incident recently is also given the crisis line number which as mentioned is a 24 hour helpline number for seeking further support from trained and qualified psychologists, if needed.

Despite these supports being in place, anecdotal evidence has indicated that, although paramedics know the Peer Support Program exists, they are not likely to use it voluntarily. Many believe that the service is too impersonal and 'not safe'. Confidentiality is a real issue for paramedics. Some question where the information gathered by the peer support worker would end up. Rather, they proposed that they would prefer to talk to a trustworthy colleague, 'buddy' or 'mentor' (someone who they had worked with regularly) after a bad job rather that someone who they thought may breach confidentiality by talking to others (Personal communication, 2007).

More recent statistics from the Victorian Ambulance Counselling Unit (VACU, 2006) indicated that while Peer Support officers are pro-active in making initial contact with paramedics after an incident was identified, follow-up by the paramedic is limited (refer Table 3). As shown in Table 3, only 21% of Metropolitan Ambulance Service and 30% of Rural Ambulance Victoria, identified paramedics, were reported as having received any follow-up after the initial contact after the incident. The initial contact is usually completed by an assigned peer support officer. Follow up is usually the responsibility of the paramedic as the peer support officer informs the paramedic of follow up supports available to them.

Table 3: MAS and RAV Contacts by Peers by Presenting Problem (VACU, 2006)

Presenting Issues	MAS Initial Contact	MAS Follow-up Contact	RAV Initial Contact	RAV Follow-up Contact
Critical Incident	1165	207	443	119
Work	372	109	67	25
Personal/Family	138	39	88	36
Totals	1675	355	598	180

Despite an early indication that the services implemented were a successful addition to the health and well-being of ambulance paramedics (Robinson, 2002), more recent results have indicated that the services are not being utilised to their full potential. Results from the 2005-2006 Metropolitan Ambulance Service Annual report statistics support this (refer Table 3). The 2008 study by Gallagher and McGilloway also support this. Only two of their 27 participants had accessed their peer support service, despite all being aware that a peer support service existed.

Limitations must be noted on the studies by Robinson. For example all have been based on self-report measures by the paramedics themselves (and their partners themselves) and have been survey based. More needs to be done in terms of hearing

from the paramedics themselves, in their own words. This highlights the need for the paramedics voices to be heard.

During its life, VACU has been located offsite and quite external to other organisational services within ambulance services offered in Victoria. However, in 2010, VACU was relocated to sit within the Head Office of the new Ambulance Victoria. This has allowed VACU to offer more than a therapeutic role through the crisis line, peer support training and delivery of the defusing and debriefings. VACU now also offers training, education and prevention programs for staff. As such, over the past few years VACU have developed numerous educational DVDs for managers and staff, offers 3 hours of awareness training for new recruits, and is currently undertaking a Good Health Initiative where ambulance paramedics are offered a 90 minute psychological assessment and self-care stress management plan. Being located within the main office also allows the administration and management VACU staff to gain a better understanding of the day to day operational side of the organisation, as well as an opportunity to liaise with management. In a heightened industrial climate, this may provide an unnecessary concern for members about the potential for their confidentiality being threatened as members from the wellbeing unit now work in the same building as management.

3.1 Ownership and Community Readiness

Past changes made to the support services within Ambulance Victoria have been made by senior management and support service personnel. It is important to discuss and highlight the need for change to be driven by the employees themselves, the paramedics on the ground should be able to have a say in what support services would benefit them the most.

Changes in organizational support (and in fact any change within a community or organization) need to involve the individuals or groups involved not only *when* the changes are taking place but *before* the changes occur. According to Armbruster Gale, Brady and Thompson (1999), the emerging force of change in many communities is the importance to offer the broad community to be involved in the planning and implementation of needed changes in health and education services. Perceived ownership promotes greater participation by the community, current efforts to involve paramedics themselves within Ambulance Victoria is currently lacking.

According to Payne (2001), it is the opinion of many practitioners and researchers of public health efforts that community involvement is necessary to improve local health status (Chilenski, Greenberg, & Feinberg, 2007). For many involved in health promotion and disease or illness prevention, community involvement and participation are deemed necessary to improve local health status. This change must come from within the community, using within community resources and strengths. According to Chilenski and colleagues (2007) the term 'community readiness' has been used for at least 50 years. Organisations themselves not only need to be ready for the change but the people within the organisation, on all levels, also need to help facilitate the change and be ready.

Prochaska and DiClemente's (1982) Transtheoretical Model of change involves individuals moving through 5 stages of change, precontemplation, contemplation, preparation, action and maintenance. Prochaska and Norcross (2001)explained that 'precontemplation' is the stage where there is no intention to change behaviour in the foreseeable future. Most individuals who are in this stage are unaware that there is a need for change. Most of the people around them (family and friends) are often aware that something needs to change. Given discussions with

paramedics from different areas, experience levels and stages in their career, the researcher believes that few paramedics within AV would be in this stage. The recent structural changes (i.e., the amalgamation of the two ambulance services in Victoria and subsequent EBA negotiations) to the organisation also support this notion.

'Contemplation' is the stage in which most people are aware that a problem exists and are serious about overcoming it. However, they have not yet committed to taking any action. This is the stage where most individuals remain for the longest period of time, contemplating what they 'should' do in order to make the change occur. 'Preparation' is the stage which combines intention and behavioural criteria. Individuals in this stage are intending to take action within the next month and have unsuccessfully taken action in the past year. While people within this stage may have made attempts or reductions in their actions (for example, joined the gym) but have not yet reached the level of effective action (going to the gym on a regular basis). 'Action' is the stage where individuals modify their behaviour, experiences and environment in order to overcome the problem. Action involves the most overt changes and requires considerable commitment of time and energy. Modifications of the problem behaviour made in this stage receive the most external recognition (i.e., comments from others 'you look great' 'have you lost some weight?'). 'Maintenance' is the stage in which people work to prevent relapses and consolidate the gains attained during the action stage. Being able to remain free of the problem behaviour and to consistently engage in a new incompatible behaviour for more than 6 months are the criteria for considering someone to be in the maintenance stage. Finally 'Termination' is an added stage in which the individual has completed the change process and no longer have to work to prevent relapse (Prochaska & Norcross, 2001).

The Transtheoretical Model of Change, a Community Readiness Theory was developed by Oetting (Oetting, Jumper-Thurman, Plested, & Edwards, 2001) by adapting Prochaska and DiClementes' (1982) model. According to Oetting and colleagues, community readiness has more than these stages and the original dimensions of readiness include existing efforts, knowledge about the problem, knowledge about alternative methods or policies, leadership as well as funding and resources. Community climate was later added and many changes in names and descriptions and stages occurred. Community readiness theory is an organic system that is flexible, can change over time and can be changed to apply to new and different problems; a system that evolves over time.

Edwards and colleagues (Edwards, Jumper-Thurman, Plested, Oetting, & Swanston, 2000) believe communities are at many different stages of readiness for implementing programs, and it is for this reason that readiness must be factored in before implementing a program. This is very important for AV as the organisation should, according to these theories, consider checking in with its employees to determine the need for change and what the changes should be. The Community Readiness Model was developed to meet research needs as well as to provide a practical tool in order to help communities implement change. The model defines nine stages of readiness in response to the problem within the community. According to Edwards et al. (2000) these include: *No awareness*, where the issue is not a problem, it's just the way things are. Again, it is unlikely that any member of AV would fall into this category given the amount of organisational change taking place currently, as well as recent media coverage which has indicated need for change within the wider organisation (see Appendix 7). *Denial* states that little or no recognition that there is a local problem. Some members of the community may think there is a problem but

major train of thought is that 'it's not our problem'. Given the community's reactions and the direct impact on community members, it is again unlikely that an organisation in AV's position would be in the denial stage. *Vague awareness* is where there is a general feeling among the community that something may need to be done about the problem. Ideas about who has the problem or solutions which may help are vague. *Preplanning* is where there is clear recognition by the majority that there is a problem and that something needs to be done. Leaders are identified but efforts are not focused. *Preparation* is when planning is commencing and practical details are discussed. *Initiation* is when information is available to justify plans. Leaders are enthusiastic, but problems and hurdles are yet to be faced. *Stabilisation* is when one or two programs may have been started. Community and decision makers are supportive. Staff are usually trained and although limitations may be known, no detailed evaluation has been done. More specifically, this may relate to the peer support program which has been running within AV. Although it has been running for years, and has many benefits, it has not been implemented by members of the organisation nor has it been evaluated. *Confirmation/expansion,* which is when standard efforts are in place. Original efforts have been evaluated and changes made. Data are regularly obtained. Finally, *Professionalisation is* when detailed and sophisticated knowledge of prevalence, risk factors and causes of the problem exist. Highly trained staff are running the program, leaders are supportive and community involvement is high (Edwards, et al., 2000).

Community readiness is similar to a medical or psychological diagnostic system. With regard to a particular problem, the Community Readiness Model (Edwards, et al., 2000) classified a community at a particular stage of readiness. The stage the community is at, has a direct relationship to the diagnosis and every

diagnosis indicates that a specific treatment is required. The treatment may not work, in fact it may fail altogether. If this is the case, the stage of readiness may not have been accurate.

Given all of the research to date, and the significant issues Robinson has brought to the fore, further research is required to help ambulance paramedics feel supported and reduce their experience of trauma. The problems of declining health and well-being (including higher rates of suicide compared to the broader community) has been highlighted as a central issue for emergency service personnel. Ambulance service providers have attempted to remediate these issues by setting up numerous programs. A peer support service for debriefing personnel following identified "high risk" incidents on the job has been one of the main sources of support for ambulance workers in Victoria. However, as noted previously, it is evident that there are still major limitations to this remediation being successful.

Ambulance paramedics should be involved in the change process regarding their own support needs. In order to address the aim of this research, which was to explore the psychological and social coping strategies of ambulance paramedics, ambulance paramedics themselves will be asked what support they feel would be useful to them in dealing with the day to day aspects of their work in the context of their long term health and well-being. The secondary aim was to examine the use of current peer support programs and other referral services used by paramedics. Again, the paramedics themselves will be asked how they feel the current support services assist them and whether in fact they use what is on offer. It is hoped by doing this, we will better be able to understand the potential changes over time among paramedics with different levels of experience.

Chapter 4

Method

The current study came about due to a discussion between some University staff members and academics in the field of paramedics, who were concerned for the wellbeing of working paramedics and an increase in the number of suicides by paramedics both in Victoria and New South Wales. To date, there had been little specific research into the experiences and meanings that paramedics placed on their roles and the inherent stressors.

The current study utilized qualitative methodology. The use of qualitative methodologies, utilizing semi-structured interview techniques, allows a grounded theoretical perspective to be utilised in this study. Grounded Theory uses categories to help with the discovery process when working with qualitative data (Willig, 2001). Grounded Theory involves moving from data to theory through the identification of categories. These categories are integrated and linked through theoretical coding (Willig, 2001).

This study is a qualitative exploration of the experiences of ambulance paramedics through interviewing. Qualitative research has allowed the researcher to make sense of the personal stories of individuals (Glesne & Peshkin, 1992) as well as understand and deduce how various participants in specific social settings or groups perceive and construct the world they experience (Glesne & Peshkin, 1992). Semi-structured interviews were used as the primary method of data collection. The purpose of these interviews was to gain an in-depth understanding of the experiences of two cohorts of paramedics; those who entered into their first year of practical work, who will be referred to as ‘Novice’ paramedics and longer term paramedics or

experienced paramedics. It aimed to gain an insight into their work practices, obstacles and coping strategies. Outcomes from these interviews were analysed for evidence of both functional (e.g., effective debriefing, exercise, positive social support) and dysfunctional (e.g., high alcohol consumption, excessive eating, anxiety) behaviours. These findings have contributed to our understanding of the work life of paramedics. Outcomes will further inform the development of "best practices" in improving the health of paramedics by providing an informed consideration of what the paramedic themselves consider to be valuable and accessible within the context of organizational support.

4.1 Participants

This study included nine 'early career' and 12 'longer term employed' paramedics within Rural Ambulance Victoria (RAV). The early career cohort consisted of paramedics who were in their first year of employment within RAV. The longer term cohort included paramedics who had been 'on the job' for a minimum of five years. Participants were recruited on the basis of gender, such that it reflected the gender ratio in the paramedic workforce.

In the present study purposive sampling was adopted. Purposive sampling, consistent with Patton (1986) targets participants who have a sound understanding of the area being investigated or are relevant to the study. The aim of purposive sampling is to gather highly meaningful information within a particular context. According to Patton, it is important to gather information from those who have quite different experiences in order to gain a more extensive data set. Therefore, the current study gathered the perspective of both newly trained and more experienced paramedics.

4.1.1 Novice Paramedics

For the early career paramedics, or novices, the time on the road ranged from eight months to 11 months. The sample consisted of 5 males and 4 females. All nine participants were university trained. Four were completing tertiary courses straight after completing high school; three came from a nursing background; and the remaining two had work experience in other fields. One novice paramedic resided with a partner who was a nurse, and one participant's partner was also a paramedic. The age of the novice paramedics ranged from 21 to 46 years. The average age was 26.3.

4.1.2 Experienced Paramedics

The age of the experienced or longer term employed paramedics ranged from 41 to 65 years, with a mean age of 49.8 years. The sample consisted of 9 males and 3 females. Time in the job ranged from 5 years to 40 years. A vast majority of participants were in management positions, such as station officers and most had over 10 years' experience. Two of the 12 experienced paramedics had a nursing background; the remainder came from unrelated fields. All were trained by the older Diploma of Ambulance and Paramedic Studies (DAPS) training. Two participants were married to nurses and one was married to another paramedic.

4.2 Procedure

Participants were recruited through the RAV internal email system. Via email (Appendix 1), potential participants were informed of the aims of the study and invited to contact the researcher or her supervisor for further information. Those who chose to participate were given a plain language statement (Appendix 2), asked to

sign a consent form (Appendix 3) and informed of their right to withdraw at any time. Participants were also assured that although the researcher could not guarantee anonymity, every participant's confidentiality would be secured through being assigned a code number rather than the provision of their names.

Interviews usually took place at paramedics' homes, or their work branches due to the rural and regional nature of their location. The rural location meant that the researcher was sometimes driving up to 4 hours to conduct interviews. The duration of each interview (ranging from one to three hours) was dependent upon each participant, as it was at the discretion of each individual as to how detailed he or she wished their account to be. For this reason, at the beginning of each interview, participants were informed of their right to withdraw from the study at any time, to stop the interview at any time and to disclose as much or as little detail as they wished. The researcher made an effort to allow the participants to steer the interview and take it where they felt comfortable. If any sensitive material was discussed, each participant was again reminded that they had a right to stop the interview at any time or refuse to answer any questions. Each interview was audio-taped and transcribed verbatim. Consent for audio-taping was included in the plain language statement but all participants were asked prior to beginning for their consent. Consistent with Grounded Theory, the researcher completed some of the interviews, collected the data, and explored this data using coding. She then attempted to establish links between participants in the early stages, and worked with her supervisor to determine if anything was missing or if anything needed to be altered within the questionnaire. She then returned to the field and continued to collect data. Data saturation was reached with the novice cohort during the ninth interview, hence only nine novice

participants were involved in the study. Data saturation for the experiences cohort occurred at the 12th interview.

4.3 Interviews

Interviews help gain an in-depth understanding of what ambulance paramedics experience and how they manage the experiences they face (Minichiello, Aroni, Timewell , & Alexander, 1990). It was most appropriate to talk directly to ambulance paramedics in order to allow their own terminology and expressions to tell the story. A series of questions were generated as a result of the researcher's experience with the literature and earlier discussions with student and novice paramedics within the university setting as well as her experience on placement with VACU. The questions (Appendix 4) centred around the experiences of the paramedics on a day to day basis, (i.e., How would you describe an average day for you at work?), the support systems they utilize, as well as exploring their exercise and diet habits.

4.4 Data analysis

All interviews were audio-taped and transcribed verbatim. Outcomes from these interviews were analysed for evidence of both functional (e.g., effective debriefing, exercise, positive social support) and dysfunctional (e.g., high alcohol consumption, excessive eating, anxiety) behaviours. Data was analysed using the Grounded Theory approach of grouping data into descriptive categories and eventually more analytic themes (via constant comparative analysis) arising from the paramedics interviews and referring to the primary areas of interest (or research questions) of the study (Willig, 2001). Themes were extracted independently from the interview transcripts by both the interviewer and her supervisor. Where disagreement between the researchers occurred, the coded themes were discussed in detail, until

agreement was reached. Data for the two target groups – those in their first year of employment as a paramedic, novice paramedics, and those who have been working in the area for more than 5 years – were analysed separately and then compared to reveal commonalities and (Horowitz, et al., 1979) differences between the two groups.

The data reduction procedure began at the transcription stage. In order to increase familiarity with the data, the researcher read through each transcript and summarised the content of each line so that categories could be identified and analysed. A theme was identified depending on the frequency with which it was spoken about. In order to ensure the data collection is trustworthy and consistent, all participants were offered copies of their transcripts and provided with the opportunity to clarify, extend upon, or include any further information which they believe has been overlooked in the first instance. Data was contrasted and compared to identify positive (regular debriefing, healthy diet, regular exercise) and negative (high alcohol consumption, insomnia) coping strategies. Similarly, information regarding the use or non-use of the peer support system or other counselling and medical supports utilized by the participants was collated and utilized to inform a conceptual map of what type and form of support services the organization will need to consider in the provision of health management and work safety for their employees.

Three case studies were developed through a process of consultation between the researcher and her supervisor. The case studies were instrumental and were deemed necessary as the data from a number of participants was quite profound. It was thought that the reader should be given the opportunity to gain insight into the world of a few participants to really capture the impact of the work over an entire career.

The overall outcomes of this study will be utilized to inform the second stage of this doctoral dissertation, and extend upon the work with the ambulance service by developing and testing identified prevention/intervention strategies within the organization.

4.5 Ethical considerations

Given the sensitive nature of the study and the involvement of human participants, the researcher was required to gain ethical approval from within the University, as well as from the paramedic organisation. This process involved numerous stages of paperwork, meetings, clarification and finally approval (Appendices 5 & 6) with conditions to time and the provision of support for the participants. The study was completed in accordance with the Australian Psychological Society (APS) Code of Conduct.

4.6 Presentation of Results

As highlighted earlier, stress and coping play an important part in reviewing the impact of work related factors for ambulance paramedics. Stress and coping literature provides many different perspectives on defining stress as well as functional ways of coping (Brickman, Carulli Rabinowitz, Coates, Cohen, & Kidder, 1982; Davidyan, 2008; Goldstein & Copin, 2007; Jones & Bright, 2001; King, et al., 1987; Lazarus & Folkman, 1984; Selye, 1956, 1974).

This study is unique in that it explored ambulance paramedics in a rural setting. This brings up issues that may not be prevalent in a metropolitan environment. The different perspectives and experiences of newly trained, on the job paramedics and more experienced paramedics are also explored.

The results from the interviews will be presented over the next three chapters. The fifth chapter highlights the background and demographics of the participants. As there are many differences between the experienced and novice groups, this background information will provide context for the presentation and interpretation of the substantive data. Three case studies will be presented in chapter 6 to provide a personalisation of the experiences of paramedics and to assist with the understanding of the thematic results that follow. Pseudonyms[4] will be used to protect the identity of participants. Chapter 7 will be an exploration of the themes which have emerged in the analysis of the interview data and the case study examples will be discussed further within the themes in chapter 7.

4.7 The Researcher

The researcher is a 31 year old female from the Eastern suburbs of Melbourne. The researcher is a registered Psychologist in Victoria and a member of the Australian Psychological Society (APS). She has completed a Masters in Community Psychology and has gained much interview experience within this time. The author works within a Community Health Service, working directly with victims of violent crime against the person. The researcher completed past theses and placements at specific units within Victoria Police. During her Honours year she conducted interviews with members of the Crime Scene Unit and have completed a Masters project titled 'Service delivery of a Sexual Offences and Child Abuse Unit (SOCAU): Perceptions of victims and police members.'

[4] Pseudonyms will be used to protect the identity of participants. No reference to any participant's real identity will be included in this thesis.

As part of her Masters she also conducted a placement within the Victorian Ambulance Counselling Unit (VACU) which provided invaluable exposure to the training Peer Support workers undertake. The researcher was also fortunate enough to be exposed to numerous on road shifts with ambulance paramedics and attended call outs as an observer. This experience allowed her to speak directly with operational ambulance paramedics and get their view on their profession and its shortfalls.

The researchers past experience has taught her that she has much to learn, but what she has realised during her exposure to those working within the Emergency Services is that the biological and psychological demands placed on many professionals are profound -- especially with regard to emotional, psychological and organisational support given to those placed under enormous strain at work.

Whilst undertaking this PhD the researcher was provided guidance from a number of psychologists with varying degrees of experience with emergency services personnel. She also attended a peer support group on a monthly basis with colleagues.

Chapter 5

Results – Demographics and Training

An introduction into why the participants became ambulance paramedics and the path which they took, as well as other influential factors, are discussed in Part 1 of the results section. This section includes *Appeal of the Job (*reasons why paramedics chose to train as paramedics); *Traditional on the job training methods versus University training*, as well as any further study and training they completed; *University course issues* were discussed by the novice group. Differences between the training over time and *experienced versus novice* paramedics' view on the training they have completed are also discussed.

While there are many similarities between participants in each group, there are also some stark contrasts. Many of the contrasts relate to time on the job and the nature of the training that people have undertaken.

5.1 Appeal of the job

Individuals enter different career paths for different reasons. As Super (1952) pointed out, individuals make decisions on their career path based on a number of factors, including personal and individual factors, as well as the realities of day-to-day life (i.e., financial reasons). Only some paramedics in this study were able to articulate their own reasons for choosing the ambulance profession. Some reasons included the influence of others, some reasons were intrinsic.

Only four of the 12 experienced paramedics, and 3 of the nine novices, highlighted their reasons for joining the ambulance career. The variety of the job

seemed to be the most important influence over why paramedics in this study chose to follow this particular profession.

One novice paramedic stated:

> *I researched ambulance and it just had so many uh appetisers I guess. Not knowing what you're going to do every day is probably exciting.*

Another novice stated:

> *I think it is a good balance between jobs where you are really challenging yourself and you are problem solving and all that kind of thing, and then there is the nice ones where you just pick people up and tuck them back into bed.*

Some paramedics indicated what they get out of the job. A passion for helping people was common, and this was also a factor when exploring appeal of the job. A more experienced paramedic stated:

> *I enjoy it because I need the stimulation of having a lot of things to do and I am not one of those people that don't do anything.*

Overall, most paramedics who made comments about why they joined the job, were satisfied with the expectation of the job, compared to the reality:

> *Overall the job itself in 12 years I've not lost any of my passion for what I do. I love it as much today as I did when I first got in and I still get a buzz out of helping people and yeah, so I think that's a big thing.*

5.2 Traditional on the job training methods versus University training in Australian context

The training path participants undertook strongly influenced their opinions on their expectations of the job, as well as their readiness and preparedness for the type of work they are now completing. There has been a dramatic shift in the way paramedics are trained. The older model saw paramedics complete more 'on the job' training, whereas since 2006 new paramedics have been required to complete a university degree. Therefore, the newly trained participants in this study have had to

complete a university course to become qualified, whereas 11 of the 12 experienced participants had been trained under the older 'on the job' model.

A majority of the experienced paramedics had much to say about the issue of training. Most experienced participants thought that the university students they had been exposed to lacked the hands-on skills required to be a successful paramedic immediately out of university:

> *Nowadays you have students coming out of university who know how to do research, who want to know the reasons and the rationale behind things, but the ones that are coming out of it are generation Y and so I might be a father to them and you know, some of the questions that I get asked is amazing, you know, it is just like I am their dad.*

Another experienced paramedic highlighted the lack of applied skills shown by Recently graduated university students:

> *And I think there's a lot of things to be said for the old apprenticeship style teaching. Especially in a practical based environment, cause I'm also a clinical instructor, they can come out and they can recite all the guidelines, they can recite work practices, they can do this and they can do that, and you ask them to put on a dressing and they can't do it. They can't apply.*

Yet another was adamant that the old system was better is preparing students for work:

> *I think they need to turn the clock way back to the system that I went through, I went to school for six weeks and then I was out on the road for three months and then you did an exam and then if you passed the exam you went to your next semester.*

One experienced paramedic took things a step further and discussed inexperience and youth as disadvantages for newly university trained students:

> *But I personally just think they're too young. From a psychological point of view, the fact that our brain's not fully developed until we're 24, and I'm concerned about…I agree with the same, Fire Brigade and Police, and any other emergency services, that the exposure and trauma that we are showing our young people…equal opportunity and all of that, that's fine, but I'm just concerned about the fact that our brain's not fully developed until you're 24, which I think we all know that, what we're getting exposed to, I think we're going to end up with a lot of people, I mean we'll soon find out, my own history, surely, with PTSD. Which concerns me greatly. So alarm bells ring for me in our recruiting process.*

A further experienced paramedic discussed the differences he had noticed between newly trained paramedics and ones who were also trained in other fields such as nursing:

> *I think that as far as, like pathways into the job, I think possibly the more difficult one to manage, even it's not the uni ones, it's really the graduate entry ones. The ones that actually have been nurses already, being, because they perhaps kind of don't appreciate the differences between the two roles, and they are significantly different, and whilst they do have…*

And another thought a mix would work the best for providing the best prepared student for the job:

> *I believe a mix between in-house training like nurses used to do, which was the old hands on training and then the university based. A good mix of that would be right. Universities would argue that's what their giving with placements, but a placement of a week or a month here and there doesn't give you any exposure at all.*

Four of the nine novice paramedics spoke of their initial experiences as paid paramedics. Most of the experiences were negative and centred around being university trained as opposed to the previous on the job training model. Two of the four novices spoke of this:

> *They're afraid we might know more than what we do, but we don't but they just think this university thing, some students don't play their cards right and try to shoot off all this stuff from their mouth and I find that gets them into a lot of trouble.*

And another:

> *I quite honestly think that they have a real dislike for the whole university system…..They find it very intimidating. And I think that there is a level of knowledge that these issues are coming out with that they find very intimidating. I think they find it really intimidating and I think as these older guys kind of come out of the service and the uni people start going up the ladder and the changes I reckon in the next five to 10 years in the Ambulance are going to be astounding. Because I still work with people who started their job as stretcher bearers, they never even had oxygen. They never had monitors, they didn't have drugs, you know, it's amazing.*

One novice participant mentioned the difficulties with being changed from branch to branch over their initial observer shifts: "You basically you start getting comfortable and then you get moved on again and have to start from scratch". This participant mentioned the disruption it caused when trying to build rapport with other staff members.

Only one experienced paramedic showed sympathy for the way students are treated by their usually older, more experienced counterparts:

> *The trouble is down here every shift, every day has a student on it and during the EBA[5] all the ambos rang up and said, "I don't want any students running with me," and they have got a right to do it. We had students rock up every day and they knock on the door and say, "I am supposed to be with you for the day." Imagine that, they are bright eyed and bushy tailed and keen and no, not even students buy it and it is just fucking rude, you feel like just giving them a clip over the ears you know, like why would you do that to someone…..The student has probably driven down from Melbourne and blown a tank of petrol that they can't afford, only to be turned away and...Some of these guys, they would go ballistic if someone did that to them, you know….*

Most of the novice paramedics implied the importance of study and training. One in particular stated "What they teach us in Uni is good". However, most had a lot to say about how demanding their university courses were. Some discussed the difficulty of balancing work, study and family.

5.3 University Course Issues

Novice paramedics who had recently completed the university-based training were keen to critique the courses. One novice came up with what he thought would be an ideal training program for paramedics:

> *I can imagine if we had a job where or a training system where you spent half your time at Uni and half your time on the job and got paid for it in that regard, that would be awesome I think and I would probably have learnt a lot better than I have now. Similar to the older model or vocational training, things like that. But that's it if you had a purely vocational model you wouldn't learn your physiology*

[5] EBA: Enterprise Bargaining Agreement --where wage and working conditions are being negotiated.

A further novice elaborated on the need for more placements:

> *So I think the universities don't put enough emphasis on the practical aspects of the job, and, you know, largely we're all left to our own devices to self direct our own learning, and yeah, that's, it's really not enough.*

This same novice paramedic, found difficulty between the inconsistencies of on the job clinical instructors, making his experience of becoming qualified even more difficult:

> *This is just to basically recap, just to say that the lack of consistency between CIs, lack of structure in the process, and the lack of consistency in the appraisal process and the lack of support in trying to get someone like myself up to an acceptable standard.*

Other gaps in the training that were highlighted included dealing with patients with mental health issues. Two of the novice paramedics in this study highlighted the difficulties they face with this and the fact that they do not feel equipped:

> *I think students need to learn that, they don't teach you to be a social worker, they don't teach you to put up with the sore ankles at three o'clock in the morning. They don't teach you to put up with the drugs and just be, people just abuse the service and yeah they don't teach you that. They teach you all the really great exciting stuff that you use once in a blue moon, so... No, they don't teach you how to look after yourself. I mean they do obvious stuff like dangers on the job and that sort of stuff.*

This quote is important as this novice paramedic, who has only been working for a very short period of time, is already able to identify the gaps in the training provided. This novice highlights the importance of self-care and the fact that it is left up to the individual to be responsible enough to recognise their own weaknesses. This is at the heart of Mitchell's (1983; 1988) work on the how stress can accumulate over time, eventually possibly having an impact in the longer term.

Another novice explained the importance of not only dealing with one's own mental health but the paramedic also deals with mentally ill patients and more training in also required around this issue. "They really need to have more appropriate training like because, yeah I feel really inadequate whenever I'm dealing with a psych patient."

The demands of the courses were also discussed:

> *When I was studying full time, I was also working part time. I was doing volunteer work with the SES, I had a student leadership role with the Student Paramedic Association as well, so I was doing all these things.*

This view shared by others who highlighted that because the course was so intense and not paid, they also had to work to earn an income:

> *It used to be that they would pay for you training, you know, on the job kind of thing whereas now you pay (for) your own degree.*

Another novice highlighted the difficulties of working via correspondence:

> *It was a lot of work for sure. Particularly online. Umm you have to motivate yourself, like it's a different experience and because we didn't have the contact time I felt they tried to make up for it by giving a lot more work.*

Gaps in the learning among novices, particularly the more applied aspects of the job were evident. Many novice paramedics felt that they were not equipped with the on-the-job knowledge that they needed to ensure they felt prepared for anything:

> *Yeah I think we really need hospital placements coz we get given a lot of theory on things one particular pregnancy. I would have liked to have an obstetrics placement cause going to an imminent birth and not knowing what they're going to and they being expected to deliver. Not knowing what a normal one looks like is pretty daunting.*

Yet another novice agreed, highlighting the lack of preparation for the field:

> *Most of us learn on the job anyway through experience and I think still to this day like if I get called to go to paediatric patients even fitting patients they sort of scare me a bit I think.*

5.4 Experienced paramedics versus Novice Paramedics

The experience (or lack thereof) of paramedics was a topic brought up by both novices as well as more experienced paramedics. One novice discussed her experience of coming straight out of high school:

> *I suppose coming straight out from high school, I don't know too many people who have had kids or the experience of so it was pretty foreign... actually with my RAV rotation I actually got a multi casualty. I got quite a lot of work, I suppose it's just luck of the draw……When I first started for the big things like, it comes up on the*

pager, like a gun shot or stabbing, I can feel the adrenalin rush for those sort of things, umm but now for the more medical cases, when initially maybe a cardiac arrest or chest pain, I start running through in my head, I could feel like positive stress I guess you could call it…thinking of what I had to do.

Another discussed his previous work history as a help when facing real jobs:

I used to work at the Alfred[6] *in trauma, so I did lot of trauma, so I probably saw, visually I saw, sort of grief or trauma that I would on the road but it's a different context I guess. So that's probably prepped me up...*

Another agreed with the lack of support within the transition of being a student to becoming qualified:

I think as an organization, there's not a lot of support to us as students and that's certainly something that there's been a lot of disappointment around when AV came out and spoke to us as second year students and put forward the opportunity for us to apply. There was an agreement that the service would release us for dates that we needed to do university stuff and if there were study days and all those sorts of things, that hasn't been seen in reality. There's certainly no flexibility or leniency towards us because we are still studying.

But in reality, working in a rural setting, if we don't do that job, then who's going to do it? So there is an onus on us as individuals to sort of take that on. And then the frustrating thing is that you don't get any sort of recognition of that from the service and so that's probably a big area that, because there is that feeling of responsibility to the community, we'll do things sort of above and beyond of what's actually expected of us.

Even once I finish the current stage that I'm in, I can be dispatched on my own. So that's certainly something that's a bit of a concern.

And yet another agreed:

Because we've got a, we see that there's a duty of care to the community and that we will say "Okay, we want a ten hour break, but we will be available until the next crew comes in at seven o'clock". Now currently that creates a whole heap of, it's like putting a stick amongst the hornet's nest that it's, you're either fatigued or you're not,

There was an incident with the girls the other week whereas they were called up during their break and they were on fatigue and their pager went off and they sort of said "We're fatigued" and they go "Well why didn't you turn your pager off". And it wasn't apparently a polite "Why didn't you turn your pager off?" so it's, I suppose it's just the politics and the people going "Well what are we going to do?"

And now they've rolled out this to say that students can now be first responders. I think that's rubbish. You're putting a whole heap of stress and unnecessary requirements onto students who may be fresh out, who haven't had the experience or the exposure to practice as a…

[6] A major general hospital and trauma centre in Melbourne.

Probably I would have to say the politics and the red tape that flows with this job. Coming, and I'm going to use it to go back to my nursing, I've come from a profession that is professionally recognised, that is well supported by the union... Here, you get a lot of people that will be, what I was saying, the union they don't seem to have as much nuts as what I've been exposed to. You're not recognised as a profession. Nothing ever seems to go forward.

Experienced paramedics spoke about more specific experiences with newly trained paramedics:

I have seen a couple of young people coming through at the moment that I am not impressed with and one was just recently in (town name). She just swore and carried on, "Why are we going and why isn't somebody else going out? We haven't finished checking the vehicle out yet?"……So that was the first job and so she argued with the controller over the radio which I would never, ever do.

Another experienced paramedic stated:

My first comment would have to be that I believe that a lot of the recruits are too young……But I think that they're too young just for the stuff that you're going to see…well look their knowledge levels are quite sound, quite good, but you see a few areas where they're underdeveloped, under done. I guess that's why we have students, but I think they're too young and that they're pushed through too quickly.

An experienced colleague agreed, "So now you get you are 18, three years at uni, they hit us at 21 and just are completely unprepared for what's expected." And another concurred:

Yeah they've got huge attitudes. Yes, most have, not all, but most. The ones coming from country Victoria are more at peace with themselves and don't have to prove too much, the ones who are from larger cities have got attitude plus and I'm assuming that their bedside manner is not as fantastic as it needs to be. I'm not the right person to ask. Because of the advancing levels of knowledge and skills required to do present day ambulance work and looking to the future I think more on road time and less…maybe half of each.

The following are statements from three experienced paramedics who discussed novice paramedics and the difficulties they face when working with newly trained paramedics. Most of these views were from paramedics who have been in the job for vast periods of time:

Look I think that the biggest difference I suppose is perhaps the lack of awareness of perhaps what they're get into it, and by that I mean it's no different to any kind of apprenticeship style training whereby you know, usually around the six months you actually on the tools or doing a job somewhere and you can pretty much quickly work out whether it's for you or not. I kind of feel that perhaps in the absence of having as much clinical exposure to the job itself, there can often be an element of not knowing

what they're really in for, not really appreciating the benefit of what they're doing now and that's going to play out later, and perhaps also, and just some others, it's, I think that there's an element of perhaps viewing the older guys in the job, like the dinosaurs and they don't really know what they're doing because they've got a university degree and these guys don't…I think they've been a good thing for the service, because they do come in with a wealth of knowledge.

There was no sitting in university for two or three years getting all these textbook ideas of what I'm supposed to experience and then going out and trying to argue with people on the road that, no that's not what the textbook says, because I knew that there's no such thing as a textbook case… I still have to deal with, "Oh, but that's not what it says in the textbook," or "Why are there so many grey areas?" and it's a lot of, "Well, that's just how it is," and if you can't accept grey areas then you may as well forget about the job because …You're dealing with human beings and nothing's ever textbook. …If there's a clinical breach or a problem don't make it acceptable but making sure that they don't make them feel like they're useless at their job and they have no purpose, because if they're going to do that they might as well just say, "Well, no. You can't do the job," and see you later. They might as well sack them straight away rather than keep them in the system ...People that are going to be stress heads for the rest of their career or people that are going to end up as a nervous wreck or, even worse, killing themselves which that's happened, and I hope that, yeah. So there's got to be some sort of like medium, like either see the potential in a student and support them and encourage them all the way through, or see that they don't have what it takes and get rid of them…

I don't think anybody should be a paramedic until they're at least 25, personally because I think they need to have their life experience there. Young people need to grow up, get some maturity, understand, because, I mean, I know. I've met some pretty immature 25 years old but...

This is important as novice paramedics feel the same way. Novice paramedics feel that they are lacking in exposure to the clinical setting and placements. This is also consistent with Gallagher and McGilloway's (2008) findings. Seventeen of their 27 participants stated that the training they had received regarding dealing with the stress associated with critical incidents was not adequate.

It seems evident that the more exposure students get within the health and/or emergency setting, prior to beginning their working life as a paramedic, the better equipped they feel for the job. These findings are consistent with evidence by Genest, Levine, Ramsden, & Swanston, (1990) as well as Palmer (1983) suggesting that the emotional distance experienced paramedics usually adopt makes it unlikely for

student or novice paramedics to receive a sufficient level of support. According to Clohessy and Ehlers (1999), this is especially relevant should the novice paramedic experience work-related difficulties. Although there are obvious differences of opinion regarding the changes to the education and training of paramedics, as will be discussed in Part 3, there are many similarities faced by *all* paramedics once on the job.

Chapter 6

Results – Case Studies

There were many profound stories and experiences discussed by the participants. Case studies can provide an insightful snapshot of the participants' experiences, in their own words. Case studies in qualitative research allow the researcher to draw on particular participant responses -- [those who seem to stand out or make important statements in order to highlight and capture recurrent issues]. These issues and experiences can then assist in developing an understanding of deeper questions, concerns or problems present in the data.

Three case studies are presented, as each participant had something to offer to the presentation of the data. Harry was chosen because his experience over the duration of his career stresses the importance of peer support, support at home and the real life impact of particular jobs "I will take to the grave with me". Leah was chosen as her recount is very specific around her experience with PTSD and how she survived. She highlights the fact that there are wider supports available as well as other issues such as suicide and the risks associated with overtime. George and Maria emphasize how jobs can resonate with individuals, the importance of having supportive people around you who will notice changes in your behavior, as well as the importance of the individual's response before, during and after traumatic incidents. The names Harry, Leah, George and Maria have been changed to protect the participants' identity.

6.1 Harry

Harry is a 46 year old male and has been an ambulance officer for almost 20 years and is MICA trained.He worked initially in the Western Suburbs of Melbourne and then shortly after went into the rostering department. After about four years in rostering, he joined Mobile Intensive Care (MICA) where he became a team manager of a branch in inner Melbourne. After 13 years, Harry left the ambulance service for 3 years and travelled overseas. The main reason Harry left was because he needed a break. He had done far too much, far too early, with far too much commitment, "I needed a change and that was around 12 or 13 years in the service." In 2000, Harry returned to the service due to a shortage in paramedics. He is currently in senior management in country Victoria.

Prior to ambulance, Harry was an apprentice boilermaker at a motor company. He went to school outside of Melbourne and at comparatively young age was a production foreman. It was after a football injury, when Harry was in the back of an ambulance that something clicked and he thought, "this is what I want to do".

Harry believes his work does have a very real impact on his family. He discussed times when he gets home from work and he is exhausted and doesn't want to talk to his family. "Sometimes I am like, 'Just leave me alone, I just need a bit of time by myself', you know."

Harry spoke about his experience at a major traffic accident in 2007 and the impact of this experience on his family.He was at the Domain Tunnel[7] "when it went up, and it was pretty scary actually being there". There are certain jobs that Harry has

[7] The Burnley and Domain Tunnels are a pair of cross-city road tunnels which carry traffic under the Yarra River in Melbourne, Australia, commonly only referred to as the 'Domain Tunnel'. On 23 March 2007 just before 10am, three trucks and four cars collided in the tunnel. The accident resulted in 3 deaths, with multiple people sustaining injuries.

done during his career that "I will take to the grave with me and you just can't get rid of them, you know." Harry was "extremely alert and saw images that you know, you...well no one should actually see them."

Harry mused that after working that horrific job at the Burnley Tunnel "how do you go home to your family and be a dad...Well my wife is a nurse and she is quite funny and she will go, "You have been in the Domain Tunnel crawling over dead bodies that are burnt to death?" And I will go, "Yeah." And she will say, "All right, well make sure you get that uniform off and go and have a shower before you go and grab the girls," you know. She is really sympathetic and understanding." This response highlights the emotion-focused coping mechanism. Harry's wife attempted to change Harry's emotional responses to the problem. She used avoidance, distraction and acceptance to help her husband attempt to cope with what he had just been through (Lazarus & Folkman).

Prior to his Burnley tunnel experience, Harry may have been more impacted by another car accident where he pulled an unconscious male out of a car that was on fire…. "You can see how people can get burnt to death." Harry had to go back into the car three or four times in his attempt to get the man out. He was:

> *Bloody six foot four or something and unconscious and like stamping on the edge of the – you know when you open up the little door, the floor seal and I am standing on that and I have got him and I am trying to walk him out and like all the flames are going up my legs and I could feel them coming through my shoes in the heat of it all. And finally someone, it must have been the fire brigade that arrived and someone grabbed me by the back and has just dragged us both out and the guy landed on me and then we had to resus him. Anyway, I rang up Kath and I said, "I am going to be late," and she was pissed off and she was like, "Why, you are supposed to be here." And I said, "Well I ended up coming across a car accident." And she said, "Well couldn't someone else have gone to it?" And I said, "Well I suppose, but I was there and anyway...*

Jonsson and Segesten (2004) named this category from their research '*To be caught in turmoil'*. The participants from their study discussed feeling confused, upset, exhausted, sad and distressed, and that the world is chaotic. To be in a chaotic

world is characterised by confusion, guilt, shame and post-traumatic distress symptoms. Like the participants in the study by Jonsson and Segesten (2004) this experienced paramedic shares the fact that he has experienced things "*I will take to the grave with me"* and powerfully stated *"you just can't get rid of them"* in reference to traumatic memories. As Jonsson and Segesten highlighted, this participant sums up that the intensity and duration of these feelings can vary considerably. Some participants passed the feelings and symptoms within a few hours after particular incidents, but others felt they took years or even decades to overcome certain experiences, like the participant in this study.

Harry went on to discuss jobs he attended which also had a major impact on him. Harry stated:

> *I suppose there was a couple of jobs. There was one job years ago where I did, in one week I did three SIDS cases and then...In one week, yeah. It was from Christmas, so it was Christmas Eve; no Christmas Eve? Christmas Eve because the next day I was going to ask (my wife's) dad if I could marry her and so it was Christmas Eve, went to a SIDS and then Boxing Day I went to a SIDS and then I can't remember, I think it was before New Years and I went to a SIDS. Like when they rang up the third time, they said, "This isn't you is it (participant's name)?" and I said, "Yeah it is," and they said, "My God, you have done three in a week." And then I on the Sunday I went back to the first one and the wife had committed suicide and she had hung herself...It was shocking, like she was hanging from the door and I had to bloody – I will never forget this, because the hallway was narrow I had to like dance with her, like I had to spin me self around to get her out because I couldn't drag her. And then her husband comes…*
>
> *It was just shocking and there was cards saying, "Congratulations on your baby." Then there are cards saying, "I am sorry about the death of your baby," and he is going I have got some terrible news and handing the phone to me. And I am like, "Who am I talking to?" And my pager is going off because a kid is playing around the corner and it was just horrendous…Horrendous. Like it still makes me feel a bit funny talking about it you know. I still feel a bit emotional about it...And at times years and years ago, I would actually cry and stuff like that over it, you know.*

It is obvious from speaking with Harry that there has been a recurrence of many issues, over many years. Each experience, both large and small, has had a compounding effect on the person he is today. Harry experienced many of the major incidents which were deemed most stressful in Gallagher and McGilloway's (2008)

study. Eleven of the 27 participants in that study deemed cot death to be the most stressful. Similar to Harry's recollection, the participants in Gallagher and McGilloway's study also discussed dealing with the family members of the deceased as particularly difficult. Road traffic accidents were also a major stressor for 17 of the participants in their study.

Another experienced paramedic discussed the seriousness of the impact of the work and how some individuals are not getting the support they need on the job. Leah spoke very freely of her own experience and how she was lucky to survive her experience of PTSD. This paramedic spoke very honestly about suicide within the organisation.

6.2 Leah

Leah, a 41 year old female, has been in the ambulance service for 13years.Leah would have joined the ambulance service earlier, but the opportunity did not exist as the service had a stage where they did not do any recruiting.

Leah was one of 96 paramedics who started at the Ambulance Officers' Training Centre. She completed MICA through the university system and was one of the first to undertake the university-based MICA course. Prior to ambulance she worked in welfare industry, had been an enrolled nurse[8], travelled a lot and had just turned 28 when she got into the job.

Leah discussed a young paramedic who committed suicide. The girl was young and committed suicide in a way that most females wouldn't, which concerned Leah. A friend of Leah's who is employed within the NSW ambulance service has

[8] Enrolled nurses are second level nurses who are enrolled in every State and Territory in Australia, except Victoria. They work under the supervision of registered nurses.

told her that there's quite a number of paramedics that are committing suicide in NSW.

According to Miller (1995), many personnel working within the helping professions, such as fire fighters, police and paramedics, often take their own lives as a result things such as relationship problems, financial difficulties, job failure or failure to achieve goals, humiliation in the presence of their peers. Miller stated that it is rarely isolated work incidents which cause such as response. Suicide is the ultimate negative consequence of stress and non-coping behaviours. This issue was also found in Robinson's (2002) study. Partners of the paramedics indicated that their spouses had often shown symptoms such as withdrawal, nightmares, chronic sleep deprivation and avoidance. These are symptoms consistent with PTSD. The negative impact on the family was great, with the partners stating that the paramedics returned home moody, often closed down (emotionally), or were emotionally distant.

That is also a concern to Leah. Leah spoke of her own experience:

> *I've had basically a massive breakdown in ambulance. I got admitted to Melbourne Clinic in 2005, post a critical incident that was an accumulation of massive events, which did not recognise my rapid, well my deterioration, to the point that was one particular job that tipped me over the edge. A major event. And then, obviously, all the signs and symptoms of PTSD, and one particular person picked it up, of which I was very thankful...At that point in time we had a very good Work Cover[9] co-ordinator working for RAV, who put me in contact with (a support service). And there were spots at the PTSD clinic at that point in time, but I got admitted to Melbourne Clinic, and was serviced with (Clinician) who's in charge of the PTSD clinic and the team out there. And so I've been managed by them since that event. Which I'm really thankful for. So that's been a little lifesaver for me, because I was treated correctly, they got me, like on the scale they got me probably about here, not too late, treated with medication, psych treatment…Helped me with rehab, to the point where I got better and got back to work, totally off medication, back working full time on the road, being back, leading, clinical instructing, fully functional.*

According to Leah, the course she participated in was two days a week for 12-weeks. This is was group therapy course, with a maximum of six people, which included things like anger management and mindfulness. Since the course, Leah has

[9]Workers' Compensation insurance scheme supported by the Victorian Government.

been completely medication free. She was on high high-dose medication. Leah stated that the impact on her family life was horrendous. Her marriage fell apart, but luckily she was able to salvage it.

Similar to Leah's experience, but on a lesser scale, Robinson's (1993) study found that 65% of participants reported that they experienced trauma reactions as a result of prior ambulance jobs. A substantial 17% reported a strong response and, despite not formally assessing the prevalence of Post Traumatic Stress Disorder (PTSD), there was an indication that symptoms of PTSD did exist in her cohort.

Leah explained a job she attended which was very difficult:

> *Yeah I remember when I did my first SIDS in the night, that weekend, I took my sister up to Queensland. It was my first niece, she's now 13, and my – I forgot, my old nan who's since died. But yeah, I was up like this, every five minutes, all night. Well I was snapping the other night when I got home. And I realised – (My husband) was like "What's wrong with you" and I'd be arguing over something, and I realised about an hour into it, I'd come back out into the lounge room and I realised I was snapping because of that job. Even though I felt okay, but I was irritated, tired, probably underneath it was all the irritation and upset and it was all about that job. I've had some pretty shitty jobs in my 13 years. Big jobs. Done a couple of triple fatalities with families, some really crappy jobs in my time. I don't really want to see anyone go through what I've gone through. And there is people going through what I've gone through.*
>
> *There's a lot of subtle things that happen in the ambulance that people don't realise. Like, I was a non-prescription drug addict prior to my breakdown, cos ambos can be really sneaky. I was gambling. I started to drink, and I wasn't a big drinker at all, didn't have a drinking problem, I was just drinking now and then. I'd go home and I'd have three or four scotches at home, and I'd notice the bottle would go down. Rather than now, I might have one scotch you know, with dinner, maybe once or twice a month. Or not even that, very rarely, have a drink*
>
> *But other ambos have nicked morphine…they've nicked other drugs from hospitals, you know, like when the old drug carts used to be accessible through the emergency department. So the ambos used to nick Panadeine forte and sleeping tablets to be able to help them sleep through the day, or they used to just get docs to write them a script, or they used to just – cos the old drug carts, after hours, used to just sit in ED and you could just get whatever you wanted. So if they wanted temazes, they could easily get temazes. Ambos, oh…but if you work in the health profession you don't want to let on that anything's wrong.*

Importantly, Leah mentioned completing overtime and states that she was doing in excess of 80 hours a fortnight in overtime by the time she had her

breakdown. Similarly, Regehr and Bober (2005) discussed that the unpredictability of overtime was discussed by several participants in their study who stated that they never knew if their spouse was coming home for dinner.

Insights such as these are profound. They indicate that employees really are under pressure and although issues such as suicide and overtime are not freely discussed, it is very important that these issues are brought to the forefront within the organisation.

Below are parts of an interview conducted with a participant and his partner who was able to provide some insight into her experience of living with someone who was experiencing PTSD. However it must be noted that the following also highlights the social support offered by his partner throughout the participants' experiences, as well as the impact on his family.

6.3 George and Maria

George is a 59 year old non-smoking male. He has been in the job for 23 years and has cut back on his drinking recently. A young George had dreams of a career in aviation, but was hampered by poor eye sight. He did some work with a research organisation and then moved location. He completed 2 years National Service, but he didn't go to Vietnam. George then completed degrees in science, psychology and geography and moved into flight service --similar to air traffic control, at Melbourne Airport. He worked at Melbourne airport for 7 years, then got a job in programming in Tasmania. It was while working in Tasmania that a car accident occurred outside his workplace and George assisted. A few people commented on how hands on and helpful he was. This experience made him reflect upon his current desk job and very quickly he decided to apply for the ambulance service. Due to the "ad hoc" nature of

recruiting back then, George applied 3 times. At this stage he was working on computers in Melbourne. He completed 3 years training, but right at the end resigned due to the toll nightshift was taking. He already knew nightshift was an issue. He took three months off, but began to miss ambulance and went back into the service "more relaxed". This was around 1989. He discusses openly, many incidents which impacted him. Maria is George's second wife. She used to teach and is from the UK. George's life has been something of a rollercoaster since they met. His job as a paramedic has impacted both his career and their personal life. Maria has done alot of research about PTSD and the kind of support George needs because of this. Throughout his experience, Maria kept a journal about what was happening, as George was living through PTSD.

George now enjoys exercising with Maria. Specifically he tries to walk 10 kilometres every day, he enjoys Pilates and eats very well.

From the very beginning of his career, George discussed "a couple of incidents around that time that did shake me up". He found his hands full with a collision; a motorcyclist had hit a pedestrian. George felt that he had been functioning on the road quite well and his sleep patterns hadn't been affected. He found it was "just little triggers that upset me and my poor first wife didn't understand what was going on and she was with me in the theatre when I had this overwhelming grief in a film. It was an ambo talking about the death of a little girl and the job with the little kids that I found too..."

George's experience is similar to findings by paramedics in the Regehr et al. (2002) study. Paramedics when asked to rate what they thought others would deem the most traumatic events to attend, claimed that 'blood and gore…' are not the incidents that 'have left me sleepless' (p.3). The most common response was suicide

or violence against children. With reference to child abuse or neglect, many respondents were able to recall a great amount of detail with regard to specific cases.

George stated that his first wife didn't really have a clear understanding of what he was going through. Because of this he was reluctant to get re-married, but with Maria, he just felt that she was such a straight talker and communication was so important to her.

The first time he realised he wasn't coping, he saw a local psychologist who mentioned PTSD. He had been open enough to talk to other people about it because it didn't really bother him. He found that lot of people didn't seem to know about it. They referred to it as Generalised Adjustment Disorder with Anxiety and that was the official diagnosis at that stage. It wasn't actually PTSD and it didn't have extreme symptoms. George just had a feeling of being wound up and his sleep patterns were irregular. He had been down on himself and called on a fellow paramedic that he admired, and who had admired some of the work that he had done. This person had written George very complementary letters. One night he was grumpy and had a go at George. George took this to heart and felt like he was being perceived as not performing to the standards he should. That was part of what got him disappointed in himself and then he just found the need to get off the road:

> *I found small things were triggers. Look one of the big triggers for me which really started to get me upset was I got dispatched to quite a serious job with a young infant; a three year old sorry. But the computer had changed the address, so I drove really hard, all the way. We didn't even rock up on time and that started to get me stressed and then I had a sequence of nasty jobs in a short space of time and I just found that my stomach was starting to churn.*

Maria interjected:

> *There are some jobs that he's done that have ended up being not very serious, but they have reminded him of previous jobs earlier in his career that are obviously still with him. You know, whether that's, I think he has moments of PTSD. He's perfectly functional most of the time, but yeah and when he's not thinking about the job, he's good. And when he starts bringing things up...*(coming off the road)*..I think*

probably, ultimately it's going to save his life, yeah, I really do. Not just mentally and psychologically, but physically.

Maria recalled an extract from her journal. On Christmas night, George had been out nonstop from one in the afternoon until 9pm, finally going to bed at 11pm. He was asleep for an hour and right in the middle of his deepest sleep cycle, his pager went off -- it was somebody who had had too much alcohol and George had to respond to that by himself because no one wanted to work over Christmas. It was a volunteer position basically. George got back an hour later and the guy was verbally abusive, could have been physically abusive.

While referring to a calendar which documented his experiences of major and what would be regarded or referred to as 'minor' incidents over his career, George discussed how 'sensitive' he became:

This case here, Christmas Eve, a double fatal, it never bothered me for my whole career and then all of a sudden it was in my face when I had the PTSD. It never bothered, sorry it started to bother me the first time I went off the road because this case, a two car collision on a dangerous corner here in Beechworth reminded me of this situation here. So I happened upon it, that a minute after it happened, Christmas Eve, we had a psych patient in the back of the vehicle, I was in the back looking after them and we came to an intersection and we go, "Oh, there is a crowd starting to gather." It's at night time, one car is pulverised and steaming over there and the other car looks pretty well alright, but upside down. And the because the patient that we had was already a problem...

I get to the car and find out how serious it is. Mum's dead in the front seat and her 14 year old daughter we discovered her in the back and she's dying basically and the friggin vehicle is full of petrol and it's upside down and the petrol tank is, it must have just been refuelled and so it's full. And so I basically had to swim into petrol to get to the girl and all I could do, I had an oxygen mask on my face for the fumes and I gave it to her and I tried to get her out of the car and I couldn't and had to retreat out and have a look around and then had to have a look again and finally get her legs free of the dashboard and get her out of the car and by that time, MICA has arrived from Monash Hospital which wasn't too far away. But my uniform was written off and I had to go in my pyjamas and I went to the hospital and showered and put on pyjamas and at the time I was kind of excited to be doing something useful in a real full on situation but at the back of me head I was shit scared that it was a Christmas Eve crowd, they are gathering around the car, there's no control scene, one cigarette butt..... and the whole scene would have gone up you know. And it kind of shocks me.. ...Well you have got these little kiddies you know..... and you can't back off and so you are driven at the time, but time and years later you think, that is one of the lives you have used up, you know.

And the other situation that became flashbacks during the PTSD was we got called to a case one night. It was called as an overdose and we get to the house and get into the hall and there was this bloke smoking and raving at this wife and they've got kids in bed and it's night time again. And the next minute he's really near us and he's got this knife which is about as long as that hidden away and he's just coming at us. And I turned and I remember looking at the door and it was shut and I thought, I have either got to immediately open that door or go straight through it. And we got outside and it became a full blown siege and...

So they sent in the police dogs and they sorted it out, but the psychologist this time around, Rachel Willis, she's been marvellous and she sort of pointed out that I was hyper vigilant, locking the house at night and in the process of locking the house one night, there was a man with a knife outside the door and I could see him through the door, a three dimensional figure and I thought, whoa this is crazy because I knew that it was me generating the image but it was very real. But you wake up in the morning and you have woken up, I believe I was awake and then suddenly there is somebody with a knife in the bedroom there.

Several cases I had debriefed with my psychologist and then I would get home and hop on the couch to relax and then suddenly another case that I had forgotten for years would be in my face… or another lass that was dying and suddenly they're there in your face and it was pointed out in some personality thing that I have a very detached mode of dealing with and that has been my style actually and they say that's not necessarily...good because there's like a backlog of detached cases reappearing.

But it's actually when you are talking about it..... it kind of brings it back occasionally. There's something under the surface and the spring is wound up a little bit tighter than normal and I can kind of sense that.

Again Maria interjected:

I was actually worried about (him) a few times because he was suicidal.
He threw a glass at me and it was, well I have still got it in the cupboard, it was one of those...it was one of those ones with an inch of solid glass on the bottom. Yeah, I think it hit the bookcase and it bounced off. There was no harm done but the intention was there. Talk about a short fuse.

George stated that he had completely forgotten about some of the incidences of aggression towards Maria. Maria recalled about half a dozen incidences where George seemed to almost "turn into someone else." This experience always followed some sort of pressure or build up of something that happened on the job. George stated that another accident he remembered was a head on and there was actually body pieces on the road from the other car.

According to Giarratano (2004) there are many factors which predict a person's vulnerability to PSTD. Pre trauma vulnerability, type of stressor,

peritraumaor immediate response to the trauma, as well as Post trauma responses all contribute to the likelihood of a person developing PTSD. Pre trauma vulnerability includes biological factors (such as gender and family history of mental illness), personality traits, previous traumatic life events and the environment to which a person has been exposed when growing up. Type of stressor includes the magnitude of the event including the intensity, duration and extent of physical injury as well as the person's preparation or warning that the event is going to happen. The peritrauma or immediate response after the event includes perceived life threat, the person's behaviours during the event, their emotional or cognitive experiences as well as their coping strategies during the event. Post trauma responses include the amount of subjective distress following the trauma, the amount of social support and quality of stress management skills, maladaptive appraisal of intrusive phenomenon and whether or not these intrusive symptoms decrease soon after the event.

These case studies will be integrated into the thematic analysis in Chapter 7. Themes will be gathered from other participants and themes present within the case study will be discussed.

Chapter 7

Results – Themes

Major themes shared by both novice and more experienced paramedics will be discussed in this chapter (see Table 4). Four major themes were prevalent for both the novice and experienced paramedics identified. ***Reality of the work*** explores expectations versus the real day to day activities of paramedics as well as *procedural difficulties* with the work they do. ***Sensitivity/Impacts of their work*** looks at the delicate day to day jobs and experiences that paramedics can come across. Within this theme, *personality issues and major holidays*, the *impact on the paramedics' families*, and *jobs that affect or remain with participants*, and *bad things happen* are discussed. ***Coping strategies used to manage their work*** is also investigated. Sub-themes within this include *Social support*, exploring *communication; Informal support*, involving *informal debriefing* and *mentoring*, the *use of humour*, and *other coping strategies* including *exercise* and *binge drinking*. ***Organisational support***, both helpful and unhelpful will be discussed, including *Peer support and confidentiality*, *Support from management*, (including subthemes such as *paramedic safety, lack of resources*, the *pressure of extra work, internal culture/politics)*. R*ural versus metropolitan working environments*, the impact of *shiftwork*, and *support needed*, will also be discussed.

7.1 Reality of the work

The type of work paramedics complete on a day to day basis can differ greatly between branches and locations. It can even vary greatly depending on the time of day or year. A shift in a busy branch can mean very little time between call outs. A quieter branch may translate to a lot of sitting around.

Table 4: Themes for both experienced and novice paramedics

Theme	Subtheme
Reality of the work	Procedural difficulties
Sensitivity/Impacts of their work	- Personality issues - Major Holidays - Impact on family - Jobs that affect or remain with participants - Bad things happen
Coping strategies used to manage their work	- Social support - Communicating -Informal support - Informal debriefing - Mentoring -Use of Humour -Other coping strategies -Exercise -Binge drinking
Organisational Support	- Peer support and confidentiality - Support from management - Paramedic Safety - Lack of resources - Pressure of extra work - Internal Culture/politics - Rural versus metropolitan - Shiftwork - Support needed

Most novice participants felt prepared for high pressure situations within their jobs. Their views were in line with the literature (Fullerton et al., 1992; Jonsson et al., 2003; Regehr et al., 2002) on the stress of the job when attending more traumatic incidents. In contrast, most were also surprised at the amount of 'down time' involved in their day-to-day shifts. This may be influenced by the fact that most of the current study's sample was based in rural and regional areas.

A majority of novice participants mentioned the impact of their expectations prior to beginning work and the real life, day-to-day work of a paramedic. One stated "Particularly now working, you need to realise that there is a lot of down time." One novice acknowledged the differences between the job in metropolitan versus rural

settings, “Well I’m working in the rural sector so it’s probably been a bit quieter than what I anticipated.”

One paramedic felt like the job had been sold to him as a high pressure, intense job, but the reality was different:

> *And you sort of feel like, oh when you are doing the paramedic course you don’t get enough time on the road to fully appreciate the monotony of it and the frustration of it and so you get, I got, since six months into my training, I was just really, I wasn’t angry or upset, I just thought this was crap you know. It was three o’clock in the morning and I would have to go and see someone’s ingrown toenail.*

Another novice paramedic stated that although there are quiet days, “I think it is a stressful job. You get to some scenes where you just go, ‘crap’.” In this case the paramedic was discussing attending less meaningful jobs. Another novice participant took this further when discussing responding to patients who were in better health than the paramedics themselves:

> *I’ve been to that many jobs where people are telling me how sick they are and I’m sitting there with a splitting headache or whatever and I am nauseous because I haven’t eaten and I am also tired and exhausted and I’ve vomited because I have been that tired.*

Another novice discussed her experience with a partner and the stress displayed by the paramedic towards a patient:

> *I’ve had partners who’ve cracked it with patients and say you know, I’ve had five hours sleep rah, rah, rah and what do you want...And that’s what the patient said as well, it’s not my fault, it’s your job and my partner turned around and said well no it actually is your fault because I was asleep until you called me. And I was sitting there going and like this is going to be a physical thing and like I know my partner got assaulted when I first started and it was you know, partly contributing, she contributed to the whole situation. And I oh this is really not good.*

These two quotes not only highlight the sometimes perceived meaningless jobs paramedics are expected to attend, and their response to them. It highlights the stress the paramedics are under in terms of missing lunch breaks and lack of sleep. This is consistent with the findings from the study by Fullerton et al. (1992) which spoke of the fatigue fire-fighters experienced during the rescue work. This is

significant as it indicates that the paramedics, too, are feeling exhausted, under resourced and unsupported. Despite the financial allowances paramedics receive, one novice paramedic stated:

> *We get a lot of allowances, we get late meals, spoilt meals and at first you think it's great -- you just get sent on a job 29 minutes into your lunch break you get money for it, but at the end of the day when you want to eat you want to eat. People sort of think oh how do you do this job and they think it's very stressful but it's stressful for different reasons, it's not necessarily that we see this blood and gore and that's what sort of affects us, it's more the fact that we become a witness almost to the worst of people's time. That's good and bad, like I feel pretty privileged that we get that opportunity and we sort of get tested in a way that most other people wouldn't, so there's that experience.*

Abuse of the ambulance service as a resource was also discussed at length. One novice stated:

> *They probably classified what we did before is go and pick up the lady who's fallen over in the nursing home over the weekend to take her on Monday for an x-ray. What a waste of time that is. Yes. It is a waste of ambulance resources, I would acknowledge that, and we see that the waste of resources, but emergency is in the eye of the beholder, and if their policy requires you to be in ambulance transport to the emergency, to the hospital for the x-ray, so be it.*

This indicates that empathy is still present in some ambulance paramedics, despite other frustrations of the job. It also highlights the personality variables which are important for the emergency service worker, as discussed by Costa (Costa, 2003). According to Costa, while negotiating what is at stake, a range of personality characteristics including values, commitments, goals and beliefs about oneself and the world, helps determine the stakes that the person identifies as having relevance to well-being in a specific stressful encounter.

In contrast to the reports from the novice paramedics, surrounding having very little to do, having a lot of down time or responding to more menial jobs, the more experienced paramedics commented on different issues with regard to the reality of their everyday work. Some issues include being rushed off their feet (this was usually more evident for participants who were in management roles), the psychological

aspect of the job, and resourcing issues, such as lack of staff. One manager spoke of the day going so quickly he misses lunch:

> *You literally walk in there and pick up the phone and you would be off and running and your shift replacement comes in and you go shoot, it is eight hours already. Like often I will want to go for a walk – I will get into work at 8:00 and then it will get to 5:30 and that and I haven't stopped for lunch or anything.*

Given that all participants were from rural services, this was an important issue. One participant mentioned the pressure of working in a small town, "the demand of the job never goes away, especially if you are the only one covering a town for eight days. You're it."

A further experienced paramedic mentioned the days where he would rather be in another job. "So there was six, I attended or knew of six deaths in less than probably 24 hours and you know like some people don't get to some of these jobs in a career…" This is consistent with the study by Regehr et al. (2002), which found that of the 86 ambulance participants, the mean length of time since their last critical incident was 3.6 years with a range of 2 weeks to 9 years --indicating the real day to day uncertainty of the work.

One novice paramedic discussed how his perspective has changed "One thing for me is that every day we're reminded that it's not that bad. Like it puts things in perspective."

7.1.1 Procedural Difficulties

Procedural errors by others or the wrong information provided by dispatch was also mentioned by 2 of the paramedics. A novice paramedic stated that "Being in a rural area, it's not likely it's just down the road here. It's down the road a significant amount of speed, time, metres, kilometres, whatever you want to call it." This indicates another layer of stress put on to paramedics, stress which is beyond the

paramedic's control. A further paramedic mentioned the frustration around getting wrong information from the dispatch centre. "You might be told that you are going to an 80 year old and it is an eight year old or eight month old." This is an important issue and has major implications for the stress on the paramedic and their frame of mind going to a particular job, as some medications are age/weight dependent and if the paramedic is trying to prepare for the job required in the very near future while driving at high speeds to the job, it may cause much confusion and lead to errors by the paramedics themselves.

7.2 Sensitivity/Impacts of their work

One of the key themes was the impact that the job has on paramedics and their families. Issues such as type of work, impacts on day-to-day life, learning over time, personality and seasonal issues were discussed. All of the participants seemed to be impacted in some way by the type of work they do. This was consistent across both the novice paramedics and the more experienced cohort. Again all of the quotes in this study and the perspectives of each participant indicate that each case is dependent on the individual and their own personality as well as the particular job and the perspective of their partner (either at work or at home). For some people talking comes more naturally, as does talking about their own feelings and the impact things have on them. What is important to note however, is that other variables, beyond the individuals control also impact one's ability to debrief. For example, as discussed previously, the inherent tough guy mentality that has been within many emergency services for centuries are out of the control of many. This culture can impact whether a paramedic, fire fighter or police officer is likely to debrief and explain how they really feel.

7.2.1 Personality issues

The personality of the people who are ambulance paramedics plays an important role and the paramedic needs to have an internal drive, or passion for helping people. Novice paramedics had a little to say about the personality of a paramedic. One stated:

> *But as I said you get a mixed bag some people are like the nicest people you'll ever meet, others are a bit more uptight. Again like it's purely subjective, you get some people who sort of want to talk about jobs and others who might not necessarily want to do it. You get that a lot so a lot of older paramedics, especially in the country, they always look out for younger students and things like that. I think it is more attitude, you know like you can get – there's always exceptions to every rule. There's young people that you talk to are really good with debriefing, others, older guys who are just hopeless at it. So I think it's probably personality.*

A further novice paramedic explained the skills he thinks are necessary to be a successful paramedic:

> *I think you have to have some leadership qualities, definitely. Communication skills, to be able to talk to people, and probably just being able to recognize, the people skills really in being able to recognize when people are distressed or whatever.*

An experienced paramedic explained some traits he thought were paramount to success:

> *I wouldn't say it is a certain personality type, I would say there are certain characteristics that you need. I think you have got to be, not laid back but not highly strung kind of thing because you will be going along and then something will happen and then you have got to be able to, even on the inside if you are stressed, you have to be able to have that calm type of thing and that is not a very good description.*

A further experienced paramedic agreed:

> *Truly, I think you're either, you're made for this job or you're not and some people who aren't they'll get by and will struggle at times with the stuff they see….You can meet somebody and go, you've got it, and I can't put my finger on what it is but they've got the type of personality that's quite resilient who actually enjoys chaos, turning chaos into order…Enjoys helping people, you know my criteria would be helping people first, not a control freak but somebody who likes to be in control. A confident person and someone who likes adrenalin you know, you've got to have a bit of that adrenalin junkie in you for this job.And some who have got that you know personality, you know they're young but they're slotting in and they're learning and taking it on board. Others are just struggling every day and you know I'll be ringing peer support, "You need to get onto these people".*

Another experienced paramedic stated:

> *And I guess I can get back to that. I became a clinical instructor for about four years and they did this personality assessment of the people as part of the training to show that there's different learning styles. Well they put the different styles of people into the four corners of the room and 98% of the people were in one corner and there was just two of us were over in the diagonally opposite corner and I could see how I am different to a hell of a lot of ambos. A lot of ambos are really more practical, at that stage a lot of ex electricians, plumbers, very hands on and me I was very bookish type...So whether you prove personality testing beforehand would probably exclude me from being an ambo, I don't know or protect you from...*

Other personality traits deemed important by another experienced paramedic included:

> *You have to have good communication skills. You need to have a high degree of tolerance, but also tolerance not only for the way people are towards you but also what you see, what you experience...*

One novice paramedic discussed his experience in the nursing profession and the differences between nursing and ambulance. He spoke specifically about the treatment of his partner (also a paramedic) after a SIDS incident:

> *Like nursing is bitchy, but ambulance is just something else entirely, because you know, I might have never met you before but we all work with the same people and so we will sit there for 10 hours and talk about people that we mutually know. And the worst one going, there is some shocking stuff being talked about because they have got nothing better to do. But you know, people are asking me about (my partner), because you know, she's sooky and she cries easily and you know, she's not cut out for this job. Because she went to a SIDS job when she was pregnant….You know and they said, "Oh she's just not handling it well and all that." It's like, "No, that's not the story. She went to a SIDS job, she was pregnant and it was really upsetting," and then everyone goes, "Oh fair enough."...Everyone puts up this...ridiculous wall and it's terrible actually, it's really bad.*

Quotes such as these indicate the difficulties paramedics face when attempting to keep at arm's length from patients in order to protect themselves. They indicate also that there is a need to protect family members from the reality of the job when returning home from a shift, however traumatic. They also highlight the difficulties of dealing with different personalities among colleagues.

The last quote is significant as it indicates that different personalities among paramedics themselves, also causes conflict and stress, and can even lead to workplace bullying. This is supported by Gallagher and McGilloway's findings which indicated that interpersonal conflict was a major stressor in the work of 10 participants in their study. Sheehan (2011)explored differences in the kinds of bullying behaviours employees are exposed to in an emergency service organisation (ESO). Sheehan discovered that "gender, sexual orientation, age, occupational group, length of service in the organisation, ethnicity and disability"(p. 63) all play a part in the bullying behaviour a person is exposed to in an ESO. However, it highlights the findings from the study by Bennett et al.(2005) regarding assumption of the *hardy* personality type, especially for a female working in a profession such as paramedicine. The authors found that women who self-select into the role of ambulance paramedics are more *hardy* and women within the paramedic field generally have more access to support services.

An experienced paramedic spoke of a further incident which has remained with her and discussed her response which she deemed appropriate so as to not be portrayed as weak:

> *Yeah you are, it's extraordinary or you know nanna who's been at home, she won't turn the heater on in the middle of winter because it's going to cost her money and she's dying of pneumonia and there's no family around and you know that, that guts me. When I was in my training there was this child he died and we, I wrapped him up because she was so I wrapped him up coming up with flowers and the boys just look at me, "You're freaking", apparently not. So yeah you know and it's a real little baby and handed him to mum and they're a mess and I was fine oddly enough and everyone's going, "Are you okay?", you know, "Seriously", you know and she, this is you feed them, where you tell them the false part and I go, "Seriously I'm fine just leave me be".*

This acknowledgement of 'faking good' and pretending to be unaffected by the work to look 'tough' to colleagues is culture driven, but clearly indicates what goes on within the individual to combat negative responses from colleagues. This is

consistent with findings by Bennett et al. (2005).The fear of 'appearing to be weak' in a male dominated occupations also came through, one experienced paramedic stated:

> *You know in fact you don't want to appear to be weak in this sort of male culture, ambulance definitely caused the tolerance to harden up, probably more empathy you know, I'm able to see things from different points of view.*

It must be noted, however, that this study only contained a relatively small sample of women, but it was representative of the population ratio of women and men working within the service. It must also be noted that quotes regarding the need to act tough were given by both men and women in this sample. An example of this is below, from an experienced male paramedic:

> *And you think, well hang on a minute, if I don't handle this too well and I suddenly go off on sick leave and everybody is down there saying, "Bloody (participant's name), he has cracked up and he has gone off on sick leave and he is out on stress related sick leave." And so you tend to say, "Shit I will just soldier on, rather than admit..."*

As mentioned previously, the type of work a paramedic does can differ depending on the branch they are working at, the time of day or even the time of year. A number of participants discussed this further.

7.2.2 Major Holidays

A novice discussed the impact of the job on life in general and like George (see case study in Chapter 6), discussed specific times of the year when tragedy can impact more:

> *'I've only had sort of the one job that was more confronting. And probably the only thing that really changed was that because it was just before Christmas, and a lot of people were driving nights and stuff I sent a message to few of my close friends to take it easy, that was it, really. Yes, it probably just makes you focus a little bit more on the things that are important to you.'*

Major holiday times are peak periods for ambulance paramedics. More people are on the roads, families are visiting one another, often more alcohol is consumed.

Arguments resulting in family violence are more likely to occur as more people are getting together. So, not only are ambulance paramedics usually busier, but more paramedics are missing out on their own family functions due to their commitment to the job.

Sansone and Sansone (2011) completed a database search exploring the hypothesis that psychopathology increases around the holidays, especially around Christmas time. Findings indicated that the mood of individuals may worsen during holiday periods. The numbers of fatalities where alcohol was involved may also increase. Further, Turkat, Farris, and Blue (1978) found that there were seasonal fluctuations in the demand for community mental health services, when they explored client intake at a community mental health clinic in the United States. From January 1974 to January 1978 the number of clients who accessed the service was documented. There were significant variations from month to month. The mean intake per month was 33.8 with the number of intakes peaking in January (m= 44.5, SD = 10.5), September (43.3, SD = 7.8) and October (42.3, SD = 7.0). This may indicate seasonal variations in the demand for service. Research has indicated that during times of family gatherings, individuals who are without loved ones, may become more depressed and isolated as a result. Therefore the number of self-harm and suicides during this period is also increased (Sansone & Sansone, 2011; Turkat, et al., 1978). Contrary to these findings, in July 2006, The Australian Transport Safety Bureau (ATSB) released a study *Characteristics of fatal road crashes during national holiday periods (ATSB., 2003)*. Data from Christmas and Easter holiday periods were reviewed between 1996 and 2005. The number of deaths on the roads fluctuated considerable between years, 'fatality numbers ranged between 48 and 86 for Christmas periods, and between 14 and 31 for Easter' (ATSB., 2003, p. 13). When

data were further examined and compared to non-holiday periods during the year 'it was found that fatality rates during the holiday periods were not systematically higher or lower than fatality rates at other times of the year' (p. 13). No seasonal patterns were found in the data.

Only one novice thought the type of hours he worked made no difference, but it is the types of things paramedics see and hear are what is most influential:

> *Because of the four on and four off[10] and it keeps rotating and the days swap around I don't think it has more impact on our family life than a 9.00 to 5.00 job would, it's just that it's spread out over different times.*
>
> *So you think you've got it set and then, do I want to add more traumatic memories to my own life, what am I doing.*

Both novice and experienced paramedics discussed more profound material relating to the impact of their work. Subthemes, such as impact on family and jobs which remain with me (the paramedics themselves), have been found within the current theme of 'sensitivity/impact of the job'.

7.2.3 Impact on family

The work we complete must impact our family in some way. Whether we have had a good day or a bad day, no matter what job we do, can impact the mood we are in when returning home from work. Paramedics discussed the impact their work has on their families.

A novice, whose partner was also a paramedic, discussed the impacts of their work on their son:

> *I think it definitely impacts with my home life, just because of the shift work with a child. As soon as he sees us in our uniform, he knows that we are leaving, so he gets a bit shitty.*

A further novice discussed the pressure of doing day to day tasks on days off, therefore impacting time with family and friends:

> *Everything that your life back* (at home town) *is crammed into those days, which is painful because you don't have any time to socialise. Your time is spent trying to catch up on things that you've missed out on for the past five to six days, like mowing the lawns, spending time with the kids, cleaning the house et cetera. Seeing your family, in-laws et cetera.*

An experienced paramedic discussed daily tasks such as exercise and meal breaks and although there are other things he's like to do, spending time with family in the limited free time he has, is a priority:

> *That's the other thing. I would like to, I find that a good de-stressing is to go to the gym, but when I work so much I don't do it. Because it's like another two hours away from the kids and that. Yeah, why can't we have gym here at the branch? Do you know how many fat ambos there are? There's heaps, because they all have to sit around on their backsides ...And they all get weird hours and then they have to ...eat and their metabolism goes to crap, and it's not necessarily a fault of our own, and we don't see as any assistance coming ..Yeah, it's stress relief, endorphins. It does a lot for my state of mind. So it's beneficial, but I just don't find the time to do it. I've probably put on 10 kilos. Whereas when I was doing a 10/14 roster, four days on four days off, I could keep up an exercise regime where I was doing something. So having to be on-call sucks because I'm eating breakfast at 4 o'clock in the morning and then I'm having lunch at 3 o'clock in the afternoon and then I don't feel like eating tea.*

An experienced paramedic reflected on the impact of his job on his family, over the years:

> *If I reflect back on it, the family probably paid a penalty. Because in all my 20 years I have been in a country branch and I have worked on call and so the inconvenience of being on call and up until somewhat recently we did seven nights call with an ambulance parked in the backyard and every time that phone ring you are responding. And you know, I can recall a couple of the times when the family has been on the phone and before mobile phones and pagers and you would have to say to them, "Get off the phone, it might be the ambulance that is trying to ring." All my family is in South Australia that is my siblings are all in South Australia. So when you want to go away for weekends, well there have been times where I have had to say, "Well I can't go." And there have been parties and even weddings that I have had to forgo because I have been on duty. They know that dad is an alcoholic; not an alcoholic but a workaholic, get it right.*

The impact on the family when he is on call:

> *Yeah and there is nothing worse than having your lovely roast dinner and you come home and it has been in the fridge for the last three hours and it loses all its appeal; it loses all its appeal and it is such a disruption to the family. And I can remember my son being home not so very long ago and he loves his mother's roast and yeah, all prepared to sit down for a meal and it goes off again. And my son, he wasn't here when I left and he rang me up, "Oh dad where are you, we are all waiting to eat?"*

[10] That is a work roster of four days working followed by four days not rostered on.

And I said, "You just start eating, you can't wait for me I am out doing a job," you know. And in recent years I think the kids have; it has started to affect the kids.

Another experienced paramedic discussed what he misses out on when prioritising his work and due to staff shortages, despite having the leave accrued, he never gets the opportunity to take it anyway:

So when you have weddings, engagements, birthdays, all that sort of stuff which we've had a host of lately, it's really difficult to try to uphold your responsibilities to both work and your family and friends, and you're torn between well if I go to work, then I'm doing the right thing in terms of work, but I'm neglecting this part of my life, and...And it just seems crazy that you could accrue RDOs[11] but you can't take them.

A further experienced paramedic explained how he copes with his family life and work life balance:

I actually try and switch off, it can be difficult some days. Depending on how much work, because we work our eight days on and with those eight days they're day shifts and then on-call, so to switch off can be a wonderful concept, difficult to do because the job follows you to home with the pager and, but as a general rule, baring I suppose the best one is, sleeping, because we've had a varied workload from a very low workload when I first got here and it's been increasing and increasing and increasing, I still don't have any trouble when I decide to go to bed and sleep, that's where I'll sleep. And I just work on the theory that I'll wake up in the morning and go back to work rather than, oh I could be waking up in five minutes time.

Over the last couple of years it's worked out, you're not going to miss any of those now, if it's a significant event, I'll find a way to be not at work. A sick day's the easiest, because I have accumulated all these hours and stuff in the past, so I don't have any hesitation in basically kicking off. And as you get older, as I've got older, health is an issue, so yeah if I think I'm going to get sick from working excessive hours in a block, I'll then have a day or so off so that I don't get sick for a fortnight.

An experienced paramedic who is also a parent spoke of the impact of her work on her children:

I'm quite cautious of you know, kids being around cars or you've just seen too much stuff so… The negatives it changed, it changed who I was as a person this job, it changed, I'm sure it changed my personality. I was married before and my ex-husband would say, "You've changed, you're different now". He would say I'm more judgemental so, which I am quite judgmental. The stuff you go out to constantly, you form opinions and it's really hard to sway them you know.

[11]Rostered Days Off.

An experienced paramedic continued talking about the real impacts of certain jobs after explaining his brother committed suicide in a similar manner. This was a common occurrence for some participants' and will be discussed further in the theme '*Jobs that affect or remain with participants'.*

> *You now know that hang on a minute, this has affected a whole raft of people and you look at it very, very differently. Yeah it does, it changes things and I had another suicide a week or two shortly after that and a bloke was sitting with a bottle in his motor car with his exhaust gases and half a bottle of bourbon and shit, that was just like my brother, sitting there listening to the football.*

Although paramedics are exposed to suicidal patients, patients who have attempted suicide, as well as those who have committed suicide, the impacts of both experiences are important and consistent with findings by Regehr et al. (2002) who showed that 82% of their participants indicated that they had been significantly overwhelmed or disturbed by an incident or incidents.

The following participant highlighted the impacts on family life, as well as the stress of the job. He discussed the real day-to-day difficulties with the job and as Regehr and Bober (2005) and Robinson (2002) found, how it impacts his relationship with his wife:

> *Look I haven't been able to sleep very well since…Started at seven o'clock in the morning. I didn't finish till 10:30 pm. And I got home and I was supposed to finish an hour and a half earlier, but we had someone we needed to bring back to look after. We got home and my wife, she was asking me why I didn't phone her, why I didn't call her. She was wondering, didn't think I was dead or anything, just wanted to communicate but the phone wasn't working. We were busy, my phone wasn't working out there. I just didn't get any cover. And so she went over this a couple of times, and I said look I was working. No, I didn't really have words, but I just made a point look I was working all right. You know. I was working, it was my second day on overtime. I'm tired and I had a thumping headache. And, still got that headache, and it's not as bad, but I've still got it. I've had it since Saturday, and I went, cause I'm going to bed cause I just start my rostered shifts tomorrow at eight o'clock in the morning and that was at 11 o'clock.*

This participant also discussed the impact on his parenting and role as a grandparent as a result of his work:

> *I'm probably overprotective of the two children that are 11 and 13 now, probably overprotective with my kids.*

Another experienced paramedic spoke of the stress of the job and impact on his family:

> *I hear of workers going on leave for stress related situations and I think okay everyone is different, I haven't experienced I haven't seen a big stress out hitting me in the face each morning or night when I leave or come home from work so it hasn't affected me at all, stress related situations.*
>
> *Certainly yeah, it means you can't always attend family or other gatherings that occur regularly but you just have to live with I, so you have to give up ideas of competitive sport. So then I thought gee I need to look at a sport or an activity I can do by myself so cycling has been a big part of my life. And unfortunately I chose those activities and unfortunately my first wife thought they were activities that would exclude her from being with me and I said that's not why I've chosen them, I told her with some explanation as to why I chose that; she went off and either accepted or refused to accept it. So second time around you have to be more considerate and fortunately my wife will stay with me and I bought her a bicycle last Christmas and we'll ride the rail trails together and so those things we can enjoy some recreation time but we also don't have the hassle of having children around when we are the age we are.*

An experienced paramedic spoke of the impact of the work and his marriage breakdown as a result of his work:

> *My wife says "Well how many times do we have to go out for dinner and you're going to leave me at the restaurant?"(and then) "No, look you don't have a say anymore", you know, "You're never at home". "You don't do this", you know, "You don't have a role as their father." So as a result the marriage broke up. So, yeah. I think it was, it also had to do with not so much the stress it was when you're in the defence force you're on a really low income. And then when I joined, and this is, it's my fault as well, and when you join the ambulance service, there's the potential to do overtime and everything as well. So you know, so there's the incentive to be at work. Initially it's the potential but then it becomes the pressure because you know, you go out… and buy that plasma screen TV and you go oh credit card I can pay that off. And then you do that, and when I was relieving I thought well I want a nice car and so I went out and bought a nice car and then the marriage has broken up and then it's well how do I pay this, or, and what I found was even, I wasn't doing a lot of overtime when I was relieving, it was that the travel money. So, you know, almost $2,000 a fortnight just in travel and living away from home and all that added up. And then so I've found out since then, when the marriage went belly up, child support's worked out on all that money. So I'm now in that situation where I've still got to work…*

Regehr (2005) explored the impact of trauma exposure on spouses of paramedics. Her findings suggested that discussing their work with family can have detrimental effects on the worker and their partner (Regehr & Bober, 2005; Robinson, 2002). However, George and Maria are an example of how a spouse can provide

social support, but can also feel the brunt of the real impacts of the job on the paramedic. Similar to much of the findings by the participants in the current study, daily hassles reported included inappropriate calls from work, changes to schedule, changing co-workers, and dealing with shiftwork. The unpredictability of overtime was also cited as a hassle encountered on a regular basis. Several participants stated that they never know if their spouse is coming home for dinner. This unpredictability reinforced concerns for the safety of their loved one. A primary concern related to shiftwork surrounded the degree to which family time is compromised and the fact that family responsibilities are not equally shared. This was also relevant for the rearing of children. Several participants in the Regehr (2005) study stated they sometimes feel like a single parent -- very similar to the quote above. This reliance on overtime and the impact on finances were also spoken about briefly by a student paramedic.

7.2.4 Jobs that affect or remain with participants

A few participants indicated that for one reason or another, a particular job may have impacted them more than others. One experienced paramedic stated:

> *He's been in the job 35 years so he's got a lot of experience, and there's one job in particular that gives him grief and there's one job that gives me grief. And we have triggers for those. So, you know.*
>
> *I know that my job in particular was a truck that left a bridge up at…. a few years ago, burst into flames, both the driver and the passenger burnt to death and I was there for a couple of hours and at the end of it they were finally able to identify the corpses. And they said "Look we have to remove the bodies before they're completely gone", and none of the SES, none of the CFA wanted to do it, so I put my hand up and said yeah look I'll do it. So I actually had to use a shovel to remove both bodies and put them in the body bags, because no one else was prepared to do it, and at the end of the job there was no peer support. The CFA, the SES, everyone got something, and the police got offered peer support. But there was no ambulance involvement. Whereas now if I went out to do a job like that, yes, there would be. So, but I can go out to a job, or even in the backyard, you can have, you can smell someone burning plastic or something like that. You know, it just… difference but that's the trigger, or if I can't sleep and I'm really tired, just hearing the trucks on the highway. So, yeah. If I get one of those triggers, it's a brief thought and, yep, just get*

on and do whatever. So I don't sit back and dwell on it or anything like that, or I don't lose sleep over it anymore, or, yeah.

A fellow experienced paramedic spoke of a similar experience:

This job has a bigger underlying stress, like that sometimes you can get a bad run of jobs, you do thinking about them, they're still there. The job is staying with me and I can't stop thinking about it, I talk to people about it and then if it doesn't stay with me I oh well you just kind of go with, for me it's like if I have to stay 24 hours thinking about it. Like I had a job where we didn't, we had a lady who had, I'd taken her to hospital a couple of days earlier and we went to her house and she'd actually, she was on the floor and she was collapsed and we put the monitor on and she just had a dying rhythm and the guy I was with said turn it off, and we didn't do anything. And like she was really old, I knew she had, and it wasn't until the doctor turned up and said she'd been released from hospital because she wanted to go home to die and she did have a not for resuscitation order on her, but that was the first time I'd ever really seen anything on the monitor and not, that was the first time I actually had to do a not for resuscitation order type thing where someone…

Yeah and you know you kind of have to say to yourself this guy was going to die or he died, it just happened to be on my shift or I just happened to be the one that come out. And when I first started I remember one of my friends she's an ambo, I said to her I want to do a resus you know, if someone has a heart attack, she's like no, you want someone to have a heart attack, I said no people have heart attacks, I just want it to be on my shift, and yeah you have to just… you think about there's a cycle of life it just happens that you get to go there. And it's a bit of a privilege in a sense too I think.

Another experienced paramedic talked about his own habits of following up on patients from previous days:

When I go to a car accident, I am looking at that car and I know who is in that car even before I pull up. When I put a person into a hospital, I cannot help myself as I walk out the corridor tomorrow, I look in that bed and see if the person is still alive and so forth and I don't get sent to house numbers, I get sent to people by name and that is the way that life is in a small country town."

This has been explored in the past with findings supported the fact that emergency service workers are more susceptible to symptoms of post-traumatic stress disorder, burnout, depression and anxiety (Bennett, et al., 2004; Regehr, et al., 2002; Robinson, 1997, 2002). Another experienced paramedic also had a job which remained with her:

And this lone man's completely organised, he had a bag over his head and he had his wallet and his keys and his suicide note and all his bags, everything's packed. There's no drugs no alcohol, the beds hadn't been sat on, he's just lying between the two single beds. He'd come up from Melbourne and I read the note and I haven't read a note again to this day because I thought, "How can such a sane… person so

something" you know if it happens to him it can absolutely, it can happen to me it astounded me.

Another explained the impact of particular jobs in his past working life:

I've felt I've handled situations myself like talk to my work mates at the end of the job or a minor debrief which I've not heard of a debrief happening in years and it should have been happening. But having said that I've still got very clear images in my head of the hangings I've been to and the suicides by shooting events and I can tell you the dimensions of the garage where we found this man or the height of the gum tree in the Drysdale picnic area; they always seem to hit you in the head or not hit you but they're in your mind so clearly… It's times like this when you're asked to comment they affect me because that person's life has ended and I can't do anything to help him whatsoever.

A few of the novice paramedics were able to recall times where in their private lives they were reminded of certain jobs they had attended and were able to directly relate to the patient they were caring for. This was particularly significant for more traumatic jobs.

The five paragraphs below, represent five separate novice participants and their opinions and experiences of attending such jobs:

This one case I tell war stories but this one was the same age, I'd just had my birthday the week before and I knew it was his birthday, he'd just turned 22, at 10.20pm went out with friends and he got bashed and umm he arrested, had a traumatic brain injury. But afterwards like he's basically a vegetable now. And I had to see all his family and his mate, doing CPR. I just thought a week ago that was me with my friends and we didn't talk about that afterwards but that sort of made me feel like crap and I was like well this doesn't take much…

Some are better than others and I know what you mean, probably some of the worst jobs we do are the ones where people don't need an ambulance at all. So you'll get like a patient who might have sort of been diagnosed with cancer or something at 50 and they've got a wife and three kids, they've got secondaries and suddenly they've got a really crap sort of prognosis and it's just that they're not coping and they'll sort of call you for that. As opposed to sort of a big car accident or something.

It's, you know, poor little thing mother. You know. And of course, yeah, that affected me you know, reminded me of, you know, my loss and gees, you know, this is going to be hard. And it was. It was very hard to deal with, you know, and try to keep it all together.

I've been labelled as a crier and stuff and I think if you actually bothered to find out the details, I remember going to a SIDS and I was pregnant so yeah that did upset me. I mean yeah things like that and you've just got to let it go because what difference is it going to make, none and it will be tomorrow's news so it doesn't worry me.

> *No, we still get jobs like you know, family members of colleagues and stuff, that happens a little bit, but yeah it's just funny. Lots of times you will go to a job and they will say, "Do you know so and so?" And you go, "How do you know them?" "Oh it's my brother's neighbour," or you know, so somehow everyone knows everyone.*

Experienced paramedics agreed with the difficulty of attending jobs which you can relate to. One stated:

> *The toughest jobs are the ones that you are close to. That one being four absolute strangers wasn't so tough, yeah. So the tough ones are the next door neighbour or someone like that or someone that you have known for a long time, they are the tough ones, yeah.*

Another discussed her advice for others:

> *I think it's the best advice, I say to them, my colleagues when you go to, and I've been saying it for years, when you go to a, like a particularly traumatic job, don't look at their faces, you know. It's a dead person in the car, treat other people. You got to do the rounds and check who's alive, who's dead, who's injured, blah, blah, blah. I've said to my colleagues, don't look at their faces. Because you see the faces sometimes when you're trying to go to sleep at night, their faces came back at you.*

Another related the resource issue to his own family:

> *Now, and having seen a kid sick, it hits home that it doesn't just happen to everybody else, it can happen to anybody, and that basically that's why you're stressed because you live in a town and you know how bad the health resources are.*

One novice spoke of how quickly the process of becoming desensitised happened:

> *It's amazing how quick it's come. Like this is going to sound morbid but what's the worst that could happen? It's highly likely they're not going to die, they've had it for awhile, like I've learnt how to look at the big picture and it's helped me deal with it a lot more…*

This desensitisation can be very detrimental over the long term. Accumulated stress which has not been dealt with, acknowledged, debriefed formally or informally, can lead to burnout. Burnout among emergency service workers is a topic of extreme importance. Many studies have found that stress leads to dysfunctional coping strategies which in turn can lead to symptoms or diagnosis of PTSD and in turn increase the possibility of burnout (Bennett, et al., 2005; Fullerton, et al., 1992; Regehr, et al., 2002).

Two of the nine novice paramedics discussed aspects of burnout. Keep in mind that these students have been out on the job *for less than one year*. One novice was able to pick up on other workers who in her opinion may have had enough exposure to traumatic incident:

> *I've had really good partners but there's been umm some partners who have been due for leave, and haven't had it for a long time. They didn't want a student and they got one so…it's just like antics, you just have to play the game, pick you're marks and yeah go from there… it's hard to stay enthusiastic when they've been doing it for years and I can totally understand where they're coming from. They're not as enthusiastic about things…*

Another novice discussed how having her first child has made her think twice about returning to ambulance:

> *Recently I've been thinking I don't know that I really want to do this anymore. I feel like everything is paramedic like at home (my husband) is a paramedic and all this kind of culture, most of our friends … I try not to have all my friends as paramedics or else it gets a bit dull because you can't help but talk shop. And I think I've just done it to death… god I need to get out.*

7.2.5 Bad things happen

A very poignant quote from a newly trained paramedic around his world view was:

> *I used to think that everything that was bad ended up on the news but with this job you see a lot of bad things and you don't hear about it a lot. You know you don't realise how common it is… And so you think like what's going on in your home life and what you see, if they get too closely connected that's the one's that affect me more. Whereas the multi causality, it was a bad thing to happen yes but I couldn't really relate in any way. I was in a position to help and I did and that's the way I see it.*

This indicates the vast impact the type of work paramedics do has on the perspective of the worker.

7.3 Coping strategies used to manage their work

Many coping strategies are adopted by individuals on a day to day basis -- some negative, some positive. Negative Coping includes things that are detrimental to one's health (such as smoking or drinking excessively). Positive coping strategies are

those that are beneficial to the individual's well-being, such as exercise or socialising. As documented by Harrison and Kinner, (1998), Jonsson and Segesten (2004), Miller (1995) and Robinson (1993, 2002), paramedics often use more dysfunctional or negative coping strategies to manage the stress they experience. Another novice was more direct. "Not being at work helps. Time, me going part time is the best thing that I ever did." Experienced paramedics discussed many strategies they use to cope or de-stress. George stated that exercise was his main coping strategy but what wasn't discussed but was clearly evident was the support from his wife Maria. The understanding she displayed and the unwavering support during his times of need. Some general comments regarding coping were:

> *I walk my dog and I play on the computer, I do a website for our bike club, but. And the other thing I've just started doing, I've got a blog I write.*

A further experienced paramedic discussed his insights into coping. He was quite detailed in his descriptions:

> *I do firmly believe there's a difference between dealing with things and coping with things, and I think they can often get confused and I try, yeah, kind of talking out loud to myself if I'm on my own and that kind of helps a bit….Well I think coping is, like gets you through on day to day, but dealing with things is, you know, like actually…Yeah. Just, you know, maybe acknowledging the effect that something's had on you and then I think if I could find an constructive way to let it out rather than let it kind of seep out in not so nice ways then that's most probably the better option, but yeah, for me I kind of, I think I find that just every so often I kind of get through a crescendo point when I will just go visit dad's grave.*

Another stated a more precise and perhaps psychological technique that he uses:

> *It's like flicking a switch. Oh that's right it was guy who was relieving here last night at the branch. And effectively, flick the switch, walk out the door. I liked the concept, and it was given to me under the peer support training program and one of the psychologists spoke of how he copes with leaving all of that stuff that he's just absorbed all day. And even on call, when I jump in the truck, I flick the switch and that's my time, I'm off to do what I want to do or head home, catch up to the girls and do whatever you know so I've always been able to just flick a switch. Probably in the first five or seven years it was probably just gung-ho you know and didn't think about coping strategies. Alcohol was involved in it for my first probably 10 or so years as well, as it is with a lot of people in other things. But then as you get married, you settle down more, you're lifestyle changes and as you get older your life and different things change. But in general the coping strategies as a very generalisation, have probably stayed the same.'*

Coping strategies which were mentioned by a number of paramedics included social support, including communication, informal support, including informal debriefing and mentoring, Use of humour and other coping strategies such as exercise and binge drinking. Six of these are positive, with the seventh, binge drinking, a negative. The major coping strategies are discussed below:

7.3.1 Social support

The importance of social support and keeping in touch with family and friends has been well researched over the years (Fullerton, et al., 1992; Jonsson & Segesten, 2004). Regehr, Hill, Knott and Sault (2003) explored social support with fire fighters who had recently qualified and more experienced fire fighters. The authors hypothesised that new recruits would have significant less social support than experienced fire fighters. They used a number of quantitative measures and the cohort consisted of 65 newly recruited fire fighters and 58 experienced fire fighters. They found that experienced fire fighters had significantly less social support from family and their employers. This is significant as in the current study no experienced paramedic mentioned the importance of social support as a means of coping. It must also be noted that the most profound cases and experiences of PTSD were from experienced paramedics in this study. Lowery and Stokes (2005) surveyed 74 student paramedics from around Australia. In order to get an indication of the respondents' exposure to trauma, the authors requested that they use a specific coding system (Code 1 = high stress, life threatening, time critical cases, Code 2 = moderate stress, acute/non time critical cases and Code 3 = low stress, non urgent cases. Analysis of the data revealed that there were 3 predictors which increased the likelihood of PTSD symptoms by 30% in the student sample. These included experience with a Code 1

job, dysfunctional peer support and a negative attitude towards emotional expression. This is important as it indicates that positive peer and social support are important factors to reduce the paramedics' chances of developing PTSD, especially when exposed to especially traumatic jobs. Although paramedics are mixed as to whether socialising with or without their colleagues is better. There are many variables which determine the paramedics' ability to socialise.

An experienced paramedic spoke of his interest in socializing with a fellow paramedic:

> *I'm quite lucky where I work coz there's only three of us, two of us socialise all the time. And we go out and we party and we'll come down to Melbourne and we'll go play golf and everything like that. But it's, I think once you have people, especially in the bigger sense, like Melbourne is spread out. There's so many branches. There's so many staff.*

Another spoke of *not* socializing with fellow staff:

> *No I don't socialise with any ambulance friends. Family, my son, my step-family, occasionally ex ambulance friends either they've retired or they've changed occupation.*

One novice mentioned the difficulties with participating in organised sport:

> *But it is really difficult and people say, "Do you want to join our netball team?" And I am like, "Well I can," but because you do shiftwork and netball was Monday, you would be there one week and not the next week. You say, "Well I can, but I am only kind of part time".*

Another novice paramedic explained the impacts of his profession on his social life:

> *When I go home I socialise with my wife and my kids, really, that's it. I don't seem to have much of a network of friends anymore.*

Another novice highlighted the sacrifices she makes:

> *I rent a property up here with another girl from the branch, and I'm away from my family three to four days a week. So that's probably the biggest negative.*

Again there were no reports from the experienced cohort which specifically mentioned the importance of social support to enhance coping. This is important as

the research suggests that social support can be a predictor of PTSD symptoms, especially in emergency service occupations.

Communication was discussed as a form of social support by both novice and experiences paramedics in this study.

-Communication

Only two out of the nine novice cohort used communication as a coping strategy or tool. One stated:

> *I'm a talker…I always talk about the job on the way there most times, unless it's a routine sort of thing… I usually just make a phone call and I'm like 'uh I've just been to this'. And I find the more people I tell, the more I deal with it. I've had some experiences in the past where I haven't handled it. I come off a night shift and caught up with friends and socialised with a few drinks and it caught up with me, hit me like a tonne of bricks, so yeah… So I could debrief with team. Talk about other staff to them, in confidence and how to take them, personality wise…but a lot of people come into (regional town), not knowing anyone. I'm not sure if they'd be saying the same sort of things to the right people and might have trouble talking to their Uni friends from outside who can't really relate to how it works in (regional town). Cause I don't know if you realise but it all operates differently where you work and there's different cultures so yeah I think it's important to establish your sort of a young foundation…*
>
> *Yeah most definitely cause it's with your partner so you should know them quite well and pick up on the signs and know how far you need to debrief. Cause I have thought, there's a couple of people on the peer support team that I know of and I think if I was to ring them, I wouldn't get out of it what I need to get out of it.*

Another participant stated:

> *I'll talk to anyone who wants to know. I've done a couple of big jobs and it's good to sit and talk to people about that.*

Experienced paramedics felt similar about the importance of communication. One mentioned that over time he has learned that increasing his communication has helped him cope:

> *I think that the big thing that I have noticed is the talking. My ex-wife said that I never used to talk to her. My current wife says that I never talk to her but she realises that there's some things that I just have to nut out and when I'm willing to talk, I'm more than happy to talk.*

Another paramedic discussed how comfortable he feels talking to his colleagues at work:

> *But work is good as a far as talking work or like you've had a good day with someone or a bad day with someone, there's a few people at work that are really good.*

This paramedic went on to discuss the difficulties with the communication between paramedics on the road and in the control room:

> *'Like a lot of the guys in the control room are really good but there's a couple in there that and it seems like they're not on the road, they've gone to light duties and they stick them in the control room and they just can't cope.'*

The communication between case study examples, George and Maria, was evident throughout the interview. They were both very open about what George had gone through and the impact his chosen career has had on his life, past relationship and current relationship.

7.3.2 Informal support

Support from colleagues was discussed at length by many participants. This included both informal catch ups in the van after each job, to informal discussions around the branch about protocol, past experiences and impacts of certain jobs on individuals. This informal way of debriefing seemed to be helpful to many of the sample. Positive and negative views were expressed about talking to a spouse with experience in a similar field.

-Informal debriefing

Debriefing was discussed at length by numerous novice and experienced paramedics. It must be noted that both formal and informal debriefing exists within the ambulance culture. Formal debriefing is led by the organisation and informal is led by the paramedics themselves. This debriefing can occur with a work partner, colleagues within the branch or other branches or their partner at home. This informal debriefing involves discussing aspects of a job, the processes followed as well as the

impact on the person. It is dependent on a number of variables, including personality types, past experiences and time on the job.

A majority of the novice paramedics, despite being in their first year, had something to say about the real impact of the work on them. One particular novice learned the hard way about the value of debriefing:

> *Yeah but it can get a bit much like when you sit in front of the telly and you're in tears when a medical show is on, you're surrounded by...so that yeah...we had a footy trip the next day and came off a night shift and we didn't debrief (formally or informally) this particular job and I went straight, no sleep on to this bus trip and started drinking. And then at some point during the day because I hadn't talked about it, ended up in tears and couldn't explain why. Had to leave the trip and then it was all a bit weird cause I didn't want to show my face and show everyone what I was doing… My girlfriend normally knows that. She'll be like 'what's wrong?' if I'm not saying much…So just over talking, basically.*

This relatively inexperienced paramedic learnt a very valuable lesson early in his career. Similar to the respondents in Fullerton et al.'s 1992 study this paramedic learnt that in order to handle a traumatic experience it is necessary to have someone to share the worries with and talk to about his feelings. This same novice also discussed the difficulties with being 'nice' all day at work and then coming home and not feeling like talking much:

> *And I've found out as well, working in this that you talk and you're friendly to people all day. When you get home you just don't feel like being friendly and nice. Which isn't fair…Like my first six or seven months I was really focused on work. I went on holidays and that's when we moved into the house and that's when some of the enthusiasm came off work, cause I have a lot going on outside work as well…so*

Another novice discussed what she struggled most with:

> *Oh I guess probably every paramedic will say kids. Children are the hardest. And you know, you always get that, you know, terrible feeling in the pit of your stomach when you get, you know, severe, you know, severe respiratory distress, blah, blah, blah, blah, three years old. Three year old and you're sitting I, and you're going through okay, three year old, should be there, so you know, if it's asthma, and you know, how much adrenalin will I be giving him… I have a good friend who committed suicide…*

Again a significant number of participants in the Regehr et al. (2002) study, claimed that violence against children, with reference to child abuse or neglect, were

the cases that respondents were able to recall a great amount of detail with regard to specific cases. Other stressors, not related to the actual work were also mentioned.

Two further novice paramedics discussed their own personal experiences. This participant discussed the benefit of having a life partner who is a nurse:

> *She's a nurse as well so she can understand where I'm coming from…. we just share our war stories, from how many jobs did you have to day to what happened and same with her and then we'll have tea and after that it's all about outside of work stuff…. to talk about it, just to get it out of the way, like I've never come home and said gees I'm sick of talking about work. But if I wanted to not talk about work she'd definitely understand so…*

A further novice paramedic discussed avoiding talking about work to her partner:

> *I think sometimes I say I just don't want to talk about work, talk about any topic but work. I don't think he really notices, I don't think he really cares…. I've got a counsellor as well that I talk to.*

Five of the 12 experienced paramedics discussed their views on debriefing. With a mix of those who were not happy to discuss their work with their partner, "I haven't told my wife about this." And others who were happy to discuss work at home:

> *Well I vent with my wife and, so she knows the ins and outs and everything of people but that's just the, that's part of the lifestyle and I know that she doesn't go around talking about things but you have to vent to someone…*

Some spoke of debriefing with colleagues and the importance of this, "but it's almost a bit of a de-briefing, we actually will do a quick de-brief." Another discussed going into more detail about both the psychological impacts as well as the procedural:

> *Because you spend a lot of time with these people so you tend to de-brief with each other just informally you know, "Look that job really sucked", and "You know how about we do this better next time", "Oh all right", so peer support's there and I've used that a couple of times and that's terrific.*

Another experienced paramedic stated he discusses things with both colleagues and his spouse:

> *You usually debrief about what you really found difficult during a job, and that could be either/or, or it could be both, depends what's going on. So therefore you just talk to them basically ...I usually talk about things with her, (partner).*

He went on to discuss the importance of debriefing prior to going home after a shift:

> *But if it's a demanding day that's been stressful from a psychological perspective, I will usually make sure I don't leave work until I've spoken through the situation with someone. Because there's no point, no one understands the job better than the person that's with you.*
>
> *The thing that I talk about things and not to try and accept them as being normal or the things that I had to learn was the debriefing because I had a situation where we've had a guy fall off Uluru probably about 150 metres straight down. Yeah, so basically I had a posttraumatic stress syndrome sort of thing that probably could have been prevented if I'd spoken about it, even though I didn't feel like speaking about it, or I didn't feel the need to speak about it at the time.*
>
> *Yeah, so I thought I did what I did. But then what I learned was don't try and fight the images, don't fight the flashbacks, don't fight the nightmares, just try and accept them and they'll eventually go. The more you fight them the more they'll stay there, and I did that, and by talking about it they were gone within a day or so. But it was just learning how to cope, and I wasn't a paramedic at that stage, I was just a volunteer.*

A further experienced paramedic discussed the lack of opportunity to debrief with colleagues after a difficult incident:

> *...they had to rush him up to theatre because he had started to bleed fairly dramatically and that incident left me feeling really guilty and there was not debrief and I didn't talk to anyone because I felt guilty about it and there was no sort of review*

An important topic brought up voluntarily by 2 participants was the impact of having someone to look up to, to turn to or to check in with.

-Mentoring

Only two novice paramedics mentioned the need for mentoring to be introduced for new members. These novices were lucky enough to have someone who mentored them throughout their early training to help give them advice and support when they needed it:

> *I just call him at least every couple of weeks… he's always interested to see how I'm going. Cause I suppose he's seen me in my initial stages… And I know if I ever had any issues I could run it by him in confidence, cause I know the way he would tackle things, would be the way I would want to tackle things so… So I think umm a mentoring sort of system would be good. Like for me, I've been a year out now so students starting out again in December/January this year, I think it would be a good idea to sort of regroup, after three months. Like if I, sort of as an example, had a group session where I talked about those sorts of things, either in a group or one. I*

think it would be less intimidating cause I've been through the ropes and know that you're not going to get ridiculed for saying this or…

A further novice paramedic stated:

Yeah an informal work related mentor but we've become pretty good friends as well and he's just had a kid so I was able to teach him kid stuff and he could teach me.

One experienced paramedic agreed:

There should be more mentoring than actual CI'ing[12]That's a differentiation in word, but mentoring is what I got. I was lucky enough in the job and that makes a difference I think to whether you'll stay. Historically people in ambulance will do five to eight years and if they stay over about eight years, they'll do 30 to 40 years' service. If they don't, if something gets in their way in or around about that five to eight year category, they'll leave because there's nothing to hold them.

I was buddied up with him for two years. I believe I learnt an awful lot from him, you know simple strategies you put in place. It was basically every job, it was what went well, what could go better and I know now that they're probably questions out of post-interview counselling and interest that you hear of later on, but he was telling me strategies.

The novice paramedics discussed their own experiences with mentors in a very positive light. This is an indication that this could possibly assist more students or novice paramedics in the early years of their work. Given the findings from experienced paramedics, and their lack of reported social support as a means of coping, the author believes this could benefit both parties. The experienced paramedic also provided insight into his positive experience with a mentor for a two year period and how he learnt his own coping strategies from this person.

7.3.3 Use of Humour

Kuiper, Martin, and Olinger (1993) suggested that humour was an important coping strategy. However, the authors stated that humour can have impacts on both the initial appraisal of the situation, as well as the perception of a person's ability to cope.

[12] Clinical Instructor

Individuals who use humour seemed to view situations as less stressful and less personally relevant than individuals who did not use humour as a strategy to cope. Also individuals with a sense of humour in a difficult or challenging situation seemed to see the situation more of a positive challenge, rather than a stressful encounter.

Three of the nine novices talked about the use of humour, "and we will go to the cafe and have a joke or something, have a laugh at other people's expense". The second novice stated, "And it's very, it's very black in its way that it's done. You talk about ambos having a very black sense of humour; it's very much done that." Another, talked about helping an elderly person who had fallen over as a regular job they attend, "you probably do three or four nanna downs a day." This humorous play on words and use of jargon, according to Harrison and Kinner (1998) is an example of how quickly these novices have learnt to attempt to release tension and alleviate stress.

Only three of the 12 experienced paramedics discussed the use of humour as a coping strategy:

> *See when my little brother suicided and black humour helped us through jobs...And the next suicide that you go through, all of a sudden you look at it very, very differently. You now know that hang on a minute, this has affected a whole raft of people and you look at it very, very differently. Yeah it does, it changes things and I had another suicide a week or two shortly after that and a bloke was sitting with a bottle in his motor car with his exhaust gases and half a bottle of bourbon and shit, that was just like my brother, sitting there listening to the football.*

A further experienced paramedic stated:

> *And there is a dark humour, like my first dead lady was lying on her face you don't mind hearing this do you? And yeah you're thinking danger response and I sort of went to see if respond, I just moved her hair back and she was, her face was purple because she was already well and truly dead, she'd been dead for a while. The guy I work with on that job, we still kind of refer to the purple lady and it's a joke, like it's. And anyone else would just be horrified that we're laughing at the purple lady but, and I still joke about like the last dead person I went to, we were trying to work out who he was so you know like he was on the ground, I was straddled over him in his pockets trying to find his wallet or something to say who he was and you think this is*

wrong, like here's me raiding a dead guy's pants looking for his wallet, this doesn't seem right, but.

And yet another stated:

Sometimes making a joke about something is just ...Seems like the right thing to do. I mean, it does release stress but it's completely wrong. It's not, to the outsider it's completely inappropriate, but to us it's, well, the old black humour. I don't know what it is, but it's just, it takes the seriousness off the situation, especially if you're feeling miserable. It's just one of those weird things that we use to cope, I suppose. But, yeah, it's not necessarily appropriate for the layperson but completely appropriate to...

Joking about topics such as death in the 'normal' word is unheard of but to these emergency service personnel it is a way to release stress and tension and importantly it is an acceptable means of coping to the majority. As Overholser (1992) indicated, using humour in stressful situations can help to decrease loneliness, can reduce depression and increase self-esteem. However, the author also noted, that these outcomes were short term, and that perhaps humour is more of a tool one can use to distract oneself from the situation at the time, rather than a useful long term coping strategy.

7.3.4 Other coping strategies

-Exercise

Surprisingly no experienced paramedics apart from the case study example (George and Maria) when talking about their current lifestyle, explored exercise further with the interviewer. However three novice paramedics spoke about the difficulties with trying to keep fit while working around shiftwork as well as what is being done to address this issue in individual branches.

One discussed other life priorities getting in the way:

Hardly, minimal. We have or (ours on) has swimming lessons once a week so I go for a swim then. We walk a bit but it's mainly to get coffee and cake so it negates the walking. Nothing else much really.

Another focused on organisational as well as individual colleagues' responses to attempting to keeping fit:

> *In saying that the branch has now got a treadmill, we've been given approval to use during work hours. So I'll definitely be making use of that, and one of the guys set up his own gym in the station and said anyone can use it sort of thing and management seemed fine with that. In saying that I know there was a question in their induction why all branches don't have some sort of...Yeah, and their sort of answer is it's an OH&S issue, if you're not trained in it which I don't really see as a sort of adequate reason.*

The only participant to mention exercise as a coping strategy or stress release was a novice paramedic:

> *I can actually make more of an effort in going to the gym before or after work, and actually have a little bit more 'me' time. So that's a big part of my life, and I'm trying to maintain that sort of fitness. It's sort of my way of dealing with stress and all that sort of stuff. If I don't do exercise, I find that I'm starting to go a bit stir crazy. And it's always been a social outlet for me as well.*

An experienced paramedic did mention the limits of findings time to exercise due to work:

> *So I sit there and I use that as my de-stresser. So if I go do a job at two o'clock in the morning and I need to do something to de-stress, I sit there and play World War Craft for a couple of hours and then I'm right to go to sleep. but exercise wise, I find it hard when I'm on shift, because we do a day shift and then we're on call, can't exercise when I'm on call because I got to take my ambulance everywhere. So, and they've brought out this silly rule that I had to be in the ambulance ready to go within five minutes. So I can't go to the pool and do laps or I can't even take a push bike down to the local running track and just ride laps, because I've got to be back there. I can't even leave the ambulance at home and go for a ride on the push bike, which I enjoy doing, just in case I have an accident myself and then it's explain "Well why you were there?*

These quotes highlight the difficulties faced by paramedics in not only finding the time to exercise but also the logistics involved in factoring exercise in while completing shiftwork for example. Dobson, Choi, Schnall, Wigger, Garcia-Rivas, Israel & Baker (2013) explored occupational and health causes of fire fighter obesity. The authors used focus group to explore a number of determinants and found that exercise patterns are not only a product of the individuals' choice but also influenced by the working environment including the culture of the fire station. The study highlighted 5 main themes, including (1) fire station eating culture; (2) night calls and sleep interruption; (3) supervisor leadership and physical fitness;

(4) sedentary work and (5) age and generational influences. These factors when combined with individual, cultural and occupational variables can lead to causes of obesity in this population.

-Binge drinking

Binge drinking is, obviously, a more dysfunctional way to cope. Only a small number of the 21 participants in total were comfortable enough to discuss drinking as a coping strategy. Two novice paramedics admitted to having a drink. "Usually, you know, when I do drink I usually like a fair size sip though so." Another novice stated:

> *Yet now cause of the shiftwork, coz I'm not drinking with them every weekend, might be every second or third week, but it's definitely. I don't know how many drinks I drink but I don't know if I'm going harder cause I need to make up for it… Yeah it would be a lot. I'll be honest, most of the times when I drink with my friends, you drink to get drunk. That's what this is about I suppose, being honest… So yeah that was a big experience for me to learn to talk straight away (laughs)*

Again this corresponds with findings by Robinson's longitudinal study (Robinson, 2002) where 91% of respondents reported that they drank up to 6 standard drinks in one sitting – which meets the definition for binge drinking.

One experienced paramedic was open and stated:

> *We discuss work way too much. And alcohol's a wonderful thing sometimes. We work to the point that we know when, and because we don't work with each other all the time but we work with each other enough that he can tell I think when things are starting to stress me out and I can tell when things are stressing him out. So we'll turn around and say "How about we go down the pub" or whatever and we have a few quiet drinks and I, when I first moved to (town), a few quiet drinks was 13 pots in an hour.*

An experienced female paramedic was quite open about her dysfunctional coping behaviours:

> *(Smoking and drinking) Yeah I do those two to excess yeah, yeah. That's would be the negative part and I don't know if that with this job but it's, yeah that's not good…too much grog. Not so much during the day it's at night I sit there with wine, you know I have, I would drink every night yeah.*

> *Yep or on my own, I'm happy, I'm happy to drink on my own too yep. It's almost a habit you know, I get home and I start cooking tea and I then get a glass of wine and you know I just fiddle around and you know I might sit on one glass for an hour but that's just what I do yeah.*

Although only a small number of participants in this study admitted to drinking, all were asked directly about their drinking habits. For some participants' it seemed a taboo topic, something they didn't seem comfortable to elaborate on. For example a standard response was 'I only drink every now and then.' Other researchers (Bennett et al., 2005; Regehr et al., 2002) have also highlighted that paramedics use increased alcohol consumption as a way to help deal with a traumatic event, when compared to members of the general public.

There are many similarities and differences that people use to cope on an individual level. Personality characteristics, past experiences, family influences and supports in place, all influence how we manage stress. Moving from the individual level of coping, it is important to examine the participants' understandings and impressions of the formal structures that the ambulance service has put in place to look after its members. The members perceptions of these services and their ownership over these services can impact the perspective they have on them and how, why and if they use them.

7.4 Organisational support

As previously noted, the organisation's responses to the needs of employees are paramount to a healthy workplace (Pohlman, 1999; 2000; Vanderpol, Gist, Braverman, & Labardee, 2006). Studies indicate that although a majority of ambulance personnel stated that they had good support from colleagues (Jonsson, et al., 2003), less than 50% stated they felt they could talk with their supervisor or manager. This finding is significant and is supported by the current study.

Paramedics in the current study had a lot to say about the current peer support program in place and the limits to their confidentiality (*peer support and*

confidentiality). Support from management, including sub-themes of *paramedic safety, lack of resources, pressure of extra work* and the *internal culture and politics* were discussed. The difference between working in *rural versus metropolitan* areas was discussed as well as *Shiftwork.* Also discussed was the *support needed.* Organisational support in terms of the recent Enterprise Bargaining Agreement (EBA), working conditions, worker safety, equipment support and replacement were also discussed more generally.

Organisations worldwide have some things in place to assist and support employees, such as peer support services. The use of these services have been researched in the past (Gallagher & McGilloway, 2008) and many findings of similar support services have been found to be inadequate. Results from the 2005-2006 Metropolitan Ambulance Service Annual report statistics also support this view (refer Table 3).

As discussed earlier in Chapter 3, the ambulance service in Victoria has many services in place to support its members and their families. They have the Peer support service, a crisis line which operates 24 hours as well as access to range of professional psychologists. There are also a number of other educational initiatives which have been developed to educate members on the importance of their psychological well-being.

One paramedic in the current study discussed organisational responses to help workers cope:

> *I think the new DVD that they have put out coping with stress, have you seen that one at all? It's good and it's relevant and it tells the story that I went through, which I didn't realise ambos went through it. You know, suddenly you can't do the job after 15 years. They sent them personally to each ambo and people that I know on the job and worked with in Melbourne and are now managers and things, talking on the and they are talking of their own experiences and good on them too.*

To hear an ambulance paramedic discuss positive support from the organisation is optimistic. Not only have Ambulance Victoria developed educational DVD's and sent them to paramedics, the most important thing is that this paramedic has obviously taken the time to sit down and watch it. A majority of other comments on organisational support, unfortunately, were negative. This is not surprising, as Gallagher and McGilloway (2008) had similar results regarding a lack of support from management.

7.4.1 Peer support and confidentiality

Peer support provided by the organisation was a major sub-theme of organisational support. A vast majority of the student paramedics were aware of peer support, but had mixed opinions about it. Similar to findings by Gallagher and McGilloway (2008), the major concern was the subject of confidentiality. It seems there are some beliefs within the service that peer support is not the best place to discuss your inner most thoughts and feelings. Other thoughts were that the rural sector did not receive the attention from peer support similar to that of their metropolitan counterparts:

> *Because you know the guy just said, "Be careful who you talk to in peer support because a lot of them are the ones who will gossip and tell everyone." And he said, "If you are going to speak to someone, just come and ask me and just say look, I need to speak to someone," and he said, "I will tell you who...". I know, my understanding in Melbourne is the peer support down there or whatever it is called, is a little bit more proactive in that sometimes they are there the next day after a job or even that afternoon, "Oh g'day, how did you do the job?" "Oh I did. "Oh, how do you feel about that?" "Oh yeah, blah, blah, blah." Whereas in RAV you here guys saying, "I went to a triple fatality and never had a phone call about it." Or you know, "This, this and this and yeah I got a phone call and it was three weeks later and I have already gone through that whole dealing with it myself." And so I think the notification process is RAV is obviously not as good in Melbourne because my understanding is that you get phone calls and you get visits and in that, what is it, a hot debrief kind of thing I think they call it. Whereas in RAV it doesn't seem to happen. I know there is a button on the back, it is automatic peer support referral, you know when you are doing your paperwork, I think there is a button. Yeah and then you talk about it and that is it kind of thing. Whereas you know, peer support, you know the tissue brigade. Like I am not going to talk to the tissue brigade. And it*

is like, well you know – yeah I like the idea of, but I don't know how you would do it though, but there is certain people who would be really good at it and you just say, "Look it is your job, go and look after, you know, check in with those people and say..."

Similarly, two other novice paramedics stated:

So I'm actually thinking about peer support as well. But in a community of paramedics which probably numbers in about 120 odd, pretty small, and while peer support paramedics, you know, I understand, then there is confidentiality and that sort of thing, they are still part of the process, still part of the whole, and I just, I'm not too sure whether I feel comfortable approaching (a colleague). And I actually had a bad experience with it.

And so I sort of put in the peer support stuff on the back of this thing and everything else and everyone else that I was working with were quite senior and experienced and when I was at the hospital I said, "Look, I am going to push the button for peers support and so everyone is going to get a phone call, but I'm doing it for the (company) people... ... and they were like, oh yeah, yeah, yeah. They were alright, no dramas or whatever." And so it still took them weeks, I didn't get a phone call for two weeks….And you know, it was really funny because the guy called me and while I was driving, I wasn't driving, I was a passenger on a job and the phone rings and I answered it. It was, I'm not even sure what it was. It was a peer support person, but I didn't know who they were. I think they were from further out west like Warrnambool or something and they obviously got the call to give us a call and I said it wasn't for us it was just for the Shell, sorry the Ford workers. "Oh yeah, yeah no problems yeah, I will have a talk to them." And they got their own people to make themselves available," and he said, "Oh sorry it's taken so long to call," and I said, "Yeah no worries." And I was just on my way, you could hear the sirens and he said, "Oh yeah, you're on your way to another job, no worries I will see you, bye," and so that was it.

Another novice didn't agree with the process peer support follow, but had heard that confidentiality is not an issue:

I don't like that personally, I've been cold called a couple of times and I don't like it….. And I didn't want to talk to someone from my area…. And I'm sure it would never work without the confidentiality and the people who do it would swear black and blue that they'd be confidential and I believe them and I haven't heard of anyone breaking confidence but I just don't want to risk it.

A further novice paramedic had an idea that all paramedics should be trained in peer support:

So you can imagine if everyone had the skills of peer support it would work two ways, one they would be able to support others, but also they would be able to identify when they were in need of it themselves. If you build a culture of that which would be very difficult anyway...I know that there's peer support. I know peer support is made up mostly of paramedics who are trained in that sort of stuff. They can contact us and ask how we're going - you can let them know that someone might need it or we can contact them whenever we want. Sort of fairly informal, there's which is independent

psychologists and counsellors. So I actually spoke with – well I had to and stuff like that, and I found both to be fairly adequate in what they are but there is a sort of like with job types that you can't necessarily have that trigger. People might not seek it out. As I said I think it would be a good idea if everyone was a peer support officer and there was just a breakdown of that culture, you know what I mean, like not that there is one but maybe there's a there with peer support, maybe people don't think they're cut out for it or it's only for certain people or it's there but I don't need it or whatever. If everyone had the skills of peer support...I don't know if it's relevant, but when I used counselling I found that to be really good and the follow-up peer support – I got a phone call yesterday from peer support, you know this is two months into when they first sort of – like this guy calls me up all the time.

Confidentiality plays a major role when we decide whom to trust. Some paramedics had a little to say on this topic. One novice paramedic stated:

Well there's a couple of people, you know I just wouldn't feel comfortable talking to them. I just think, they wouldn't understand where I was coming from to be honest yeah. So talking to someone from my station, we can just relate a bit more than these people would.

Only one experienced paramedic discussed this and agreed. "Yeah I would perhaps discretely make some enquiries so as I know who I was going to talk to and if it was somebody that I didn't respect, I just wouldn't follow it up." This information is vital for the current peer support program in place within this organisation.

7.4.2 Support from Management

Paramedics discussed a number of sub-themes related to the support they receive from management. These included the safety of the paramedic, lack of resources, the pressure of completing extra work and the impact of this and the culture and politics they deal with on a daily basis. These issues are important as they impact the way the paramedic not only feels about coming to work, but also what a paramedic feels they can and cannot do as well as how safe they feel to speak up.

-Paramedic safety

Similar to the experience of novice paramedics, worker health and safety was a concern for experienced paramedics. This paramedic was quite passionate:

The, primarily health and safety, primarily that management fails to provide a health and safety work place as it's required. ...Misuse of power. Misuse of authority at all levels. Victimising people, humiliating people, harassing people, bullying, lies… if you take a stand you're targeted. You're identified, you stand out. There's many, many, many injuries, lifting stretchers, we've got to lift stretchers, many injuries. It puts people out of, cripples some paramedics and puts them out of the job. That's not the worst thing. The worst thing is that we kill people. Three paramedics have been killed in the last ten years through motor accidents, not to mention paramedics that kill themselves, or are killing themselves, or are killing themselves through substance abuse and alcoholism and things like that. The unrecognised…

Overtime and fatigue and shiftwork. The people that are slowly being killed… I have a reputation. I take them on. They can't handle my shit and they're trying to control me. So…They've got crap management too in the fire and police, but it's because of the strong medical link and the need to develop and research and progress our practices that we need to be linked to health. I can appreciate that. Managers feather their own nest. They look after themselves. No. There's no safety culture in this organisation. I want to make it safer so we don't have as many injuries. We've got a moral obligation to make sure that people don't get injured, just like those bullshit commercials on television from Work Safe, which are just bullshit cause it's not like that in the real world, so just a bunch of fucking assholes. Weak as water. And it would save them money.... injuries they'd save money, wouldn't pay…

I can remember doing lots of horrible jobs and you'd just go on to the next, okay, clear from that one there, you've just taken a dead baby to the hospital, to the morgue. We used to do that. "And you're clear now. Okay. Can you go on to this case please?" And probably, you know, we do a lot of our management today, I think half of them are probably traumatised as well.

Another was even more direct. "Yeah I don't think it's morale down against each other as much, it's just against the service, the service doesn't support us on the road." Another experienced paramedic was quite disgruntled at the organisation:

But the actual organisation I work for have let everyone down to, you know, massively, and they've done nothing to instil any confidence that they will look after us in any regard whatsoever, so therefore I feel for the sake of protecting my financial viability to family and, that I need to look at other avenues to earn money, so at least if I have a degree, then maybe I could look at doing a diploma of education or maybe another form of study altogether, but at least having some academic qualification might lead me down another path, that could perhaps lead to other fields of employment.

Really I think the only thing, I think the thing that would most probably make the job less stressful and easier would be for starters acknowledgement from at least our management about what we do and how we do it. And not in dollar terms, but in resourcing. You know, appropriate resourcing would make a big difference. I think that would make all the difference really. But almost every paramedic I could think of, I think on top of that I think the other thing that would make the job a lot less stressful is just to get rid of the stupid dual tiered system. I think it adds unnecessarily stresses in the job as well, from the point of view that you know, if you go to a job and you think they need X, and that X is you know, 30 minutes away, you know, they're going to die because you can't do it. You know, that's a stress you

> *could do without, knowing that within ambulance practice it does occur, but yet they won't allow me to do it. I just think that's, once again, not fair. Not fair to the patient and not fair to the practitioner either. They're the two things I could think of most of all. Yeah. So it's not all about the dollars, it's about, just, you know, doing the job properly.*

Experienced paramedics discussed direct threats to their safety. One experienced paramedic discussed his own specific experience.

> *When it comes to paramedic health and safety, because I've been bashed, I've got a damaged back from lifting, because of all those things I've lived, I don't want to see other paramedics go through it.*

Another discussed the processes involved to manage threats.

> *Yeah well when they got there they basically got a really bad reception and they got threatened and why did they take so long to get there and I don't know what threats were made exactly but we got told there were threats made and the police had to get involved and if we had to go back to that area for the next few days to take a police escort.*

> *And violence against paramedics is increasing. Yeah, yeah. We have the duress alarm, it is the little orange button and you hold that down for two seconds and then it cuts out the radio system for 50 seconds, but they are not to contact you, they are to send the police straight to the ambulance.*

Paramedic safety is very important, however, previous findings regarding the impact on paramedics has varied. It was an important aspect in Robinson's (2002) study, but in contrast Regehr et al. (2002), found that violence directed toward the paramedics themselves was not deemed as traumatic.

Alarmingly, another mentioned that in his opinion, physically witnessing a traumatic incident as the least stressful thing he has to contend with:

> *So it's not the job where you go and see someone with their arm hanging off and that's pretty nasty and it might give you a nightmare but you can talk to your mates about it, and within a couple of days you've forgotten about it, or it will stay with it, but it might give you a nightmare every now and then, but that sort of stuff you can talk about in debrief. But you can't talk about in debrief with anybody that can do anything about the whole resourcing issue and stuff, you know what I mean.*
> *I*

It is obvious from the paramedics in this study that they are under resourced in many areas. One would hope that employees should feel safe at work and given the nature of emergency service work, support from management should be a given to all employees. Resources such as staffing issues, equipment and meal breaks were discussed.

-Lack of resources

One participant felt strongly about the lack of resources in the service at the current time, and the impacts this is having on workers as well as members of the community:

> *There's been times where we've gone fatigued at half past four and someone's had a cardiac arrest at 6.30 in the morning and there's been, an ambulance has had to come from (a neighbouring town). Now, I'm not telling you anything that hasn't been on the radio...*

This particular issue has been extremely topical of late, especially in Melbourne, Victoria, Australia (see related news articles in Appendix 7). Another experienced paramedic discussed the day-to-day pressures as well as the bigger picture:

> *One of the problems with the ambulance service is that...the normal shift is stressing enough, you know, eight days long, 24/7, but they are so desperate to fill shifts, especially here in country towns that the money is really good for the overtime. They just dangle the golden carrot and the money's such that you just can't say no and (My partner) is one of these people who has two modes; stop or go. And he would get almost like this insane look in his eyes and he would be so wound up and he would have been working so much that he couldn't not work and he would just keep working.*
>
> *And not having to feel that you have got to fight, you know, we have got a 10 hour break now. But one of the triggers for me again finally, it when even the controller could hear that I was going off. Was I worked overnight, three hours, I did a great job on my own with this old dear who sort of carved herself up, you know in a fall. You get home and the clock starts ticking from as soon as you are home and cleared and then eight hours later, bang on the dot, the pager goes and I was having a go at the controller. He said, "How are you?" I said, "I need more fucking sleep!" "Don't be like that." I'm saying, I could have driven down there and punched him out.*

The debate about ambulance as a health service or an emergency service was also discussed:

> *They need to really put us under emergency services because then that way there's a bit more budget allowance. One of the most basic important life saving things and we still have to beg and plead to be part of the health budget and that's just ridiculous.*
>
> *That's the whole problem. That's the crux of the whole problem in the rural areas is that, because a lot of them grow up in the towns, a lot of them live in the town, they have kids in the town, they know that they have a certain responsibility, or they feel that they have a certain responsibility, to the community. Even if it's my mate down there on that corner, if he sees me parked up here with an ambulance and I'm on a*

fatigue break, people ring up and say, "Well, no, hang on. You're telling me there's no ambulance available. I can see the ambulance from here." People can be done for negligence and misconduct if the ...If they are found to be not rested properly when they're driving. So it is an issue for us, and we've been told that we're quite entitled to go fatigued whenever we like, but taking a fatigue break and actually...

Oh yeah, we talk about it all the time. We come up with ideas and rosters and everything, and we try and put statistics together to prove why we need more help and stuff and give examples and things, and if we were, yeah, you talk about it and you get quite positive about things, but you know that at the end of the day no one really gives a stuff, or no one can do anything about it.

I would start by giving paramedics an incentive by increasing their wages to something that was comparable to South Australia or Australian Capital Territory, because they've both been awarded professional rates. That would then allow, then it would probably make people feel a bit more appreciated therefore reduce the amount of stress on them, therefore reduce the amount of sick days taken, and at least hopefully making people want to be at work a bit more.

What I think is that if you start off with the professional rates let people feel like they didn't have to work so much to keep up, they don't have to accept overtime, then what you'd find is that the appreciation and the value that you get from the job is there financially, as well as psychologically. You'd get more family time because you're not feeling like you have to do as much overtime and stuff like that, but also I would also believe that people would go to it more if they felt ...

The absenteeism would be less. I think that's an issue. There needs to be that sort of on the professional level, acknowledgement of the work we do. We know that the community thinks we're pretty good.

Make sure you've got a good mix of rural and metro people in the head office, and make sure that they don't forget that there is a Victoria outside of Melbourne.

An experienced paramedic discussed the working conditions in which he and other colleagues were forced to work under:

Yeah and we had a dorm that was split up with a partition, a pin board basically and a two people were sleeping and that it's just amazing that what's acceptable in ambulance compared with fire...

Equipment issues were also discussed and the lack of up to date equipment at hand. Leading to more undue stress, specifically for paramedics in the rural area:

And like for instance we had a cardiac monitor that broke and we had a spare one so we used that, but our other car was going to be used by another crew in a couple of days' time. So we contacted our group manager and stuff to get a replacement, they turn around and said oh I think there's only one replacement for rural Victoria. Yeah and we'll try tracking one down but we don't know what we're going to do sort of thing. And I told my partner which was a metro paramedic based and she's like you're kidding me aren't you, she goes in Melbourne there's branches with spare stores in cupboards, there's going to be four or five monitors in there. It's just

amazing the sort of varies between the two areas even though we're an allied service and...

Experienced paramedics also had a lot to say with regard to the lack of support from the organisation as a whole:

I don't know, but you know, I have been saying for a long time that they have got to seriously look into it. And the other thing is with doctor shortages and so it has been partly pushed by paramedics for a long time, with them saying, "Oh we want more skills and we want to elevate our skills and we can do the doctors' job and we don't need a doctor anymore," and well guess what, it is getting to that point now where we are getting short of doctors everywhere and as a result of that, then you know more and more workload is being put on us and I couldn't tell you the last time that I am aware of that a doctor made a house call in this town. We need more support from management, you know. The job could be managed far better than it is and you know.

This lack of resources has a major impact on the service as a whole but also on each paramedic. Specifically paramedics who are working in rural areas where they are a part of a small team, and covering shifts and areas becomes challenging as soon as someone needs to take leave. Increasing the need for individuals to cover one another's shifts and increasing the pressure to do so, even at the risk of one's health.

-Pressure of extra work

Four of the nine novice paramedics in the current study mentioned the pressure to complete extra work. One novice, in particular, explained in detail the miscommunication evident from the call centre about when he is on leave:

They're keen to sort of get you to work overtime and you'll get a lot of calls. Like I'm on annual leave at the moment and I'm still getting calls at the start of my annual leave because people don't realise or you're on compassionate leave and people are sort of ringing up and it's just the communication between them.

He went on to say:

There's heaps of overtime, like people will be working and they're like doubling their wage even more just from overtime if they want it. Because the workload is probably less, they can do it. Because we earn so much money doing that, that's where the real money comes from, it's not money that you could be making its money that you're losing. Then a lot of people base their lifestyle on that amount as opposed to...

Highlighting the financial gain which some paramedics put before their physical, and psychological well-being. A further participant supported the experience of pressure from the organisation:

> *And I don't think the service would ever encourage anyone not to do over time, I don't, I know this is my first set of days off that I haven't been called to do over time in twelve months. I'm generally called on my first day off at 9:30am in the morning.*

Other comments included participants who put their own lives before accepting overtime:

> *Sometimes I will do a little bit of overtime and it will be bedtime and I haven't seen him (my son) for the whole day, which sucks. Otherwise, you know... Continuous overtime is just whenever it happens, which is fairly regularly. But actual overtime, overtime, I did my first one this week all year.*

Another participant stated 'I would never cancel anything to do overtime.'

The more experienced sample was more adamant that there needed to be a change to the current overtime system and the pressure they feel to complete extra shifts. One participant stated:

> *There should be some kind of restriction and I don't care how short staffed, because the amount of overtime that people are doing is phenomenal and it is just leading to burn out and it is leading to dissatisfaction.*

Another participant stated in detail his experience:

> *It is absolutely a mess the pressure for overtime. I remember when we were building this house and I was up on the rafters just helping our electrician to do some work and they rang me up and said, "We have got a job, can you help us out and come back on duty and help us out?" I am two weeks into my holidays and yesterday morning at about 20 past six I got a phone call..."Oh well we have got nobody else in the area, you are the only bloke in the area," blah, blah, blah and in the end I said, "Look, I have had six stubbies, do you really want me to go and do this job?" "Oh no, no you can't work if you have been drinking." And I found that as the answer to stop them pestering me, is to say, "Oh sorry, I have been drinking, do you really want me to drive the ambulance while I have been drinking?" That is sad, isn't it but that is the only thing I have got. I am going to get painted as an alcoholic next, because every day... "No, I am in Echuca, aren't you listening to what I am saying?" "Oh well if you have a pair of overalls you could still." "I am not driving from bloody Echuca to Ballarat to do a night shift, bugger you."*

The same participant went on to explain his lack of taking any leave entitlements in his long career:

> *I am currently owed seven and a half months annual leave and I haven't even started on my long service leave and I have got 49 weeks of long service leave and I have got 2,500 hours of sick leave and you know, if something was to happen to be, if I won Tattslotto I am taking my seven and a half months annual leave and I am going to take my long service leave...And certainly our figures here in (region of work) show that and workload is in overload. I had worked 18 consecutive days without a break and as a result of that, I had to be paid triple time for those last five days because...*

A further participant explained how dangerous it is to drive fatigued, but that the pressure from the dispatch centre is such that many paramedics take the risk:

> *Because they'd rather have a bum on the seat you know, we've been lucky since I've been in the job there's only been three ambos who have died on the job and I know of guys who have run off the road and done this and I know myself I've thought well, you know, I've just, I'll be right. I'm tired but I'm right. I'll do this one more job and then, you know, you've had a micro sleep and you think well okay it's time to, I'm out. Pull the pin and you ring up and say look I'm now fatigued and then the controllers make you feel guilty "Well you know that we don't have anyone around to replace you" and you go well too bad. You know. And originally I thought well you know, community deserves me to be around. I need to do it. But, no, wait a sec, I need to be around. I need to be around for my kids…*

He went on to highlight the fact that the community is being put at risk:

> *I'm sure if the community…was aware of the state of some of the ambulance paramedics, because they have done x number of overtime shifts or whatever, overtime hours, that their actual competence level is not…*

Another participant mentioned the noticeable difference between resting between shifts:

> *A couple of weeks ago I had four days off where I didn't do any overtime and I really noticed how good is this, compared to like when you're (exhausted).*

All of the issues mentioned within this theme so far have been highlighted by other researchers, such as Zimmerman's (2012) study and Dobson et al, (2012). The issues seem to steam from the organisational culture and how management 'manage' certain issues. Again if members of the organisation do not feel safe to speak their mind about issues concerning their safety, both physically and psychologically, this culture breeds very quickly and suddenly the entire workforce is at risk.

-Internal Culture/Politics

The internal culture within ambulance was discussed by a few of the participants in the current study. A few experienced paramedics had a lot to say about the culture of the organisation:

> *I'm sure you've heard the story about how they informed all the communication centres, the staff that work in them in the rural centres, they told them that they're going to become redundant via an email, it was just, you know, there was no, I mean that kind of, you know, being told you're going to lose your job via an email, I think lacks any kind of sense of concern or personalising… and then they wonder why, now, that like there's people getting counselling, they're so irate….so pretty much it's every man for himself and so with the loss, and that's what so now people won't do anything unless they know there's a dollar value attached to it.*

This particular paramedic went on to discuss what he termed 'a grandfather clause':

> *So we've got guys in the job that, you know, are basically, well that they don't have any advanced skills, they've just opted not to do that and yet they're still employed as paramedics and paid senior paramedical allowances and, now the thing with that is that it's not good for the, like that in itself is not good for the community because they can't reliably expect a certain level of care. And unfortunately you know, some of them are outright killers, like they're just, you know, people are dying in their care and yet the system. "They're so short staffed so people someone they know on, even if they're killing someone and I know that sounds an horrendous claim, it's not a secret.*

Topical and recent EBA issues were discussed by a student paramedic in relation to the impact they have on his family life:

> *But yeah I think when there's stuff going on at work, like you know, this EBA stuff, you know you get home and like everyone is angry and it's just like the morale at work is so poor. And you come home and you're angry and go you go, "Oh this is crap and this is crap," and it's hard on (my partner), because you know what, "I dealt with that at work yesterday, I don't want to hear it" you know? And it's like yeah, you try not to bring it home, but sometimes I think it's good and bad. You can bring it home and it's good that (my partner) is in the job as well now. Also it can be...too much.*

A further novice explained the real impact the EBA were having on him. The participant even stated considering leaving the job, despite a relatively short period of time actually working. He stated said:

> *And went through the whole sort of EBA issues, you've probably heard about. And I was actually thinking about leaving at that stage because everyone was just sort of really over it and...Yeah and I was just starting to think do I really want to be a paramedic sort of long term sort of thing. And I started questioning whether I wanted to deal with this sort of every you know, four years or whatever it is. I guess just what I mean is the whole issue around the EBA and everyone talking amongst themselves*

of you know, we're not valued by management, we're not valued by the government, you start to question why you're actually there doing it. And I guess you just have to take the personal thing, reasons that you want to be there rather than sort of external factors.

A further experienced paramedic went on to say:

I think that with the EBA that we might have been sold out there, but as far as resourcing and stuff's concerned, I think the buck's really got to stop with the minister and the health department, those higher up than the guys down here. But it's, I mean, I understand that everybody's got their jobs to do and the budget's the and everything, but you can't put a budget on an ambulance service. You can't put a price on people's lives and you can't put a price on people's lives, and if people want to be trained as MICA paramedics...

Astoundingly, he made a job comparison:

I could go and work in Woollies and get paid as a manager and get paid better per hour, or I could go and fix the car and get paid better than. You can jump start a car for RACV and get paid more than I do for jump starting someone's heart.

But I certainly enjoy the job, don't get me wrong, it's just that there are aspects of it that I find particularly frustrating and that's why I jumped at the chance to do this because I thought well if I could voice this to someone that might be able to ...But then, when you read the stories in the front page of the Herald Sun and then you also get told that there's no place for MICA paramedics in the bush, that's just stupidity and neglect on a grander scale.

Two novice paramedics also discussed an internal culture within the organisation:

You get told once you're qualified you can't ask questions and I find that surprising and I personally don't plan to stick with that, I think if you don't ask questions then how can you ever possibly learn and you don't know it all the day you qualify, that blows my mind.

Yeah so I think he's a bit tired and with the recent EBA and stuff like that there's a lot of jaded, unhappy people and it's tiring coming to work to hear union talk every time and I just walk away I don't want to hear it, I've heard it before all you're doing is whinging you're not actually doing anything constructive.

They've just gotten over installing female toilets in the branches, it's so backwards this organisation, I did not expect that I did not expect it to be so far behind the times. And it's not run like a business it's run like Uncle Mick's ambulance service, I didn't expect that.

A further stated:

There are some aspects of ambulance that you think this is just rubbish. Like the policies. They'll just, slowly, 11 months into it and I'm slowly being shown politics of the service which is quite interesting.

A few participants had a few ideas regarding the support needed within the service as it stands.

7.4.3 Rural versus Metropolitan working environments

The differences between metropolitan and rural workforces were evident throughout discussions with participants. Given the two services were 2 distinct organisations during data collection, there were often comparisons made regarding how busy branches were. Participants also discussed the resources made available to each service, in terms or equipment. However different they seem to be, the following paragraph indicates that similarities are evident within the two different working environments also:

> *Yeah and they're pushing their sort of KPI's and not worrying about the safety and like I had a partner of mine that was saying she was working in Melbourne and was going to a stabbing and the offenders still, the offenders in the same house as the patient, yeah right we're waiting for police. … Yeah absolutely and you very much feel like the only person that's going to look after you is you so you kind of just have to stand your ground a little bit. Like I recently ended up in the back of an ambulance with a guy who's you know, six foot something, 130 kilos, just got out of prison. And you know, we're sitting in the back of the car going and like wasn't talking either and obviously me going I don't like people if they don't talk to me. Yeah and because of that I wasn't wearing a seat belt, I wanted to be able to move if I had to but we were driving from [town] to Bendigo doing 100kms an hour and I was sitting there going do I wear a seat belt in case we get into a car accident or not wear it and he assaults me. And you kind of just have to weigh up which one you're going to go with and most paramedics will say don't wear the seat belt.*

There are numerous logistical concerns and differences between both services. For example time to get to jobs in the rural setting differs from times to get to inner city jobs. Therefore pressures to speed, (again increasing risk to the paramedics and patients) in order to meet response time target between the 2 areas is another point of difference. These issues are however unavoidable.

The merger between the rural ambulance service and the metropolitan ambulance service was a topic discussed at length:

> *They've created this huge business which is there for helping people, you know it's a service that we provide, it's not about making money and cutting money for training and you know things like that. So that's frustrating because I'd just like to see more ambulances. It's a takeover, everything's coming out of Melbourne and they don't necessarily understand what's happening in the country. They're unhappy campers. I've never seen morale so low or people so angry and frustrated, sick leave's exploded. Yeah it's just astounding yeah, people are jaded, they're suspicious, no*

faith in the powers that be, it's just extraordinary and now with the Melbourne stuff coming out it feels it's a persecution. We've had huge upheavals just in management; you know our latest manager's gone we don't know what's happened to him. He was told to go on leave or something or other so I don't know whether he's coming back. Yeah that report, the Health and Well-being report, did you see that? There was a, they came in and did this Health and Well-being report on the area and that really came out scathing of management. It's not a business, it's not about I don't think making money everything going to the wire so, you know recently we've been told they've got to cut twenty million dollars from the budget and training stopping and it, this is stopping and upward relieving stopping and you know there is no money for anything at all. But I don't, how can you get rid of training when…This, this is what we do. You know it's not our fault all that money went into the sub-prime market or whatever, you know it should be about making ambos better so we can help the public, providing more ambulances…So we can the budget cut in that control room, we've got pagers we get our messages sent on pagers it costs I don't know, 15 cents for argument sake per page to be sent they entered into a contract. We've been told in the control room we cannot test the pagers so I'd come on shift and I, you know I'd call on say pager six radio blah, blah, blah, blah, blah and our test base would come through, "Yep received it, all right to go". We've been told we cannot send test pagers because it costs money.

It's frightening, (Town name) on the weekends we don't have enough crews, commonly wait a Code One case which is lights and the sirens, will be waiting for over an hour… Because we don't have the resources. It's just the rostering, no funds for more cruisers. People have been from their shift down there that can't be filled today, that's one half of the issue they can't fill is because people go, "No I'm not doing it", which is fair enough. Yeah nasty, nasty the ambulance service is in a state of crisis.

Another factor which was discussed previously in 'jobs that affect or remain with participants' is the fact that in the rural settings, the chances of having to treat someone the paramedic knows is usually increased. Especially if the paramedic grew up in the area in which they now work. Participants discussed being called to a job and recognising a car or being told that the person they are treating is a neighbours relative. Again this is an issue, less likely to occur in the metropolitan area and would add more stress to workers within the regional environment.

7.4.4 Shiftwork

Shiftwork and its impacts have been well documented (Costa, 2003; Courtney, Francis, & Paxton, 2010). Shiftwork has been found to be manageable for some people, however, its impact on the family as well as the individual's physical and emotional well-being are usually seen to be negative.

The novice paramedics discussed the impact of shiftwork on them. Issues brought up included the impact on the individual's social life and exercising:

> *I try to (exercise) but with shiftwork …a big part of my social life was football but with shiftwork you can't do that anymore… so it has a lot of effects because it seems to be a lot more work to contact your mates.*

Another novice paramedic discussed the real life danger to adapting to shiftwork:

> *I've always been a fairly nocturnal person so I thought that I wouldn't have any issue with nightshift but I remember working my very first couple of nightshifts and they were fairly busy and I remember just being absolutely wrecked from that...We were driving around hallucinating things like that, like it was really really big sleep deprivation sort of stuff.*

Although this novice paramedic went on to say that as time went on, he did get used to nightshift and he actually preferred it. The initial days on nightshift, however, sound like they were very dangerous, for both worker and the community and other drivers on the road.

One paramedic highlighted the positives to doing shiftwork, compared to the average person:

> *I have got four days off now and I will work for five or four and then have four or five days off, so it is a good break and you can go away and I have just had five days off – what did I do? My boyfriend came down for a night and then we went to the Yarra Valley for three nights and I mean you can't do that if you work nine to five sort of thing, unless you are on holidays or it is a long weekend and everyone else is away.*

Another agreed:

> *Love shiftwork. I was talking to the wife about this the other week, sort of saying "I wonder what it'd be like to have a nine to five, Monday to Friday job, where your weekends are free?" I'm a bit of a stickler for trying to avoid routine.*

This participant went on to highlight other realities and difficulties of shiftwork:

> *You only half sleep and you can hear things that are going on and you look at the clock every half an hour and I don't think I will ever get good at sleeping during the day because that is the same type of thing as nursing.*

She then went on to highlight a further positive:

> *See we give away our secrets because on an ambulance night shift, there are beds and you are allowed to go to bed... You take off your overalls and if your pager goes off you just pull your overall straight on you and you are in the car within a minute and a half or something. So if is quiet at midnight or if you are tired, you know the set thing is midnight you are allowed to, but if it is 10 o'clock and you are buggered, you can go to bed.*

Another paramedic agreed with the difficulties of shiftwork and its negative impacts:

> *You can't sleep and then you're sort of getting sleep and come home, it's the afternoon or something, some noise or you know, neighbours are cutting down a tree or something, do you have to do it today like of all days. Got a little bit difficult, I know it affects your social life quite a bit.*

Another highlighted the quieter rural ambulance branches that may not be as busy as others 'Because of where I'm working, I don't have those insane night shifts where you don't get any sleep at all. So it means I'm able to handle it a bit more.'

Another again highlighted the positives:

> *You don't have weekends, but during the week you can go down and have coffee when there's no one else there, pay the bills et cetera, and there's no big issue. I can take my kids to school. There's perks about working shiftwork. It's being able to manage it and see those positives as opposed to the negatives.*

A third of the experienced paramedics discussed the impacts of shiftwork during the interviews. One stated "I prefer to work call than night shifts. I like sleeping in my own bed". Another stated "Night shifts are difficult; I get really tired after a night shift so I'll be quite groggy and I try not to be but that sort of comes through." A further ambulance paramedic stated "I resigned from Ambulance because I found that the night shift was taking too much of a toll."

Lifestyle factors have been explored with police officers in the United States (Baughman, Hartley, Burchfiel, & Violanti, 2012; Zimmerman, 2012). For example Zimmerman explored cardiovascular disease and other risk factors in law enforcement

personnel. Hypertension, Obesity, Diabetes and sedentary lifestyle factors were explored. Occupation risk factors such as shiftwork were also taken into account. It was concluded that although management and supervisors of these personnel must respond and assist in encouraging better lifestyle choices, the individuals also have to take responsibility for their own health.

7.4.5 Support needed

Novice paramedics had many ideas to help support them more. One discussed the need for the organisation to help assist workers with exercise. This includes making fitness easier to access:

> *I think, you know you always hear 'a healthy body is a healthy mind' I think they need to play the fitness card a bit harder. For sure. Umm and promote healthy eating. I don't know if they could tee up some sort of gym membership, I don't know through work or…You know get more people on board and that's another way you could socialise with people. Oh are you going to this gym class, let's do that together you know…*

If fitness was easier for the paramedics to access, it would lead to healthier employees overall. Employees would be less likely to call in sick, less likely to suffer cardiovascular disease (Zimmerman, 2012) and more likely to enjoy coming to work. This in turn could address the resource issues at hand.

This same novice participant discussed further the need for mental health to be a subject addressed within the paramedics training course:

> *Personality is definitely the biggest thing but umm I took a mental health subject here at Vic Uni but that wasn't a compulsory subject but I think it probably should be. Because I did take quite a lot from that because it talked a lot about stress and coping mechanisms and I thought it was really interesting… Yeah. It was pretty depressing though cause it didn't paint a pretty picture for shiftworkers (laughs). Oh we're going to die…young… (we)get the diabetes and bad eating habits but I suppose awareness is the best way to prevent.*

This insight is very mature for a student who has not been exposed to the job as a paramedic for very long. It highlights the need for students who are in training to

become paramedics (who are saving lives everyday), to be reminded of the importance of their own wellbeing, both physically and mentally.

Another novice had a few ideas with regard to the need for further support for students during their first years out. He then went on to mention the under-resourcing of the service in general:

> *The peer support, you know that's there in the background, but the people that you need support from is Clin Ed. When you're a new student that's what you need but there is no support and you don't feel like you are being supported. The only time you hear something from them is when something bad is happening, so no news is good news, but at the same time you don't feel that you have got any support and yeah and if you are having any hassles on the road and you approach them, they don't want to know about it. The biggest issue in talking about support is that we are under resourced, I think we are grossly underpaid and our management does not support us and our employer doesn't support us being the government and the management and this EBA thing has decimated the morale. Everyone whinges but they will stay in the job and not quit which I the ridiculous thing.*

The support being discussed could come from a number of sources. These sources could include colleagues who are more experienced, management or simply the re-training of clinical instructors to be mandated to check in with students at regular intervals to provide feedback to the students, both positive and negative.

Another novice stated the need for further organised training:

> *I would like to say more sort of your in-house training. Well that's, "Yeah, we'll do a scenario". I'm not talking about a scenario, I'm talking about once a year we are re-accredited to do our first aid et cetera.*

This chapter has provided a thorough description of the themes uncovered and developed from 21 participants working in rural branches throughout Victoria, Australia. The insight provided by these participants' has supported previous research (Robinson, 1993, 1997, 2002; Regehr, 2005) regarding the reality of the work paramedics do, the impact of the job on them and the coping strategies they use to manage the experiences they face on a regular basis. The findings are important to lead future study direction regarding what organisations in the emergency service field need to do in order to better support their valuable staff.

The paramedics within this study spoke freely about their feelings of satisfaction and dissatisfaction over a number of areas. As the interviews were open ended and led by the participants, many issues came up which the researcher had not considered prior to embarking on the research. The impacts of the four major themes will now be discussed in terms of the impact on the real world of ambulance as well as how they relate to previous research, the paramedic as an individual, and the organisation as a whole.

Chapter 8

Conclusion and Summary

The current research was designed to address research questions such as: What are the psychological and social coping strategies that ambulance paramedics use to help manage the demands of their job? What are the support services ambulance paramedics use to help manage the demands of their job? What are the obstacles faced by paramedics in the workforce? What coping mechanisms are utilized to manage the obstacles faced? Are there differences between novice paramedics compared with experienced paramedics with regard to the coping strategies and resources they use/access? What is clear from the results is that ambulance paramedics use many psychological and social coping strategies to help manage the demands of their job.

The knowledge gained from the current research will be used in a theoretical sense to: (1) Inform theory in relation to the well-being of emergency service personnel, specifically ambulance paramedics, (2) Contribute to literature on workplace practice, (3) Develop an understanding of paramedic work experiences and inform better ways of coping with the job, and finally (4) contribute to the knowledge of the clinical aspects of the ambulance paramedic's profession, specifically focusing on prevention and intervention modalities

All four of the above theoretical aims will, hopefully, be achieved by ensuring that universities are informed of the findings of the research. Feedback specifically relating to suggested changes to curricula, as well as support required during practical placements will be highlighted to universities with paramedic courses. Obvious changes suggested by the paramedics include the need and importance of mental health subjects to better equip students to deal with the trauma they are bound to be

exposed to. This includes both issues relating to the self-care of the paramedics themselves, as well as support and training around dealing with mental health patients. It is anticipated that the knowledge gained will be utilized by improving the overall training, expectations and ongoing support provided to newly trained paramedics, as well as paramedics already employed.

A further important finding is that universities and ambulance services could work more closely during the period of time when novice paramedics are completing placements. Some of the novices stated that there was often a discrepancy between the universities expectations and that of the clinical instructor they were assigned to. This, too, should be highlighted to both the ambulance service and the universities. The need for consistency between clinical instructors and the importance of feedback from the clinical instructor should also be highlighted.

A discussion regarding the more important aspects of the results will now be further explored and discussed. The main themes which emerged from the data were training and expectations, well-being issues, as well as coping strategies and organizational issues.

8.1 Training and Expectations

The reasons why paramedics chose to train as paramedics were not surprising. They were expecting a highly intense, adrenalin pumping career, but the reality, according to the novices in this study, was quite different. Although the participants were from rural areas, the nature of the work they reported completing on a day to day basis led to reports of boredom among newly trained paramedics. This is important as it indicates a vast difference among what the paramedics thought they would be doing on a regular basis, compared with completing more mundane tasks a majority of the

time. Student paramedics need to be better informed as to the real life jobs they are likely to attend (especially in rural and remote areas). This could be in the form of more placements in quieter branches where the paramedics are likely to be working, or simply more education awareness within their courses. It should also be noted however that the other aspect of their work may involve traumatic incidents where they may find themselves treating someone they know or recognise and how to deal with situations like these.

Findings from the current study indicate that participants who were mature aged, or who had experience within a medical setting, were better equipped and felt better prepared to face and cope with the demands of paramedic work, than their younger colleagues. This could indicate that the new university system is not resulting in better prepared paramedics within their first years on the job. Mature age entry into the courses could be an option, or as a few participants had already experienced, possibly recruiting paramedics from other fields, such as nursing may result in better prepared paramedics. This notion is supported by West (1977) who found that of the 98 institutions surveyed regarding special entry requirements for mature aged students, 14 reported that mature aged students performed better students straight out from school. Twelve of the educational institutions surveyed stated that mature aged students perform just as good as their younger counterparts.

Some novices were very happy with the university courses, but most stated that it was personally challenging, particularly with regard to time management. The courses within Victoria are very demanding and place a lot of pressure on students to complete tasks, assignments and placements. A lot of these assignments are due all in the same time period, when students are also expected to be studying for examinations while also completing placements. Some students are mature aged with families and

financial commitments such as mortgages. These participants found it extremely difficult to keep up with the demands of the course, as well as work enough to provide for their families by working part time or casually. Perhaps the universities could re-evaluate the need for so many assignments and instead change their focus to more practical tasks which students could fulfil in class time. This would minimise the time required outside of class hours and allow them to concentrate on placements, etc. Another recommendation could be encouraging students to get paid work within a trauma setting (such as a hospital) this could help better prepare them as well as assist them financially. In contrast, the experienced paramedics who completed on the job training through the Diploma of Ambulance and Paramedic Studies (DAPS) program, and who were paid during this training, did not mention any difficulties regarding being under prepared or under financial strain while training to become a qualified paramedic.

Such findings are important for ongoing feedback to the universities providing training to paramedics. This direct feedback from student participants should drive universities to modify courses to better prepare students for the real job ahead. This is important as, again, changes which are driven by the students themselves, albeit past students, can help future students feel better prepared for the job.

8.2 Well-being

No-one will be able to change the nature of the work paramedics undertake, or reduce the severity of the trauma emergency service workers see. The numerous impacts of the traumatic aspects of the work were discussed at length during the interviews of the current study – with the impacts on their families of major concern for current and future paramedics. Ways to manage these impacts could be

highlighted within their training, as well as support services made more readily available to paramedics and their families. In this way, both Universities training new paramedics, as well as the ambulance organisations themselves, would be responsible for the required changes. A further option is making the support available to them completely separate from the service itself. This would combat the confidentiality issue and allow employees to feel safer when discussing the issues they made have with line management.

The paramedics in this current study were asked about what support they need. Some suggestions include better education, training, and support. This support could be offered during their training through incorporating more placements, therefore, increasing their exposure to traumatic incidents as well as the support offered during and after a critical incident. This could also involve more experienced paramedics coming into the university setting and explaining some of the jobs he/she has attended in their career, allowing students to ask questions. The families of the students could be encouraged to attend also to ask questions around their concerns about their family members chosen career. Universities could adapt their courses to include required subjects to better equip paramedics for on the job challenges.

Possible changes to the current support offered by paramedic organisations include a buddy or mentor system as well as better resources within the service as a whole. Studies such as this should inform future ways to better support employees and their families. Organisations should take note of the paramedics' concerns and needs and respond appropriately by incorporating support services as requested by the paramedics themselves (i.e., buddy/mentor system).

In this unique case, universities and paramedic organisations could work more collaboratively to allow paramedic students, novices, newly qualified paramedics and their families to feel better supported.

8.3 Coping strategies

The coping strategies of paramedics within this study were, perhaps, the least surprising of the findings. As past literature has indicated, positive informal peer and social support are important factors to reduce a paramedic's chances of developing PTSD, especially when exposed to especially traumatic jobs (Lowery & Stokes, 2005). Mentoring, communicating and informal debriefing were found to be positive coping strategies in the current study, as reported by the participants.

The use of humour (particularly black humour) as a coping strategy was, again, not surprising (Kuiper, et al., 1993; Overholser, 1992). Three of the nine novices in the current study talked about the use of humour. One stated "we will go to the cafe and have a joke or something, have a laugh at other people's expense". The second novice stated, "And it's very, it's very black in its way that it's done. You talk about ambos having a very black sense of humour, it's very much done that." Another, talked about helping an elderly person who had fallen over as a regular job they attend, "you probably do three or four nanna downs a day." This coping strategy seems to be embedded within the culture of many emergency services and an expected way to cope on the scene as well as, apparently, light hearted means of debriefing.

Drinking alcohol as a dysfunctional way of coping has been discussed at length (Robinson, 1984). One participant stated "alcohol's a wonderful thing sometimes." Another admitted to drinking "to excess" and stated "I'm happy to drink

on my own too yep. It's almost a habit you know." Even novice paramedics in the current study admitted to drinking. One stated "Yeah it would be a lot. I'll be honest, most of the times when I drink with my friends, you drink to get drunk." Another stated "Usually, you know, when I do drink I usually like a fair size sip". Both drinking and the use of humour seem to be embedded within the culture of many emergency service organisations. How this can be tackled by the organisation remains to be seen.

Exercise has been found to improve mood and decrease depression (Fox, 1999). Exercise as a coping strategy was mentioned by a number of participants. In the current study, limitations to accessing exercise was discussed as a major issue. This has implications for individuals as not only does this impact their physical well-being, but their psychological well-being, also. Many participants mentioned the limits to their ability to participate in organised exercise programs. With shiftwork and pressure to complete over time mentioned as some limits. A few participants suggested possible ways to manage these limitations. Better resources provided at branches, more staff employed and therefore less pressure to complete overtime, were discussed as strategies to enhance the ability of paramedics to exercise. Some others mentioned changes to the type of shiftwork they complete. This has implications for the organisation as a result.

Participants were aware of other emergency service organisations whose branches are equipped with gymnasium equipment – although one participant highlighted the possible occupational health and safety reasons which may be given as an excuse as to why branches are not equipped with gyms. This participant stated that if other emergency services can get past this challenge, Ambulance Victoria should be able to also. After collecting the data, it has come to the researcher's attention that

Ambulance Victoria have in fact made attempts to equip branches with gymnasiums, however, due to OH&S issues, they had to be removed. Other suggestions included being subsidised for use of a local gym.

8.4 Organisational Issues

The results of this study and others (Alexander & Klein, 2001; Gallagher & McGilloway, 2008) indicate that ambulance organizations need to respond to a number of issues. Occupational Health and Safety (OH&S) programs are present in most organizations. Usually these programs include representatives from differing levels of employment who bring to the organizations attention any issues pertaining to the safety of their fellow employees. Employee assistance programs are also often offered to employees (and sometimes their families). These usually involve an external agency providing psychological and/or emotional support for employees, targeting both professional and personal issues. By using external providers, employers are able to have an arm's length approach, which is designed to maintain the feelings of confidentiality and objectivity of the services. Regardless of what is present within organizations, the support required must be driven from the employees themselves, in order to be successfully implemented. At present, AV has many systems in place to support its employees. Services such as the 24 hours crisis line and the peer support program have been available to employees for years. However, as the initiation of these supports was not originally driven by the employees themselves, they have not been as successful as they could be. As Payne (2001) highlighted, community involvement is necessary to improve local health status (Chilenski et al., 2007). Community involvement and participation are a requirement

to improve local health status and when this change comes from within the community, using within community resources and strengths, success is more likely.

In order for change to take place, change which is long-lasting, it is important to get the workers perspective on what should be done. The workers who are involved should be consulted at every step, to ensure they feel as though they have ownership of the changes and embrace them when they are put in place. This will also ensure that those involved act and respond to make further changes should their needs not be being met. Top down change is not helpful or worthwhile in the longer term. Workers do not respond well to this as it gives them no voice in the entire process.

Peer support may be good and worthwhile, but because the data collected by Robinson (1984) led to change initiated by the organisation, the peer support program has not been as successful as it may have been, had paramedics had some ownership of the change. In essence the paramedic community itself do not feel that it 'owns' the change or the current program. The initial contact numbers with workers are high, however, this is because the peer support team initiates most of the contact. Follow-up numbers indicate that workers themselves are not actually accessing all the services available to them (refer to Table 3). Therefore, the best thing to do is to speak directly to the paramedics and have them inform the researchers as to what they think they need to best support them in the field.

There is also a significant subjective element in the current peer support process. The peer support officer has a computer system which flags who has attended a 'tough job' in the past few days. This peer support officer then proceeds to cold call or drop by the branch of the affected person. However, this does not capture the experience of individuals who may have negative reactions to what may be deemed as more minor jobs or which may link to previous personal experiences. This was very

evident in examining current processes as well as during the placement experience of the researcher. An example of this was the novice paramedic who recounted the experience of his partner, also a paramedic who was pregnant and required to attend a SIDS job.

> *People are asking me about (my partner), because you know, she's sooky and she cries easily and you know, she's not cut out for this job. Because she went to a SIDS job when she was pregnant….You know and they said, "Oh she's just not handling it well and all that." It's like, "No, that's not the story. She went to a SIDS job, she was pregnant and it was really upsetting,"*

It is unlikely that this particular pregnant paramedic would have received a call from peer support regarding her own personal experience. She may have received a call checking in on how she felt regarding attending the SIDS job, but it is unlikely that the peer support officer would be aware that she was pregnant and impacted because she was pregnant. Quite simply, the system is not designed to deal with the complexity of individual officer's circumstances.

Further examples of this were also evident in the recollections and experiences of all three case studies. Harry, Leah and George all discussed how it was an accumulation of a number of incidents, some very minor, which triggered memories of more critical incidents. This in turn impacted these particular participants the most. In these cases it was not a peer support who came to their aid, but mentor types, colleagues or managers who noticed they were not coping and encouraged them to seek help.

Although, as research (Miller, 1995; Regehr et al., 2002) has indicated, there are many jobs which most paramedics do not like attending (jobs where children are involved, suicides, unexplained deaths), the current system still allows for affected paramedics to miss out on the formal support they may need, unless they seek help themselves or a colleague is able to make an informal referral.

Participants in the current study, when discussing the reasons they would not access the formal peer support service in place, went one step further with some suggesting a buddy system or mentoring system may assist future newly trained paramedics feel better supported. A further suggestion was that all paramedics are trained to be peer support officers. This would impact the organisation immensely as it would mean more resources, better training and a system implemented whereby newly trained paramedics are matched up with one or two people at the onset of their career.

A further important observation was that, although a few participants mentioned that they knew about the 24 hour helpline, no-one actually stated that they had utilised the service voluntarily. George and Leah are two paramedics who eventually sought help, but in both their cases in seems a third person such as a mentor, colleague or manager helped make them aware of their own need for help.

Resources are a major issue within the researched organisation. Short staffing leading to increased need for paramedics, especially in rural areas, to complete over time, fail to get meal breaks as well as pressure from within the organisation to meet response times, are impacting individual employees every day. Shiftwork is a further factor which causes stress (Costa, 2003; Courtney et al., 2010) and although this factor cannot be changed, other organisational resources can be enhanced to better support paramedics. The organisational culture or increased over time, missed meal breaks and pressure to meet target response times, can then lead to interference with employees family life, causing even more stress, as indicated by the participants in this study.

8.5 Impact on the Researcher

Being exposed to an emergency services culture was an eye opener for me. I had been exposed to trauma while completing my professional training placements as a psychologist within a school setting, as well within a Sexual Offences and Child Abuse Unit (SOCA). There was, however, no way of explaining my experiences within ambulance setting. In the short amount of time when I was immersed in the culture by being exposed to the job, completing readings and in regular meetings and conversations surrounding the ambulance profession I experienced many things. These experiences were physiological as well as psychological in nature.

My first experience of vicarious trauma[13]. It began around three weeks after starting the placement I did with an organisation related to the ambulance profession. Although I was engaged in extensive supervision sessions, keeping a log or diary of my experiences, almost every day there would be an occurrence which could only relate to the work experience I was undertaking. Driving in my car became frightening. I would drive under bridges, imagining them collapsing, hairs would stand up on the back of my neck when I drove under a bridge with a train crossing above. My mind would race ahead with amazingly specific detail, as an imagined an accident unfolding before my eyes. I discussed this phenomenon with numerous colleagues and they reassured me that it was completely 'normal'.

During the time I completed on placement, I was fortunate enough to have shared many conversations with paramedics at different stages of their careers. Each of these members shared unique and sometimes similar stories of heartache, pain, and hopelessness. However at the same time many reminisced about the elderly couple

[13] Vicarious trauma is a process of negative experiences as a result of being exposed to the trauma of others (Giarratano, 2004).

they helped, the grieving family who were so grateful for support or the friendships they have made through their job.

In the lead up to beginning this study, I spent approximately 30 days, over 4 months within the ambulance culture. Not a terribly long time in reality. The impact that this minimum amount of exposure had on me was immense. The mind is a truly powerful machine. It makes me wonder what it must be like for the people who live this everyday; who face trauma, tragedy, heartache and situations which are out of their control every day, as part of their job. In my opinion, they deserve as much support as possible to complete the work they do. I feel very blessed that they felt safe to share their experiences with me. It was a privilege to listen to the journey they had each taken. They are truly everyday heroes.

8.5.1 Journal Entry 1 – After interview with paramedic – 16 years in job

What an intense experience. I just interviewed a paramedic who has been in the job for over 15 years and I feel so drained. I need to go for a run. He had so much to tell me. He has had so many wonderful experiences but also so many demanding full on tiresome experiences, that it is a wonder he is still employed. He does love it though, that was one thing that was very clear. He came across very passionate and it seems he has a relatively good balance in terms of positive coping strategies. I can't imagine what it must be like though, coming home from work and not feeling like it is appropriate to speak with my partner and family about my job over the dinner table. He said he makes a concerted effort not to talk to them, to protect them in a way from 'the real world'.

8.5.2 Journal Entry 2

Completing the interviews with the paramedics is challenging. But even more challenging is reading and re-reading the transcripts to get a real grasp of what went on during the interview. Having the transcripts in hard form, gives me the chance to really digest the paramedics' experience, and this is tough. What was even more frightening in hindsight, is the fact that very few of the participants were emotional during the interviews. And despite how graphic or moving or traumatic an event, majority kept their composure. This is difficult for an "outsider" to come to terms with as a lot of the information is about real people, with real experiences. The paramedics seem almost desensitised to the impact of the work they do. The impact on others as well as the impact on themselves as mothers, fathers, husbands, wives, sisters, brothers, aunts, uncles. It was an interesting, roller coaster to travel on.

8.6 Future research directions

A vast majority of the studies within this area use self-report measures to determine the extent of trauma and its effects on the individual (Robinson, 1984, 1993). Perhaps future studies could utilise both a mixed methodology to explore well-being among paramedics. Paramedics from differing organisations could also be compared as findings from different studies in different countries suggest a difference in the reported psychopathology amongst paramedics. For example, Sterud, Hem, Ekeberg and Lau (2008) explored anxiety and depression and the relationship between professional help-seeking, among operational ambulance personnel and a general working population in Norway. They found that reported levels of anxiety and depression were lower among the ambulance cohort than that of the general population. In contrast, Alexander and Klein (2001) claim that when compared to the

general population, paramedics in the UK have higher levels of psychopathology. There are likely to be many variables and factors which influence the discrepancies between the psychological well-being of ambulance paramedics in different countries. A more recent study by Sterud, Hem, Lau and Ekeberg (2011) explored the importance of general job-related stressors, ambulance specific stressors and individual differences relating to ambulance staff. The authors found that frequent lack of support from managers predicted emotional exhaustion and low job satisfaction. Lack of co-workers support was found to predict psychological distress. Other reasons as to why there are discrepancies include differences in structured organisational support, cultural differences within each ambulance organisation and differences in training and education.

As a result of the current peer support service not being utilised to its full potential and employee concerns regarding risks to their confidentiality, one recommendation which could be put forward is a buddy system or mentor system. This could be set up for paramedics in their first two years on the job and would allow for relationships to be developed and a more informal reliance on one another to be sustained over a paramedics career, should they wish. An ongoing induction process would also be recommended. Allowing newly trained paramedics to be given the ongoing on the job support they need in the early part of their career. This would need to be piloted before being implemented.

Organisational intervention suggested by the participants in this study which could also be explored include, changes to overtime allowances. For example, mandated maximum overtime which can be accepted in any weekly or fortnightly period. More consistent support from peers, especially for newly trained paramedics in their first 2 years and implementing a compulsory informal debrief system.

The organisation as a whole could also consider making exercise more accessible for workers. A range of options regarding exercise could be explored. From tilt boards, skipping ropes, bikes or exercise bikes in the more remote and smaller branches to access to gym equipment or gymnasium subsidies, depending on the location of the branch. Again the type of exercise would need to be further explored with the employees from each branch.

It is also recommended that a study similar to this one be conducted with Metropolitan Ambulance personnel in the same organisation in order to draw differences and similarities between rural and metropolitan working conditions and experiences.

8.7 Limitations

During the completion of this study many variables impacted the results and discussions which were pertinent and thoroughly discussed by most participants. For example, an enterprise bargaining agreement (EBA) between the organisations staff, the union and the government occurred. This greatly impacted the morale of many ambulance staff as the staff were feeling as though they were not being listened to. A further major factor to be considered, while taking the findings of this study into account, and not to discount any participants' feelings, is the fact that prior to the onset of the study, RAV and MAS were two separate services. During this study, the two services amalgamated into one service, AV. All participants were recruited from a rural service, however.

Due to the organisational merger which took place during data collection and write up of the current study, a further qualitative exploration could be completed in a

different contextual setting. This would moderate the variables relating to organisational dissatisfaction due to the merger itself.

Also given this study was qualitative in nature, it is important to note that the results are all based on self-report, therefore hypothesis generation is the result, rather than causal inferences and conclusions being made.

8.8 Final Conclusion

Unlike other studies, this study was qualitative in nature and highlights the differences among novice paramedics and experienced paramedics. The focus was on the support and training of staff as well as the coping mechanisms in place, both useful and not so useful. The study was conducted with staff in rural Victoria and has many implications for the support requirements for staff within this organisation. The sample of participants was representative of the workforce, given the ratio of gender, range of location, experience, educational background, previous employment experience and age. It is also believed that the stratification of paramedics based on their experience has strengthened the data.

During the interviews participants were asked to describe their job in 3 words. Some of most common adjectives received back were ‘Fantastic, challenging, rewarding, unpredictable, enjoyable, stressful, frustrating’. Most of the descriptors were relatively positive, despite the fact that they all discussed how stressful the job could be at times. Ambulance paramedics are amazing individuals. The work they do is courageous, mind blowing and challenging. They should be supported, well-resourced and acknowledged for the work they do for our communities.

References

Alexander, D., & Klein, S. (2001). Ambulance personnel and critical incidents. *British Journal of Psychiatry, 178*, 76-81.

Armbruster, C., Gale, B., Brady, J., & Thompson, N. (1999). Perceived ownership in a community coalition. *Public Health Nursing, 16*(1), 17-22.

Association, A. P. (2003). *Diagnostic and statistical manual of mental disorders.Fourth edition. Text revision. (DSM-IV-TR), .* Washington, DC: American Psychiatric Association Inc: .

ATSB., A. T. S. B. (2003). *The Characteristics of Fatal Crashes During the Christmas/New Year Holiday Period.* Canberra: Australian Transport Safety Bureau.

Baughman, P., Hartley, T., Buechfiel, C & Violanti, J. (2012). Stress and health in law enforcement. *NIOSH Science Blog.* 2012/08

Bennett, P., Williams, Y., Hood, K., & Wollard, M. (2004). Levels of mental health problems among UK emergency ambulance workers. *Emergency Medical Journal, 21*, 235-236.

Bennett, P., Williams, Y., Page, N., Hood, K., Woolard, M., & Vetter, N. (2005). Associations between organisational and incident factors and emotional distress in emergency ambualnce personnel. *British Journal of Clinical Psychology, 44*, 215-226.

beyondblue.org.au. (2012) Retrieved 23/6/2012, 2012

Brickman, P., Carulli Rabinowitz, V., Coates, D., Cohen, E., & Kidder, L. (1982). Models of helping and coping. *American Psychologist, 37*(4), 368-384.

Brough, P. (2005). A comparitive investigation of the predictors of work-related psychological well-being within police, fire and ambulance workers. *New Zealand Journal of Psychology, 34*(2), 127-134.

Brough, P., & Frame, R. (2004). Predicting job satisfaction and turnover intentions: The role of social support and police organisational variables. *New Zealand Journal of Psychology, 33*(1), 8-18.

Burke, R. (1998). Work and non-work stressors and well-being among police officers: The role of coping. *Anxiety, stress and coping, 11*, 345-362.

Catterall, M., & Dean, D. (2003). Cause, effects and management of stress in paramedics. *Emergency Medicine Journal, 20*(1), 94.

Chilenski, S., Greenberg, M., & Feinberg, M. (2007). Community readiness as a multidimensional construct. *Journal of Community Psychology, 35*(3), 347-365.

Clohessy, S., & Ehlers, A. (1999). PTSD symptoms, response to intrusive memories and coping in ambulance service workers. *British Journal of Clinical Psychology, , 38*, 251-265.

Corneil, W., Beaton, R., Murphy, S., Johnson, C., & Pike, K. (1999). Exposure to traumatic incidents and prevalence of posttraumatic stress symptomatology in urban fire fighters in two countries. *Journal of Occupational and Health Psychology, 4*(2), 131-141.

Costa, G. (2003). Factors influencing health of workers and tolerance to shiftwork. *Theoretical Issues in Ergonomics Science, 4*,(3-4), 263-288.

Courtney, J., Francis, A., & Paxton, S. (2010). Caring for the carers: Fatique, sleep and mental health in Australian paramedic shiftworkers. *The Australian and New Zealand Journal of Organisational Psychology, 3*, 32-43.

Davidyan, A. (2008). Theories of Stress. *Theories of Stress*. Retrieved from

Day, G., Minichiello, V., & Madison, J. (2007). Nursing morale: Predictive variables among a sample of registered nurses in Australia. *Journal of Nursing Management, 15*(3), 274-284.

Dobson, M., Choi, B., Schnall, P., Wigger, E., Garcia-Rivas, J., Israel, L., & Baker, D. (2013). Exploring occupational and health behavioual causes of firefighter obesity: A qualitative study. *American Journal of Industrial Medicine. 57*(7). 776-790.

Edwards, R., Jumper-Thurman, P., Plested, B., Oetting, E., & Swanston, L. (2000). Community readiness: Research to practice. *Journal of Community Psychology, 28*(3), 291-307.

Elliot, G., & Eisdorfer, C. (1982). *Stress and Human Health*. New York: Springer.

Everley, G., & Lating, J. (Eds.). (1995). *Psychotraumatology*. New York: Plenum Press.

Foa, E., Cashman, L., & Jaycox, L. (1997). The validation of a self-report measure of post-traumatic stress disorder: The Posttraumatic Diagnostic Scale. *Psychological Assessment, 9*, 445-451.

Folkman, S., Lazarus, R., Gruen, R., & DeLongis, A. (1986). Appraisal, coping, health status and psychological symptoms. *Journal of Personlity and Social Psychology, 50*(3), 571-579.

Fox, K. (1999). The influence of physical activity on mental well-being. *Public Health Nutrition, 2*(3a), 411-418.

Fullerton, C., McCarroll, J., Ursano, R., & Wright, K. (1992). Psychological responses of rescue workers: Fire fighters and trauma. *American Journal of Orthopsychiatry., 62*(3), 371-378.

Gallagher, S., & McGilloway, S. (2008). Living in critical times: The impact of critical incidents on frontline ambulance personnel: A qualitative perspective. *International Journal of Emergency Mental Health, 9*(3), 215-223.

Genest, M., Levine, J., Ramsden, V., & Swanson, R. (1990). The impact of providing help: Emergency workers and cardiopulmonary resuscitation attempts. *Journal of Traumatic Stress, 3*, 305-313.

Giarratano, L. (2004). *Clinical skills for managing PTSD: Proven practical techniques for treating post traumatic stress disorder.* N.S.W: Talomin Books.

Glesne, C., & Peshkin, A. (1992). Meeting qualitative inquiry . An Introduction (chapter 1). *Becoming Qualitative Researchers: .* NY: Longman.

Goldstein, D., & Copin, I. (2007). Evolution of concepts of stress. *Stress, 10*(2), 109-120.

Haley, W. E., & Strickland, B. R. (1977). *Locus of control and depression.* Paper presented at the The Annual Meeting of the Eastern Psychological Association., Boston, Massachusetts.

Harrison, C., & Kinner, S. (1998). Correlates of physiological distres following armed robbery. *Journal of Traumatic Stress, 11*, 789-798.

Haseed, C. (2002). *Know Thyself*. Melbourne: Michelle Anderson.

Hobfoll, S., Schwarzer, R., & Koo Chon, K. (1998). Disentangling the stress labrunth: Interpreting the meaning of the term stress as it is studied in health context. *Anxiety, stress and coping, 11*, 181-212.

Holmes, T., & Rahe, R. (1967). The social readjustment rating scale. *Journal of Psychosomatic Research, 11*, 213-218.

Hood, C., & Carruthers, C. (2002). Coping skills theory as underlying framework for therapeutic recreation services. *Therapeutic Recreational Journal*. Retrieved from

Horowitz, M., Wilner, N., & Alvarez, W. (1979). Impact of event scale: a measure of subjective stress. *Psychosomatic Medicine, 41*, 209-218.
Jones, F., & Bright, J. (2001). *Stress: Myth, theory and research*. Essex: Pearson Education Limited.
Jonsson, A., & Segesten, K. (2004). Guilt, shame and a need for a container: A study of post-traumatic stress among ambulance personnel. *Accidents and Emergency Nursing, 12*(4), 215-223.
Jonsson, A., Segesten, K., & Mattsson, B. (2003). Post traumatic stress among Swedish ambulance personnel. *Emergency Medical Journal, 20*, 79-84.
King, M., Stanley, G., & Burrows, G. (1987). *Stress: Theory and Practice*. Marrickville: Grune & Stratton Australia.
Kostanski, M., & Porter, S. (2007). *Student paramedics*. Victoria University. Melbourne.
Kuiper, N., Martin, R., & Olinger, L. (1993). Coping, humour, stress and cognitive appraisals. *Canadian Journal of Behavioural Science, 25*, 151-160.
Landers, D. (1997). The Influence of Exercise on Mental Health. *The Presidents Council on Physical Fitness and Sports, 2*(12).
Lazarus, R. (1966). *Psychological stress and the coping process*. New York: McGraw-Hill.
Lazarus, R. (1993). Coping theory and research: Past, present and future. *Psychosomatic Medicine, 55*, 234-247.
Lazarus, R., & Folkman, S. (1984). *Stress, Appraisal and coping* New York: Springer.
Lazarus, R., & Folkman, S. (1987). Transactional Theory and Research on emotions and coping. *European Journal of Personality, 1*, 141-170.
Litz, B. T., Gray, M. J., Bryant, R. A., & Adler, A. B. (2002). Early Intervention for trauma: Current status and future directions. *Clinical Psychology: Science and Practice, 9*, 112-134.
Lowery, K., & Stokes, M. (2005). Role of peer support and emotional expression on posttraumatic stress disorder in student paramedics. *Journal of Traumatic Stress, 18*(2), 171-179.
Luthar, S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. . *Child Development, 71*(3), 543.
MAS. (2006). *Metropolitian Ambulance Service*. Melbourne: MAS.
Maslach, C., & Jackson, S. (1986). *Maslach Burnout Inventory (2nd edn)*: Palo Alto.
McCammon, S., Durham, T., Allison, J., & Williamson, J. (1988). Emergency workers' cognitive appraisal and coping with traumatic events. *Journal of Traumatic Stress, 1*, 353-372.
McCarrol, J., Ursano, R., Wright, K., & Fulerton, C. (1993). Handling bodoes after violent death: Strategies for coping. *American Journal of Orthopsychiatry., 63*, 209-214.
Miller, L. (1995). Tough guys: Psychotherapeutic strategies with law enforcement and emergency services personnel. *Psychotherapy: Theory, Research, Practice and Training., 32*(4).
Minichiello, V., Aroni, R., Timewell , E., & Alexander, L. (1990). *Interview processes. In depth interviewing: Researching People.* Melbourne: Longman Chesire.
Mitchell, J. (1983). When disaster strikes: The critical incident stress debriefing process. *Journal of Emergency Medicine, 1*(1). 36-39.

Mitchell, J. (1988). Development and functions of a critical incident stress debriefing team. *Journal of Emergency Medicine, 13*(12). 39-58.
Monk, T., & Folkard, S. (1992). *Making Shiftwork Tolerable*. New York: John Wiley.
Moran, C., & Massam, M. (1997). An evaluation of humour in emergency work. The Australiasian Journal of Diaster and Trauma Studies. 3. 26-38.
Myers, D. (1982). *Social Psychology (7th Edition)*. New York McGraw-Hill.
Oetting, E., Jumper-Thurman, P., Plested, B., & Edwards, R. (2001). Community Readiness and Health Services. *Substance Use and Misuse, 36*(6 & 7), 825-843.
Overholser, J. (1992). Sense of humour when coping with life stress. *Journal of Personality and Individual Differences, 13*(799-804).
Palmer, E., C. (1983). A note about paramedics' strategies for dealing with death and dying. *Journal of Occupational Psychology, 56*, 83-86.
Parkes, K. (1986). Coping in stressful episodes: the role of individual differences,environmental factors and situational characteristics. *Journal of Personlity and Social Psychology, 51*(6), 1277-1292.
Patton, M. (1986). *Utilisation Focused Evaulation (2nd Ed.)*. Illinois: Sage Publications.
Payne, C. (2001). The evolution of community involvement in public health community-based efforts: A case study. *Journal of Health and Social Policy, 14*(2), 55-70.
Pohlman, C. (1999). *Study on workplace satisfaction in public, private sectors Pohlman, C. (1999).* . Toronto: Canadian Federation of Independent Business.
Prochaska, J., & DiClemente, C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, research and practice., 19*(3), 276-288.
Prochaska, J., & Norcross, J. (2001). Stages of change. *Psychotherapy, 38*(4), 443-448.
Raphael, B., & Wilson, J. E. (Eds.). (2000). *Psychological Debriefing: Theory, Practice and evidence.* . Cambridge UK: Cambridge University Press.
Regehr, C. (2005). Bringing the trauma home: Spouses of paramedics. *Journal of Loss and Trauma., 10*, 97-114.
Regehr, C., & Bober, T. (2005). *In the line of fire: Trauma and th emergency services* New York: Oxford University Press.
Regehr, C., Goldberg, G., & Hughes, J. (2002). Exposure to human tragedy, empathy and trauma in ambulance paramedics. *American Journal of Orthopsychiatry., 72*(4).
Regehr, C., Hill, J., Knott, T., & Sault, B. (2003). Social support, self efficacy and trauma in new recruits and experienced fire fighters. *Stress and Health., 19*, 189-193.
Resick, P. (2001). *Stress and Trauma*. East Sussex: Psychology Press Ltd.
Robinson, R. (1984). Health and Stress in Ambulance Services. Report of evaluation study-Part 1. In R. Robinson (Ed.), *Health and Stress in Ambulance Services*. Melbourne: Social Biology Resource Centre.
Robinson, R. (1993). Follow-up study of Health and Stress in Ambulance Services of Victoria, Australia 1993, Part 1. In R. Robinson (Ed.), *Health and Stress in Ambulance Services*. Melbourne: Victorian Ambulance Crisis Counselling Unit.
Robinson, R. (1997). *Evaluation of the Victorian Ambulance Crisis Counselling Unit*. Melbourne: Victorian Ambulance Crisis Counselling Unit.

Robinson, R. (2002). *Follow up study of health and stress in ambulance services of Victoria, Australia: Report 1. Paramedics and their partners*. Melbourne: Victorian Ambulance Counselling Unit.
Rotter, J. (1966). Generalised expectancies for internal versus external locus of control of reinforcement. *Psychological Monographs: General and Applied, 80* (1). 1-28.
Sansone, R., & Sansone, L. (2011). The Christmas effect on psychopathology. *Innovations in Clinical Neuroscience., 8*(12), 10-13.
Selye, H. (1956). *The Stress of Life*. New York: McGraw-Hill Book Co.
Selye, H. (1974). *Stress without distress*. New York: First Signet Printing.
Shakespeare-Finch, J., Smith, S., & Obst, P. (2002). Trauma, coping resources and family functioning in emergency services personnel: A comparative study. *Work & Stress, 16*(3), 275-282.
Sheehan, M. (2011). Exploring workplace bullying in an Emergency Service Organisation (ESO). *International Journal of Business and Management., 6*(3), 63-80.
Spikard, A., Gabbe, S., & Christensen, J. (2002). Mid-caeer burnout in generalists and specialist physicians. *Journal of the American Medical Association, 288*(12), 1447-1450.
Sterud, T., Elkeberg, O., & Hem, E. (2006). Health status in the ambulance services: A systematic review. *BMC Health Services Research, 6*(82).
Sterud, T., Hem, E., Ekeberg, Ø., & Lau, B. (2008). Health problems and help-seeking in a nationwide sample of operational Norwegian ambulance personnel. *BioMed Central Public Health, 8*(3).
Sterud, T., Hem, E., Lau, B., & Ekeberg, Ø. (2011). A comparison of general and ambulance specific stressors: predictors of job satisfaction and health problems in a nationwide one-year follow-up study of Norwegian ambulance personnel. *Journal of Occupational Medicine and Toxicology, 6*(10).
Super, D. (1952). A theory of vocational development. *American Psychologist*, 185-190.
Tunick, J. (2000). Preventing Burnout. *Civil Engineering, 70*(12).
Turkat, D., Farris, L., & Blue, R. (1978). Seasonal demands in community mental health. *Psychological reports., 43*(2), 489.
Tyssen, R., Vaglum, P., Gronvold, N., & Ekeberg, O. (2001). Factors in medical school that predict postgraduate mental health problems in need of treatment. A nationwide and longitudinal study. *Medical Education, 35*(110-120).
VACU. (2006). *Victorian Ambulance Counselling Unit Annual Report*. Melbourne: Vixtoria Ambulance Counselling Unit.
Vanderpol, B., Gist, R., Braverman, M., & Labardee, L. (2006). Strategic Speciality Partnerships. *Journal of Workplace Bhavioural Health, 21*(3), 119-131.
West, L. (1977). Mature Age Students in Tertiary Education. Retrieved 16/12/2012, from Monash Univ., Clayton, Victoria (Australia)
Willig, C. (2001). *Introducing qualitative research in psychology*. Philadelphia: Open University Press.
Zimmerman, F. (2012). Cardiovascular disease and risk factors in law enforcement personnel: A comprehensive review. *Cardiology in Review, 20*(4). 159-166.

Appendix 1: Email to participants

Email to participants

You are invited to participate in a research project entitled An Exploration of the Support Needs of Ambulance Paramedics.

This project is being conducted by a student researcher Sandra Porter, as part of a PhD study at Victoria University under the supervision of Adrian Fisher from the School of Psychology; Faculty of Arts, Education and Human Development.

The aim of this study is to investigate the experiences of ambulance paramedics at differing stages of their employment. We are particularly interested in learning about issues of health and well-being and the ways in which you manage your everyday work experiences.

Your participation will involve an interview of around 1 hour which will be audio-taped to allow for accurate transcriptions of data.

Victoria University is conducting this study with the support of a rural ambulance provider within Australia.

If you wish to be involved in the study please contact either the Principal researcher: Adrian Fisher, adrian.fisher@vu.edu.au or the Student Researcher: Sandra Porter, sandra.porter@research.vu.edu.au

Thank-you for your time.

Appendix 2: Plain Language Statement paramedics

INFORMATION TO PARTICIPANTSINVOLVED IN RESEARCH

You are invited to participate in a research project entitled An Exploration of the Support Needs of Ambulance Paramedics.

This project is being conducted by a student researcher Sandra Porter as part of a PhD study at Victoria University under the supervision of Adrian Fisher from School of Psychology; Faculty of Art, Education and Human Development.

Project explanation

The aim of this study is to investigate the experiences of student ambulance paramedics in order to identify hurdles they may face during the transitional phase of study and work

What will I be asked to do?

Your participation will involve an interview of approximately 1 hour. Each interview will be audio-taped in order to allow for accurate transcriptions of data.

What will I gain from participating?

The benefits of this study include (a) an improved understanding of the issues affecting student ambulance paramedics, (b) the potential improvement of awareness of participants regarding what they deal with everyday, (c) a wider understanding and recognition of hurdles faced by student ambulance paramedics, and (d) a provision of data for future research.

How will the information I give be used?

Participants will be informed of the limits of anonymity (i.e., that they will not be identified by name, but that other identifiers, e.g. profession, will be included in the final report), and as such they may choose their level of disclosure accordingly.

What are the potential risks of participating in this project?

As is the case when discussing demanding aspects of an individual's life, there may be sensitive material brought up within the confines of the interview with paramedics. Discussion surrounding work and personal pressures may arise.

How will this project be conducted?

Participants will be recruited through the RAV internal email system as well as through the student email directory at Victoria University. Via email, potential participants will be informed of the aims of the study and invited to contact the researcher or her supervisor for further information. Those who then choose to

participate will be given a plain language statement, asked to sign a consent form and informed of their right to withdraw at any time. Participants confidentiality will be secured through being assigned a code number rather than the provision of their names.

Who is conducting the study?

Victoria University together with Rural Ambulance Victoria (RAV)

Principal researcher: Adrian Fisher, Adrian.fisher@vu.edu.au

Student Researcher: Sandra Porter, sandra.porter@research.vu.edu.au

Any queries about your participation in this project may be directed to the Principal Researcher listed above. If you have any queries or complaints about the way you have been treated, you may contact the Secretary, Victoria University Human Research Ethics Committee, Victoria University, PO Box 14428, Melbourne, VIC, 8001 phone (03) 9919 4781.

Appendix 3: Consent Form

CONSENT FORMFOR PARTICIPANTS INVOLVED IN RESEARCH

INFORMATION TO PARTICIPANTS:

We would like to invite you to be a part of a study into…'An Exploration of the Support Needs of Ambulance Paramedics'

CERTIFICATION BY SUBJECT

I, _____
of _____

certify that I am at least 18 years old* and that I am voluntarily giving my consent to participate in the study:
'An Exploration of the Support Needs of Ambulance Paramedics' being conducted at Victoria University by: Adrian Fisher

I certify that the objectives of the study, together with any risks and safeguards associated with the procedures listed hereunder to be carried out in the research, have been fully explained to me by:

Sandra Porter

and that I freely consent to participation involving the below mentioned procedures:

Interview of approximately 1 hour I duration

I certify that I have had the opportunity to have any questions answered and that I understand that I can withdraw from this study at any time and that this withdrawal will not jeopardise me in any way.

I have been informed that the information I provide will be kept confidential.

Signed:
Date:

Any queries about your participation in this project may be directed to the researcher Adrian Fisher ,adrian.fisher@vu.edu.au, 99195221. If you have any queries or complaints about the way you have been treated, you may contact the Secretary, Victoria University Human Research Ethics Committee, Victoria University, PO Box 14428, Melbourne, VIC, 8001 phone (03) 9919 4781

[*please note: Where the participant/s are aged under 18, separate parental consent is required; where the participant/s are unable to answer for themselves due to mental illness or disability, parental or guardian consent may be required.]

Appendix 4: Interview questions

Sample questions and prompts for semi-structured interviews.

Getting to know participant/background information

What made you want to become an Ambulance Paramedic?
-Any particular experience?

Education and employment background.
-Training
-Years as a paramedic

Useful things within the training so far?
-University/study

Unhelpful within training so far?

Daily Life (Questions posed in order to gain a rich understanding of the work and demands of being a paramedic)

How would you describe an average day for you at work?
-Doesn't exist but closest to?

Who do you socialize with at work? Outside work?
-Colleagues?

Do you have any hobbies/interests?

Do you think your work has any impact (positive or negative) on your family life?
-Children
-Partner
-Lifestyle

Coping strategies (Questions posed to examine ways in which paramedics manage the demands of their job)

Can you tell me what you do after an average day at work?
-Exercise?
-Eating/drinking

Can you tell me what you do after a more demanding day at work?

Do any of these activities help you cope with the influences that your job has on your health and well-being?

Do you speak with any one about your work?
-Colleagues
-Partner

Is this useful as a strategy for coping with the demands of your day to day job??

Do you know of or use any support services?
Prompt: Peer support services, 24 hours help line, workplace services

Helpful in future (questions posed in order to give participants a chance to have come control and ownership into the service recommendations)

What would you suggest could be done to better support you in your work?

Do you have any suggestions on how your workplace or RAV may better support you in your work and the effects your work has on your health and well-being?

Question for newly employed paramedics

Do you feel that your recent training in the area provided you with useful strategies to deal with the demands of your job?

Question for later career paramedics

Since you started out as a paramedic do you feel your coping strategies have changed?
If so, does this mean you are better able to cope now?

Appendix 5: Victoria University Ethical approval

VICTORIA UNIVERSITY | A NEW SCHOOL OF THOUGHT

MEMO

TO Dr. Marion Kostanski
School of Social Sciences and Psychology
Footscray Park Campus

DATE 11/09/2008

FROM Dr Alan Hayes
Chair
Faculty of Health, Engineering and Science Human Research Ethics Committee

SUBJECT Ethics Application – HRETH 08/51

Dear Dr. Kostanski

Thank you for submitting this application for ethical approval of the project:

HRETH08/51 An Exploration of the Support Needs of Ambulance Paramedics

The proposed research project has been accepted and deemed to meet the requirements of the National Health and Medical Research Council (NHMRC) 'National Statement on Ethical Conduct in Human Research (2007)' by the Faculty of Health, Engineering and Science Human Research Ethics Committee. Approval has been granted from 21 August 2008 to 31 January 2009.

Continued approval of this research project by the Faculty of Health, Engineering and Science Human Research Ethics Committee is conditional upon the provision of a report within 12 months of the above approval date (by ***21 August 2009***) or upon the completion of the project (if earlier). A report proforma may be downloaded from the VUHREC web site at: http://research.vu.edu.au/hrec.php

Please note that the Human Research Ethics Committee must be informed of the following: any changes to the approved research protocol, project timelines, any serious events or adverse and/or unforeseen events that may affect continued ethical acceptability of the project. In these unlikely events, researchers must immediately cease all data collection until the Committee has approved the changes. Researchers are also reminded of the need to notify the approving HREC of changes to personnel in research projects via a request for a minor amendment.

If you have any queries, please do not hesitate to contact me on 9919 4658.

On behalf of the Committee, I wish you all the best for the conduct of the project.

Dr Alan Hayes
Chair
Faculty of Health, Engineering and Science Human Research Ethics Committee

Appendix 6: Ethical Approval AV

Rural Ambulance Victoria

22nd April 2008

Ms Sandra Porter
64 Andrew Street
GLENROY VIC 3046

Dear Sandra

Re: Research Proposal R08-001: "An exploration of the support needs of ambulance paramedics."

I am pleased to inform you that the Rural Ambulance Victoria (RAV) has approved participation in the above study, subject to;

1. Evidence of HREC approval
2. RAV reviewing any potential publications or presentations prior to submission
3. Your supervisor reassuring the Committee that the sample size (n=24) is appropriate
4. RAV approving the interview questions prior to recruitment of participants

You will need to sign a confidentiality agreement (attached) and return it to Paul Jennings, Manager Clinical Effectiveness and Research as soon as possible.

As a component of the ongoing communication processes, RAV requires quarterly status reports and a final report on completion of the study. Status reports are required to be submitted by e-mail.

We look forward to working with you on this important project. If you require any further information please contact Paul Jennings on (03) 5338 5308 or email paul.jennings @rav.vic.gov.au

Yours sincerely,

Tony Walker

Assoc Prof Tony Walker ASM
General Manager Clinical Governance

cc: Dr Marion Kostanski

CERTIFIED QUALITY MANAGEMENT SYSTEM

23 WETLANDS DRIVE
MOUNT HELEN
VICTORIA 3350

LOCKED BAG 9000
BALLARAT MAIL CENTRE
3354 VICTORIA AUSTRALIA

TELEPHONE
03 5338 5000

FACSIMILE
03 5338 5211

WEB
www.rav.vic.gov.au

Appendix 7: Related News articles

heraldsun.com.au Herald Sun, Tuesday, June 8, 2010 9

Frustrated paramedics reveal patients are dying without MICA care

Ambos' pleas ignored

QUESTIONS have been raised over the deaths of up to eight people in South Gippsland by paramedics who say pleas for intensive care specialists have been ignored.

Outlining a horrifying dossier of patient deaths and near misses to their union, South Gippsland paramedics have highlighted 12 cases since January where they say patients did not receive appropriate care.

Grant McArthur and Marianne Betts

The list — seen by the *Herald Sun* — was prepared after the State Government announced last week that it was going to base a new dedicated MICA service in Morwell, which already has one.

The move has angered the South Gippsland paramedics, who had prepared a business case pleading for the specialised intensive care service to instead be located in Wonthaggi to cover the South Gippsland region, which has no dedicated MICA.

One angry senior paramedic has delivered a worrying dossier of 12 tragic cases in the region this year, warning the lack of MICA in South Gippsland is costing lives.

"I believe that had there been a dedicated MICA resource based in South Gippsland, that most of the problems associated with these cases could have been averted," the paramedic said.

The cases include:

ON Saturday the only duty MICA officer was on a non-urgent job when a 68-year-old man had a cardiac arrest in Cowes and needed MICA care. None was provided, and the man died.

A HORRIFYING January 4 head-on crash in which one man died and five were injured. Despite tens of thousands of holiday makers in the area no MICA paramedic was rostered on in South Gippsland.

A MOTORCYCLIST was critically injured in a crash at the Phillip Island MotoGP Circuit in March in which an ambulance crew requested MICA support, but it could not be provided. MICA paramedic assistance eventually arrived via helicopter an hour after the request but the man died.

Ambulance Employees Association general secretary Steve McGhie said there was a clear need for a dedicated MICA service in South Gippsland, but the Government ignored a business case prepared by local paramedics, and a letter and a Budget submission from the union.

"Some of these people, particularly where people have died or have been seriously compromised, would have had far better outcomes if there had been dedicated MICA resources available," he said.

Ambulance Victoria Gippsland regional manager Mark Cooke said Morwell needed the extra MICA unit, and one being placed in Wonthaggi would be explored.

Ambo stress leave soars

11/7/10 HS

PETER ROLFE

STRESSED Victorian ambulance employees took 4342 days off work in a year, with more than four workers a week taking stress leave of 10 days or more.

Paramedics, MICA specialists, operational staff and clinical transport officers lodged 236 WorkCover claims between April last year and March 31, Ambulance Victoria figures obtained by the *Sunday Herald Sun* through Freedom of Information reveal.

The figures, which do not include stress claims of fewer than 10 days, show the average ambulance employee took more than 18 days off to recover from illness or injury.

Auditor-General Des Pearson last week confirmed he would investigate the operation and management of Ambulance Victoria following a two-month campaign by the *Sunday Herald Sun* that exposed widespread concerns about ambulance waiting times, availability and fatigue among paramedics.

Ambulance Employees Australia state secretary Steve McGhie said the WorkCover data showed the under-resourced service was taking its toll on its estimated 2500 staff.

"That amount of claims works out to nearly 10 per cent of the work force, so it's a really high number," he said. "But I'm not surprised with the pressures they're under and the increased workload."

The most common WorkCover claim was "manual handling" (149 grievances and 2929 days off work).

The highest number of claims (38) came from ambulance metropolitan "group 5", which covers bayside suburbs, Caulfield, Richmond and the CBD.

Ambulance officers driven beyond brink

BY TYRON BUTSON
20 Oct, 2008 11:51 PM
BULLYING and mismanagement has driven many Hunter paramedics to attempted suicide, marriage breakups and alcohol abuse, a senior paramedic's submission to an inquiry into the NSW Ambulance Service says.

Jodie Adams' submission includes damning claims that her superiors were unconcerned about widespread depression and suicide attempts among officers pushed to the breaking point by stress.

A paramedic for 16 years Ms Adams, who has been twice nominated for Australian of the Year, said she was eventually demoted from her role as district officer after repeatedly raising the high attempted suicide rates and low morale among paramedics to her superiors.

Hers was one of about 20 submissions from Hunter officers to a parliamentary inquiry into the management and operations of the ambulance service, which has called for a fresh start for the service.

More than 260 front-line paramedics made submissions to the parliamentary inquiry, which yesterday made 45 recommendations for reforms that "must occur as a matter of urgency".

"I personally have had an officer attempt suicide because leave would not be granted and he was too emotional to just take sick leave," Ms Adams said in her statement, presented as part of the report.

"When I told senior management the officer had threatened self-harm, I was told 'he is responsible for his own actions'."

She also told the inquiry of another paramedic who had completed his own case sheet, ensuring his co-workers would only have to complete a minimum amount of paperwork when he killed himself.

"Other officers, due to their stress, either drink too much, have family breakups or simply resign . . . these are good officers, who with proper help could have longevity in this career," Ms Adams said.

She said in her submission that she was told she was "too passionate about the job" and was "too soft" on her subordinates.

More than 260 frontline paramedics made submissions to the inquiry which made 45 suggestions, including that Ambulance Service ensure all on-duty crews in the Hunter Region consist of at least two officers by June 30 2009.

comments

Date: Newest first | **Oldest first**
Why are we accepting this? Why aren't we standing up with our ambos & supporting them? Who do we call when we are sick & need to get to hospital.....the ambos. Please support them.

Paramedic reveals extent of our ambulance

Kyle Pollard

March 24th, 2010

A SENIOR paramedic has revealed only two of the three ambulances working in Geelong on Saturday night could respond to serious emergency situations.

The paramedic, who asked to remain anonymous, said the third ambulance was manned by a student who had only been on the road for three weeks, and a public transport officer who normally only transported patients between hospitals.

Have your say on the feedback form below

"Saturday night was not out of the ordinary, this kind of thing is happening all the time," he said.

"On top of the brawl outside Room 99, there was a patient suffering cardiac issues in Torquay that had to wait more than an hour for assistance, and another patient suffering a suspected heart attack who also had to wait an hour."

The paramedic said at least four ambulances were left unmanned throughout the region because of a lack of resources and overworked paramedics.

"People are not prepared to work overtime because the pay has gone down significantly for overtime shifts, and people are just so fatigued from unfavourable rostering," he said.

Related Stories

- Ambulance shortage f victims to hospital
- Ambulance 'disgrace' bash victims to hospit

"I'm not trying to say ambos are martyrs but we get into this job because we care, and that e away by the atrocious morale and conditions."

The paramedic called on Geelong residents to fight for better conditions for ambulance work

"I am pleading with the Geelong media and community to get on our side because they shou things are at the moment," he said.

"People need to make some noise and raise this issue with the local politicians because at t helping your own community."

MEANWHILE police association officials fear the two constables who acted quickly to ferry t hospital because no ambulances were available could be punished for not following procedu

LET US KNOW
News Tip
Letter to the Editor
Sports Results

ADVERTISE WITH US
Media Guide
Digital Media Guide
Learn Media Guide

PLACE A CLASSIFIED
The Geelong Advertiser
GeelongNEWS
echo

INFORMATION
Home delivery
About Us
Contact Us
News Ltd Sites
Sponsorship
Terms and Conditions
Copyright

OTHER LINKS
Geelong Info
Geelong Bride
Geelong Football Club
G.A. Music Competition
Sustainable Living

Association secretary Senior Sergeant Greg Davies yesterday said the state's chronic police without any choice but to bend rules in an attempt to save lives.

"They could well end up in trouble over this. This is another example of police having to cut c community," Sen-Sgt Davies said.

Sen-Sgt Davies said the incident pointed to the problems faced by rank-and-file members on

His comments follow revelations the shortage of ambulances meant the police would have b the two young victims to hospital.

The Brumby Government and ambulance chiefs drew heated criticism over the incident yest

Opposition Leader Ted Baillieu said that under Premier John Brumby a culture of violence w regional Victoria.

"Police in Geelong are under enormous pressure due to a lack of resources and it is a disgra to transport the victims of these terrible bashings because there were no ambulances availat

A Brumby Government spokesman yesterday said the state had provided $185.6 million to b and had reached a new agreement with paramedics to provide improved working conditions.

" "

Share this article

HAVE YOUR SAY

Latest Comments:

On saturday night I was available to work as a qualified paramedic, however melbourne. Even though we have joined services I am still not allowed to wor areas on overtime or to cover shifts. I would have happily and I know many c would have travelled from melbourne to geelong to work these shifts and ther transport this poor young man. The govt and in particualar out management h red tape to allow this not to occur. As a melbourne paramedic i can only work unless it is for a minumum month period. I have a heart and if an area of victc uncovered and i am able to work, why the hell cant I? It is because of our CE assistants. By the way i did not get a call to work in melbourne and was at ho movie wishing i was working!!! and would have travelled anywhere to work in

Posted by: ***Annoyed Ambo*** *12:10am Thursday 25th March*

THE NEW AMBULANCE AGREEMENT OVERTIME IS PAID AT 27% LESS THE AGREEMENT. WHO WOUILD WORK OVERTIME ON WEEKENDS SC SUFFERS.

Posted by: ***TJF of GEELONG*** *05:54pm Wednesday 24th March*

With all the shortages of ambos not filling shifts, why aren't the bosses, most Paramedics, not filling these shifts? Too hard?

Posted by: ***Frustrated Ambo of Geelong*** *12:42pm Wednesday 24th March*

We welcome your comments on this story. Comments are submitted for possible publication may be edited. Please provide your full name. We also require a working email address - not verification. The location field is optional. **Read our publication guidelines**.

Submit your feedback here:

Full name: **Email address:**

Location (optional):

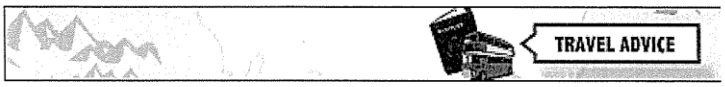
Your comments:

Remember my details
(so you don't have to retype your details each time you send feedback

Email me if my comment is published Subm

Also in this section

- Ambulance 'disgrace' as police forced to ferry bash victims to hospital
- Paramedic reveals extent of our ambulance crisis
- DRUG RAID: Police pounce across Geelong, arresting 15, grabbing drugs, cash and g
- Shell to cut 20 jobs locally
- Room 99 reaped cash from moonshine vodka, court told
- I am not a shonk, says Apollo Bay developer
- Justin Madden to reveal if state broke own planning rules
- Boozy hoon rammed Norlane party house
- 15 arrested in drug busts in Geelong
- Gary Ablett may have made up his mind says Geelong coach



The Sydney Morning Herald

National

Anguish starts after the sirens stop

May 1, 2010

Traumatising work... Ambulance staff have committed countless suicides and attempted suicides. Photo: AFR

We call the ambulance in hours of urgent need but the grisly work we pass on takes its toll on the paramedics. Natasha Wallace reports on suicides and official stonewalling.

It is one of the toughest jobs in the country - an adrenalin-charged ride through what is often the worst of human experiences. But the state's ambulance service, after countless suicides and attempted suicides by staff, 11 parliamentary and internal inquiries over a decade and 96 complaints to the corruption watchdog, has yet to acknowledge the impact of years of neglect on its traumatised workforce.

Paul* is haunted by the screams of distressed children. After 32 years in the ambulance service witnessing unspeakable sadness, the sobs of the young ones who lost their siblings in a house fire a few years ago jolt him from his slumber at night. The raw howling still rings in his ears.

"When you hear it, it haunts you forever and you know that everything is futile," he says. "The shriek … that helpless plea, that last expiring of breath."

The nagging thought of whether more could have been done - another crew sent sooner, perhaps - tears at his psyche. "No one ever offered me any counselling. We just went on to another job," he says. "I relive it every day that I see a house fire."

Paul does not wish to use his real name because, like so many of his former colleagues, he has been medically retired and is awaiting the outcome of a claim for post-traumatic stress disorder.

A parliamentary inquiry in 2008, the 11th inquiry into the Ambulance Service of NSW since 2001, heard shocking evidence of distress among its officers.

"There is a view that the level of suicide in the service is indicative of a highly dysfunctional working environment in which management fail to offer their employees adequate support," the inquiry's final report says.

A review earlier this year of the service's progress since says many officers are still "teetering on the brink".

Ballarat's ambulance crisis continues

KIM STEPHENS
03 May, 2010 12:14 AM
BALLARAT is at extreme risk of suffering a tragedy similar to one in which a five-year-old Gippsland boy died after waiting more than an hour for specialty paramedics, the ambulance union warned yesterday.

Ambulance Employees Australia Victorian General Secretary Steve McGhie said Ballarat was uncovered by a Mobile Intensive Care Ambulance unit overnight last night, a scenario not uncommon in the city.

Mr McGhie said a shortage of the specially trained paramedics in the region was placing lives at risk, with the resource pool not large enough to ensure the city was covered by a MICA unit all day, every day.

Mr McGhie's comments came after a report in the Sunday Herald-Sun revealed Maffra's Rupert Rafferty, 5, died after suffering a suspected seizure and waiting 65 minutes for a MICA unit to arrive.

"It happens fairly regularly - if there is not a shift dropped every weekend, it's at least every fortnight," he said.

"Ballarat would normally have four night shift crews, including a MICA crew but the reason it is not staffed (overnight) is there is not a big enough pool to draw upon of paramedics on duty.

"They certainly require more employees to meet the minimum standard of rostering."

MICA paramedics are trained to a higher skill level than regular ambulance officers to administer a broader range of drugs, can place patients in induced comas and specialise in treating cardiac patients.

The MICA units are also fitted with a more extensive range of equipment to treat critical patients.

He said while Single Response Units - one MICA trained paramedic on duty with regular ambulance officers - were generally available, the effect was not the same as having a MICA unit available to respond to life-threatening situations.

Mr McGhie said it was unfortunate it took a tragedy such as the death of Rupert to highlight the under resourcing across the state.

"In Ararat a couple of weeks ago, there was an incident where police had to transport a gentleman in cardiac condition to hospital," he said.

"We don't want those sorts if things to happen but unfortunately they do and we would hope that by raising this, the government act quickly to address it."

In March, leaked Ambulance Victoria documents revealed that paramedics in the region were near breaking point due to staffing shortages, which were impacting upon response times. At the time, Ambulance Victoria's Grampians region general manager Greg Leach denied a shortage of paramedics was causing rostering problems.

comments

Date: Newest first | **Oldest first**
The ambos do an absolutely excellent job with the resources they have. They need all the support from government and community that is available, and then some.
Posted by **foodforthought**, 3/05/2010 8:14:58 AM, on The Ballarat Courier
I find it disgusting that the Gippsland tragedy should be used for such blatant purposes. The problem in Gippsland was not lack of a MICA but that it took the first ambulance officers to arrive on the scene to diagnose that a MICA was required to treat the young lad and one was promptly called for and despatched. No-one is at fault for that but it wasn't an underresourcing problem. Returning to Ballarat: If, for whatever reason, a MICA is not available in Ballarat at a particular time but is required, can MICA officers be called in to attend that emergency? Secondly, I would like to know how often MICAs are required to attend an emergency in any given week in Ballarat? Finally, what happens if Ballarat's MICA has already been called out to, say, an accident on the highway and another is required? It's one thing to debate an issue when the facts are known but, at the moment, it seems that the facts aren't publicly

available.
Posted by **Ed**, 3/05/2010 12:18:02 PM, on The Ballarat Courier
All very good points by Ed, the fact is people die, before ambos get to them, while in the ambo, and at hospitals. In the case of Rupert a lot of facts are unknown but distance is one point as to why it took so long. One would ask qustions of what was his medical condition, did his parents give full information to allow dispatch to make a fair judgment to send a general anbo or a mica in the first place or did the dispatch make an error in assesment.
Posted by **david**, 3/05/2010 3:50:58 PM, on The Ballarat Courier
If there is no MICA unit in Ballarat then that's it....to bad so sad hope you don't need one. The Ambulance service will not recall off duty MICA officers for a case as it is too costly and the fact that the person would be dead before the off duty MICA got to work. Ballarat's MICA ambulance attends between 1 to 2 cases per hour, 24 hours a day 7 days a week - unless they are not there of course! Don't forget Ballarat MICA attend cases in Ballan, Daylesford, Clunes, Maryborough, etc and regularly do emergency transfers to Melbourne and Geelong. Third point of needing a MICA should the crew be busy - happens all the time. It's only due to the skill, dedication and talented ALS officers that critically ill rural Victorians are not needlessly dying. It's all well and good to have a MICA ambulance, but without the ALS guys/girls doing what they do day in and day out the service would fall in a heap. You should be so lucky that you live in one of the four rural areas that has a designated MICA ambulance - the vast majority of regional Victoria had limited or no access to Intensive Care ambulances instead relying on ALS crews and talented doctors.
Posted by **Raoul**, 5/05/2010 10:13:50 PM, on The Ballarat Courier

post a comment

Most popular articles

1. Anger over Civic Hall squatters
2. Mair St high-rise raises heritage concerns
3. World Cup: AFL says no to Ballarat option
4. Main Rd scores an extra funding boost
5. WINNERS and LOSERS
6. Another break-in at Daylesford bottleshop
7. Cycling boon for Ballarat region

An AEA-LHMU campaign

RESPONSE TIME!
OUR AMBOS. OUR LIVES.

AMBOS FEEL UNDER PUMP

Monday, 15 December, 2008

Geelong Advertiser
Michael Auciello

LOCAL ambulance officers are suffering from increasing levels of assault and abuse from patients because of long response times to jobs, one Geelong paramedic said.

The Ambulance employees' union yesterday released information the log detailing 291 incidents between August and November involving "dangerously slow response times, paramedic overwork and inadequate ambulance coverage in Victoria."

The union said the log was just a sample of incidents, and that the actual figure was likely to be higher.

One local ambulance officer with more than 20 years experience, who did not want to be named, said the issues of long response times to jobs was getting worse.

He said the main cause was an increased number of long transfer trips, for example of a stroke patient to Melbourne, without adequate cover in the Geelong area.

He said a new in-car computer system had increased the time needed to do paperwork, that there was a shortage of cars and that "our workload is ever increasing but the resources haven't kept pace".

"There's been an increase in assaults on paramedics directly related to tardy response times," he said.

"(In Geelong), one ambo was spat on, they spat in his face, and another one was assaulted as well, both in the last fortnight."

The ambulance officer said paramedics were working up to 16-hour shifts and said it would not be uncommon for every crew in Geelong to miss meal breaks in the one shift.

He said that led to fatigued paramedics, who would become sick, have to take a day of work, only adding to the problem.

Ambulance Victoria yesterday said some of the information released by the union yesterday was incorrect. "While AV takes the issues raised by the union today very seriously, our initial investigation shows between 40 and 50 per cent of its claims are inaccurate," rural operations executive general manager Greg Leach said.

"AV treats paramedic and patient safety as an absolute priority. We have been working to address issues including fatigue and resourcing for more than 12 months.

http://www.geelongadvertiser.com.au/article/2008/12/16/37635_news.html

An AEA-LHMU campaign

RESPONSE TIME!
OUR AMBOS. OUR LIVES.

AMBO UNREST ON THE RISE

Tuesday, 30 December, 2008

Bendigo Advertiser
By Nicole Ferrie

THE Ambulance Employees Australia union believes a row between local paramedics and management has become unworkable.

Four senior paramedics have been told to "mind their tongues", after expressing their concern about the way Ambulance Victoria treated a colleague for speaking to the media.

The move is the latest in a series of issues between management and paramedics.

It is believed the paramedics, who are well regarded in the service, wrote to AV regional general manager David Burns expressing their disappointment with the disciplinary action taken against a Bendigo paramedic who spoke of his frustrations with an under-resourced emergency service.

The paramedics were told that if the tone of the emails continued they may be called to meetings to discuss their behaviour.

Ambulance Victoria acting chief executive Keith Young said the four paramedics were not under any formal disciplinary process.

"We have met with a Bendigo paramedic about a breach of his employment contract, including certain comments to the media," he said.

"Following this, four other paramedics emailed one of our managers to express their views about this decision, and the language and tone used to do so was inappropriate and offensive.

"The manager replied to these emails simply stating that he felt the language was not appropriate and that if it continued then there may be a need to meet to discuss this behaviour.

"I think it is fair to expect that if someone wants to say something to you, then they do so in the same way they would want us to deal with them."

Mr Young said the issue would only escalate if the behaviour continued.

However, AEA state secretary Steve McGhie said the situation needed to be addressed.

"It's unworkable for both parties," he said.

"There is too much unrest and things are not being dealt with."

Mr McGhie said the paramedics would not have written to management unless they felt strongly about the issue.

"These guys are senior paramedics, this is not something they would do lightly," he said.

http://www.bendigoadvertiser.com.au/news/local/news/general/ambo-unrest-...

MEDIA MONITORS

Wangaratta Chronicle
Friday 15/5/2009
Page: 11
Section: General News
Region: Wangaratta VIC Circulation: 5,111
Type: Regional
Size: 176.13 sq.cms.
Published: M-W-F--

Brief: VU

Fatigue not the only issue

Paramedics worried about careers: union

By TRISH GALLAGHER

FATIGUE isn't the only concern that has local paramedics disillusioned, according to the Ambulance Employees Association.

Paramedics across the state are poised to take their first industrial action in 36 years in support of minimum 10-hour rest breaks as part of their new work conditions.

And association general secretary, Steve McGhie, said local paramedics also feared Ambulance Victoria (AV) was Melbourne-centric.

"They fear rural areas are being hardest hit in the economic downturn and they are not getting the same opportunities as city paramedics," he said.

Last week AV confirmed Wangaratta's ambulance control room will be axed and moved to Ballarat in 12 to 18 months, prompted by a statewide integration with CFA and SES communications.

AV said all 14 Wangaratta control room staff will be offered continuing employment.

Mr McGhie said local paramedics were angry that colleagues seeking higher training have been told they can't do it.

He said they feel blocked from career advancement in order to keep the higher qualified mobile intensive care ambulance (MICA) paramedics in Melbourne, where there is a shortage.

But AV Central Hume group manager, Ian Hunt, said these concerns were misplaced.

"The simple fact is we have more MICA paramedics than funded places in the country," he said.

"We are overstocked and Melbourne is understocked.

"There won't be a reduction in MICA places."

A spokesman for Health Minister Daniel Andrews said since the government committed to recruit 258 paramedics, 285 had either started or had been offered a job with AV.

During the same period, two of the 22 new positions earmarked for Hume region had been filled.

Mr Hunt said many places were taken up by students.

This is another bugbear of local paramedics who point to AV recruiting second-year graduate paramedics from Victoria University.

Around 130 second-year graduates were to be employed when finishing their third year of study.

The Sydney Morning Herald

National

Another tragedy for the ambulance service

Natasha Wallace
May 19, 2010

A NSW paramedic has committed suicide in Kempsey on the mid-north coast of NSW.

The chief executive of the Ambulance Service of NSW, Greg Rochford, posted a message on the intranet on Monday night notifying staff of Paul Clough's death earlier that day.

"It is with great sadness I advise that paramedic Paul Clough passed away at his home this morning," Mr Rochford said. "The police are currently investigating and have provided early advice that there appear to be no suspicious circumstances."

Mr Clough's death follows a *Herald* investigation this month which revealed that the family and friends of the majority of paramedics who have committed suicide over the past decade partly blamed work stress.

The ambulance service has refused to take any responsibility for the deaths, even after a 2008 parliamentary inquiry found "the level of suicide in the service is indicative of a highly dysfunctional working environment".

One paramedic commits suicide each year in NSW, and the rate of one in 3500 is almost three times higher than the general community's one in 10,000.

A spokesman for the ambulance service yesterday appeared to blame the *Herald* for Mr Clough's death. "It doesn't surprise me … I did tell you if you published something like this that it would tip someone over the edge," he said.

The Health Services Union organiser for the Hunter and mid-north coast, Jim Arneman, said: "It's disappointing that the service does seem to take a somewhat defensive attitude … it would be far more helpful if they addressed some of the causes of the job-related stress that they have responsibility for."

Mr Clough joined the service in 1994 and worked mostly in Sydney until he took a position at Kempsey station in 2003.

"He was well respected by his peers, colleagues and friends and, as one close colleague remarked today, 'He brought light' to the workplace," Mr Rochford wrote.

"This [is a] very distressing time for those who knew Paul. I know that as health professionals, paramedics deal with tragedy as part of their duties on a daily basis, and each individual develops their own way of dealing with these situations."

Lifeline: 131 114

Close

Also in National:
Girls interrupted: same-sex couple banned from ball

Suicide letter blames ambulance service

18:56 AEST Mon Jul 19 2010
By Andrew Drummond

Knowing he was to be sacked from his dream job, NSW Ambulance officer Trent Speering mailed out numerous "vindictive and hateful" letters before killing his elderly mother and turning the gun on himself.

The 40-year-old shot Monica Mary Speering, 72, twice in the head as she prepared vegetables for dinner at the sink of her Baulkham Hills home on June 11, 2008.

After covering his beloved mother's body with a blanket and resting her head on a pillow, he shot himself in her bedroom, an inquest into the deaths was told on Monday.

Police discovered the bodies at the home in Sydney's northwest the following day.

Counsel assisting the inquest, John Agius SC, said that according to his letters - only some of which were posted - Mr Speering blamed his actions on numerous people.

It included those at his workplace, where he claimed to have been victimised, partly because of his red hair.

In a letter to Sydney's Daily Telegraph newspaper, opened on June 12, 2008, Mr Speering detailed two reasons for his actions.

"One is that there is a lot of bigotry towards people with red hair in this worthless place and I have copped my share over a lifetime," he wrote.

"Secondly, I happen to work for the ambulance service of NSW and you would be hard-pressed to find an organisation full of more moral bankrupts and degenerates if you tried...

"The ambulance service is run by a bunch of vermin that pride themselves on their corruption."

The letter went on to detail Mr Speering's intention to kill his mother.

"I don't want to leave her behind as there would be no one to look after her as she got older," it said.

Newspaper staff alerted police but by the time officers arrived at the house, it was too late.

Mr Agius said that when considering the contents of Mr Speering's correspondence it should be remembered that he had "serious psychological problems and it would not be fair to take as gospel anything that he said".

The inquest heard that Mr Speering - a licence holder of two beretta pistols - had worked as an ambulance officer since August 1996, but that his employment was plagued by a string of complaints by him and against him.

During these industrial matters - in 2003 and 2004 - two medical experts contracted by the Ambulance Service recommended that Mr Speering undergo psychological assessment.

However, Mr Agius said these written recommendations did not reach the service and were not acted on.

At the time of the shootings, he had been suspended from duty for some 10 months and on the day itself had been called into a meeting with service CEO Greg Rochford to be sacked.

Mr Rochford also received a letter from Mr Speering.

"My intention was not to kill you but to maim you... by shooting you in the balls and then giving you a good kicking," it said.

Mr Agius said the inquest would look at five main areas including the police investigation of the deaths and the Ambulance Service's management of Mr Speering.

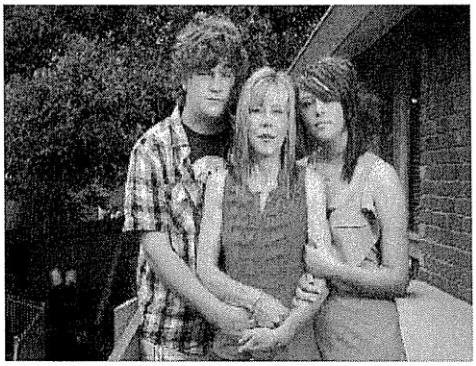
The inquest before State Coroner Mary Jerram continues.

* Readers seeking support and information about suicide prevention can contact Lifeline on 13 11 14 or SANE Helpline on 1800 18 SANE (7263).

Herald Sun

Paramedic's family lodges County Court claim

- Sue Hewitt
- From: Sunday Herald Sun
- August 01, 2010 12:00AM



Lisa Niit with her teenage children Thomas and Amy. Picture: Tim Carrafa
Source: Herald Sun

THE wife of a paramedic who took his own life believes the pressures of the job he loved killed him and that other ambulance officers have committed suicide because of stress.

Stephen Niit was a dedicated MICA paramedic who worked in confronting situations which took their toll on him, according to his wife, Lisa.

Mr Niit had been depressed for about five years and by the time he killed himself in an Echuca police cell had stopped work as an operational paramedic.

Mrs Niit has launched a County Court action seeking workers' compensation because she believes his work contributed to his depression and death.

"This is not an attack on Ambulance Victoria, but I am aware that other ambulance officers have suffered and even taken their lives as a result of the stresses of their work," she said.

The father of two was in Echuca and was voluntarily placed into police custody because he was drunk and distressed three days before Christmas last year.

He was travelling to Canberra with his 19-year-old daughter to see his unwell father.

Mr Niit, 46, of Doncaster East, told police he was depressed and had drunk a lot of alcohol.

Police checked with his doctors, who police said did not indicate he was a suicide risk.

The police let him take his dog into the cells to give him some comfort but he was dead in less than 20 minutes.

His family have called for an investigation into the circumstances of his death and why there were hanging points in the cells.

Mrs Niit described her late husband as "a gentle, loving, giving and generous man".

"Stephen dedicated his working life to giving to people and he enjoyed serving the community." she said.

"He trained as a nurse and we met while training together, then he later trained as a paramedic.

"He was a mild mannered and easy going man who enjoyed the simple things in life, and loved the outdoors and camping.

"He was a committed family man and took great pride and enjoyment in his two children."

The family's lawyer, Andrew Dimsey, of Maurice Blackburn, said it was a great tragedy, but the family did not blame Ambulance Victoria.

"Stephen, like so many ambulance officers, was committed to helping others in need," Mr Dimsey said.

"The tragedy is that he was a man who loved his work and yet became a victim of his work.

"He had wrestled with depression for at least five years and sought treatment and support within Ambulance Victoria.

"He had stopped work as an operational paramedic because of his depression and anxiety."

Mr Dimsey said the legal action was a WorkCover claim and not a negligence claim.

"We simply say that Stephen's illness and tragic death was work-related, in that the stresses of his work as a paramedic caused his depression and subsequent death," he said.

He was confident the claim would be successful.

He said the Niit family felt strongly that the circumstances of the tragic death at the Echuca Police Station had to be investigated by a coronial inquiry.

"Stephen was taken into custody in a confused state and warning lights should have been flashing," Mr Dimsey said. "He should have been safe in police custody."

He said it was ironic the police officers would have been affected by events similar to the traumatic circumstances Mr Niit experienced in his work as a paramedic.

Herald Sun

Ambulance delays threat to lives

- Peter Rolfe and Mitchell Toy
- From: Sunday Herald Sun
- September 25, 2010 10:14PM

DESPERATELY ill Victorians seeking urgent ambulance assistance are routinely facing a life-threatening waits for help, new documents reveal.

More than one in six Victorians calling for emergency aid are waiting longer than the State Government benchmark for acceptable service, the previously unseen Ambulance Victoria information shows.

A dossier of Code One (lights and sirens) ambulance response times for metropolitan Melbourne over a two-year period shows 87,514 cases where patients waited longer than the 15-minute threshold set by the Brumby Government.

Analysis of the documents, obtained through Freedom Of Information, reveals 321 cases of patients waiting more than an hour from April 2008 to April 30 this year - an average of more than 13 a month.

On January 29 last year, 12 ambulance call-outs took more than an hour each to reach their destinations on the same day, including a call at 4.20pm to Kew that took more than one hour and 50 minutes and a call to Reservoir three minutes later that took more than one hour and 40 minutes.

On a single day in October 2008, four ambulances dispatched within 20 minutes of each other to different part of Melbourne were delayed for more than an hour.

Other shock findings from the log include:

AN ambulance to Springvale on March 23 that took an hour and 40 minutes;

A WAIT of more than two hours for specialist help in Gladstone Park on August 24, 2008 when an ambulance called at 11.58am from a house did not arrive from nearby Essendon until 2.11pm;

A PATIENT stranded in Hastings on April 10 for an hour and 30 minutes; and

AN ambulance to McMahons Creek on April 10 that took an hour and 31 minutes.

Ambulance Victoria defended its performance in the Gladstone Park emergency, suggesting that the call had originally been logged as Code Two, but was upgraded once ambulance officers arrived.

The response times are based on arrival of the first ambulance only, not subsequent units with specialist equipment that may be required.

Release of the data comes days after a man with a severed finger had to pay a $300 taxi fare from Maryborough to Melbourne because no ambulance was available.

Ambulance Employees' Australia state secretary Steve McGhie said the trend continued with a 55-year-old Lalor woman suffering severe abdominal pain who was forced to wait more than two hours for a Code One ambulance last Sunday.

"I don't even think that waiting 15 minutes is acceptable," he said.

The big wait

Code one calls 512,067

Waits of more than 15 minutes 87,514

Waits of more than an hour..... 321

Waits of more than an hour last year..... 183

Waits of more than an hour Jan-April 2010... 30

Source: Ambulance Victoria

---

weeklytimes now
Powered by WEEKLY TIMES

Article from:

Ambulance crisis hits Victoria

Christopher Gillett | October 12, 2011

AMBULANCE shifts across Victoria cannot be filled - pushing the system to breaking point, industry figures say.

Paramedics' logs obtained from the union show that hundreds of shifts have no staff.

A veteran paramedic from the Macedon Ranges said shortages were widespread, causing longer delays for the public.

On October 3, she said, three of the four ambulance stations in the area had dropped shifts, resulting in no staff. The next closest station was Castlemaine, more than 35km away.

"The risk has become much, much higher, especially if it's a dire emergency," she said.

"Ambulances are not based in every town, they already have to cover large areas."

She said paramedics were at breaking point, working up to 17-hour shifts.

Ambulance Union state secretary Steve McGhie said lives were being compromised.

"Even with a full team it's hard for paramedics to keep up with the workload," he said.

"It can't keep going the way it is. It must improve, otherwise it is going to get much, much worse."

He said the dispatch system needed to be overhauled so the struggling system could cope.

Ambulance Victoria's annual report showed its target of reaching 85 per cent of code-one patients within 15 minutes was steadily declining.

In 2006-07, ambulance services reached 85.7 per cent of patients within 15 minutes, but that figure dropped to 80.7 per cent by 2009-10, and fell to 77.1 per cent in 2010-11.

Ambulance Victoria operations manager Simon Thomson said there were times when the number of paramedics who called in sick exceeded the organisation's back-up capacity.

"We constantly prioritise cases to ensure that the sickest patients get the ambulance soonest, so life-threatening patients will always get an ambulance quicker than those with less serious conditions," Mr Thomson said.

A spokesman for Health Minister David Davis blamed the problem on mismanagement by the previous Labor government.

He said the Government had invested $151 million for additional staff.

Follow weeklytimesnow.com.au on Twitter

Damning survey highlights ambulance bullying problem

Updated Mon Dec 3, 2012 7:08am AEDT

A survey of Ambulance Victoria employees has found widespread bullying and morale problems.

The Victorian Opposition says a survey of 880 ambulance employees found one in three had been bullied and two-thirds of respondents were considering leaving because of low morale.

Victoria Labor's Health Parliamentary Secretary Wade Noonan says Ambulance Victoria is in crisis.

"There needs to be an acknowledgment that these sorts of results cannot continue," he said.

"The Government has to come out strongly and say that they are prepared to tackle the problems of workplace stress and bullying among our paramedics and Ambulance Victoria staff.

"Unless they actually acknowledge the problems, there's little chance we'll see any change."

Ambulance Victoria chief executive Greg Sasella says many respondents have interpreted things like rostering and procedural changes as bullying.

"New systems of rostering and dispatching and so forth, some people interpret that as bullying," he said.

"Delays at hospitals are very frustrating for people. We try and manage that tightly and they're interpreting that as bullying.

"Our attrition rate, people leaving the service, is less than 3 per cent."

The union representing Victorian ambulance workers says it disagrees with management's explanation.

Steve McGhie from the Ambulance Employee's Association says he was not surprised by the survey's findings.

"These issues have been brewing within the ambulance service for some time now and paramedics regularly inform the union of their concerns, the low morale, their consideration at leaving the job," he said.

"We've been signalling this to Ambulance Victoria and the State Government for quite some time now and unfortunately it hasn't been addressed."

Topics: bullying, doctors-and-medical-professionals, vic, australia

First posted Sun Dec 2, 2012 11:19am AEDT

15